Agenda Supplement – Health, Social Care and Sport Committee

Meeting Venue:

Committee Room 2 – Senedd

Meeting date: 11 January 2018

Meeting time: 09.30

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Public Health (Minimum Price for Alcohol) (Wales) Bill: Consultation Responses

Please note the documents below are in addition to those published in the main Agenda and Reports pack for this Meeting

8 Public Health (Minimum Price for Alcohol) (Wales) Bill: Consultation Responses

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Attached Documents:

MPA 01 Rob Bailey

MPA 02 Public Health Wales

MPA 03 BMA Cymru Wales

MPA 04 Welsh NHS Confederation

MPA 05 Directors of Public Protection Wales, The Wales Heads of Trading Standards and the Welsh Local Government Association

MPA 06 Royal College of Psychiatrists

MPA 07 Sheffield Alcohol Research Group

MPA 08 Royal College of Physicians

MPA 09 Professor Jon Nelson

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MPA 01

Bil Iechyd y Cyhoedd (Isafbris am Alcohol) (Cymru)

Public Health (Minimum Price for Alcohol) (Wales) Bill

Ymateb gan Rob Bailey

Response from Rob Bailey

Dear Sir/Madam

Please direct this to the appropriate place.

I have a few concerns with some draft legislation that is coming out, as your constitute I was hoping you could raise them on my behalf.

I am writing to your with regard to the Welsh Governments latest plan to bring in minimum pricing for alcohol, which I believe to be a poorly designed plan. Whilst I appreciate that this legislation has the very noble aim of reducing alcohol related deaths it has a massive potential of backfiring and affecting people who enjoy a drink in moderation from poorer backgrounds. I've always felt that the Labour party has prided itself on looking after the working class but now it appears to be turning its back.

If you consider the perspective of someone taking home £1000 per month who spends roughly £500 on rent and bills therefore has £500 a month to live on leaving them with £115 a week to live on. Now if that person spends £20 a week on transport and £25 a week on food, £30 a week on social activities that person only has £40 a week left to save or buy miscellaneous items. If that person buys a crate of beer for £11 at Aldi out of their budget for social activities and consumes 14 units a week they would be spending £4.54 per week on beer with a 50p minimum pricing that would meant the beer now costs £7 per week. Which may not sound like much but when you look at how tight a budget for this person already is, you'd push them further into poverty or they'd have to give up what little luxuries they afford. On the other hand if someone who earns £60,000 buys 4 bottles of wine per week which they consume they'd have no impact whatsoever on their income.

Thus this becomes a regressive taxation on the poor, and what this draft legislation is essentially saying is that poor people drink too much and that drinking problems amongst the middle class are simply not an issue. I understand minimum pricing has worked in principle in other countries, but it is important to remember that we

are a very different country with very different social issues. Wales and the UK as a whole issues with binge drinking come from a deep cultural issue that can go back centuries. To solve the issue we need to look at ways to educate people about safe levels of alcohol consumption, invest more in rehabilitation and mental health I am not by any means against increasing taxes as a whole on alcohol if it is costing the NHS more money, but these taxes should be applied on all alcohol products, not just the products that only the working class can afford. Finally heroin addicts manage to buy a very expensive drug on a regular basis, an increase in crime in particular theft is highly likely if you impose this legislation on the people. I've always been a very loyal labour supporter but I fear this type of legislation will alienate the party from its working class roots.

Kind Regards

Rob Bailey

MPA 02
Bil Iechyd y Cyhoedd (Isafbris am Alcohol) (Cymru)
Public Health (Minimum Price for Alcohol) (Wales) Bill
Ymateb gan Iechyd Cyhoeddus Cymru
Response from Public Health Wales

Public Health Wales NHS Trust Response to the Health, Social Care and Sport Committee on the Public Health (Minimum Price for Alcohol) (Wales) Bill

Date: 10 November 2017	**Version:** 1

1 Introduction

Public Health Wales welcomes the opportunity to provide evidence on the Public Health (Minimum Price for Alcohol) (Wales) Bill.

Public Health Wales strongly supports implementation of the minimum unit price for alcohol in Wales. There is compelling evidence, which is outlined in more detail below, that introducing a minimum unit price in Wales would lead to significant improvements in health and well-being.

Our views on minimum unit pricing were previously articulated in some detail in our submissions to the consultations on the White Paper in 2014 and the Public Health (Wales) Bill in 2015. This paper has updated the original response to reflect current statistics and evidence to inform the areas for consideration outlines in the Terms of Reference for the scrutiny of the Bill by the Health, Social Care and Sport Committee.

As the areas for scrutiny identified for consideration by Health, Social Care and Sport Committee on the Public Health (Minimum Price for Alcohol) (Wales) Bill vary to some extent to those consulted on and responded to the White Paper in 2014. This paper presents the original considerations which have been updated where relevant.

Evidence published since previous responses further reinforces evidence cited in original submissions and provides a greater insight into the harm caused by alcohol to individuals, their families and the wider community. This includes;

- Public Health England (2016) The Public Health Burden of Alcohol and the Effectiveness and Cost-Effectiveness of Alcohol Control Policies - An Evidence Review.
- UK Chief Medical Officers' Low Risk Drinking Guidelines (2016)
- Alcohol Health Alliance, (2016). 'Cheap Alcohol, the Price We Pay'
- Alcohol's Harms to Others: the harms from other people's alcohol consumption in Wales (Quigg et al, 2016).
- Public Health Wales (2015) Adverse Childhood Experiences and their impact on health-harming behaviours in the Welsh adult population.
- Welsh Government, (2014) Model-based appraisal of minimum unit pricing for alcohol in Wales An adaptation of the Sheffield Alcohol Policy Model version 3.

2 Terms of Reference

2.1 The general principles of the Public Health (Minimum Price for Alcohol) (Wales) Bill and the extent to which it will contribute to improving and protecting the health and well-being of the population of Wales, by providing for a minimum price for the sale and supply of alcohol in Wales and making it an offence for alcohol to be sold or supplied below that

The following points were originally made in response to the 2014 Public Health White Paper. The response provided by Public Health Wales to the White Paper in June 2014 has been used as a framework to provide this response as many of the views remain unchanged. The statistics and evidence sources in the original submission have been updated and are provided below.

2.1.1 Public Health Wales strongly supports implementation of the minimum unit price for alcohol in Wales. There is compelling evidence, which is outlined in more detail below, that introducing a minimum unit price in Wales would lead to significant improvements in health and well-being. Recent decades have seen increases in alcohol consumption and health harms associated with alcohol across Wales. These increases are linked with real terms reductions in the cost of alcohol. A minimum unit price is a targeted measure that will impact beneficially on the heaviest drinkers and other groups particularly at risk from alcohol related harms – such as young people. Moderate drinkers will experience relatively little change in the amount they have to pay for alcohol.

2.1.2 Minimum Unit Price (MUP) sets a floor price for a unit of alcohol[1], meaning that alcohol could not legally be sold below that price. This would not increase the price of every drink, only those that are sold below the minimum price; for example very cheap spirits, beer and wine. MUP is based on two fundamental principles that are widely supported by scientific evidence:[2][3][4]

- When the price of alcohol increases consumption by most drinkers goes down including, critically, consumption by hazardous and harmful drinkers (i.e. heavier drinkers)

- When alcohol consumption in a population declines, rates of alcohol-related harms also decline.

2.1.3 Drinking alcohol increases the risk of developing over 60 different health problems[5,6] including a range of cancers, liver disease, high blood pressure, injuries and a variety of mental health conditions. It also increases the risk of causing harms to the health of others.

2.1.4 The UK CMO's guidance on low risk drinking was based on a comprehensive review of the evidence about the health harms associated with alcohol consumption. The review found that the risk of developing health problems increases with the amount of alcohol consumed on a regular basis. The UK Chief Medical Officers advise that to keep health risks from alcohol to a low level it is safest not to drink more than 14 units a week on a regular basis. [7]

2.1.5 The 2011 General Lifestyle Survey (GLS16)[8] showed that the percentage of persons that drank more than 3-4 units on at least one day in Wales (28 per cent) was similar to Scotland (31 per cent) and England (31 per cent). Those drinking more than 6-8 units on at least one day was the same in Wales (15 per cent) as in England (15 per cent) and similar to Scotland (16 per cent). Residents of England and Wales (13 per cent and 12 per cent respectively) were more likely than men in Scotland (7 per cent) to have had an alcoholic drink on at least five days in that week.

2.1.6 National Survey for Wales 2016-17[9] reported that twenty percent of adults (16+) reported drinking above the recommended weekly guidelines. 13 per cent of people aged 16 and over reported binge drinking (men drinking more than 8 units or women drinking more than 6 units on a single occasion). Men were more likely than women to report drinking above the recommended weekly guidelines (27 per cent of men compared with 14 per cent of women) and to report binge drinking (18 per cent of men, 13 per cent of women).

2.1.7 Importantly, social surveys consistently record lower levels of consumption than would be expected from data on alcohol sales, partly because people often underestimate how much alcohol they consume.

2.1.8 Sales data show that 10.8 Litres of pure alcohol was sold per adult (16+) drinker in England and Wales in 2016[10]. One unit is 10ml of pure alcohol so this equates to an estimated average consumption of 20.8 units per drinker per week. This is a much greater level than recorded in surveys and suggests that more people exceed weekly guidelines than surveys would suggest.

2.1.9 The past three decades have seen a steady increase in alcohol consumption and although the reasons behind this are complex and multi-factorial, affordability is a key factor. It has been reported that alcohol is 60% per cent

more affordable than in 1980[11] and the increase in affordability of alcohol has been linked with increased alcohol consumption and related health harms[12,13.]

2.1.10 A price review by the Alcohol Health Alliance UK[14], found that 3-litre bottles of 7.5% ABV cider (containing the equivalent of 22 units) for just £3.59 in 2017 (or 16p per unit).

2.1.11 A 2005 review by the World Health Organisation (WHO)[15] of 32 European alcohol strategies found that the most effective measures to curb alcohol related health harms include changes to price and availability.

2.1.12 By comparison other measures (public service campaigns, education initiatives, and voluntary self regulation preferred by the alcohol industry) have more limited impacts on drinking patterns and problems.[16]

2.1.13 This evidence has led several countries to consider MUP policy[17].

2.1.14 Sufficient modelling has been undertaken for Wales, in England and elsewhere to estimate the benefits that a 50 pence MUP would have on alcohol consumption and related health harms. However, this was based on levels of affordability of alcohol in 2014, and we consider that MUP should be linked to an inflationary measure to ensure it remains an effective measure to reduce alcohol health harms. Should the introduction of MUP be delayed the initial MUP should be adjusted from 50p to account for inflationary trends up to the point of its introduction.

2.1.15 Both US and UK data show that the heaviest drinkers gravitate towards the cheapest alcohol[18,19]. As a result MUP affects heavy drinkers' consumption much more than light or moderate drinkers. Consequently, MUP is a targeted measure which primarily impacts heavy drinkers.

2.1.16 In Wales, modelling[20] suggests that a 50 pence MUP would result in:

- a high risk drinker drinking 293 fewer units per year
- a moderate drinker drinking 6.4 fewer units per year
- an annual reduction in alcohol related deaths of 12.3 per cent and in alcohol related hospital admissions of 10.3 per cent.

2.1.17 The reductions are also substantially larger for high risk drinkers in poverty (e.g. a reduction of 487.3 units per year vs. 243.0 units per year for high risk drinkers not in poverty).

2.1.18 Concerns around the possibility of a hard-hitting impact on those with low incomes have been a critical consideration of MUP debate,[21,22] however, for the majority of people on low incomes who are abstainers, light or moderate drinkers, the financial impacts of MUP are very small.

2.1.19 The modelling report for Wales (2014) estimates that moderate drinkers[23] (62% of the population) consume on average 5.5 units per week, spending £310 per year on alcohol. High risk drinkers[24] (7% of the population) consume on average 78.1 units per week, spending £2,960 per annum. These patterns differ somewhat when examined by income group, with moderate drinkers in poverty estimated to drink 4.9 units per week, spending £200 per annum, whilst moderate drinkers above the defined poverty line consume 5.6 units per week and spend £340 per annum.

2.1.20 Based on a minimum unit price of 50p it is estimated that high risk drinkers will spend an extra £32 (1.1%) per year whilst moderate drinkers' spending increases by £2 (0.8%). It is important that this should is seen in the context of national costs from alcohol related harms (health, social, economic and criminal justice) being equivalent to around £900 in 2014 per family. These harm-related costs could be substantially reduced if a MUP was introduced.

2.1.21 Modelling suggests that an MUP of 50 pence per unit would result in a reduction of 53 deaths and 1,400 fewer hospital admissions per year in Wales, 10,000 fewer days sickness absence and would reduce criminal offences by 3,684, with a total value of an estimated saving of £882 million over the 20 year period modelled.[25]

2.1.22 The inclusion of impacts of MUP on crime is an important health and well-being consideration. Therefore, as well as harm to the individual who is drinking, alcohol consumption can also impact the wellbeing of wider society through reducing alcohol-related crime, including those relating to violent, anti-social and disorderly behaviour, acquisitive crime and criminal damage.

2.1.23 The Crime Survey for England and Wales reports that within the year 2014/15 there was 592,000 violent incidents where the victim believed the offender(s) to be under the influence of alcohol, accounting for 47 per cent of violent offences that year. Alcohol routinely accounts for over 40 per cent of all violent crimes committed[26]31 and, as well as youth violence, is strongly associated with domestic violence, child abuse and self-directed violence (e.g. suicide)[27]

2.1.24 In a recent survey over half those questioned (59.7% of adults aged 18 years and older) in Wales had experienced at least one harm from someone else's drinking in the last 12 months. Nationally, this is estimated to be equivalent to 1,460,151 people[28].

2.1.25 Young people are particularly vulnerable to the harmful effects of consuming alcohol[29] and harm from other people's drinking. Results from the first Welsh Adverse Childhood Experience (ACE) study in 2015[30,31] demonstrate the long term impact of parental alcohol misuse and other alcohol related negative experiences such as abuse, domestic violence and having a family member in prison. The study found that experiencing four or more traumatic experiences in childhood increases the chances of committing violence against another person in adulthood by 15 times. A vicious cycle of harm is also created as

children that have four or more adverse childhood experiences are four times more likely to grow up to be a high risk drinker themselves.

2.1.26 A MUP of 50 pence would not impact the cost of alcohol in licensed settings (e.g. pubs) but would increase the cost of the cheapest alcohol sold in off-licences settings (e.g. supermarkets). This is an important affect as the difference in costs between the two settings is driving health harming behaviours such as pre-loading with alcohol especially in young people, before going out for a night[32].

2.1.27 MUP in Canada has proved a successful measure for reducing alcohol-related harms; including reducing alcohol-related deaths.[33]

2.1.28 In British Columbia with a population of 4.6million, a 10 per cent increase in the average minimum price of all alcoholic beverages was associated with a 9 per cent decrease in acute alcohol-attributable admissions and a 9 per cent reduction in chronic alcohol-attributable admissions two years later[34]. It was estimated from this that a 10 cent (approximately 6 pence) increase in average minimum price was associated with 2 per cent (166) fewer acute admissions in the first year and 3 per cent (275) fewer chronic admissions two years later. Canada is one of six countries that have introduced some form of MUP and in every case the observed impacts on reducing consumption (and consequently preventing related harms) have been larger than those estimated.

2.1.29 The estimated costs to the health service in Wales of alcohol-related harm are between £70 and £85 million each year.[35] These costs have increased since the 1970s, as alcohol has become more affordable and alcohol-related deaths and disease have risen. Therefore, Wales appears to be price sensitive to alcohol with harms increasing as alcohol becomes more affordable.

2.1.30 Using the ONS definition, in 2016 there were 504 alcohol related deaths registered in Wales, an increase of 8.9 per cent on the previous year. 336 of these were men (66.7 per cent, up from 61.8 per cent of deaths in 2015) and 168 were women (33.3 per cent, down from 38.2 per cent in 2015).[36]

2.1.31 10,081 individuals were admitted to hospital in Wales with a condition caused solely by alcohol (e.g. alcoholic liver disease or alcohol poisoning) in the year 2016-17, accounting for 13,512 admissions. The number of individuals admitted for alcohol specific conditions has continued to fall in 2016-17 for both men and women, however, this decrease was only marginal, 0.1 per cent, from 2015-16 and 1.4 per cent since 2012-13.[33]

2.1.32 When considering alcohol specific conditions plus alcohol related conditions (those that are caused by alcohol in some, but not in all cases; e.g. stomach cancer and unintentional injury) 35,521 people were admitted to hospital in Wales in 2016/17. This is a slight increase on the previous year and there has been and increase over the last five years of 6.7 per cent for males and 6.9 per cent for females.[37]

2.1.33 Many of the health harms associated with alcohol fall disproportionately on the most deprived communities, with levels of alcohol related deaths across Wales increasing from the most affluent to the most deprived quintile.[34] Tackling alcohol related ill health, therefore, is an important element in reducing inequalities in health.

2.1.34 Based on evidence from Canada and elsewhere, MUP would help substantially in reversing these health harming trends relating to alcohol consumption in Wales.

- that public health benefits should justify the measures implemented and that the same outcome would not be achievable by a less intrusive measure.

- Public Health Wales believes that there is a strong case across Wales that MUP is a measure proportionate to expected reductions in health harms and numbers of lives saved.

2.2 Whether there are any unintended consequences arising from the Bill;

There are some consequences arising from the Bill that should be considered, but should not prevent the Bill being passed by the Assembly.

2.2.1 Public Health Wales is not in a position to provide specialist advice on enforcement; however we are aware that Local Authority enforcement is currently stretched. Effective implementation of the provisions is dependent on good and robust enforcement systems, it will be essential therefore that sufficient resources are available to enforce the legislation and that enforcement of this legislation does not negatively impact on other public health related activity within local authorities.

2.2.2 It will be important to ensure that resources are available to provide adequate, appropriate and timely support for the small percentage of dependant drinkers who will need help to reduce their drinking.

2.3 The financial implications of the Bill (as set out in Part 2 of the Explanatory Memorandum);

2.3.1 There are no additional costs that we are aware of that have not been considered within the financial implications of the Bill set out in Part 2 of the Explanatory Memorandum.

2.3.2 It is welcomed that the financial implications include £350,000 for the evaluation of the Bill to ensure that it leads to the necessary outcome that it aims to achieve.

2.4 The appropriateness of the powers in the Bill for Welsh Ministers to make subordinate legislation (as set out in Chapter 5 of Part 1 of the Explanatory Memorandum).

2.4.1 We support the powers for Welsh Ministers to make subordinate legislation to specify the MUP. Based on the evidence provided in the original submission, Public Health Wales regarded a level of 50 pence per unit MUP as an appropriate level at which to initially establish a MUP in 2014. Sufficient modelling had already been undertaken for Wales, in England and elsewhere to estimate the benefits that a 50 pence MUP would have on alcohol consumption and related health harms. This was, however, based on the prices of alcohol in 2014 and we consider that MUP should be linked to an inflationary measure to ensure it remains an effective measure to reduce alcohol health harms. Consequently, the introduction of MUP should be adjusted upwards from 50p (in 2014) to account for inflationary trends since that date both at its date of introduction and then routinely at least on a three year basis.

2.4.2 Public Health Wales recommends a range of other evidence based measures should be considered in order to reduce the harms caused by alcohol to Welsh citizens. None of these require MUP so are not dependent on MUP being in place but would work in synergy to reduce alcohol harms to health. Not all of these measures can be unilaterally implemented in Wales as

devolved powers do not allow their introduction. However, we believe Wales can still act as a powerful advocate for creating a culture where people are better informed about the harms associated with alcohol consumption and the real costs of alcohol are reflected in the price at which it is sold. Further work is required to identify the best way of delivering these through action and advocacy within existing devolved powers. While provision of evidence to support all the actions suggested below would be inappropriate in this consultation we believe there is sufficient evidence already available to support[xxxviii]:

- Public health and community safety should be given priority in all public policy-making about alcohol.
- At least one third of every alcohol product label is an evidence based health warning from an independent regulatory body.
- Sales in shops should be restricted to specific times of the day and designated areas with no promotion outside these areas.
- Tax on alcohol products should be proportionate to volume of alcohol to incentivise sales of lower strength products.
- Licensing authorities should be empowered to tackle alcohol-related harm by controlling total availability in their area.
- Alcohol advertising should be strictly limited to newspapers and other adult press while its content should be limited to factual information.
- There should be an independent body to regulate alcohol promotion, including product and packaging design for public health and community safety.
- The legal limit for blood alcohol concentration for drivers should be reduced to 50mg/100ml.
- Graduated driver licensing should be introduced, restricting the circumstances in which young and novice drivers can drive.
- All health and social care professionals should be trained to provide early identification and brief alcohol advice.
- People who need support for alcohol problems should be routinely referred to specialist alcohol services for assessment and treatment.
- Existing laws to prohibit the sale of alcohol to individuals who are already heavily intoxicated should be enforced in order to reduce acute and long term harms to their health and that of the individuals around them.

1 25ml spirit (40%) is one unit, 175ml of wine (13%) 2.3 units, a pint of cider (4.5%) 2.6 units, a pint of beer (4%) 2.3 units

2 Stockwell and Thomas, (2013). Is alcohol too cheap in the UK? The case for setting a Minimum Unit Price for alcohol.. Institute of Alcohol Studies Report

3 Wagenaar AC, Salois MJ, and Komro KA (2009) Effects of beverage alcohol price and tax levels on drinking: a meta-analysis of 1003 estimates from 112 studies. Addiction, 104, 179-90

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5 World Health Organisation (2009) Harmful Use of Alcohol [online] Available at: http://www.who.int/nmh/publications/fact_sheet_alcohol_en.pdf

6 Public Health England (2016) The Public Health Burden of Alcohol and the Effectiveness and Cost-Effectiveness of Alcohol Control Policies - An Evidence Review. [online] Available at: https://www.gov.uk/government/publications/the-public-health-burden-of-alcohol-evidence-review

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14 Alcohol Health Alliance, (2016). 'Cheap Alcohol, the Price We Pay'. [online] Available at: http://12coez15v41j2cf7acjzaodh.wpengine.netdna-cdn.com/wp-content/uploads/2016/11/AHA-price-survey_FINAL.pdf

15 WHO fact sheet. 2005. www.parpa.pl/download/fs1005e2.pdf.

16 Public Health England (2016) The Public Health Burden of Alcohol and the Effectiveness and Cost-Effectiveness of Alcohol Control Policies - An Evidence Review.

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[23] Women drinking less than 14 units a week and men drinking less than 21 units a week.

[24] Women drinking more than 35 units a week and men drinking more than 50 units a week

[25] Welsh Government, (2014) Model-based appraisal of minimum unit pricing for alcohol in Wales

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MPA 03

Bil Iechyd y Cyhoedd (Isafbris am Alcohol) (Cymru)

Public Health (Minimum Price for Alcohol) (Wales) Bill

Ymateb gan BMA Cymru Wales

Response from BMA Cymru Wales

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PUBLIC HEALTH (MINIMUM PRICE FOR ALCOHOL) (WALES) BILL – GENERAL PRINCIPLES

Consultation by the National Assembly for Wales Health, Social Care and Sport Committee

Response from BMA Cymru Wales

13 November 2017

INTRODUCTION

BMA Cymru Wales is pleased to provide a response to the Stage 1 consultation by the Health, Social Care and Sport Committee into the general principles of the Public Health (Minimum Price for Alcohol) (Wales) Bill.

The British Medical Association (BMA) is an independent professional association and trade union representing doctors and medical students from all branches of medicine all over the UK and supporting them to deliver the highest standards of patient care. We have a membership of approximately 160,000. BMA Cymru Wales represents over 7,100 members in Wales from every branch of the medical profession.

RESPONSE

BMA Cymru Wales very much welcomes the publication of the Public Health (Minimum Price for Alcohol) (Wales) Bill and fully supports the intended purpose of this legislation. Indeed, we would congratulate the Welsh Government for bringing this legislation forward. BMA policy, agreed at UK level, is fully in support of the introduction of a minimum unit price (MUP) for alcohol. Since 2009, motions in support of such a measure have been passed at the association's annual representative meeting on a number of occasions, thereby demonstrating broad support for this public policy intervention amongst our

membership. A call for a minimum price of no less that 50p per unit was also contained within the manifesto we produced ahead of the 2016 National Assembly elections.[1]

In responding to this consultation, however, it should be noted that the comments we are submitting primarily concern the general principles of the Bill. As an organisation representing doctors we do not feel we are best placed to respond to the specific detail of certain other aspects of the Bill, such as the measures that will be employed to put into effect the enforcement of the minimum price. We do, however, have a clear position in support of the proposed intent based on our analysis of available evidence which we outline in the next section of this response.

The case for introducing a minimum price for alcohol

Alcohol is a normal part of life for many in the UK. It is readily available, increasingly affordable and heavily marketed as an established part of modern society. Despite this, the significant harms caused by alcohol are widely recognised and well known.[2] Doctors witness first hand this harmful impact on their patients. Faced with an increasingly unmanageable and unsustainable workload, and rising demand for healthcare services, tackling the underlying causes of alcohol-related harm should be a key public health focus across the UK.[3,4,5,6] BMA Cymru Wales believes there is now a well-established evidence base to support a range of different alcohol-related interventions, including the introduction of a minimum price as proposed by this Bill.

The scale of the problem

Drinking alcohol is an established weekly activity for the majority of adults in the UK. Fifty-eight per cent of the population report drinking alcohol in the previous week, and despite a decline in number of people drinking weekly, overall consumption remains at a historically high level.[7] In 2014, over 10 million adults were regularly drinking more than 14 units of alcohol each week (which is above the recommended weekly intake for men and women).[7] In England, 18% of men and 13% of women drink at increased levels of harm,[8] with similar proportions in Scotland, Wales and Northern Ireland.[9,10,11] The UK's relationship with alcohol is normalised from an early age – 17% of males in Wales aged 11-16, and 14% of females, reported drinking alcohol at least once a week in 2009-10.[12] In England, one in 10 school pupils report drinking alcohol in the last week, and two fifths say they have drunk alcohol at some point.[7,13] Despite some progress to reduce the number of school pupils drinking,[10,14,15] a significant number still drink alcohol from an early age.

Alcohol causes significant harm. It is causally linked to over 60 different medical conditions including liver damage, brain damage, poisoning, stroke, abdominal disorders and certain cancers.[16] Partially attributable alcohol-related cancer, liver disease and kidney problems are the cause of a rising number of alcohol-related hospital admissions.[13] Cardiovascular disease has risen particularly rapidly, more than doubling to reach over 1.5 million related admissions every year.[17] While liver disease is responsible for 86% of directly attributable mortality from alcohol in the UK.[18]

Deaths and hospital admissions

Alcohol causes thousands of deaths every year in the UK. In 2015 there were 8,758 alcohol related deaths in the UK.[19] The rate of alcohol-related mortality for men in 2015 (19.2 per 100,000) was more than double the rate for women (9.7 per 100,000). The combined rate for men and women was found to be higher in Wales (19.3 per 100,000) than it was in England (17.8 per 100,000).[19]

Alcohol is also a leading factor in over a million hospital admissions every year. In Wales there were 15,114 alcohol related hospital stays related to alcohol consumption in 2014-15,[20] with 35,059 in Scotland[21] and 26,236 in Northern Ireland.[22] In England, there were an estimated 1,085,830 admissions in 2014-15, increasing for the tenth consecutive year.[13] Almost half (47%) of all hospital admissions occur in the lowest socioeconomic groups.[8] Mental and behavioural disorders due to alcohol use, account for over 200,000 (19%) alcohol-related hospital admissions every year across the UK.[8]

Other alcohol-related harms

Domestic violence is routinely linked to drinking. Alcohol is particularly associated with incidents of physical and severe domestic violence, as well as incidents of sexual assault. The most recent annual data show that in 53% of violent incidents in 2013-14, victims perceived the offender to be under the influence of alcohol.[23] Children are especially vulnerable to alcohol-related harm in the home. Drinking is a contributory factor in family and relationship breakdown. Over 2.5 million children in the UK are living in a home where their parents are drinking hazardously.[24] Nearly four thousand children in the UK contact *ChildLine* every year worried about their parents' drinking or drug use.[25]

Alcohol is also a significant factor in violence outside of the home. Drinking is particularly prevalent in violent incidents involving strangers – 64% across the UK were perceived to be alcohol related, as well as 70% of violent incidents which took place in a public space. This compares to 40% of incidents that occurred in the home, and 43% of incidents that happened in and around the workplace.[23]

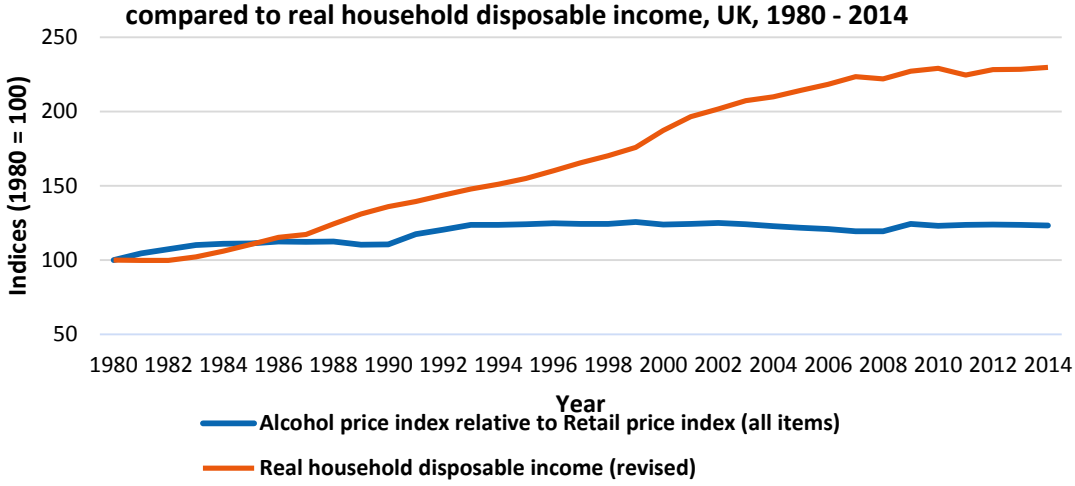
Costs of alcohol-related harm

The cost of alcohol-related harm in the UK is substantial. Various estimates have considered the total social and economic cost – for example, to cost £21 billion a year in England and Wales;[26] £7.2 billion a year in Scotland;[27] and £680 million a year in Northern Ireland.[28] Within these total costs, the costs to specific services are equally significant. For instance, the cost of lost productivity across the UK was estimated as being £7.3 billion a year in 2009–10.[29] The cost of alcohol increases further when, as well as the societal cost, the costs to the individual from alcohol misuse are included. This is wide ranging and may include tobacco and illicit drug use; accidents and injuries; malnutrition and eating disorders; unemployment; self-harm and suicide.[30] Alcohol and homelessness also have a complex relationship – dependence can lead to homelessness while for others alcohol problems may develop as a result of being homeless.[31]

Affordability of alcohol

There is very good evidence that the affordability of alcohol drives consumption and harm.[32,33,34] In the UK, the affordability of alcohol increased between the 1980s and 2014 (see Figure 1 below), with household disposable income rising significantly faster than the cost of alcohol over this period.[35] The BMA has consistently called for a dual strategy to address this rising affordability; increasing taxation on alcohol above inflation and introducing an MUP for alcohol to target the cheapest, highest strength alcohol.

Figure 1 - Alcohol price index relative to Retail Price Index (all items) compared to real household disposable income, UK, 1980 - 2014



Effect of price on consumption and alcohol-related harm

There is strong and consistent evidence that increases in the price of alcohol are associated with reduced consumption at a population level.[36,37,38,39,40,41,42,43,44] Access to cheap alcohol has been found to correlate with more regular and increased total alcohol consumption.[45] There is evidence that young people, binge drinkers and harmful drinkers prefer cheaper drinks,[34,38] and that heavy drinkers and young drinkers are known to be especially responsive to price.[36,37,46,47,48,49]

Increasing the price of alcohol has also been found to reduce the rates of alcohol-related harms, including violence and crime, deaths from liver cirrhosis, other drug use, sexually transmitted infections and risky sexual behaviour, and drink driving deaths.[34,36,37,44,50,51,52,53,54,55,56,57]

Rationale for MUP

MUP is a targeted measure designed to tackle the cheapest, high strength drinks on the market. As we have touched upon, these are increasingly popular among lower income, high dependence drinkers, and their sale undermines the effectiveness of tax-based approaches.[58,59] The more units a drink contains, the stronger it is and therefore the more expensive it will be with an MUP.

While a ban on below-cost sales of alcohol (for less than the cost of excise duty plus VAT) was introduced in England and Wales in 2014, this has had minimal impact on consumption – this approach only affects the price of a very small proportion of the alcohol sold in the UK and the prices that are affected are only affected to a small degree.[60] We therefore believe that the implementation of an MUP will be a more effective approach.

In addition to the limited empirical evidence of the effectiveness of minimum pricing in British Colombia in Canada,[61] UK-specific modelling supports this policy approach.[62,63,64,65] A modelling comparison shows only 1% of units drunk by harmful drinkers are affected by a ban on below-cost sales, compared to 43.6% of units that would be affected under a 50p minimum pricing policy. This results in a reduction of over 5% (or 200 units per year per person) with MUP, compared to just 0.1% (or three units) under a ban on below-cost sales. Evidence from Newcastle also supports this, showing that 26.2% of price discounts result in alcohol being sold at or below a 50p MUP, compared to only 1.4% of alcohol sold at below-cost price.[66]

It is projected that a 50p MUP would lead to over 2,000 fewer deaths and nearly 40,000 fewer hospital admissions in the first 20 years of its introduction.[63] The National Institute for Health and Care Excellence

(NICE) has also concluded that minimum pricing would encourage producers to reduce the strength of their products and the cost saving of alcohol-related problems would be £9.7 billion.[67]

Critics of MUP cite evidence that it would disproportionately affect consumption among low income groups, with smaller reductions in high income groups, while not dealing with the issue of harmful drinking.[68] However, modelling shows that MUP would specifically target harmful drinkers, thus reducing health inequalities.[63,64,65] This is supported by data that show the impact of minimum pricing falls almost entirely on the heaviest drinkers, irrespective of income.[69]

Impacts of MUP

The following tables which highlight what the impact would be of introducing an MUP in Wales are based on version 3 of the Sheffield Alcohol Research Group model of MUP[64] which was previously commissioned by the Welsh Government.

	Proportions sold below thresholds (2014 prices)		
	40p	**45p**	**50p**
Off-trade beer	40.8%	55.2%	72.1%
Off-trade cider	59.7%	70.3%	78.2%
Off-trade wine	12.2%	24.9%	41.5%
Off-trade spirits	9.3%	47.0%	65.5%
Off-trade RTDs (ready to drink)	0.0%	0.0%	0.0%
On-trade beer	1.4%	1.9%	2.4%
On-trade cider	0.0%	0.0%	3.4%
On-trade wine	0.1%	0.1%	0.1%
On-trade spirits	1.4%	2.7%	4.5%
On-trade RTDs	0.0%	0.0%	0.0%

Table 1 – Impact of MUP on different products

	Population	**Male**	**Female**	**Moderate**	**Increasing risk**	**High risk**
Population ('000)	2490	1193	1297	1955	392	143
Change in consumption per drinker of 50p MUP	-4.0%	-4.5%	-2.8%	-2.2%	-2.0%	-7.2%
Change in consumption per drinker of 50p MUP (units per year)	-30.2	-45.7	-14.7	-6.4	-28.8	-239.2

Table 2 - the relative and absolute changes in consumption from a 50p MUP

	Population	Male	Female	Moderate	Increasing risk	High-risk
Population ('000)	2092	1045	1048	1557	392	143
Change in spending per drinker of 50p MUP	1.6%	0.6%	3.7%	0.8%	2.8%	1.1%
Change in spending per drinker of 50p MUP (units per year)	10.14	5.69	14.58	2.37	32.88	32.35

Table 3 – summary of relative and absolute estimates effects of 50p MUP on consumer spending

	Change in duty & VAT to government			Change in revenue to retailers (excluding duty & VAT)		
	Off-trade	**On-trade**	**Total**	**Off-trade**	**On-trade**	**Total**
Baseline receipts (£m)	248.0	268.2	553	203.9	606.6	810.6
Relative change	-2.0%	0.0%	-1.0%	12.2%	0.3%	3.3%
Absolute change	-5.7	0.0	-5.8	25.0	2.0	27.0

Table 4 - summary of estimated effects of pricing policies on retailers and government

	Deaths reduction in 20th year					Hospital admission reduction in 20th year					QALYs gained in 20th year
	100% attributable	**Partially attributable chronic**	**Partially attributable injury**	**Heart disease, stroke, diabetes**	**total**	**100% attributable**	**Partially attributable chronic**	**Partially attributable injury**	**Heart disease, stroke, diabetes**	**total**	
Alcohol attributable harm	404	743	194	-556	785	15378	21985	5151	-5074	37350	6381
Relative change of 50p MUP	-5.9%	-3.0%	-4.4%	-0.2%	-6.8%	-4.6%	-2.5%	-3.8%	-0.5%	-3.8%	7.2%
Absolute change of 50p MUP	-24	-23	-9	1	-53	-704	-545	-196	23	-1422	458

Table 5 - summary of estimated impact on health outcomes – changes in alcohol-related deaths, hospital admissions and QALYs (quality-adjusted life year) per year at full effect (in 20th year)

Table 1 shows the proportion of alcohol within each category sold below several MUP thresholds. This provides an approximation of the overall proportion of alcohol within each category that would be

affected by differing levels of MUP. It is clear that on-trade prices would be largely unaffected – as prices in the on-trade already exceed the level of an MUP – while the policy would specifically target the off-trade, where products are currently sold below the thresholds an MUP would introduce.

Table 2 clearly shows that a 50p MUP would specifically target high-risk drinkers, of which men more commonly make up this group.

Table 3 again shows that an MUP would target increasing risk, and high-risk drinkers. The impact would be greater in increasing risk drinkers as they typically have more disposable income.

Table 4 shows that MUP specifically targets the off-trade and the on-trade would remain unaffected, as these products already generally meet the threshold.

Table 5 shows that a 50p MUP would reduce the number of deaths and hospital admissions, across all categories, in its 20th year of implementation. It would therefore dramatically increase QALYs (quality-adjusted life years). The modelling also shows the specific breakdown for different categories such as liver disease.

BMA Cymru Wales fully supports the main conclusions drawn from this study, namely:

1. MUP policies would be effective in reducing alcohol consumption, alcohol related harms (including alcohol-related deaths, hospitalisations, crimes and workplace absences) and the costs associated with those harms.
2. A ban on below-cost selling (implemented as a ban on selling alcohol for below the cost of duty plus the VAT payable on that duty) would have a negligible impact on alcohol consumption or related harms.
3. MUP policies would only have a small impact on moderate drinkers. Somewhat larger impacts would be experienced by increasing risk drinkers, with the most substantial effects being experienced by high risk drinkers.
4. MUP policies would have a larger impact on those in poverty, particularly high risk drinkers, than those not in poverty. However; those in poverty also experience larger relative gains in health and the high risk drinkers are estimated to marginally reduce their spending due to their reduced drinking under many policies.

The provisions in the Bill as published

As we have previously indicated, BMA Cymru Wales does not seek to offer detailed commentary on the specific provisions contained within the Bill as published as we do not feel best qualified to do so.

Having studied the Bill as it has been introduced, we are however of the opinion that the measures proposed would appear to be both reasonable and proportionate. We particularly note that the manner for calculating the minimum price for alcoholic drinks to comply with the Bill's provisions has been presented in a clear and straightforward manner.

We also support the proposals for the value of the MUP to be determined in regulations rather than being defined within the Bill itself, as this will give scope for the MUP to be periodically reviewed to ensure it remains set at an appropriate level, and can be suitably revised to take account of future price and wage inflation. This can therefore ensure that its impact on alcohol affordability, and hence the intent of the Bill to reduce alcohol-related harm, can be maintained into the future,

We support the Bill as it stands, and do not have any specific suggestions for ways in which it could be amended before being adopted. We would strongly urge Assembly Members to support it.

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MPA 04

Bil Iechyd y Cyhoedd (Isafbris am Alcohol) (Cymru)

Public Health (Minimum Price for Alcohol) (Wales) Bill

Ymateb gan Conffederasiwn GIG Cymru

Response from The Welsh NHS Confederation

	The Welsh NHS Confederation response to the Health, Social Care and Sport Committee consultation on the Public Health (Minimum Price for Alcohol) (Wales) Bill.
Contact	Nesta Lloyd – Jones, Policy and Public Affairs Manager, the Welsh NHS Confederation. [redacted] Tel: [redacted].
Date:	10 November 2017.

Introduction

1. The Welsh NHS Confederation welcomes the opportunity to respond to the Health, Social Care and Sport Committee consultation on the Public Health (Minimum Price for Alcohol) (Wales) Bill.

2. The Welsh NHS Confederation represents the seven Health Boards and three NHS Trusts in Wales. The Welsh NHS Confederation supports our members to improve health and well-being by working with them to deliver high standards of care for patients and best value for taxpayers' money. We act as a driving force for positive change through strong representation and our policy, influencing and engagement work.

3. We support the introduction of Minimum Unit Pricing (MUP) to reduce the substantial harm associated with excess alcohol consumption in Wales. There is overwhelming scientific evidence that excessive consumption of alcohol significantly increases risk to long-term health. Alcohol is a factor in a wide range of serious medical conditions, including liver disease and cancer, and leads to thousands of hospital admissions every year. We agree that one of the best, and proportionate, way to reduce ill-health and other related social costs of excessive alcohol consumption in Wales is to control the price of alcohol.

Terms of Reference

The general principles of the Public Health (Minimum Price for Alcohol) (Wales) Bill and the extent to which it will contribute to improving and protecting the health and well-being of the population of Wales, by providing for a minimum price for the sale and supply of alcohol in Wales and making it an offence for alcohol to be sold or supplied below that price.

4. We support the general principles of the Public Health (Minimum Price for Alcohol) (Wales) Bill. There is compelling evidence, both from across the UK and internationally, that introducing a MUP in Wales would lead to significant improvements in health and well-being of the population.

5. Recent decades have seen increases in alcohol consumption and health harms associated with alcohol across Wales. These increases are linked with real terms reductions in the

cost of alcohol. A MUP is a targeted measure that will impact beneficially on the heaviest drinkers and other groups particularly at risk from alcohol related harms. Moderate drinkers will experience relatively minor change in the amount they have to pay for alcohol.

6. MUP sets a floor price for a unit of alcohol, meaning that alcohol could not legally be sold below that price. This would not necessarily increase the price of every drink, only those that are sold below the minimum price e.g. cheap spirits, beer, ciders and wine. MUP is based on two fundamental principles[i] that are widely supported by evidence:
   - When the price of alcohol increases consumption by most drinkers goes down including, critically, consumption by hazardous and harmful drinkers (i.e. heavier drinkers); and
   - When alcohol consumption in a population declines, rates of alcohol-related harms also decline.

7. Alcohol has become steadily more affordable in recent years, with there being a real term reduction in the cost of alcohol.[ii] Whilst overall alcohol consumption has declined in the last few years, in the UK we are still drinking over 40% more litres per head of population than we were in 1970.[iii] Although the reasons behind this are complex and multi-factorial, affordability is a key factor, and more than 100 international studies clearly demonstrate a link between affordability of alcohol and alcohol consumption.[iv] Alcohol is 60% more affordable than it was in 1980[v] when compared with average household income, and channels for its availability have multiplied far beyond the local pub. The majority of alcohol is now sold in the off-trade (such as in off licences and supermarkets), where alcohol is routinely offered at reduced prices to attract people into their stores.

8. In Wales, one in five (20%) of adults in 2016 said that they had drank more than the recommended guidelines and almost a third (31%) of adults drank more than three units (women) or four units (men) on at least one day the previous week.[vi] Increased drinking over time has had a detrimental impact on the nation's health and well-being. Alcohol consumption accounts/ accounted for:
   - 504 alcohol-related deaths registered in Wales in 2016;[vii]
   - Around 30,000 hospital bed days in Wales. It is estimated that, on average, there is an alcohol-related hospital admission every 35 minutes;[viii]
   - 15,165 hospital admissions related to alcohol in 2016 – 17;[ix]
   - 10,081 individuals admitted with an alcohol specific condition in any diagnostic position in 2016-17, accounting for 13,512 admissions.[x] When considering alcohol specific conditions plus alcohol related conditions (those that are caused by alcohol in some, but not in all cases; e.g. stomach cancer and unintentional injury) 35,521 people were admitted to hospital in Wales in 2016/17;[xi]
   - Estimated cost to NHS Wales is between £70 million and £85 million each year[xii] (the combined cost of alcohol-related chronic disease and alcohol-related acute incidents). National costs from alcohol related harms (health, social, economic and criminal justice) are equivalent to around £900 per family annually,[xiii] with the estimated to cost the Welsh nation £1 billion per year;[xiv]

- 592,000 violent incidents where the victim believed the offender(s) to be under the influence of alcohol, accounting for 47% of violent offences that year. Alcohol routinely accounts for over 40% of all violent crimes committed[xv] and, as well as youth violence, is strongly associated with domestic violence, child abuse and self-directed violence (e.g. suicide);[xvi] and
- Increased risk of developing over 60 different health problems[xvii] including a range of cancers, liver disease, high blood pressure, injuries and a variety of mental health conditions. It also increases the risk of causing harms to the health of others;

9. Young people are especially vulnerable to harms of drinking alcohol.[xviii] They are also vulnerable to the harms from other people's drinking particularly their parents. The Public Health Wales NHS Trust Welsh Adverse Childhood Experience study in 2015 found long term impacts on children of parents who misused alcohol (and other negative experiences relating to alcohol misuse such as abuse, domestic violence and a family member being in prison). This results in a vicious cycle of harm – children who have four or more adverse childhood experiences are themselves four times more likely to grow up to be high risk drinkers themselves.[xix]

10. These harm, and the related costs, could be substantially reduced if MUP was to be introduced. Based on the evidence, highlighted below, we regard a level of 50p per unit MUP as an appropriate level at which to initially establish a MUP. It is estimated that a minimum price of 50p per unit would see 53 fewer deaths and 1,400 fewer hospital admissions in Wales per year.[xx]

11. Sufficient modelling has already been undertaken in England, and elsewhere, to estimate the benefits that a 50p MUP would have on alcohol consumption and related health harms. However, this is based on current levels of affordability of alcohol, and we consider that MUP should be linked to an inflationary measure to ensure it remains an effective measure to reduce alcohol health harms. Should the introduction of MUP be delayed the initial MUP should be adjusted from 50p to account for inflationary trends up to the point of its introduction and the frequency of review should be based on the level of change in the retail price index.

12. Numerous studies have shown that the price of alcohol, and more particularly its price relative to income, is one of the main factors in determining levels of consumption. Both US and UK data show that the heaviest drinkers gravitate towards the cheapest alcohol.[xxi] As a result, MUP affects heavy drinkers' consumption much more than light or moderate drinkers. Consequently, MUP is a targeted measure which primarily impacts heavy drinkers and the evidence, both in the UK and internationally, has led several countries to consider MUP policy.

13. A 2005 review[xxii] by the World Health Organisation (WHO) of 32 European alcohol strategies found that the most effective measures to curb alcohol related health harms include changes to price and availability. In 2011, researchers at Bangor and Glyndŵr Universities[xxiii] came to the following conclusion: "*Within the international literature on reducing alcohol consumption and the harm related to alcohol, the finding with the*

strongest evidence base is that consumption of alcohol is highly sensitive to changes in price (or, to be more accurate, affordability). When the price of alcohol drops, more is consumed; when alcohol becomes more expensive, less is consumed."

14. In 2014, research by Sheffield University[xxiv] on the impacts of introducing a 50p minimum unit price estimated the following:
    - A 50p MUP would result in 53 fewer deaths and 1,400 fewer hospital admissions in Wales per year;
    - A 50p MUP would save the Welsh NHS more than £130m over 20 years, by reducing impacts on health services, such as Accident and Emergency;
    - It would reduce workplace absence, which is estimated would fall by up to 10,000 days per year;
    - Crime is estimated to fall by 3,700 offences a year overall. A similar reduction is seen across the three categories of crime – violent crimes, criminal damage and robbery, burglary and theft;
    - The total societal value of these reductions in health, crime and workplace harms is estimated at £882m over the 20-year period modelled.

15. Recent modelling in England[xxv] suggests that a 50p MUP would result in:
- A harmful drinker drinking 368 fewer units per year;
- A moderate drinker drinking 11 fewer units per year; and
- An annual reduction in alcohol related deaths of 12.3% and in alcohol related hospital admissions of 10.3%.

16. Work in Scotland suggests that an MUP of 50p per unit would reduce alcohol-related hospital admissions in Scotland by 8,900 annually and would reduce alcohol related criminal offences by 4,200, with a total value of an estimated saving of £1.3 billion over 10 years.[xxvi]

17. In Wales, modelling[xxvii] suggests that a 50 pence MUP would result in:
    - A high-risk drinker drinking 293 fewer units per year;
    - A moderate drinker drinking 6.4 fewer units per year; and
    - An annual reduction in alcohol related deaths of 12.3 per cent and in alcohol related hospital admissions of 10.3 per cent.

18. MUP in Canada has proved a successful measure for reducing alcohol-related harms; including reducing alcohol-related deaths. In British Columbia,[xxviii] with a population of 4.6million, a 10% increase in the average minimum price of all alcoholic beverages was associated with a 9% decrease in acute alcohol-attributable admissions and a 9% reduction in chronic alcohol-attributable admissions two years later. It was estimated from this that a 10% (approximately 6p) increase in average minimum price was associated with 2% (166) fewer acute admissions in the first year and 3% (275) fewer chronic admissions two years later. Canada is one of six countries that have introduced some form of MUP and in every case the observed impacts on reducing consumption (and consequently preventing related harms) have been larger than those estimated.

19. Although the explanatory memorandum says MUP is not massively regressive, the evidence is still unclear on this point. However, what is clear from the evidence is that if MUP is regressive, this regressivity is not unfair when considered against the social pattern of alcohol related harm. By comparison to MUP other measures (public service campaigns, education initiatives, and voluntary self-regulation preferred by the alcohol industry) have more limited impacts on drinking patterns and problems.

20. Based on evidence from Canada and elsewhere, MUP would help substantially in reversing these health harming trends relating to alcohol consumption in Wales.

Any potential barriers to the implementation of the provisions and whether the Bill takes account of them;

21. One of the significant barriers to implementation of the Bill is the outcome of the Supreme Court case, Scotch Whisky Association and others (Appellants) v The Lord Advocate and another (Respondents) (Scotland), which we are still waiting judgement on.

22. While the Alcohol (Minimum Pricing) (Scotland) Act 2012 was passed in June 2012, the legislation has not yet been implemented due to a legal challenge led by the Scotch Whisky Association. The Supreme Court hearing took place in July 2017 and the judgement due imminently (15th November 2017).

23. Another barrier, which is highlighted in more detail below, is the ability of Local Authorities to enforce the MOU. The receipt of penalty notice payments should mitigate but upfront costs could still present a barrier.

Whether there are any unintended consequences arising from the Bill;

24. There are some consequences arising from the Bill that should be considered, but should not prevent the Bill being passed by the Assembly.

Consumers/ the public;

25. Moderate drinkers are unlikely to change their habits. For harmful and hazardous drinkers, if they are able to make a rational decision, it is possible that alcohol consumption will fall. However, a proportion of people in these categories will be addicted to alcohol and will need help to reduce their drinking. Many middle-class people whose drinking exceeds the recommended limits are likely to continue to do so, as it is a lifestyle choice which they will remain able to afford.

26. Concerns around the possibility of a hard-hitting impact on those with low incomes have been a critical consideration of MUP debate.[xxix] Many of health harms related to alcohol misuse disproportionately on most deprived communities – alcohol related deaths in Wales increase as levels of deprivation increase (quintiles).[xxx] Research shows that people on a low income or who are living in deprived areas are more likely to suffer from a long-term illness as a result of drinking too much. A recent annual statistical report[xxxi] on alcohol and drug use in Wales highlights that the proportion of all patients admitted for

alcohol specific conditions living in the most deprived areas was 3.8 times higher than those from the least deprived areas. However, MUP can potentially reduce levels of harmful drinking in these groups, meaning the risk of alcohol-related harm would be reduced.

27. The impact on low income drinkers will depend on whether they are alcohol dependent (alcoholic) or heavy drinkers by choice. The impact on alcoholics will further depend on whether or not appropriate treatment and support services are available to help them to quit. It is possible that NHS costs could increase in the short term, as additional services for alcoholics who wish to quit may be required.

28. The modelling report for Wales in 2014[xxxii] estimates that moderate drinkers (62% of the population) consume on average 5.5 units per week, spending £310 per year on alcohol. High risk drinkers (7% of the population) consume on average 78.1 units per week, spending £2,960 per annum. These patterns differ somewhat when examined by income group, with moderate drinkers in poverty estimated to drink 4.9 units per week, spending £200 per annum, whilst moderate drinkers above the defined poverty line consume 5.6 units per week and spend £340 per annum.

29. There is a potential impact upon young people, who are often the consumers of high strength, low price alcohol, in that they may turn to other substances which are lower cost e.g. legal highs, solvents or illegal drugs. The population level consumption data suggests that young people are drinking less than they used to, which is a positive trend, but care should be taken to observe whether there is a shift to use of other substances and this should be tracked as the MUP Act is implemented. Those professionals who work with and educate young people should be aware of a potential shift. The Bill and the evidence behind it could be communicated through substance misuse education programmes in children and young people's settings, as it provides an opportunity to raise awareness of the implications of hazardous and harmful drinking amongst this population group. It could also raise children and young people's understanding of the signs of alcohol withdrawal which could be affecting their family members.

30. There will be a need for public awareness work to ensure that the wider population are aware of the signs of withdrawal from alcohol where individuals who are unknowingly dependent and consume less following introduction of the Bill, may be at risk of harm through withdrawal.

Retailers;

31. It is possible that retailers will see a reduction in sales. Supermarkets should be able to compensate for reductions in alcohol sales by promoting other lines, but small off-licences are likely to be hardest hit.

Public sector

32. The burden of inspection and control will fall on Local Authorities, adding to their costs, which have been considered within the financial impact of the Bill. Local Authority enforcement is currently stretched. Effective implementation of the provisions is

dependent on good and robust enforcement systems, it will be essential therefore that sufficient resources are available to enforce the legislation and that enforcement of this legislation does not negatively impact on other public health related activity within Local Authorities.

33. The health service in Wales should ultimately benefit, as there should be fewer admissions for alcohol related conditions, but it may be difficult to attribute reductions to the introduction of MUP, as alcohol consumption at most ages, but particularly in young people, has already begun to decline. There may be greater demands on primary care from people trying to reduce their alcohol intake. It will be important to ensure that resources are available to provide adequate, appropriate and timely support for the small percentage of dependant drinkers who will need help to reduce their drinking. Health Boards need to develop and promote non-abstinent harm reduction treatment and support programmes for alcohol users that focus on reducing consumption to less harmful levels, rather than eliminating consumption. There may be a perception among the general public that all alcohol treatment and support has a default expectation of achieving abstinence – this may discourage harmful drinkers seeking to support in order to reduce and control their alcohol consumption levels.

34. The inclusion of impacts of MUP on crime is an important health and well-being consideration. As well as harm to the individual who is drinking, alcohol consumption can also improve the well-being of wider society through reducing alcohol-related crimes, including those relating to violent, anti-social and disorderly behaviour, acquisitive crime and criminal damage. It is possible that there could be some cost reduction for Local Authority social services if reductions in alcohol intake result in reduced rates of domestic violence and family breakdown attributable to alcohol.

35. Finally, there is a need to ensure that those professionals who are working with and supporting people who are living in the most deprived communities are aware of the introduction of this Bill and the potential implications. As highlighted, it is the areas of highest deprivation that experience the highest levels of alcohol related harms, suggesting that many people in these communities are drinking at hazardous levels. It is possible that people who are dependent on alcohol, or heavy drinkers by choice, may sacrifice other expenditure, such as food or paying bills, in order to continue to buy alcohol at the higher prices. This could have implications for their families and their own well-being, and professionals should be alert to this and raise concerns if they feel this is happening.

The financial implications of the Bill (as set out in Part 2 of the Explanatory Memorandum);

36. There are no additional costs that we are aware of that have not been considered within the financial implications of the Bill set out in Part 2 of the Explanatory Memorandum.

37. As highlighted within the Explanatory Memorandum, the key costs will be for Local Authorities in relation to the compliance costs and the funding required for additional inspection and enforcement, including training. The costs within these areas seem reasonable and the challenging financial environment within which Local Authorities are

currently managing their services means the need to ensure that any additional duties come with adequate funding.

38. It is welcomed that the financial implications include £350,000 for the evaluation of the Bill to ensure that it leads to the necessary outcome that it aims to achieve.

The appropriateness of the powers in the Bill for Welsh Ministers to make subordinate legislation (as set out in Chapter 5 of Part 1 of the Explanatory Memorandum).

39. We support the powers for Welsh Ministers to make subordinate legislation to specify the MUP. As previously highlighted, based on present evidence we regard a level of 50p per unit MUP as an appropriate level at which to initially establish a MUP in 2014. However, the initial MUP should be adjusted to account for inflationary trends up to the point of its introduction and the frequency of review of the MUP level should be based on the level of change in the retail price index.

40. As part of the Bill, or as part of subordinate legislation or other policies, we recommend other evidence based measures could be considered in order to reduce the harms caused by alcohol to Welsh citizens. Not all of these measures can be unilaterally implemented in Wales as devolved powers do not allow their introduction. However, we believe Wales can still act as a powerful advocate for creating a culture where people are better informed about the harms associated with alcohol consumption and the real costs of alcohol are reflected. We would support the following:[xxxiii]
    - Public health and community safety should be given priority in all public policy-making about alcohol;
    - At least one third of every alcohol product label is an evidence based health warning from an independent regulatory body;
    - Sales in shops should be restricted to specific times of the day and designated areas with no promotion outside these areas;
    - Tax on alcohol products should be proportionate to volume of alcohol to incentivise sales of lower strength products;
    - Licensing authorities should be empowered to tackle alcohol-related harm by controlling total availability in their area;
    - Alcohol advertising should be strictly limited to newspapers and other adult press, while its content should be limited to factual information;
    - There should be an independent body to regulate alcohol promotion, including product and packaging design for public health and community safety;
    - All health and social care professionals should be trained to provide early identification and brief alcohol advice;
    - People who need support for alcohol problems should be routinely referred to specialist alcohol services for assessment and treatment and further investment in these services provided; and
    - Existing laws to prohibit the sale of alcohol to individuals who are already heavily intoxicated should be enforced in order to reduce acute and long-term harms to their health and that of the individuals around them.

41. Introduction a MUP and the measures highlight above have successfully improved health elsewhere and can do the same in Wales. However, we also need to empower individuals in Wales to make the right choices about their own drinking. Too many drinkers fail to recognise how even moderate drinking can increase their risks of developing diseases such as cancer. The Government, public health professionals and the wider public sector professionals must rise to the challenge of informing the public about these risks in an environment dominated by advertising intent on increasing consumption of their products. Our experience with tobacco suggests that sustained and population wide messages about harms were only possible once legislation stipulated prominent health information on all advertisements and products. The risks related to alcohol use are now clear, what is needed is the policy to allow them to be communicated at scale to the public.

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[i] Stockwell and Thomas, 2013. Is alcohol too cheap in the UK? The case for setting a Minimum Unit Price for alcohol Institute of Alcohol Studies Report

[ii] Public Health Wales, 2014. Public Health Wales NHS Trust Response to the Health and Social Care Committee Consultation on the Public Health (Wales) Bill

[iii] History and Policy, 'The Highs and Lows of Drinking in Britain', http://www.historyandpolicy.org/opinion-articles/articles/the-highs-and-lows-of-drinking-in-britain

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[vi] Welsh Government, National Survey for Wales 2016.

[vii] Public Health Wales, 2017. 'Data mining Wales: The annual profile for substance misuse 2016-17' [online] Available at: http://howis.wales.nhs.uk/sitesplus/documents/888/FINAL%20profile%20for%20substance%20misuse%202016-17%20%282%29.pdf

[viii] Public Health Wales Observatory, Alcohol and Health in Wales 2014: Wales Profile.

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[x] Ibid

[xi] 'Alcohol specific conditions' are commonly defined as those conditions, such as alcoholic liver disease, which are 100% attributable to the use of alcohol. Recently, additional measures related to 'alcohol-attributable conditions' have become more frequently reported in literature evaluating alcohol harms. Alcohol-attributable measures include those conditions which have been evaluated as partially, but not completely, caused by alcohol consumption when considered across the whole population. Alcohol-attributable figures therefore add a further dimension to analysis of alcohol harms. Both alcohol specific and alcohol attributable hospital admissions can be described in 'person based' measures (the number of individuals admitted in a given time period, with each counted only once) or 'admission based' measures (where all admissions of all individuals are included, as often one individual may be admitted on more than one occasion in a given year).

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[xiii] Alcohol Concern Cymru, 'A drinking nation? Wales and alcohol', p.11.

[xiv] Welsh Government, 2015. Draft Pubic Health (minimum price for alcohol) (Wales) Bill Explanatory Memorandum

[xv] British Crime Survey, ONS;
http://www.ons.gov.uk/ons/taxonomy/index.html?nscl=Crime+in+England+and+Wales

[xvi] World Health Organisation (2006) Interpersonal violence and alcohol.
http://www.who.int/violence_injury_prevention/violence/world_report/factsheets/pb_violencealcohol.pdf

[xvii] Public Health England, 2016. The Public Health burden of alcohol and the Effectiveness and Cost-Effectiveness of Alcohol Control Policies – an Evidence Review.
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[xxxii] Welsh Government, 2014. Model-based appraisal of minimum unit pricing for alcohol in Wales.
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The Public Health (Minimum Price for Alcohol) (Wales) Bill 2017

Evidence to the National Assembly for Wales, Health, Social Care and Sport Committee from The Directors of Public Protection Wales, The Wales Heads of Trading Standards and the Welsh Local Government Association.

13th November 2017

1. We welcome the opportunity to provide information to the Committee in relation to the proposed Bill.
2. It is envisaged that local Government will be provided powers and duties to act to ensure compliance with the minimum unit price of alcohol requirements.
3. We believe that local government is well placed to receive these duties and powers, and the framework, as currently presented will allow the new requirements to become embedded into the wider public protection and regulatory functions of our services.
4. In the preceding months, we have welcomed the opportunity to discuss with policy officials the overarching principles, which will engage local authority staff once the Bill is enacted.
5. We have limited our evidence to the compliance and enforcement provisions within the Bill, recognising that others are more qualified and better placed to discuss the wider policy drivers around the health and social need, and the factors which have arrived at the practical minimum price point of alcohol.
6. However, we record that we are supportive of the intention to reduce the harmful effects of excessive drinking, and the wider comprehensive strategies surrounding this.
7. Local authority public protection officers have long-standing advice, education and enforcement experience, and act as a critical interface between government and businesses, where the primary intention of the relationship is to encourage compliance with legislation.
8. In this regard, there are a number of critical factors which should be considered in framing new legislation, to ensure that the policy goals can be achieved via compliance or regulatory interaction.
9. Local Authority experience of enforcing new legislation suggests that early compliance is more likely when:
    - The new legislation is seen as necessary, reasonable, easy and cheap to comply with
    - The Trade has a clear understanding of what is required of them, and advice and education of the requirements is provided to them
    - The enforcing authority has capacity to check compliance early in the new regime

- This is made easier if the legislation is unequivocal and simple with absolute offences that do not need to be argued through the Courts (this limits case preparation time and frees officer time for more checks to be made)
- Certain and quick enforcement outcomes (like Fixed Penalty Notices, with appropriate appeal mechanisms) where appropriate, also maximises efficiency

10. The Committee will be aware that local authority regulation budgets have suffered dramatically over the last period. It is regrettable, that as Local Authority regulatory services continue to be cut, it is no longer realistic to expect proactive, consistent enforcement activity across Wales.
11. New legislation such as this, adds to the existing burden and will compete for officer time with existing enforcement activities. Since public protection services activity is prioritised on the basis of risk to the public, initiatives to change behaviour are unlikely to be prioritised unless extra provision is made.
12. The Wales Heads of Trading Standards have been engaged in dialogue with Welsh Government regarding the new burden which will be placed on local government. There is a common desire to establish an efficient and successful regime which will ensure broad compliance.
13. The proposed legislation appears clear and easy to understand, and is generally framed in a manner which is familiar to officers when dealing with other enforcement matters.
14. The engagement of the trade at the earliest opportunity is essential and we are pleased to note that this is acknowledged. Public protection officers already provide advice on a vast range of complex legal and technical legislation, and the existing skills of those officers can be utilised during the implementation of the Bill. e
15. We welcome the broad range of powers which are available, and believe these are sufficient to enable compliance to be achieved.
16. The fixed penalty enforcement mechanism is an appropriate and efficient mechanism for minimum unit pricing. Although not extensively used, enforcement officers are familiar with exercising this method of enforcement activity.
17. We welcome the acknowledgment of a training need for officers, and would be pleased to work with officials on how to most effectively deliver this.
18. The provision to review the policy after five years is welcomed. Local authorities will however need to invest to amend their current databases. It will be essential that codes and

definitions are agreed to be able to record and analyse data consistently to ensure efficient reporting in due course.

Health, Social Care and Sports Committee inquiry into the general principles of the Public Health (Minimum Price for Alcohol) (Wales) Bill

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The Royal College of Psychiatrists is the professional medical body responsible for supporting psychiatrists throughout their careers, from training through to retirement, and in setting and raising standards of psychiatry in the United Kingdom.

The College aims to improve the outcomes of people with mental illness, and the mental health of individuals, their families and communities. In order to achieve this, the College sets standards and promotes excellence in psychiatry; leads, represents and supports psychiatrists; improves the scientific understanding of mental illness; works with and advocates for patients, carers and their organisations. Nationally and internationally, the College has a vital role in representing the expertise of the psychiatric profession to governments and other agencies.

RCPsych in Wales is an arm of the Central College, representing over 550 Consultant and Trainee Psychiatrists working in Wales.

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The general principles of the Public Health (Minimum Price for Alcohol) (Wales) Bill and the extent to which it will contribute to improving and protecting the health and well-being of the population of Wales, by providing for a minimum price for the sale and supply of alcohol in Wales and making it an offence for alcohol to be sold or supplied below that price.

1. The Royal College of Psychiatrists in Wales welcomes the proposals as set out in the Public Health (Minimum Price for Alcohol) (Wales) Bill and we are pleased to respond to the Committee's inquiry. The Bill is a clear indication of the Welsh Government's commitment to tackling problem drinking as a public health issue for individuals, their families, and the wider public.

2. The aim of this important piece of public health policy is to reduce, in particular, the consumption of harmful and hazardous drinking. Minimum unit pricing (MUP) of alcohol will not affect moderate drinkers but will have a significant impact on reducing alcohol related deaths, hospital admissions, and will result in fewer crimes.

3. The College has always supported MUP and pressed for all governments in the UK to adopt legislation. Our members across the UK see the harmful impact of low cost alcohol daily in their clinical practice, not just on drinkers, but on their families. Alcohol is a huge burden on our society, affecting the health of individuals and those around them and often hitting those hardest in deprived and poor communities.

4. We are pleased that the Welsh Government has pressed ahead with this policy, following the lead of the Scottish Government, and despite the many barriers that Scotland has faced. The Supreme Court's ruling is especially welcomed, which means that we can now pave the way for Wales to make real improvements to people's lives.

5. We believe that the general principles of the Bill will go a long way to addressing the concerns around problem drinking and youth drinking, and this is supported by robust evidence.[1] [2] [3] [4] We would hope that the Bill proceeds quickly through the Assembly given the overwhelming evidence that supports the benefits of MUP and the positive feedback from stakeholders received through previous consultations.

[1] Booth A, Meier P, Stockwel T et al (2008) *Independent review of the effects of alcohol pricing and promotion. Part A: systematic reviews.* School of Health and Related Research, University of Sheffield.
[2] Elder RW, Lawrence B, Ferguson A et al (2010) The effectiveness of tax policy interventions for reducing excessive alcohol consumption and related harms. *American Journal of Preventive Medicine* 38: 217-229.
[3] Jackson R, Johnson M, Campbell F et al. (2010) *Interventions on control of alcohol price, promotion and availability for prevention of alcohol use and disorders in adults and young people.*
[4] Wagenaar AC, Salois MJ & Komro KA (2009) Effects of beverage alcohol price and tax levels on drinking: a meta-analysis of 1003 estimates from 112 studies. *Addiction* 104: 179 –90.

Why MUP works

6. The most notable in-depth studies into the impact on reducing alcohol related harm when applying a minimum unit price for alcohol have been conducted by Sheffield Hallam University. Their evidence shows that MUP is the most effective means of improving the health and wellbeing of individuals and those they are close to. The Sheffield Alcohol Research Group has gathered a wealth of international evidence on the impact that MUP has on people's drinking habits. They were commissioned by the Welsh Government to conduct a study into the impact in Wales for the purposes of the Bill and concluded that there would be a reduction in the consumption by those considered to be in the high-risk category of 7.2% and a reduction of 2.2% for moderate drinkers.[5] [6] Their research shows that an MUP set at 50p would result in 53 fewer deaths per year, 1400 fewer hospital appointments per year and save the public purse by £882m in 20 years. Their evidence also shows that an increase in MUP correlates with a decrease in harm – so that the benefits increase with an increase in the floor price. An MUP of 60p would have even more health and social benefits.

7. Countries that have adopted a floor price for alcohol are reporting benefits. British Columbia, Canada, has seen a marked reduction in harmful drinking[7], hospital admissions[8], deaths and crime[9].

8. A survey in 2011 showed that 70% of the units of alcohol consumed were under 40p and 83% under 50p highlighting that the price influences the choices we make when buying alcohol.[10] This is consistent with College members' observations in clinical practice, who noticed the popularity of 'super lagers' in the 1990s was supplanted by white cider and vodka by 2000s as these drinks became cheapest.

9. The UK Government has already recognised the importance of pricing to reduce alcohol related harm through its ban on the sale of alcohol below the total of VAT and excise duty. However, this policy has been found to affect only around 1% of the alcohol sold in the UK, and even then to have raised

[5] Meng Y. et al. (2014); Sheffield: ScHARR, University of Sheffield.

[6] The Meng Model (2010) class moderate drinkers as men/women who consume no more than 21/14 U.K. units per week, hazardous drinkers as consuming between 21/14 and 50/35 units per week, and harmful drinkers as consuming more than 50/35 units per week, respectively.

[7] Stockwell T, Auld MC, Zhao J et al (2012) *Does minimum pricing reduce alcohol consumption? The experience of a Canadian province.* Addiction 107 (5): 912-920

[8] Stockwell T, Zhao J, Martin G et al (2013) *Minimum Alcohol Prices and Outlet Densities in British Columbia, Canada: Estimated Impacts on Alcohol-Attributable Hospital Admissions* Am J Public Health. 103:2014–2020. doi:10.2105/AJPH.2013.301289

[9] Stockwell T, Zhao J, Martin G et al (2015) *Relationships Between Minimum Alcohol Pricing and Crime During the Partial Privatization of a Canadian Government Alcohol Monopoly*. Journal of Studies on Alcohol and Drugs, 76(4), 628–634 (2015).

[10] Black, H., Gill, J. & Chick, J. (2011) *The price of a drink: levels of consumption and price paid per unit of alcohol by Edinburgh's drinkers with a comparison to wider alcohol sales in Scotland. Addiction*, 106, 729–736.

prices only slightly.[11] Minimum alcohol pricing affects the floor price and is thus targeted at the retail practices which are most likely to result in harm. An MUP would effectively ban the offering of price reductions for larger quantities of alcohol sales – multibuys for example. For this reason, the College continues to support minimum unit pricing as one of the most effective measures to prevent alcohol-related harm.

Why MUP is important

10. Overconsumption of alcohol can lead to many social problems, such as increased crime particularly violent crime. ONS figures from 2005 – 2016 show a fluctuation between 562,000 and 1.1m violent incidents recorded in England and Wales where the victim believed the offender to be under the influence of alcohol.[12] This translates into 39% and 55% of all violent crimes.

11. Overconsumption of alcohol also often increases the likelihood of accidents and it contributes to a multitude of health problems such as premature death, cirrhosis of the liver, heart disease, cancer, alcoholism, and mental health conditions. This places a huge cost on the NHS. In Wales, in 2016 there were 54,000 admissions to hospital for alcohol related harm[13] and around 10,300 patients admitted to hospital in 2014 for a specific alcohol specific condition. Of those 10,300 patients, 66% had mental health and behavioural disorders (70.1% in males and 58.5% in females).[14]

12. According to the Welsh National Database for Substance Misuse, there were 9,127 referrals for alcohol and drug misuse treatment between January and March – up 1,827 on the same period in 2012-13.[15] The latest figures by Welsh Government also show that 504 people died last year in Wales due to alcohol, which is an increase of 8.9% from 2015 to 2016.[16]

13. World Health Organisation data for OECD (Organisation for Economic Co-operation and Development) countries in 2015 show that the UK is ranked at number six by alcohol consumption per capita (at 12l).[17] In the Government's Alcohol Strategy (2012) they recognised that Alcohol was one the three biggest lifestyle risk factors for disease and death in the United Kingdom, after smoking and obesity.[18]

[11] Brennan A, Meng Y, Holmes J et al. (2014) *Potential benefits of minimum unit pricing for alcohol versus a ban on below cost selling in England 2014: modelling study.* The BMJ 349: g5452

[12] Crime Survey for England and Wales, Office for National Statistics

[13] Public Health Wales (2016) *Piecing the puzzle: The annual profile for substance misuse*. NHS Wales.

[14] Public Health Wales (2014) Alcohol and Health in Wales 2014: Wales Profile. pg. 22.

[15] http://www.infoandstats.wales.nhs.uk/page.cfm?orgid=869&pid=41017

[16] Welsh Government (2017) Substance Misuse Strategy: Working Together to Reduce Harm Annual Report.

[17] World Health Statistics data visualizations dashboard http://apps.who.int/gho/data/node.sdg.3-5-viz?lang=en

[18] HMGovernment (2012). The Government's Alochol Strategy. CM8336

14. A recent AHA review of prices found 3-litre bottles of 7.5% ABV cider, which contain the same amount of alcohol as 22 shots of vodka, being sold for just £3.50, or 16p per unit.[19]

How MUP should be set

15. We agree with current proposals that the price should be set in regulations, and not defined in the Bill, so that the rate can be adjusted in line with changes in the market. It is important that the MUP level reflects the growing affordability of alcohol, and affordability should be considered when MUP levels are under review in the future. We agree to monitoring the impact of the legislation to determine the reduction in harm.

16. The College feels that the MUP should be set at 50p initially and that a review of the price should take place annually, as it is the case in Canada and Australia. After the recent announcement by the Supreme Court, the Scottish Government will launch a consultation on the appropriate level of MUP and if the level of 50p, which was set five years ago, will have the desired impact.

Any potential barriers to the implementation of the provisions and whether the Bill takes account of them;

17. This is not our area of expertise; however, we would just like to raise a few points for the Committee to consider when speaking with other witnesses:

    1) Local Authorities would be responsible for enforcing the Act and with ever decreasing budgets, will they have the resources to meet their statutory obligations?

    2) The Assembly should consider the possibility of an increase in cross-border importation of alcohol and whether this increase could offset the advantages of a MUP. We would, however, hope that England will follow the devolved nations and themselves introduce an MUP so cross-border trade would not be an issue.

    3) The Supreme Court Ruling on 15 November should pave the way for other UK nations to adopt similar public health legislation without legal challenges by the drinks industry.

Whether there are any unintended consequences arising from the Bill;

18. It is possible that the number of referrals to Community Mental Health Teams as well as Community Drug and Alcohol Teams would rise initially as a result of the legislation. This would be welcomed as it would indicate that the legislation was meeting its objectives and that people were instead seeking

[19] Alcohol Health Alliance (2016). *Cheap Alcohol: the price we pay*. Available at http://12coez15v41j2cf7acjzaodh.wpengine.netdna-cdn.com/wp-content/uploads/2016/11/AHA-price-survey_FINAL.pdf

help and treatment. We would need to ensure that CMHTs and CDATs could cope with a possible increase in patients seeking help.

The financial implications of the Bill (as set out in Part 2 of the Explanatory Memorandum);

19. The Explanatory Memorandum takes evidence from the study commissioned to Sheffield University, which concluded that a MUP of 50p is estimated to be worth £882m to the Welsh economy in terms of reductions in illness, crime and workplace absence over a 20-year period. The cost in hospital admissions alone from alcohol related illnesses in Wales is currently £120m. The financial and societal burden of alcohol related harm is a major public health issue. We are pleased that the Welsh Government is seeking to address this through legislation and would urge robust evaluation of the policy post implementation.

20. We would like the Welsh Government to explore the possibility of working with retailers and alcohol producers to annex a portion of the retailers anticipated profits and ring fence the money for treatment services – services that are currently stretched, and likely to experience an increase of referrals as a result of the legislation.

END

MPA 07

Bil Iechyd y Cyhoedd (Isafbris am Alcohol) (Cymru)

Public Health (Minimum Price for Alcohol) (Wales) Bill

Ymateb gan Grŵp Ymchwil Alcohol Sheffield

Response from Sheffield Alcohol Research Group

Written submission to the Health, Social Care and Sport Committee on the Public Health (Minimum Price for Alcohol) (Wales) Bill.

Sheffield Alcohol Research Group, School of Health and Related Research (ScHARR), University of Sheffield

We wish to submit evidence in three areas: (1) the effects of alcohol price changes on alcohol consumption and related harm; (2) our analyses of the potential effects of minimum unit pricing in Wales; (3) other evidence relating to the effects of minimum unit pricing.

1. The effects of alcohol price changes on alcohol consumption and related harm

There is a large body of peer-reviewed evidence documenting the effectiveness of using alcohol price increases to reduce alcohol consumption and alcohol-related harm.[1] A systematic review of 112 studies in 2009 found that increases in alcohol prices, including those resulting from increased taxation, were consistently and significantly associated with falls in consumption.[2] This was the case for both total alcohol consumption and for individual beverage types (e.g. beer, wine and spirits). Similarly, both younger and older drinkers as well as heavy episodic (or binge) drinkers were responsive to price changes. An example finding is that, on average, across different times and places, a 10% increase in alcohol prices is associated with a 4.4% fall in consumption. Comparable findings have been obtained in at least three further systematic reviews of this literature.[3,4,5]

There is also a smaller, but still substantial, body of evidence assessing the impact of tax or price changes on alcohol-related harm. Although this evidence based has limitations, the studies consistently suggest that increases in taxation or pricing are followed by reductions in alcohol-related harm. This is true for both acute harms arising immediately after drinking and chronic harms arising from the cumulative effects of drinking over several years. A major review and meta-analysis of 50 studies from this literature in 2010 found that doubling US alcohol taxes would be associated with a 35% fall in alcohol-related mortality, an 11% fall in traffic crash deaths and smaller reductions in sexually transmitted diseases, violence and crime.[6]

2. The potential effects of minimum unit pricing in Wales

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[1] Booth, A. et al. (2008) 'The Independent Review of the Effects of Alcohol Pricing and Promotion: Summary of Evidence to Accompany Report on Phase 1: Systematic Reviews', Project report prepared for the Department of Health.

[2] Wagenaar A. et al. (2009) 'Effects of beverage alcohol price and tax levels on drinking: a meta-analysis of 1003 estimates from 112 studies', *Addiction*, 104:179-90

[3] Gallet, C.A. (2007) 'The Demand for Alcohol: A meta-analysis of elasticities', *Australian Journal of Agricultural and Resource Economics*, 51(2):121-35

[4] Fogarty J. (2012) 'The nature of demand for alcohol: understanding elasticity', *British Food Journal*, 108(4):316-32

[5] Nelson J.P. (2013) 'Meta-analysis of alcohol price and income elasticities – with corrections for publication bias', *Health Economic Review*, 3(17)

[6] Wagenaar et al. (2010) 'Effects of Alcohol Tax and Price Policies on Morbidity and Mortality: A systematic review', *American Journal of Public Health*, 100(11):2270-8

In September 2014, the Welsh Government published the results of an independent analysis which they had commissioned from our research group to appraise the potential effects of introducing different alcohol pricing policies in Wales.[7] The analyses examined outcomes including alcohol consumption, spending and related revenue to the exchequer and retailers, alcohol-attributable mortality and morbidity, alcohol-related crime and workplace absence, and associated costs of the above harms to public services and individual drinkers.

The policies appraised were minimum unit prices (MUP) of between 35p and 70p in 5p increments, a general price increase of 10%, and a ban on selling alcohol below the cost of the duty and VAT payable. The analyses examined policy effects for moderate, increasing and high risk drinkers[8] and for drinkers who were and were not in poverty. An update to this report is almost complete and will be published by the Welsh Government in due course.

Methodology

The analyses were conducted using the Sheffield Alcohol Policy Model (SAPM), a decision-support tool which has informed policy-making in the UK and internationally. Results from SAPM analyses have been published in the most prestigious scientific journals including the *Lancet*, *BMJ* and *Plos Medicine*.[9,10,11,12]

SAPM uses varied modelling techniques to combine data from a range of sources. Figure 1 shows how SAPM works sequentially to first estimate how the policy affects prices, then how those price changes affect consumption, spending and revenue, then how consumption changes affect levels of alcohol-related harm and, finally, how changes in levels of harm affect associated costs.

[7] Meng Y. et al. (2014) 'Model-based appraisal of minimum unit pricing for alcohol in Wales: An adaptation of the Sheffield Alcohol Policy Model version 3', Sheffield: ScHARR, University of Sheffield.
[8] Moderate drinkers are men/women who consume less than 21/14 units per week, hazardous drinkers are men/women consuming between 21/14 and 50/35 units per week, harmful drinkers are men/women consuming more than 50/35 units per week. In our forthcoming updated report, moderate drinkers will be defined as men or women who consume less than 14 units per week. This aligns with the updates to the UK Chief Medical Officers' low risk drinking guidelines.
[9] Purshouse, R. et al. (2011) 'Estimated effect of alcohol pricing policies on health and health economic outcomes in England: an epidemiological model', *The Lancet*, 375(9723):1355-64
[10] Holmes, J. et al. (2014) 'Effects of minimum unit pricing for alcohol on different income and socioeconomic groups: a modelling study', *The Lancet*, 383 (9929):1655-64
[11] Brennan, A. et al. (2014) 'Potential benefits of minimum unit pricing for alcohol versus a ban on below cost selling in England 2014: modelling study', *BMJ*, 349:g5452
[12] Meier P.S. et al. (2016) 'Estimated effects of different alcohol taxation and price policies on health inequalities: A mathematical modelling study', PLOS Medicine, 13 (2), e1001963

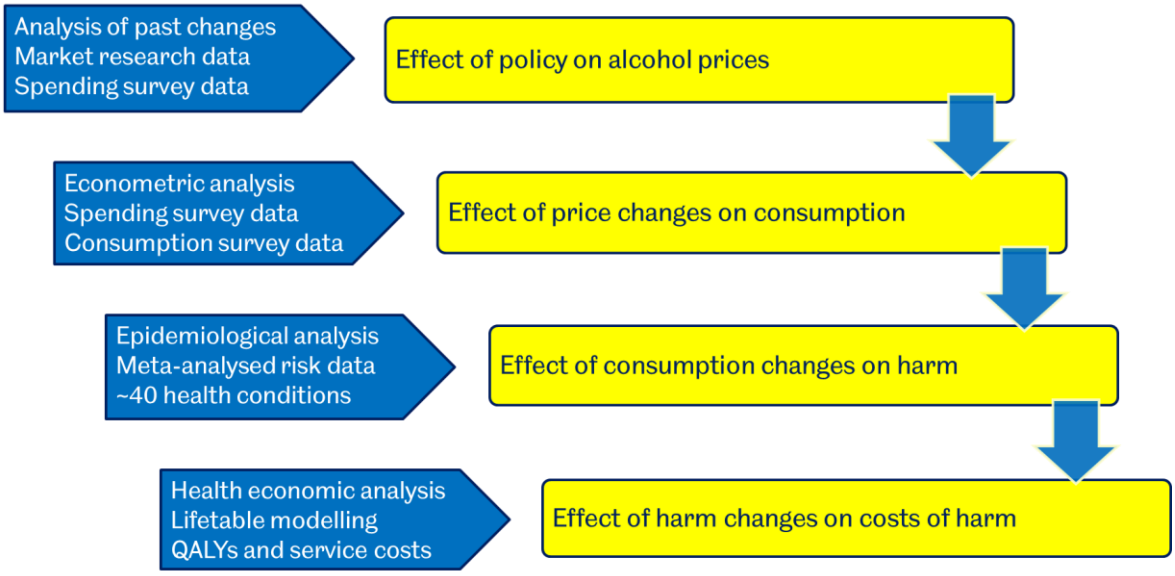

Figure 1: Overview of how the Sheffield Alcohol Policy Model estimates the effects of alcohol pricing policies

The data underpinning the model are the most recent available and, where feasible, are specific to Wales. For example, to estimate the effects of pricing policies on alcohol consumption, we use Welsh market research data and data from the Welsh samples of two Britain-wide surveys: the General Lifestyle Survey and the Living Costs and Food Survey (the updated report will draw on newly available data from the National Survey for Wales). To estimate the effects of consumption changes on alcohol-related harm, we use the best-available international evidence detailing how risks of harm increase as alcohol consumption goes up. This evidence is combined with Welsh administrative data on rates of alcohol-attributable diseases and hospitalisations, crime and workplace absence. Costings for each alcohol-related harm come from UK Government data. Sensitivity analyses are used to explore how alternative modelling assumptions, data and analytic approaches affect the estimates of policy impacts. Full details of the modelling methods can be found in the project report.[13]

Results for the population

The estimated effects of introducing different levels of MUP in Wales on total alcohol consumption are shown in Figure 2 along with the effects of the two non-MUP policies. Effects on consumption are relatively small for MUPs below 45p per unit but increase steadily as the minimum price threshold increases above that level. The ban on sales below the cost of duty and VAT was introduced by the UK Government in 2014 but, due to its small anticipated impact, this should not substantially affect estimates of the effects of other policies.

Figure 2: Estimated effects of minimum unit pricing and other alcohol pricing policies in Wales

[13] Meng Y. et al. (2014) 'Model-based appraisal of minimum unit pricing for alcohol in Wales: An adaptation of the Sheffield Alcohol Policy Model version 3', Sheffield: ScHARR, University of Sheffield.

Attention in public debate has focused on a MUP of 50p. Therefore, Table 1 presents estimated effects on alcohol-related harms and associated costs of introducing a 50p MUP in Wales. In each case, harm and cost reductions are estimated to be greater for higher minimum prices.

Table 1: Estimated effects of introducing a £0.50 minimum unit pricing in Wales

£0.50 minimum unit price		
Overall reduction in consumption	4.0%	
Annual health savings in year 20		
Deaths	53 (6.8%)	
Hospital admissions	1,400 (3.8%)	
First year reductions		
Deaths	21 (2.7%)	
Hospital admissions	1,200 (3.2%)	
Crimes	3,700 (4.6%)	
Days absent from work	10,000 (4.6%)	
Total cost reduction over 20 years (discounted)		
Health	Direct: £131m (4.8%)	QALYs: £489m (6.9%)
Crime	Direct + QALY: £248m (4.7%)	
Workplace absence	£14m (4.7%)	
Total	**£1.3bn (5.8%)**	
Revenue changes	**Off-trade**	**On-trade**
Retailers	+£25.0m (12.2%)	+£2.0m (0.3%)
Exchequer (Duty + VAT)	-£5.7m (2.0%)	-£0.0 (0.0%)

Table 1 also presents estimated impacts on retailers. Off-trade retailers (i.e. shops and supermarkets selling alcohol for consumption away from the premises) would see an increase in their revenue as MUP is not a tax and the extra revenue from higher priced alcohol is retained by retailers (excepting the additional VAT to be paid) and may be passed up the supply chain. On-trade retailers (i.e. pubs, restaurants, nightclubs and other venues selling alcohol for consumption on the premises) are estimated to see a small increase in revenue, potentially due to people moving their drinking away from the home. However, there is substantial uncertainty around this small change in on-trade revenue and it should not be given undue emphasis.

Finally, Table 1 presents estimated impacts on revenue to the exchequer. Revenue from off-trade and on-trade sales combined is estimated to decline by 1.0%. This change is much smaller than for retailers due to two counteracting changes: a fall in duty revenue due to less alcohol being sold and an increase in VAT revenue from the remaining sales being at higher prices.

Results for subgroups within the Welsh population

An important focus of our analysis is how the effects of MUP vary across the population. In general, MUP is effective in achieving targeted reductions in the consumption and harm experienced by high risk drinkers while having a smaller effect on other drinkers. This is true irrespective of whether drinkers are or are not in poverty.

For a 50p MUP, the amount of alcohol consumed per person per year is estimated to fall by 2.2% (6 units) among moderate drinkers, 2.0% (29 units) among increasing risk drinkers and 7.2% (293 units)

among high risk drinkers. Figure 2 shows that a similar pattern is seen for drinkers who are and are not in poverty. Alcohol is a significant contributor to health inequalities. For England, age-standardised alcohol-specific mortality rates were 3.3 times higher for women and 4.5 times higher for men when comparing the most deprived with the least deprived quintiles of the Index of Multiple Deprivation.[14] This inequality is partly due to there being more very high risk drinkers in low income groups but also because lower income groups appear to experience a greater risk of harm from each alcohol unit consumed compared to higher income counterparts. By targeting price increases on the alcohol consumed by low income high risk drinkers, MUP is expected to contribute to the reduction of health inequalities. Under a 50p MUP, alcohol-attributable mortality is estimated to fall by 9.9% among those in poverty and 5.6% among those not in poverty. Similarly, alcohol-attributable hospital admissions are estimated to fall by 6.6% among those in poverty and 3.0% among those not in poverty.

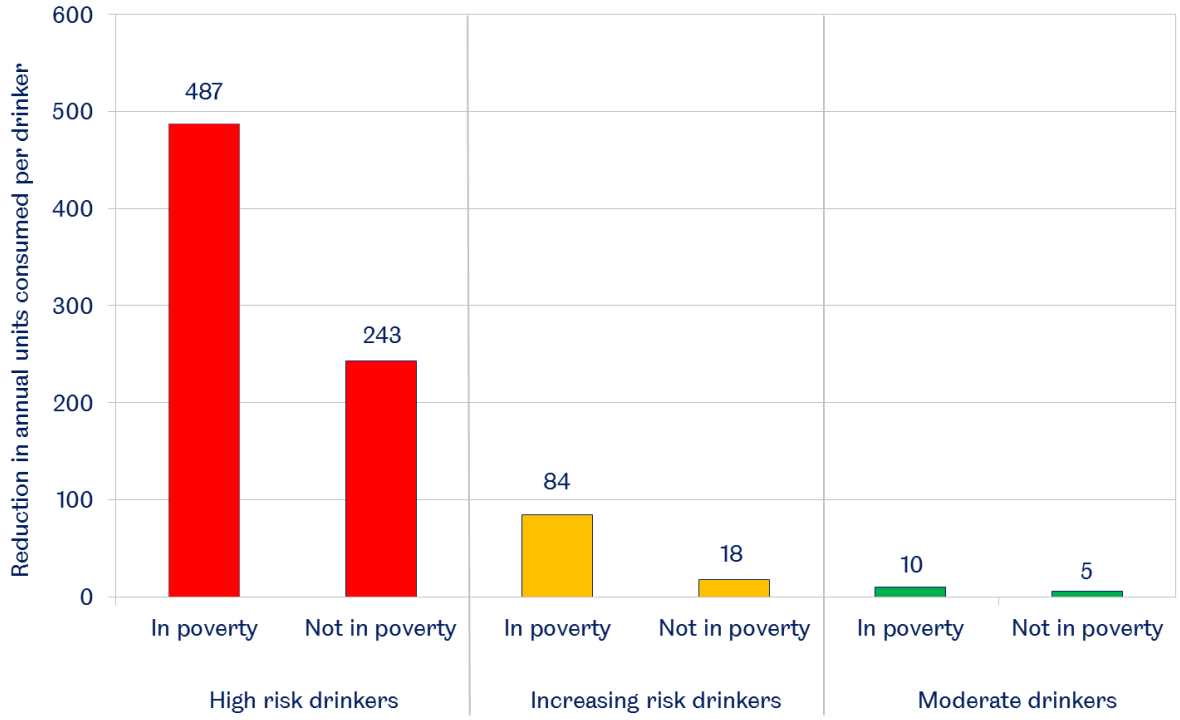

Figure 3: Estimated reduction in annual units of alcohol consumed by population subgroup from introducing a £0.50 minimum unit price in Wales

3. Other evidence relating to the effects of minimum unit pricing

Below we comment on evidence relating to the effects of increasing minimum prices for alcohol in Canada and the relative effectiveness of alcohol tax increases compared to MUP.

[14] ONS (2017) 'Alcohol-specific deaths in the UK: registered in 2016', https://www.ons.gov.uk/peoplepopulationandcommunity/healthandsocialcare/causesofdeath/bulletins/alcoholrelateddeathsintheunitedkingdom/registeredin2016

Evidence from Canada

Several Canadian provinces have operated minimum pricing policies for alcohol (sometimes called social reference pricing) for many years.[15] These policies are not identical to MUP as they do not consistently link the minimum price threshold to the amount of alcohol in the product. Therefore, from a public health perspective, they can be considered a suboptimal implementation of minimum pricing when compared to the policies under consideration in Wales. Nonetheless, the basic mechanism of a setting a price threshold below which alcohol cannot be sold to consumers is the same and evidence from evaluations of the Canadian policies can be considered informative.

A series of studies by the University of Victoria in British Columbia have examined associations between changes in the value of the minimum price and a range of alcohol-related outcomes in two provinces, British Columbia and Saskatchewan. The key results of these evaluations are summarised in Table 2 and indicate that alcohol consumption and alcohol-related harm typically fall when minimum prices are raised. Additionally, a recent study in British Columbia provided further evidence that minimum price increases reduce health inequalities. That study found reductions in hospital admissions following a minimum price increase were largest in areas with lower average incomes.[16] The evaluation results also suggest that estimates from SAPM may be conservative as the falls in alcohol consumption and related harm are larger than those estimated in our Canadian adaptation of the model.[17]

Table 2: Estimated effects of increasing minimum prices by 10% from multiple Canadian studies

10% increase in minimum prices			
	British Columbia	**Saskatchewan**	
Reductions in alcohol consumption	3.4%[18]	8.4%[19]	
Reductions in alcohol-related health problems			
Deaths wholly attributable to alcohol	32%[20]	Not studied	
Alcohol-related hospital admissions	9%[21]		
Reductions in alcohol-related crime		**Men**	**Women**
Traffic violations	19%[22]	8%[23]	*
Violence or crimes against the person	9%[21]	*	*
Total crimes	9%[21]	Not studied	

**Non-significant effects found although, in some cases, delayed effects were identified*

[15] Giesbrecht N. et al. (2016) 'Pricing of alcohol in Canada: A comparison of provincial policies and harm-reduction opportunities', *Drug and Alcohol Review*, 35(3):289-97

[16] Zhao J. et al. (2017) 'The impact of minimum alcohol pricing on alcohol attributable morbidity in regions of British Columbia, Canada with low, medium and high mean family income', *Addiction*, 112(11):1942-51

[17] Hill-McManus, D. et al. (2012) 'Model-based appraisal of alcohol minimum pricing in Ontario and British Columbia: A Canadian adaptation of the Sheffield Alcohol Policy Model Version 2'. Sheffield: ScHARR, University of Sheffield

[18] Stockwell T. et al. (2011) 'Does minimum pricing reduce alcohol consumption? The experience of a Canadian province?', *Addiction,* 107:912-20

[19] Stockwell T. et al. (2012) The raising of minimum alcohol prices in Saskatchewan, Canada: Impacts on consumption and implications for public health', *American Journal of Public Health*, 102(12)e103-10

[20] Zhao J. et al. (2013) 'The relationship between minimum alcohol prices, outlet densities and alcohol-attributable deaths in British Columbia, 2002-09', *Addiction*, 108(6):1059-69

[21] Stockwell T. et al. (2013) 'Minimum alcohol prices and outlet densities in British Columbia, Canada: estimated impacts on alcohol-attributable hospital admissions', *American Journal of Public Health*, 103(11):2014-20

[22] Stockwell T. et al. (2015) 'Relationships between minimum alcohol pricing and crime during the partial privatization of a Canadian government alcohol monopoly', *Journal of Studies on Alcohol and Drugs*, 76:628-34

[23] Stockwell T. et al. (2017) 'Assessing the impacts of Saskatchewan's minimum alcohol pricing regulations on alcohol-related crime', *Drug and Alcohol Review*, 36:492-501

MUP vs. alcohol taxation

The evidence above suggests MUP and alcohol tax increases are both effective policies for improving public health and should be considered as complementary options within a wider strategic approach to addressing alcohol-related harm. However, the policies are not identical. Whereas increasing alcohol taxes affects all products and all drinkers proportionate to the amount they drink, MUP targets price increases on the cheaper and higher strength products which are disproportionately purchased by those at greatest risk of harm from their drinking. This means improvements in public health can be achieved while having only a small impact on moderate drinkers.[24]

MUP has two other key advantages:

1. **Ensuring prices are increased:** Tax increases do not automatically lead to price increases as producers may adopt an alternative response such as absorbing the increased costs using their profits, passing it on to suppliers or passing it on to retailers who can cover the cost by increasing the price of other goods (e.g. food-stuffs). We have previously demonstrated that when alcohol taxes go up, leading supermarkets increase the price of cheap alcohol by less than would be expected and increase the price of expensive alcohol by more than would be expected.[25] This means those buying cheaper products, who tend to be heavier drinkers, are being subsidised by price increases on those buying more expensive products. Introducing an MUP would prevent such pricing strategies.
2. **Preventing trading down**: There is evidence that when alcohol prices go up, heavier drinkers switch to cheaper products to maintain their consumption.[26] MUP prevents this by prohibiting all sales below a specific threshold.

Contact:

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Tel: [redacted]

[24] Holmes, J. et al. (2014) 'Effects of minimum unit pricing for alcohol on different income and socioeconomic groups: a modelling study', The Lancet, 383 (9929):1655-64

[25] Ally, A. et al. (2014) 'Alcohol tax pass-through across the product and price range: do retailers treat cheap alcohol differently?', Addiction, 109 (12), pp.1994-2002

[26] Gruenewald, PJ. et al. (2006) 'Alcohol prices, beverage quality, and the demand for alcohol: Quality substitutions and price elasticities', *Alcoholism: Clinical & Experimental Research*, 30(1): 96-105

Royal College of Physicians | Coleg Brenhinol y Meddygon (Cymru)

Health, Social Care and Sport Committee: Inquiry into the general principles of the Public Health (Minimum Price for Alcohol) (Wales) Bill

RCP Wales response

About us

The Royal College of Physicians (RCP) aims to improve patient care and reduce illness, in the UK and across the globe. We are patient centred and clinically led. Our 35,000 members worldwide, including 1,200 in Wales, work in hospitals and the community across 30 different medical specialties, diagnosing and treating millions of patients with a huge range of medical conditions.

Amdanom ni

Mae Coleg Brenhinol y Meddygon yn amcanu at wella gofal cleifion a lleihau salwch, yn y DU ac yn fyd-eang. Rydym yn sefydliad sy'n canolbwyntio ar y claf ac sy'n cael ei arwain yn glinigol. Mae ein 35,000 o aelodau o gwmpas y byd, gan gynnwys 1,200 yng Nghymru, yn gweithio mewn ysbytai a chymunedau mewn 30 o wahanol feysydd meddygol arbenigol, gan ddiagnosio a thrin miliynau o gleifion sydd ag amrywiaeth enfawr o gyflyrau meddygol.

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1. Introduction

1.1 The Royal College of Physicians welcomes the opportunity to respond to the committee's inquiry into the general principles of the Public Health (Minimum Price for Alcohol) (Wales) Bill. We would be more than happy to provide any further evidence to the committee or discuss any of the points raised in this submission in further detail.

1.2 We have focused our comments on the areas in which we hold expertise, as a membership body supporting the physician workforce and working to improve the health of the population.

2. Key points

- Strong evidence suggests that a minimum unit price for alcohol set at 50 pence, with a mechanism to regularly review and revise this price, will reduce the amount of alcohol drunk by the most vulnerable in society, while decreasing hospital admissions due to alcohol and levels of illnesses directly caused by excessive drinking.
- The increasing affordability and accessibility of alcohol - particularly high-strength drinks - is a key contributing factor to levels of excessive consumption and a minimum unit price will target high-strength, low-cost drinks while having a minimal impact on other alcoholic drinks sold.

- MUP will deliver savings through lifting some burden from health services and reducing costs to the economy (for instance through reducing time taken off work due to alcohol) – but substance misuse services must be adequately funded to cope with any increase in demand. Local authorities must also be adequately funded to implement their duties under the Bill.

3. The general principles of the Public Health (Minimum Price for Alcohol) (Wales) Bill and the extent to which it will contribute to improving and protecting the health and well-being of the population of Wales, by providing for a minimum price for the sale and supply of alcohol in Wales and making it an offence for alcohol to be sold or supplied below that price.

3.1 The RCP have long campaigned for the introduction of minimum unit pricing for alcohol across UK nations and are very pleased to see proposed legislation on this issue in Wales, as are a large number of health-focused organisations we work closely with. We hope that the wealth of available evidence supporting the principles and aims of the Bill will facilitate broad support for the legislation as it progresses.

3.2 The RCP is also a founding member of the Alcohol Health Alliance (AHA), a group of more than 50 health and alcohol organisations. We work together to promote evidence-based policies to reduce the damage caused by alcohol misuse. The AHA's key recommendations detailed later in this document are based on clear evidence that the most effective way to reduce the harm from alcohol is to reduce its affordability, availability and attractiveness.

3.3 Strong evidence suggests that a minimum unit price for alcohol set at 50 pence, with a mechanism to regularly review and revise this price, will reduce the amount of alcohol drunk by the most vulnerable in society. This will in turn increase the health of the population, and reduce the burden on clinicians and others who treat those with problems linked to alcohol.

3.4 The impact of alcohol harm in Wales is one of the most significant public health challenges facing us today. Welsh Government report that there were 504 alcohol-related deaths in Wales in 2016, an increase of 8.9% from 2015.

3.5 The increasing affordability and accessibility of alcohol - particularly high-strength drinks - is a key contributing factor to levels of excessive consumption. Alcohol is 60% more affordable than it was in 1980[1]. Supermarket own-brand vodkas and high-strength ciders are typically the cheapest on offer. For example, a recent Alcohol Health Alliance review of prices found 3-litre bottles of 7.5% ABV cider, which contain the same amount of alcohol as 22 shots of vodka, being sold for just £3.50, or 16p per unit[2]. A minimum unit price of 50 pence will target the price of these high-strength, low-cost drinks accessed by many of the heaviest drinkers, while having a limited impact on moderate drinkers.

3.6 For further evidence supporting the likely positive impact of minimum unit pricing in Wales, we refer the committee to the model-based appraisal of minimum unit pricing for alcohol in Wales[3], commissioned by Welsh Government and published in 2014. The research sets out estimated reductions in hospital admissions, alcohol related deaths and crime under a policy of MUP.

3. Any potential barriers to the implementation of the provisions and whether the Bill takes account of them

3.1 We hope and expect that the Supreme Court decision announced on 15 November[4] regarding minimum unit pricing in Scotland has decisively paved the way for smooth implementation of similar policies in other UK nations.

3.2 We also hope that the UK Government in Westminster will follow the other UK nations in proposing legislation for an identical minimum unit price for alcohol in England, thus removing potential barriers/complications that could arise from cross-border and online sales.

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[1] NHS Digital (2017). *Statistics on Alcohol*. Available at http://www.content.digital.nhs.uk/catalogue/PUB23940/alc-eng-2017-rep.pdf

[2] Alcohol Health Alliance (2016). *Cheap Alcohol: the price we pay*. Available at http://12coez15v41j2cf7acjzaodh.wpengine.netdna-cdn.com/wp-content/uploads/2016/11/AHA-price-survey_FINAL.pdf

[3] Model-based appraisal of minimum unit pricing for alcohol in Wales. Available at http://gov.wales/docs/caecd/research/2014/141208-model-based-appraisal-minimum-unit-price-alcohol-en.pdf

[4] Scotch Whisky Association and others (Appellants) v The Lord Advocate and another (Respondents) (Scotland). Available at https://www.supremecourt.uk/cases/uksc-2017-0025.html

3.3 The issue of excessive alcohol consumption impacts on society in a variety of ways, spanning multiple policy areas. While we are fully behind the introduction of this Bill, we feel it is vital to take a long-term holistic view of how other measures could support the impact of MUP, and not to see it as a stand-alone solution. We would like the committee and Welsh Government to continue to consider further complementary measures to reduce alcohol related harm alongside MUP that could be introduced in future. The Alcohol Health Alliance has ten key recommendations, of which MUP is one. We have set out the other nine recommendations below. While many of the recommendations fall outside of the current legislative competence of the National Assembly for Wales, we believe a long-term vision for tackling these issues should include regular reviewing of changes and developments in legislative competencies, and the opportunities such developments could present.

3.4 Recommendations from the Alcohol Health Alliance:

- At least one-third of every alcohol product label should be given over to an evidence-based health warning specified by an independent regulatory body.
- The sale of alcohol in shops should be restricted to specific times of the day and designated areas. No alcohol promotion should occur outside these areas.
- The tax on every alcohol product should be proportionate to the volume of alcohol it contains. In order to incentivise the development and sale of lower strength products, the rate of taxation should increase with product strength.
- Licensing legislation should be comprehensively reviewed. Licensing authorities must be empowered to tackle alcohol-related harm by controlling the total availability of alcohol in their jurisdiction.
- All alcohol advertising and sponsorship should be prohibited. In the short-term, alcohol advertising should only be permitted in newspapers and other adult press. Its content should be limited to factual information about brand, provenance and product strength.
- An independent body should be established to regulate alcohol promotion, including product and packaging design, in the interests of public health and community safety.
- The legal limit for blood alcohol concentration for drivers should be reduced to 50 mg/100 ml.

- All health and social care professionals should be trained to routinely provide early identification and brief alcohol advice to their clients.
- People who need support for alcohol problems should be routinely referred to specialist alcohol services for comprehensive assessment and appropriate treatment.

4. Any unintended consequences arising from the Bill

4.1 A consequence of the Bill, though not necessarily an unintended one, is that more people will seek help from substance misuse support services. People who need support for alcohol problems should be routinely referred to specialist alcohol services for comprehensive assessment and appropriate treatment. An increase in demand could place existing services under pressure, and it is crucial that this is considered.

4.2 At a time of tight budget constraints for local government, we also recommend that it is ensured that local authorities in Wales are adequately funded to carry out their duties under the Bill should it pass successfully into an Act. Funding arrangements to support the Act should be regularly reviewed to ensure the delivery of the legislation is being properly resourced.

MPA 09

Bil Iechyd y Cyhoedd (Isafbris am Alcohol) (Cymru)

Public Health (Minimum Price for Alcohol) (Wales) Bill

Ymateb gan Yr Athro Jon Nelson

Response from Professor Jon Nelson

November 26, 2017

Dr. Dai Lloyd, AM
Chair, Health, Social Care and Sport Committee
National Assembly for Wales
Cardiff Bay, Cardiff, CF99 1NA
[redacted]

cc: Ms. Sarah Sargent
Policy and Legislative Committee Service
[redacted]

Re: Evaluation of Minimum Price for Alcohol (MPA) Bill

Dear Dr. Lloyd:

Thank you for your request of 26 October for my views on the MPA Bill, presently before the National Assembly for Wales. As I understand from your letter and HSCSC webpage, Stage 1 scrutiny of the Bill allows for continued consideration of general principles of MPA and extent to which this Bill will improve the health and well-being of the population of Wales. This letter contains my independent review and skepticism regarding the MPA Bill and supporting documents on minimum unit pricing (MUP).

Some details on my background; since 1990 I have conducted academic research on economic aspects of alcohol use and alcohol-related harms. I have published over 40 articles and book chapters related to this research, with an emphasis on marketing and pricing of beverage alcohol. Collectively, this body of research has been cited more than 750 times. A listing of my work published since 2006 appears at the end of the evaluation. Most of these publications have undergone the anonymous peer-review process employed by academic journals and compendiums.[1] My recent research has focused on systematic reviews of empirical work on alcohol use and misuse, which are highly pertinent to the MPA Bill. I have published 10 meta-analyses and systematic reviews focused on alcohol marketing, alcohol pricing and alcohol-related harms, including drinking by youth and young adults. All 10 articles were peer reviewed. Some of my past research was supported financially by US public agencies; some was supported by industry-associated groups; and some was conducted independently as a normal part of academic employment. In the Economics Discipline, most economists take the position that scientific research reports are evaluated on their merits, absent innuendos and claims of personal bias. I resent crude *ad hominem* attempts to discredit my research as somehow tainted by industry support, without arguments that detail the scientific basis for such claims or errors on my part. Several recent attempts to do so have in my opinion failed (see Nelson 2008a, 2014e, 2016a). This letter presents my independent views, and received no financial support, input, or consultation of any kind or manner from individuals associated

[1] EM (p. 80) argues that peer-review is strong evidence of support for a research approach, but fails to address other research-related issues such as publication bias and general issues of statistical hypothesis testing. I have written extensively on issues of *publication bias* in alcohol-related research (Nelson 2010a, 2011, 2013d, 2013e, 2014a).

with the alcohol industry. As in all my publications, it is my work alone, and does not necessarily represent the opinion or position of other groups or institutions.

A summary of my recent research is available as: "Economic evidence regarding alcohol price elasticities and price responses by heavy drinkers," **Public Health Open J**, 1 (2), August 2016, 36-39. Open Access at: http://dx.doi.org/10.17140/PHOJ-1-108

Much of the literature on MUP is focused on hypothetical price changes, including the Sheffield Model, and not real-world price changes. Actual policy-induced price changes have been the focus of my recent research, including effects on heavy drinkers and alcohol-related harms for adults and youth. As demonstrated below, the Evaluation Memorandum (EM) and report of the Advisory Panel on Substance Abuse (APoSM) are incomplete, misleading, and deeply flawed as scientific documents. An assessment of the MPA Bill indicates that it is unlikely to achieve its objectives. The main reason is that harmful and hazardous drinkers are relatively insensitive to price changes contrary to claims in the Bill's supporting documents (EM, p. 84; APoSM, p. 58). As shown below, evidence that alcohol-related harms will be lessened by price increases or minimum prices is not extensive or convincing. However, this letter is not a complete appraisal as several issues deserve more attention, such as methods used to determine benefits and costs of MUP and the major deficiencies in empirical studies of MUP in Canada and elsewhere.

The focus of the Bill is a reduction in alcohol-related harms that are a consequence of harmful or hazardous use alcohol. However, heavy drinkers, including youth, are not responsive to alcohol prices as depicted by the Sheffield Model or other claims in the public health literature. Many of these claims concern population-level drinking, including moderate drinkers (e.g., APoSM, p. 54). Review of changes in alcohol prices from survey data and natural experiments reveals that price effects on heavy drinking and alcohol-related harms are more nuanced than earlier studies suggest, including the Sheffield Study for Wales. My detailed evaluation, attached to this letter, sets out reasons for my conclusions. It is my opinion that other policy actions besides MPA need to be considered:

1. Maintain the existing policy banning below-cost sales of alcohol at off-premise outlets.

2. Adopt policies proposed under EM Option Two (p. 92), especially education programs targeting children and young people, that strengthen the focus on alcohol misuse. Implement laws and regulations to reduce alcohol sales and drinking in conjunction with athletic sporting events and other youth-oriented events, such as public concerts. Consider limits on beverages that combine alcohol and caffeine. Consider an increase in the legal age to 19 or 20 years. Better enforce existing laws on underage consumption.

3. Adopt additional policy actions that better target harmful and hazardous drinkers of all ages, including strengthening of laws and penalties for drink-driving, public intoxication, underage drinking, and other actions that are closely related to harmful or hazardous consumption. Penalties such as drink-driving fines are more salient than broad population-level policies such as advertising bans and minimum prices. Better enforce existing laws on hazardous consumption.

Thank you for this opportunity to comment on the MPA Bill. Alcohol-use harms are a serious problem in Wales and other countries. Such problems deserve serious assessment and evaluation, including scientific reviews that do not meet the current public health view of political correctness. Evidence-based policies should be based on consideration of all scientific evidence, and not a selective slice thereof.

Respectfully submitted:

X
Jon P. Nelson

Jon P. Nelson, Ph.D. <[redacted]>
Professor Emeritus of Economics
Pennsylvania State University

Evaluation of Minimum Price for Alcohol (MPA) Bill in Wales (dated November 26, 2017)

Jon P. Nelson, Ph.D. <[redacted]>
Professor Emeritus of Economics
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Introduction

1. I reviewed the following MPA reports:

> Public Health (Minimum Price for Alcohol) (Wales) Bill – Explanatory Memorandum incorporating the Regulatory Impact Assessment and Explanatory Notes, October 2017 [EM].
>
> Model-based Appraisal of Minimum Unit Pricing for Alcohol in Wales – An Adaptation of the Sheffield Alcohol Policy Model version 3, September 2014 [Sheffield Study or SS].
>
> Advisory Panel on Substance Misuse, Minimum Unit Pricing: A Review of Its Potential in a Welsh Context, July 2014 [APoSM].

2. EM (p. 124) states that:

> *The objective of the minimum pricing legislation is to tackle alcohol-related harm, including reducing alcohol-attributable hospital admissions and alcohol-related deaths, by reducing alcohol consumption among harmful and hazardous consumers, including among young people in Wales.*

3. While the above reports contain evidence regarding possible effects of higher prices on alcohol consumption and alcohol-related harms, evidence for harmful and hazardous drinking is incomplete or presented in a misleading manner. Additional evidence reviewed here indicates that MPA will not be as effective as claimed for consumption or harms. Major errors and problems are detailed below.

3.1 EM and APoSM also employ rhetorical language in attempting to make a case for MPA. Examples of misleading language from EM include: "strong evidence" (p. 10); "growing body of evidence and research that shows a strong link" (p. 20); "there is clear evidence" (p. 47); "there is a strong evidence base" (p. 65); "strong and consistent link" (p. 78); "robust process, using conservative assumptions" (p. 80); "robust evidence base" (p. 84); and "strong and consistent evidence" (p. 121). APoSM employs similar rhetorical language, including: "the evidence base is extensive" (p. 10); "modelling is … well-founded and robust" (p. 10); "strong evidence" (p. 55); and "evidence consistently indicates" (p. 55).

4. As shown below, these bold claims ignore conflicting evidence, and often are presented prior to an actual examination of evidence, so the accompanying review is presented, *ipso facto*, as obvious truth. This language is misleading and in the current context, deliberately so. It should be removed or modified.

Economic modelling by Sheffield

5. In principle, minimum unit pricing operates by placing a floor under prices for alcohol beverages, with an intended effect of limiting choice for all drinkers, especially harmful or hazardous drinkers who tend to consume greater quantities of low-cost and/or higher-alcohol content beverages. Evidence for beneficial effects of minimum pricing are based largely on the University of Sheffield Model as adapted for Wales. The Sheffield Study is deficient:

5.1 Many details of the Sheffield Model are largely unknown or underreported for Wales and other countries (e.g., Canada, Scotland, UK), including forecast error intervals for policy simulations. Confidence intervals for forecasts increase in size as model inputs or parameters are changed importantly relative to current values.[2] Sheffield regressions and simulations lack standard measures of forecasting accuracy. The estimates are always presented as "precise" *point estimates* (e.g., reduction of 53 deaths and 1,400 fewer hospital admissions, SS, p. 10), which hides the range of uncertainty for effects and possible benefits of MPA. Although a sensitivity analysis is presented for some parameters (p. 77), this does not fully capture uncertainty surrounding forecasts for a 20-year period. Statistical forecast intervals and forecast statistics should be presented for all Sheffield Model estimates. Point estimates are insufficient as the sole scientific basis for MPA. All estimates should include standard errors, and confidence intervals for parameter estimates should be reflected in the sensitivity analysis.

5.2 Estimated own-price elasticities for the UK (SS, p. 25) are not representative of values obtained elsewhere for beverage alcohol, and most cross-price elasticity estimates do not meet a widely-accepted test for statistical significance ($p < 0.05$). For example, a meta-analysis by Nelson (2014a) reports a consensus beer price elasticity that is only -0.20 compared to values of -0.98 (off-premise) and -0.79 (on-premise) used by Sheffield (p. 25).[3] Even if the Model can be shown to be internally valid, its external validity is in doubt. Further, large elasticities by beverage reported by Sheffield do not coincide arithmetically with an overall average elasticity of -0.50 used elsewhere in MPA reports (APoSM, p. 54; EM, p. 28; and SS, p. 79). Price elasticity estimates for Wales for harmful and hazardous drinkers are required to formulate an evidence-based MPA policy.

5.3 Various other Sheffield estimates show low overall levels of statistical reliability. As one example, the Sheffield Study (p. 29) in Table 4.5 reports statistical models for risks of binge drinking and mean daily consumption. Values for R-squared statistics range from only 0.19 to 0.45, indicating that less than 50% of variation in the data are explained by the regressions. Uncertainty in estimates in

[2] As explained by P. Kennedy, A Guide to Econometrics, 6th ed. (2008, p. 332), an error interval is smallest at average values of a data set and expands away from the means. See also J.S. Armstrong, Standards and Practices for Forecasting (2001), available at http://forecastingprinciples.com. One possible way to demonstrate legitimacy of a forecast or simulation is to save part of a data sample for model validation. This is referred to as *cross-validation* (Kennedy, p. 102), and helps to internally validate a given model. To the best of my knowledge, Sheffield has not done this modelling exercise. Hence, robustness of the Model is largely unknown, contrary to EM (p. 80).

[3] The consensus value of -0.20 is incorrectly reported as -20 in EM (p. 32). The full citation for Nelson (2014a) is given below, which is incomplete in EM (p. 32). EM also incorrectly reports the year of publication. For additional evidence regarding own-price elasticity values, see the reviews in Nelson (2013d, 2013e, 2014a, 2016c), which correct for "*publication bias*."

Table 4.5 is not reflected in model simulations.[4] This is important because some alcohol-related harms are linked to "peak day consumption." In many cases, parameters are reported without standard errors or other indicators of significance. For example, Table 4.13 (p. 48) simply reports slope estimates for work absence, without regressions or associated standard errors. This is incomplete reporting of key results. All statistical estimates and simulations using the Sheffield Model need to report standard errors, complete regression results, and forecast error intervals and other pertinent statistics.[5] Only if model simulations reflect statistical (in)accuracy can policymakers accurately judge the possible range of impacts of MPA.

5.4 A major omission in the Sheffield Study is its failure to model outcomes if there is a shift in major parts of the price distribution when a MUP is imposed on the lower end of that distribution (EM, p. 135). An across-the-board shift in prices imposes costs on all consumers, regardless of drinking level, which are not accounted for in current benefit-cost calculations.[6] Sheffield Model simulations need to be modified to account for this possibility, but more importantly benefit-cost analysis for MPA needs to reflect costs that will be imposed on moderate consumers due to higher prices generally.

5.5 EM (p. 64) argues erroneously that it is not possible to quantify ". . . a possible reduction in consumer utility" **[**due to higher prices**].** Monetary measurement of loss of consumer surplus from price increases is a standard exercise in benefit-cost analysis, and it is inconceivable that this statement was written by a trained economist. Hence, it is not known accurately that ". . . MUP policies would have only a small impact on moderate drinkers" (EM, p. 65). The benefit-cost analysis should be modified to account for loss of consumer surplus arising due reduced consumption of alcohol by all consumers, under a variety of assumptions concerning the final distribution of prices.

5.6 In addition to MUP, the Sheffield Model is used to evaluate other possible policies, including a general 10% price increase and a ban on below-cost selling. For the latter, the Sheffield Study (p. 79) argues that "a policy to ban below-cost selling has virtually no impact on consumption and alcohol-related harms." This conclusion is premature without statistical confidence intervals for all Model estimates. The statement is based on point estimates, which might have wide ranges. Simulations of other policies require confidence intervals for the forecasts involved. The estimates also fail to account for a general shift in the distribution of alcohol prices, following imposition of a MUP.

5.7 Simulation modelling is not a perfect substitute for evidence of actual real-world price differences and changes. The Sheffield Model is based on general population data. The scientific evidence assessed, however, should be focused on harmful and hazardous drinkers. Population-level econometric studies incorporate all manners of drinking levels and patterns, including in many instances individuals who abstain from consumption of alcohol.

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[4] The Sheffield Study (p. 28) incorrectly reports that these estimates are contained in Table 4.6.

[5] Coefficient of determination or R-squared is the standard measure of the amount of variation explained by a regression model. It is subject to possible misuse if investigators simply miss-specify the model to increase R-squared. However, the Sheffield Study for Wales fails to include specification tests of any kind.

[6] For example, Stockwell et al. (2011, p. 916) reports actual price-distribution increases for moderate- and higher-priced products of about 1% to 2.6% compared to average real price increases of 3.6% for lower-end products.

Evidence relating to heavy drinking, alcohol prices, and alcohol harms

6. EM (pp. 27-35) provides a highly selective survey of the evidence base relating to impacts of price on alcohol consumption and associated harms. The survey is neither comprehensive nor systematic, but it is used to arrive at a sweeping conclusion that ". . . in the *majority of cases*, this evidence demonstrates that in response to an alcohol price increase, there is a decrease in alcohol consumption and – crucially – a decrease in alcohol-related harm and mortality. Likewise, when there is a decrease in price, alcohol-related harm increases" (EM, p. 32, emphasis added). These claims are erroneous and misleading.

7. A comprehensive review of alcohol policies related to taxes and prices is important for several reasons. First, the Sheffield Model is not a study of real-world policy changes relating to prices, alcohol taxes, minimum prices, below-cost selling, or other policy changes. The Sheffield Model might be best described as a "correlational study," which leaves issues of causality unresolved. Second, MUP is targeted toward heavy and hazardous drinking, and many economic studies are based on population-level data. Third, as noted by EM (p. 32, citing Boniface et al. 2017), the evidence-base for MUP has been produced by a small number of research teams and "the quantitative uncertainty in many estimates or forecasts is often poorly communicated outside the academic literature." This comment echoes my concern above that the Sheffield Study has failed to provide sufficient statistical uncertainty measures.[7]

8. I next provide several examples of the incompleteness of evidence cited by EM for alcohol and price as it relates to both heavy drinkers and alcohol-related harms. My critique is not complete, but is provided to indicate that there are important scientific omissions in EM and APoSM, which need to be rectified before decisions are made on the MPA Bill. The additional evidence considered here pertains to real-world price changes, and not those produced by model simulations. This is important as external validation of Sheffield Model estimates for Wales.

8.1 **Switzerland** – EM (p. 33) cites one study for Switzerland (Heeb et al. 2003) for an actual policy-induced change in alcohol prices.[8] However, there have been five studies of this policy change for alcohol consumption, with conflicting results (Nelson and McNall 2017, p. 430). Overall, Swiss results indicate that spirits consumption rose *modestly and temporarily* for heavy drinkers following a price reduction. One study also is available for Switzerland for changes in alcohol dependency among younger drinkers, with *null results* (Nelson and McNall 2016b, p. 268).

8.2 **Finland** – there has been extensive study of policy-induced changes in Finnish prices, but EM (p. 33) reports results for only three studies for alcohol-related harms. This is selective reporting. For consumption changes, Nelson and McNall (2017, p. 424) report results for nine studies. We conclude that "overall, consumption results for Finland are mixed" (p. 425), with possible *short-term effects* on heavy drinkers and little effect on lower-income younger persons and youth. For alcohol-related harms, Nelson and McNall (2016b, p. 267) review 28 studies covering multiple harms, including

[7] Similar issues exist in other Sheffield studies cited in support of MUP, such as Meir et al. (2009) that reports off-premise and on-premise average prices paid by UK drinkers with different average consumption levels. Results in Meir et al. do not include standard errors, so it is uncertain if any of the reported differences in average prices are statistically significant.

[8] Studies of actual policy-induced changes are often characterized as "natural experiments" in contrast to more abstract modelling approach used by Sheffield. Natural experiments address some causality issues left uncertain in the abstract modelling approach.

studies relating to mortality and hospitalizations (15 studies); assaults and other crimes (5 studies); drink-driving (3 studies); intoxication (4 studies); and alcohol-dependency (2 studies). Results are generally mixed for most harms, but lower prices in Finland had some effects on mortality and hospitalizations, especially for liver disease among older persons (p. 270). This result is indicative of nuanced or selective effects of alcohol price changes on distinct subpopulations and/or distinct alcohol-related harms.

8.3 **Sweden** – EM (p. 34) ignores the large body of evidence relating to price reductions in Sweden, and chooses to focus exclusively on one study of quality substitution due to a price increase. Nelson and McNall (2017, p. 427) examine 13 studies of Swedish alcohol consumption following actual policy-induced changes in prices. Numerous null or negative results are reported in these studies, and again any increases in consumption appear to be *short-term* in nature. In addition, Nelson and McNall (2016b, p. 267) review 20 studies for alcohol-related harms in Sweden following actual price changes. We conclude (p. 270) that any effects on mortality and hospitalizations were *short-term* in nature, and other effects were weak or non-existent.

9. **Summary of alcohol consumption changes following actual price changes in five countries** – In a peer-reviewed study, Nelson and McNall (2017) examined 29 primary studies containing 35 sets of results for alcohol consumption, including results for binge drinking (18 studies), young adult and youth alcohol consumption (18 studies), and older adults and heavy-drinking adults (16 studies). Results are reported for five countries, and some studies cover multiple countries or outcomes. Our general conclusion from a comprehensive review is as follows:

> *Overall, we find a general lack of consistent results that can provide a sound evidence-base for development of alcohol tax policy. In all countries there is a lack of robust results for major segments of the population, following interventions that reduced prices and relaxed import quotas . . . In many cases, positive policy effects are short-term in nature or apply to particular groups of individuals or subpopulations . . . what we learn from this review is that alcohol tax and price changes are likely to have selective effects on drinking and drinking patterns* (Nelson and McNall 2017, p. 431).

10. **Summary of alcohol harm changes following actual price changes in nine countries** – In a peer-reviewed study, Nelson and McNall (2016b) examined 45 studies for nine countries for five harmful outcomes: mortality and hospitalizations; assaults and other crime; drink-driving; intoxication; and alcohol-dependency.[9] We reviewed 69 outcomes as some studies covered more than one harm or country. Our results and conclusion are summarized as follows:

> *Findings indicate that changes in taxes and prices have selective effects on harms. Mortality outcomes are positive for liver disease and older persons, especially in Finland and Russia. Mostly null results for assaults and drink-driving are found for five countries. Intoxication results*

[9] It is worth noting that EM fails to address issues of social unrest, public nuisance, and other anti-social behaviors that are often associated with drinking by youth and young adults and sporting events. Results in Nelson and McNall (2016b) for intoxication may capture this type of harm. There is not strong evidence that intoxication is increased by lower prices. Some indirect evidence on this issue might also be found in so-called field studies that examine several on-premise pricing practices such as happy hours, pitcher specials, drinking games, and buying rounds. Boniface et al. (2017, p. 10) review only one laboratory study in their "systematic" review of minimum pricing. In contrast, Nelson (2015a, p. 9) reviews six field studies, with mixed results for binge drinking outcomes.

> *for Nordic countries are mixed for selective subpopulations. Results for survey* [dependency] *indexes are mixed, with no strong pattern of outcomes within or across countries. Prior reviews stress taxes* [and pricing] *as a comprehensive and cost-effective intervention for addressing alcohol-related harms. A review of natural experiments indicates the confidence placed on this measure is too high, and natural experiments in alcohol policy had selective effects on various subpopulations* (Nelson and McNall 2016b, p. 264).

11. While policy changes studied by Nelson and McNall (2016b, 2017) do not include minimum unit prices as such, they do provide information on the kinds of evidence cited by EM in support of a MUP policy for Wales. Further, these policy changes entail across-the-board price reductions. Heavy drinkers account for a substantial share of total alcohol consumption. If harmful and hazardous drinkers are as sensitive to prices as claimed by supporters of MUP, then one might expect to see dramatic effects of these natural experiments on both alcohol consumption and alcohol-related harms. Dramatic effects are not apparent, especially over the longer-run.

12. Three other systematic reviews by Nelson (2013c, 2014d, 2015a) – all peer-reviewed – provide evidence on price-sensitivity of individuals who engage in heavy or hazardous consumption of alcohol. Only one study – Nelson (2013c) – was incorporated in EM (p. 82) and APoSM (p. 54), which again is indicative of uninformed or selective reporting. A summary of each review follows:

12.1 **Nelson (2013c)** examined 19 individual-based studies (survey sample methods) that examine price responses by heavy-drinking adults and nine studies of prices and cirrhosis mortality. A total of 573 studies relating to alcohol prices and taxes were retrieved as a first step in the review process, with final selection based on further examination of studies and their content. The 19 studies for consumption excludes population-level empirical studies. The 19 studies include results from five countries, while the nine studies cover multiple countries, including an international OECD panel.[10] This peer-reviewed study concluded the following:

> *The review finds only two studies* [out of 19] *of heavy drinking with a significant and substantial negative price response. For cirrhosis mortality, only two studies* [out of 9] *find a significant negative price response. Overall, the role of price and taxes as a significant deterrent to heavy drinking by adults is uncertain* (Nelson 2013c, p. 265).[11]

12.2 **Nelson (2014d)** provides a review of alcohol prices and gender differences for drinking and heavy drinking by adults and young adults. Starting again with a broad database, relevant studies were narrowed to 15 studies of adult drinking and eight studies of drinking by young adults, aged 18-26 years. As in Nelson (2013c), this review included discussion of samples, measurement and econometric issues, and key empirical results in each primary study. I attempt to review all relevant

[10] Small samples of studies in systematic reviews result from a tight focus on closely-related studies. This contrasts with the "kitchen-sink" approach used in some studies; e.g., a MUP review by Boniface et al. (2017) combines MUP studies with several other studies are not closely-related to MUP; see EM (p. 32). The same problem occurs in the sample of "heavy drinking" studies reviewed in Wagenaar et al. (2009); see EM (p. 29).

[11] Since publication of this survey, I have re-examined EU data on cirrhosis mortality with a focus on statistical outliers in the data sample; see Nelson (2015b). My study of "affordability" of alcohol is contained in Nelson (2014b), which demonstrates that increased "affordability" of alcohol in most countries of the OECD and EU is due to rising real personal incomes and not falling real prices.

evidence on the issue at hand, and not a selective slice thereof. Results of the peer-reviewed study are as follows:

> *First, adult men have less* [price] *elastic demands compared to women. Second, there is little or no price response by heavy-drinking adults, regardless of gender. Third, although the sample is small, price might be important for drinking participation for young adults. Fourth, the results strongly suggest that heavy drinking by young adults, regardless of gender, is not easily dissuaded by higher prices* (Nelson 2014d, p. 1260).

12.3 **Nelson (2015a)** conducted a systematic review – again peer-reviewed – for effects of alcohol prices (or tax surrogates) on binge drinking for three age groups: youth, young adults, and adults. Outcomes examined include binge participation, intensity and frequency. Criteria for data collection and potential sources of bias are discussed, including adequacy of price data. Fifty-six relevant studies were found, with studies and results distributed equally among three age groups. Also found were five natural experiments for tax reductions and six field-based studies examining price-promotions in bars and pubs. This is a much larger sample of results compared to reviews used in EM (p. 29, citing Wagenaar et al. 2009; Elder et al. 2010). My review included results for four countries. An innovation in Nelson (2015a, p. 4) is a demonstration of under-reporting of econometric studies that occurs in earlier reviews by public health researchers, such as Wagenaar et al. (2009, 2010). My systematic review of binge drinking studies concludes that:

> *Null results or mixed results are found in more than half of the studies. The body of evidence indicates that binge drinkers are not highly-responsive to increased prices. Non-responsiveness holds generally for younger and older drinkers and for male and female binge drinkers alike. Increased alcohol taxes or prices are unlikely to be effective as a means to reduce binge drinking, regardless of gender or age group* (Nelson 2015a, p. 1).

13. As MUP is specifically targeted at harmful and hazardous drinking, it is particularly important that the evidence-base focus on that element of drinking and on real-world price changes as opposed to simulations of price changes or evidence for population-level drinking. Evidence for alcohol harms does suggest that there might be some positive benefits for highly-selective subpopulations, but selective effects are better dealt with through more targeted policies, rather than a population-level MUP policy.

14. **Overall, these five reviews cover numerous studies, countries, sub-populations, drinking patterns, and outcomes. My systematic reviews provide virtually no support for the notion that MUP will be effective over the long-term in reducing heavy use of alcohol or alcohol-related harms. The extensive nature of these reviews is in stark contrast to the limited and selective summaries contained in EM and APoSM.**

15. Based on a limited review, APoSM (p. 54) argues that ". . . taken as a whole, there are far more estimates demonstrating a strong relationship between alcohol and price compared to a handful that do not [citing only studies by Nelson 2013c and Ayyagari et al. 2013]. As such there is strong evidence to support a connection between the price of alcohol and demand for alcohol."

15.1 **This statement is a red herring** in my opinion, and unfortunately appears repeatedly in the public health research literature (e.g., Babor et al. 2010, p. 125). The issue is not overall "demand for alcohol," but price responses of those drinkers who are targets of the MPA Bill, *viz., harmful and*

hazardous drinkers. APoSM is correct that numerous studies demonstrate a relationship between price and alcohol demand (see Nelson 2013e, 2013d, 2014a), but most of these studies are not relevant for evaluation of the MPA Bill – they are concerned with all manners of drinking levels and patterns, including light, moderate, and heavy drinkers combined in population-level studies. It is my professional opinion that only studies in my five systematic reviews – and similar focused studies – are relevant to the MPA Bill and MUP.[12] These reviews and primary studies should be given careful assessment prior to final consideration of the Bill. APoSM fails to provide sufficient appraisal of the evidence-base for heavy drinkers and real-world price changes. The APoSM report is incomplete and misleading.

16. EM (pp. 31-32) also selectively cites literature pertaining to alcohol prices and heavy drinking. The EM report appears to be suggesting that only one or two studies have reported a weak link between prices and heavy drinking. **This suggestion is false and misleading**. The EM (p. 32) also incorrectly cites Nelson (2014a) as a study of "harmful and hazardous drinkers." It is not; rather it is a study of population-level drinking.

17. As an indication of results in other studies relevant for MPA, I have appended quotations and references from 16 selected studies. The appendix provides a summary of studies that report null or negative statistical results for alcohol prices and heavy drinking or alcohol-related harms. None of these 16 studies are cited in EM and only one of the studies is cited in APoSM. More complete and detailed results are contained in tables in my five reviews:

- Nelson (2013c) – Table 3 for 19 primary studies for heavy-drinking adults (p. 274); Table 4 for 9 primary studies cirrhosis mortality (p. 277).
- Nelson (2014d) – Table 2 for 15 primary studies for adults (p. 1267); Table 3 for eight primary studies for young adults (p. 1270).
- Nelson (2015a) – Table 2 (p. 7), with binge-drinking studies divided according to youth (18 studies); young adults (20 studies); adults (19 studies); and studies using natural experiments (5 studies) and field methods (6 studies).
- Nelson and McNall (2016b) – Table 3 (p. 268) for a summary of five categories of alcohol-related harms, divided by positive vs. null evidence, for 69 outcomes (45 primary studies).
- Nelson and McNall (2017) – Table 2 for alcohol consumption in Denmark (6 studies); Table 3 for Finland (9 studies); Table 4 for Hong Kong (2 studies); Table 5 for Sweden (13 studies); and Table 6 for Switzerland (5 studies).

18. A summary of these five systematic reviews is Nelson (2016c), "Economic evidence regarding alcohol price elasticities and price responses by heavy drinkers," **Public Health Open J**, 1 (2), Aug 2016, 36-39. Open Access at: http://dx.doi.org/10.17140/PHOJ-1-108

[12] Empirical results in Stockwell et al. (2001, 2012) for minimum pricing in Canada do not address heavy, harmful or hazardous drinkers, and are therefore largely irrelevant for evaluation of the MPA Bill. As noted by EM (p. 31) ". . . an MUP is more targeted towards the heaviest drinkers," but alcohol measures in the Stockwell studies concern entire provincial populations of drinkers. There are numerous other flaws in Stockwell's empirical studies, including: omission of "adding-up" constraints; omission of cross-price effects; omission of measures of goodness-of-fit; and inconsistent results. Results also are not robust to a first-differencing of data, which likely renders the data stationary. Numerous other MUP studies in the alcohol literature are based on hypothetical changes in prices, and not actual real-world price changes as in the natural experiments reviewed in Nelson and McNall (2016b, 2017).

Anticipating unintended consequences

19. Governments around the globe have experimented with population-level market interventions to limit undesired activities or promote those activities that are currently politically popular or desired. Unintended consequences often result since it is impossible to close-off all forms of innovation by consumers and producers. The EM report, MPA Bill, and several commentaries speak to issues of unintended consequences, such as cross-border shopping (EM, p. 84, p. 128); product substitution and/or innovations (p. 132, p. 140); rent-seeking activity (p. 136); non-price competition (p. 139); mixed or joint sales (Bill, sections 5-7); illicit and illegal alcohol use (EM, p. 83; Duffy and Snowdon 2012; O'May et al. 2015, 2016); and general effects on consumer spending patterns (EM, p. 83; Snowdon 2014). This is a long list. The MPA Bill also incorporates a "sunset provision" in Section 21-22, which provides for a report on operation and effects of MPA. This is at least tacit recognition that MPA could be ineffective or have unintended consequences that may not be desired.

19.1 Another unintended consequence of alcohol policy is that beneficial effects are often short-lived. As discussed above, this is apparent in many studies examined by Nelson and McNall (2016b, 2017). Other recent econometric studies also indicate that alcohol policy interventions can have short-run effects for alcohol-related harms that do not carry-over in the long run.[13]

19.2 The possibility exists for positive short-run effects if a MUP is instituted, but null or negative effects in the long run. Hence, provisions should be made that anticipate this consequence.[14] First, political and governmental organizations should refrain from self-congratulatory speeches and notices regarding MUP, since effects may be short-lived. Second, for appraisal of effects of MUP (if implemented), methodologies should be adopted that recognize the potential for short-run effects only.[15] Third, considering the highly political nature of alcohol policy in Wales and the UK, those groups who are closely associated with the Bill should not be major participants in the "sunset review." This includes individuals responsible for the Sheffield Model as well as other prominent members of the public health research community, who have been at the heart of MUP debate in Wales, UK, Ireland, and Scotland. Frankly, it is ludicrous to suggest that such vested interests do not exist.

19.3 As discussed by Craven et al. (2013), there are a wide range of issues that proponents of minimum prices must first resolve, including such concerns as substitution of marijuana and other illegal or illicit drugs for low-price alcohol.[16]

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[13] See, e.g., R. McClelland and J. Iselin, Do alcohol excise taxes reduce motor vehicle fatalities? Evidence from two Illinois tax increases, Tax Policy Center, Urban Institute and Brookings Institution, October 2017. This study is consistent with long-term results reported in Nelson and McNall (2016b, 2017), and contrary to results in Wagenaar et al. (2015) and Wagenaar et al. (2010). The latter study is cited favorably in EM (p. 29).

[14] In financial markets, short-run effects are referred to as "announcement effects." For a recent study of this economic phenomenon, see H. Allcott and T. Rodgers, The short-run and long-run effects of behavioral interventions: Experimental evidence from energy conservation, American Economic Review 104, 2014, 3003-37.

[15] What I have in mind here are assessment methods that address issues of causality and selection, such as employed for assessment of US labor supply programs. For an introduction, see J.D. Angrist and J-S Pischke, Mostly Harmless Econometrics: An Empiricist's Companion (Princeton University Press: 2009).

[16] B.M. Craven, et al., The economics of minimum pricing of alcohol, Economic Affairs 32, 2013, 174-89.

What can be done

20. A brief review of the MPA Bill indicates that it is unlikely to achieve its objectives. The EU and APoSM reports are incomplete as scientific evidence in support of MPA. My evaluation indicates the scientific errors and omissions in these reports. However, this letter is not a complete evaluation as several additional issues deserve attention, such as methods used to determine benefits and costs of MPA and major shortcomings in empirical studies of existing MUP policies. The focus of the MPA Bill is harmful and hazardous consumption of alcohol and alcohol-related harms that are a consequence of this level or pattern of alcohol use. Harmful and hazardous drinkers, including youth, are not responsive to alcohol prices as depicted by the Sheffield Model or many other claims in the public health literature. **Population-level studies do not reveal this insensitivity.** Review of real-world changes in alcohol prices indicates that effects on alcohol-related harms are likely to be nuanced or selective.[17] These effects also may be short-term in nature. It is important to remember that the objective of the Bill goes beyond just increasing prices at the low-end, and entails a desired long-term reduction in harms.

21. In conclusion, it is my opinion that other policy actions besides MPA need to be considered:

1. Maintain the existing policy banning below-cost sales of alcohol at off-premise outlets.

2. Adopt policies proposed under EM Option Two (p. 92), especially education programs targeting children and young people, that strengthen the focus on alcohol misuse. Implement laws and regulations to reduce alcohol sales and drinking in conjunction with athletic sporting events and other youth-oriented events, such as public concerts. Consider limits on beverages that combine alcohol and caffeine. Consider an increase in the legal age to 19 or 20 years. Better enforce existing laws on underage consumption.

3. Consider additional policy actions that better target harmful and hazardous drinkers of all ages, including strengthening of laws and penalties for drink-driving, public intoxication, underage drinking, and other actions that are closely related to harmful or hazardous consumption. Penalties such as drink-driving fines are more salient than broad population-level policies such as advertising bans and minimum prices. Better enforce existing laws on hazardous consumption.

22. Thank you for this opportunity to comment on the MPA Bill. Alcohol-use harms are a serious problem in Wales and other countries. Such problems deserve serious review and evaluation, including scientific reviews that do not meet current public health views on political correctness. Evidence-based policies should be based on consideration of all scientific evidence, and not a selective slice thereof.

Respectfully submitted:

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Dated: November 26, 2017

[17] See, e.g., A. Allamani, et al., A commentary on the limits of alcoholic beverage policies, Alcohol and Alcoholism 52, 2017, 706-14 [suggesting that alcohol policy must consider social and cultural context].

Appendix – 16 representative studies reporting negative/null results for heavy drinking:

● The estimated tax effects among the whole population . . . are relatively large and significant among light drinkers but shrink substantially for moderate and heavy drinkers. We cannot reject that alcohol consumption of the latter types is unresponsive to tax changes (An and Sturm 2011, p. 19).

● The more [price] responsive group is more likely to be non-white, female, married, and older and to consume less alcohol . . . Our results indicate that the heavier drinking group is insensitive to price; thus higher taxes would be unlikely to reduce negative externalities for older drinkers (Ayyagari et al. 2013, p. 102).

● Taxation policies which increase the price of alcohol, and are very efficient at decreasing harms associated with reduced average consumption, may be relatively inefficient at decreasing alcohol harms associated with high-intensity drinking (Brynes et al. 2012, p. 2).

● The beer tax estimate for heavy episodic drinking is negative in sign but not statistically significant (Carpenter et al. 2007, p. 9).

● Increases in beer prices . . . [for] both binge drinking and underage drinking . . . indicate that male college students are virtually unresponsive to price (Chaloupka and Wechsler 1996, p. 122).

● The liquor [tax] responsiveness of self-reported drinks per month is large among women and those aged 25 to 55. . . . results based on the full sample had suggested that binge drinking was unresponsive to all of the tax measures. This pattern is repeated in models based solely on these particular groups. More specifically, none of the results in Table 5 indicates that increased alcohol taxation reduces binge drinking (Dee 1999, p. 15).

● For heavier drinking . . . the overall price elasticity of increased salience of drinking is negative (-0.411) but not statistically significant . . . the qualitative pattern in the price elasticities is largely insensitive to our inclusion of these [state alcohol] policy variables (Farrell et al. 2003, pp.129-30).

● According to the results, alcoholic beverage taxes have no effect on alcohol consumption. For the general population, taxes have no effect on neither the number of drinks consumed nor binge drinking (Gius 2002, p. 80).

● The negative own price effect for occasional and moderate drinkers is consistent with the consumer behaviour but the insignificant effect for the heavy drinkers is against intuition . . . the results are not inconsistent with those found in Manning et al. (Harris 2006, p. 794).

● Both the frequency and intensity of moderate drinking are sensitive to price . . . At the extremes, heavy drinking by the most-informed consumers is much more price elastic than moderate drinking, while the estimated price elasticities of heavy drinking for the least-informed consumers are not statistically significantly different from zero (Kenkel 1996, pp. 306-07).

● The results indicate that both light and heavy drinkers are much less price elastic than moderate drinkers. Further, we cannot reject the hypothesis that the very heaviest drinkers have perfectly price inelastic demands (Manning et al. 1995, p. 123).

● Alcohol prices do not affect mortality rates due to chronic liver diseases. Empirical results in the study do not lend support to broad price-based approaches to alcohol policy (Nelson 2015, p. 1).

● All three models show a negative impact of current distilled-spirits taxes on log cirrhosis mortality rates, although the effect is not significant in Model 2 . . . Wine and beer tax rates . . . are never significant predictors of cirrhosis mortality (Ponicki and Gruenewald 2006, p. 936).

● Logistic regression analyses were conducted to identify predictors of heavy drinking . . . Neither degree of crowding nor the discounting of drinks significantly contributed to the model (Stockwell et al. 1993, pp. 1522-23).

● Price had negative effects on the probability of heavy episodic drinking and drinking and driving among heavy drinkers, but the effects were not statistically significant (Stout et al. 2000, p. 408).

● However, after adjustment for adult binge drinking, the association between tax and youth drinking was attenuated and no longer statistically significant [i.e., no direct effect] . . . We observed similar findings when assessing the effect of adult binge drinking on the relationship between tax and youth binge drinking (Xuan et al. 2013, p. 1717).

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"What Happens to Drinking when Alcohol Policy Changes? A Systematic Review of Five Natural Experiments for Alcohol Taxes, Prices, and Availability" (w/ A.D. McNall), **European Journal of Health Economics**, 18 (4), April 2017, 417-34.

Written evidence from Christopher Snowdon, Institute of Economic Affairs

The evidence in favour of minimum pricing comes almost exclusively from theoretical modelling from the Sheffield Alcohol Research Group (SARG) based at Sheffield University. SARG has been repeatedly commissioned by governments to update and revise their findings, but nobody - to my knowledge - has been commissioned to replicate their research or verify their results.

In the view of statisticians I have spoken to, it would be impossible for an independent researcher to replicate the findings because the underlying assumptions are not always made clear. Insofar as its assumptions are discernible, they are frequently wrong. I wrote a paper discussing some of these flaws with the statistician John Duffy several years ago which can be found here:

https://static1.squarespace.com/static/56eddde762cd9413e151ac92/t/573d9a94859fd04293de33a8/1463655061615/ASI_SAPM.pdf

For a shorter read, this recent article by the Adam Smith Institute's Sam Bowman gives a good overview of some of the problems with the Sheffield University approach:

https://www.adamsmith.org/blog/minimum-alcohol-pricing-is-policy-based-evidence-making

What is being proposed is unprecedented and it is impossible to predict how consumers will react to a 50p minimum unit price. The data do not exist for a reliable model to be created. But a lack of evidence does not mean that we should trust anything that calls itself evidence. The SARG reports are based on assumptions that are often dubious and sometimes manifestly incorrect. It brings the policy-making process into disrepute when an unrealistic computer model designed by vocal advocates of minimum pricing is treated with the same respect as scientific evidence.

So, what is *likely* to happen?

a) The only certain outcome is that it will raise the cost of a wide range of alcohol products (sparkling wine being the notable exception) and therefore increase the cost of living for millions of people. Unlike alcohol duty, it will not provide any revenue for public services. It will simply wipe out the bottom end of the market and force consumers who have a preference for budget brands to buy mid-range brands.
b) It will almost certainly incentivise cross-border alcohol sales between England and Wales. Much of this is likely to be for personal consumption, but the profits to be had from selling the cheapest ciders, beer and spirits in Wales under MUP are far from trivial.
c) It is likely to lead to a shift from cider to spirits for dependent drinkers. A shift to the cheapest illegal drugs is also highly plausible among some groups, including young people.
d) The increase in the cost of living for those who do not wish to reduce their alcohol consumption will likely lead to cuts in other parts of the household budget, such as food and heating, by those on low incomes.
e) It is likely to further damage the pub trade as drinkers aim to economise on alcohol (see this article: https://health.spectator.co.uk/its-the-economy-stupid-why-minimum-pricing-wont-work/)

f) For all these reasons, it is likely to be unpopular with the general public when they are finally confronted with the newly priced products. The fact that the policy is plainly regressive and effectively exempts the rich makes its unpopularity more likely.

For a brief overview of the likely unintended consequences, see here: https://health.spectator.co.uk/minimum-pricing-wont-end-alcoholism-it-will-make-the-addiction-more-deadly/

Finally, many untruths are routinely told by advocates of minimum pricing. The following list is by no means exhaustive, but is offered as a starting point to bring the debate into the arena of reality.

a) 'Alcohol is much cheaper than it was in previous decades' (usually 1960 or 1980 are mentioned). Untrue: the price of alcohol has risen in both nominal and real terms almost continuously for decades. Between 1980 and 2015, for example, alcohol price inflation was 23% higher than retail price inflation (see Table 4: http://digital.nhs.uk/catalogue/PUB20999). This is largely due to above-inflation rises in alcohol duty implemented over many years. The UK currently pays 40 per cent of all the alcohol duty in the EU. By the standards of many European countries, there is no cheap alcohol in Britain.
b) 'Consumption rises in line with affordability'. Untrue. When people say that alcohol is cheaper (see (a) above), the most charitable interpretation is that they mean that alcohol is more *affordable.* Greater affordability is largely a function of rising incomes which have made nearly everything more affordable over several decades. One of your witnesses on 23 November noted that alcohol consumption rose between 1960 and 2002 as alcohol became more affordable. It is telling that he stopped at 2002 as there has been an 18 per cent drop in consumption in the UK in the years since despite alcohol becoming still more affordable (and despite the absence of any significant new alcohol policies, bar the relaxation of licensing laws). An 18 per cent decline in alcohol consumption is more than four times greater than the four per cent decline that will be brought about by a 50p MUP if the Sheffield model is correct. The Welsh Assembly's website says: 'Alcohol is now 60 per cent more affordable than it was in 1980.' This is true, but it is also a fact that per capita alcohol consumption in the UK is exactly the same as it was in 1980 (9.4 litres). These are interesting figures and yet I do not see much interest shown in them by health groups and legislators.
c) 'Minimum pricing has been shown to work in Canada'. Untrue: the system used in some Canadian provinces is not the same as minimum unit pricing as advocated in Wales and it has not been shown to 'work'. One activist-researcher, Tim Stockwell, has made several claims about unfeasibly large declines in alcohol-related deaths, hospital admissions and crime as a result of relatively small increases in the minimum price in British Columbia. Official statistics do not support any of these claims. This article gives a good layperson's overview: http://www.thejournal.ie/minimum-unit-pricing-alcohol-ireland-facts-2932210-Aug2016/?utm_source=shortlink
d) 'Minimum pricing will not affect moderate drinkers.' Untrue: as I show in (e) below, the policy will affect most alcohol sales. The claim that moderate drinkers will pay only slightly more under minimum pricing is based on findings from the Sheffield model and is based on the assumption that moderate drinkers consume just 5.5 units per week. This is not a definition of moderate drinking that most people would recognise.

e) ‘Minimum pricing will only affect the cheapest, high strength alcohol.’ Untrue: around three-quarters of off trade beer and cider sales, two-thirds of spirits sales and two-fifths of wine sales will be affected by the policy. See table below (taken from SARG’s 2014 analysis).

Table 4.2: Proportion of alcohol sold in Wales below a range of MUP thresholds

	Proportions sold below thresholds (2014 prices)		
	40p	**45p**	**50p**
Off-trade beer	40.8%	55.2%	72.1%
Off-trade cider	59.7%	70.3%	78.2%
Off-trade wine	12.2%	24.9%	41.5%
Off-trade spirits	9.3%	47.0%	65.5%
Off-trade RTDs	0.0%	0.0%	0.0%
On-trade beer	1.4%	1.9%	2.4%
On-trade cider	0.0%	0.0%	3.4%
On-trade wine	0.1%	0.1%	0.1%
On-trade spirits	1.4%	2.7%	4.5%
On-trade RTDs	0.0%	0.0%	0.0%

f) ‘Minimum pricing is needed to address the negative externalities of alcohol.’ Untrue: excessive drinking creates negative externalities, such as costs to the police and health services, and raising the cost of alcohol to the point at which those costs are internalised is an idea of which economists generally approve. Normally this is done with a Pigouvian tax, but minimum pricing could serve the same purpose. However, alcohol duty currently raises £12.8 billion in the UK, exceeding the costs to public services by around £8 billion. Most of the costs that anti-alcohol campaigners claim are externalities are actually internal costs borne by the individual. Failing to make the appropriate distinction leads to greatly inflated estimates of the costs and gives the misleading impression that drinkers are not ‘paying their way’.

Christopher Snowdon
23 November 2017

Supplementary evidence from Christopher Snowdon, Institute of Economic Affairs

The committee asked me to provide evidence that alcohol and drugs can be substitute goods. Here are a few studies showing this…

1. http://www.sciencedirect.com/science/article/pii/S0165176505002016 This study finds that cannabis is a substitute for alcohol, with alcohol consumption declining when cannabis is legalised.

2. http://www.nber.org/papers/w4212 This study looks at minimum purchase laws for alcohol and concludes: "We find that increases in the minimum drinking age did reduce the prevalence of alcohol consumption. We also find, however, that increased legal minimum drinking ages had the unintended consequence of increasing the prevalence of marijuana consumption."

3. http://www.nber.org/papers/w4662 This study looks at youth consumption of cannabis and alcohol and finds that "successful marijuana related efforts in the 'War on Drugs', which can be expected to reduce the supply of marijuana and, hence, increase its price will not only lead to less marijuana consumption, but will have the unintended consequence of raising alcohol consumption".

4. http://www.journals.uchicago.edu/doi/abs/10.1086/668812 This US study looks at medical marijuana legalisation and finds that it leads to fewer alcohol-related traffic fatalities, suggesting lower rates of binge-drinking. (Note that the alcohol industry in the US lobbies against marijuana liberalisation. This study also finds that alcohol prices fell when medical marijuana was legalised which, as the authors note, "marijuana and alcohol are substitutes". Both these facts suggest that drinks companies are well aware that cannabis is a rival product.)

5. https://www.ncbi.nlm.nih.gov/pubmed/15380293 This study found that amphetamines were a substitute for alcohol and that cocaine & ecstasy were complements.

6. https://www.ncbi.nlm.nih.gov/pubmed/18201842 This study found that alcohol was a substitute for cocaine, amphetamine and cannabis.

7. https://academic.oup.com/alcalc/article/45/5/403/184976 Finally, this study contains a useful review of the evidence and links to other studies. "While alcohol is the most heavily consumed intoxicant worldwide and the volume of harms attributable to alcohol use are considerable, it is fallacious to presume that consumers do not have a choice of intoxicant and are not willing to substitute and complement substances in order to achieve intoxication… Policies aimed at reducing alcohol consumption can be successful. However, evidence suggests a significant minority of consumers are likely to substitute or complement consumption with a range of intoxicants suggesting that policy is unlikely to reduce all-cause mortality and morbidity."

That study also mentions the experience in Russia which is relevant to minimum pricing: "The rapid increase in the alcohol price in Russia motivated consumers to substitute licit alcohol with illicit alcohol, likely exposing themselves to similar levels of harm and possibly greater harm and, critically, placing themselves outside of further policy-level interventions."

I was also asked about the price of drug Spice. Here are DrugWise's latest estimates of drug prices in the UK: http://www.drugwise.org.uk/how-much-do-drugs-cost/

MPA 11
Bil Iechyd y Cyhoedd (Isafbris am Alcohol) (Cymru)
Public Health (Minimum Price for Alcohol) (Wales) Bill
Ymateb gan Yr Athro Stockwell
Response from Professor Stockwell

University of Victoria

Canadian Institute for Substance Use Research
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November 27, 2017

Dr Dai Lloyd
Chair, Health, Social Care and Sport Committee
National Assembly for Wales
Cardiff Bay
Cardiff, CF99 1NA

Dear Dr Lloyd,

Re: Public Health (Minimum Price for Alcohol) (Wales) Bill.

Thank you for inviting my comments on this important proposed new alcohol and public health legislation. My experience has been principally around evaluating the impact of changes in the minimum price rates applied by Canadian provincial government monopolies, describing the ranges of minimum pricing policies used and analysing them from the perspective of public health. Much of the proposed Bill concerns enforcement practices of which I have some limited local knowledge. In May 2016, the British Columbia's government Liquor Distribution Branch (LDB) applied its minimum pricing regulations explicitly for the first time to private liquor stores along with a system of warnings and fines. Prior to that, minimum prices for applied in government liquor stores and only in theory to private liquor stores which we found in price surveys would be often non-compliant. We did a small evaluation (as yet unpublished) of this new policy which may be relevant to the Welsh situation. It uncovered the fact that the LDB relied heavily on information provided by competitors i.e. if one outlet broke ranks and priced too low, their competitors were naturally keen to draw this fact to the attention of the enforcement agency. The point of this is to suggest that in the regulations thought is given to adequate enforcement structures as well as enabling and encouraging information from the public and from industry members if they see a failure to comply with the new Bill.

In reading your draft Bill (I am no lawyer) I noted a few things. Firstly, the formula for calculating the appropriate price is incredibly elegant and that should aid interpretation and compliance. I think it will also be necessary to provide some kind of app for people to make these calculations - and perhaps a regularly updated and searchable website with information on most commonly available brands.

I notice also how carefully the Bill is worded to stop loopholes such as bulk discounting, multi-buy and other schemes offering alcohol along with other goods as part of a package discount. I expect there may be problems with enforcement of this in practice with questions about what would be the applicable price for the other product if it was not sold with alcohol. Supposing the product was unique and not otherwise available for sale? How would one determine its usual price?

It may be obvious in the UK context, but is it worth stipulating that the minimum price applies to the final retail price inclusive of all sales and other taxes? In Canada we have the bizarre situation that all prices are quoted in retail outlets before such taxes are applied so we would

not make the assumption that it applies to the final price. I wonder though if some retailers might try to claim they misunderstood the Bill in this regard?

I notice some exemptions include products which are at least occasionally used as alcoholic drinks even if they are not intended to. Cooking wine is a good example. Here we also have medicinal alcohol or "rubbing alcohol" which is sometimes purchased and consumed after being mixed with soft drinks to disguise the flavour and make it more drinkable. It may complicate things too much but you might like to consider including some of these other products and consider ways in which access to them might be limited e.g. if they are available for sale in a department store for the general public then the MUP would apply because risk of misuse is high. If sales of the product are limited to people in a recognised business (e.g. restaurants, food manufacturers) then the lower price could apply. I would note that we have a small problem here with the misuse of non-beverage alcohol, I believe more so than you do in the UK, possibly because we cannot buy products like white cider at ridiculously low prices! However, we have collected evidence that using these products is a last resort for a few people who would mostly use less harmful strategies when they cannot afford alcohol.

I notice the fine is stated as £200 although this might be varied in the future. This strikes me as an incredibly small fine if it were to be applied to a chain of stores where the potential for a mistake to reach many customers is much larger. I recommend consideration is given to varying the fine according to different categories of alcohol suppliers. I also recommend that consideration be given to a system of warnings in the first instance as the legislation is enacted and that repeated offences attract higher fines on a sliding scale.

I may have missed it, but I don't see reference to linking the MUP to the cost of living. This is a really important aspect. A few Canadian provinces (e.g. Ontario) ensure their minimum prices are updated annually. I would recommend if possible updating the MUP quarterly so it doesn't attract so much attention each time it is changed and is routine. Failure to adjust values with inflation will obviously reduce floor prices in real terms and put upward pressure on consumption and, in turn, alcohol-related problems.

Many thanks again for requesting my input. I hope some of these points may be of use. Please do not hesitate to contact me for any further information about our research on minimum prices in Canada.

Sincerely,

[redacted]

Tim Stockwell, PhD, FCAHS, MA (Oxon.), M.Sc.
Director, Canadian Institute for Substance Use Research
Professor, Department of Psychology
University Victoria

University of Victoria

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December 5, 2017

Dr Dai Lloyd
Chair, Health, Social Care and Sport Committee
National Assembly for Wales
Cardiff Bay
Cardiff, CF99 1NA

Dear Dr Lloyd,

Re: Canadian evidence examining associations between minimum price changes and levels of alcohol related harm

Please find enclosed/attached some copies of published papers on this topic. These papers focus primarily on British Columbia where my research base is located. Please note that minimum prices have been in operation here for at least 30 years. They have not kept pace with inflation and have only occasionally been adjusted. Our research has examined short and longer term impacts each time a minimum price for a particular beverage is increased. Alcohol industry critics of our research have pointed out that over much of the period we look at, alcohol consumption and related harm has increased despite our having minimum pricing. This criticism indicates a complete lack of understanding of what our research achieved as we simply demonstrated an inverse association between price and harms – for most of the time the value of minimum pricing has declined in British Columbia resulting in increased consumption and related harm. This research was primarily funded by a peer reviewed grant I obtained with a team of other researchers from the US and UK from the Canadian Institutes of Health Research. We also published three papers examining the experience of Saskatchewan where there was an especially sudden change in minimum pricing policy that presented more a clear-cut natural policy experiment. Note that this resulted in estimates of higher impacts on alcohol consumption than in British Columbia.

Please find below a list of the papers (from oldest to newest) provided with comments (**) about their contribution.

1. Hill-McManus, D., Brennan, A., Stockwell, T., Giesbrecht, N., Thomas, G., Zhao, J., Martin, G. and Wettlaufer, A. (2012) Model-based appraisal of alcohol minimum pricing in Ontario and British Columbia: A Canadian adaptation of the Sheffield Alcohol Policy Model Version 2. Technical Report, Centre for Addictions Research of BC, University of Victoria, British Columbia, Canada. See: Services Society by the Centre for Addictions Research of BC, University of Victoria, BC.
https://www.uvic.ca/research/centres/cisur/assets/docs/report-appraisal-alcohol-minimum-pricing.pdf

** The Sheffield University modelling team collaborated with us to generate estimates of the potential benefits of introducing minimum unit pricing into Canadian provinces. Of note is that their estimates are highly conservative in comparison with the empirically derived estimates of actual impacts each time minimum price rates have been adjusted in British Columbia.

2. Stockwell T, Auld MC, Zhao JH, Martin G. (2012) Does minimum pricing reduce alcohol consumption? The experience of a Canadian province. *Addiction*, 107(5): 912-20. http://onlinelibrary.wiley.com/doi/10.1111/j.1360-0443.2011.03763.x/epdf

** This paper examined a long time series of precise alcohol sales data for different beverage types across 89 areas of British Columbia to examine how this changed each time the minimum price of a particular beverage increased. Note that the overall trend in consumption is both up and down, more recently it has been up reflecting increasing privatization of the liquor market in this province. Nonetheless significant and measurable downward impacts on consumption are detected each time the minimum price increases in real terms. On average, a 10% change in minimum price is associated with an opposite effect on per capita consumption of 3.4%.

3. Stockwell, T., Zhao, J., Martin Stockwell T, Zhao J, Giesbrecht N, Macdonald S, Thomas G, Wettlaufer A. (2012). The raising of minimum alcohol prices in Saskatchewan, Canada: impacts on consumption and implications for public health. American Journal of Public Health. 102(12): e103-10, http://ajph.aphapublications.org/doi/pdf/10.2105/AJPH.2012.301094.

** This paper documents a sudden impact on consumption when a policy quite similar to Minimum Unit Pricing is introduced overnight. A 10% change in average minimum pricing was associated with an opposite effect on per capita consumption of 8.4%. Consumers also shifted to lower strength beer and wine. The government owned alcohol distributor collected more revenue after the policy was introduced.

4. Stockwell, T., Zhao, J., Martin, G., Macdonald, S., Vallance, K., Treno, A., Ponicki, W., Tu, A. & Buxton, J. (2013). Misleading UK alcohol industry criticism of Canadian research on minimum pricing. *Addiction*, 108(6) 1172 http://onlinelibrary.wiley.com/doi/10.1111/add.12178/pdf .

** This paper explains how industry criticisms of our research were deliberately misleading and did not reflect the methods we used or conclusions reached.

5. Zhao, J., Stockwell, T., Martin, G., Macdonald, S., Vallance, K., Treno, A., Ponicki, W., Tu, A. and Buxton, J. (2013). The relationship between changes to minimum alcohol price, outlet densities and alcohol-related death in British Columbia, 2002-2009. *Addiction*, 108(6) 1059-1069 URL:http://onlinelibrary.wiley.com/doi/10.1111/add.12139/pdf. Accessed: 2013-02-27. (Archived by WebCite® at http://www.webcitation.org/6EkhrCmAX).

** A large and immediate effect was detected in relation to changes in average minimum pricing having opposite effects on 100% alcohol caused deaths across 89 local areas of BC. A delayed impact after three or four years was also detected on alcohol-related diseases following changes in minimum price rates.

6. Stockwell, T., Zhao, J., Martin, G., Macdonald, S., Vallance, K., Treno, A., Ponicki, W., Tu, A., & Buxton, J. (2013). Minimum alcohol prices and outlet densities in British Columbia, Canada: Estimated impacts on alcohol-attributable hospital admissions. *American Journal of Public Health*, 103(11) 2014-2020. http://ajph.aphapublications.org/doi/pdf/10.2105/AJPH.2013.301289

** A significant association was found between changes in average minimum prices in BC and opposite effects on rates of acute alcohol-related hospital admissions (i.e. injuries, poisonings). Similar to Zhao et al (2013) an association was also found between changes in average minimum price and opposite changes in rates of alcohol-related diseases.

7. Stockwell, T. (2014). Minimum unit pricing for alcohol. *British Medical Journal*, 349:g5617. http://www.bmj.com/content/349/bmj.g5617

** This paper is a high-level commentary and makes reference to likely reasons multinational alcohol companies oppose minimum pricing even though it guarantees increased profits to high-profile producers such as those represented by the Scotch Whiskey Association.

8. Stockwell, T., Zhao, J., Marzell, M., Gruenewald, P., Macdonald, S., Ponicki, W. & Martin, G. (2015). Relationships between minimum alcohol pricing and crime during the partial privatization of a Canadian government alcohol monopoly. *Journal of*

Studies on Alcohol and Drugs, 76(4), 628-634. http://www.jsad.com/doi/abs/10.15288/jsad.2015.76.628

** Large and inverse associations were reported between average minimum alcohol pricing and some crimes. The estimates have wide confidence intervals. The direction of the relationship is more certain than its estimated level.

9. Stockwell, T., Zhao, J., Sherk, A., Callaghan, R., Macdonald, S., & Gatley, J. (2017). Assessing the impacts of Saskatchewan's minimum alcohol pricing regulations on alcohol-related crime. *Drug and Alcohol Review,* 36, 492–501. http://onlinelibrary.wiley.com/doi/10.1111/dar.12471/epdf

** Some short-term and delayed impacts detected on Saskatchewan crime rates following the major overhaul in minimum pricing in that province in 2010.

10. Thompson, K., Stockwell, T., Wettlaufer, A., Giesbrecht, N. & Thomas, G. (2017). Minimum Alcohol Pricing Policies in Practice: A Critical Examination of Implementation in Canada. *Journal of Public Health Policy*, 38 (1): 39-57. https://link.springer.com/content/pdf/10.1057%2Fs41271-016-0051-y.pdf

** This paper describes the diversity of how minimum pricing is applied in liquor stores and bars across Canada's 10 provinces. Wide differences are reported in terms of how comprehensive the minimum prices are, whether they are applied to bars and/or liquor stores, the level that is set and whether they are indexed to the cost of living.

11. Zhao, J., & Stockwell, T. (2017). The impacts of minimum alcohol pricing on alcohol attributable morbidity in regions of British Colombia, Canada with low, medium and high mean family income. *Addiction*, 112, 1942-1951. http://onlinelibrary.wiley.com/doi/10.1111/add.13902/epdf

** This paper explores relationships previously reported in study #6 above for different regions of British Columbia divided according to average household income. Larger and more significant associations are mostly found for lower income regions. It is concluded that minimum pricing as an effective method for reducing health inequalities.

Please do not hesitate to ask if you would like more information discussion of these published findings.

Sincerely,

[redacted]

Tim Stockwell, PhD, FCAHS, MA (Oxon.), M.Sc.
Director, Canadian Institute for Substance Use Research
Professor, Department of Psychology
University Victoria

Alcohol Concern
Hybu iechyd;
Gwella bywydau

Alcohol Concern
Promoting health;
Improving lives

Alcohol Concern's written evidence to the Health, Social Care and Sport Committee of the National Assembly for Wales on the Public Health (Minimum Price for Alcohol) (Wales) Bill

General principles

1.0 Alcohol Concern strongly supports the principles of the Public Health (Minimum Price for Alcohol) (Wales) Bill. Despite a small decline in alcohol consumption in the UK over the last few years,[1] more needs to be done to reduce the avoidable harms resulting from alcohol misuse. Managing the price of alcohol is an important component of that work.

1.1 A review of international evidence, published by Bangor and Glyndŵr Universities in 2011 came to the following very clear conclusion: "Within the international literature on reducing alcohol consumption and the harm related to alcohol, the finding with the strongest evidence base is that consumption of alcohol is highly sensitive to changes in price (or, to be more accurate, affordability). When the price of alcohol drops, more is consumed; when alcohol becomes more expensive, less is consumed. This effect is seen across the entire population that drinks alcohol".[2]

1.2 Historically, taxation has been the method used in the UK to adjust the price of alcohol. However:

- The duty system for alcohol in the UK is loaded with historical anomalies and does not relate closely to the alcoholic strength of drinks.[3] For example, even after the recent Budget announcement on cider duty comes into force in 2019, the duty on all ciders from 1.3% to 6.8% ABV will be the same[4]

[1] British Beer and Pub Association (2017) *Statistical handbook 2017*, London, BBPA.
[2] Bailey, J. et al. (2011) *Achieving positive change in the drinking culture of Wales*, Wrexham, Glyndŵr University.
[3] op. cit. British Beer and Pub Association.
[4] HM Treasury (2017) *Autumn Budget 2017: duty on high strength ciders*, London, HM Treasury, online, available at:

- Research has shown that after rises in alcohol duty, some supermarkets pass more of the duty increases on to mid-range and top-end products, in order to keep their cheapest alcohol prices down;[5] and some drinks producers have said quite openly that they absorb some duty increases so as not to raise their prices for consumers.[6]

1.3 A form of baseline price for alcohol in England and Wales was established in 2014 when the then Chancellor introduced legislation banning the sale of alcohol below the combined cost of excise duty and VAT. This was intended to prevent "businesses from selling alcohol at heavily discounted prices" and thereby reduce "excessive alcohol consumption and its associated impact on alcohol-related crime and health harms."[7] However, the total of VAT and duty is a very low threshold, and it has been found that less than 1% of alcoholic drinks on sale have been affected by this measure.[8] Researchers have concluded that it has had "almost no impact on population consumption, spending and alcohol-related harms".[9]

1.4 Minimum unit pricing (MUP) is a more effective, fairer and more targeted method of regulating the price of alcohol, in that it correlates directly with the amount of pure alcohol (ethanol) in any container or serving of a drink, regardless of what type of drink it is (beer, cider, wine, spirit or mixed) and regardless of where it is sold (in a pub, club, restaurant or shop). By setting a baseline price below which a unit of alcohol (10ml of ethanol) cannot be sold, MUP will have the greatest impact on drinks sold at the lowest prices relative to their alcoholic strength – drinks which tend to be favoured by the heaviest drinkers.[10, 11] This will be most obvious in the case of white ciders, for which there is little or no demand apart from that from people who are dependent on alcohol.[12, 13] Conversely, MUP would have a minimal financial impact on people drinking moderately (within the UK Chief Medical Officers' guidelines), for whom there would be a projected average increase in the cost of drinking of a few pounds per year (or a few pence per week).[14] As such, MUP very much

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https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/661438/duty_on_high_strength_ciders.pdf [accessed 22 November 2017].

[5] Ally, A. K. et al. (2014) *Alcohol tax pass-through across the product and price range: do retailers treat cheap alcohol differently?*, Addiction, 109(12), pp1994-2002.

[6] Turney, E. (2010) *Magners absorbs cider duty hike*, Morning Advertiser, 26 March 2010.

[7] Home Office (March 2017) *Guidance on banning the sale of alcohol below the cost of duty plus VAT*, London, Home Office.

[8] Brennan, A. et al. (2014) *Potential benefits of minimum unit pricing for alcohol versus a ban on below cost selling in England 2014: modelling study*, BMJ, September 2014.

[9] Meng Y. et al. (2014) *Model-based appraisal of minimum unit pricing for alcohol in Wales: An adaptation of the Sheffield Alcohol Policy Model version 3*, Sheffield: ScHARR, University of Sheffield.

[10] Alcohol Concern (2015) *Alcohol brands consumed by young people in treatment 2015*, London, Alcohol Concern, 2015.

[11] Holmes, J. et al. (2104) *Effects of minimum unit pricing for alcohol on different income and socioeconomic groups: a modelling study*, The Lancent, 10 February 2014.

[12] Goodall, A. (2011) *White cider and street drinkers: recommendations to reduce harm*, London, Alcohol Concern.

[13] Chick, J. et al. (2016) *Alcohol pricing and purchasing among heavy drinkers in Edinburgh and Glasgow*, London, Alcohol Research UK.

[14] op. cit. Meng Y. et al.

accords with the Prudent Healthcare principles of doing only what is needed, no more, no less; and of reducing inappropriate variations in health outcomes using evidence-based practice.[15]

1.5 MUP could also not be side-stepped by alcohol retailers in the way that the 2010 Scottish ban on multiple purchase discounts (such as three bottles for the price of two) has been, with "the industry appearing to have responded to the ban by replacing multi-buy with simple price reduction [on individual items]."[16]

Unintended consequences

2.0 Given that Wales and Scotland will be the first territories in the world to introduce MUP based solely on the alcoholic strength of drinks, there may be unforeseen or unintended consequences, as with any new policy or initiative. Alcohol Concern therefore advocates robust evaluation of the implementation of MUP in Wales and its effects (as will also be happening in Scotland as part of Monitoring and Evaluating Scotland's Alcohol Strategy).[17] In both territories, this will provide a unique opportunity to carefully observe the impacts of MUP in a real-world environment. Similarly, the inclusion of a 'sunset clause' will mean that, should the anticipated reductions in harm not manifest within an agreed period, then the measure could be adjusted or reversed.

We have examined some of possible consequences of MUP below.

Will MUP undermine local pubs?

2.1 The impact of MUP will be felt almost entirely in the off-trade (off-licences and supermarkets) rather than the on-trade (pubs, clubs and restaurants). Field research by Alcohol Concern in Wales in October and November 2017 found many products on sale in shops well below the probable MUP threshold of 50p per unit. These included:

- 70cl of vodka or gin for £10.00: 38p per unit
- 70cl of fortified wine for £2.99: 27p per unit
- 3 litres of strong cider for £3.99: 18p per unit.[18]

[15] Welsh Government (2015) *Prudent healthcare – setting out the prudent principles*, online, available at: http://www.prudenthealthcare.org.uk/principles/ [accessed 16 November 2017].
[16] University of Cambridge press release (2013), *New study reveals that the ban on alcohol multi-buy promotions in Scotland did not reduce the amount of alcohol purchased*, online, available at: http://www.cam.ac.uk/research/news/new-study-reveals-that-the-ban-on-alcohol-multi-buy-promotions-in-scotland-did-not-reduce-the-amount [accessed 29 November 2017].
[17] See: http://www.healthscotland.scot/health-topics/alcohol/monitoring-and-evaluating-scotlands-alcohol-strategy [accessed 17 November 2017].
[18] Full survey findings available on request from Alcohol Concern Cymru.

Conversely, when we surveyed the price per unit of popular drinks sold in pubs and bars,[19] the cheapest drink we found was cider at 98p per unit, nearly twice the proposed 50p per unit threshold. The average prices we found for cider, lager and red wine in pubs were £1.36 per unit, £1.43 per unit and £1.53 per unit respectively.[20]

2.2 Many publicans believe that MUP could be advantageous to them by redressing to some extent the price disparity between the on- and off-trades. An Alcohol Concern survey of publicans in Wales in 2012 found that 77% supported a 50p MUP, and that 94% believed that cheap alcohol in supermarkets and off-licences was damaging their trade.[21] More recently, UK-wide research has found that 83% of publicans believe supermarket alcohol is too cheap, and 73% think increasing its price should be a priority for politicians in tackling alcohol problems.[22] In 2010, the Rural Development Sub-Committee of the National Assembly concluded that "the availability of cheap alcohol in supermarkets…undermines those smaller producers seeking to develop and sell quality products, as well as threatening the future of community pubs".[23]

Incentivising reductions in the alcoholic strength of drinks

2.3 One unintended but welcome consequence of MUP may be that it creates an incentive for producers to innovate by offering a greater range of less alcoholic drinks or by lowering the strength of some current brands, thereby providing more options for consumers who wish to moderate their consumption. A similar effect was observed following the 50% reduction in 2011 in the duty on beers of 2.8% ABV or less.[24] Within a year, sales of these products had reportedly risen by more than 40% nationwide.[25]

2.4 To illustrate this possible impact of MUP on the strength of drinks: wine typically has an alcohol content of around 12% to 13%, meaning that a standard bottle contains 9 to 10 units of alcohol. If we take the example of a 12.5% Sauvignon Blanc currently on sale in a popular supermarket for £3.89,[26] this contains just over 9 units per bottle, and with a 50p

[19] The drinks surveyed were Strongbow or Magners cider at 4.8% ABV, Heineken or San Miguel lager at 5% ABV, and Merlot wine at 12.5% to 13.5%.
[20] Full survey findings available on request from Alcohol Concern Cymru.
[21] Alcohol Concern (2012) *Minimum unit pricing and the pub*, Cardiff, Alcohol Concern.
[22] Institute of Alcohol Studies (2017) *Pubs quizzed: What publicans think about policy, public health and the changing trade*, London, IAS.
[23] National Assembly for Wales Rural Development Sub-Committee (2010) *The wine, beer, cider and spirits industries*, Cardiff, National Assembly for Wales.
[24] Leicester, A. (2011) *Alcohol pricing and taxation policies*. IFS Briefing Note BN124, London, Institute of Fiscal Studies.
[25] Roberts, G. (2012) *Low-alcohol beers show their true calibre*, The Independent on Sunday, 18 March 2012 online, available at: http://www.independent.co.uk/life-style/food-and-drink/news/low-alcohol-beers-show-their-true-calibre-7576435.html [accessed 17 November 2017].
[26] See: https://www.lidl.co.uk/en/White-Wine-3659.htm?articleId=1384 [accessed 17 November 2017].

per unit MUP could not be sold for less than £4.69. However, by reducing the alcoholic strength from 12.5% to 10%, the unit content would be reduced to 7½ units and the minimum price at 50p per unit would therefore be £3.75, i.e. less than its current price. Given the incremental increase in the alcoholic strengths of wines over the past 10 to 20 years, this may be a very welcome development.[27] The Scottish Government has already suggested of its own MUP measure that "it is possible that its introduction will incentivise producers to produce lower strength alcohol products as these would retail more cheaply".[28]

Cross-border alcohol shopping

2.5 It is sometimes suggested that MUP in Wales will push consumers who live close to the border with England to purchase their alcohol there. Cross-border food and drink shopping already occurs, of course, where it is more convenient for consumers; but any additional or particular cross-border alcohol shopping will depend on people's willingness and ability to travel, and the price differential compared to the costs of transport. With regards to their own MUP measure, the Scottish Government has concluded that "for most Scots, purchasing in England would incur both a time and travel cost…likely to outweigh any savings on the price of alcohol".[29] Similarly, in instances where shoppers have travelled from the Republic of Ireland to Northern Ireland to take advantage of cheaper alcohol, it has been found that the motivation was cheaper groceries overall, not alcohol in particular.[30] (The comparison with Northern Ireland is probably the most relevant here, since, like Wales, it is a relatively small country with a relatively long border with the adjoining territory; the border between Scotland and England is comparatively short and quite some distance from Scotland's major centres of population).

2.6 In 2011, researchers at Bangor and Glyndŵr Universities reviewed international evidence on cross-border alcohol purchases in various territories and concluded that "overall, the evidence on availability does not uniformly suggest that reducing availability in one area simply leads to people travelling to less restrictive areas" and that "a significant proportion of the population choose to drink less rather than to travel to purchase alcohol".[31] Research by Cardiff and Swansea Universities in 2016 found a strong link

[27] Alston, J.M. et al. (2011) *Too much of a good thing? Causes and consequences of increases in sugar content of California wine grapes*, Journal of Wine Economics, Vol. 6, No. 2, Autumn 2011.
[28] Scottish Government (2012) *Final business and regulatory impact assessment for minimum price per unit of alcohol as contained in Alcohol (Minimum Pricing) (Scotland) Bill*, Edinburgh, Scottish Government.
[29] ibid.
[30] ibid.
[31] op. cit. Bailey, J. et al.

between people's alcohol consumption habits and the distance to their nearest alcohol outlet, suggesting a reluctance to travel more than a few minutes to purchase alcohol.[32]

2.7 References are sometimes made to the Sunday Closing (Wales) Act 1881, which kept pubs in some parts of Wales closed on Sundays until 1991. Although the attempts to evade this measure have entered into folklore – what one Archbishop of Wales memorably described as the "Sunday trek across the English border for drinking purposes"[33] – the vast majority of evasion of this Act involved use of the loophole allowing drinking on private premises, rather than travelling to purchase alcohol.[34]

Cross-border online sales

2.8 The Explanatory Memorandum to the Bill states that "online and mobile businesses licensed in Wales will need to ensure they are charging in line with the MUP when supplying to customers in Wales" but that "online and mobile businesses licensed in England will not be covered by the legislation when supplying to customers in England or Wales".[35] However, it is worth noting that the Home Office's 2015 guidance on the Licensing Act 2003 states that, legally, a sale of alcohol takes place at the point at which the alcohol is "appropriated to the contract (i.e. the place where it is identified and specifically set apart for delivery to the purchaser)" rather than the place where payment is made.[36] This means that even if a Welsh customer purchases alcohol at below the MUP via an internet server outside Wales (as many retailers' servers will be) that order could not be packed and dispatched from any supermarket or warehouse in Wales.

2.9 When the Scottish Government introduced a ban in 2010 on multiple-purchase discounts, Tesco announced that they would side-step the measure by using distribution centres in England.[37] However, it is not clear to what extent this actually happens, and no other retailers appear to have followed suit. Both Tesco and Sainsbury's operate their online service from the local shops, and in the case of Tesco this is what allows them to offer same-day delivery to 98% of UK addresses.[38, 39] Shifting from this distribution model in order to circumvent MUP in Wales would incur substantial extra costs, and seems unlikely to occur.

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[37] BBC Scotland Online (2011) *Online loopholes in Scottish alcohol bill*, online, available at: http://www.bbc.co.uk/news/uk-scotland-15123533 [accessed 17 November 2017].

[38] Withers, I. (2017) *Tesco launches same day delivery across the UK*, Daily Telegraph, 24 July 2017.

[39] See: https://www.tesco.com/wine/help/default.aspx?name=deliveryoptions [accessed 1 December 2017]

Home brewing

2.10 Although home brewing has been mentioned as a possible means to evade MUP,[40] it is unlikely to become anything other than the minority pursuit it currently is,[41] given the time, expense and effort it involves. Our own research indicates that the cheapest home brewing ingredients would allow the production of 40 pints of beer at a price of around 13p per unit (around ¼ of the likely MUP) but an that initial capital investment of around £48 is needed for equipment (taking the cost of the first batch to 66p per unit) and each batch of beer will take 3 to 4 weeks to be drinkable.[42]

Illicit alcohol sales

2.11 The extent and importance of illicit (untaxed) alcohol sales in the UK has been emphasised by some sections of the alcohol industry, although there appear to be some commercial motivations behind this. The Wine and Spirit Trade Association (WSTA) highlight illicit sales in the context of campaigning for reducing the excise duty on their members' products, claiming that current duty rates "create an incentive for duty fraud".[43] Although the British Beer and Pub Association (BBPA) state that "the problem [of illicit alcohol] is being overestimated", they also blame any illicit sales that are occurring on "the huge, and growing discrepancy in rates of beer duty between the UK and neighbouring countries",[44] again as part of a broader campaign for duty reductions for their members.[45]

2.12 On the specific question of MUP, the Scottish Government has said that it does not consider its proposed 50p baseline price is likely to incentivise illicit sales.[46] Even if MUP could be said to provide such an incentive, it is worth remembering that the fact a particular criminal activity is rendered attractive by the costs of producing and selling a product via legitimate channels is not generally regarded as a reason in itself for decriminalising that activity. HMRC, the UK Border Force and other agencies have an extensive range of sanctions they can apply to penalise those involved in the transport and sale of illicit alcohol, including seizure of goods and substantial fines; and since April 2017 it has been an offence for a retailer to buy alcohol from an unapproved source.[47]

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[40] McDonald, L. (2010) *Price-fixing is the wrong way to tackle binge drinking*, IEA blog, 13 August 2010, online, available at: https://iea.org.uk/blog/price-fixing-is-the-wrong-way-to-tackle-binge-drinking [accessed 21 November 2017].

[41] According to one 2014 estimate, "up to 14,000" people in the UK "dip their toe in occasionally" into the hobby, i.e. around 25 in every 10,000 adult drinkers. See: Lee, A. (2014) *Small beer...big business*, Daily Express, 7 July 2014.

[42] Information from the Wilko and Love Brewing websites [accessed 17 November 2017].

[43] See: http://www.wsta.co.uk/what-we-do/policy?id=256 [accessed 17 November 2017].

[44] See: http://www.beerandpub.com/dutyfraud [accessed 17 November 2017].

[45] See: http://www.beerandpub.com/campaigns/pub-jobs [accessed 22 November 2017].

[46] op. cit. Scottish Government.

[47] HM Revenue & Customs (2016) *The HMRC alcohol strategy: modernising alcohol taxes to tackle fraud and*

Increasing supermarket profits at the expense of consumers

2.13 Given that MUP will drive up the price of some drinks (as it is intended to do), one possible consequence could be that it produces a 'windfall' of additional revenue for retailers. However, any such increase is questionable given the tendency of alcohol price increases to drive down sales.[48] It is also worth asking why the major supermarkets, as represented by the British Retail Consortium, have been so persistent in their opposition to MUP if they thought it could be commercially advantageous to them.[49] Should that opposition prove to have been misplaced from a business point of view, with off-trade retail revenues growing as a result of MUP, a portion of this new revenue would be taken by HM Treasury in the form of VAT and excise duty, as at present,[50] and we would advocate a dialogue between the Welsh Government and HM Treasury as to how these new monies might be redirected to provide assistance to those affected by alcohol problems.

Increasing the cost of bulk alcohol purchases

2.14 As noted, above MUP will have the greatest impact on the drinks sold at the lowest prices relative to their alcoholic strength, for a number of which there is little or no demand apart aside from amongst alcohol-dependent drinkers.[51, 52] Alcohol Concern's own research in Wales indicates that there will be less impact on the prices of the drinks brands favoured by most consumers, most of which are sold above the likely MUP of 50p per unit, or only slightly below it.[53] However, MUP is likely to have an impact when such brands are made available with bulk-purchase discounts ('multi-buy' deals). For example:

- We found Isla Negra Merlot on sale in Tesco in November 2017 for £5.00 a bottle, or 53p per unit. However, taking advantage of an offer of 25% off when buying 6 or more bottles took the price down to 40p per unit[54]
- Similarly, Captain Morgan Spiced Rum was on sale in Morrisons at £17 for 70cl, or 69p per unit. The offer of 2 bottles for £22 took the price down to 45p per unit.[55]

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reduce burdens on alcohol businesses, London, HMRC.

[48] op. cit. Bailey, J. et al.

[49] Talking Retail (2009) *Retailers slam minimum pricing*, Talking Retail, 30 September 2009, online available at: https://www.talkingretail.com/news/industry-news/retailers-slam-minimum-pricing-30-09-2009/ [accessed 21 November 2017].

[50] See: https://www.gov.uk/government/publications/alcohol-duty-rate-changes/alcohol-duty-rate-changes [accessed 17 November 2017].

[51] op cit. Goodall, A.

[52] op cit. Chick, J. et al.

[53] Full survey findings available on request from Alcohol Concern Cymru.

[54] See: https://www.tesco.com/groceries/en-GB/products/252954913 [accessed 20 November 2017].

[55] See: https://groceries.morrisons.com/webshop/product/Captain-Morgans-Spiced-Rum/119524011?from=offer_details&param=1003264065&parentContainer=PROMO [accessed 20 November 2017].

2.15 The British Retail Consortium has previously stated that large purchases of alcohol sold at a discount by supermarkets are "for enjoying at home with family and friends over a long period",[56] although they have not so far been able to provide any evidence for this. There is some evidence from other sectors that multiple purchase discounts encourage consumers to make one single large purchase instead of a series of smaller ones. However, such discounts are also routinely used to entice customers to buy more than they initially intended.[57] One Australian study found that consumers who took advantage of point-of-sale alcohol promotions purchased a greater quantity of alcohol than those who did not, and that 40% of customers who took advantage of such promotions said that they had bought a specific quantity of alcohol because of the promotion.[58] Similarly, research undertaken for HMRC in 2013 found that "promotions on less expensive wine and less expensive beer tend to lead to an increase in the total units [of alcohol] purchased" and that "for spirits, the application of individual promotions always led to an increase in the total units purchased".[59]

2.16 Given what we know about the importance of ease of availability and convenience in people's drinking habits, it follows that having a larger stock of alcohol already bought and stored at home is likely to lead to higher consumption. As one participant in research by Greenwich University in 2009 put it, "You can relax more at home…You can just go and get yourself a drink. You sit down and you are pretty much there for the rest of the night."[60]

[56] British Retail Consortium (2014) *Policies and issues: food – alcohol,* online, available at: http://www.brc.org.uk/brc_policy_content.asp?iCat=46&iSubCat=654&spolicy=Food&sSubPolicy=Alcohol [accessed 20 August 2014].
[57] Mohammed, R. (2013) *When it's wise to offer volume discounts*, Harvard Business Review, 25 October 2013.
[58] Jones S.C. et al. (2015) *The influence of price-related point-of-sale promotions on bottle shop purchases of young adults*, Drug and Alcohol Review, 2015;34(2):170–6, cited in Public Health England (2016) *The public health burden of alcohol and the effectiveness and cost-effectiveness of alcohol control policies: An evidence review*, London, Public Health England.
[59] Rohr, C. et al. (2013) *Consumers' responsiveness to alcohol multi-buy sales promotions: results from a stated preference choice experiment*, London, HMRC.
[60] Foster, J. (2009) *Why do people drink at home? An exploration of the perceptions of adult home consumption practices*, London, Greenwich University.

Impacts on dependent drinkers

2.17 Legitimate concerns have been expressed about the possible effects of MUP on alcohol-dependent drinkers; for example, that it could drive them to steal alcohol (or steal in order to buy alcohol), to consume other potentially dangerous alcohols (such as methanol), or to substitute other substances for alcohol.

2.18 It is worth clarifying to start with some of the confusion of terms that has grown up in the public discourse around MUP, in which various supposed types of drinkers have been conflated. Terms such as 'hardened drinkers', 'addicts', 'alcoholics', and 'binge drinkers' are used largely interchangeably to refer to people whom the observer believes have little or no wish or ability to control their drinking. In reality, these terms encompass a range of people who may consume very different amounts of alcohol, over different periods of time, and for very different reasons; and who may have varying degrees of control over their drinking behaviour.

2.19 Alcohol-dependent drinkers are in some senses a distinct group, in that they are people who have become physiologically dependent on alcohol as a result of long-term heavy use. They need to regularly consume alcohol in order to avoid physical withdrawal symptoms (which can occasionally cause death), and they should not stop drinking altogether without a medically supervised detox. The number of dependent drinkers in the population is estimated to be 1.4% of adults, or around 36,000 people in Wales.[61]

2.20 It is possible for dependent drinkers to reduce their alcohol intake, and the experience of alcohol treatment services is that dependent drinkers do adjust their consumption according to supply;[62] but this is only true up to a point. We would therefore argue strongly that in order to be effective, and to avoid potentially dangerous consequences for dependent drinkers, MUP must be accompanied by adequate treatment services to enable people to exit a life of destructive drinking. This should include assertive outreach to engage with the most chaotic drinkers who may not show obvious motivation to drink less.[63] For drinkers who are not physiologically alcohol-dependent, reducing consumption is, perhaps, more straightforward, but we should never underestimate the difficulties faced by those seeking to change their ingrained drinking habits; and again, we will need to ensure that adequate support services are in place.

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[61] Pryce, R. et al. (2017) *Estimates of alcohol dependence in England based on APMS 2014, including estimates of children living in a household with an adult with alcohol dependence: prevalence, trends, and amenability to treatment*, Sheffield, University of Sheffield.

[62] Sherwood Forest Hospitals NHS Trust (2012) *Alcohol: how to reduce your intake safely*, Sutton in Ashfield, Sherwood Forest Hospitals NHS Trust.

[63] Ward, M. and Holmes, M. (2014) *Alcohol Concern's Blue Light project: working with change-resistant drinkers*, London, Alcohol Concern.

2.21 The availability of alternative substances to alcohol for alcohol misusers cannot be ignored. The UK Government has recently noted that new psychoactive substances (NPS) "continue to appear rapidly on the market" and that "use among certain groups is problematic, particularly among the homeless population and in prisons", two populations in which alcohol misuse is also often a serious issue.[64] The Scottish Government has already expressed its intention to commission research into any possible displacement or substitution effects of MUP, including any increase in the use of illicit substances.[65]

2.22 At present, the question of whether alcohol-dependent drinkers will turn to other substances, or to criminal behaviour in order to obtain alcohol, is as yet unanswered. Encouragingly, a recent analysis of patients with serious alcohol problems at two hospitals in Edinburgh found that whilst "cheapness was quoted commonly as a reason for beverage choice…stealing alcohol or drinking alcohol substitutes was only very rarely reported". The researchers concluded that fears of such behaviour "may fit a caricature of the alcoholic" but that "a considerable shift in self-concept of this population would have to occur for substantial numbers to fulfil that stereotype".[66] Similarly, a study in New Zealand of 115 dependent drinkers found that only 2 participants mentioned non-beverage alcohol (such as methylated spirits) as something they had actually consumed, and stealing alcohol was used as a strategy by just 9 people. The research team concluded that "as has been shown in other literature, there is minimal evidence in this group of accessing non-beverage alcohol or of criminal activity to access alcohol when it becomes unaffordable" and that "fears of such behaviours are not valid reasons for rejecting a minimum pricing regime".[67]

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Alcohol Concern, 8 Museum Place, Cardiff, CF10 3BG.

[64] Home Office (2017) *2017 Drug strategy*, London, Home Office.
[65] op. cit. Scottish Government.
[66] Black, H., et al. (2011) *The price of a drink: levels of consumption and price paid per unit of alcohol by Edinburgh's ill drinkers with a comparison to wider alcohol sales in Scotland*, Addiction, 106(4), 729-736.
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MPA 13
Bil Iechyd y Cyhoedd (Isafbris am Alcohol) (Cymru)
Public Health (Minimum Price for Alcohol) (Wales) Bill
Ymateb gan Barnardo's Cymru
Response from Barnardo's Cymru

Credwch mewn plant
Believe in children
Barnardo's Cymru

Barnardo's Cymru Legislative Scrutiny Response

Health, Social Care and Sport Committee Scrutiny

Public Health (Minimum Price for Alcohol) (Wales) Bill

4th December 2017

[redacted]

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- **This response may be made public**
- **This response is on behalf of Barnardo's Cymru**

1. Information and working context of Barnardo's Cymru

Barnardo's Cymru has been working with children, young people and families in Wales for over 100 years and is one of the largest children's charities working in the country. We currently run 86 diverse services across Wales, working in partnership with 16 of the 22 local authorities.

Every one of our services is different, but each believes that every child and young person deserves the best start in life, no matter who they are, what they have done or what they have been through. We use the knowledge gained from our direct work with children to campaign for better child and social care policy and to champion the rights of every child. We believe that with the right help, committed support and a little belief, even the most vulnerable children can turn their lives around. We aim to secure better wellbeing outcomes for more children by providing the support needed to ensure stronger families, safer childhoods and positive futures.

Public Health (Minimum Price for Alcohol) (Wales) Bill

2. Response overview

To inform this response we have sought the opinions of Barnardo's Cymru service managers and team leaders. Consequently this response is informed by the views of Barnardo's Cymru services and will not be repeating or referencing research well known to the committee.

The weight of evidence makes the case for this legislation undeniable; however, as recognised, the positive effects of the legislation are unlikely to make as significant a difference as hoped for in isolation of other measures and approaches.

In short Barnardo's Cymru:

- supports the principle of the Bill
- suggests that approaches to address harmful and hazardous drinking that exists across income groups is required
- would welcome campaigns to address the issues of acceptance within a generally unhealthy drinking culture, and
- would welcome consideration of a stronger children's rights, exploitation and safeguarding focus in the bill

- believes that it will effect a change on the retail purchase of lower cost higher alcohol by volume drinks.

3. Service input

Whilst recognising the issue being addressed by the bill, Barnardo's Cymru services have highlighted a number of issues that will need to be addressed in conjunction with the bill in order to achieve greater change.

Drinking and Children and Young People

These issues generally fall into two areas, firstly children and young people who drink and secondly those affected by family or parent/carer drinking.

Firstly we must recognise that some young people purchase and drink alcoholic beverages legally and responsibly and as such may be unfairly affected by the bill.

Parents and carers behaviour in relation to alcohol exerts a strong influence on their children's alcohol use. The majority of children and young people understand how to manage alcohol with their parents/carers guidance. This will involve parents taking responsibility for purchasing alcohol for older teenagers as part of managing the quantity and strength of alcohol they drink, by advising on the impact and risks of alcohol and by role modelling safe and responsible drinking for them. All of our services reported that much of the alcohol consumed by children, that they are aware of, is provided by parents, family or is usually available at home. Much of this alcohol would not fall into those categories of drinks affected by minimum unit price and isn't being purchased by the children or young people.

Included in this, however, there were anecdotes relating to families where guidance was unhelpful or misguided and examples of some families providing money to young people without considering the associated risks of how this would be spent.

One team leader with significant experience in substance misuse has reported hearing situations new to her. She reported having met a 15 year old boy who on completion of his domestic chores including walking the dog and cleaning his room is rewarded on a Friday with a bottle of Vodka to share with his mates. The boy thinks this is within good and safe parameters; he has earned the

reward by contributing and he and his mates are not sourcing and consuming in unsafe environments.

The same service reported another 15 year old as having in the region of £400 per month disposable pocket money meaning that alcohol costs were of no particularly concern. Both of these boys are from middle income families where parents believe they are acting responsibly.

For many of the children and young people who use substance misuse services because of their own use of substances, it is considered that this legislation will have little effect as alcohol is not usually the drug of choice but one of convenience being utilised if available.

Much is known about the lives of children and young people affected by harmful, hazardous or dependent drinking within the family with significant potential to experience adverse circumstances throughout childhood.

It is also the case that lower income families in general face greater health issues which, when compounded by harmful or hazardous drinking, will make it more likely that the family will suffer the effects of serious ill health and early death.

Barnardo's Cymru supports the intention of this bill to reduce the impact of hazardous and harmful drinking on individuals and that this may have both emotional and practical benefits for the drinker's family.

The Bill and Domestic Violence

This is one of the areas where the weakness of the legislation is most stark. When asked if the bill would help reduce levels of domestic violence, one service manager replied 'That would depend on whether the perpetrator was only violent every time they drank alcohol that was strong and cheap.'

Alcohol generally contributes to experiences, frequency and nature of domestic violence but is not a factor in all circumstances. Domestic violence plays across all income groups leading to the question of what can be done to address equally detrimental effects of alcohol on income groups other than the lowest.

Potential for Unintended Negative Consequences

The responses from Barnardo's Cymru services also highlighted some possible negative impacts. As well as the evident possibility of substituting alcohol with other drugs; services were highlighting the possibility of supplementing family income through prostitution, increases of offending to obtain, increases in exploitation for alcohol and a profitable black market for alcohol.
The legislation could potentially be relatively simple to enforce as this is limited to predominantly licenced and regulated retail activity. There will however inevitably be issues of capacity in trading standards departments to deliver this additional function on much reduced staffing levels.

4. Conclusion

As stated earlier we find that the case for the legislation is undeniable. As also stated the bill might achieve limited progress towards its aims in isolation of other developments. Services highlighted the need for public health education programmes to address knowledge, understanding and culture. They also made comparisons with changes in tobacco use suggesting further restrictions in advertising, consideration of plain packaging and restricted visibility or access on shelves.

Tim Ruscoe
December 2017

MPA 14
Bil Iechyd y Cyhoedd (Isafbris am Alcohol) (Cymru)
Public Health (Minimum Price for Alcohol) (Wales) Bill
Ymateb gan Cancer Research UK
Response from Cancer Research UK

Health, Social Care and Sport Committee – Public Health (Minimum Price for Alcohol) (Wales) Bill
Written evidence from Cancer Research UK

About Cancer Research UK[1]

1. Cancer Research UK is the world's leading cancer charity dedicated to saving lives through research. The charity's pioneering work has been at the heart of the progress that has already seen survival rates in the UK double in the last forty years. In 2015/16, we spent £432 million on research in institutes, hospitals and universities across the UK, funding over 4,000 researchers, clinicians and nurses. We receive no funding from the Government for our research. Our ambition is to see three in four patients survive cancer by 2034.

2. In 2015/16, we funded over £4 million of life saving research in Wales. We have 14 research nurses in Wales working alongside doctors across the country to care for patients taking part in clinical trials.

3. Over 19,000 people in Wales were diagnosed with cancer in 2015 – a 10% increase from 2005.[2] More people are expected to be diagnosed year-on-year, and it is estimated that the number of new diagnoses in Wales will soon reach 20,000.[3]

Question 1: Do you agree with the general principle of the Bill? To what extent will it contribute to improving and protecting health and wellbeing in Wales?

1. We welcome the Public Health (Minimum Price for Alcohol) (Wales) Bill and support its general principles. We are pleased that the Welsh Government intends to introduce of minimum unit pricing (MUP) in Wales.

2. We support this Bill because alcohol consumption is the third biggest preventable risk factor for cancer.[4] MUP has the potential to prevent alcohol related cancers, in turn reducing mortality and reducing financial pressure on the NHS in Wales. This legislation will target the heaviest drinkers at the biggest risk of harm, rather than moderate consumers. Modelling indicates that under a 50p MUP, annual alcohol consumption among moderate drinkers will fall by around 2 units, while consumption among hazardous drinkers will fall by almost 40 units and consumption among harmful drinkers by almost 270 units.[5]

3. MUP will be a crucial component of a comprehensive strategy to reducing levels of alcohol consumption and harm. After this legislation is passed, we would like the Welsh Government

to set the MUP limit at no less than 50p per unit of alcohol. This limit should be reviewed on a frequent basis with a view to increase it to match factors including inflation, if necessary. We believe that 50p is currently the most appropriate pricing limit for Wales. A 50p limit was recommended by the UK Chief Medical Officer in 2008,[6] is likely to be implemented in Scotland in 2018,[7] and has been assessed as likely to be effective by academics.[8] Lower limits will not deliver the required health benefits, while the potential impacts of higher limits have not yet been fully assessed.

4. Alcohol is a major risk factor for cancer and been classified as a Group 1 carcinogen by the International Agency for Research into Cancer (IARC; part of the World Health Organisation) since 1988.[9] [10] Alcohol consumption has been linked to around 12,800 cancer cases in the UK, and is linked with an increased risk of seven types of cancer (mouth and upper throat, larynx, oesophageal, breast in women, liver and bowel).[11]

5. Alcohol is also implicated in a wide range of social problems, particularly crime and workplace absences. In combination, these health and social problems impose a substantial burden on public services and the wider economy. The UK Government estimates that the total cost of alcohol-related harm in England and Wales is £21 billion per year.[12]

6. MUP is a very effective tool in reducing alcohol harm. A major review of the evidence into MUP, which synthesised over 100 systematic reviews and meta-analyses, showed that increasing the price of alcohol is associated with falls in both alcohol consumption and alcohol-related harm.[13] This review noted that 'minimum pricing strategies may constitute an effective part of a broad public health strategy to deal with alcohol-related problems'.[14]

7. Research by the University of Sheffield identified that introducing an MUP of 50p in Wales could lead to almost 1,300 fewer hospital admissions and over 65 fewer deaths per year, with the strongest impact felt among people living in poverty.[15] Earlier economic modelling suggested a potential £131 million of savings in healthcare costs in Wales over 20 years.[16]

8. MUP may also help reduce health inequalities. Price dominates public product choice and consumption, with strong white cider – a product likely to be affected by MUP – forming 25% of the alcohol intake for harmful and hazardous drinkers in all except the most affluent social economic groups.[17] Consumption of white cider creates significant health inequalities in lower socio-economic groups.[18]

9. As well as modelling research, the case for a minimum unit price is justified by several real-world case studies. One study based in Saskatchewan, Canada showed that increasing the MUP by 10% led to an 8.43% decline in the consumption of alcohol.[19] A study based in British Colombia, Canada showed that MUP was linked with reduced acute alcohol related admissions to hospitals after a year, and with reduced alcohol related hospital admissions for chronic problems such as liver disease and cancer after a period of 2-3 years.[20] Raising the price of the cheapest alcoholic drinks in rural Australian communities led to a 19% decline in consumption and subsequent reductions in crime levels and hospital admissions.[21]

Question 2: What are the barriers towards the implementation of the provisions and does the Bill takes account of them?

10. To support the implementation of this Bill, the Welsh Government should provide local authorities with dedicated funding to enforce the legislation. Additional funding will address uncertainties identified in the impact assessment over additional costs arising from "the need for longer or more frequent checks".[22]

11. Additional funding for enforcement is important as Welsh local authorities have limited budgetary and operational capacity. The Welsh Government has already outlined provisional local authority budgets reductions of 0.5% in 2018/19 and a further 1.5% in 2019/20.[23] These reductions may have knock-on effects on both public health and licensing enforcement.

Question 3: Will there be any unintended consequences arising from the Bill?

12. We do not anticipate any unintended consequences arising from the Bill. To prevent any issues arising from inconsistency between MUP levels between each UK nation, and ensure the smoothest possible implementation, the Welsh Government should actively encourage cross-nation collaboration in setting a uniform limit. One avenue for discussion could be through regular chief medical officer meetings.

Question 4: What are the financial implications of the Bill?

13. The Bill's impact assessment gives a fair assessment of its likely financial implications. We agree with its primary message: that the Bill's net health, social and retail benefits will significantly outweigh its introduction, enforcement and evaluation costs.

14. We agree with the impact assessment that MUP will not penalise moderate drinkers. Evidence shows a 50p MUP could lead to moderate drinkers spending £3 per year more a year; hazardous and harmful drinkers face increases of £18 and £48 per annum.[24] This is because MUP increases the cost of cheap, high-strength alcoholic beverages generally consumed by harmful and hazardous drinkers, while maintaining the price of alcohol already sold at the equivalent or above a minimum price.[25]

15. MUP will not affect drinks already sold above the set MUP level. As the University of Sheffield note, assuming a pint of beer contains two units, it would need to cost at least £1, and a bottle of wine containing nine units would need to cost at least £4.50. This means the measure will have most impact upon drinkers who consume large quantities of very cheap, super-strength alcohol, and who are at-risk from a range of health harms.

16. We also agree with the impact assessment's assertion that retailers will benefit from MUP, rather than see revenues contract. A modelling study in Scotland predicted the increase would be around £200 million in the off-trade.[26]

17. As highlighted in the impact assessment, introducing MUP will also deliver significant savings elsewhere. This includes reduced healthcare costs and better population health.

Question 5: Is it appropriate for the Bill to allow Welsh Ministers to make subordinate legislation?

18. Yes, we believe that it is appropriate for the Bill to allow Welsh Ministers to make subordinate legislation – particularly to set the pricing level later. This will allow the Welsh Government to regularly review the price to ensure its continued effectiveness. The process for reviewing the initial limit should be transparent and evidence-based. As part of this process, the Welsh Government should also liaise with other UK nations with MUP to set a uniform pricing level at 50p per unit, to ensure consistency and ease of implementation. It is imperative that price reviews place the interests of public health as the priority mechanism for its revision.

19. The affordability of alcohol shapes consumer behaviour; alcohol prices have increased at a slower rate than incomes, leading to growing affordability and increased consumption.[27] So long as taxes on alcohol are fixed costs on top of the retail price, they will be undermined by inflation unless regularly reviewed and increased at rates at, or above, inflation.[28] It is also important to consider that even if taxes do keep up with inflation levels, alcohol affordability will increase if personal incomes rise.[29] Taxes also do not set a floor price on alcohol multi-buy promotions; an adaptively priced MUP can guard against the cheapest deals.

20. We believe that the Welsh Government should consider a 50p limit when setting the price limit, given strength of evidence of its effectiveness compared to other higher and lower limits, uniformity with Scotland's likely 50p limit, and previous policy recommendations from the UK CMO and other advocacy groups such as the Alcohol Health Alliance.[30] Modelling in England suggested that a limit of 50p would see a 6.8% reduction in alcohol related deaths and a 3.8% fall in hospital admissions each year (after 20 years), compared to 4.3% and 2.4% for a 45p limit.[31]

References

[1] Registered charity in England and Wales (1089464), Scotland (SC041666) and the Isle of Man (1103). Registered as a company limited by guarantee in England & Wales No.4325234. Registered address: Angel Building, 407 St John Street, London EC1V 4AD
[2] Welsh Cancer Intelligence and Surveillance Unit (2017) Cancer in Wales (pdf)
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About the Institute of Alcohol Studies

The Institute of Alcohol Studies (IAS) is an independent institute bringing together evidence, policy and practice from home and abroad to promote an informed debate on alcohol's impact on society. Our purpose is to advance the use of the best available evidence in public policy decisions on alcohol.

Consultation Response

1 We welcome the opportunity to participate in the Health, Social Care and Sport Committee's consultation on the Public Health (Minimum Price for Alcohol) (Wales) Bill. At the outset, we would like to endorse the measures and objectives of the Bill, and to emphasise that minimum unit pricing is an effective, evidence-based, targeted and proportionate way to improve the health and well-being of the Welsh people.

2 The Explanatory Memorandum accompanying the Bill is a thorough and well-researched piece of work, which clearly lays out the case for minimum unit pricing (MUP). We believe that it persuasively demonstrates:

- Alcohol harm carries a vast toll in Wales
- The wealth of academic research shows that raising the price of alcohol reduces consumption, which, in turn, leads to lower rates of harm
- The evidence, both from the actual experience of minimum pricing in Canada and modelling of the effects of the policy in Wales, strongly suggests that MUP would save lives and reduce illness
- MUP would reduce health inequality, as poorer groups would benefit most
- Alcohol taxes would have to be raised dramatically to achieve equivalent health benefits to MUP, and would do so in a less targeted way

3 It is not our intention here merely to repeat the evidence and arguments of the Memorandum. Instead, we wish to use this opportunity to do two things. First, we wish to address some of the objections to MUP raised in the Memorandum. Second, we would like to draw your attention to evidence on certain issues omitted by the Memorandum, but which may be of interest to the inquiry.

Countering challenges to MUP

4 To reiterate, the Memorandum arrays a large number of arguments and pieces of evidence in support of MUP. However, the memorandum cites some challenges to the policy that are not fully dismissed. We believe it would be helpful to explore these to demonstrate the strength of the evidence in favour, as opposed to against, MUP.

Challenge 1: Altering prices has a limited/weak effect on harmful consumption

5 The first challenge to MUP cited in the memorandum is that certain studies suggest that altering prices may have limited or only weak effect on consumption, particularly among harmful drinkers.

6 The Memorandum rightly acknowledges that the vast bulk of academic research indicates that higher alcohol prices are associated with lower consumption and harm. However, it references three studies which call this consensus into question.

7 It is notable that all three of these studies were funded by the International Alliance for Responsible Drinking (previously the International Center for Alcohol Policies), a group with financial ties to the alcohol industry. Such studies are widely treated with suspicion, since industry-funded research has often been found to favour commercial interests, through a mix of deliberate and unconscious bias.[1] Moreover, studies from this research program have been accused of selective use of evidence, and reinterpretation of results to underestimate the impact of price on consumption.[2]

8 Even taken at face value, the studies referenced do not significantly undermine the case for MUP. For example, the Memorandum discusses Nelson & McNall's review of the impact of tax reductions in five countries, suggesting that "not all research shows this direct link between price and consumption".[3] Yet these Nelson & McNall are very different to MUP. Whereas MUP involves price increases, the study looks only at decreases. Especially at high levels of consumption ('saturation'), it is possible that drinkers are less likely to consume more in response to lower prices than they are to cut back in response to higher prices.[4]

9 The Memorandum also claims that there is "some disagreement over the extent to which harmful and hazardous drinkers are responsive to increases in the price of alcohol". This is correct, not least because of the difficulty of researching such groups.[5] Yet even if heavy drinkers are *less* price sensitive, MUP will still be effective so long as it achieves *some* reduction, which most analyses suggest is likely.[6] The fact that increasing alcohol prices has been consistently found to be associated with lower alcohol-related mortality, morbidity and crime is a further reason to believe that it must affect the most harmful drinkers.[7]

10 Moreover, much of the evidence of the consumption patterns of heavier drinkers comes from more modest changes than the introduction of MUP. In many cases, it is plausible that heavy drinkers may respond to an increase in prices by 'trading down' to cheaper products. However, as the Memorandum notes, under MUP there would be far less scope to do this, since the cheapest products would be far more expensive.

11 There is strong suggestive evidence from research with harmful and dependent drinkers, in the UK and abroad, that they would in fact reduce their consumption in response to a substantial increase in prices. For example, Chick & Gill's interviews with patients receiving

[1] Babor, T. & Robaina, K. (2013), Public Health, Academic Medicine, and the Alcohol Industry's Corporate Social Responsibility Activities, American Journal of Public Health 103, pp. 206–14
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[4] Ibid.
[5] Nelson, J.P. (2013), Does Heavy Drinking by Adults Respond to Higher Alcohol Prices and Taxes? A Survey and Assessment, *Economic Analysis & Policy* 43:3, pp265-91.
[6] Wagenaar, AC et al, op. cit.
[7] Ludbrook, A. et al, op. cit.

treatment for alcohol-related conditions in Glasgow and Edinburgh revealed that some had previously cut down in response to a fall in income, while others had traded down to cheaper drinks (which of course would be less possible under MUP).[8] Similarly, a study of New Zealand drinkers in treatment found that 25% reported 'going without' alcohol when they were unable to afford any more – again, the authors note that this would likely be higher if there were less scope to trade down to cheaper products.[9] These findings were replicated in a Canadian study, which found 80% of homeless drinkers have gone without alcohol when unable to afford it.[10]

Challenge 2: MUP will lead to illicit consumption and/or crime

12 The second challenge to MUP referenced in the Memorandum is the possibility that MUP would lead to an increase in illicit alcohol consumption or crime. Again, interviews with harmful and dependent drinkers suggest that such fears are likely overstated. Chick & Gill found widespread suspicion of products of unclear provenance. As one participant put it: "I'm scared of what I put in my body. I know if it's on sale in a supermarket, then it's relatively safe. I wouldn't know what I'd be buying, and I wouldn't know what was in it, and that would scare me".[11] The aforementioned studies in New Zealand and Canada also found that non-beverage alcohol use was very uncommon when heavy drinkers were unable to afford alcohol, as were reports of crime to support drinking.[12] Crucially, the evidence from Canada suggests that any such substitution – if it did occur – would be more than offset by the benefits to those who lower their drinking, since overall the number of deaths decline.[13]

Additional Evidence in Support of MUP

13 While it is entirely appropriate that the Memorandum has focused on the health arguments for MUP, we would like to take this opportunity to draw your attention to the growing evidence of the wider harmful effects of cheap alcohol, so as to demonstrate the full range of potential benefits to the well-being of the Welsh people from the policy.

14 First, we would like to point out that there is widespread public support for MUP. According to the Alcohol Health Alliance's most recent polling, 51% of Welsh residents support the policy, with only 15% opposed (the rest were neutral).[14]

15 Second, we would like to emphasise the potential economic benefits of reducing harmful alcohol consumption. As the Memorandum notes, alcohol negatively affects the economy in a number of ways, including absenteeism through sickness, lower productivity at work, higher unemployment. Of these, absenteeism alone is estimated to cost the Welsh economy £290m over 20 years.[15] Perhaps the most significant economic consequence is premature death:

[8] Chick, J. & Gill, J. (2015), *Alcohol pricing and purchasing among heavy drinkers in Edinburgh and Glasgow*. London: Alcohol Research UK.
[9] Falkner, C. et al (2016), The effect of alcohol price on dependent drinkers' alcohol consumption, *New Zealand Medical Journal* 128: 1427, pp9-17.
[10] Stockwell, T. et al (2012), Working and waiting: Homeless drinkers responses to less affordable alcohol, *Drug & Alcohol Review* 31, pp823-4.
[11] Chick, J. & Gill, J., op. cit.
[12] Falkner et al, op. cit.; Stockwell et al, op. cit.
[13] Stockwell, T. & Thomas, G. (2013), Is alcohol too cheap in the UK? The case for setting a Minimum Unit price for alcohol. London: Institute of Alcohol Studies.
[14] Alcohol Health Alliance opinion Polling 2017. Conducted August 2017 on a nationally representative sample of 110 respondents
[15] Meng, Y. et al (2014), Model-based appraisal of minimum unit pricing for alcohol in Wales. An adaptation of the Sheffield Alcohol Policy model version 3. Cardiff: Welsh Government.

Public Health England estimates that in England 167,000 years of working life are lost each year due to drinking – 16% of the overall total.[16] The burden in Wales is likely to be similar. Despite concerns that reducing alcohol consumption negatively affects industry, econometric analysis has shown that higher alcohol taxes are in fact associated with faster income growth.[17]

16 A common misconception regarding MUP is the concern that it would negatively affect pubs. In fact, almost all pub prices are well in excess of proposed minimum prices – for example, a 50p MUP would require a typical pint of beer to be sold for no less than £1. Less than 1% of pub sales would be affected by MUP.[18] On the contrary, MUP would have greatest impact on the cheap supermarket alcohol that is widely held to be the greatest threat to the survival of pubs. When we surveyed publicans earlier this year, we found that they favoured MUP by a ratio of 2:1, 41% in favour, 22% against.[19]

17 A further, often neglected consequence of cheap alcohol is its impact on emergency services – although the Memorandum describes the impact of alcohol on hospitalisations on page 30. When we investigated the issue in 2015, we found that over half of police time is spent dealing with alcohol-related incidents and that fear and harassment were rife.[20] For example, 76% of police and 50% of ambulance staff had been injured by a drunken member of public; and 52% of ambulance staff had suffered sexual harassment or assault. There was a sense that these services were at breaking point, and MUP was often mentioned as part of the solution. As one police constable put it, “Alcohol price needs to be regulated to be price per unit across the board it would lead to less people drinking at home. At present alcohol is so cheap in supermarkets it is causing a real big issue”.

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[16] Burton, R. et al (2016), The Public Health Burden of Alcohol and the Effectiveness and Cost-Effectiveness of Alcohol Control Policies: An evidence review. London: Public Health England.
[17] Cesur, R. & Kelly, I. R. (2014), Who pays the bar tab? Beer consumption and economic growth in the United States, *Economic Inquiry* 52:1, pp477-94.
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[20] Institute of Alcohol Studies (2015), Alcohol’s impact on emergency services. London: Institute of Alcohol Studies.

The Association of Directors of Public Health

Response to Public Health (Minimum Price for Alcohol) (Wales) Bill Consultation

The Association of Directors of Public Health (ADPH) is the representative body for Directors of Public Health (DsPH) in the UK. It seeks to improve and protect the health of the population through collating and presenting the views of DsPH; advising on public health policy and legislation at a local, regional, national and international level; facilitating a support network for DsPH; and providing opportunities for DsPH to develop professional practice.

The Association has a rich heritage, its origins dating back 160 years. It is a collaborative organisation working in partnership with others to maximise the voice for public health.

ADPH welcomes the opportunity to respond to this consultation and continue to make the case for the implementation of a Minimum Unit Price (MUP) in Wales. As has been shown by a large body of evidence MUP is an effective tool for reducing alcohol harm and its introduction is a key priority for ADPH members.

We are delighted that the Supreme Court on Wednesday 15th November 2017 judged that MUP is legal, clearing the way for its implementation in Scotland. We hope this will further make the case for its implementation in Wales and across the UK.

1. **The general principles of the Public Health (Minimum Price for Alcohol) (Wales) Bill and the extent to which it will contribute to improving and protecting the health and wellbeing of the population of Wales, by providing a minimum price for the sale and supply of alcohol in Wales, and making it an offence for alcohol to be sold or supplied below that price.**

1.1 ADPH strongly supports the introduction of a MUP in Wales.

1.2 ADPH responded to the previous consultation on the Draft Public Health (Minimum Price for Alcohol) (Wales) Bill and that consultation response is available here. In this response we made the case that there is significant evidence for the effectiveness of MUP for reducing alcohol harm, that the legislation would help to strengthen existing strategic action by the Welsh government to reduce alcohol harm, and that MUP would lead to huge savings to society in terms of health costs, crime costs, reduced workplace absence and gains in societal health including the number of years of healthy life.

1.3 The introduction of MUP is a top priority for ADPH members and was the number one policy priority for members in our most recent policy survey. 75% of DsPH who responded said this was in their top five priorities.[1]

1.4 A plethora of evidence exists to support the fact that MUP is an effective policy lever for reducing alcohol harm particularly amongst at-risk groups. A recent systematic review exploring the effectiveness of minimum unit pricing for alcohol concluded that it was highly probable that

introducing MUP would reduce alcohol consumption and alcohol-related harms.[2] We were pleased to see such an extensive body of evidence quoted in the Explanatory Memorandum (EM) as part of the Bill and are delighted that the case for MUP has been so strongly made.

1.5 The overall societal cost of alcohol misuse in Wales is estimated at £15.3bn over 20 years.[3] As detailed in the EM, the Sheffield Alcohol Research Group has concluded that the introduction of MUP in Wales would reduce alcohol consumption and alcohol-related harm, have a small impact on moderate drinkers but a larger impact on hazardous drinkers, and deliver great gains to the Welsh economy through reduction in crime, illness and workplace absence.[4]

1.6 We believe that the case for MUP has been made robustly and repeatedly and look forward to seeing it becoming reality in Wales. We applaud the Welsh government for taking this step and hope to see a similar approach implemented in all four nations of the UK in the future.

1.7 We note that the MUP will be specified by Welsh Ministers in secondary legislation. We are keen to stress that it must be equivalent to or more than 50p per unit as this is where there is evidence of potential to reduce alcohol consumption among hazardous and harmful drinkers while only having a small impact on moderate drinkers.[5]

1.8 It is important to note that the introduction of MUP will not be a 'silver bullet' for reducing alcohol harm and the introduction of other policy interventions alongside MUP would be helpful in this regard. For example, action is needed on alcohol advertising, standardised health risk warning labels should be introduced, the tax escalator on alcohol should be re-introduced and we would like to see the introduction of a public health licensing objective.

2. Any potential barriers to the implementation of the provisions and whether the Bill takes account of them.

2.1 The Bill places the responsibility for enforcing MUP at the local level. This is the most appropriate lever but it must be recognised that there are costs associated with enforcement. Appropriate funding must be available to enable local authorities to carry out this new duty.

3. Whether there are any unintended consequences arising from the Bill.

3.1 There is an argument that the introduction of MUP has a disproportionate impact on those from low-income households. We believe that the argument for the benefits of MUP and the harm reduction it will bring outweighs this argument as, while the impact on low income drinkers is likely to be higher than on high income drinkers, the policy only has a substantial impact on those drinking at a high level.

3.2 For example, if a 50p MUP were implemented in England moderate drinkers with low incomes would reduce their consumption by six units per year. However, harmful drinkers with low

incomes would reduce their consumption by 425 units per year (over 200 pints of beer) and harmful drinkers with higher incomes would reduce their consumption by 50 units per year.[6]

3.3 Modelling carried out by Sheffield University has found that, in Wales, for a 50p MUP moderate drinkers are expected to reduce their consumption by 6.4 units per year with a change in spending of £2.37 per year. However, high risk drinkers in poverty would reduce their consumption by 490 units per annum.[7]

3.4 We are pleased that the Bill will set out the applicability of MUP in situations where alcohol is bought as part of a multi-buy, supplied with other goods or where some alcohol in a special offer is a different strength. It is vital that loopholes are not inadvertently created which allow alcohol to be purchased at price that represents below MUP on some occasions.

3.5 If MUP is not applied correctly to multi-buy or special offer purchases this could have the inadvertent effect of incentivising bulk buy or the purchase of special offer high strength drinks.

4. The financial implications of the Bill.

4.1 No further comment.

5. The appropriateness of the powers in the Bill for Welsh Ministers to make subordinate legislation.

5.1 No comment.

Association of Directors of Public Health

November 2017

[1] The Association of Directors of Public Health, 'ADPH Policy Survey Report 2016' (November 2016)
[2] Boniface S, Scannell JW, Marlow S. Evidence for the effectiveness of minimum pricing of alcohol: a systematic review and assessment using the Bradford Hill criteria for causality. BMJ Open 2017;7:e013497. doi:10.1136/bmjopen-2016013497
[3] University of Sheffield, 'An adaption of the Sheffield Alcohol Policy Model version 3' (September 2014)
[4] University of Sheffield, 'An adaption of the Sheffield Alcohol Policy Model version 3' (September 2014)
[5] University of Sheffield, Model-based appraisal of the comparative impact of Minimum Unit Pricing and taxation policies in Scotland (April 2016)
[6] Sheffield Research Alcohol Group, 'Frequently asked questions' [https://www.sheffield.ac.uk/scharr/sections/ph/research/alpol/faq] accessed 13th November 2017
[7] University of Sheffield, 'An adaption of the Sheffield Alcohol Policy Model version 3' (September 2014)

MPA 17

Bil Iechyd y Cyhoedd (Isafbris am Alcohol) (Cymru)

Public Health (Minimum Price for Alcohol) (Wales) Bill

Ymateb gan Coleg Brenhinol Pediatreg a Iechyd Plant Cymru

Response from the Royal College of Paediatrics and Child Health Wales

Written evidence submitted by the Royal College of Paediatrics and Child Health (RCPCH) to the Health, Social Care and Sport Committee inquiry into the general principles of the Public Health (Minimum Price for Alcohol) (Wales) Bill

About the RCPCH

The RCPCH works to transform child health through knowledge, innovation and expertise. We have over 500 members in Wales and over 17,500 worldwide. The RCPCH is responsible for training and examining paediatricians. We also advocate on behalf of members, represent their views and draw upon their expertise to inform policy development and the maintenance of professional standards.

For further information please contact Gethin Jones, External Affairs Manager for Wales: [redacted] or [redacted].

Minimum Unit Pricing (MUP) in Wales

We welcome the Public Health (Minimum Price for Alcohol) (Wales) Bill, which we believe will have a significant positive impact on child health in Wales. With MUP to be introduced in Scotland in May, we are pleased to see this action in Wales which will offer children and young people similar protection from the harms associated with alcohol consumption.

In January 2017, we published the State of Child Health[1] report and alongside it a Recommendations for Wales[2] document, with policy proposals based on the data contained in the report. These documents made the case for introducing MUP to improve the health and wellbeing of children and young people.

[1] https://www.rcpch.ac.uk/system/files/protected/page/SoCH%202017%20UK%20web%20updated.pdf
[2] https://www.rcpch.ac.uk/system/files/protected/page/SOCH-recommendations-Wales-eng-lang.pdf

13 percent of fifteen year olds in Wales admit to drinking alcohol once a week and alcohol abuse remains a concern for young people in Wales. Young people between the ages of 15 and 17 years are more likely to binge drink (drinking multiple drinks in a row), which is linked with other health risk behaviours such as unprotected or regretted sexual activity, antisocial and criminal behaviour, and self-harm and thoughts of suicide. Alcohol use among school-aged children often predicts negative social and health outcomes into adulthood[3].

On this basis, we called upon the Welsh Government to implement Minimum Unit Pricing for alcohol in Wales.

Alcohol and child health

The British Medical Association have also made this case from a child health point of view. They argue that "large number of children are born every year in the UK with lifelong physical, behavioural or cognitive disabilities caused by alcohol consumption during pregnancy. These disorders have a substantial impact on the lives of individuals affected, and those around them"[4] and their report, *Alcohol and pregnancy: Preventing and managing fetal alcohol spectrum disorders*[5] calls for the introduction of MUP as a key part of a wider suite of policies to reduce the harms associated with alcohol consumption.

The Substance Misuse Programme within Public Health Wales has noted the role of alcohol in accidents leading to children and young people dying:

"The CDRP team recognise the relevance of considering alcohol as a factor in deaths amongst younger people, with the recent review on deaths through drowning amongst children and young people aged up to 24 in Wales reporting that eight of the 26 cases were linked to alcohol"[6].

For further information please contact Gethin Jones, External Affairs Manager for Wales: [redacted] or [redacted].

[3] Newbury-Birch D. Impact of alcohol consumption on young people: a systematic review of published reviews. 2009.
[4] https://www.bma.org.uk/collective-voice/policy-and-research/public-and-population-health/alcohol/alcohol-and-pregnancy
[5] https://www.bma.org.uk/-/media/files/pdfs/working%20for%20change/improving%20health/fetal-alcohol-spectrum-disorders-report-feb2016.pdf?la=en
[6]https://www.wales.nhs.uk/sitesplus/documents/888/LEADR%20report%20FINAL%20for%20publication%20Jan%202017.pdf

MPA 18

Bil Iechyd y Cyhoedd (Isafbris am Alcohol) (Cymru)

Public Health (Minimum Price for Alcohol) (Wales) Bill

Ymateb gan Goleg Brenhinol Meddygaeth Frys

Response from the Royal College of Emergency Medicine Wales

National Assembly for Wales, Health Social Care and Sport Committee

Consultation into Public Health (Minimum Price for Alcohol) (Wales) Bill

Written evidence submitted on the behalf of the RCEM Wales (December 2017)

The Royal College of Emergency Medicine Wales (RCEM Wales) is the single authoritative body for Emergency Medicine in the Wales. RCEM Wales works to ensure high quality care by setting and monitoring standards of care, and providing expert guidance and advice on policy to relevant bodies on matters relating to Emergency Medicine.

Views on: The general principles of the Public Health (Minimum Price for Alcohol) (Wales) Bill and the extent to which it will contribute to improving and protecting the health and well-being of the population of Wales, by providing for a minimum price for the sale and supply of alcohol in Wales and making it an offence for alcohol to be sold or supplied below that price.

1. The Royal College of Emergency Medicine is extremely concerned by the harm attributable to alcohol in our society, particularly those relating to short and long-term health, crime and disorder. The brunt of the short-term health consequences of excess and irresponsible alcohol consumption falls on the ambulance service and the UK's already hard-pressed Emergency Departments (EDs).[1] It is with this in mind that the RCEM Wales supports any initiative to improve the health and well-being of Wales' population – including the Minimum Price for Alcohol Bill.

2. The short and long-term negative effects of alcohol on a person's health is undeniable. Alcohol abuse can affect your body, lifestyle, personal relationships and mental health. Short-term harms consist of deaths and illness from accidents and injuries, drownings, alcohol poisoning and self-harm related to alcohol. It is also associated with an increased risk of high blood pressure, liver diseases (such as cirrhosis), stroke, oropharyngeal cancer, esophageal cancer, pancreatitis, depression, dementia and infertility.[2]

3. The Welsh Government's Annual Statement of Progress for Liver Disease shows that in 2015, 807 people died from liver disease, an increase of 131 deaths (19.4%) over the past five years. Of these, alcohol-related liver disease accounts for over a third of liver disease deaths.[3]

4. Although the report also shows a fall in alcohol-related liver disease deaths, from 504 in 2012 to 463 in 2015[4], people in Wales are statistically more likely to binge drink than anywhere else in Britain. An Office for National Statistics (ONS) survey found that almost one in seven adults (14%) in Wales had drunk 14 units or more in a single day - higher than England (8%) and Scotland

[1] RCEM, Alcohol-related harm position statement (2015)
[2] NHS Choices, The risks of drinking too much
[3] Welsh Government, Annual Statement of Progress for Liver Disease (2017)
[4] Ibid.

(13%).[5] To put this in perspective, the NHS recommends that "to keep health risks from alcohol to a low level, men and women are advised not to drink more than 14 units a week on a regular basis".[6] Drinking the weekly recommended amount in the space of a day increases the likelihood of harm.

5. The impact of alcohol on health also creates a significant pressure on our health systems. In Wales, it is estimated that every week our hospitals handle as many as 1,000 admissions related to alcohol, contributing to stresses on services already working at maximum capacity.[7] A Public Health Wales report revealed that in 2015-16, there were around 54,000 alcohol-attributable hospital admissions in Wales[8] - just short of 150 per day. A significant proportion of these patients will have entered into the service via the front door, the Emergency Department.

6. Estimates vary, but a significant proportion of Emergency Department attendances are alcohol related, presenting 24 hours a day. In England, it has been estimated that 70% of incidents at the weekend are alcohol-related.[9] The RCEM Wales believe that we can reasonably make similar connections to Welsh Emergency Departments located in densely populated areas. These cases hamper the ability of our emergency care systems to look after other patients.

7. ED staff are confronted daily with the health impacts of alcohol use, including: serious accidents (some resulting in death and permanent disability, particularly road traffic collisions), assaults, domestic abuse, collapse and self-harm. Furthermore, all Emergency Departments admit, on a daily basis, patients suffering from the longer-term health effects of sustained alcohol misuse, for example acute withdrawal fits secondary to alcohol dependence, liver failure and Wernicke's Encephalopathy - a neuropsychiatric disorder.[10]

8. Many of our Members have reported that it is common practice to attend to acutely intoxicated patients throughout every night of the week, and what was previously a weekend problem, confined mostly between the hours of 2200 and 0200, is now a 24-hour issue.[11] Yet, many alcohol-related attendances at EDs are potentially avoidable.

9. Furthermore, a survey undertaken by the Alcohol Health Alliance UK (AHA) revealed that most Emergency Department and ambulance staff feel as though they are at risk of harm at work – whether it be risk of assault, threatened or verbally abused by drunken members of the public.[12] Figures from Wales, obtained via a Freedom of Information request, show that there were 18,000 physical assaults against NHS hospital staff in a five-year period from 2011 to 2016 (or 360 reported cases per year on average).[13] No-one should be made to feel unsafe at work. The well-being of our emergency services staff is vital, and the College believes that the implementation of minimum pricing might help to curb these issues.

10. There is a growing body of evidence and research that shows a link between raising prices of alcohol and reduced consumption, leading to improved well-being. Researchers from the University of Sheffield, for example, have estimated that hundreds of deaths could be avoided every year with a minimum price for alcohol units. The recent study evaluated the potential impact of two alcohol control policies that were under consideration in England - banning

[5] ONS, Adult drinking habits in Great Britain: 2005 to 2016 (2016)
[6] NHS Choices, Alcohol Units
[7] NHS Wales, Alcohol and health in Wales (2014)
[8] Public Health Wales, Piecing the puzzle: The annual profile for substance misuse (2016)
[9] K. Parkinson et al., Prevalence of alcohol related attendance at an inner city emergency department (2015)
[10] RCEM, Alcohol-related harm position statement (2015)
[11] Ibid.
[12] AHA, Alcohol's impact on emergency services (2015)
[13] BBC Wales, 18,000 physical attacks on hospital staff in Wales (2016)

below cost selling of alcohol and minimum unit pricing. It concluded: "a minimum unit price, if set at levels between 40p and 50p per unit, is estimated to have an approximately 40-50 times greater effect" and would save lives and cut hospital admissions.[14]

11. Another study on the effects of unit pricing for alcohol, found that a minimum unit price of 45p led to an immediate reduction in consumption of 1.6%. It showed that moderate drinkers were least affected in terms of consumption and spending but concluded: "the greatest behavioural changes occurred in harmful drinkers with a reduction in consumption of -3.7% or 138.2 units per drinker per year and a decrease in spending, especially in the lowest income quintile".[15] Therefore, the minimum unit price seemed to safeguard the most vulnerable in society against dangerous alcohol consumption.

12. The Scottish Government also predicts that a minimum unit price of 50 pence would cut alcohol-related deaths by 392 (from 1,265 to c.873) over the first five years of the policy.[16] In Scotland, a date of May 2018 has been set for the minimum unit pricing for alcohol to come into force.

13. Numerous other research projects across the globe have evidenced the benefits of raising prices of alcohol in order to reduce consumption and harm, including a paper prepared for the European Commission and a study by the Society for the Study of Addiction. The latter concluded that raising the minimum price of the cheapest beverages is effective in influencing heavy drinkers and reducing rates of harm. It also highlighted that this method of reducing harm from drinking has been under-used.[17]

14. The Welsh Government should not remain behind the curb on such an important initiative that might help to save lives and cut hospital admissions. The RCEM Wales fully supports the Minimum Price for Alcohol (Wales) Bill. The evidence suggests that it has the potential to alleviate the current burden on our services that accompanies substance abuse and to help to improve the health and well-being of Wales' population.

View on whether there are any unintended consequences arising from the Bill.

15. The argument against minimum price for alcohol in terms of health is twofold:

- **a.** Other alcohol-related problems, for example the 'drinking culture', may remain despite the Bill. A significant number of adults continue to binge drink despite price increases. Therefore, setting a minimum price may not meaningfully reduce the quantity of consumption or improve the health of those drinking an excessive amount.
- **b.** A higher minimum price could encourage people to use to illicit 'home brews' as a replacement. This can be dangerous as it leaves people exposed to alcohol of an unknown concentration.

16. The College also considers that tackling alcohol marketing might be instrumental in the Bill's success and in helping Wales' population to live happier and healthier lives. The Alcohol Health Alliance UK has shown that awareness of the harms attributable to alcohol is very low. The Alliance's research found that 82% of people are not aware of national alcohol guidelines and only 1 in 10 people are aware of the link between alcohol and cancer.[18]

[14] A. Brennan, Potential benefits of minimum unit pricing for alcohol (2014)
[15] J. Holmes et al., Effects of minimum unit pricing for alcohol on different income and socioeconomic groups (2014)
[16] Scottish Government, Minimum unit pricing (2017)
[17] Society for the Study of Addiction, Alcohol: No Ordinary Commodity (2010) and Lila Rabinovich et al., The affordability of alcoholic beverages in the European Union (2009)
[18] AHA, Right to know: are alcohol labels giving consumers the information they need? (2017)

17. Researchers that have studied the labelling of cigarette boxes have speculated that similar labelling of alcohol products has the potential to increase awareness of the harm associated with drinking - as was the case with cigarette labelling.[19] Although unproven, labelling might better educate some and prevent the downward spiral into alcohol abuse and dependency.

18. However, the unintended consequences of the Bill are only hypothetical. The RCEM Wales strongly urge the Welsh Government to support the Minimum Price for Alcohol (Wales) Bill and the consequential possibility of improving the health and well-being of the population of Wales.

Views on: the financial implications of the Bill.

19. A study undertaken by Astrid Ledgaard Holm on the cost-effectiveness of changes in alcohol taxation in Denmark, concluded: "increasing the current level of alcohol taxation can be a cost-saving way to reduce alcohol related morbidity and mortality. Our results support the growing evidence that population strategies are cost-effective and should be considered for policy making and prevention of alcohol abuse."[20]

20. The Society for the Study of Addiction highlighted that the cost of restricting physical availability of alcohol is cheap relative to the costs of health consequences related to drinking.[21]

21. Perhaps then the financial burden that alcohol misuse places upon the NHS can be partially mitigated by the introduction of the Bill, when considering long-term possibilities.

22. Hospital admissions due to alcohol abuse costs the Welsh NHS at least £109 million every year, as reported by Public Health Wales.[22] As discussed above, researchers predict that minimum pricing has the potential to cut hospital admissions considerably. Therefore, it is reasonable to assume that the £109 million might be reduced if we are able to improve the health and well-being of Wales' population over a sustained length of time.

23. Spending on gastrointestinal problems (which include alcohol-related liver disease) has increased from £339.3 million in 2014-15 to £362.6 million in 2015-16. Spending per head of population has increased from just under £110 to £117 over the same timeframe.[23] If incidents of alcohol-related liver disease can be lessened by reducing cases of excessive alcohol consumption, then the Bill has the potential to cost-save for the NHS, in time. Similarly, perhaps in the long-term the Bill might help to save time, work and money with regards to Emergency Departments and Ambulance services, which are confronted daily with the health impacts of alcohol use.

24. Therefore, if the Bill can help to improve the health and well-being of the population in Wales, we can hope that some of the financial consequences associated with alcohol related issues may be reduced. The College consequently recommends that to achieve the Welsh Government's stated objective, option three – introduce a minimum price for which alcohol can be sold or supplied in Wales – as outlined in the Explanatory Memorandum, is taken into further consideration.

[19] G. Agostinelli et al., Alcohol counter-advertising and the media. A review of recent research (2002) and C. Wilkinson et al., Warnings on alcohol containers and advertisements: international experience and evidence on effects (2009)
[20] Astrid Ledgaard Holm et al., Cost-effectiveness of changes in alcohol taxation in Denmark: a modelling study (2014)
[21] Society for the Study of Addiction, Alcohol: No Ordinary Commodity (2010)
[22] NHS Wales, Alcohol and health in Wales (2014)
[23] Welsh Government, Annual Statement of Progress for Liver Disease (2017)

Hywel Dda University Health Board Response to the National Assembly of Wales Call for Evidence on the introduction of the Public Health (Minimum Price for Alcohol) (Wales) Bill

Introduction

From reviewing the strengthening evidence base on the impact of an introduction of minimum unit price for alcohol (MUP) as a means of reducing alcohol related harm, Hywel Dda University Health Board strongly supports this policy initiative as evidenced in the proposed introduction of the Public Health (Minimum Price for Alcohol) (Wales) Bill. We believe that if the rate is set at a minimum of 50p per unit of alcohol this will result in a reduction of health related alcohol harms, which impact upon services delivered by the University Health Board to its population.

Legislation of this kind is one of the most important and most powerful tools available to tackle public health issues. In bringing forward this policy, we acknowledge that Welsh Government is seeking to shape the social, economic and environmental conditions that are conducive to good health and averting health harms, and we welcome policy change that results in improved health and wellbeing for our population. Furthermore this policy approach supports an increased emphasis on personal responsibility, an approach at the forefront of prudent health care that is vital to the long term sustainability of the University Health Board and the NHS in Wales. More detailed justification in support of this proposal is outlined below.

Principles and Impact on Health and Well Being

The impact of alcohol on health is a significant issue. Alcohol consumption has increased over the past decade, resulting in the growth of associated health harms. Drinking alcohol increases the risk of developing over 60 different health problems[1] , including a range of cancers, liver disease, high blood pressure, injuries and a variety of mental health conditions. It also increases the risk of causing harms to the health of others. Furthermore alcohol related deaths in Wales have risen, as has the rate of alcohol related hospital admissions. Alcohol is now one of the three biggest lifestyle risk factors for disease and death in Wales after smoking and obesity.

In Wales, a report by the Public Health Wales Observatory, Alcohol in Wales (2014)[2] states: “Every week in Wales, alcohol results in 29 deaths; around 1 in 20 of all deaths. The impact of alcohol on health also creates enormous pressures on our health systems. Every week our hospitals handle as many as 1,000 admissions related to alcohol, increasing strains on already stretched services. Such admissions are only

[1] World Health Organisation (2009) Harmful Use of Alcohol http://www.who.int/nmh/publications/fact_sheet_alcohol_en.pdf
[2] Public Health Wales (2014) Alcohol and health in Wales. Wales profile.

the tip of an iceberg which includes many more presentations at emergency departments, ambulance requests and GP appointments, all resulting from alcohol."

Data shows increasing levels of health related harm both in terms of binge drinking and short term problems from alcohol use but also chronic alcohol misuse. Hospital admission data for the year 2012/13 shows that 16,128 bed days in Hywel Dda hospitals were taken up by patients with alcohol related conditions costing the Health Board over £5.3 million per year in inpatient treatment alone. The majority of costs were incurred in non elective general medical and adult mental health admissions. In relation to alcohol related attendances at Emergency Departments, it is estimated that nearly £6.5 million per annum is spent by Hywel Dda attendances having a link to alcohol misuse. A broad estimate of direct costs to the University Health Board from addressing the health impacts of alcohol misuse would suggest a figure of £11,852,493 for 2012/13[3]. Alongside this, our rates of person based alcohol specific and alcohol attributable admissions in 2016/17 in Carmarthenshire and Ceredigion has seen the highest rises of all local authority area of Wales compared with the previous year (25% and 13% respectively)[4].

There is compelling strong, consistent, and robust evidence that alcohol price increases, reduce alcohol consumption and related harm[5] . Introducing a minimum unit price (MUP) for alcohol in Wales would lead to significant improvements in health and well-being for the population of Wales. NICE[6] guidance called for alcohol to be made less affordable by introducing a MUP (Recommendation 1), and provides further evidence for this justification within its NICE guidance evidence update[7]. In addition to this the Advisory Panel on Substance Misuse for Wales has also strongly supported the introduction of MUP to address alcohol related harm in those vulnerable groups most affected by hazardous and harmful levels of drinking[8].

Minimum unit pricing is a targeted measure that will impact beneficially on alcohol consumption of harmful and hazardous consumers as well as other groups particularly at risk from alcohol related harms – such as young people. Moderate consumers of alcohol will experience relatively little change in the amount they have to pay for alcohol. The intended effect of this initiative is to reduce the harms associated with excessive consumption such as the number and associated costs of alcohol related crimes; alcohol related health problems, and deaths due to alcohol.

Minimum Unit Pricing is based on fundamental principles that are widely supported by evidence:

- when the price of alcohol increases, consumption by most drinkers decreases, critically including hazardous and harmful drinkers

[3] Hywel Dda University Health Board (2014) Alcohol issues in Hywel Dda Board Paper
[4] Public Health Wales (2017) Data Mining Wales The annual profile for substance misuse 2016-17.
[5] Welsh Government Social Research (2014) Model-based appraisal of minimum unit pricing for alcohol in Wales Summary Report

[6] NICE (2010) Nice recommends action to reduce alcohol related harm (NICE press release, 2 June 2010

[7] NICE (2014) Alcohol-use disorders: preventing harmful drinking Evidence Update Public Health Guidance PH24

[8] Advisory Panel on Substance Misuse. 2014. Minimum unit pricing: a review of its potential in a Welsh Context. Available at: http://gov.wales/docs/dhss/publications/140725uniten.pdf

- When alcohol consumption in a population declines, rates of alcohol related harm also decline.

The experience of introducing a MUP in two provinces in Canada, showed that when alcohol price was raised by 10% there was a reduction in alcohol consumption, alcohol related mortality and alcohol related hospital admissions[9] [10]

Minimum Unit Pricing will form part of a comprehensive package of measures and non legislative action to deal with problems and harms associated with alcohol as set out in the proposed Bill and also the implementation of 'Working Together to Reduce Harm' (The Substance Misuse Strategy for Wales 2008-2018) and its delivery plans. In line with NICE guidance (2010; 2014) [2,3] such policy changes complement ongoing work at national and local levels to reduce the harm caused by alcohol in Wales such as Alcohol Brief Intervention engagement, increased scrutiny of licensing applications and education in the school environment via mechanisms such as the Police Core Schools Liaison Programme and the All Wales Network of Healthy Schools. As such these provide a combination of interventions that are needed to reduce alcohol-related harm in order to benefit society. Both population-level and individual level approaches are important because they can help reduce the aggregate level of alcohol consumed and therefore lower the whole populations' risk of alcohol-related harm.

In order to further strengthen actions to reduce alcohol related harm we would also reiterate that Welsh Government should continue to lobby strongly for a Public Health objective to be included within any licensing objectives under the Licensing Act 2003. Therefore due to the weight of evidence outlined above, Hywel Dda University Health Board believes that the proposed legislation to introduce a minimum unit price for alcohol in Wales will strengthen the existing actions being undertaken by the Welsh Government to reduce alcohol consumption and alcohol related harm.

Potential Barriers to Implementation

Public Acceptance

Over the last few years, Hywel Dda University Health Board has undertaken a number of consultations in partnership with Public Health Wales, its three Local Authorities and Dyfed Powys Police around the issues of alcohol misuse. Questions on MUP have been included in each of these consultation processes and it is positive to note that a significant percentage of respondents have indicated their support for MUP as concept.

For instance Carmarthenshire 50+ Forum members were asked in 2015 to indicate the extent to which they would agree with a minimum price of 50p per unit of alcohol in Wales[11] . Results show that nearly half of all respondents (48%) support the idea of a minimum price for Wales (28% strongly support; 20% support), with 27% against

[9] Stockwell, T and Thomas, G, (2013), *Is alcohol too cheap in the UK? The case for setting a Minimum Unit Price for alcohol,* Institute of Alcohol Studies report

[10] Stockwell, , Auld MC, Zhao JH and Marin G. (2012) Does minimum pricing reduce alcohol consumption? The experience of a Canadian province. Addiction, 107 (5): 912-20

[11] Carmarthenshire County Council (2015) 50+ Forum Survey

(15% opposed; 12% strongly oppose). Over a quarter (26%) of respondents refrained from making judgment in favour or against[29].

Respondents were asked to explain their answer. A range of responses were cited, covering the following points (noted below in order of frequency):

- Amelioration of binge drinking – a commonly held view was that increases in price would impact upon binge drinking levels
- Unduly penalises responsible drinkers – a perception that responsible drinkers are being penalised for the actions of a few
- Improves drinking culture – There was agreement that minimum pricing would put a swift end to the increasing tendency to 'pre-drink' – consuming a significant amount of alcohol before a night out

In 2014 the three local authority areas of Hywel Dda as part of their regular Citizen Panel consultations included questions on MUP. The Carmarthenshire Citizens' Panel results showed 53% (200 respondents) supported the idea of a minimum price of 50p per unit of alcohol in Wales, while 32% (122 respondents) did not, and 16% (59 respondents) were unsure[12].

For Ceredigion[13], 56% (175 respondents) support the idea of a minimum price of 50p per unit of alcohol in Wales, 30% (93 respondents) do not, while 14% (44 respondents) are unsure.

Finally for Pembrokeshire[14] 50% (225 respondents) supported the idea of a minimum price of 50p per unit of alcohol in Wales, while 34% (152 respondents) did not, and 17% (75 respondents) were unsure.

Unintended Consequences

Impact on Off/On Licensed Retail Outlets

It is important to distinguish between the impacts of MUP upon the on and off license trades. Cheap alcohol in the off trade has contributed to the closure of many local pubs due to an increase in home drinking and pre loading. A number of surveys have highlighted that there is significant support for MUP amongst pub landlords.

Impact on Drinks Manufacturers

The introduction of MUP may have the effect of encouraging drinks manufacturers to give serious consideration to producing alcohol products that have a lower alcohol by volume percentage, in order to maintain profit levels. For example, alcohol by volume in table wines has been increasing over time and introduction of MUP may support a reversal in this trend thereby further decreasing population level health harms related to alcohol. This may also be the case for high-strength lagers.

[12] Carmarthenshire Citizen's Panel (2014) survey 40 Hywel Dda University Health Board Alcohol Awareness Report
[13] Ceredigion Citizen's Panel (2014) survey 17 Hywel Dda University Health Board Alcohol Awareness Report
[14] Pembrokeshire Citizen's Panel (2014) survey 27 Hywel Dda University Health Board Alcohol Awareness Report

Serious consideration should be given to measures in order to ensure that any increase in profits to drinks manufactures following the introduction of MUP, should be subject to appropriate levy by government in order to develop population level alcohol awareness campaigns and prevention programmes including those with children and young people.

Additional Enforcement Costs

There may well be resource implications to Local Authorities in relation to introducing MUP and the requirement to enforce any new legislation. Although both trading standards and licensing teams currently undertake inspection and control of some alcohol vendors, consideration should be given to whether or not to introduction of MUP would place an increased demand on already stretched services.

Impact on Low Income Households

Consumers who currently purchase alcohol priced at less than the set MUP will be directly affected with the introduction of this policy, and this includes those on low income. Those in poverty may experience a greater impact than those not in poverty, as they tend to buy cheaper products. There may also be a risk that harmful and hazardous drinkers from low income households may continue to consume alcohol at existing levels and thereby utilise money that is needed for other household expenses. There is evidence however to support that there will be a substantive impact on harmful drinkers with the lowest income gradient[15], who may experience larger relative gains in health from this policy.

Financial Implications

Review of MUP Level

Further consideration of MUP setting should be linked to an inflationary measure to ensure it remains an effective measure to reduce alcohol health harms, as outlined by NICE (2010; 2014)[16] [17] guidance Recommendation 1: Regularly review the minimum price per unit to ensure alcohol does not become more affordable over time.

Costs of Enforcement

As noted above, the introduction of a MUP in Wales could lead to additional regulatory inspection requirements for colleagues in local authority public protection teams. Within the Explanatory Memorandum this is explicitly referred to in sections 295-298 (pages 106-107) and an acknowledgment given that additional costs may therefore be incurred in enforcement activity. This acknowledgement is to be welcomed and we

[15] Welsh Government (2014) Model-based appraisal of minimum unit pricing for alcohol in Wales

[16] NICE (2010) Alcohol-use disorders: preventing harmful drinking. Public Health Guidance PH24

[17] NICE (2014) Alcohol-use disorders: preventing harmful drinking Evidence Update Public Health Guidance PH24

would ask that Welsh Government make realistic provision for such costs in light of financial challenges faced by local authorities within the existing funding climate.

Legislative Powers

Hywel Dda University Health Board has no comment to make on the appropriateness of the powers in the Bill for Welsh Ministers to make subordinate legislation on this issue.

Conclusion

Hywel Dda University Health Board has consistently supported the introduction of a Minimum Unit Price for alcohol over many years of previous submissions to UK and Welsh consultations on this policy initiative. We see no evidence to alter our view on this matter and, as has been referenced in our response and in the papers circulated with this latest request for evidence, the research base has significantly strengthened the argument in favour of its introduction.

Therefore, due to the positive impact on health and well being that the introduction of the Public Health (Minimum Price for Alcohol) (Wales) Bill will bring, we fully support this proposal and look forward to it being brought forward to the chamber of the Senedd for debate.

Addictions Department PO48
Institute of Psychiatry, Psychology & Neuroscience
16 De Crespigny Park
King's College London
London SE5 8AF

[redacted]

12th December 2017

To whom it may concern,

Re. Public Health (Minimum Price for Alcohol) (Wales) Bill

Thank you for inviting us to give our views on the proposed Bill, following our recent publication on this topic - *Evidence for the effectiveness of minimum pricing of alcohol: a systematic review and assessment using the Bradford Hill criteria for causality* - in the journal BMJ Open (available online at: http://bmjopen.bmj.com/content/7/5/e013497).

In this review we synthesised evidence from a wide range of studies, and found that there was strong support that minimum unit pricing for alcohol would benefit society in the form of reduced consumption overall, reduced alcohol morbidity and mortality. The policy should also narrow health inequalities. There is strong scientific evidence that the cheapest products are disproportionately consumed by the heaviest drinkers. In particular, introducing minimum unit pricing should help to address one of the flaws in the excise system whereby having different taxation of different types of alcohol means that white ciders are subject to a lower amount of taxation per unit than all other drink categories, therefore are disproportionately cheaper when compared on alcohol content.

We are supportive of the Bill as one component of a wider strategy to reduce alcohol related harm. Alcohol marketing and availability also have roles to play, and provision of specialist treatment services is crucial, particularly given the cuts in addiction services in recent years. If minimum unit pricing is implemented, there should be adequate resource available for a rigorous independent academic evaluation.

We do not feel best-placed to comment on the potential barriers to implementation or unintended consequences of the Bill, but would encourage the National Assembly for Wales to work with the Scottish Government to learn from the experience with implementation following the legal challenges faced in Scotland.

Yours sincerely,

Dr Sadie Boniface & Dr Sally Marlow

MPA 21

Bil Iechyd y Cyhoedd (Isafbris am Alcohol) (Cymru)

Public Health (Minimum Price for Alcohol) (Wales) Bill

Ymateb gan Balance

Response from Balance

Balance response to the Health, Social Care and Sport Committee's consultation on the Public Health (Minimum Price for Alcohol) (Wales) Bill

Balance welcomes the opportunity to respond to the Health, Social Care and Sport Committee's consultation on the Public Health (Minimum Price for Alcohol) (Wales) Bill.

Balance is currently commissioned by 11 local authorities in the North East of England to deliver an evidence-based, population wide approach to alcohol harm reduction and in this context, Balance works with a range of partners to tackle alcohol-related issues. For more information visit www.balancenortheast.co.uk

1. Introduction

Balance believes that the introduction of a minimum unit price (MUP) for alcohol in Wales would be highly beneficial and would make a substantial contribution to reducing levels of alcohol consumption and its associated harms.

Consumption per drinker has doubled in the UK since the 1950s. There is no single solution to tackling alcohol-related harm and Balance feels that we need a package of measures to limit the affordability, availability and promotion of alcohol. However, independent evidence tells us that getting rid of the cheapest, strongest alcohol would have the most impact as it is typically consumed by young people and those drinking at harmful levels.

There is a large and significant body of international evidence which demonstrates that the price and affordability of alcohol is the key factor in driving consumption. In the 2009 Global Strategy, the World Health Organisation recommends introducing pricing policies to reduce alcohol-related harm and recognises the option to ''establish minimum prices for alcohol where applicable'' as an appropriate action.

Furthermore, Minimum Unit Price is already working in several countries, including Canada. Figures from British Columbia indicate that a 10% increase in average minimum price would result in a fall in consumption of 8%[i]; a 9% reduction in alcohol specific hospital admissions[ii]; a 32% reduction in wholly alcohol caused deaths[iii]; and a 10% fall in violent crime.[iv]

From a North-East perspective, the cheapest, strongest alcohol is responsible for some of the greatest problems in our local communities. Although more affluent groups of the population tend to drink at higher levels, the people in our most deprived communities suffer from the worst alcohol-related harms - harmful drinkers on the lowest incomes spend on average almost £2700 a year on alcohol, with 41% of the alcohol they consume purchased for less than 45 pence per unit.[1] These are the people who end up in hospital time and time again and die prematurely, whilst their families pay the price of cheap alcohol.

Taking all of this into account, Balance firmly welcomes the Welsh Government's commitment to introduce minimum unit pricing as an effective and evidence-based measure to reduce alcohol consumption and alcohol-related harm. More specific comments in relation to the general principles of the Bill, barriers to implementation and any unintended consequences are below.

2. The general principles of the Bill and the extent to which it will contribute to improving and protecting the health and well-being of the population of Wales.

2.1 As noted above, there is a wealth of evidence to demonstrate that minimum unit pricing (MUP) is the single most targeted and effective intervention aimed at reducing alcohol-related harm, and there are strong indications that its introduction would significantly improve the health and well-being of people across Wales, whilst reducing a range of alcohol-related harms, such as alcohol fuelled crime and disorder. Introducing MUP at this time would be particularly important, given the recent announcement by the Welsh government that alcohol-related deaths in Wales increased by 9% in 2016 compared to 2015.[2]

2.2 Balance believes that it is important to reiterate the findings of research carried out by Sheffield University, on behalf of the Welsh government, which estimated the impact of minimum unit pricing in Wales from a health perspective. This indicated that once the full effects of MUP were in place, the policy would lead to approximately:

- 53 fewer deaths a year
- 1,400 fewer hospital admissions a year
- £131 million a year saved in healthcare costs
- £882 million in savings to society overall each year

2.3 Minimum unit pricing can also act as an extremely effective population measure, helping to reduce overall levels of consumption. Where MUP is particularly effective is at protecting the most vulnerable groups, as it reduces the amount of alcohol drunk by harmful drinkers who buy most of the cheap high strength alcohol. Survey evidence from Scotland shows that 30% of the population drink over 80% of the alcohol and it is this group which minimum unit pricing will target. As a result, moderate drinkers will experience a very small impact with costs expected to rise by only £8 per year with the proposed 50 pence per unit minimum price[3].

[1] Effects of minimum unit pricing for alcohol on different income and socioeconomic groups: a modelling study Holmes et al May 2014

[2] Welsh government (14 November 2017), 'Increase in alcohol-related deaths in Wales – new report shows'. Available at http://gov.wales/newsroom/health-and-social-services/2017/item/?lang=en

[3] Scottish Government (2014) Scottish Government's position on Minimum Unit Pricing of alcohol

3. Any potential barriers to the implementation of the provisions and whether the Bill takes account of them

3.1 Balance believes that it is worth acknowledging that local authorities will be affected by an obligation to monitor compliance under the new legislation and to act against businesses which fail to comply. Local authority budgets are coming under increasing pressure from budget cuts, and the effectiveness of legislation could be undermined by an authority's ability to devote sufficient resources to monitoring and enforcing the legislation.

However, we feel that it is difficult to predict the potential costs to local authorities, or the possible extent of non-compliance. There may also be longer term savings for local authorities from the introduction of MUP, in terms of a reduction in the burden on services which respond to alcohol misuse, such as street cleaning services and anti-social behavior units. For example, Balance estimates that alcohol impacts on social services costs in the North East to the tune of £121m a year. Similarly, the alcohol harm costs the wider North East economy a further £353m a year. As drinking patterns in Wales and our region are similar, it is to be expected that the costs of harm will also be similar and that the introduction of MUP would reduce those costs. Finally, local authorities are responsible for monitoring compliance with the current below cost sales ban – the introduction of a regulated MUP would potentially be easier to monitor than the existing arrangements.

4. Whether there are any unintended consequences arising from the Bill

4.1 One consequence of MUP, though not necessarily an unintended one, is that more people may seek help from substance misuse services. An increase in demand could place existing services under further pressure, and it is crucial that this is considered.

4.2 Several potential negative consequences of the Bill have been suggested, and we summarise these below, and give our response to each.

4.3 A common criticism of MUP is that it is a **'tax on the poor'**, which would place financial pressure on lower income groups.

However, the results of a study published in the Lancet showed that a minimum unit price (MUP) of 45p would reduce deaths and hospital admissions among high risk drinkers but have negligible effects on low-income moderate drinkers'. Produced by the University of Sheffield, the paper provided the most in-depth analysis of consumer responses to changes in alcohol prices yet.

According to the authors' predictive models, MUP is estimated to have the most pronounced effects on the 5% of the population whose drinking is classified as harmful (more than 50 units per week for men, and more than 35 units per week for women). Three quarters of the total reduction in alcohol consumption resulting from MUP would occur in harmful drinkers, with a predicted total reduction in alcohol-related deaths of 860 per year and hospital admissions by 29900 per year after the policy has been in effect for 10 years.

Harmful drinkers in the lowest income quintile (bottom 20%) would be most affected by minimum pricing, because on average around two-fifths (41%) of the alcohol they consume is purchased for less than 45p per unit, putting this group at greatest risk of health harm from alcohol. These low

income harmful drinkers are projected to reduce their alcohol by nearly 300 units per year under minimum unit pricing and they would also accrue 81·8% of reductions in premature deaths and 87·1% of gains in terms of quality-adjusted life-years.

In contrast, the effects on low-income moderate drinkers would be very small, as moderate drinkers in the lowest income group buy on average less than one unit of alcohol per week below the 45p threshold. They would reduce their consumption by an estimated 3.8 units (approximately 2 pints of beer) per year, with an increase in spending of just 4p per year. Across the entire population, moderate drinkers are estimated to reduce their consumption by just 1.6 units (approximately 1 pint of beer) and spend just 78p more per year.[4]

In short therefore, it can be argued that **MUP does not unfairly discriminate against low income groups, particularly those drinking at moderate levels**. However, those who drink at harmful levels in lower income groups drink greater amounts on average than those drinking at harmful levels in higher income groups. The harms caused by this increased consumption are compounded by the broader health inequalities that those from poorer backgrounds face. Alcohol-related deaths are around 7.7 times higher in the most deprived areas than in the least deprived areas[5], while alcohol-related hospital admissions are eight times higher[6]. Harmful drinkers on low incomes will therefore benefit most from MUP in terms of improved health outcomes and general wellbeing.

4.4 Concern has also been expressed that MUP could lead to increases in dependent drinkers **committing crime to obtain alcohol**, or that dependent drinkers may choose to consume harmful alcohol substitutes such as methylated spirits.

4.5 However, a study of dependent drinkers' behaviour following an increase in the price of alcohol found that these unintended effects were very uncommon and unlikely.[7] A review of the negative impacts of MUP has concluded that, 'unintended negative consequences from MUP are minor in comparison with the substantial health, social and economic benefits the policy creates.'[8]

4.6 Another concern is that MUP may lead to increased profits for some alcohol producers and retailers in the off-trade, due to the increased prices of the cheapest products. Increased profits could then be spent on activity (e.g. alcohol marketing) which are linked with alcohol harm. However, we believe that, on balance, the large benefits of MUP in terms of people's health significantly outweigh this potential consequence.

4.7 Finally, concern has been expressed that MUP would negatively affect pubs. However, assuming the MUP is set at 50p, pub prices will be left unchanged. For example, with a 50p MUP, a pint of average strength beer could not be sold for less than around £1, but this is well below the cost of average prices in the on trade. In fact, according to a Balance survey carried out in 2012, most

[4] Effects of minimum unit pricing for alcohol on different income and socioeconomic groups: a modelling study Holmes et al May 2014
[5] Scottish Government (2014) Scottish Government's position on Minimum Unit Pricing of alcohol
[6] NHS Scotland Information Services Division (2015) Alcohol-related hospital admissions 2014-15 www.isdscotland.org/Health-Topics/Drugs-and-Alcohol-Misuse/Publications/2015-10-13/2015-10-13-ARHS2014-15-Report.pdf?
[7] Falkner, C. et al (2016), The effect of alcohol price on dependent drinkers' alcohol consumption, *New Zealand Medical Journal* 128: 1427, pp9-17.
[8] Stockwell, T. & Thomas, G. (2013), Is alcohol too cheap in the UK? The case for setting a Minimum Unit price for alcohol. London: Institute of Alcohol Studies.

publicans in the North-East support MUP and believe that cheap alcohol, sold by the off-trade, represents the biggest threat to their livelihoods going forward. Rather than affecting the on trade, MUP would increase the price of the cheapest, strongest, most harmful alcohol in our supermarkets and off-licenses and provide a boost to our pubs and clubs, which are currently closing daily and suffering from the impact of pocket money prices.

4.8 Similarly, for the population as a whole, public opinion research commissioned by Balance shows that 54% of people would support the introduction of MUP[9]. Furthermore, MUP has the backing of large sections of the medical community, the police and other public services, due to the compelling evidence base which demonstrates how MUP could reduce the burden on the frontline.

For example, a recent Balance survey of the North-East Ambulance Service found that, for most respondents, alcohol takes up as much as half of their time which prevents them from deploying their services in other areas of often significant need. There is also a significant cost involved. Across all the emergency services in the UK, it is estimated that alcohol costs £2.845 billion every year. Minimum unit pricing would have clear benefits to the emergency services by reducing the overall cost burden on these services and ensuring staff feel safer when carrying out their duties.

Overall therefore, we fully support the Welsh Government's proposals and agree that there are hugely strong and compelling arguments for introducing MUP at the earliest opportunity in Wales.

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[i] Stockwell, T., et al. (2012), The Raising of Minimum Alcohol Prices in Saskatchewan, Canada: Impacts on Consumption and Implications for Public Health. American Journal of Public Health

[ii] Stockwell, T., et al. (2013), Minimum alcohol prices and outlet densities in British Columbia, Canada: Estimated impacts on alcohol attributable hospital admissions. American Journal of Public Health

[iii] Zhao, J., et al. (2013), The relationship between changes to minimum alcohol price, outlet densities and alcohol-related death in British Columbia, 2002-2009. Addiction.

[iv] Stockwell, T., et al. currently unpublished research on the effects of minimum pricing on crime in Canadian provinces

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[9] Balance Public Perceptions Research September 2017

Faculty of Public Health

of the Royal Colleges of Physicians of the United Kingdom

Working to improve the public's health

About the UK Faculty of Public Health

The Faculty of Public Health (FPH) is a membership organisation for nearly 4,000 public health professionals across the UK and around the world. We are also a registered charity. Our role is to improve the health and wellbeing of local communities and national populations.

We do this in a number of ways: we support the training of the next generation of public health professionals by designing and managing the curriculum and exams that people training for a career in public health need to take, we support our members in their continuing professional development and help them revalidate their licenses, we are a hub for public health learning and policy development through our over 30 Special Interest Groups, we encourage and promote new public health research through the Journal of Public Health, and we seek to improve public health policy and practice at local, national, and international level by campaigning for change and working in partnership with local and national governments.

For us 'public health' is about promoting and protecting the health and wellbeing of people at a population-level. It's a very broad agenda covering everything from tobacco to transport, children's health to climate change, and violence to viruses – pretty much anything which directly or indirectly impacts on people's health and wellbeing.

Introduction

The UK Faculty of Public Health welcomes the opportunity to respond to the Health, Social Care and Sport Committee's consultation on the Public Health (Minimum Price for Alcohol) (Wales) Bill. We strongly support the implementation of a minimum unit price (MUP) for alcohol in Wales. There is compelling evidence, which is presented thoroughly in the formal consultation document, that it is an effective and cost effective measure targeting heavy drinkers that would lead to significant improvements in health and well-being, and narrow health inequity. We believe MUP forms a key part of a national strategy to tackle alcohol-related harm. We fully endorse the comprehensive evidence response by our colleagues in Public Health Wales, and from the UK Health Forum. We will not duplicate their comments but would highlight the following points.

1) Comment on the general principles of the Bill and the extent to which it will contribute to improving and protecting the health and well-being of the population of Wales

1. Alcohol consumption increases the risk of over 60 conditions in the drinker and also has major effects on the health of others such as through adverse child events and domestic violence. Alcohol misuse is a major public health problem in the UK; recent decades have seen increases in alcohol consumption and its associated health harms, with for example over 1 million hospital admissions attributed to alcohol. The impacts are not only on health, but on employment and productivity and the social care and criminal justice systems. The Lancet Liver Commission as highlighted the increasing toll of alcohol related harm in the UK, with a 400% increase in liver disease mortality since 1970 largely ascribed to alcohol. (1)

2. National health surveys have shown that there has been an increase in the proportion of alcohol drunk by the heaviest drinkers (>75 units/week) which has increased from 13% to 17% from 1990-

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2014. (1) It is these heavy drinkers who are most at risk of alcohol related morbidity and premature mortality.

3. There is a paradox that alcohol related mortality has an inverse gradient with socio-economic status, and yet data from national health surveys do not find the corresponding pattern of risky consumption. However, recent research from pooling such surveys has identified a key explanation: whilst lower socioeconomic status is associated with lower likelihood of exceeding recommended limits for weekly and episodic drinking, there are higher likelihoods of exceeding more extreme thresholds (for weekly >110units in men and ><85 in women). (2) To maintain such high consumption levels very heavy drinkers migrate to cheap higher strength alcohol such as strong cider.

4. There is convincing evidence that alcohol consumption is directly driven by its price. (i.e., there is elasticity to price) and heavy drinkers are most responsive to price changes. However the 'affordability' of alcohol (which compares price to earnings) has increased significantly over the last twenty five years. Between 2008 and 2012, the UK Government increased the alcohol duty escalator automatically by 2% above inflation each year, with consequent effect on affordability and on overall consumption. (1, 3) However, this was stopped for beer in 2013 and for wine, cider and spirits in 2014. Alcohol duties were then cut or frozen in 2015 and 2016. Whilst they were all increased in line with inflation in the 2017 Spring Budget in March, the 2017 Autumn Budget announced that they will be frozen for a year from February 2018. The net effect is alcohol will become even more affordable; compared to 2012 by 2018/19 beer duty will be 16% lower, cider and spirits duty 8% lower and wine duty 2% lower. Whilst the Government intends to introduce a new duty band in 2019 for cider of a strength between 6.9-7.5% alcohol by volume, the Institute of Alcohol Studies says the impact of this new band will be modest. (3) They recommend implementing a MUP by 2018/19, to deal with the particular problem of the cheapest strongest drinks favoured by the heaviest drinkers, with MUP being complementary to reforming the alcohol duty structure for other products.

5. MUP differentially effects the consumption of heavy drinkers (including dependent drinkers) who are most likely to consume low cost high strength alcohol. Such drinkers are most at risk of the health harms of alcohol, particularly alcoholic liver disease. There is minimal impact of MUP on moderate drinkers or poor drinkers who are not also drinking heavily. It would increase the cost of the cheapest alcohol sold in off-licences settings but not those in pubs and other on sale settings. This may target young people who pre-load before going out for a night.

6. The level at which the MUP is set needs to take not account the affordability of alcohol (as above) and inflation, it needs to be broadly applied, enforced and reviewed.

7. A recent systematic review of the global evidence found 33 studies which included natural experiments of introducing MUP in Canada and comprehensive modelling studies in the UK. (4) It concluded that the Bradford Hill criteria for causality were satisfied for MUP and there was very little evidence that minimum alcohol prices were not associated with consumption or subsequent harms. MUP is likely to reduce alcohol consumption, alcohol-related morbidity and mortality. Nevertheless the overall quality of the evidence was variable with uncertainty in many quantitative estimates. In Wales, modelling suggests that a 50 pence MUP would result in substantial fall in consumption in heavy drinkers especially poorer ones, and significant annual reduction in alcohol related deaths and alcohol related hospital admissions of about 10%.

8. Additionally, recent drinking (e.g. during the working day) is a major cause of accidents at work. From steel mills to docks, making alcohol consumption less frequent during the day, may reduce this costly disruption of economic activity. Tourism, sport and transport are also all blighted if antisocial behaviour fuelled by alcohol disrupts them, and puts off their potential customers.

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9. In conclusion if MUP is introduced in Wales it would reduce the health harms from alcohol in heavy drinkers by reducing their consumption of cheap strong alcohol, and their effects on 'others' and would reduce the health inequity. It may also contribute to greater workplace productivity. However the extent of the proposed benefits of MUP are based on modelling and recognised as uncertain, so we fully support the need for the proposed evaluation of MUP if it is introduced in Wales, and to robust measures to see it is enforced to maximise impact.

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1. Williams R, Alexander G, Aspinall R et al. New metrics for the Lancet Standing Commission on Liver Disease in the UK. Lancet 2017; 389:2053–80
2. Lewer D, Meier P, Beard E, Boniface S, Kaner E. Unravelling the alcohol harm paradox: a population-based study of social gradients across very heavy drinking thresholds BMC Public Health 2016;16:599
3. Institute for Alcohol Studies. Budget Analysis 2017. December 2017 www.ias.org.uk
4. Boniface, S., Scannell, J. W. and Marlow, S. Evidence for the effectiveness of minimum unit pricing of alcohol: a systematic review and assessment using the Bradford Hill criteria for causality. BMJ Open 2017;7:.e013497.

Contact

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MPA 23

Bil Iechyd y Cyhoedd (Isafbris am Alcohol) (Cymru)

Public Health (Minimum Price for Alcohol) (Wales) Bill

Ymateb gan Sefydliad Iechyd y Geg

Response from Oral Health Foundation

Oral Health Foundation Response to the Health, Social Care and Sport Committee's consultation on the Public Health (Minimum Price for Alcohol) (Wales) Bill

Date: 15th December 2017

Contact: David Arnold, Director of Communications
Email: [redacted]

About the Oral Health Foundation

The Oral Health Foundation is the leading national charity working to improve oral health. Our goal is to improve people's lives by reducing the harm caused by oral diseases – many of which are entirely preventable. Established more than 45 years ago, we continue to provide expert, independent and impartial advice on all aspects of oral health to those who need it most. We work closely with Government, dental and health professionals, manufacturers, the dental trade, national and local agencies and the public, to achieve our mission of addressing the inequalities which exist in oral health, changing people's lives for the better.

The Oral Health Foundation welcomes the opportunity to respond to the Health, Social Care and Sport Committee's consultation on the Public Health (Minimum Price for Alcohol) (Wales) Bill. Our comments on the general principles, barriers to implementation and any unintended consequences of the Bill are answered below.

Answers to questions:

1) Comment on the general principles of the Bill and the extent to which it will contribute to improving and protecting the health and well-being of the population of Wales

- The Oral Health Foundation welcomes and supports this legislation. We have long supported Minimum Unit Pricing (MUP) for alcohol.

- MUP is one of the most effective and cost-effective measures to reduce alcohol-related harm and it will improve and protect the health and well-being of the population of Wales significantly.

- Introducing this measure at this time is especially important, given the recent announcement from the Welsh government that alcohol related deaths in Wales increased by 9% in 2016 compared with 2015 [1].

- The latest statistics from Wales show that between 2013-2015 there were 2,766 people in Wales diagnosed with oral cancer[2]. Alcohol is classified as a leading cause of oral cancer. An estimated 30% of oral cancers are linked to excessive alcohol consumption[3]. The Oral Health Foundation believes that the introduction of MUP for alcohol would ultimately reduce excessive consumption and have a direct impact on the number of oral cancer cases presented in Wales.

- Excessive alcohol consumption also impacts on oral health in several ways. Drinking hazardously is not only a risk factor for sustaining oro-facial injuries, either through falls, road traffic accidents or violence, but alcohol and lifestyles closely associated with alcohol misuse can also have detrimental effects on the dentition: dental erosion, dental caries and periodontal disease.

[1] Welsh government (14 November 2017), 'Increase in alcohol-related deaths in Wales – new report shows'. Available at http://gov.wales/newsroom/health-and-social-services/2017/item/?lang=en

[2] Public Health Wales, Cancer Incidence in Wales: Dashboard & Data. Available at http://www.wcisu.wales.nhs.uk/dashboard-data

[3] Parkin DM. Cancers attributable to consumption of alcohol in the UK in 2010. Br J Cancer 2011; 105 (S2):S14-S18).

The Oral Health Foundation firmly believe tackling alcohol misuse will be greatly beneficial to the population of Wales.

- Committee members will be aware of the work Sheffield University has done on behalf of the Welsh government to estimate the impact of MUP in Wales on population health. This work is referenced in the Explanatory Memorandum for the Bill. To summarise some of the Sheffield team's key findings, once the full effects of the policy are in place, MUP in Wales is estimated to lead to:

  - 53 fewer deaths a year
  - 1,400 fewer hospital admissions a year
  - £131 million a year saved in healthcare costs
  - £882 million in savings to society overall each year

At the same time, reductions in drinking will predominantly occur amongst high-risk drinkers, with moderate drinkers barely noticing the difference. According to Sheffield University's analysis, under a 50p MUP, moderate drinkers will spend just £2.37 a year more on alcohol, and consume just 6.4 fewer units a year [4]

2) Comment on any potential barriers to the implementation of the provisions and whether the Bill takes account of them

- We would draw attention to the fact that there will be costs associated with the enforcement of the Act by local authorities, at a time when local authorities are under tight financial pressures

- The Welsh government will need to ensure that local authorities have sufficient funds and support in order to carry out their enforcement work

- The implementation of MUP should include a mechanism to ensure any windfall gained is re-invested into additional public health work

3) Comment on whether there are any unintended consequences arising from the Bill

- One consequence of MUP, though not necessarily an unintended one, is that more people may seek help from substance misuse services. An increase in demand could place existing services under further pressure, and it is crucial that this is considered. Treatment services should be funded adequately to meet this demand

A number of negative consequences of the Bill have been suggested, and we summarise these below, and give our thoughts on each

- Concern has been expressed that MUP could lead to increases in dependent drinkers committing crime in order to consume alcohol, or that dependent drinkers may choose to consume harmful alcohol substitutes such as methylated spirits in order to become intoxicated

[4] Sheffield University (2014), Model-based appraisal of minimum unit pricing for alcohol in Wales. Available at http://gov.wales/docs/caecd/research/2014/141208-model-based-appraisal-minimum-unit-price-alcohol-en.pdf

A study of dependent drinkers' behaviour following an increase in the price of alcohol found that these effects were very uncommon.[5] A review of the negative impacts of MUP has concluded that, 'unintended negative consequences from MUP are minor in comparison with the substantial health, social and economic benefits the policy creates' [6]

- Another criticism of MUP has been that it has a disproportionately negative impact on those from low-income households

Whilst the impact of MUP on high-income drinkers is likely to be less than that felt by low-income drinkers, moderate drinkers at all income levels will barely notice the difference in costs, and we believe the health benefits of MUP outweigh this concern. Those from the lowest incomes stand to benefit the most from MUP, with an estimated 8 out of 10 lives saved coming from the lowest income groups,[7] and of all price-related alcohol policies, MUP reduces health inequalities the most [8]

- Another concern is that MUP may lead to increased profits for some alcohol producers and retailers in the off-trade, due to the increased prices of the cheapest products. Increased profits could then be spent on activity (e.g. alcohol marketing) which are linked with alcohol harm

We believe that, on balance, the large benefits of MUP in terms of people's health significantly outweigh this potential consequence

- Concern has also been expressed that MUP would negatively affect pubs

Assuming the MUP is set at 50p, pub prices will be left unchanged. For example, with a 50p MUP, a pint of average strength beer could not be sold for less than around £1, but this is well below the cost of average beer prices.

MUP could actually be of benefit for pubs, as it would increase the low prices of supermarket alcohol which have led more people to drink at home rather than in pubs

[5] Falkner, C. et al (2016), The effect of alcohol price on dependent drinkers' alcohol consumption, *New Zealand Medical Journal* 128: 1427, pp9-17.
[6] Stockwell, T. & Thomas, G. (2013), Is alcohol too cheap in the UK? The case for setting a Minimum Unit price for alcohol. London: Institute of Alcohol Studies.
[7] Holmes, J., et al. (2014) 'Effects of minimum unit pricing for alcohol on different income and socioeconomic groups: a modelling study', *The Lancet*, 383 (9929), 1655-64.
[8] Meier, P. M., *et al*., 2016. *Estimated Effects of Different Alcohol Taxation and Price Policies on Health Inequalities: A Mathematical Modelling Study*. PLOS One. Vol: 13 Iss: 2.

MPA 24

Bil Iechyd y Cyhoedd (Isafbris am Alcohol) (Cymru)

Public Health (Minimum Price for Alcohol) (Wales) Bill

Ymateb gan Alcohol Health Alliance UK

Response from Alcohol Health Alliance UK

Alcohol Health Alliance UK response to the Health, Social Care and Sport Committee's consultation on the Public Health (Minimum Price for Alcohol) (Wales) Bill

About the Alcohol Health Alliance UK

The Alcohol Health Alliance UK (AHA) is a group of over 50 organisations including the Royal College of Physicians, Royal College of GPs, British Medical Association, Alcohol Concern and the Institute of Alcohol Studies. The AHA works together to:

- Highlight the rising levels of alcohol-related health harm
- Propose evidence-based solutions to reduce this harm
- Influence decision makers to take positive action to address the damage caused by alcohol misuse

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1. Introduction

1.1 The AHA welcomes the opportunity to respond to this consultation. Our comments in relation to the general principles of the Bill, barriers to implementation and any unintended consequences of the Bill are below.

2. The general principles of the Bill and the extent to which it will contribute to improving and protecting the health and well-being of the population of Wales.

2.1 The Alcohol Health Alliance welcomes and supports this legislation. We have long supported minimum unit pricing for alcohol.

2.2 Minimum unit pricing (MUP) is one of the most effective and cost-effective measures to reduce alcohol-related harm, and it will improve and protect the health and well-being of the population of Wales significantly.

2.3 Introducing this measure at this time is especially important, given the recent announcement from the Welsh government that alcohol deaths in Wales increased by 9% in 2016 compared with 2015.[1]

2.4 Committee members will be aware of the work Sheffield University has done on behalf of the Welsh government to estimate the impact of minimum unit pricing in Wales on population health. This work is referenced in the Explanatory Memorandum for the bill. To summarise some of the Sheffield team's key findings, once the full effects of the policy are in place, MUP in Wales is estimated to lead to:

- 53 fewer deaths a year
- 1,400 fewer hospital admissions a year
- £131 million a year saved in healthcare costs
- £882 million in savings to society overall each year

2.5 At the same time, reductions in drinking will predominantly occur amongst high-risk drinkers, with moderate drinkers barely noticing the difference. According to Sheffield University's analysis, under a 50p MUP moderate drinkers will spend just £2.37 a year more on alcohol, and consume just 6.4 fewer units a year.[2]

3. Any potential barriers to the implementation of the provisions and whether the Bill takes account of them

3.1 We would draw attention to the fact that there will be costs associated with the enforcement of the Act by local authorities, at a time when local authorities are under tight financial pressures.

3.2 The Welsh government will need to ensure that local authorities have sufficient funds and support in order to carry out their enforcement work.

4. Whether there are any unintended consequences arising from the Bill

4.1 One consequence of MUP, though not necessarily an unintended one, is that more people may seek help from substance misuse services. An increase in demand could place existing services under further pressure, and it is crucial that this is considered. Treatment services should be funded adequately to meet this demand.

4.2 A number of negative consequences of the Bill have been suggested, and we summarise these below, and give our response to each.

[1] Welsh government (14 November 2017), 'Increase in alcohol-related deaths in Wales – new report shows'. Available at http://gov.wales/newsroom/health-and-social-services/2017/item/?lang=en

[2] Sheffield University (2014), Model-based appraisal of minimum unit pricing for alcohol in Wales. Available at http://gov.wales/docs/caecd/research/2014/141208-model-based-appraisal-minimum-unit-price-alcohol-en.pdf

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4.3 A common criticism of MUP is that it is a 'tax on the poor', and that it will place financial pressure on lower income groups who, like most people, enjoy having a drink, and who are already struggling financially.

4.4 In response to this, we would point that **all moderate drinkers, including those in poverty, are estimated to barely change their spending in response to MUP**. Sheffield University's modelling estimates that moderate drinkers who are not in poverty will spend an average of £2.44 more per year under a 50p MUP.[3]

4.5 In contrast, **moderate drinkers who are in poverty will see a smaller rise in their spending**, at an average of £2.15 per year under a 50p.[4]

4.6 It is true that, according to Sheffield's analysis, high-risk drinkers (making up 5.7% of the Wales population) are estimated to spend an average of £32 more per year under a 50p MUP[5], and this increase in spending is likely to be felt more by those on low incomes. However, this increase in spending would occur whilst these high-risk drinkers (who are consuming over 71 units of alcohol per week) decrease their alcohol consumption by 13%, bringing numerous health benefits. We believe that, on balance, these health gains should outweigh other concerns.

4.7 In addition, overall we know that it is those on low incomes who have the most to gain from MUP, with 8 out of 10 lives saved from MUP predicted to come from the lowest income groups.[6]

4.8 Finally, we would point out that since Sheffield University's modelling work for the Welsh government in 2014, research has suggested that in England, a 50p MUP would mean that **harmful drinkers in poverty will actually spend £88 less per year**.[7] This is because harmful drinkers are predicted to drastically cut their drinking in response to MUP. We see no reason why this analysis could not be applied to Wales.

4.9 Concern has been expressed that MUP could lead to increases in dependent drinkers committing crime in order to consume alcohol, or that dependent drinkers may choose to consume harmful alcohol substitutes such as methylated spirits in order to get drunk.

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[3] Ibid.
[4] Ibid.
[5] Ibid.
[6] Ibid.
[7] Meier, P. et al (2016), Estimated Effects of Different Alcohol Taxation and Price Policies on Health Inequalities: A Mathematical Modelling Study, *PLOS Medicine*. doi: http://dx.doi.org/10.1371/journal.pmed.1001963

4.10 However, a study of dependent drinkers' behaviour following an increase in the price of alcohol found that these effects were very uncommon.[8] A review of the negative impacts of MUP has concluded that, 'unintended negative consequences from MUP are minor in comparison with the substantial health, social and economic benefits the policy creates.'[9]

4.13 Another concern is that MUP may lead to increased profits for some alcohol producers and retailers in the off-trade, due to the increased prices of the cheapest products. Increased profits could then be spent on activity (e.g. alcohol marketing) which are linked with alcohol harm. However, we believe that, on balance, the large benefits of MUP in terms of people's health significantly outweigh this potential consequence.

4.14 Finally, concern has been expressed that MUP would negatively affect pubs. However, assuming the MUP is set at 50p, pub prices will be left unchanged. For example, with a 50p MUP, a pint of average strength beer could not be sold for less than around £1, but this is well below the cost of average beer prices.

4.15 MUP could actually be good for pubs, as it will increase the price of cheap supermarket alcohol which has been able to undercut pub prices, and lead to more people deciding to drink at home. In addition, research done by the Institute of Alcohol Studies found that pub managers support minimum unit pricing by a margin of 2 to 1.[10]

[8] Falkner, C. et al (2016), The effect of alcohol price on dependent drinkers' alcohol consumption, *New Zealand Medical Journal* 128: 1427, pp9-17.
[9] Stockwell, T. & Thomas, G. (2013), Is alcohol too cheap in the UK? The case for setting a Minimum Unit price for alcohol. London: Institute of Alcohol Studies.
[10] Institute of Alcohol Studies (2017), Pubs Quizzed: What Publicans Think About Policy, Public Health and the Changing Trade. Available at: http://www.ias.org.uk/uploads/pdf/IAS%20reports/rp26092017.pdf

Arbenigwyr mewn Busnes
Experts in Business

14th December 2017

Dai Lloyd AM
Chair, Health and Social Care Committee
National Assembly for Wales
Cardiff Bay
CF99 1NA

Dear Dai

RE: Public Health (Minimum Price of Alcohol) (Wales) Bill

FSB Wales welcomes the opportunity to comment on the Health and Social Care Committee's consideration of the Public Health (Minimum Price of Alcohol) (Wales) Bill.

FSB Wales is not best placed to comment on the potential health and social impacts of the Bill to introduce a minimum unit price for alcohol (MUP). As such, we have no fixed view on the principles that relate to the introduction of a MUP policy. Our comments therefore relate only to the implementation of the policy and the potential impact this may have on smaller retailers.

One key concern for us relates to how the Bill will be implemented in the future. We know from previous research around regulatory policy in Wales that public protection and trading standards departments at local authorities have experienced significant levels of cuts to their budget as a result of being unprotected areas of spend. Indeed, we note that the evidence provided by the WLGA to the committee suggests that "*it is regrettable, that as Local Authority regulatory services continue to be cut, it is no longer realistic to expect proactive, consistent enforcement activity across Wales.*"

FSB Wales has in the past called for a much stronger statement of direction from Welsh Government in relation to regulatory policy through our report *Better Regulation for Wales*. Our concern is that as the regulatory responsibility grows on local authorities as the result of Welsh Government legislation, there is a lack of emphasis on how that regulation is going to be delivered. This in turn results in patchy or poorly focused regulatory enforcement that doesn't have the capacity to educate and advise firms at risk of non-compliance.

It is notable that the only local authority currently pursuing a better regulation agenda through the UK Government's *Better Business for All* scheme is Denbighshire. Whilst we would encourage all local authorities to follow Denbighshire's example, Welsh Government clearly has a role to play in showing leadership and direction in this area.

In relation to the specific regulatory requirements that would be brought in by the Bill, FSB Wales agrees with other contributors including the WLGA that the best way to ensure good implementation of this policy is to ensure that there is a well-resourced communication campaign to ensure that those businesses required are aware of their responsibilities in terms of implementation.

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Arbenigwyr mewn Busnes
Experts in Business

Furthermore, sufficient resource should be available through public protection departments to provide the correct level of advice and support for smaller firms that may have questions about how they go about implementing MUP in their business.

I hope you find our comments of interest as you scrutinise the Public Health (Minimum Price of Alcohol) (Wales) Bill.

Yours sincerely

Janet Jones
Wales Policy Chair
Federation of Small Businesses Wales

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MPA 26

Bil Iechyd y Cyhoedd (Isafbris am Alcohol) (Cymru)

Public Health (Minimum Price for Alcohol) (Wales) Bill

Ymateb gan Samaritans Cymru

Response from Samaritans Cymru

Public Health (Minimum Price for Alcohol) (Wales) Bill

Samaritans Cymru response

1. Samaritans is a registered charity aimed at providing emotional support to anyone in emotional distress. In Wales, Samaritans works locally and nationally to raise awareness of their service and reach out into local communities to support people who are struggling to cope. They seek to use their expertise and experience to improve policy and practice and are active contributors to the development and implementation of Wales Suicide and Self Harm Prevention Action Plan 'Talk to Me 2'.

2. Globally, over 800,000 people die by suicide each year.[1] In the United Kingdom and Ireland, more than 6000 people take their own lives each year and in Wales, between 300 and 350 people die by suicide each year. This is about 3 times the number killed in road accidents. In both England and Wales, suicide is the most common cause of death for men aged 20-49. Of the 322 suicides in Wales in 2016, 265 (82%) of these were by men.[2] In 2015, the age groups with the highest suicide rate per 100,000 in Wales were: 30-34 years, for all persons and 30-34 years for males. In reviewing trends over time, there has been a general increase in male suicide in Wales over the last 30 years, with a specific trend of increase since around 2008. Female suicide in Wales has decreased over same period, however, in line with the male trend, there has been a period of general increase since 2008.[3]

The extent to which the Bill will contribute to improving and protecting the health and well-being of the population of Wales

3. Although many factors are involved in suicide, the link between alcohol misuse and suicide has been well established. The risk of suicide is up to eight times greater when someone is abusing alcohol. Alcohol can reduce people's inhibitions enough for them to act on suicidal thoughts and it can increase impulsivity, change people's mood and deepen their depression. Young people under 24 are particularly vulnerable to thoughts of suicide, suicide attempts and suicide under the influence of alcohol.

4. The burden of alcohol related harm is carried by those in the most deprived groups in society, and Samaritans has previously found that men are more likely than women to use drugs or alcohol in response to distress. Of the 322 suicides in Wales in 2016, 265 (82%) of these were by men. This sits

[1] World Health Organization (WHO). (2014). *Preventing suicide: A global imperative*. Retrieved from: http://www.who.int/mental_health/suicide-prevention/world_report_2014/en/

[2] ONS. (2016). *Suicides in the United Kingdom, 2015 registrations*. United Kingdom: Office for National Statistics

[3] Scowcroft, E. (2016). *Suicide statistics report 2016: Including data for 2012-2014*. Surrey: Samaritans.

alongside data which shows men drink alcohol more frequently than women, and report to drinking above guidelines, heavy (binge) drinking or very heavy drinking.[4]

5. In our 2015 manifesto 'Four Steps to Save Lives', we focused on tackling alcohol misuse as one of the main steps required to reduce suicide rates in Wales, with the introduction of Minimum Unit Pricing being one of our main recommendations. Therefore, we welcome the Public Health (Minimum Price for Alcohol) (Wales) Bill and believe that the introduction of MUP would help save lives and make a significant contribution to suicide prevention in Wales.

6. Samaritans believes that a combination of policies which address both individual behaviour and the culture which normalises harmful drinking is required. Initiatives need to address the underlying emotional distress people experience and provide support as well as reduce access to alcohol. The World Health Organisation has found that the alcohol policies most effective in reducing harms and costs are pricing and availability policies such as minimum pricing. We support evidence-based interventions to reduce alcohol related harm.

[4] Public Health Wales *Alcohol and health in Wales 2014: Wales profile*

Bil Iechyd y Cyhoedd (Isafbris am Alcohol) (Cymru)

Ymateb Samariaid Cymru

1. Mae'r Samariaid yn elusen gofrestredig â'r nod o ddarparu cymorth emosiynol i unrhyw un sydd mewn trallod emosiynol. Yng Nghymru, mae'r Samariaid yn gweithio'n lleol ac yn genedlaethol i godi ymwybyddiaeth o'u gwasanaeth ac estyn allan i gymunedau lleol i gynorthwyo pobl sy'n cael trafferth i ymdopi. Maent yn ceisio defnyddio eu harbenigedd a'u profiad i wella polisïau ac arferion ac yn gyfranwyr gweithgar i'r gwaith o ddatblygu a rhoi ar waith Gynllun Gweithredu Atal Hunanladdiad a Hunan-niwed Cymru 'Siarad â Fi 2'.

2. Dros y byd i gyd, mae mwy nag 800,000 o bobl yn marw trwy hunanladdiad bob blwyddyn.[5] Yn y Deyrnas Unedig ac Iwerddon, mae mwy na 6000 o bobl yn lladd eu hunain bob blwyddyn ac yng Nghymru, mae rhwng 300 a 350 o bobl yn marw trwy hunanladdiad bob blwyddyn. Mae hyn tua theirgwaith y nifer sy'n cael eu lladd mewn damweiniau ar y ffyrdd. Yng Nghymru ac yn Lloegr, hunanladdiad yw achos mwyaf cyffredin marwolaeth ymysg dynion 20-49 oed. O'r 322 o hunanladdiadau yng Nghymru yn 2016, roedd 265 (82%) gan ddynion.[6] Yn 2015, y grwpiau oedran â'r gyfradd hunanladdiadau uchaf am bob 100,000 o bobl yng Nghymru oedd: 30-34 oed, i bawb, a 30-34 oed, i ddynion. Wrth adolygu tueddiadau dros amser, bu cynnydd cyffredinol mewn hunanladdiadau ymysg dynion yng Nghymru dros y 30 mlynedd ddiwethaf, a gwelwyd tuedd benodol ar i fyny ers o gwmpas 2008. Mae hunanladdiadau ymysg menywod yng Nghymru wedi gostwng dros yr un cyfnod ond, yn unol â'r duedd ymysg dynion, gwelwyd cyfnod o gynnydd cyffredinol ers 2008.[7]

Y graddau y bydd y Bil yn cyfrannu at wella a diogelu iechyd a lles poblogaeth Cymru

3. Er bod llawer o ffactorau ynghlwm wrth hunanladdiad, mae'r cysylltiad rhwng camddefnyddio alcohol a hunanladdiad wedi'i hen sefydlu. Mae risg hunanladdiad hyd at wyth gwaith yn fwy pan fo rhywun yn camddefnyddio alcohol. Gall alcohol leihau ataliadau pobl ddigon iddynt weithredu ar feddyliau hunanladdol a gall gynyddu byrbwylltra, newid hwyliau pobl a gwaethygu eu hiselder. Mae pobl ifanc iau na 24 oed yn arbennig o agored i feddyliau am hunanladdiad, ceisiadau i ladd eu hunain a hunanladdiad o dan ddylanwad alcohol.

4. Mae baich niwed sy'n gysylltiedig ag alcohol yn cael ei gario gan y rheiny yn y grwpiau mwyaf difreintiedig yn y gymdeithas. Hefyd mae'r Samariaid wedi canfod o'r blaen bod dynion yn fwy tebygol na menywod o ddefnyddio cyffuriau neu alcohol wrth ymateb i drallod. O'r 322 o hunanladdiadau yng

[5] Sefydliad Iechyd y Byd (WHO). (2014). *Preventing suicide: A global imperative.* Cafwyd o: http://www.who.int/mental_health/suicide-prevention/world_report_2014/en/

[6] Swyddfa Ystadegau Gwladol (2016). *Suicides in the United Kingdom, 2015 registrations.* Y Deyrnas Unedig: Swyddfa Ystadegau Gwladol

[7] Scowcroft, E. (2016). *Suicide statistics report 2016: Including data for 2012-2014.* Surrey: Samaritans.

Nghymru yn 2016, roedd 265 (82%) gan ddynion. Mae hyn yn cyd-fynd â data sy'n dangos bod dynion yn yfed alcohol yn amlach na menywod, ac yn dweud eu bod yn yfed mwy na'r canllawiau, yn yfed yn drwm (mewn pyliau) neu'n yfed yn drwm iawn.[8]

5. Yn ein maniffesto o 2015 'Pedwar Cam i Achub Bywydau', rhoesom sylw i fynd i'r afael â chamddefnyddio alcohol fel un o'r prif gamau yr oedd eu hangen i leihau'r cyfraddau hunanladdiad yng Nghymru, a chyflwyno isafswm pris uned oedd un o'n prif argymhellion. Felly, rydym yn croesawu Bil Iechyd y Cyhoedd (Isafbris am Alcohol) (Cymru) ac yn credu y byddai cyflwyno isafswm pris uned yn helpu i achub bywydau ac yn gwneud cyfraniad sylweddol i atal hunanladdiad yng Nghymru.

6. Mae'r Samariaid yn credu bod angen cyfuniad o bolisïau sy'n mynd i'r afael ag ymddygiad unigolion ac â'r diwylliant sy'n gwneud yfed niweidiol yn beth normal. Mae angen i fentrau fynd i'r afael â'r trallod emosiynol sylfaenol mae pobl yn ei brofi a darparu cymorth yn ogystal â lleihau'r gallu i gael gafael ar alcohol. Mae Sefydliad Iechyd y Byd wedi canfod mai'r polisïau ar alcohol sy'n fwyaf effeithiol wrth leihau niwed a chostau yw polisïau ar brisiau ac argaeledd, megis isafbris. Rydym yn cefnogi ymyriadau seiliedig ar dystiolaeth i leihau niwed sy'n gysylltiedig ag alcohol.

[8] Iechyd Cyhoeddus Cymru *Alcohol and health in Wales 2014: Wales profile*

MPA 27

Bil Iechyd y Cyhoedd (Isafbris am Alcohol) (Cymru)

Public Health (Minimum Price for Alcohol) (Wales) Bill

Ymateb gan John Holloway

Response from John Holloway

Public Health (Minimum Price for Alcohol) Wales Bill - Explanatory Memorandum

Comments and observations by John Holloway , [redacted], [redacted], [redacted]

EMail: [redacted]

Case Studies

In paragragh 275 it states the Average extra costs will be £2.37 per annum for moderate drinkers and £32 per annum for Moderate drinkers.

I thought I would test this against my own and my mothers consumption , we are both moderate drinkers and always have been so here are two case studies.

John

Drinkers a can of beer (Fosters 440ml 4% Alcohol 1.8units) a day (with his evening meal) , he buys this in packs of 20 usual price £14 per pack , maybe less than this on the run up to rugby days and Bank holidays. (Current price £11 per pack in Asda Cwmbach)

These packs will now increase to £18. £14 / 20 cans = 70p a can now, MUP price (1.8 *0.50p) 90p. So each day John will have to pay an extra £0.20p a day £1.40 a week and **a staggering £72.80 per annum.**

Johns Mum (aged 85)

Has a small glass of Sherry before dinner she drinks Asda own brand Pale Sherry and buys one litre every 3 weeks from this she gets 20 glasses (50ml each) the bottle is 17.5 units so her consumption is 5.8 units a week well below the government guideline of 14 units

The bottle now costs her £7.15 with MUP this will rice to £8.75 an extra 53p a week **or £27 a year.**

This figures are massively at variance with the figures in paragraph 279, as neither of us are "in poverty" the prediction is we incur an extra cost of £2.44 each per annum.

I've thought about this long and hard perhaps we are atypical but I don't think my local Asda has allocated 12 linear metres for large packs of beer just in case I decide to go on a spending spree.

What seems to be missing from the document is any allowance for moderate drinkers , sensibly, taking advantage of cheap deals. In fact there is no explanation of how these extra costs are arrived at.

Measuring The Effectiveness of MuP

The legislation provides for a full? review in 5 years . However certain benefits that related to Acute Alcohol Problems should become evident within a year (or sooner) From the memorandum these are

Violent Acts

Work Abscences

Public Disorder

Emergency Hospital Admissions

The Sheffield Model sets out very specific expected reductions in the above area , therefore tracking the expected against the actual should give a very early indication of the effectiveness (or otherwise) of the implementation of MUP . Clearly alcohol abuse is a major problem and if MUP does not deliver as expected then other avenues need to be explored - five years plus time to decide on a new approach is just too long.

I would like to see a full annual report measuring expected against actuals, including problems associated with Chronic Alcohol problems although clearly the effective on this group will take longer to show through.

Extra Income to Retailers

The people of Wales are being forced to donate £0.25 Billion to retailers over 10 years. I find this most unpalatable.

Although not part of this proposal my suggestion is:-

The major retailers are asked to join a scheme where any excess profit created by MUP is donated to respected established charities that deal with problems caused by Alcohol abuse. They would be able to put a sticker on any products saying £x of this purchase will be donated to "Good Causes helping people (and their Families) deal with Alcohol problems ". Plus a table of donations could be published every month.

I would suggest this scheme could be investigated with the aim of introducing it say 12 months after MUP is introduced.

Document Bias / Lack of Investigation

Internet Shopping

Paragraph 238 - bizarre comment these people don't need to buy online when there is no price differential. They don't buy on line NOW but with a substantial price difference this may change. The whole proposal is about changing habits!

The whole process of internet shopping is not discussed in detail in the document - In view of the way this could derail the whole proposal it merits some investigation. I don't claim to be an expert on this subject , but here are my observations.

If you order alcohol from a company with an English address MUP does not apply - that company could have a warehouse in Wales from which it supplies those orders. Additionally local pickup is becoming more prevalent with corner shops serving as distribution outlets for online orders - pick up locally and pay locally.

All you need is an English Address that you notionally order from.

Cross Border Shopping

In the 80s, 90s and early 2000s there was massive cross channel trade South of England / France (mostly Calais) in cheap alcohol - van loads of cheap french booze were imported. In the end , as HRMC were reputedly down £4 billion per annum, a "for personal consumption" only rule was introduced with inspections at the arrival point.

I'm amazed there is no discussion of this in the Memorandum.

The situation in Wales is simpler for the importers as there are no customs posts between England and Wales so load up your van with Frosty Jacks in England and sell on in Wales. Perfectly legal provided you are "shopping for a friend".

Lower Quality Products

Blatant Bias in Paragraph 365:- this mentions a price gap between "Lower Quality products and Higher quality or branded products"

This is an expression of opinion not a fact and is trying to instil the view that lower priced products are Inferior (and therefore should be avoided) which is not the case Own branded products are in many cases better or equal to branded products. (a quick search on the internet will support this view).

Responses to Previous Consultation

Bias in Paragraphs 176 to 180

Negative responses are attributed to the "alcohol retail and ....." there is no such qualification to the positive responses documented in Paragraph 178. *Presumably some from Religious Groups and others that oppose any alcohol consumptio*n?

Illicit Alcohol

Unsubstantiated Comment in Paragraph 229

Third sentence beginning. "The Welsh Government does not consider..." this is just an opinion accredited to no one in particular, who exactly in "The Welsh Government" is being referred to and where is this opinion documented. In fact the whole paragraph is decidedly woolly - failing to cite any evidence.

Callous Attitude

Paragraph 362 - If it's the only local shop in a village that goes out of business then this could have a serious effect on the community.

MPA 28
Bil Iechyd y Cyhoedd (Isafbris am Alcohol) (Cymru)
Public Health (Minimum Price for Alcohol) (Wales) Bill
Ymateb gan Federation of Independent Retailers
Response from the Federation of Independent Retailers

Written Evidence on the Public Health (Minimum Price for Alcohol) (Wales) Bill

Executive Summary

- The Federation of Independent Retailers (NFRN) believes that introducing a minimum unit price (MUP) is the best course of action in combating anti-social behaviour and improving public health. However, it has concerns regarding two potential unintended consequences arising from the bill.

    1. MUP could drive crime rates as well as verbal and physical abuse of retailers working in public-facing roles.

    2. MUP could have a negative impact on the poor, vulnerable, and those with alcohol dependency.

- The NFRN calls on the Welsh Assembly to consider rising crime rates, police response times, and the sufficiency of social programmes capable of absorbing the sudden increase in people with alcohol dependency being hit by soaring prices caused by the MUP Bill.

Introduction

1. The NFRN was founded in 1919 and is one of Europe's largest employers' associations with over 15,000 independent retailers in membership throughout the UK and Ireland. The NFRN exists to help the independent retailer compete more effectively in today's highly competitive market. Membership of the NFRN consists of a variety of independent retailers, including newsagents, convenience stores, confectioners, florists, petrol forecourts, news deliverers, off-licences, post offices, coffee shops, and card and stationery shops.

2. Approximately 9 per cent of Welsh businesses are retailers, with the majority (around 90 per cent) being local multiples and small independents who increasingly deliver wider services to the public and present a fundamental part of local communities.[1] Retail contributes 6 per cent of Welsh gross value added (GVA) and currently provides 137,000 jobs.[2]

[1] Welsh Retail Consortium. (2017). Shaping the Future of Welsh Retail. *Welsh Retail Consortium*, pp.1-14:2.
[2] Ibid.

The Impact of MUP for Alcohol on Human Health

1. A minimum price for the sale and supply of alcohol has great potential to reduce anti-social behaviour and improve the health and well-being of the population of Wales.

2. Dr Petra Meier's research for the Department of Health found that a minimum unit price set at 50p per unit would save 3,400 lives and reduce hospital admissions by a staggering 98,000 per year.[3]

3. Studies looking at countries where minimum unit pricing has already been implemented also offer promising results. A report by the Institute of Alcohol Studies (IAS) highlighted that data from Canadian provinces showed that a 10 per cent increase in the minimum unit price of alcohol would "result in the region of an 8 per cent reduction in consumption, a 9 per cent reduction in hospital admissions, and a 32 per cent reduction in wholly alcohol caused deaths – with further benefits accruing two years later".[4] Furthermore, the report emphasised that a 10 percent increase in minimum unit price would also have the effect of reducing the impact of alcohol-related anti-social behaviour.[5]

The Impact of MUP for Alcohol on Independent Retailers and the Local Communities They Serve

1. In addition to the positive impact on human health, MUP will create a more levelled playing field for independent retailers. The growing presence of supermarket chains in local areas has led to a decline in the retail sector, as independents have to contend with unachievable price cuts driving them out of business. Current home-brand alcoholic drinks would have to increase their prices substantially. Sainsbury's 2-litre bottle of own-brand dry cider, for example, currently sits at £2.35. Under a MUP of 50p, however, the cost of the cider would need to be £5.

2. The MUP can help secure the future of the local shop. Independent retailers provide an invaluable service to local communities by providing more tailored services and promoting local causes. For example, several independent retailers in England have introduced a 5 pence charge on single-use carrier bags, with proceeds going to local charity projects.

[3] UK Alcohol Alert (2009). Cheap Alcohol Issue 2. *Institute of Alcoholic Studies*, pp.1-22:2.
[4] Thomas, G. and Stockwell, T. (2013). Is Alcohol Too Cheap in the UK? The Case for Setting a Minimum Unit Price for Alcohol. *Institute for Alcoholic Studies*, pp.1-22:2.
[5] Ibid:3.

Unintended Consequences Arising from the Bill

Crime Rates and Abuse

1. Statistics by the British Retail Consortium show that one shop worker is attacked or threatened every minute of the shopping day.[6] In comparison to the previous year, violence and assault have increased by a staggering 40 per cent, with over 51 incidents of violence and abuse per 1,000 staff.[7] USDAW's latest Freedom from Fear survey found that violence remains an unacceptable threat to retail employees in public facing roles, with an average of 241 retail staff being assaulted every single day. Furthermore, 33 per cent of shop workers surveyed stated that they were threatened by customers, and over half were verbally abused in 2014.[8]

2. In South Wales, the number of retail crime incidents has increased by 464 per cent to 70,727 recorded incidents of retail crime.[9] An element of this threat can be linked to alcohol, with it fuelling crime and anti-social behaviour.

3. Independent retailers do not have the same level of security as supermarkets, although independent retailers are continuing to invest heavily in loss prevention measures, including CCTV, mirrors, panic alarms, and shutters, as well as placing high-value items in a secure location. They cannot, however, afford physical security. Micro businesses and local independent retailers do not have the financial capability to invest the same as large national chains, who have a physical security presence.

4. The introduction of the MUP might contribute to the ever-rising number of violent incidents. Independent retailers, in particular, are vulnerable to anti-social behaviour due to their late opening times and lack of security measures. There is a real concern that without physical protection and funds for further security measures, the independent retailer will be the main target of costumers angered by the MUP. As one of Wales' biggest employment sectors, retailers need to have the confidence that they will be protected in their place of work.

5. Additionally, the NFRN is concerned that police in Wales may be prioritising responses to supermarkets rather than a balanced approach in responding to retail crime by risk. Responses received from several police forces in Wales and around the UK reveal that a higher percentage of incidents occurring in supermarkets or hypermarkets are dealt with by an "immediate response" or a "prompt response". Incidents occurring at independent retailers, on the other hand, tend to receive more "prompt responses" followed by "scheduled appointment visits" following a retail crime incident.[10] These

[6] SkyGuard. (2017). The Retail Sector – How to Avoid Danger at the Workplace. *SkyGuard.* (27th of September).
[7] Retail Risk. (2017). UK Retail Crime Survey Shows Rise in Cyber Fraud and Abuse of Staff. *Retail Risk*. (3rd of February).
[8] Union of Shop, Distributive and Allied Workers. (2015). Violence, Threats and Abuse Against Shopworkers Is Still A Big Problem Says USDAW. *Union of Shop, Distributive and Allied Workers*. (19th of January).
[9] NFRN. (2017). Independent Retail Report 2017. *NFRN*, pp.1-33:14.
[10] NFRN. (2017). Independent Retail Report for Wales 2017. *NFRN*, pp.1-19:12.

trends are worrying in light of the introduction of the MUP. Retailers need to have confidence that retail crimes are taken seriously.

Negative Impact on the Poor, Vulnerable, and Those with Alcohol Dependency

1. In 2016-17, there were 6,518 hospital admissions related to illicit drugs in Wales and 15,165 alcohol-specific admissions.[11] Furthermore, in 2016, ONS registered 504 alcohol-related deaths in Wales in 2016, an increase of 8.9 per cent on the previous year. 336 of those deaths were men, and 168 were women. [12] These statistics show that alcohol dependency remains a real public health issue in Wales.

2. The NFRN is concerned that the introduction of MUP will negatively impact on the poor, vulnerable, and individuals with an already existing alcohol dependency. A 2008 study by the University of Sheffield found that heavy and problem drinkers were more likely to select cheaper alcohol products, arguing that "it follows that raising floor prices will have a disproportionate effect on those drinkers at most risk of harm"[13]

3. Programmes will be needed that help individuals with alcohol dependency suddenly finding themselves in a position of financial inability regarding alcohol purchases. Otherwise, there is a high risk that they would either steal, turn to other substances that will satisfy their needs at a lower financial cost, or obtain alcohol through illegal means, thus fuelling the already growing illicit alcohol trade.

[11] Public Health Wales. (2017). Data Mining Wales: The Annual Profile for Substance Misuse 2016-17. *Public Health Wales*, pp.1-89:10.
[12] Office for National Statistics. (2017). Alcohol-Specific Deaths in the UK: Registered in 2016. *Office for National Statistics*. (7th of November).
[13] Meier, P. (2008). Independent Review of the Effects of Alcohol Pricing and Promotion. *The University of Sheffield*, pp.1-243:34.

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Coleg Nyrsio Brenhinol Cymru
Royal College of Nursing Wales

14 December 2017

Response from the Royal College of Nursing Wales to the Health, Social Care and Sport Committee's inquiry into the general principles of the Public Health (Minimum Price for Alcohol) (Wales) Bill

The Royal College of Nursing Wales is grateful for the opportunity to respond to the inquiry into the general principles of the Public Health (Minimum Price for Alcohol) (Wales) Bill. We would like to raise a number of issues in relation to the terms of reference:

I. The Royal College of Nursing has for some time been calling for the introduction of Minimum Unit Pricing (MUP) for alcohol and on that basis the Royal College of Nursing Wales unequivocally supports the introduction of this piece of legislation.

II. Nurses in Wales are faced and challenged with the consequences of alcohol misuse every day. These range from dealing with violent and aggressive patients in accident and emergency departments (A&E) to caring for people suffering from long term poor health as a result of sustained alcohol abuse. Nurses throughout Wales have a role and commitment to assist the people of Wales by supporting the population to make healthier choices.

III. The RCN's prevention work is underpinned by the principle that we should empower individuals with the appropriate information they will need to understand the impact of alcohol misuse in order for them to make healthier lifestyle choices. The RCN, however, also believes that more can be done to change the wider environment so that the healthier choice is the easy choice. Sometimes, this may require regulation by government, and on the subject of alcohol misuse the RCN's stated position is that this is one area that requires urgent government intervention.

IV. Excessive alcohol consumption is a major source of morbidity and premature death in Wales, and RCN Wales acknowledge the research undertaken by the University of Sheffield in identifying the benefits to be accrued by the health services in Wales by the introduction of MUP[1].

V. It is RCN Wales' view that the evidence presented in the Explanatory Memorandum is compelling and, as already stated, it is the RCN's position that the introduction of MUP will have an impact on alcohol consumption as it drives down the level of purchasing. It is, however, our contention that MUP does not go far enough. As such, the RCN urge government to also:
   - Legislate to prevent the alcohol industry from undertaking promotional activities which encourage excessive consumption or target children.

[1] Sheffield Alcohol Policy Model (SAPM) (Brennan et al, 2008).

- Legislate for the mandatory labelling of all alcohol drinks with unit and health information in a consistent format.
- Introduce a drink drive limit of 50mg per 100 millilitres of blood alcohol content.

Alcohol Health Alliance

VI. The Committee may want to be aware of the following statement made by the Alcohol Health Alliance UK, of which the Royal College of Nursing was a signatory:

"We unequivocally endorse the Welsh government's adoption of a minimum unit price for alcohol. Minimum unit pricing is a highly effective tool to reduce the number of deaths related to alcohol, crime and workplace absence. The Welsh government continues to demonstrate its firm commitment to tackle the problem of cheap alcohol and the devastating effect this has on our communities, especially its most vulnerable members.

"This decisive action will not impact prices in pubs or bars but target pocket-money-priced alcohol. It is simply unacceptable that three litres of white cider, containing the equivalent alcohol of 22 shots of vodka, can be bought for just £3.49.

"With alcohol misuse costing £21bn-£52bn per year, the UK government must now follow Wales and Scotland by implementing a policy that will save lives, relieve pressure on our NHS and fulfil its commitment to even out life chances."

About the Royal College of Nursing

The RCN is the world's largest professional union of nurses, representing over 430,000 nurses, midwives, health visitors and nursing students, including over 25,000 members in Wales. The majority of RCN members work in the NHS with around a quarter working in the independent sector. The RCN works locally, nationally and internationally to promote standards of care and the interests of patients and nurses, and of nursing as a profession. The RCN is a UK-wide organisation, with its own National Boards for Wales, Scotland and Northern Ireland. The RCN is a major contributor to nursing practice, standards of care, and public policy as it affects health and nursing. The RCN represents nurses and nursing, promotes excellence in practice and shapes health policies.

MPA 30

Bil Iechyd y Cyhoedd (Isafbris am Alcohol) (Cymru)

Public Health (Minimum Price for Alcohol) (Wales) Bill

Ymateb gan Alcohol Focus Scotland

Response from Alcohol Focus Scotland

ALCOHOL FOCUS SCOTLAND RESPONSE TO HEALTH, SOCIAL CARE AND SPORT COMMITTEE'S CONSULTATION ON THE PUBLIC HEALTH (MINIMUM PRICE FOR ALCOHOL) (WALES) BILL

Alcohol Focus Scotland (AFS) is Scotland's national charity working to prevent and reduce alcohol harm. We aim to reduce the impact of alcohol in Scotland - and beyond - through the implementation of effective alcohol control policies and legislation. We have been at the forefront of the campaign to introduce minimum unit pricing in Scotland for the last decade.

1.1 AFS welcomes the opportunity to respond to this consultation. Our comments in relation to the general principles of the Bill, barriers to implementation and any unintended consequences of the Bill are below.

2. The general principles of the Bill and the extent to which it will contribute to improving and protecting the health and well-being of the population of Wales.

2.1 AFS welcomes and supports this legislation. We have long advocated supported minimum unit pricing for alcohol.

2.2 The international evidence is clear that low alcohol prices drive consumption and harm. The World Health Organization, therefore, recommends minimum unit pricing (MUP) as an intervention to prevent and reduce non-communicable diseases.[1] As a highly effective and cost-effective measure, MUP it will significantly improve and protect the health and well-being of the people of Wales.

[1] World Health Organization, "' Best Buys' And Other Recommended Interventions for the Prevention and Control of Noncommunicable Diseases", May 2017. Available at: http://who.int/ncds/management/WHO_Appendix_BestBuys.pdf

2.3 Introducing this measure at this time is especially important, given the recent announcement from the Welsh government that alcohol deaths in Wales increased by 9% in 2016 compared with 2015.[2]

2.4 Committee members will be aware of the work Sheffield University has done on behalf of the Welsh government to estimate the impact of minimum unit pricing in Wales on population health. This work is referenced in the Explanatory Memorandum for the bill. To summarise some of the Sheffield team's key findings, once the full effects of the policy are in place, MUP in Wales is estimated to lead to:

- 53 fewer deaths a year
- 1,400 fewer hospital admissions a year
- £131 million a year saved in healthcare costs
- £882 million in savings to society overall each year

2.5 Reductions in drinking will predominantly occur amongst high-risk drinkers, with moderate drinkers barely noticing the difference. According to Sheffield University's analysis, under a 50p MUP moderate drinkers will spend just £2.37 a year more on alcohol, and consume just 6.4 fewer units a year.[3]

2.6 It should also be recognised that alcohol harm affects not only the drinker but their families and communities, through family breakdown, neglect and violent crime. Reductions in alcohol consumption as a result of MUP will, therefore, improve the lives of many thousands of people in Wales.

3. Any potential barriers to the implementation of the provisions and whether the Bill takes account of them

3.1 The Welsh government will need to ensure that local authorities are adequate trained and supported to carry out enforcement work in relation to this legislation.

4. Whether there are any unintended consequences arising from the Bill

4.1 One consequence of MUP, though not necessarily an unintended one, is that more people may seek help from substance misuse services. An increase in demand could place existing services under further pressure, and it is crucial that treatment services are adequately funded to meet this demand.

4.2 A number of negative consequences of the Bill have been suggested, and we summarise these below, and give our response to each.

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[2] Welsh government (14 November 2017), 'Increase in alcohol-related deaths in Wales – new report shows'. Available at http://gov.wales/newsroom/health-and-social-services/2017/item/?lang=en

[3] Sheffield University (2014), Model-based appraisal of minimum unit pricing for alcohol in Wales. Available at http://gov.wales/docs/caecd/research/2014/141208-model-based-appraisal-minimum-unit-price-alcohol-en.pdf

4.3 A common criticism of MUP is that it is a 'tax on the poor', and that it will place financial pressure on lower income groups who, like most people, enjoy having a drink, and who are already struggling financially.

4.4 The reality is that those in lower income groups suffer the greatest harms from alcohol consumption. **In Wales the proportion of all patients admitted for alcohol specific conditions who lived in the 10 per cent of most deprived areas was nearly 4 times higher than those from the least deprived areas.** [4] Conversely, this means people in the most deprived areas have the most to gain from minimum unit pricing in terms of health benefits.

4.5 **All moderate drinkers, including those in poverty, are estimated to barely change their spending in response to MUP**. Sheffield University's modelling estimates that moderate drinkers who are not in poverty will spend an average of £2.44 more per year under a 50p MUP.[5]

4.6 In contrast, **moderate drinkers who are in poverty will see a smaller rise in their spending**, at an average of £2.15 per year under a 50p.[6]

4.7 High-risk drinkers (making up 5.7% of the Wales population) are estimated to spend an average of £32 more per year under a 50p MUP[7], and this increase in spending is likely to be felt more by those on low incomes. However, these high-risk drinkers (who are consuming over 71 units of alcohol per week) would decrease their alcohol consumption by 13%, bringing numerous health benefits. We believe that, on balance, these health gains should outweigh other concerns.

4.8 Furthermore, we would highlight that since Sheffield University's modelling work for the Welsh government in 2014, research has suggested that in England, a 50p MUP would mean that **harmful drinkers in poverty will actually spend £88 less per year**.[8] This is because harmful drinkers are predicted to drastically cut their drinking in response to MUP. We see no reason why this analysis would not apply to Wales.

4.9 Concern has been expressed that MUP could lead to increases in dependent drinkers committing crime in order to consume alcohol, or that dependent drinkers may choose to consume harmful alcohol substitutes such as methylated spirits in order to get drunk.

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[4] Public Health Wales and the Welsh Government, "Data mining Wales: The annual profile for substance misuse 2016-17", October 2017. Available at: http://gov.wales/docs/dhss/publications/171025data-miningen.pdf

[5] Ibid.

[6] Ibid.

[7] Ibid.

[8] Meier, P. et al (2016), Estimated Effects of Different Alcohol Taxation and Price Policies on Health Inequalities: A Mathematical Modelling Study, *PLOS Medicine*. doi: http://dx.doi.org/10.1371/journal.pmed.1001963

4.10 However, a study of dependent drinkers' behaviour following an increase in the price of alcohol found that these effects were very uncommon.[9] A review of the negative impacts of MUP has concluded that, 'unintended negative consequences from MUP are minor in comparison with the substantial health, social and economic benefits the policy creates.'[10]

4.11 Another concern is that MUP may lead to increased profits for some alcohol producers and retailers in the off-trade, due to the increased prices of the cheapest products. Increased profits could then be spent on activity (e.g. alcohol marketing) which are linked with alcohol harm. We believe that, on balance, the large benefits of MUP in terms of people's health significantly outweigh this potential consequence.

4.12 Finally, concern has been expressed that MUP would negatively affect pubs. However, assuming the MUP is set at 50p, pub prices will be left unchanged. For example, with a 50p MUP, a pint of average strength beer could not be sold for less than around £1, but this is well below the cost of average beer prices.

4.13 MUP could actually be good for pubs, as it will increase the price of cheap supermarket alcohol which has been able to undercut pub prices, and lead to more people deciding to drink at home. In addition, research done by the Institute of Alcohol Studies found that pub managers support minimum unit pricing by a margin of 2 to 1.[11]

[9] Falkner, C. et al (2016), The effect of alcohol price on dependent drinkers' alcohol consumption, *New Zealand Medical Journal* 128: 1427, pp9-17.
[10] Stockwell, T. & Thomas, G. (2013), Is alcohol too cheap in the UK? The case for setting a Minimum Unit price for alcohol. London: Institute of Alcohol Studies.
[11] Institute of Alcohol Studies (2017), Pubs Quizzed: What Publicans Think About Policy, Public Health and the Changing Trade. Available at: http://www.ias.org.uk/uploads/pdf/IAS%20reports/rp26092017.pdf

Scottish Health Action on Alcohol Problems (SHAAP) response to National Assembly of Wales on 'Public Health (Minimum Price for Alcohol) (Wales) Bill' [submitted 14 December 2017]

Introduction

Scottish Health Action on Alcohol Problems (SHAAP) welcomes the opportunity to comment on the proposed measures contained in the **Public Health (Minimum Price for Alcohol) (Wales) Bill'**. SHAAP provides the authoritative medical and clinical voice on the need to reduce the impact of alcohol related harm on the health and wellbeing of people in Scotland and the evidence-based approaches to achieve this.

SHAAP was set up in 2006 by the Scottish Medical Royal Colleges through their Scottish Intercollegiate Group (SIGA) and it now resides as a project within the Royal College of Physicians of Edinburgh (RCPE). SHAAP is advised by a Steering Group made up of members of the Royal Colleges and Faculties in Scotland and invited experts.

SHAAP works in partnership with a range of organisations in Scotland and beyond. Key partners include Alcohol Focus Scotland, the British Medical Association (BMA), the Scottish Alcohol Research Network (SARN), the Alcohol Health Alliance, the Institute of Alcohol Studies, Eurocare and the European Public Health Alliance (EPHA).

Consultation Response (general)

Scottish Health Action on Alcohol Problems (SHAAP) welcomes and supports the general principles of the Public Health (Minimum Price for Alcohol) (Wales) Bill as a measure which will contribute to improving and protecting the health and well-being of the population of Wales, by providing for a minimum price for the sale and supply of alcohol in Wales and making it an offence for alcohol to be sold or supplied below that price. SHAAP has long campaigned for the introduction of Minimum Unit Pricing (MUP) in Scotland because there is strong evidence to indicate that raising the price of alcohol, along with marketing restrictions and licensing regulation, is the best means of reducing consumption.

We think it relevant to note that the Scottish Parliament also took this view in 2012, when it passed with cross-party support and the backing of the medical professions the Alcohol (Minimum Pricing) (Scotland) Act. This legislation will be enacted in May 2018 with a minimum price per unit of 50p initially (as foreseen in the Wales Bill) and mechanisms have been put in place to monitor and evaluate the effect that introducing a minimum price for alcohol will have on the behaviours of the entire population, but in particular, those most affected by their hazardous drinking of the cheapest and most harmful, drinks. One of the agencies that contributed to the research for the Minimum Pricing Act in 2012 was the University of Sheffield's Alcohol Research Group and we note that this group also provided the evidence for the 2017 Wales Bill. This group's research and the experience

from British Columbia of price increases leading to reductions in harmful consumption were integral to the Scottish government's determination to implement this policy. SHAAP is satisfied that the research and modelling used to support the Wales Bill is robust and credible.

Price matters because it influences consumption. Alcohol is 60% more affordable today than it was in 1980. The latest sales figures show that enough alcohol is sold in England and Wales for every drinker to consume an average of 22 units per week, far higher than Chief Medical Officers' new weekly low-risk guidance of 14 units. The harms related to cheap alcohol are far-reaching. It is estimated that alcohol misuse costs the NHS £3.5 billion every year, equivalent to £120 for every UK taxpayer. The cost to wider society is even greater at around £21 billion. We are all paying the price of cheap alcohol in terms of lives and the wider impact of alcohol harm on families, communities and the criminal justice system. SHAAP therefore applauds the Welsh Assembly's intention to reduce these harms with this Bill.

SHAAP's response to the challenges:

1. *Altering prices has a limited/weak effect on harmful consumption*
   The Memorandum claims there is disagreement about the extent to which harmful drinkers will react to price increases and whilst this is true, given the difficulty of researching the actual behaviour of such groups, MUP will still be effective if it achieves some reduction in their consumption, as most analyses suggest is likely – even if heavy drinkers are less price-sensitive. Much of the evidence for their habits comes from more modest price changes than MUP and even where heavy drinkers might react by buying cheaper products, this will not be possible as a MUP of 50p per unit will significantly increase the price of their preferred drinks. In Scotland, for example, Chick & Gill's interviews with patients receiving treatment for alcohol-related conditions in Glasgow and Edinburgh revealed that some had previously cut down in response to a fall in income, while others had traded down to cheaper drinks (which of course would be less possible under MUP). Similarly, a study of New Zealand drinkers in treatment found that 25% reported 'going without' alcohol when they were unable to afford any more – again, the authors note that this would likely be higher if there were less scope to trade down to cheaper products. These findings were replicated in a Canadian study, which found 80% of homeless drinkers have gone without alcohol when unable to afford it.

2. *MUP will lead to illicit consumption and/or crime*
   With regard to the above possibility, interviews with harmful and dependent drinkers suggest that such fears are likely to be overstated. Chick & Gill found widespread suspicion of products of unclear provenance. As one participant put it: "I'm scared of what I put in my body. I know if it's on sale in a supermarket, then it's relatively safe. I wouldn't know what I'd be buying, and I wouldn't know what was in it, and that would scare me". Studies in New Zealand and Canada also found that non-beverage alcohol use was very uncommon when heavy drinkers were unable to afford alcohol, as were reports of crime to support drinking. Crucially, the evidence from Canada suggests that any such substitution – if it did occur – would be more than offset by the benefits to those who lower their drinking, since overall the number of deaths decline.

Additional considerations in support of Minimum Unit Pricing:

- **Public support**: We note that there is widespread public support for MUP. In Alcohol Health Alliance's most recent poll, conducted in August 2017, 51% of Welsh residents supported the policy, with only 15% opposed. Similarly in Scotland a majority of the public also supports MUP.
- **Effect on the licensed trade**: Concerns that a minimum unit price would negatively affect pubs and the licensed trade are, in our view, misplaced. During the campaign for MUP in Scotland, we found that there was considerable support for MUP within the alcohol industry, particularly among the pub trade and smaller producers. At a European event held by SHAAP in September 2014, industry supporters of MUP from the Scottish Licensed Trade Association and the C&C group which produces Tennent's Lager, spoke of the harm which the proliferation of cheap supermarket alcohol caused to UK business and growth. At a price level, pubs would be largely unaffected by a minimum unit price. The opposition to MUP comes from the global producers and from large retailers, in particular supermarkets.
- **Effect on health services**: In supporting a MUP policy for Scotland, the Scotland Health Minister Shona Robison MSP, recently quoted research by Health Scotland which showed that *'a minimum unit price of 50 pence would cut alcohol-related deaths [in Scotland] by 392 and hospital admissions by 8,254 over the first five years of the policy'.* It can therefore be assumed that the MUP policy for Wales would have a similar effect on reducing deaths and hospitalisations in Wales, positively influencing the health of the Welsh people and reducing pressure on health services.

In conclusions, SHAAP would like to congratulate the Welsh Minister of Health for bringing forward the Public Health (Minimum Price for Alcohol) (Wales) Bill and wish the Bill a speedy and successful passage through the Welsh Assembly.

***

Response sent to: seneddhealth@assembly.wales on 14 December 2017

Contact

For further information please contact Felicity Garvie, Policy Officer, SHAAP; [redacted] or [redacted].

For more information about SHAAP, please visit http://www.shaap.org.uk/

WAGE Response to Public Health (Minimum Price for Alcohol) (Wales) Bill

1) Introduction:

The Welsh Association for Gastroenterology and Endoscopy (WAGE) represents healthcare professionals with an interest in hepatology in Wales. WAGE exists to promote improvements in the care of patients with gastrointestinal and liver diseases in the principality. WAGE welcomes the opportunity to respond to this consultation on an extremely important public health matter.

2) The general principles of the Bill and the extent to which it will contribute to improving and protecting the health and well-being of the population of Wales

WAGE strongly supports the concept of MUP for alcohol as an effective measure to reduce alcohol related harm. Methods to reduce the harm that alcohol causes remain a vitally important issue given the 9% rise in alcohol related deaths between 2015 and 2016.

MUP is evidence based, and is thus not merely a highly sensitive measure but is also targeted to the population most at risk of alcohol related harm. As such MUP has the potential to benefit the health of the most economically deprived and vulnerable members of our society.

MUP introduction to Wales is estimated to result in 53 fewer death per year from alcohol and over 1,400 fewer hospital admissions. Importantly (and unusually for a Public Health measure), MUP's effect is rapid with a reduction in mortality seen within 6-12 months.

3) Any potential barriers to the implementation of the provisions and whether the Bill takes account of them

There are many misconceptions held by the wider public around the benefits and impacts of MUP and this is a barrier that needs to be overcome through ongoing clear communication with the public. One example of this is the fear that public houses and restaurants will be adversely affected – they may actually benefit, whereas supermarkets, and manufacturers of low-cost high-concentration drinks may suffer. Incorrect assumptions made about MUP will need to be strongly challenged using the clear evidence behind its benefits.

4) Whether there are any unintended consequences arising from the Bill

There is an increased cost for moderate drinkers under a MUP plan but this effect is extremely small.

Those on lower incomes who do spend significantly more on alcohol under MUP are also those who are consuming hazardous amounts of alcohol and we therefore believe the health benefits of the reduction of consumption far outweigh concerns about the spending power of these individuals.

The final unintended consequence is the potential for negative perception among the general public which can impact on the acceptance of public health measures. The solution to this lies in engagement and education as per response to 3) above.

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Rebecca Evans AM
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National Assembly for Wales
Cardiff Bay
Cardiff, CF99 1NA
Seneddhealth@assembly.wales.gov.uk

15th December 2017

Public Health (Minimum Price for Alcohol) (Wales) Bill Consultation

Dear Ms Evans,

I write to you from Pernod Ricard, a wine and spirits business which employs 18,500 people globally, and over 2,000 in the UK through Pernod Ricard UK, and our sister companies, Chivas Brothers Ltd and Pernod Ricard Global Travel Retail. We export circa. £1 billion of Scotch whisky and British gin annually to almost 160 countries, and are the world's second-largest wine and spirits company.

Given the size and importance to us of the UK market, we welcome the opportunity to respond to the Welsh Government's consultation on Minimum Unit Pricing (MUP).

Level of the MUP

We note that the Welsh Government intends to specify a level of MUP in secondary legislation, and that Sheffield University are currently producing modelling which will be available in 2018 on the potential impact.

Given the Welsh Government intends to target "low cost and high alcohol content products", we strongly believe the level of MUP should not be in excess of 50p a unit, and that this level should be fixed for the duration of the initial legislation (six years), pending full review of its impact. 50p per unit is sufficient to target the use and abuse of cheap alcohol, given modelling for the Scottish Government shows that 51% of alcohol products in shops and supermarkets are presently sold at a price beneath this.

As the Supreme Court Judgement on MUP notes, "the system will be experimental", "will involve a market distortion", and a "significant factor" in the proposals being "proportionate" was the inclusion of a "sunset" clause.

Indeed, the Welsh Government's Explanatory Memorandum also states "the actual impacts of an MUP in Wales will only be known by implementing the policy", and acknowledges the concerns of the Institute of Economic Affairs that it could have some negative health consequences, for instance if people on low incomes maintain their level of alcohol consumption, but spend less on healthy food and heating.

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Given a MUP of 50p will already affect around half of products on the market, and the legislation is experimental, we believe a MUP beyond 50p would be disproportionate – and therefore go against the spirit of the Supreme Court's Judgement.

Furthermore, it is important to note that alcohol-related trends have been moving in the right direction in Wales for quite some time, for instance with:

- The percentage of adults binge drinking falling from 28% in 2008, to 24% in 2015.
- A 25% fall in the number of referrals in Wales for alcohol misuse in the last 5 years, to 9,480 in 2016-17.
- 16% of adults abstaining from alcohol entirely in 2016-17.
- The percentage of adults exceeding 3-4 units in their heaviest drinking day declining 11% since 2008.

Whilst further work is needed to bring down alcohol-related harm, this long-term progress is important in determining the proportionality of the level of MUP.

Unintended consequences & potential barriers

Staff sales & employee benefits

As a producer, we are very clear with all of our employees about the need to drink in moderation. We communicate the CMO guidelines very clearly, and also provide a range of materials and events to promote responsible consumption. We do not have, and would not tolerate, levels of harmful drinking in our organization. Therefore, we would like to see an exemption for staff sales, to ensure this benefit can continue for Pernod Ricard's 2,000 UK employees.

Charitable fundraising

Likewise, we also raise a significant sum, in the region of £40-£50,000 annually, for charities such as The Benevolent. Much of this is through sales of surplus or discontinued stock in charitable sales. A requirement to sell these products at near full retail price would significantly impact on these fundraising efforts, and the charities recipient of this support. For this reason, we do believe there should be an exemption from the legislation for charitable sales and fundraising activities.

Online sales

Our understanding is the MUP would apply at the point of sale, i.e. the warehouse from which the product is delivered. Therefore, an online sale could take place from a distribution warehouse in England, and be delivered to an address in Wales, for a price beneath the MUP. This could competitively disadvantage some retailers without an online presence (e.g. small convenience shops), or those with a distribution warehouse based within Wales. It could also result in different consumers within Wales paying a different price depending on where their products are distributed from.

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Cross border sales & the illicit trade

There is a risk of consumers crossing the border into England to purchase alcohol, which may competitively disadvantage retailers located in Wales close to the border. There is also a risk of MUP driving the illicit trade. Clearly, the higher the MUP, and the greater the price differential between Wales and England on many products (and not just cheap, high strength products) the greater the risk on both fronts; cross border and illicit sales.

Retailers

We believe the Welsh and Scottish Governments should adopt the same level of MUP, in order to minimise the disruption to the pricing plans of national retailers. Should major supermarkets have to adopt different pricing structures in Scotland, England and Wales, they may incur additional costs, and these costs could be passed on to consumers and/or their suppliers.

Wholesalers

Some wholesalers will sell product to both the trade, and the general public. In such instances, a mechanism will need to be established to ensure that trade sales do not suffer. MUP is a consumer-facing policy, and it is the final price consumers pay which is relevant. If, through wholesalers, many off-licenses and convenience stores are required to pay an MUP, this will increase further the final price consumers pay – and would therefore be disproportionate.

Financial implications

Pernod Ricard is a premium wine and spirits producer, and therefore the vast majority of our products already retail at a price above 50p per unit. We would expect the financial implications for us as a business to be less material therefore than for producers and retailers at the cheaper end of the market.

In terms of the implications for UK public finances, whilst we note the Welsh Government estimates a reduction of £5.8 million a year in duty and VAT, we believe this is far from certain and should form part of the monitoring and evaluation process. Whilst there could be a drop off in sales, there could also be a benefit from price inflation and therefore to tax receipts.

Regardless, the alcohol industry plays a key role in the UK's economy, and this should not be overlooked. Taxation on a typical bottle of Scotch whisky currently stands at 80% of the price; the wine and spirits industry employs over 550,000 people across the UK, and sales of wines and spirits alone contribute £17.7 billion to UK public finances. We do not believe the Welsh Government should seek to introduce any further taxation burdens on the industry.

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We remain keen to work with the Welsh Government – and other industry partners – to ensure that trends around responsible alcohol consumption continue to move in the right direction. As part of this, we work extensively with organizations such as Drinkaware, the Portman Group, and Best Bar None, to educate consumers about responsible drinking.

To this end, should you require any more information please do not hesitate to get in touch. We firmly believe that partnership working is the best approach.

Yours sincerely,

Laurent Pillet
Managing Director
Pernod Ricard UK

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GRAFFIGNA
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Response to the consultation on Public Health (Minimum Price for Alcohol) (Wales) Bill

Rachel Griffith
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Copy-edited by Judith Payne

Published by

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This is an edited version of:

"Proposed minimum unit price for alcohol would lead to large price rises", by Rachel Griffith, Martin O'Connell and Kate Smith, IFS Briefing Note No. 222, published 15 December 2017.

The proposed 50p minimum unit price for alcohol would have a large impact on prices. Almost 70% of off-trade alcohol units purchased (i.e. those bought in supermarkets and off-licenses) in Britain between October 2015 and September 2016 were priced below 50p per unit. The prices of these products would increase by at least 35%, on average, if a 50p minimum unit price is introduced. Price increases would occur across alcohol types, from cider (e.g. the price of a 20×440ml pack of Strongbow would double) to fortified wines (e.g. the price of a bottle of Tesco cream sherry would increase by 20%).[1]

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[1] A 20×440ml pack of 5% Strongbow cider contains 44 units and was sold for £11 by Tesco on 12 December 2017 (https://www.tesco.com/groceries/en-GB/products/274108990). A 1l bottle of Tesco cream sherry contains 17.5 units and was sold for £7.15 by Tesco on 12 December 2017 (https://www.tesco.com/groceries/en-GB/products/255246451). Under a minimum unit price of 50p per unit, it would be unlawful to sell these products for less than £22 and £8.75.

Summary

The Welsh National Assembly is considering introducing a minimum unit price for alcohol.[2] The aim of adopting a minimum unit price is to reduce the prevalence of harmful and hazardous drinking. Estimates of the precise magnitude of the social costs of drinking vary, but are invariably high. The Welsh National Assembly cites research by the University of Sheffield that estimates that the overall cost to society of alcohol misuse in Wales is £15.3 billion over 20 years.[3]

A minimum unit price would make it unlawful to sell alcohol below a price that is based on the alcoholic content of the product. We show that a minimum unit price of 50 pence would have a substantial impact on off-trade alcohol prices. During the period October 2015 to September 2016, 68% of off-trade alcohol units sold in Britain were priced below the proposed 50 pence floor, with the average price of these products over 20% below the floor, at around 39 pence per unit. These numbers are similar across Scotland, Wales and England.

The effectiveness of the policy will depend on whether it successfully targets heavy drinkers and how they change their behaviour in response. We provide evidence that heavy drinkers do tend to buy cheap alcohol. This suggests a minimum unit price may well be reasonably well targeted at this group. However, the impact of the policy will depend crucially on the price sensitivity of different types of drinkers, i.e. how much less alcohol they consume in response to a rise in price. We also show that heavier drinkers tend to buy stronger alcohol, suggesting that redesign of the current system of alcohol excise duties could also help target problem drinkers. Tax reform is likely to avoid the main drawback of minimum unit pricing, which is that it boosts the profits of the alcohol industry.

A minimum unit price of 50 pence would have a substantial impact on prices

We assess how big an impact a minimum price of 50 pence per unit of alcohol would likely have on prices using detailed data that are representative of the British population. These data contain information on the alcohol purchases of around 27,000 households over the period October 2015 to September 2016; they include purchases made off-trade (in supermarkets and off-licences) but not those made on-trade (in pubs and restaurants). It is likely that very few on-trade prices would be directly impacted by a minimum unit price of 50 pence.

The first column of Table 1 shows the average per-unit prices that households paid for different types of alcohol and (in the bottom row) for all alcohol. The second column shows the percentage of alcohol units that were sold for less than 50 pence per unit. The third column shows how much, in pence, below the proposed 50 pence floor these units were priced, on average. The fourth column shows the average percentage increase in

[2] http://senedd.assembly.wales/mgConsultationDisplay.aspx?id=282&RPID=1509748630&cp=yes.

[3] Table 5.14, page 69 of Y. Meng, S. Sadler, L. Gell, J. Holmes and A. Brennan, *Model-Based Appraisal of Minimum Unit Pricing for Alcohol in Wales: An Adaptation of the Sheffield Alcohol Policy Model Version 3*, School of Health and Related Research, University of Sheffield, 2014; available at https://www.sheffield.ac.uk/scharr/sections/ph/research/alpol/research/sapm.

prices for products priced below 50 pence, assuming that their prices increased to the 50p floor.[4] Columns 3 and 4 give the minimum average price increases that the introduction of a 50 pence minimum unit price would imply for those units priced at less than 50 pence.

The numbers make clear that the introduction of a minimum unit price of 50 pence would represent a significant intervention in the market. In the calendar year beginning October 2015, the average price per unit paid for off-trade alcohol was 47.2 pence; cider had the lowest average price at 37.6 pence and alcopops had the highest at 86.8 pence. A minimum unit price of 50 pence would directly affect 68.2% of alcohol units purchased. On average, these units were priced 11.3 pence below the proposed 50 pence price floor.[5] Lager, cider, spirits and fortified wines all had over 70% of units purchased at below 50 pence. Of these groups, cider products priced below 50 pence per unit were cheapest – priced, on average, 21.2 pence below the proposed price floor.

Table 1. Off-trade alcohol prices

Alcohol type	Average price per unit of alcohol	% of units bought below 50 pence	Average price increase for units priced below 50 pence†	Average % price increase for units priced below 50 pence†
Wine	48.8	62.2	8.8	23.5
Spirits	47.6	75.4	9.1	23.4
Lager	39.5	85.6	14.2	43.8
Cider	37.6	79.7	21.2	89.5
Beer	54.0	46.5	6.9	18.8
Sparkling wine and perry	62.8	28.3	24.7	115.6
Fortified wine	45.0	71.5	12.1	39.0
Alcopops	86.8	1.5	7.9	20.8
All alcohol	47.2	68.2	11.3	35.1

Note: Alcohol types make up the following percentages of total units of alcohol purchased: wine, 36.7%; spirits, 27.3%; lager, 14.7%; cider, 7.8%; beer, 5.8%; sparkling wine, 4.1%; fortified wine, 2.9%; and alcopops, 0.7%. † This assumes that all products priced below 50 pence would be priced at the price floor of 50 pence.

Source: Authors' calculations using Kantar Worldpanel. Data are based on alcohol purchases made off-trade by a representative sample of British households over October 2015 to September 2016.

Following the adoption of a 50 pence minimum unit price, the price of all products that were priced below this floor would increase to at least 50 pence per unit. Over the period October 2015 to September 2016, this represents 68.2% of alcohol units purchased and implies an average price increase for these units of 35.1%. It is possible that, for some of these products, manufacturers and retailers would even raise the price to above 50 pence per unit. They may also respond to the policy intervention by changing the price of some

[4] Note that this differs from computing the percentage change in the average price.

[5] The average price per unit paid by households living in Wales was 45.2p; 72.6% of units bought were priced below the 50p floor, with these units priced 12.3p below the floor, on average.

products that cost more than 50 pence per unit prior to the policy's introduction. These industry pricing responses are difficult to predict in advance and would depend on the nature of competition in the alcohol market.

Heavy drinkers tend to purchase cheaper alcohol

The main rationale for policies that seek to raise alcohol prices is to deter problem drinking. In particular, there are costs associated with alcohol consumption that are not fully taken into account by some drinkers. These include public health costs, but also the costs of anti-social behaviour, drink-driving etc. Evidence suggests the majority of these costs are generated by a small number of heavy drinkers.[6] A well-designed policy should reduce the consumption of socially costly (typically heavy) drinkers, while limiting the impact of higher prices on light and more moderate drinkers.

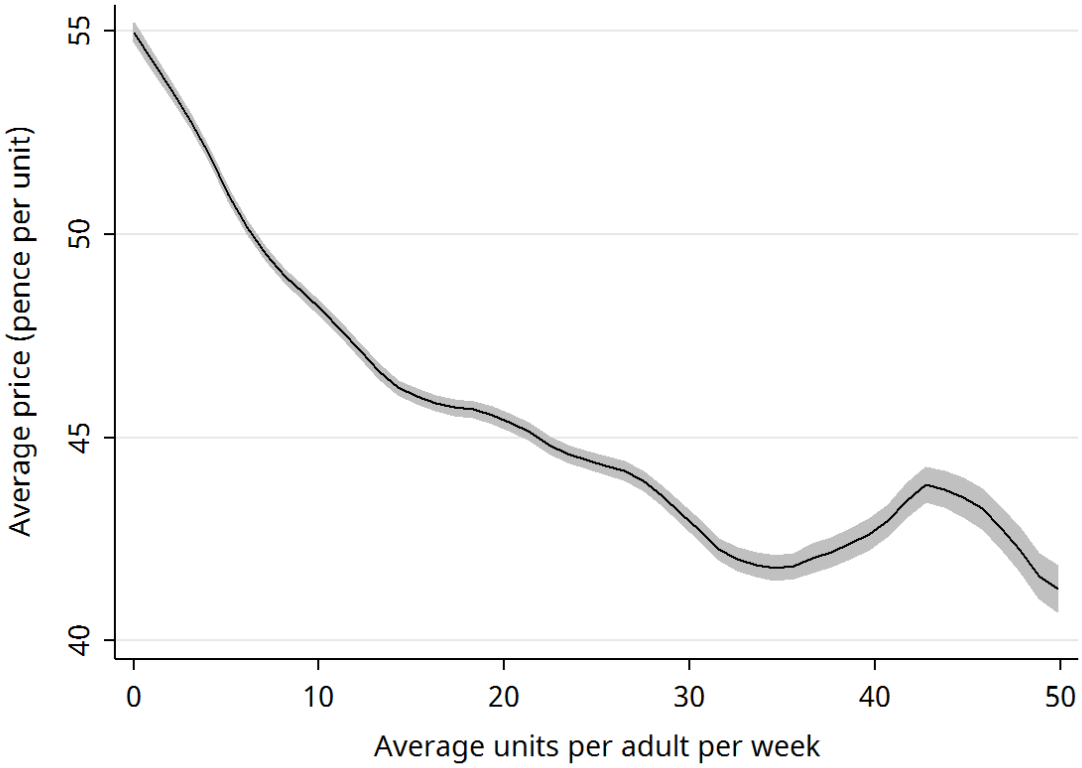
A minimum unit price targets low-priced alcohol. Figure 1 is based on a graph from a recent working paper,[7] which shows how the average price per unit that households pay varies with the average number of units of alcohol they buy per week. The figure shows that relatively heavy drinkers systematically purchase cheaper alcohol than more moderate drinkers; therefore a higher fraction of their alcohol purchases would be directly affected by the introduction of a minimum unit price.

However, this is only part of the story. Policies that increase the price of alcohol would only be effective at reducing harmful drinking if they induce problematic drinkers to switch away from alcohol. In the working paper, we estimate how different households respond to changes in the prices of different alcohol products. We show that, although the heaviest-drinking households are more willing to switch away from a given product in response to an increase in its price, they are much more likely to switch to another alcohol product, rather than to choose not to buy alcohol at all. This means that the proportional reduction in total alcohol purchases in response to a rise in the price of alcohol will be considerably less for the heaviest drinkers than for lighter drinkers. This does not mean that the use of price-based policies to combat problematic drinking is a bad idea, but this differential price responsiveness should be taken into account when designing policy and when assessing the likely impact of policy change.

[6] S. Cnossen, 'Alcohol taxation and regulation in the European Union', *International Tax and Public Finance*, 14, 699–732, https://doi.org/10.1007/s10797-007-9035-y.

[7] R. Griffith, M. O'Connell and K. Smith, 'Tax design in the alcohol market', IFS Working Paper W17/28, https://www.ifs.org.uk/publications/10239.

Figure 1. Relationship between average price and drinking level



Note: Shaded grey area represents 95% confidence intervals.

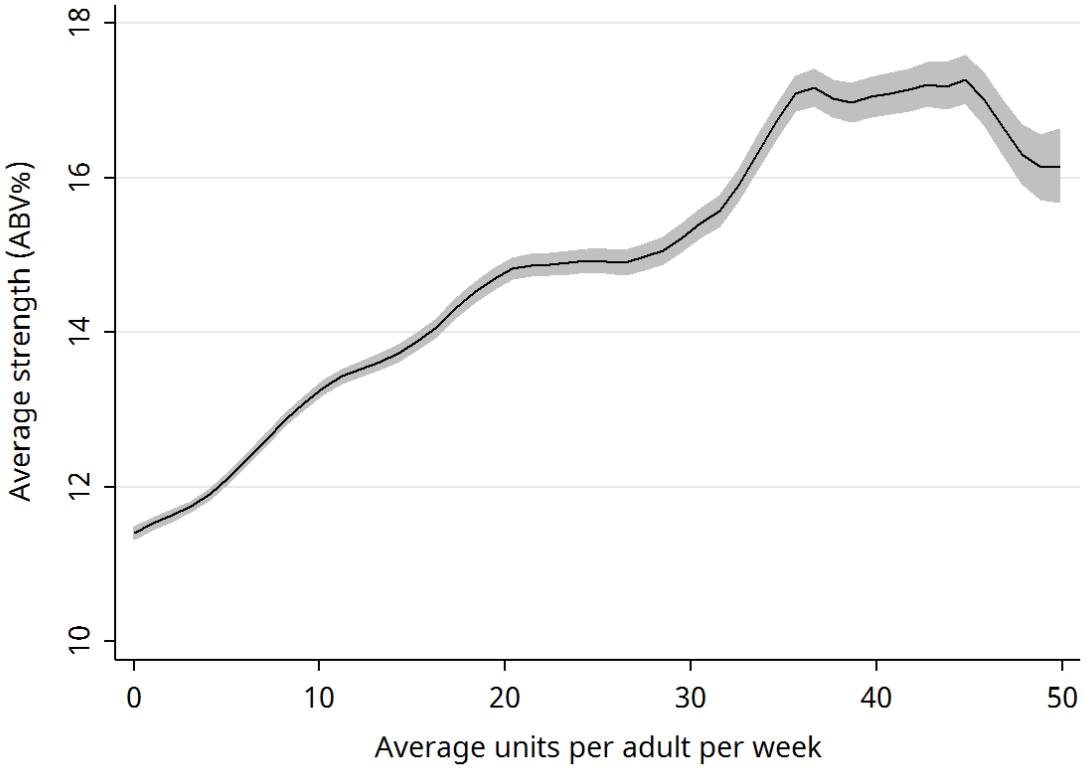
Source: Figure is based on figure 3.2(a) in R. Griffith, M. O'Connell and K. Smith, 'Tax design in the alcohol market', IFS Working Paper W17/28, https://www.ifs.org.uk/publications/10239. Numbers are based on authors' calculations using Kantar Worldpanel, 2011–12.

Heavy drinkers tend to purchase stronger alcohol

Raising the price of cheap alcohol is not the only way to target heavy drinkers. As shown in Figure 2, households that purchase a large amount of alcohol per adult typically purchase stronger alcohol. This is partly down to a tendency of heavy drinkers to get a higher share of their alcohol from spirits compared with more moderate drinkers. However, even within broad alcohol types, heavy drinkers tend to buy stronger alcohols.

An implication is that alcohol policy that raises the relative price of stronger alcohol products would affect a higher fraction of the alcohol purchases of heavy drinkers than of more moderate drinkers. The correlation between alcohol ABV and price per unit is very weak; strong products are not systematically cheaper in per-unit terms, or more likely to be affected by a minimum unit price, than weaker products. This means reforms that seek to raise the relative price of stronger alcohol products could be used either instead of, or as a policy complementing, minimum unit pricing.

Figure 2. Relationship between average alcoholic strength and drinking level



Note: Shaded grey area represents 95% confidence intervals.

Source: Figure is based on Figure 3.2(b) in R. Griffith, M. O'Connell and K. Smith, 'Tax design in the alcohol market', IFS Working Paper W17/28, https://www.ifs.org.uk/publications/10239. Numbers are based on authors' calculations using Kantar Worldpanel, 2011–12.

With or without minimum unit pricing, reform of alcohol duties is overdue

By far the most well-established way for governments to influence alcohol prices is through the use of alcohol duties. In the UK, as in the rest of Europe, these are applied in addition to a broad-based value added tax. As with minimum unit pricing, the most compelling argument in favour of alcohol duties is to reduce problem drinking. Power over the system of alcohol duties resides with the Westminster Government; the Welsh Governments are unable to alter alcohol duties.

The current UK alcohol duty system is chaotic. Due to EU requirements, within broad strength bands, wine and cider must be taxed per litre, which means that higher ABV products are taxed less per unit of alcohol than lower ABV products. In addition (and not due to EU requirements), taxes levied on cider are much lower than those for other types of alcohol; for instance, a litre of 7.5% beer is taxed more than three times as much as a litre of 7.5% still cider. The very low tax rate on cider is a central reason why cider products will be impacted so strongly by the adoption of a minimum unit price; in effect, relative to other forms of alcohol, cider is under-taxed, and a minimum unit price would mean that the implicit subsidy from a lower tax rate is passed on to producers (or retailers) of cider rather than to drinkers of cider.

A sensible reform that would substantially improve the system of alcohol duties would entail taxing directly the alcohol in wine and cider (a move which exiting the European Union will presumably make legally feasible) and increasing the tax on cider to bring it into line with that on beer. A more ambitious reform would involve adjusting rates to target more systematically the high-strength products most popular with heavy drinkers.

Such moves could be introduced along with a minimum unit price. However, there is a case to be made for alcohol duty reform being undertaken instead of adoption of a minimum unit price. The reason is that minimum unit pricing has a substantial disadvantage: by introducing a price floor, the policy is likely to dampen competition in the retail market, resulting in increases in profits to the alcohol industry.[8] In contrast, reform of alcohol duties that acts to raise the price of strong products, as well as cider, is likely to raise tax revenue.

[8] R. Griffith, A. Leicester and M. O'Connell, 'Price-based measures to reduce alcohol consumption', IFS Briefing Note 138, 2013, https://www.ifs.org.uk/publications/6644.

MPA 35

Bil Iechyd y Cyhoedd (Isafbris am Alcohol) (Cymru)

Public Health (Minimum Price for Alcohol) (Wales) Bill

Ymateb gan Gymdeithas Siopau Cyfleustra

Response from the Association of Convenience Stores

ACS Submission: Public Health (Minimum Price for Alcohol) (Wales) Bill

ACS (the Association of Convenience Stores) welcomes the opportunity to respond to the National Assembly for Wales Health, Social Care and Sport Committee's consultation on the Public Health (Minimum Price for Alcohol) (Wales) Bill. ACS is a trade association, representing 33,500 local shops across the UK including Co-Op, One Stop, McColls Retail and thousands of independent retailers. In Wales, there are 3,185 convenience stores, employing 20,380 people[1].

Convenience stores provide a range of products and services, including Post Offices, bill payment services, and ATMs to local communities. Alcohol is an important product category for convenience retailers, with 80%[2] of stores in Wales holding an alcohol licence, and an average of 14.3% of store sales represented by alcohol[3]. ACS supports the Welsh Government's aims to tackle alcohol related harm and is an active member of the Welsh Government Alcohol Industry Network.

Convenience stores have a role to play in addressing alcohol-related harm and are taking action to reduce underage sales and promote responsible retailing. We acknowledge that there is more work to be done to reduce alcohol-related harm. ACS will continue to work with convenience retailers to promote responsible retailing and encourage retailer engagement with local partnerships.

ACS is not convinced that the introduction of Minimum Unit Pricing (MUP) will have a significant impact on alcohol related harm. We believe that tackling alcohol related harm is more complex than the introduction of an increase in price. Instead, tackling alcohol-related harm must be done in partnership with all stakeholders to instigate long term change in drinking behaviours.

Alcohol consumption and alcohol related harm is in long term decline. The proportion of people who drank in the last week fell from 64.2% in 2005 to 56.9% om 2016[4] and the proportion of people that have binged in the last week has fallen from 29% in 2005 to 26.8% in 2016[5].

ACS previously responded to the Welsh Government's consultation on minimum unit pricing in 2015. Our submission can be found here. In our submission, we raised concerns about the additional administrative and financial burdens that the introduction of minimum unit pricing would have on retailers and recommended that instead the Welsh Government

[1] ACS Welsh Local Shop Report 2018
[2] ACS Welsh Local Shop Report 2018
[3] ACS Local Shop Report 2017
[4] ONS: Adult drinking habits in Great Britain: 2005 to 2016
[5] ONS: Adult drinking habits in Great Britain: 2005 to 2016

continue to focus on using existing powers under the licensing system and targeted funding at a local level to tackle alcohol related harm.

Impact on Retailers

We expect that there will be a limited business impact on convenience stores in terms of the price of the alcohol products sold in store. However, we agree with the Impact Assessment's conclusion that "that considerable uncertainty exists regarding retailers' responses to the introduction of an MUP. Retailers and producers may make a range of additional changes to both prices and products which may impact on resulting revenue changes to the Exchequer and retailers and other modelled outcomes". As MUP has yet to be introduced elsewhere, we will not be aware of the full impact on retailers until the legislation has been introduced. Therefore, we encourage the Welsh Government monitor and evaluate the introduction of minimum unit pricing in Scotland before implementing the legislation in Wales.

What we do expect from the introduction of MUP is a significant impact in relation to implementation and compliance. MUP will bring a training burden for retailers to ensure staff aware of the new law and its implications for them and the business. It is not simply about ensuring the prices on the shelf are not in breach of the law, but also how they handle more complex customer transactions such as promotions, vouchers or refunds - all of which will require a procedural overhaul. National retailers will also incur additional costs with having a different pricing and promotion regime in Wales.

Cross-border sales will also impact retailers. The Bill's Impact Assessment currently estimates that 4.91% of the total Welsh grocery spend is spent in England and not anticipated to increase following the introduction of MUP. However, as MUP has yet to be introduced elsewhere, and without understanding Welsh consumers' current alcohol spend in England the full impact of cross-border sales is unknown.

Moreover, while the Bill's Impact Assessment recognises that cross-border sales will have an impact on retailers, it states "the cross-border issues are further mitigated by the fact the target population for minimum unit pricing mostly do not live close to the Wales- England border.". As stated above, minimum unit pricing is a blunt instrument and affects all consumers. Therefore, the impact of cross-border sales cannot be mitigated by the fact the target population do not live on the border. We would welcome further assessment of MUP's impact of cross-border sales.

Given that the Scottish Government intend to introduce MUP in 2018, and that it is still under consideration in England, we would welcome assurances from the Welsh Government that they will ensure consistency with the Scottish MUP legislation. National retailers will incur additional costs with having a different pricing and promotion regime in Wales and Scotland. Consistency will ensure that these retailers do not face further burdens by being required to comply with different minimum unit price legislation in each country.

Legal Issues

We seek clarification that the provisions in the Public Health (Minimum Price for Alcohol) (Wales) Bill are within the legislative competence of the Welsh Government[6]. While the Presiding Officer has confirmed that the Bill is within the Welsh Government's powers to introduce legislation for the 'promotion of health', minimum unit pricing relates directly to the sale and supply of alcohol, which the Welsh Government do not have the legislative powers for.

[6] National Assembly for Wales: Presiding Officer's Statement on Legislative Competence of Public Health (Minimum Price for Alcohol) (Wales) Bill

We would also welcome further clarity on the legality of these proposals and their interaction with the Licensing Act 2003. Currently the Bill intends to amend the Licensing Act 2003, for example, making it a relevant offence to breach the Public Health (Minimum Price for Alcohol) (Wales) Bill. If the Welsh Government are to introduce minimum unit pricing under their powers for the 'promotion of health', the Bill should be independent of the Licensing Act.

Tackling Alcohol Harm

As set out above, we believe that minimum unit pricing would act as a blunt instrument instead of focusing more on drinkers who would need more support to curb their consumption. We instead recommend that the Welsh Government prioritise work that is already being done to reduce alcohol-related harm, through partnerships with industry, and increasing enforcement action against irresponsible retailers.

Tackling Illicit Alcohol

The Welsh Government should consider tackling the illicit alcohol trade as part of its strategy to tackle alcohol-related harm. The illicit trade poses a significant threat to legitimate sales and we do not agree with the Welsh Government's view in Paragraph 229 of the Explanatory Memorandum which states that illicit alcohol is "not currently a significant problem in Wales". The cost of the illicit alcohol trade to the Exchequer was £1.3 billion in 2015-16[7] and undercuts legitimate retailers by driving footfall away from their stores

We have concerns that MUP will only add further pressure on already limited enforcement resources. We believe the police and other enforcement bodies, including trading standards, should focus on tackling the non-duty paid and illicit alcohol trade. The Licensing Act 2003 provides licensing authorities with powers to remove alcohol licences from retailers who participate in the sale of non-duty paid alcohol, however this power is not often used. In a survey of independent convenience retailers, 67% agreed that retailers that are found selling illicit alcohol or tobacco should have their alcohol licence removed[8]. ACS supports the introduction of tougher penalties for retailers that engage in the illicit market and greater funding for police, HMRC and trading standards to tackle this issue.

Industry Action

Retailers have taken proactive action to tackle alcohol-related harm and have been heavily engaged with a number of age verification schemes including 'Challenge 25'[9] which has reduced underage access to alcohol. Polling of ACS members in 2012 showed that 70% of retailers had an age verification policy in store and it was found that more than a quarter of retailers refused age restricted sales more than ten times a week[10]. Serve Legal, an independent test purchasing company, found in 2015 that convenience stores had an 83% pass rate[11], an increase of 18% since 2008.

The industry has also taken proactive action to promote responsible retailing amongst the off-trade. Most notably, the industry set up the Retail of Alcohol Standards Group (RASG)[12],

[7] HMRC Measuring Tax Gaps 2017
[8] ACS Voice of Local Shops Survey August 2016
[9] 'Challenge 25' ensures that anyone that looks under 25 is challenged for proof of age. It is made up of several components including training, display of signage, staff support, record keeping and guidance and clarity on acceptable forms of ID.
[10] ACS Voice of Local Shops May 2012
[11] Serve Legal, Independent Test Purchasing Key Trends 2015
[12] The Retail of Alcohol Standards Group is a committee of high street off-trade alcohol retailers who meet to exchange best practice in the responsible retailing of alcohol. The group produced best practice guidance for the sale of alcohol in England and Wales.

Proof of Age Standards Scheme (PASS)[13], and Community Alcohol Partnerships (CAP). ACS continues to promote the work of CAP which are locally based projects that tackle underage sales and anti-social behaviour by bringing retailers. We would welcome further engagement with the Welsh Government on how we can work together to promote CAP in Wales.

For more information about this submission, please contact Julie Byers, ACS Public Affairs Manager by emailing [redacted] or calling [redacted].

[13] The Proof of Age Standards Schemes (PASS) was set up to provide retailers reassurance about which cards can be accepted as valid proof of age.

Annex A

ABOUT ACS

The Association of Convenience Stores lobbies on behalf of around 50,000 convenience stores across mainland UK on public policy issues that affect their businesses. ACS' membership is comprised of a diverse group of retailers, from small independent family businesses running a single store to large multiple convenience retailers running thousands of stores.

Convenience stores trade in a wide variety of locations, meeting the needs of customers from all backgrounds. These locations range from city centres and high streets, suburban areas such as estates and secondary parades, rural villages and isolated areas, as well as on petrol forecourts and at travel points such as airports and train stations.

ACS | the voice of local shops

WHO WE REPRESENT

INDEPENDENT RETAILERS

ACS represents 22,397 independent retailers, polling them quarterly to hear their views and experiences which are used to feed in to Government policy discussions.

These stores are not affiliated to any group, and are often family businesses with low staff and property costs. Independent forecourt operators are included in this category.

SYMBOL GROUPS AND FRANCHISES

ACS represents 14,659 retailers affiliated with symbol groups. Symbol groups like SPAR, Nisa, Costcutter, Londis, Premier and others provide independent retailers with stock agreements, wholesale deliveries, logistical support and marketing benefits.

Symbol group forecourt operators and franchise providers like One Stop are also included in this category.

MULTIPLE AND CO-OPERATIVE BUSINESSES

ACS represents 12,862 stores that are owned by multiple and co-operative retailers. These businesses include the Co-Operative, regional co-operative societies, McColls, Conviviality Retail and others.

Unlike symbol group stores, these stores are owned and run centrally by the business. Forecourt multiples and commission operated stores are included in this category.

THE CONVENIENCE SECTOR

In 2017, the total value of sales in the convenience sector was £38bn.

The average spend in a typical convenience store transaction is £6.28.

There are 49,918 convenience stores in mainland UK. 74% of stores are operated by independent retailers, either unaffiliated or as part of a symbol group.

The convenience sector provides flexible employment for around 370,000 people.

24% of independent/symbol stores employ family members only.

20% of shop owners work more than 70 hours per week, while 19% take no holiday throughout the year.

72% of business owners are first time investors in the sector.

Convenience stores and Post Offices poll as the two services that have the most positive impact on their local area according to consumers and local councillors.

79% of independent/symbol retailers have engaged in some form of community activity over the last year.

Between August 2016 and May 2017, the convenience sector invested over £858m in stores.

The most popular form of investment in stores is refrigeration.

OUR RESEARCH

ACS polls the views and experiences of the convenience sector regularly to provide up-to-date, robust information on the pressures being faced by retailers of all sizes and ownership types. Our research includes the following regular surveys:

ACS VOICE OF LOCAL SHOPS SURVEY

Regular quarterly survey of over 1200 retailers, split evenly between independent retailers, symbol group retailers and forecourt retailers. The survey consists of tracker questions and a number of questions that differ each time to help inform ACS' policy work.

ACS INVESTMENT TRACKER

Regular quarterly survey of over 1200 independent and symbol retailers which is combined with responses from multiple businesses representing over 3,000 stores.

ACS LOCAL SHOP REPORT

Annual survey of over 2400 independent, symbol and forecourt retailers combined with responses from multiple businesses representing 6,291 stores. The Local Shop Report also draws on data from HIM, IGD, Nielsen and William Reed.

BESPOKE POLLING ON POLICY ISSUES

ACS conducts bespoke polling of its members on a range of policy issues, from crime and responsible retailing to low pay and taxation. This polling is conducted with retailers from all areas of the convenience sector.

For more information and data sources, visit www.acs.org.uk

Public Health (Minimum Price for Alcohol) (Wales) Bill Consultation Response

On behalf of The Methodist Church and the United Reformed Church

Introduction

The Methodist Church in Britain and the United Reformed Church together represent around 250,000 Christians in the UK. We have a significant presence in Wales and submit this consultation response on behalf of our Churches and their members there. The United Reformed Church National Synod of Wales/Eglwys Ddiwygiedig Unedig Synod Cenedlaethol Cymru comprises 92 congregations with 2,600 members and adherents. The Methodist Church in Wales/Yr Eglwys Fethodistaidd yng Nghrymu comprises two Districts, the Wales Synod and Synod Cymru, which have a combined total of nearly 260 churches and chapels spread across 16 circuits.

Christians have historically been, and continue to be, concerned around the dangers of alcohol misuse, and the damaging effects that hazardous drinking can have on individuals, families, communities and broader society. Where in the past some Churches have promoted total abstinence from alcohol, our Church bodies encourage a responsible and moderate approach. As a result, we welcome Government policies that protect all people, especially those who are most vulnerable, from the damaging effects of hazardous levels of drinking.

Consultation Response

1. We welcome this consultation into introducing minimum unit pricing (MUP) in Wales. The Methodist Church and the United Reformed Church support the introduction of this important policy. We have publicly supported minimum unit pricing since the UK Government first explored the policy in 2011, and are encouraged by this progress towards introduction of MUP in Wales. We welcomed the Supreme Court's ruling allowing the introduction of MUP in Scotland, and hope that the outcome from this consultation will lead to further progress across the rest of the United Kingdom, starting with the National Assembly for Wales.

General Principles

2. We commend the general principles within this Bill. There is strong evidence that the UK has developed problems linked to alcohol consumption, and Wales is no exception. Alcohol is linked to 29 deaths every week in Wales,[1] and NHS services are already strained by the short and long-term health impacts of alcohol misuse. There is a need for the Government to respond to this harmful level of drinking.
3. As this Bill's Explanatory Memorandum demonstrates, the price of alcohol is linked to its consumption. The evidence strongly points to the fact that introducing a minimum price per unit of alcohol will save lives, reduce hospital admissions and reduce the costs to wider society. Although the Bill proposes that the minimum price per unit will be specified in regulations, it is important that the right price is chosen in order to maximise the effect of the policy.
4. Section 22 of the Bill proposes a six-year 'sunset clause'. If this trial period is to show the effects of minimum unit pricing clearly, we propose that the minimum unit price should be no less than

[1] http://www2.nphs.wales.nhs.uk:8080/PubHObservatoryProjDocs.nsf/85c50756737f79ac80256f2700534ea3/d7ead329fc08591480257d7200326f03/$FILE/AlcoholAndHealthInWales2014_v2a.pdf

45p.[2] The most recent research suggests that a minimum unit price of 60p will produce the most desirable outcomes.[3] With a 60p minimum unit price, we would expect to see significant results before the sunset provision takes effect.

5. Although the Explanatory Memorandum states that there is no consensus over the responsiveness of harmful and hazardous drinkers to the price of alcohol, we cite the prominent simulation of minimum unit pricing, Sheffield University's *Sheffield Alcohol Policy Model* (SAPM) 2013, the conclusion of which states: 'Somewhat larger impacts would be experienced by hazardous drinkers, and the main substantial effects would be experienced amongst harmful drinkers'.[4]

6. Our Churches work actively towards a society which protects the vulnerable, encourages behaviour that is healthy and allows individuals and communities to flourish. Minimum unit pricing is a particularly effective policy because of the projection that 90% of those whose lives are saved will come from the lowest income groups.[5] These are groups where hazardous drinking is not only related to health and social problems, but also to poverty.

7. It is important to note that this policy will not indiscriminately target those in the lowest income group, but rather only those who are hazardous drinkers. It will not work, however, to target those who drink excessively in licensed premises or who drink hazardous levels of more highly priced alcohol. It should, therefore, sit within a suite of policies that encourage a healthier approach to alcohol consumption across the whole of the population.

Barriers

8. The decision of the Supreme Court on 15 November 2017 to allow the introduction of minimum unit pricing in Scotland ended the legal challenge posed by the alcohol industry. With this development, Scotland will become the first country in the world to introduce universal minimum unit pricing. This is an encouragement to Wales to become the first country in the world to follow suit.
9. The Explanatory Memorandum sets out the difficulty of introducing MUP in communities next to the border with England as consumers could travel across the border to purchase cheaper alcohol from English retailers. We commend the work that the National Assembly has undertaken to ensure that the use of Welsh-registered debit and credit cards used to purchase alcohol in England is monitored in order to track any changes that MUP may provoke. Of course, our Churches continue to call for MUP in England, which would remove this potential barrier to effective introduction of the policy.

Financial Implications

10. The Explanatory Memorandum concludes that MUP is more effective than taxation in reducing problematic drinking. We point out the additional benefit to any increase in public revenue offered by increased taxation, would be balanced with the decreased pressure on social spending that minimum unit pricing will offer. A 2003 Cabinet Office report cited £21 billion as the cost of alcohol abuse to public revenue per annum in England and Wales,[6] although this has been widely cited as a conservative estimate.[7] The introduction of minimum unit pricing in

[2] https://www.sheffield.ac.uk/polopoly_fs/1.291621!/file/julyreport.pdf
[3] http://www.thelancet.com/pdfs/journals/lancet/PIIS0140-6736(16)32420-5.pdf
[4] https://www.sheffield.ac.uk/polopoly_fs/1.565373!/file/Scotland_report_2016.pdf
[5] http://dx.doi.org/10.1371/journal.pmed.1001963
[6] http://alcoholresearchuk.org/wp-content/uploads/2014/01/strategy-unit-alcohol-costs-2003.pdf
[7] Bhattacharya, A. (2016), Which cost of alcohol? What should we compare it against?, Addiction doi:10.1111/add.13335; Full Fact (2012), Does Britain lose £21 billion to alcohol abuse each year?

British Columbia, Canada, has shown a reduction of health-related costs within two years of introduction.[8] We expect to see the same in Wales. The cost to emergency services, the police force, and social services of alcohol misuse should also be expected to fall with the introduction of MUP, as well as the decreased productivity associated with excessive alcohol consumption.[9]

Conclusions

11. To conclude, our Churches continue to call for the introduction of minimum unit pricing as an effective policy which can save lives, reduce costs to the public, and target particularly hazardous drinkers. Our Church members also express an expectation that this policy will work towards making our town centres feel safer through reduced alcohol abuse. We endorse this Bill and look forward with anticipation to the National Assembly for Wales' decision. For the most effective outcomes, we recommend a floor price of no less than 45p and ideally nearer 60p. To quote a letter our churches, alongside other faith groups and charities, wrote to David Cameron in 2012, calling for minimum unit pricing to be introduced in England and Wales: 'There are various factors involved in problem drinking, but numerous studies have shown that price is the key determinant. Unless you include strong action on per unit pricing, other measures such as a ban on below-cost sales, a special tax on strong beers or a voluntary code for advertising are likely to be inadequate.'

Name: Lucy Zwolinska

[redacted]

[redacted]

[redacted] http://ajph.aphapublications.org/doi/abs/10.2105/AJPH.2013.301289

[9] http://www.ias.org.uk/uploads/pdf/Factsheets/FS%20economic%20impacts%20042016%20webres.pdf

MPA 37

Bil Iechyd y Cyhoedd (Isafbris am Alcohol) (Cymru)

Public Health (Minimum Price for Alcohol) (Wales) Bill

Ymateb gan British Liver Trust

Response from British Liver Trust

British Liver Trust Wales response to the Health, Social Care and Sport Committee's consultation on the Public Health (Minimum Price for Alcohol) (Wales) Bill.

About British Liver Trust

- We support patients and families so you don't have to face liver disease alone.
- We campaign to improve awareness so more people are aware of the risks to the liver.
- We lobby for improved services for patients.
- We fund research to find the causes and treatments of liver disease.
- We work across the UK – England, Scotland, Wales and Northern Ireland.
- We are a small charity tackling a serious and growing health problem – every donation makes a difference.

Our key activities

- Patient services, including websites, information line, publications and patient support groups.
- Improving awareness of the risks and causes, including our ***Love Your Liver*** campaign.
- Research into causes and treatments, when funding allows.
- Supporting health care professionals to deliver high standards of care and support.
- Ensuring patients have a voice at local and national government level.
- Educating the public about the risks and how to avoid preventable liver conditions.
- Sharing information about non-preventable conditions to improve understanding of all liver disease.

1. Introduction

1.1 The British Liver Trust welcomes the opportunity to respond to this consultation. Our comments in relation to the general principles of the Bill, barriers to implementation and any unintended consequences of the Bill are below.

2. The general principles of the Bill and the extent to which it will contribute to improving and protecting the health and well-being of the population of Wales.

2.2 Minimum unit pricing (MUP) is one of the most effective and cost-effective measures to reduce alcohol-related harm, and it will improve and protect the health and well-being of the population of Wales significantly.

2.3 Introducing this measure at this time is especially important, given the recent announcement from the Welsh government that alcohol deaths in Wales increased by 9% in 2016 compared with 2015.[1]

2.4 Committee members will be aware of the work Sheffield University has done on behalf of the Welsh government to estimate the impact of minimum unit pricing in Wales on population health. This work is referenced in the Explanatory Memorandum for the bill. To summarise some of the Sheffield team's key findings, once the full effects of the policy are in place, MUP in Wales is estimated to lead to:

- 53 fewer deaths a year
- 1,400 fewer hospital admissions a year
- £131 million a year saved in healthcare costs
- £882 million in savings to society overall each year

2.5 At the same time, reductions in drinking will predominantly occur amongst high-risk drinkers, with moderate drinkers barely noticing the difference. According to Sheffield University's analysis, under a 50p MUP moderate drinkers will spend just £2.37 a year more on alcohol, and consume just 6.4 fewer units a year.[2]

3. Any potential barriers to the implementation of the provisions and whether the Bill takes account of them

3.1 We would draw attention to the fact that there will be costs associated with the enforcement of the Act by local authorities, at a time when local authorities are under tight financial pressures.

3.2 The Welsh government will need to ensure that local authorities have sufficient funds and support in order to carry out their enforcement work.

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[1] Welsh government (14 November 2017), 'Increase in alcohol-related deaths in Wales – new report shows'. Available at http://gov.wales/newsroom/health-and-social-services/2017/item/?lang=en

[2] Sheffield University (2014), Model-based appraisal of minimum unit pricing for alcohol in Wales. Available at http://gov.wales/docs/caecd/research/2014/141208-model-based-appraisal-minimum-unit-price-alcohol-en.pdf

4. Whether there are any unintended consequences arising from the Bill

4.1 One consequence of MUP, though not necessarily an unintended one, is that more people may seek help from substance misuse services. An increase in demand could place existing services under further pressure, and it is crucial that this is considered. Treatment services should be funded adequately to meet this demand.

4.2 A number of negative consequences of the Bill have been suggested, and we summarise these below, and give our response to each.

4.3 A common criticism of MUP is that it is a 'tax on the poor', and that it will place financial pressure on lower income groups who, like most people, enjoy having a drink, and who are already struggling financially.

4.4 In response to this, we would point that **all moderate drinkers, including those in poverty, are estimated to barely change their spending in response to MUP**. Sheffield University's modelling estimates that moderate drinkers who are not in poverty will spend an average of £2.44 more per year under a 50p MUP.[3]

4.5 In contrast, **moderate drinkers who are in poverty will see a smaller rise in their spending**, at an average of £2.15 per year under a 50p.[4]

4.6 It is true that, according to Sheffield's analysis, high-risk drinkers (making up 5.7% of the Wales population) are estimated to spend an average of £32 more per year under a 50p MUP[5], and this increase in spending is likely to be felt more by those on low incomes. However, this increase in spending would occur whilst these high-risk drinkers (who are consuming over 71 units of alcohol per week) decrease their alcohol consumption by 13%, bringing numerous health benefits. We believe that, on balance, these health gains should outweigh other concerns.

4.7 In addition, overall we know that it is those on low incomes who have the most to gain from MUP, with 8 out of 10 lives saved from MUP predicted to come from the lowest income groups.[6]

4.8 Finally, we would point out that since Sheffield University's modelling work for the Welsh government in 2014, research has suggested that in England, a 50p MUP would mean that **harmful drinkers in poverty will actually spend £88 less per year**.[7] This is because harmful drinkers are predicted to drastically cut their drinking in response to MUP. We see no reason why this analysis could not be applied to Wales.

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[3] Ibid.
[4] Ibid.
[5] Ibid.
[6] Ibid.
[7] Meier, P. et al (2016), Estimated Effects of Different Alcohol Taxation and Price Policies on Health Inequalities: A Mathematical Modelling Study, *PLOS Medicine*. doi: http://dx.doi.org/10.1371/journal.pmed.1001963

4.9 Concern has been expressed that MUP could lead to increases in dependent drinkers committing crime in order to consume alcohol, or that dependent drinkers may choose to consume harmful alcohol substitutes such as methylated spirits in order to get drunk.

4.10 However, a study of dependent drinkers' behaviour following an increase in the price of alcohol found that these effects were very uncommon.[8] A review of the negative impacts of MUP has concluded that, 'unintended negative consequences from MUP are minor in comparison with the substantial health, social and economic benefits the policy creates.'[9]

4.13 Another concern is that MUP may lead to increased profits for some alcohol producers and retailers in the off-trade, due to the increased prices of the cheapest products. Increased profits could then be spent on activity (e.g. alcohol marketing) which are linked with alcohol harm. However, we believe that, on balance, the large benefits of MUP in terms of people's health significantly outweigh this potential consequence.

4.14 Additionally, concern has been expressed that MUP would negatively affect pubs. However, assuming the MUP is set at 50p, pub prices will be left unchanged. For example, with a 50p MUP, a pint of average strength beer could not be sold for less than around £1, but this is well below the cost of average beer prices.

4.15 MUP could actually be good for pubs, as it will increase the price of cheap supermarket alcohol which has been able to undercut pub prices, and lead to more people deciding to drink at home. In addition, research done by the Institute of Alcohol Studies found that pub managers support minimum unit pricing by a margin of 2 to 1.[10]

4.16 Finally, whilst our position supports MUP, we feel that it is not a standalone solution but part of wider work, which needs to be done to change the *culture* of drinking in Wales. We feel that the issues around this are complex and for many are linked to a range of issues such as mental health, job security, job stress, loneliness, availability of support services etc.

[8] Falkner, C. et al (2016), The effect of alcohol price on dependent drinkers' alcohol consumption, *New Zealand Medical Journal* 128: 1427, pp9-17.
[9] Stockwell, T. & Thomas, G. (2013), Is alcohol too cheap in the UK? The case for setting a Minimum Unit price for alcohol. London: Institute of Alcohol Studies.
[10] Institute of Alcohol Studies (2017), Pubs Quizzed: What Publicans Think About Policy, Public Health and the Changing Trade. Available at: http://www.ias.org.uk/uploads/pdf/IAS%20reports/rp26092017.pdf

Welsh Retail Consortium response to the National Assembly for Wales Health Committee's consultation on the Public Health (Minimum Price for Alcohol) (Wales) Bill

Introduction

The Welsh Retail Consortium is the leading trade association and authoritative voice for the Welsh retail sector. We represent the whole range of retailers, from large multiples and department stores through to independents, selling a wide range of both food and non-food items. Our members include all major supermarkets, accounting for over 90% of all grocery sales. Alcohol is an important element of those grocery sales, equivalent of 10% turnover in a typical supermarket.

WRC members fully accept their responsibility as responsible retailers and are working with their customers to promote and encourage moderate and responsible drinking. We recognise that more is needed to address the problems caused by those who drink irresponsibly and we will continue to work with stakeholders and Government to achieve the cultural change required. The WRC and our members are active participants of the Welsh Government's Alcohol Industry Network and we work closely with officials on issues of relevance to this group.

We welcome the opportunity to contribute to stage one of the legislative process following the introduction of the Public Health (Minimum Price for Alcohol) (Wales) Bill. In the event the legislation is passed our members, who have a proud record of retailing alcohol responsibly, stand ready to work with the Government to ensure this is implemented quickly and effectively

Following the recent decision in Scotland we strongly urge the respective Governments to work together on this issue to minimise the undoubted operational impacts that are likely to be particularly acute in Wales given the porous border. We would urge, where practical and reasonable, that the Welsh Government takes the same approach as in Scotland to ensure clarity and consistency both for retailers who operate in both nations and for the consumer.

Current retailer activity – supporting responsible behaviour

Our members have supported responsible consumption messaging throughout store and through contributions to the Drinkaware Trust, the independent organisation that has campaigned extensively to reinforce responsible drinking with both existing drinkers and parents.

We have taken the lead in encouraging more responsible behaviour towards alcohol through our new revised label that appeared on alcoholic products in supermarkets across the country earlier this year. The BRC/WRC and our members took the initiative to revise their existing alcohol labelling following updated advice from the UK's four Chief Medical Officers on the maximum number of units that should be consumed in a week as well as the recommended frequency of alcohol consumption.

WRC members have also been at the forefront of initiatives to prevent sales to underage customers. They pioneered the Challenge 25 policy, whereby all customers who appear to be under 25 are challenged for ID. Collectively, through the Retail of Alcohol Standards Group (RASG), our members

have ensured consistency in the way Challenge 25 is operated. The June report by the Retail of Alcohol Standards Group into the application and impact of Challenge 25 showed people in Wales had the second highest level of support for the scheme in the UK (84%). Since the scheme's introduction there has been a UK wide fall in alcohol consumption by 16-24 year olds of 24%.

Retailers are also an integral part of Community Alcohol Partnerships (CAPs), which work at a local level with enforcers and local communities to tackle under age sales and low level disorder. It is no surprise that retailers consistently outperform other sellers of alcohol in preventing underage sales. CAPs are evidence-based, tailored partnerships that bring all stakeholders together to resolve issues. Small and large retailers, trading standards, schools, the police and the licensing authority can make a real difference when working together, tackling the local and cultural issues associated with anti-social behaviour. Recent studies have shown a 41% decrease in anti-social behaviour together with a reduction in reports of under 18's drinking in public through the implementation of CAPs. Our members are committed to supporting and developing CAPs in Wales and to working with the community to ensure their long term success.

The investment in promoting the responsible sale and consumption of alcohol demonstrates how seriously our members regard the licensing regime and their selling of alcohol. We have always argued that the system should enforce rigorously against those alcohol sellers who act irresponsibly. We also believe, however, that changes to licensing legislation and controls on sales should follow the basic rules of better regulation. Any changes should be based on clear evidence that further regulation is needed and will be effective. It should also be proportionate and targeted and not simply blanket measures that affect all alcohol sellers regardless of their policy and performance.

The unintended consequences

We believe excessive alcohol consumption is due to complex reasons influenced by cultural and social factors. The measures we have embarked upon, clear information for drinkers and Drinkaware campaigns, targeting both existing drinkers and the next generation, are having an impact now and will continue to have an impact in the future.

It is important to look very closely at how the introduction of MUP could affect all consumers, including those moderate drinkers and those that are less affluent. We must ensure that public policy always takes into account the public impact and mitigates against the unintended consequences wherever possible. The potential to penalise those that drink responsibly, through what might be seen as a blanket measure, must be considered when identifying the best route to challenging negative behaviours.

Some retailers will see a greater impact from the introduction of a minimum price, particularly smaller retailers for whom alcohol is a more significant percentage of their overall turnover. Higher prices for alcohol could see consumers crossing over the border to buy alcohol more cheaply in England and there are a number of operational issues around the cross border impact that we outline below as part of the considerations needed during this legislative process. Our members have experience of this in Northern Ireland, where changes in the Euro exchange rate have encouraged shoppers either side of the border to change where they shop.

There is also a risk that own brand alcohol will be disproportionately affected by a minimum unit price. That will lead to reduced choice for consumers, and impact on those producers.

Key considerations

i) Practical Considerations

At what price will the MUP be set? We remain concerned that this figure has not be included in the bill and will be set by regulations; this provides uncertainty as to what level of impact the MUP will have operationally and on our consumers. We would strongly urge that there is parity with Scotland on the setting of the price, all modelling has been undertaken at this level and evaluation will be more effective if both nations are working within the same framework.

How will retailers be expected to manage markdowns of short dated or packaging damaged alcoholic products? These would currently retail below the MUP, and are unlikely to sell above that. There will be both a cost and waste impact on retailers.

What guidance will be put in place to manage cross border sales? In particular, putting the structures in place for online retailing will be complicated, and will require all retailers (and producers) to be aware and abide by the rules to ensure there is a fair and level playing field. Amongst this there will need to be guidance around how things like home shopping substitutions work. We request early engagement on these issues to ensure transparency, accountability and clarity in terms of guidance issued.

How will retailers be expected to manage colleague discounts? Similarly, what guidance will there be on coupons and meal deals.

With the price of alcohol rising there is likely to be an increase in retail crime, especially shoplifting. Will resource be put in place to support retailers?

A consistent enforcement approach is important to ensure different retailers are not unfairly impacted by the proposals. How will the enforcement regime work, what penalties and sanctions will be used, and what approach will be taken? We are keen to understand how better regulation in this respect can be delivered through the 22 local authority public protection and licensing teams.

ii.) Economic Considerations

The implementation of MUP will be burdensome to some Welsh retailers to implement and deliver. Creating new systems and processes is time consuming and requires investment from those businesses at a time where grocery retail margins are small and other cost pressures in the supply chain are significant. Whilst this is not a reason not to implement the policy, it is worth noting these costs will affect retailers. In order to reduce any additional burden on retailers of implementing MUP in Wales, we'd advocate, as far as possible, regulatory and operational alignment with the system being set up in Scotland.

It is inaccurate to assume retailers will be able to profit from the increased price of alcohol. Many lines which were previously below MUP levels will no longer be viable, and those lines which are sold at a higher price will be less popular. Consequently, there will be little profit increase due to the higher prices. Additionally, we do not know how alcohol producers will react in shifting their cost prices or changing their promotional strategies. The University of Sheffield academic modelling suggests that there will be 'additional revenue for the industry as a whole' but that 'no-one knows where this additional revenue will end up along the supply chain'.

Furthermore, whilst the price may rise on branded alcohol products, in many case these will only previously have been below the MUP level due to promotional activity. In these instances, ending the promotion merely means that the item returns to a normal price, with the original margin.

Consequently, the likelihood is that when costs and producer engagement is completed retailers will at best be in a position which is no worse than the status quo, and potentially the new systems will actually have cost implications for retailers.

It is of course worth noting there may be an impact on some suppliers whose products will now struggle against more established brands. We will need to take decisions about the range of products that we sell, but we would expect it to be very difficult to sell own brand products if they are raised close to the current price of the major brands.

iii.) Implementation

Retailers anticipate it will take around twelve months to bring forward the systems and processes necessary to implement MUP. That will vary between businesses, with larger retailers being more able to accommodate these changes more quickly.

Retailers would ask that Implementation does not take place during the final three months of the year as alcohol sales play a significant role in Christmas promotional activity and this would be challenging to implement simultaneously.

iv.) Data

A large number of claims have been made during the long debates over what impact MUP will have. Retailers would like to see clear and robust analysis and assessment of the policy so the exact impact of the policy can be accurately assessed. We welcome that the bill proposes a report on the operation and effect of the legislation to be published at the end of a five-year review period. There needs to be a strong evidence-based approach to any future changes in the MUP, and on its viability as an effective tool in changing negative consumer behaviours.

Conclusion

Key for retailers will be early clarity on how Minimum Unit Pricing of alcohol will work in Wales, and a fair timeframe to allow businesses to make necessary price changes.

Should the bill be passed we request a reasonable implementation period, of at least twelve months, and that clear guidance needs to be in place so retailers understand exactly how they can effectively implement the policy.

It's also crucial Ministers strike the right balance of taking measures to tackle problem drinking, without inadvertently hitting hard pressed households who consume alcohol responsibly in line with the recommended guidelines. At a time when consumers are already facing increased inflation, rising interest rates, and even potential rises in income tax this issue is even more pertinent.

We will continue to engage, through the Welsh Government Alcohol Industry Network and with key officials, to seek assurances to the considerations outlined above.

-Ends-

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MPA 39
Bil Iechyd y Cyhoedd (Isafbris am Alcohol) (Cymru)
Public Health (Minimum Price for Alcohol) (Wales) Bill
Ymateb gan Plant yng Nghymru
Response from Children in Wales

Children in Wales
Plant yng Nghymru

Consultation response

National Assembly for Wales: Health, Social Care and Sports Committee inquiry into the general principles of the Public Health (Minimum Price for Alcohol) (Wales) Bill

Children in Wales is the national umbrella organisation in Wales for children and young people's issues, bringing organisations and individuals from all disciplines and sectors together to speak with one voice, to exchange knowledge and practice, and to provide opportunities to enhance policy and practice through shared learning. One of our core aims is to make the United Nations Convention on the Rights of the Child (UNCRC) a reality in Wales. Children in Wales campaigns for sustainable quality services for all children and young people, with special attention for children in need and works to ensure children and young people have a voice in issues that affect them. Children in Wales facilitates the voice of children and young people to influence government policy making through its 'Cymru Ifanc/Young Wales' programme of work.

For further information on the work of Children in Wales, please see www.childreninwales.org.uk and www.youngwales.wales

1. Our Response

1.1 Children in Wales welcomes the opportunity to inform the **Health, Social Care and Sports Committee inquiry into the general principles of the Public Health (Minimum Price for Alcohol) (Wales) Bill** and the extent to which the Bill will contribute to improving and protecting the health and well-being of the population of Wales, and more specifically in the context of our response, children and young people.

1.2 We are in support of the General Principles of the Bill. The research evidence is clear and unequivocal in that hazardous levels of drinking has a negative impact on the health outcomes of individuals and presents a number of challenges and adverse costs to their families and to society as a whole. We support the Ministers assertion based on robust

academic research which Committee members will be familiar with that *"There is a very clear and direct link between levels of excessive drinking and the availability of cheap alcohol"*

1.3 For children and young people, the consequences of living in a household where a parent/carer or another family member consumes harmful levels of alcohol can be destructive, compromising their own immediate and long term health and wellbeing outcomes. Children and young people exposed to adverse childhood experiences and trauma in their formative years, including through pregnancy and during the first 1000 days, have increased vulnerabilities to poor health, education and employment outcomes, and are far more likely to develop long term problems and adopt health harming behaviours as adults. There are also indirect consequences for children in terms of the detrimental impact on household budgets from excessive and dependent drinking within the family home.

1.4 Having a chance of good health outcomes is not only an economic asset, but also a child's right.

1.5 The **United Nations Convention on the Rights of the Child (UNCRC)** sets out a set of rights to which all children and young people are entitled to, including Articles 6, 24 and 33 which seek to promote and protect the health needs of all children, and eliminate health inequalities in health outcomes. The UN's supplementary General Comment 15 on the right of the child to the enjoyment of the highest attainable standard of health is also in place to support Governments delivery of their obligations to all children and young people.

1.6 Since devolution, the National Assembly for Wales and successive Welsh Governments have made great strides in championing, protecting and further enhancing children's rights through Wales specific legislation. The Rights of Children and Young Persons (Wales) Measure 2011 provides that Welsh Ministers have due regard to the United Nations Convention on the Rights of the Child (UNCRC) when exercising their functions, with similar duties placed on relevant public bodies at a local level through the Social Services and Well-being Act 2014.

1.7 We agree that a minimum cost of alcohol would be a means towards combatting alcohol related harm and is consistent with the Welsh Government approach towards prioritising 'Prevention' of harm as one of the 5 ways of working reinforced through the Well-being of Future Generations (Wales) Act 2015.

1.8 It cannot be the only means however, and must be part of a broader public health programme of work which seeks to improve whole population health outcomes alongside tackling socio economic deprivation and tackling poverty.

1.9 Alongside the proposals put forward to increase the minimum unit cost of alcohol, there has to be an on-going comprehensive education and awareness raising campaign for both parents and young people to inform and support individuals seeking to change harmful and adverse risk taking behaviours; to inform parents and young people about the risks and potential consequences of excessive drinking, and to inform on safe ways/point in time for parents/carers to appropriately introduce alcohol, and discussions around alcohol use to children. The **education elements are essential** given that it is questionable how responsive

young people as consumers of alcohol will be to any price increase as proposed by this legislation.

1.10 The Welsh Government and Public Bodies will also need to ensure that the necessary accessible bespoke specialist support services are in place throughout Wales, free at the point of use, to compliment and sit alongside the key role universal services are also taking.

1.11 Appropriate tailored education within a reformed curriculum for all children and young people, harnessing the expertise of the Third Sector, also has to be included, to ensure that they develop an understanding of the risks and are able to make informed choices around managing alcohol intake during adolescents.

2. Consultation with young people and those professionals who support

2.1 During December 2015, Children in Wales and Young Wales undertook a piece of work with professionals, parents and young people to ascertain their views on the prospect of the Welsh Government introducing legislation and a Minimum Unit Price for Alcohol in Wales.

2.2 Overall, comments proved favourable in terms of introducing a minimum unit price for alcohol, although it was recognised that some respondents believed that there would be no impact, or potentially some unintended consequences for individuals and employers which should be considered.

2.3 The following are some of the comments received to the question - **Do you think we should change the law to have a MUP for alcohol in Wales?**

Selection of responses from young people

- For some the cost going up would help them to consider drinking less and maybe a lifestyle change
- For some people it could mean that they go without other essentials to still buy the amount they usually drink. This could have a knock on affect to young families who are already on a low income.
- MUP will help to stop young people drinking too much. Young people would drink less if it costs more
- Young people will get it if they want it. Young people would get the money somehow
- MUP will help more adults drink within safe levels. Possibly parents would buy less
- Not sure that it would make a difference. If they want it they will get it
- People dependant on alcohol will still buy it
- MUP will be good for the Health Service. MUP will be good for employers
- Bargain booze – May have to close if they can't sell at cheaper prices
- May have an impact on the amount of staff (businesses) employ
- Depends of the cost they buy it in at.

Selection of responses of professionals working with children and young people

- The issue is not in the pubs, it's with people buying huge amounts of alcohol from supermarkets at such cheap prices.
- This charge would affect strong ciders - which tend to be the drink of choice of the dependent drinkers,
- A higher minimum price would reduce the habits of younger people, but dependent drinkers would probably put up with it.
- People are prepared to pay for alcohol so people will spend and get drunk whether a young person or not, however if the prices were higher for certain drinks currently marketed as being very cheap for the younger person to get drunk on, it may reduce the frequency or degree slightly.
- Addiction and abuse of anything isn't down to cost. People will come up with other ways to get what they need despite MUP.
- Educate the people at risk. (A need for) Advertising and informing the public on MUP
- The MUP is a drive to encourage responsible drinking where industry has failed
- Having a MUP on alcohol is not the answer, education and training starting at school level would be the first approach. The price of alcohol has increased every year yet we still have very high levels of alcohol related incidence and supermarket promoting purchasing alcohol in bulk buy
- I have worked as an alcohol therapist for six years and drug specialist for 11 years previously I strongly believe that if there was a minimum price of 50p a unit this would reduce the consumption of the white cider (nasty stuff) which has 18 units per bottle and being sold for £2.79.
- MUP would penalise low income adults who choose to drink responsibly - especially if they drink spirits or high %abv drinks
- Many people who are alcohol dependent will still need to drink and will be prepared to find alternative methods to meet their needs
- Another benefit would be that some people would be less likely to become dependent on the (currently cheap) high %abv white ciders etc. - due to the massive price increase, if MUP happens
- Is there the same plan in England? I can't see this working unless Scotland, England and Wales all do it. Without this there will just be an increase in drives over the border to stock up?
- Is the amount suggested enough? Underage drinking is not usually found to be the cheapest alcoholic products which 50p is aimed at and needs to set slightly higher. It is only one measure and needs to be part of a bigger education programme as supply often comes through parents/family where M.U.P. will not have a huge impact if not set high enough.

3. Closing Remarks

3.1 There are significant public health challenges to be tackled in Wales which this legislation in part will seek to address. However, the legislation has to be one important component of a wider programme of work informed by the growing evidence base which supports the shift towards a preventative agenda, informed by adopting a rights based approach. The success or otherwise of the Bill in meeting its objectives of tackling excessive

drinking and the harmful impact this can have on children and young people, will very much depend on the packages of measures put in place to support its delivery.

3.2 The state has a key role to play in providing the necessary leadership and direction which helps shape the social, economic and environmental conditions which are conducive to good health and averting health harms which could be avoided. Intervening to manage the cost of alcohol in an attempt to better protect individuals, and achieve improved current and future health outcomes for children, young people and their families is an intervention which Children in Wales are very much prepared to support.

December 2017

Public Health (Minimum Price for Alcohol) (Wales) Bill Consultation

Health, Social Care and Sport Committee

National Assembly for Wales

December 2019

Response from the Wine and Spirit Trade Association

Introduction

The Wine and Spirit Trade Association (WSTA) is the UK organisation for the wine and spirit industry representing over 300 companies from major retailers, brand owners and wholesalers to fine wine and spirit specialists, logistics and bottling companies.

We campaign for a vibrant and sustainable wine and spirit industry, across the UK, helping to build a future in which alcohol is produced, sold and enjoyed responsibly.

The wine and spirit industry's contribution to the UK is often underestimated. Over 550,000 jobs are supported in the UK directly and through the wider supply chain. It contributes £50bn in economic activity and pays more than £17.5bn in tax.

The industry's contribution to the Welsh economy is significant too. Wine and spirit sales are worth around £1bn to Welsh shops, supermarkets, pubs and restaurants. In addition there has also been a resurgence in Welsh whisky and gin production. Wales now has 13 distilleries, up from just 1 in 2010, many of which are producing award winning products. There are even over a dozen Welsh vineyards producing wine.

Consultation response

- **General Principles of the Public Health (Minimum Price for Alcohol) Bill**

The WSTA set out its position on the principles of Minimum Unit Pricing during the Welsh Assembly Government's initial consultation on the subject in 2014, a copy of which is available here: http://www.wsta.co.uk/images/PAN/2014/WalesConsultationResponse.pdf

With regards to this specific consultation the WSTA would make the following observations regarding the principle of the policy:

- This approach to Minimum Unit Pricing has not been implemented anywhere else previously and therefore the exact impact and consequences are unknown. The implementation of the policy in Scotland is going ahead on the 1st May 2018, however, and this will give the Welsh Assembly the ability to learn about the actual impact of Minimum Unit Pricing before committing itself to the policy. Therefore, before proceeding with the implementation of this legislation, the Welsh Assembly should first monitor and evaluate the impact of Minimum Unit Pricing in practice.
- Should the Welsh Assembly decide move ahead with Minimum Unit Pricing, then this should be on the basis of as close as possible regulatory alignment with the model adopted in Scotland. Multiple regulatory systems operating across the UK place an additional cost burden on national retailers and producers. The Welsh Assembly approach to Minimum Pricing, including the price at which it is set and the specifics of the regulations that cover it, should therefore be aligned with the Scottish model in order to help reduce this burden. Given the impact of Minimum Pricing in Wales and Scotland have been calculated using the same modelling, and in light of the Supreme Court view that the Scottish Government's preferred price of 50p per unit was proportionate, this alignment would be both reasonable and practical.
- It is right that the draft Bill contains a sunset clause, however it is important that there is a full evaluation of the impact of Minimum Unit Pricing, covering every aspect of its operation, before the clause period ends. While the Bill contains provision for Ministers to report on its effectiveness, this provision should be strengthened to mandate the Minister to commission and submit a full and wide-ranging evaluation of

the policy for consideration to the Assembly. The Welsh Assembly should also follow the example of the Scottish Government and establish an Evaluation Advisory Group which includes representations from key stakeholders, including from across the industry, to shape and commission that evaluation.

- **Whether there are any unintended consequences arising from the Bill;**

The exact impact of Minimum Unit Pricing will not be known until the policy is in operation. However, there are a number of potentially significant unintended consequences that may result in the implementation of the draft Bill. Evidence from the Measuring and Evaluating Scotland's Alcohol Strategy[1] shows that around half of all products on shops and supermarket shelves will be impacted by the regulations at a Minimum Unit Price of 50p. This will inevitably have an impact on the market and examples of potential unintended consequence include:

Loss of value and non-branded products - Minimum Unit Pricing is a distortion of the market that will increase the price of around half the products on the shelf. The impact of this will increase the average price of alcohol products and reduce the price differential between branded products and value or non-branded products. The likely to result in the loss of a number of these products from the market and significantly reducing consumer choice and impacting on jobs where those products are produced. There will therefore be a knock-on effect to the wider supply chain in those areas where those businesses are located.

Increase in illicit or black-market trade – There is a real concern that the implementation of a Minimum Unit Price provides a significant incentive to trade alcohol illicitly. Minimum Unit Pricing will create a price differential between the production cost of a product and its retail price well in excess of the retailer margin. For example, a 3 litre bottle of high strength cider that currently retails for £3.99 would retail for no less that £11.25 under the Minimum Unit Pricing regulations at 50p. This therefore creates an incentive to sell products that will be available at wholesale, or from other parts of the UK where the regulations do not apply, outside of legitimate retailing channels to profit from this while still under cutting legitimate retailers. This is not an incentive that currently exists. Should the sale of alcohol outside of legitimate channels increase, it may appear through retail data that alcohol consumption or sales are declining, when in fact consumption remains the same.

Loss of economic activity in border towns – There is evidence to suggest a price differential across a border could lead to consumers shifting their purchases out of Wales. Welsh border towns that sell alcohol may lose custom to those across the border as they seek to either purchase products that are no longer available in Wales or reduced the cost of their shop. This could lead to a decline in economic activity in those border towns.

Impact on the low income – By its nature Minimum Unit Pricing is regressive and will impact those on low incomes the most. Alcohol consumed by those on higher incomes is more likely to be above a Minimum Unit Price level and therefore the impact will be most felt by those on low income who purchase alcohol at the lower price level. The consequence is making a regular shop for people on low incomes more expensive which will impact on their standards of living. This is particularly the case at a time when inflation is over 3% and it continues to outpace wage inflation.

Retaliatory trade barriers for exports – The WSTA is working to promote the export of British wine and spirits abroad, including Welsh Gin and Whisky. However, as a barrier to

[1] MESAS

trade, Minimum Unit Pricing could potentially result in retaliatory measures that restrict access for Welsh wine and spirit producers making it hard for them to export.

- **Potential barriers to the implementation**

Section 5, 6 and 7 – Special Offers

As outlined above, the Welsh Assembly should choose as close as possible regulatory alignment with the provisions in Scotland. However, the Scottish Government have not yet brought forward their regulations on how special offers will apply to the Minimum Unit Pricing provision. It is recommended the detail of Section 5,6 and 7 is amended to follows that of the Scottish Regulations which will be published on the 1st March and be implemented by the 1st May.

Section 9 - Fixed Penalty Notices

(a) Questions over the powers to grant fixed penalty notices

It is not clear from the draft Bill under what legislation the Welsh Assembly will grant local authorities power to issue fixed penalty notices for this offence. An offence of this type cannot be regarded as a low level environmental crime, under which local authorities have powers, as the relevant Acts contain definitions for offences such as littering or flytipping etc.

Penalty notices of this kind are issued by enforcement officers for a range of licensing offences. However, the powers to issue Penalty Notices for Disorder were introduced under the Criminal Justice and Policing Act and apply only to specific offences. Additionally, should the draft Bill be seeking to create powers under this act there are number of issues:

- The Act is very specific about the offences that a penalty notice can be issue and these emanate from the Licensing Act 2003 – of which Minimum Unit Pricing is not a part.
- Chapter 1 of Part 4 of the Police Reform Act 2002 only permits a chief officer of police to grant accreditation to a weights and measures inspector (commonly known as Trading Standards Officer (TSO) so that they may give a PND for certain offences. However, the Act does not allow local authorities to grant this power as the draft Bill sets out.
- The upper limit for penalty notices under this Act is £90, which is lower than the £200 outlined in the draft Bill.

Given that Crime and Policing are not matters devolved to the Welsh Assembly, meaning it does not have the powers to create new criminal offences, and that there are no provisions on Public Health Grounds, that we are aware of, for local authority officers to issue fixed penalty notices, further clarity on the legislation from which these fixed penalties derive would be welcome.

(b)

There is concern with Section 9 of the Bill which outlines powers on Fixed Penalties. The wording of this section states:

Where an authorised officer of a local authority has reason to believe that a person has committed an offence under section 2 in the local authority's area, the officer may give that person a fixed penalty notice in respect of that offence.

Issuing a fixed penalty notice simply on the basis of have "a reason to believe" an offence has been committed appears to contradict the Code of Practice on age restricted products

developed by Regulatory Delivery[2] which states that response to complaints or intelligence received about a specific business in relation to age related sales should be proportionate. More specifically, Section 12 of this Code sets out that enforcement officers should consider (a) the credibility, quality and quantity of information about possible breaches, (b) their understanding of the business approach to compliance, (c) whether it is in a Primary Authority relationship and (d) whether it is appropriate to first discuss the intelligence received with the business.

The Welsh Assembly Government's own guidance on Penalty Notices states *"It is essential, therefore, that they are only issued where* ***there is adequate evidence*** *to support a prosecution if a notice is not paid, and that unpaid notices are followed up. Failure to pursue unpaid notices through the courts will discredit the use of fixed penalties in the locality, and will lead to declining rates of payment"*[3]. guidance on Fixed Penalty Notices for Disorder states that A PND may only be given where a constable has reason to believe that a person aged 18 or over has committed a penalty offence and ***they have sufficient evidence to support a successful prosecution***[4].

The WSTA would urge the Welsh Assembly to reconsider these provisions so that the mechanism for dealing with a potential breach of the code is proportionate and promotes constructive dialogue between the trade and enforcement agencies which are the guiding principles of this code. This would require an amendment to ensure that fixed penalty notices could only be issued where there is evidence, and not simply a reason to believe, an offence has been committed.

There is a broader question as to whether the powers in Section 9 are required. Either products are being offered for sale, or have been sold, for below the level allowed in the regulations. Should an enforcement officer receive information on this, they have the power to investigate this in the manner outlined above, the power to undertake a test purchase to see if an offence is committed and has penalties available should a breach have occurred.

Section 10 (2) (a)

This section appears to be overly prescriptive and burdensome for the local authority. Additionally, as outlined above, enforcement action taken by local authority officers should always be evidence-based and operations should seek to establish constructive relationships between enforcement agencies and retailers. The powers that the draft Bill creates should be used only as and when evidence suggests they are required and programmes of enforcement should be based on this evidence, as well as interaction with premises, and not simply because of a legislative requirement. A licensing policy statement, for example, is reviewed every 5 years and there is no reason that a local authority should not reconsider its overall approach to enforcement of the regulations over the same time period.

Section 10 (3) (a)

This section sets out two areas in which officers must have due regard when considering the provision in 10 (2).

[2] Full details of the code are available here: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/299373/13-537-code-of-practice-age-restricted-products.pdf
[3] Full guidance available at: http://gov.wales/desh/publications/enviroprotect/cleanneighbours/fixedpenalty/fixedpenaltye.pdf?lang=en
[4] Full guidance available at: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/403812/penalty-notice-disorder-police-guidance.pdf

In relation to Protecting Children from Harm. Any enforcement action should be considered on an evidential basis and if there are circumstances where there is any evidence that underage sales, proxy sales or the unlawful supply of alcohol to children is taking place then this should be dealt with by appropriate officers under the provisions of the Licensing Act 2003 which set out the relevant offences and provide officers with requisite powers. It is more appropriate that matters relating to underage sales and the protection of children from harm, and consideration of any enforcement action taken on this basis, are by officers that may be delegated authority under the Licensing Act and not this draft Bill. We cannot envisage any circumstances when the provisions under this draft Bill would be more appropriate than those under the Licensing Act 2003 in relation to protecting Children from Harm.

With regard to Protection of Public Health. The Welsh Assembly should be aware of the potential difficulties in the application of this provision. Even in Scotland, where protection of public health is a full licensing objective and has full implications for the granting of licenses, the outlet density of an area, the timing of licenses and so on, questions remain over its effectiveness[5]. Given the provision of this draft Bill is in relation to the enforcement of this one regulation on the sale of alcohol below a certain price, and cannot be applied more widely, and that the focus of draft Bill is reducing consumption of hazardous and harmful drinkers over the longer term, it is difficult to see how this measure could work practically.

Section 11

Wording in this section gives the local authority power to appoint relevant officers in relation to enforcing this provision. We would recommend that the powers for the purposes of this bill are only given to those that are trained in, and understand, the provision of the Licensing Act 2003. The nature of the enforcement action suggest that this should be taken by an officer with appropriate training and standing, and any enforcement action taking place in relation to the sale of alcohol should be done by those regularly involved so that they will be aware of any intelligence or information that may exist regarding particular licences.

- **The financial implications of the Bill (as set out in Part 2 of the Explanatory Memorandum);**

The regulatory compliance cost for businesses in Wales appears low at just £800,000, given the cost of changing systems for all alcohol retailers including staff training cost, reworking pricing and promotion policies and technological changes to accompany this. But it is important to note that the actual cost of compliance for retailers will depend on the final regulations. As outlined above, should the regulations follow those of Scotland, including price and approach, then compliance costs will be reduced for national retailers.

It is concerning that no estimated cost has been made on the impact of a reduction of consumption of particular products which may become financially unviable under the new regulations. This could have a direct effect on those businesses and the local supply chain. Additionally, limited assessment appears to have been made on the impact of black market and cross border sales. The modelling simplistically assumes a direct link between increasing price and increasing sales through legitimate retail channels, and that cross border and black-market impacts will be limited.

[5] Further information available at: http://alcoholresearchuk.org/alcohol-insights/using-licensing-to-protect-public-health-from-evidence-to-practice-2/

UK Health Forum Response to the Health, Social Care and Sport Committee's consultation on the Public Health (Minimum Price for Alcohol) (Wales) Bill

Date: 15th December 2017

Contact: Danielle Costigan Policy/Research Officer
Email: [redacted]

About the UK Health Forum

The UK Health Forum (UKHF), a registered charity, is both a UK forum and an international centre for the prevention of non-communicable diseases (NCDs) including coronary heart disease, stroke, cancer, diabetes, chronic kidney disease and dementia through a focus on up-stream measures targeted at the four shared modifiable risk factors of poor nutrition, physical inactivity, tobacco use and alcohol misuse. UKHF undertakes policy research and advocacy to support action by government, the public sector and commercial operators. As an alliance, the UKHF is uniquely placed to develop and promote consensus-based healthy public policy and to coordinate public health advocacy.

UKHF welcomes the opportunity to respond to the Health, Social Care and Sport Committee's consultation on the Public Health (Minimum Price for Alcohol) (Wales) Bill. Our comments on the general principles, barriers to implementation and any unintended consequences of the Bill are answered below.

Answers to questions:

1) Comment on the general principles of the Bill and the extent to which it will contribute to improving and protecting the health and well-being of the population of Wales

- The UK Health Forum welcomes and supports this legislation. We have long supported Minimum Unit Pricing (MUP) for alcohol

- MUP is one of the most effective and cost-effective measures to reduce alcohol-related harm and it will improve and protect the health and well-being of the population of Wales significantly

- Introducing this measure at this time is especially important, given the recent announcement from the Welsh government that alcohol deaths in Wales increased by 9% in 2016 compared with 2015 [1]

- Committee members will be aware of the work Sheffield University has done on behalf of the Welsh government to estimate the impact of MUP in Wales on population health. This work is referenced in the Explanatory Memorandum for the Bill. To summarise some of the Sheffield team's key findings, once the full effects of the policy are in place, MUP in Wales is estimated to lead to:

    - 53 fewer deaths a year
    - 1,400 fewer hospital admissions a year
    - £131 million a year saved in healthcare costs
    - £882 million in savings to society overall each year

    At the same time, reductions in drinking will predominantly occur amongst high-risk drinkers, with moderate drinkers barely noticing the difference. According to Sheffield University's

[1] Welsh government (14 November 2017), 'Increase in alcohol-related deaths in Wales – new report shows'. Available at http://gov.wales/newsroom/health-and-social-services/2017/item/?lang=en

analysis, under a 50p MUP, moderate drinkers will spend just £2.37 a year more on alcohol, and consume 6.4 fewer units a year.[2]

- Drinking alcohol regularly can increase the risk of seven different types of cancer. These include: Oral/Mouth cancer, Pharyngeal cancer (upper throat), Oesophageal cancer (food pipe), Laryngeal cancer (voice box), Breast cancer, Bowel cancer, and Liver cancer.

  The incidence of alcohol related cancers is rising. For example, according to Cancer Research UK, the incidence of oral cancers in the U.K increased by 68% in the last 20 years.[3] In Wales alone, 2,766 people were diagnosed with oral cancer between 2013 and 2015.[4]

  The introduction of MUP of alcohol would ultimately reduce excessive consumption and have a positive impact on the number of cancer cases attributed to alcohol that are presented in Wales.

- MUP would also have positive impacts on other aspects of society. It would reduce dangerous, excessive, 24 hour drinking episodes with important implications for occupational and public safety.

- In addition, among the positive economic effects, fewer days would be lost from work absences, and there would be less disruption from anti-social behavior at cultural and sporting events and on public transport services.

2) Comment on any potential barriers to the implementation of the provisions and whether the Bill takes account of them

- There may be costs associated with the enforcement of the Act by local authorities, at a time when local authorities are under tight financial pressures.

- The Welsh government will need to ensure that local authorities have sufficient funds and support in order to carry out their enforcement work.

- The implementation of MUP should include a mechanism to ensure any windfall gained is re-invested into additional public health work.

3) Comment on whether there are any unintended consequences arising from the Bill

- One consequence of MUP, though not necessarily an unintended one, is that more people may seek help from substance misuse services. An increase in demand could place existing services under further pressure, and it is crucial that this is considered. Treatment services should be funded adequately to meet this demand.

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[2] Sheffield University (2014), Model-based appraisal of minimum unit pricing for alcohol in Wales. Available at http://gov.wales/docs/caecd/research/2014/141208-model-based-appraisal-minimum-unit-price-alcohol-en.pdf

[3] Cancer Research UK (2017) Available at http://www.cancerresearchuk.org/health-professional/cancer-statistics/statistics-by-cancer-type/oral-cancer/incidence#heading-Two

[4] Welsh Cancer Intelligence and Surveillance Unit (2017) Available at http://www.wcisu.wales.nhs.uk/dashboard-data

A number of negative consequences of the Bill have been suggested, and we summarise these below, and give our thoughts on each:

- Concern has been expressed that MUP could lead to increases in dependent drinkers committing crime in order to consume alcohol, or that dependent drinkers may choose to consume harmful alcohol substitutes such as methylated spirits in order to become intoxicated.

A study of dependent drinkers' behaviour following an increase in the price of alcohol found that these effects were very uncommon.[5] A review of the negative impacts of MUP has concluded that, 'unintended negative consequences from MUP are minor in comparison with the substantial health, social and economic benefits the policy creates.' [6]

- Another criticism of MUP has been that it has a disproportionately negative impact on those from low-income households.

Whilst the impact of MUP on high-income drinkers is likely to be less than that felt by low-income drinkers, moderate drinkers at all income levels will barely notice the difference in costs, and we believe the health benefits of MUP outweigh this concern. Those from the lowest incomes stand to benefit the most from MUP, with an estimated 8 out of 10 lives saved coming from the lowest income groups,[7] and of all price-related alcohol policies, MUP reduces health inequalities the most. [8]

- Another concern is that MUP may lead to increased profits for some alcohol producers and retailers in the off-trade, due to the increased prices of the cheapest products. Increased profits could then be spent on activity (e.g. alcohol marketing) which are linked with alcohol harm.

We believe that, on balance, the large benefits of MUP in terms of people's health significantly outweigh this potential consequence. In addition, ensuring that any windfall gains from MUP are reinvested in additional public health activities will further help to address these concerns.

- Concern has also been expressed that MUP would negatively affect pubs.

Assuming the MUP is set at 50p, pub prices will be left unchanged. For example, with a 50p MUP, a pint of average strength beer could not be sold for less than around £1, but this is well below the cost of average beer prices.

MUP could actually be good for pubs, as it would increase the low prices of supermarket alcohol which have led more people to drink at home rather than in pubs.

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[5] Falkner, C. et al. (2016) The effect of alcohol price on dependent drinkers' alcohol consumption, New Zealand Medical Journal 128: 1427,9-17

[6] Stockwell, T. & Thomas, G. (2013) Is alcohol too cheap in the UK? The case for setting a Minimum Unit price for alcohol. London: Institute of Alcohol Studies

[7] Holmes, J. et al. (2014) 'Effects of minimum unit pricing for alcohol on different income and socioeconomic groups: a modelling study', The Lancet, 383 (9929), 1655-64

[8] Meier, P. M. et al. (2016) Estimated Effects of Different Alcohol Taxation and Price Policies on Health Inequalities: A Mathematical Modelling Study. PLOS One. Vol: 13 Iss: 2

MPA 42

Bil Iechyd y Cyhoedd (Isafbris am Alcohol) (Cymru)

Public Health (Minimum Price for Alcohol) (Wales) Bill

Ymateb gan Bwrdd Iechyd Addysgu Powys

Response from Powys Teaching Health Board

Powys Teaching Health Board Response to the Health, Social Care and Sport Committee Consultation on the Public Health (Minimum Price for Alcohol) (Wales) Bill

Date: 29th November 2017	**Version:** 1

Terms of reference

To consider—

- *the general principles of the Public Health (Minimum Price for Alcohol) (Wales) Bill and the extent to which it will contribute to improving and protecting the health and well-being of the population of Wales, by providing for a minimum price for the sale and supply of alcohol in Wales and making it an offence for alcohol to be sold or supplied below that price.*
- *any potential barriers to the implementation of the provisions and whether the Bill takes account of them;*
- *whether there are any unintended consequences arising from the Bill;*
- *the financial implications of the Bill (as set out in Part 2 of the Explanatory Memorandum);*
- *the appropriateness of the powers in the Bill for Welsh Ministers to make subordinate legislation (as set out in Chapter 5 of Part 1 of the Explanatory Memorandum).*

Invitation to contribute to the inquiry

The Committee welcomes evidence on the terms of reference and the extent to which the Bill will contribute to improving and protecting the health and well-being of the population of Wales.

1. Introduction

1.0 Powys Teaching Health Board (PTHB) welcomes the opportunity to comment and give evidence on the Public Health (Minimum Price for Alcohol) (Wales) Bill. However, please note that the response set out below is being submitted subject to formal approval by PTHB Board to comply with the consultation response deadline.

1.1 PTHB submitted a consultation response to the Public Health (Wales) Bill in 2015. As stated in 2015, PTHB strongly supports the implementation of minimum unit pricing (MUP) and believes that the implementation of MUP signifies a firm commitment to improving and protecting the health of the population in Wales.

1.2 The current consultation questions set out by the Health, Social Care and Sport Committee on the Public Health (Minimum Price for Alcohol) (Wales) Bill differ from those presented in 2015. Therefore, the current document provides an updated response (where relevant). However, our views on the implementation of MUP remain unchanged. We have sought to update key facts and evidence which lend further support to the implementation of MUP in Wales.

2. Terms of Reference

The general principles of the Public Health (Minimum Price for Alcohol) (Wales) Bill and the extent to which it will contribute to improving and protecting the health and well-being of the population of Wales, by providing for a minimum price for the sale and supply of alcohol in Wales and making it an offence for alcohol to be sold or supplied below that price.

2.0 Many of the points set out below were included in the consultation response submitted by PTHB in 2015. Our previous submission has been used as a framework in responding to the terms of reference stated above.

2.1 PTHB welcomes the Welsh Government's proposal to introduce a "floor price" below which alcohol cannot be sold. The Health Board considers a pricing policy to be an important part of any effective strategy to reduce the harm that alcohol causes to people's health and wellbeing and to reduce the costs to health and social care services resulting from alcohol misuse.

2.2 Minimum unit pricing is a particularly important measure as it specifically targets drinks which are cheap relative to their alcohol content. As a result, it is likely to have the greatest impact on

people who are at the highest risk from alcohol-related illness and death i.e. people who drink at a hazardous or harmful level whilst having only a limited impact on the drinking habits of those who drink at a moderate level (including those on low incomes).

2.3 Overall, alcohol places a considerable burden on the healthcare system in Powys and on the services that the Health Board provides and commissions for the local population. We know that drinking alcohol increases the risk of developing over 60 different health problems including a range of cancers, liver disease, high blood pressure, injuries and a variety of mental health conditions[1,2]. It also increases the risk of causing harms to the health of others.

2.4 As a Health Board we consider that the introduction of a minimum price for alcohol is an important, highly cost effective, public health intervention that has the potential to make a significant contribution towards improving the health of our local population and, through its impact on heavier drinkers, to contribute over time to a reduction in health inequalities. We anticipate that it would be effective both as a targeted and as a population-wide public health intervention.

2.5 In support of our view, we note that minimum unit pricing is supported by the National Institute for Health and Care Excellence (NICE) as an effective way to reduce alcohol-related harm[3]. Considerable research evidence is available which shows that alcohol consumption is sensitive to cost, that minimum unit pricing would make alcohol less affordable by targeting price increases to low cost/high strength beverages, that minimum unit pricing would have the greatest impact on people who drink at harmful levels, and that it would have whole population benefits whilst having only limited effect on alcohol consumption amongst people who drink at moderate levels[3,4,5].

2.6 In addition, in the UK we have seen significant improvements in relation to other health harming behaviours with the introduction of policy and law changes (e.g. the introduction of the smoking ban in public places).

2.7 A model-based appraisal of minimal unit pricing for alcohol in Wales produced using methodology developed from the Sheffield Alcohol Policy Model suggests that the introduction of MUP;[5]

- would be effective in reducing alcohol consumption, alcohol-related harms and the costs associated with alcohol-related harms (including alcohol-related deaths, hospitalisations, crimes and workplace absences);

- would have only a small impact on moderate drinkers, a bigger impact on "increasing risk" drinkers and the greatest impact on "high risk" drinkers;
- would have a larger impact on people living in poverty, particularly high risk drinkers compared to those not in poverty and would therefore have the potential to support a reduction in alcohol-related health inequalities.

2.8 The introduction of minimum unit pricing would complement other work that is already taking place in Powys to address alcohol-related harm to health. This includes the work of the Harm Reduction Group under the Substance Misuse Area Planning Board, the implementation of Making Every Contact Count, and alcohol brief advice training, and the work done in schools by the School Nursing Service, the Healthy Schools Scheme and the Community Alcohol Partnerships currently operating in two towns in Powys. It would also complement the work taking place locally and nationally to address Adverse Childhood Experiences (ACE's). The proposed legislation therefore also has the potential to strengthen existing actions to reduce alcohol consumption and alcohol-related harm.

Any potential barriers to the implementation of the provisions and whether the Bill takes account of them;

2.9 PTHB acknowledges that there may be some barriers in implementing the Bill and we agree that the Bill has taken account of these barriers. We do not feel that any of the barriers mentioned in the Bill should prevent it being passed.

2.10 Many of the barriers relate to the implementation costs for retailers. For example there will be a cost to updating systems to reflect the new prices. This is recognised within the Bill, although the costs are currently unknown. Certain chain stores (e.g. supermarkets) will need different pricing systems depending on whether they are based in England or Wales. There will also be a time cost in relation to implementing the MUP for retailers.

2.11 Online/mobile businesses licensed in Wales will need to charge in line with MUP when supplying to customers in Wales. Welsh Government does acknowledge that such sales may cause a significant implementation challenge for some retailers. Views were sought on this subject in the consultation on the draft Bill. It was generally agreed that alcohol sold online/via telephone is mostly priced above the MUP, and therefore sales would be largely unaffected. In addition, harmful and hazardous drinkers who are the main targets of MUP are more likely to buy alcohol in

supermarkets/grocers than online[6]. However as stated within the Bill, it is important that this is monitored.

Whether there are any unintended consequences arising from the Bill;

2.12 PTHB acknowledges that there may be some unintended consequences that arise as a result of implementing the Bill. However we believe that these consequences should not prevent the Bill from being passed.

2.13 Differences in the legislation in Wales and England could affect purchasing behaviours. It is possible that some individuals may order or purchase alcohol from England or other countries to avoid paying the minimum price (depending on availability and ability and willingness to travel). However, evidence presented within the Bill demonstrates that the online sales market is currently dominated by drinks which are already priced above the proposed minimum unit price of 50p. There is also evidence that harmful and hazardous drinkers (who are the main targets of MUP) are more likely to buy alcohol in local supermarkets/grocers than online[7]. In addition, few border areas have a high concentration of very heavy (binge) drinkers. Therefore it is acknowledged that it is unlikely that minimum unit pricing would have a major impact on current patterns of purchasing including online sales of alcohol.

2.14 In the longer-term, minimum unit pricing is likely to lead to a range of savings for local authorities. This may include savings associated with the provision of social care and potentially in other areas such as housing, employability, community safety and education. However, in the short term there is likely to be a cost to implementation of MUP, for activities such as enforcement, publicity and education. It is important that local authorities are aware of potential cost increase for trading standards services and for retailers and the public. However, as stated within the Bill, it is likely that overall for local authorities, savings would outweigh any costs.

2.15 There is a possibility that people on low incomes who currently purchase alcohol below MUP will continue to drink alcohol and pay the higher price, but spend less on food/heating for family. This is detailed by Christopher Snowdon (2014)[8] from the Institute of Economic Affairs. This is likely to cause health related problems and complexities for the individual and their family. If this pattern is observed on a wide scale, it could contribute to a widening of health inequalities. This is something that we believe would need to be monitored. The evaluation of MUP outlined within the Bill is welcomed in this respect.

2.16 If the MUP legislation is successful in motivating dependent drinkers to give up alcohol, there is likely to be an increased demand on services[9]. Again, this is something that needs to be monitored in order to ensure services are able to accommodate a potential increased demand.

2.17 It is possible that the MUP could lead to an increase in the trading of, and use of illicit alcohol[8] which is not currently a significant problem in Wales. If this does happen it is likely to put increasing pressure on Trading Standards in local authorities. The Bill recognises that this is a low risk, but will remain under review.

2.18 We acknowledge that alcohol production makes a contribution to the local economy (such as from distillery and microbrewery businesses). However protecting the public from harmful or hazardous drinking must be our priority.

The financial implications of the Bill (as set out in Part 2 of the Explanatory Memorandum);

2.19 There will undoubtedly be costs associated with implementing the Bill, particularly in relation to administrative costs, enforcement, evaluation, compliance costs for retailers, and the increase in costs to consumers who currently purchase alcohol below MUP.

2.20 However there are significant benefits and cost savings related to implementing MUP in the long term, including a reduction in costs related to health harms, crime, workplace absenteeism.

2.21 PTHB believes that although there will undoubtedly be significant costs relating to implementing the Bill, the long-term savings will outweigh these costs. These projections are highlighted by the Sheffield Model[5] and detailed within the Bill. There are no additional costs that we are aware of that have not been considered within the Bill.

The appropriateness of the powers in the Bill for Welsh Ministers to make subordinate legislation (as set out in Chapter 5 of Part 1 of the Explanatory Memorandum).

2.22 PTHB agrees that the subordinate legislation outlined within the Bill is appropriate and relevant. We agree that it is important to adjust MUP in consideration of inflationary trends.

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MPA 43

Bil Iechyd y Cyhoedd (Isafbris am Alcohol) (Cymru)

Public Health (Minimum Price for Alcohol) (Wales) Bill

Ymateb gan Cytûn

Response from Cytûn

Cytûn (Churches Together in Wales)
Response to the Committee consultation on the Public Health (Minimum Price for Alcohol) (Wales) Bill

1. Introduction

1.1 Cytûn (Churches Together in Wales) brings together the main Christian denominations of Wales, and a number of other Christian organisations, to work together on matters of common concern. The 17 member denominations have around 165,000 adult members in every community across Wales, and regular contact with many more adults, children and young people. A full list of member churches and organisations can be found at: http://www.cytun.cymru/us.html

1.2 We would welcome the opportunity to be involved further in the work of the Committee. Any queries should be directed to the Revd Gethin Rhys, National Assembly Policy Officer for Cytûn, at [redacted]. This response may be published in full.

2. The general principles of the Bill

2.1 Christian churches in Wales have a lengthy history of encouraging and supporting legislation designed to limit the irresponsible sale of alcohol, beginning with one of the first Wales-specific pieces of legislation in modern times, the Sunday Closing (Wales) Act 1881. Although some Christians are motivated by a belief in total abstinence from alcohol, most support such measures as ways of curbing irresponsible use, rather than preventing all use, of alcohol.

2.2 While the 1881 Act targeted public houses, in more recent years the Christian churches have established more positive relationships with those who own and run pubs and clubs licensed for alcohol consumption on the premises, notably through the work of Street Pastors, Street Angels and NightLight groups in many parts of Wales, working to reduce the harm caused by excessive alcohol consumption in the night-time economy. These groups are also often involved in their local Community Safety Partnerships. The experience of these groups is that alcohol consumption in on-licensed premises is much less harmful than alcohol bought at off-licensed premises, which is then consumed in the street or on private premises where there is no supervision or support available. The monitoring of customer behaviour by licensees and door staff, and the work of the police in monitoring the premises, as well as the work of CSPs and our own volunteers, have all helped to reduce the harm caused by alcohol consumption in on-licensed premises. Cytûn was pleased to draw on the experience of Street Pastors and similar Christian groups to contribute to the developing of the Welsh Government's Framework for Managing the Night-time Economy in Wales[1] We note that pubs and clubs will be little affected by the new legislation, and welcome the possible effect of displacing some sales from off- to on-licences, and reducing the prevalence of "pre-loading" cheap alcohol before going to a club, meaning that customers may be less likely to arrive already intoxicated.

2.3 Our member church, the Salvation Army, has long supported setting a minimum price for alcohol, and has submitted a separate response to you and provided oral evidence on

[1] http://gov.wales/topics/people-and-communities/communities/safety/substancemisuse/availability/night/?lang=en

December 13. Two member churches, the United Reformed Church and the Methodist Church, have submitted a joint response, and the Presbyterian Church of Wales has also responded. All these responses support the general principles of the Bill. This response does not seek to repeat the detailed arguments contained therein.

2.4 Following extensive consultation through the church and society officers of our member churches and organisations, we are not aware of any members of Cytûn who would oppose the principles of this legislation.

2.5 A number of specialist charities founded by or linked to our member churches also support the principles of the Bill. For example, Quaker Action on Alcohol and Drugs, which is closely linked to Cytûn member the Society of Friends in Wales, says:
The affordability of alcohol has dropped significantly relative to income in the last thirty years, whilst alcohol-related health problems have risen. The Chief Medical Officer, Royal College of Physicians, Alcohol Concern and many health bodies that have united in the Alcohol Health Alliance, have all concluded that a minimum price per unit of alcohol would be one of the most effective ways of reducing harm. We accept this evidence and support minimum unit pricing.[2]

3. Potential barriers to the implementation of the provisions and any unintended consequences.

3.1 **Cross-border issues**. It appears to us inevitable that the introduction of a minimum unit price for alcohol in Wales without such a measure being introduced in England will result in some displacement of sales to off-licences on the English side of the border (as the 1881 Act increased the patronage of public houses on the 'wet' sides of county borders on Sundays). We note the Welsh Government's assessment that this effect will be small, as in most cases the cost of reaching such premises will be greater than the saving effected by so doing, but we are aware that some small village shops in villages in Wales very close to the border fear that their sales will reduce and their viability may be threatened. We would certainly regret the loss of such valued small shops in such communities, but hope that the long lead-in time to this legislation, and the possibility of similar legislation following in England, will mean that businesses can plan to diversify their sales to ameliorate any such effects.

3.2 **Internet and postal sales.** While the legislation attempts to cover orders made over the internet and by phone (Explanatory Memorandum para 286), our understanding is that the legislation can only apply where both the supplier and the customer are based in Wales. This is likely to lead to some displacement of sales to suppliers licensed outside Wales, who can then deliver to customers in Wales. Unlike cross-border sales involving additional travel (3.1), there will not necessarily be any additional cost to the Welsh consumer in accessing cheap alcohol through such sources. There will also be some administrative costs to any such businesses which are licensed in Wales in needing to operate two pricing systems, depending on the location of each customer. We are aware that the powers of the National Assembly are limited in this regard, but would encourage the Assembly to use its ingenuity to see if the legislation can be tightened up to cover this issue.

3.3 Some members of our churches have expressed concern that the effect of this measure will be regressive, i.e. poorer drinkers will be affected far more proportionate to their income/wealth than richer drinkers. Churches have consistently been concerned about taxation being regressive (as alcohol duty and VAT are), but we are generally more relaxed about pricing mechanisms being regressive. For example, we support the 5p carrier bag charge and actively promote the Fairtrade movement, which increases prices in order to ensure a fair income for producers. Many of our member churches therefore support the real Living Wage, enabling

[2] http://qaad.org/public-issues-alcohol-2/ accessed 13.12.17

its recipients to make informed choices in their purchases rather than always having to buy the cheapest product.

3.4 We note also the counter-argument to that in 3.3 put forward by our member, The Salvation Army, in its written response (section 2):
However, through our work with those who are most marginalised and excluded from society, we also know that it is these groups who are most disproportionately affected by alcohol misuse. Indeed, ..., according to the Welsh Index of Deprivation (WIMD), those from the most deprived communities are much more likely to be admitted to hospital, or die, as a result of harmful drinking than their better off counterparts. We therefore welcome any intervention that makes a significant difference to the health of a population group which has been difficult to engage in recent years and who, with the introduction of MUP, would have the most health benefits to gain.
We note that figures 5 and 6 in the Government's Explanatory Memorandum corroborate this view.

4. The financial implications of the Bill

4.1 We note the view expressed in Part 2 of the Explanatory Memorandum that costs to Welsh Government and costs of enforcement on Local Government will be relatively low. There should be some longer term savings if the harm from alcohol consumption is reduced, although these will be difficult to measure and will be felt in different budgets to the costs.

4.2 We would emphasise that, at a time of financial stringency, every effort should be made not to meet such additional costs as will arise by reducing expenditure on other measures which also mitigate harmful alcohol consumption – e.g. local authorities should not find resources to enforce the new legislation by reducing resource in regulating other licensed premises or by reducing their commitment to Community Safety Partnerships (see para 2.2).

4.3 In line with the oral evidence provided by the Salvation Army on December 13, we would therefore urge continued investment by Welsh Government and local government in public education on the abuse of alcohol and other substances, and regarding the importance of the choices that young people, especially, make. Programmes of rehabilitation for those dependent on alcohol should remain fully accessible regardless of income. Alcohol abuse is related to such fundamentals as poverty and poor education, so strategies like Prosperity for All and the continued observance of the principles of the Well Being Future Generations (Wales) Act will play a vital role in underpinning the objectives of minimum pricing.

5. **The appropriateness of the powers in the Bill for Welsh Ministers to make subordinate legislation**

5.1 We support the delegation of powers to Welsh Ministers to set the minimum unit price rather than include it on the face of the Bill in order that the effects of inflation, and experience of operating the minimum unit price in Wales and other jurisdictions (notably Scotland), can be taken into account without needing to amend the primary legislation.

5.2 We consider that the other delegated powers are appropriate.

15th December 2017.

Parch./Revd Gethin Rhys
Swyddog Polisi'r Cynulliad Cenedlaethol / National Assembly Policy Officer
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MPA 44
Bil Iechyd y Cyhoedd (Isafbris am Alcohol) (Cymru)
Public Health (Minimum Price for Alcohol) (Wales) Bill
Ymateb gan Goleg Brenhinol yr Ymarferwyr Cyffredinol
Response from The Royal College of General Practitioners

RCGP Wales
Regus House
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CF10 4RU

Dr Dai Lloyd AM
Chair of the Health, Social Care and Sports Committee
National Assembly for Wales
Cardiff Bay
CF99 1NA

Friday 15th December

Dear Dr Lloyd,

Thank you for asking the RCGP Wales to comment on the proposals set out in the Public Health (Minimum Price for Alcohol) (Wales) Bill ("the Bill") which was laid before the National Assembly of Wales on 23 October 2017.

We endorse the comments we made to consultation in 2015. We welcome the fact that in Scotland the appeal against a similar bill has failed.

Generally we are supportive of all parts of the Bill. We do have some concern about allowing other goods and services to be parts of deals with alcohol, and feel that this may in some cases reduce the effect of the minimum alcohol price. We feel that multi-buys should either be only alcohol or non-alcoholic goods. There may need to be exemptions for alcohol provided as a deal with a meal and the total price of the meal and alcohol should not be less than the price of the sum of the separate components.

The outcomes we expect to see from the Bill are increased public awareness of the potential harmful effects of alcohol to their health, and in particular of high alcohol intake or binge drinking. Potentially this may be measured by a reduction in sales of alcohol in Wales but this could be accounted for by a variation in

alcohol bought from outside Wales. A better measure would be reductions in patients diagnosed with or dying from alcohol related disease, particularly cirrhosis of the liver. A better measure would also be a reduction in the incidence of patients attending Emergency units or being involved with the police under the influence of too much alcohol.

There are real concerns that minimum alcohol pricing may effect those who are dependent, and particularly those on lower incomes more adversely than those on higher incomes. There may also be an increase in the need for increased support for those who are dependent. GPs are managing these patients with support of the substance misuse units, some of which have waiting lists. It may be appropriate for Welsh Government to review substance misuse services and look at developing improved services in local communities, including consideration of enhanced alcohol abuse services for GPs to manage patients as part of improved shared care services.

We have some concern that increasing the price of alcohol may result in increased use of other illegal substances and there will need to be increased vigilance by health and law enforcement to ensure that this does not involve more dangerous substances.

Generally we feel we support the responses relate to health issues given by the Cabinet Secretary in his recent letter of 14 November following your questions in your letter dated 9 November 2017.

Yours sincerely,
RCGP Wales.

To:	**Health Social Care and Sport Committee**
Subject:	Betsi Cadwaldr University Health Board (BCUHB) Response to Consultation on the Public Health (Minimum Price for Alcohol) (Wales) Bill
Contact:	**Executive Director Public Health- Teresa Owen**
Date:	**15th December 17**

Purpose

To provide an organisational response from Betsi Cadwaldr University Health Board (BCUHB) to the Consultation on the Public Health (Minimum Price for Alcohol) (Wales) Bill.

Introduction

There is strong and compelling evidence to suggest that the introduction of a minimum unit price (MUP) for alcohol across Wales would have positive and significant effects on the alcohol consumption of the population.

Alcohol consumption has increased among the population of North Wales, as in all other areas of Wales, over the last forty years and studies show that such an increase is linked to the affordability of alcohol. Published research from elsewhere in the world unambiguously shows that when the price of alcohol increases, consumption by most drinkers decreases. Evidence also shows that when alcohol consumption in a population declines, rates of alcohol related harm also decline.

Cancers, liver disease, high blood pressure, injuries and a variety of mental health conditions can all be linked to drinking alcohol. Alcohol is also related to increasing the risk of causing harms to the health of others and the financial burden associated with this is significant. In BCUHB's view harm-related costs could be substantially reduced if minimum unit pricing is introduced.

There is robust evidence that the health service in Wales would benefit through an overall decrease in alcohol related harm, morbidity and mortality. Whilst it may be challenging, particularly in the short term, to directly attribute reductions in measures such as alcohol related hospital admission, to the introduction of minimum unit pricing, other measures focussing on those populations likely to be most affected may be used. Over time, we believe that the health service is likely to see benefits in terms of cost savings related to both acute and chronic alcohol related harms.

Alcohol related crime including violent crime, acquisitive crime and criminal damage is well evidenced. Recent figures show that up to 53% of all reported violent crime is alcohol related and alcohol is a consistent element in domestic abuse, self harm and suicide.

The impact of a minimum unit price would particularly affect harmful and hazardous drinkers who would be considered to be a priority group for intervention. It is also believed that there

would be positive impact on children and young people who are also more likely to buy cheaper brands of alcohol.

BCUHB believe that the benefits of introducing MUP would not only be seen within targeted groups but felt by the whole of Wales both in terms of a reduction in burden on the NHS and the associated crime and disorder that is linked to alcohol.

In preparing the response key individuals/ areas within the Health Board including but not limited to Gastroenterology, Substance Misuse services and Psychiatric liaison were asked to input to the consultation. This document is representative of those collective views.

There is significant support from BCUHB for the introduction of Minimum Price for Alcohol, although a number of considerations are put forward to inform this consultation.

Information/ Considerations

The Bill appears to have considered fully potential loopholes and how MUP would apply in these situations e.g. multi purchase offers which should ensure intended impact is not diluted.

Learning from the Scottish model is vital to learn lessons and ensure a smooth implementation of this bill.

The set price point will be key to the success of the initiative and careful consideration is needed around this, discussion with Scottish colleagues has suggested that slightly higher than 50p would be advantageous but we understand that modelling has taken place on this basis and fully support this as a starting point.

BCUHB believe that minimum unit pricing should be linked to an inflationary measure to ensure it remains an effective measure to reduce affordability, consumption and resultant alcohol health harms. Review should be independent and at pre determined intervals based on key milestones for evaluation.

Consideration needs to be given to the potential to influence the alcohol industry's spend of the increased revenue, there may be opportunities to do this through their social responsibility policies and this should be examined in more detail.

Enforcement activity needs careful consideration and it is recommended there is accompanying guidance to ensure consistency of approach and to ensure the bill is prioritised and upheld. Resource implications for effective enforcement also need to be considered in more detail.

Current proposed fixed penalty of £200 may require further consideration as to whether this is sufficient to discourage non compliance in what is considered to be a buoyant industry.

Issues regarding border areas need to be considered where alcohol can still be obtained more cheaply in England. We believe that this will be a significant challenge which could compromise implementation and impact of the bill, particularly for North Wales in terms of its borders with England. Similarly, cross border online shopping and deliveries will require careful thought.

We also believe that potential unintended consequences need further discussion in order to minimise them as much as possible. They include:

- Potential for stronger illicit/ fake alcohol market

- Retailers substituting other products as loss leaders which may potentially have negative impacts for health e.g. high sugar, high fat foods
- Individuals in poverty who drink as much as they can afford each day having to either acquire debt to maintain their dependency or worse, aving to reduce their consumption abruptly. This resulting in potential harm and an influx of hospital admissions for those severely withdrawing. We understand that numbers are proportionately low, however, risk presented could be high and therefore it may be useful to consider a phased/ delayed implementation approach to try and manage this. This is at least worthy of a discussion and increased treatment/ support (e.g. detoxification) may be required to be in place in preparation.
- Potential for problematic/ dependent drinkers reprioritising alcohol over food, rent, electricity etc adding to the health inequalities that exist within this group.

In line with the above is the need for a clear communications strategy regarding implementation and lead up period to ensure readiness for adoption in considering unintended consequences. This is particularly pertinent for health services.

Need to understand a problematic/ dependent alcohol user perspective in order to minimise risks associated with this group and ongoing dialogue during implementation.

BCUHB believe MUP will be an important stride forward in terms of alcohol policy. However, although highly significant and much welcomed, care should be taken that it is not seen as the panacea to tackling alcohol related harm in its entirety as is a multi faceted and complex issue.

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MPA 46

Bil Iechyd y Cyhoedd (Isafbris am Alcohol) (Cymru)

Public Health (Minimum Price for Alcohol) (Wales) Bill

Ymateb gan Eglwys Bresbyteraidd Cymru

Response from Presbyterian Church of Wales

Response to the consultation on the Minimum Pricing of Alcohol

Presbyterian Church of Wales. 15th December 2017

Question 1

We are in favour of the plan to introduce minimum alcohol pricing.

We are also of the opinion that the legislation would help strengthen the present steps that are being taken by the Welsh Government to reduce the consumption of alcohol.

Question 2

We are satisfied that the evidence presented in the Explanatory Memorandum in favour of the aims listed in the question.

Question 3

We agree that setting a minimum price for alcohol for Wales would lessen the strain on the NHS in Wales.

Crime

Setting a minimum price for alcohol would be an important step towards further lowering of the annual incidence of crimes believed to be committed under the influence of alcohol, especially violent crimes. In 2014-2015 the Crime Survey for England and Wales reported that victims believed that 47% of violent crimes had been committed under the influence of alcohol.

http://www.ias.org.uk/Alcohol-knowledge-centre/Crime-and-social-impacts/Factsheets/Alcohol-related-crime-in-the-UK-what-do-we-know.aspx

Recent evidence from New Zealand shows that people who suffer from Foetal Alcohol Spectrum Disorders are 19 more likely to go to prison for offending.

http://www.ias.org.uk/What-we-do/Publication-archive/The-Globe/Issue-1-2013/Children-with-Foetal-Alcohol-Spectrum-Disorder-19-times-more-likely-to-end-up-in-prison.aspx

Question 4. Impact Assessment/Equality and Question 5 on Children and Young People

We believe that introducing a minimum price for alcohol contributes to the Welsh Government's strategy to improve the health and well-being of the following groups ,but that not enough attention was given to this in the Impact Assessment by the Welsh Government in the consultation document.

Marriage, families and children

Alcoholism can lead to marital breakdown and family breakdown. Regarding the effect on families, we would like to see attention given to the effect of alcohol on family breakdown where the parents are still in the care of their parents, but also the effect of alcoholism on the annual number of children in Wales who are taken into the care system, to be adopted or fostered.

There should also be an emphasis on information and policy on the effect of alcohol on domestic violence, in light of the national strategy for preventing domestic violence which is set out in the Violence Against Women, Domestic Abuse and Sexual Violence Act (Wales) 2015.

Preventing Visual Impairment and Hearing Impairment

Visual Impairment can occur because of Foetal Alcohol Syndrome. This should be ntoed in the Imipact Assessment on people with Visual Impariment, as setting a minimum price for alcohol could lead to fewer caes of FAS. The same is true for Learning Difficulties and Hearing Impairment. For example, this year new evidence from Japan was published showing that Hearing Impairment could be caused by pregnant mothers drinking alcohol.

https://www.ncbi.nlm.nih.gov/pubmed/15223541

https://academic.oup.com/alcalc/advance-article-abstract/doi/10.1093/alcalc/agx092/4626776?redirectedFrom=fulltext

Ethnicity and religion

Introducing a minimum price for alcohol would help with regard to improving relations between people of different ethnic and religious backgrounds, as there is evidence that people, especially young people, of ethnic and religious minorities, especially those who practise their religion, are less likely to drink alcohol and drink to excess. At the moment the culture of socialising centred on alcohol excludes very many people of different backgrounds. Here is a survey of the evidence on drinking, ethnicity and religion in the UK (up to 2010).

http://eprints.mdx.ac.uk/7951/1/Hurcombe-ethnicity-alcohol-literature-review-full_0.pdf

Question 7 (Section 1)

The formula and example is easy to understand.

Question 8 (Section 2)

We agree that retailers who sell from a shop in Wales for a price lower than the minimum price should be found guilty of committing an offence. We believe that subsections 3 and 4 are fair.

Question 9 (Section 3 a 4)

There aren’t other places that need to be listed.

Question 10 (Section 5)

We are of the view that the section covers the transactions sufficiently to ensure that alcohl is not supplied at a price below the Minimum Price for Alcohol.

Question 11 (Sections 6 a 7)

These penalties are fair enough.

Question 12 (Section 8 a 9)

We are of the view that the provisions in section 8 will ensure the relevant aims are met.

We believe that the minimum price unit should be enforced by local authorities.

Regarding section 8(3)(a) and (b), we agree that an authorised officer is needed. We would like to know what are the Welsh Government's plans for a job description for such an officer. Would the post-holder be working from the field of social work, or also visiting local schools to do work preventing alcohol abuse?

Question 13 (section 11-13)

We agree with the suggestion made here.

Question 14 (section 15 a 16)

We are of the view that section 15 gives appropriate powers to authorised officers.

We agree with section 16.

Question 15 – Schedule to the Bill

We are satisfied with the contents of the Schedule.

Question 16

<u>Monitoring the effect of the intended law</u>

We agree with the aim of monitoring the effect of the proposed law through collecting annual data by Public Health Wales and other bodies. We wonder whether it is possible to produce data on the effect of parental alcoholism on children, and on alcoholism among individuals on domestic violence and violence against women.

We would also like to recommend adding annual data on the crimes believed to be caused by the effect of alcohol from Welsh police forces, crime surveys such as the Crime Survey for England and Wales and the Crown Prosecution Service.

MPA 47

BIL IECHYD Y CYHOEDD (ISAFBRIS AM ALCOHOL) (CYMRU)

PUBLIC HEALTH (MINIMUM PRICE FOR ALCOHOL) (WALES) BILL

YMATEB GAN

RESPONSE FROM QUAKER ACTION ON ALCOHOL AND DRUGS

Registered Charity No: 1059310
A Company Limited by Guarantee
Registration No 32655669
Director: Alison Mather
[redacted] **E- mail:** [redacted]
Website: www.qaad.org

Quaker Action on Alcohol and Drugs' written evidence to the Health, Social Care and Sport Committee of the National Assembly for Wales on the PUBLIC HEALTH (MINIMUM UNIT PRICE FOR ALCOHOL) WALES) BILL

1. Our work and principles

Quaker Action on Alcohol and Drugs is a Recognised Body of the Religious Society of Friends (Quakers) and a registered charity which became a company limited by guarantee in 1996. It is managed by a Committee of Trustees who are appointed and conduct their business in accordance with Quaker practice as observed by the Religious Society of Friends.

Over many years, QAAD's work has focused on three main strands:

- Reviewing research on issues relating to drug, alcohol and gambling addiction and disseminating key findings through our quarterly newsletter (QAADRANT); a biennial conference; regional meetings; and direct contact with Quakers and professionals, ecumenical colleagues and others with an interest and concern.
- Offering pastoral support and signposting for Friends and close others experiencing substance and gambling addiction and recovery.
- Providing young Quakers with information and resources to help them to make positive, healthy choices about the use and impact of drugs, alcohol and involvement in gambling.

We join with Ecumenical colleagues (the Methodists, the Church of England, the Evangelical Alliance, the Salvation Army and CARE) to demonstrate to MPs and to government that substantial numbers of people understand the need for and welcome changes in policy regarding alcohol.

In 2012, QAAD was included as a co-signatory to a letter to the Prime Minister, David Cameron from several faith based organisations (Appendix 1), calling on him to realise his government's commitment to implement minimum unit pricing for alcohol (MUP).

> *'There are various factors involved in problem drinking, but numerous studies have shown that price is the key determinant. Unless you include strong action on per unit pricing, other measures such as a ban on below-cost sales, a special tax on strong beers or a voluntary code for advertising are likely to be inadequate.'*

We welcome the findings of the 2017 annual report for the Welsh Government's 10 year substance misuse strategy, 'Working Together to Reduce Harm', particularly the progress that has been made on providing speedier access to treatment for those suffering from problematic substance, including alcohol, abuse.

QAAD is responding to this call for evidence due to our serious concern, and that of the Quaker community, with the human costs of alcohol-related harm. The spiritual perspective - that we are all connected - finds an echo in the evidence that problems in the minority are related to wider social behaviours and that 'whole population measures' are most effective.

We are aware that the Welsh Government has already received, and in some cases discussed, substantial quantitative and qualitative, academic evidence in response to this consultation. We judge that it would not add significant value to the process to reiterate data quoted by academics, charities and other specialists in this field. We strongly endorse the evidence which supports the implementation of a 50p MUP in Wales and have included, in the remainder of this submission, further data to support this view.

2 Alcohol harms

Alcohol has long had a central place in British culture. Popular thought tends to associate caution about drinking with old-fashioned moralistic or fringe religious positions. However, the fact remains that, despite more recent reductions in overall consumption, alcohol misuse continues to result in serious public health, criminal justice, community safety and child welfare problems throughout the UK. Awareness of these harms has grown, and clear policy recommendations have emerged from research, but there is still insufficient recognition of the national scale of the problem.

> '*There is...a clear association between per capita alcohol consumption in the UK and various alcohol-related diseases.... an increase of one litre in per capita consumption was associated with approximately ...a total of 928 deaths in the UK per annum.*'[i] Plant, M, (2009)

Such problems are not confined to a small minority of dependent drinkers: it has been estimated that a quarter of adults (10 million people) drink hazardously over weekly recommended levels and more exceed daily limits. About 6% exceed weekly limits by twice the recommended level.[ii] These drinkers account for 73% of total alcohol consumption.[iii]

Co-morbidity of alcohol misuse with drug and gambling addiction, and its dual diagnosis with mental ill-health, are widely recognised and place further, complex demands on health and recovery services. A 2011 European report indicated that, in the UK, 1 in 10 of male cancers and 1 in 33 female cancers are caused by alcohol.[iv]

Alcohol plays a part in a quarter to a third of cases of child abuse, and approximately 300,000 children live with a 'harmful' drinking parent, but with much higher figures for 'binge' or 'hazardous' drinking patterns [v] More recent research (Forrester D, 2012) suggests that one million children reside with a parent with an 'alcohol problem'.

> *'Parental alcohol problems are associated with negative outcomes in children, e.g. poorer physical and psychological health (and therefore higher hospital admission rates), poor educational achievement, eating disorders and addiction problems (West & Prinz, 1987; Girling et al., 2006), many of which persist into adulthood (Balsa et al., 2009).'*

In its 2014 report, Alcohol and Health in Wales 2014, the Public Health Wales Observatory confirmed that alcohol is a major cause of death and illness in Wales, with around 15,000 (1 in 20) deaths attributable to alcohol each year.

In addition, this report highlighted that 1 in 6 boys and 1 in 7 girls aged 11-16 years old had drunk alcohol and around 400 young people are admitted to hospital for alcohol-specific conditions each year, although this rate has been decreasing for several years. The percentages of young people drinking alcohol at least once a week are higher in Wales than in Scotland, England and Ireland. Cheap alcohol

plays a significant role in initiating and sustaining early problematic drinking that continues into adulthood. Minimum pricing per unit would mean fewer people become severely dependent.

Almost half (49%) of offenders have an alcohol problem relevant to their offending[vi], and a Parliamentary answer in November 2010 stated that 37% of offenders subject to community penalties have an alcohol issue.

2. Support for MUP

MUP correlates directly with the level of alcohol content in a drink, irrespective of the type of drink and where it is sold. This will enable the Welsh government to regulate the price of drinks favoured by the heaviest drinkers i.e. with the highest alcohol content, whilst sending out a clear message that alcohol content is the key issue for all drinkers.

MUP has previously been recommended by the Chief Medical Officer (2009), the Royal College of Physicians, the British Medical Association (2008), the National Institute for Clinical Excellence (NICE, 2010), the all-party Parliamentary Committee on Alcohol (2010), and Alcohol Concern (2016). National and international studies have consistently shown that consumption - both harmful and general - rises and falls with price[vii].

> *'The evidence reviewed supports the general principle that increasing alcohol price reduces alcohol consumption by young people, with a greater impact on more frequent and heavier drinkers.'* [viii] *'Home Office review of evidence on pricing, 2011*

3 The Potential Benefits of introducing an MUP

The ScHARR report estimates that a minimum price of 50p per unit would result in significant reductions in alcohol related hospital admissions and fatalities; violent crime, and absenteeism from work. It predicts reductions in consumption for young people and adults in higher-risk categories, and cost savings in the first year alone of £66m (health) and £49.6m (criminal justice). Potential savings in deep, long-term personal costs of family breakdown, child abuse and neglect, job loss, and many other impacts of alcohol misuse are incalculable.

Given that the Sheffield model suggests that such benefits increase over time, the introduction of an MUP would be a preventative measure as well as one that addresses current problems. Over ten years, £1.37 billion in health care costs could be saved, with an immeasurable benefit in quality of life for individuals, families and communities.

One of the strongest arguments for a minimum price per unit is that this policy is the most likely to be effective in reducing drinking and harmful drinking among children and young people.

> *'There is strong evidence to suggest that young drinkers, binge drinkers and harmful drinkers tend to choose cheaper drinks.' (ScHARR report, page 5)*

A study of 15-16 year olds showed that disposable income was related to consumption, and that drinking cheap alcohol in volume was associated with various kinds of harm. It also showed that these harms could occur at any level of drinking.[ix]

> *'Results suggest a strong relationship between consumption of cheaper alcohol products and increased proportions of respondents reporting violence when drunk, alcohol-related regretted sex and drinking in public places.' Bellis et al. (2009)*

MUP may also have an impact on the market. For example, Over half (57%) of women's total alcohol consumption is in wine,[x] which has become stronger over recent years. A bottle of 10% proof wine contains 7.5 units; a bottle of 14.5% proof wine contains 10.9 units. The respective cost, at 50p per unit, would be £3.75 and £5.45: cheap wine would be more likely to mean weaker wine.

4 Objections to minimum unit pricing

The majority of responsible drinkers should not be penalised for the minority

- There might be differential effects on individuals depending on the cost of the alcohol that an individual favours but the average financial impact on moderate drinkers would be relatively light.
- 'Softer' benefits, in terms of greater safety and amenity for example, would also be experienced by moderate drinkers. Environmental ill-effects are felt particularly acutely in poorer areas.
- Even drinking within recommended limits is not risk-free. Approximately 10% of those who drink within current daily/weekly limits have a lifetime risk of dying from an alcohol-related condition.
- Cheap alcohol enables daily drinking, which increases lifetime risk even at relatively low levels. The protective effects of small amounts of alcohol for the cardio-vascular system, which have received publicity, apply in small quantities and mainly to middle-aged people. [xi]

MUP would penalise those on lower incomes

- People in the most deprived groups are more likely not to drink at all: one study found only a third of households in the lowest income band purchased alcohol in the last week, as opposed to 70% in the highest.[xii] The same study showed that the purchase of low-priced alcohol is distributed across income groups.
- People on lower incomes are more likely to drink 'on-trade' (for example, in pubs) where prices would be largely unaffected.
- People in less advantaged socio-economic groups are more likely to suffer alcohol-related harm if they do drink, possibly due to health and social problems exacerbating each other (as the book 'The Spirit Level'[xiii] would also suggest). In the most deprived areas, men are five times as likely to die of an alcohol-related illness compared with those in the most affluent areas; women are three times as likely.[xiv]

  'The proportions of people exceeding 4/3 units and of people drinking heavily rose with increasing gross weekly household income. In households with a gross weekly income of £200 or less, 30% of men drank more than 4 units and 14% drank more than 8 units on at least one day in the previous week. In households with an income of over £1,000 the figures were 46% and 26% respectively.[xv]

Hazardous and problem drinkers would be unlikely to change their behaviour because they are dependent

- There is relatively little research on the most heavily dependent group and findings are inconclusive. Whilst some researchers have argued that they are less price-responsive, others suggest the opposite is the case:

  '*Contrary to our expectations, the heaviest drinkers changed their consumption most. They were quite sensitive to price. Furthermore, that group showed a marked reduction in all kinds of health measures.' Dr Bruce Ritson, describing the effects of increased prices in evidence to the Scottish health committee.*[xvi]

'Harmful drinkers have both a higher mortality risk and respond to policy changes with larger absolute changes in consumption than moderate and hazardous drinkers.' ScHARR report (p124)

- It is true that MUP could present difficulties for some dependent drinkers, but we strongly believe that increased access to high quality treatment and support (rather than to cheap alcohol) needs to be the response.

Falls in overall alcohol consumption suggest that problems will also begin to fall without such drastic measures

- It is true that there has been a fall in consumption and risky consumption from a high-point in 2007/8, although women's drinking and harmful drinking has shown one of the steeper increases[xvii]. However, levels of consumption and risky drinking are still extremely high in historical terms, and are now similar to those in 2004. Hospital admissions for alcohol-related conditions have continued to rise and 70% of peak time attendances to Accident and Emergency Departments are alcohol-related.
- The vast majority of people drinking over recommended limits are not dependent, but they are drinking enough to damage their health:

  'The health dangers of domestic drinking are less apparent because binge-drinking, though technically referring to episodes of heavy alcohol consumption, has come in cultural terms to mean dangerous drinking by young people in town centres. Thus many interviewees, whose home consumption far exceeded government-recommended weekly limits, continued to regard their own practice as unremarkable and felt unwarrantedly insulated from public health messages....' [xviii] Professor Gill Valentine

  'Our work has shown that the majority of these individuals are heavy social drinkers often with only mild levels of alcohol dependency but they present with diseases which are fatal in 25-50% of cases.' Dr Nick Sheron, Liver specialist.[xix]

- This group is the most likely to underestimate personal consumption, and switch to cheaper drinks if costs rise. The ScHARR research found that the higher the minimum price level is, the less 'switching' there would be, because there would be fewer 'pockets' of cheap alcohol:

  'Policies targeting price changes specifically on low-priced products lead to smaller changes in consumption, as they only cover a part of the market. Targeting low priced products also causes some switching.... Higher minimum prices reduce switching effects.' ScHARR report (p6)

- Even if consumption figures fall, they are far too high. The economic climate may be linked with the downturn in drinking, but whatever the reasons, alcohol consumption remains far too high given the serious risks to health and social wellbeing. The price of alcohol needs to be rebalanced to reduce harm - and this needs to be done on the rational basis of alcohol content.

Action targeting sales of alcohol to under-aged drinkers is enough to tackle youth alcohol problems

We welcome increased penalties for sale of alcohol to under-age drinkers, together with Identity/proof of age schemes. However, Scottish evidence suggests that despite more stringency about the law, the buying of alcohol by third parties remained an important problem, and this is obviously much harder to police.[xx] The affordability of alcohol for children and for young legal drinkers needs to be tackled alongside accessibility. These are complementary rather than alternative policies, which will be more effective if combined.

6. Conclusion

Should the decision be taken to implement an MUP, Wales will join Scotland as one of the first two territories in the world to introduce MUP based solely on the alcoholic strength of drinks. The impact cannot be guaranteed, only anticipated on the basis of extensive and peer reviewed research. We strongly support Alcohol Concern's call for a robust evaluation of MUP, together with a 'sunset clause' which would enable the Welsh Government to refine or reverse its implementation in the light of real world findings.

MUP alone cannot resolve the many and complex issues associated with the misuse of alcohol. QAAD supports a range of additional measures which, if combined with MUP, could make a significant, positive impact on individuals, families, employers and wider communities. These include tax or other incentives to favour lower alcohol drink; the banning of promotions/discounting; the prevention of advertising that affects children; an increase in licensing controls; and a lowering of the blood alcohol limit for legal driving to 50 mg. We strongly support increased investment in prevention and treatment.

MISSION & PUBLIC AFFAIRS

27 January 2012

The Rt Hon David Cameron MP
Prime Minister
10 Downing Street
London
SW1A 2AA

Please respond to:
Joint Public Issues Team
Methodist Church House
25 Marylebone Road, London NW1 5JR
Tel: [redacted]
Email: [redacted]

Dear Prime Minister

We write to you as a coalition of Churches, charities and Christian volunteer groups with long running experience in the field of alcohol policy, and in helping individuals and communities harmed by alcohol misuse.

We welcome recent indications that, in recognition of the danger posed by cheap alcohol, the Government is seriously considering the introduction of a per unit minimum price. We believe that action on pricing must form the central element in the Alcohol Strategy which your Government is due to publish in February. There are various factors involved in problem drinking, but numerous studies have shown that price is the key determinant. Unless you include strong action on per unit pricing, other measures such as a ban on below-cost sales, a special tax on strong beers or a voluntary code for advertising are likely to be inadequate.

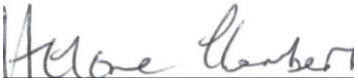
We recognise that there may be complex legal issues involving competition law. But current levels of ill health and public disorder associated with problem drinking mean that these issues must be addressed. In 2011, leading medical experts including Sir Ian Gilmore (Chairman of the UK Alcohol Health Alliance) and Andrew Langford (Chief Executive at the British Liver Trust), predicted that unless strong action is taken 250,000 lives could be lost over the next 20 years. They specifically advocate introducing a minimum unit price of 50p and implementing stricter controls on advertising. Alcohol misuse costs the UK an estimated £25 billion per year in public spending, without even considering the serious (but

harder to measure) effects on people's wellbeing, including their mental health, family and social relationships and careers.

A YouGov poll commissioned by the Methodist Church and its partners in November 2011 found that 61% of UK adults felt that excessive drinking was a problem in their neighbourhood. We have seen the effects of cheap, strong drink on our streets, in our hospitals and police stations. It is in local communities that the damage caused by alcohol misuse is felt most deeply, particularly disadvantaged communities, which continue to suffer disproportionately from alcohol-related harms. Furthermore, it is estimated that between 1.3 and 2.6 million children are affected by parental problem drinking. Neglect is a particular concern and these children are more vulnerable to developing other problems, including substance misuse. A joined-up national solution for these issues is clearly in the UK's best interests as a whole.

Some are concerned that per unit minimum pricing would penalise responsible drinkers. But research by the University of Sheffield found that a minimum price of between 40p and 50p per unit would save thousands of lives at the cost of only a few extra pence per week to the average drinker.
Legislation containing provisions for per unit minimum pricing will soon be considered by the Scottish Parliament. Northern Ireland and the Republic of Ireland are developing a cross-border alcohol strategy and working towards the possibility of agreeing a minimum price by December 2012. We are very encouraged by reports that you have taken a lead on per unit minimum pricing, as this is central to ensuring the success of the Alcohol Strategy. This is an opportunity for the Government to make a real difference to communities and vulnerable people across the UK.
Yours sincerely,

Dr Dave Landrum
Director of Advocacy
Evangelical Alliance



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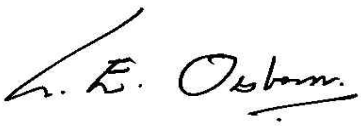

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Health, Social Care and Sport Committee
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December 2017

Asda Consultation Response: Health, Social Care and Sport Committee Inquiry into the General Principles of the Public Health (Minimum Price for Alcohol) (Wales) Bill

About Asda

Founded in the 1960s in Yorkshire, Asda is one of Britain's leading retailers and helps customers save money and live better through shopping in our stores, online and through their mobile devices. Asda has 646 stores across the UK employing more than 150,000 people, including 43 sites in Wales employing more than 10,000 colleagues. Our main office is in Leeds, Yorkshire and our George clothing division is in Lutterworth, Leicestershire.

Asda and alcohol

Alcohol consumption in the UK has been on a sustained downward trajectory for more than a decade, with the most recent ONS data showing that the proportion of adults drinking alcohol at the lowest level on record: only 56% had had a drink in the week before being interviewed - a fall from 64% in 2005. Binge drinking and harmful drinking have also declined by 17% and 23% respectively since 2005, and the proportion of young people who are teetotal has risen over the same period.

There is, however, still a long way to go, and at Asda we accept that more can be done to tackle alcohol misuse. As a responsible retailer, we continue to demonstrate our willingness to act by implementing an extensive package of retail measures and advocacy work to ensure we sell alcohol responsibly and help our customers to make informed choices.

In 2010 we made a voluntary commitment not to sell alcohol at a price below the cost of excise duty plus VAT – the only retailer to commit to doing so – and we offer a wide range of low or alcohol-free products to help customers moderate their alcohol consumption. We were the first retailer to introduce Challenge 25 in every store and we use an independent verification system (Serve Legal) to ensure that all of our colleagues are applying the policy consistently and appropriately.

We have voluntarily delisted certain high alcohol products from our shelves and reduced the alcohol content of others. The products we have removed from sale include all strong white cider, including Frosty Jacks (7.5% ABV) and Diamond White (7.5% ABV) and all non-premium, high-strength beers and lagers including Tennent's Super (9% ABV) and Carlsberg Special Brew (8% ABV). We do not sell any carbonated product with more than four units of alcohol in a single-serve can or 15 units in a PET plastic bottle.

We support Community Alcohol Partnerships (CAP) that aim to tackle public underage drinking and alcohol related anti-social behaviour through co-operation between alcohol retailers and local stakeholders. We currently participate in 18 local partnerships across the UK and continue to work

closely with new CAPs as they develop. We would encourage communities in Wales to get in touch with the CAP team if they would like to set one up in their area.

We are a leading funder of alcohol education charity Drinkaware, and this year extended our partnership to deliver alcohol awareness information events to Asda shoppers in 100 of our top alcohol selling stores, including four in Wales. Due to the success of these events, which actively engaged over two thousand customers, we will be repeating the activity in January 2018.

General principles of the Bill

While we welcome the intention of the Welsh Government to tackle alcohol misuse, we believe that the introduction of minimum pricing will penalise responsible drinkers on low incomes and could result in significant and undesirable unintended consequences.

Evidence shows that a relatively small number of drinkers in the UK consume a disproportionately large amount of alcohol, with close to 70% of alcohol consumed by one fifth of the population. Heavy drinking amongst a minority drastically pushes up the average. Policies which aim to reduce per capita alcohol consumption through price controls not only fail to help problem drinkers, but punish the majority of responsible consumers.

Independent research by the Centre for Economic and Business Research (CEBR) shows that minimum pricing is a regressive measure that will have the biggest impact on those on the lowest incomes. This is despite the evidence showing that low earners drink less and are less likely to exceed recommended drinking guidelines than those in higher income groups. Recent evidence from the ONS shows that the highest earners (those earning £40,000 and above annually) are more likely to be frequent drinkers and twice as likely to "binge" on their heaviest drinking day when compared with the lowest earners.

Minimum pricing also fails to target irresponsible drinking: when calculating the elasticity of alcohol products, the Sheffield model's analysis shows that, overall, heavier drinkers are least responsive to price changes. Responsible drinkers on a budget will be hit harder than irresponsible drinkers with higher incomes.

The architects of the Sheffield Study have admitted that minimum pricing will not tackle binge drinking. In fact, the research shows that those drinkers most commonly associated with alcohol-fuelled crime and antisocial behaviour are amongst the least likely to be affected.

There is widespread evidence from around the world that there is no simple link between alcohol price, consumption and harm. Indeed, other countries alongside the UK with the highest alcohol taxes and highest prices, such as Sweden and Ireland, also experience problems with alcohol misuse. France actually has higher levels of overall consumption than the UK, but they don't see the same levels of alcohol related harm. This suggests that alcohol consumption is more closely associated with cultural factors than price and availability.

Cost of living

As a value retailer, we believe minimum pricing will unfairly increase the basket-spend for the vast majority of our responsible customers, many of who are on limited incomes, at a time when household incomes continue to be squeezed and inflation continues to rise. In the two most recent

Asda Income Tracker reports, produced alongside the Centre for Economics and Business Research, we found that the discretionary income of the average family in Wales had stagnated at £170 a week, behind the UK average of £198, whilst food price inflation rose to 4% in October reaching a four year high. In this context, minimum pricing would represent a significant additional burden on our Welsh customers at a time when they can least afford it.

It's important to remember that pricing is subjective, and for many of our customers our prices are not 'cheap', they are affordable. Minimum pricing wrongly assumes that everyone who looks for value for money is a binge-drinker.

Unintended consequences

Minimum pricing is an artificial market intervention which currently exists in no comparable country on a nationwide basis, and it is therefore hard to assess what its impact will be on sophisticated market dynamics. It is likely to have a number of significant unintended consequences, in addition to increasing prices for responsible drinkers.

The likelihood of cross border trade is significant, as demonstrated by our experience in Northern Ireland. As well as being the top performers in the chain, our border stores significantly outperform the rest of the chain on alcohol sales, with many customers driving over an hour and a half from across the Republic of Ireland. Importantly, when they travel they also do so for their wider grocery shopping. Retailers with no physical presence in the Republic of Ireland now have almost 2% of the grocery market due to cross border trade.

We have nine Asda superstores within 40 minutes' drive of Welsh borders, including two superstores within five miles of the Severn Bridge – where tolls will soon be scrapped – and three within five miles of the border in North Wales. We would expect distortions in trade in these concentrated areas where customers are likely to make purposeful trips to buy alcohol in England. In these circumstances, we expect some customers will divert their entire grocery shopping away from Welsh stores, putting trade and potentially jobs at risk.

Online sales are a fast growing market and this Bill will provide a boost to that growth. It is very likely that many customers will choose to purchase alcohol online from retailers based in England if a significant price gap opens up. This raises the prospect of a digital divide where often lower income groups will be faced with higher prices, while more affluent consumers will avoid price hikes through internet purchases. It will put Welsh businesses, including Asda's Welsh stores, at a competitive disadvantage.

Major price differences with England will also promote black market sales through both organised crime and 'white van man' deliveries, often in the most deprived areas without concern for selling to under 18s. It will be easier for counterfeit alcohol to be passed off as cheap alcohol from England.

A large proportion of in-store theft already occurs in our beers, wines and spirits aisle, with a particular concentration on spirits, and we expect this to increase should prices rise with the introduction of minimum pricing.

Minimum pricing is also likely to cause a significant increase in waste, which has serious implications for sustainability and cost. From time to time all retailers will have unsold or redundant stock, which includes items with a limited shelf life, products with label and packaging damage, and deleted lines.

Reducing the price of these items by even the smallest amount usually allows all this stock to be sold. Under minimum pricing, however, such stock clearance discounts will be prohibited, and retailers will be forced to resort to disposal. Given that most alcohol products are packaged in glass, both the monetary costs and the environmental impacts of this disposal will be high. At Asda, our aim is to send zero waste to landfill, from any part of our operations, and this unintended consequence of minimum pricing will be a serious consideration for the business.

Business costs of implementation

In addition to the likelihood of increased thefts and the impact of cross-border sales, there are significant costs for businesses in Wales – large and small – associated with the implementation of complex new systems to handle minimum pricing. As an indication of the scale of these costs, preparing our pricing systems for the implementation of minimum pricing in Scotland cost Asda more than £1million and took approximately three years.

Evaluation and implementation

At Asda we do not believe that minimum pricing is the solution to tackling alcohol misuse. If the Welsh Government is determined to proceed, however, and believes that it has the legislative competence to bring forward a legal and workable scheme, then there are some key considerations that must be taken into account.

The Scottish Government is due to implement minimum unit pricing, likely to be set at a price of 50p per unit, on 1 May 2018. It is imperative that any system of minimum pricing introduced in Wales mirrors that introduced in Scotland, including the price per unit, to avoid worsening the market distortions and creating further complexity and cost for businesses operating across the UK. The system should also replicate the Scottish approach in terms of the practical details of retailer implementation, including, for example, the treatment of meal deals containing alcohol products and customer goodwill vouchers.

The Welsh Government should allow for a sufficient implementation period for businesses to upgrade their systems and prepare for the likely unintended consequences. We believe that an implementation period of a minimum of two years after the Bill reaches Royal Assent would be appropriate.

We welcome Section 21 and 22 of the Bill that will legislate for the reporting of the effectiveness of the Act at the end of a five year period and will feed into whether the Government of the time make regulations to prevent the repealing of the Bill. The legislation must be robustly monitored on a wide range of indicators including consumption and harm levels, the knock-on impact on substance misuse, the impact on responsible drinkers on low incomes, rates of illicit trade and the extent of cross-border trading. There must also be a detailed and independent evaluation of the claims made in the Sheffield study, including about the reductions in crime and harm. The evaluation must be open to consultation from a broad range of stakeholders, including industry.

For further information:
Chris Lowe, Senior Director – Public Affairs [redacted]

MPA 49

Bil Iechyd y Cyhoedd (Isafbris am Alcohol) (Cymru)

Public Health (Minimum Price for Alcohol) (Wales) Bill

Ymateb gan Byddin yr Iachawdwriaeth

Response from Salvation Army

Public Health (Minimum Price for Alcohol) (Wales) Bill

Response from The Salvation Army to the Welsh Government's Health and Sports Committee's call for a response on the Public Health (Minimum Price for Alcohol) (Wales) Bill

11 December 2017

Introduction

The Salvation Army has worked with women and men with problematic substance use since it was founded in the nineteenth-century – and we continue to do so today, offering aftercare and rehabilitation services, psycho-social support, education and training amongst other things. It is in our day-to-day work that we witness first-hand the devastating effect drugs and alcohol dependency can have on individuals, as well as their friends and families.

For this reason we welcome the introduction of this Bill and would like to reiterate our support for a policy of minimum unit pricing (MUP), making the following points:

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

There are multiple advantages of introducing MUP, not least as a means of reducing the social harm associated with excessive drinking. Indeed, as a recent study by Sheffield University[1] has highlighted:

- There is a link between the price and availability of alcohol and societal problems: namely, that as alcohol becomes more affordable the number of alcohol-related deaths and hospital admissions increases;
- The number of alcohol-related hospital admissions and deaths increases as levels of social deprivation rise.

We would also add that, as well as coming at a significant financial and human cost, harmful drinking has a further impact on other areas, such as levels of crime and family trauma.

Much to our concern, further studies have cited examples of alcohol being available for as little as 14p per unit and that two cans of 'own brand' lager can be purchased for less than the price of branded Cola.[2] An appropriately set minimum unit price will effectively remove 'cheap' alcohol from the market, which tends to be purchased by harmful drinkers (including young, underage drinkers), with evidence suggesting that the alcohol consumption of the heaviest drinkers will also be affected by price.[3] This research, along with other academic studies, shows that a policy of MUP could not be more warranted.

[1] Model-based Appraisal of the comparative impact of Minimum Unit pricing and taxing policies in Wales: Interim report - an update to the 50p MUP example (Cardiff: Welsh Government 2017)

[2] *The Four Steps to Alcohol Misuse*, Alcohol Focus Scotland, Scotland Health Action on Alcohol Problems, Balance, the North East Alcohol Office and Our Life (November 2011)

[3] Model-based Appraisal of the comparative impact of Minimum Unit pricing and taxing policies in Wales

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

It has been argued previously that MUP would be against European legislation and that, if passed into law, such a policy will be challenged by the alcohol industry and result in protracted legal battles. However, as the Scottish example has recently shown, such rulings can be overcome - paving the way for the Welsh Government to push on with addressing the practice of selling low cost alcohol and tackling alcohol-related problems.

It has also been postulated that MUP will adversely impact the poorest communities in Wales. The Sheffield University study confirms this will indeed be the case (especially for those drinking harmfully and hazardously).[4] However, through our work with those who are most marginalised and excluded from society, we also know that it is these groups who are most disproportionately affected by alcohol misuse. Indeed, the same study goes on to explain that, according to the Welsh Index of Deprivation (WIMD), those from the most deprived communities are much more likely to be admitted to hospital, or die, as a result of harmful drinking than their better off counterparts. We therefore welcome any intervention that makes a significant difference to the health of a population group which has been difficult to engage in recent years and who, with the introduction of MUP, would have the most health benefits to gain.

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

This is a matter for experts to decide; however it is important that the minimum price set is sufficiently high so as to have an impact on purchasing behaviour. Research by Sheffield University has produced a convincing model measuring the potential impact of MUP on a variety of population groups. The findings indicate that:

- Setting a level of 50p per unit would result in a significant reduction in alcohol-related harms, whilst ensuring alcohol remains affordable for moderate drinkers;
- Alcohol consumption would be reduced across all population groups, with the most significant reduction noticed amongst harmful drinkers from the most deprived areas (a relative change of -25.6%)[5]

Alongside the obvious public health benefits for our population, there would also likely be a significant reduction in alcohol-fuelled crime and disorder, thus improving the safety of our communities. We therefore support a starting position of 50p per unit and would recommend that the MUP is set by secondary legislation, in order that Ministers are able to vary the price as circumstances change.

4. The rationale behind the use of minimum pricing as an effective tool.

There is a significant body of research on the relationship between the price of alcohol and consumption levels. In one such piece of research the authors concluded:

"…price affects drinking of all types of beverages, and across the population of drinkers from light drinkers to heavy drinkers. We know of no other preventive intervention to reduce drinking that has the numbers of studies and consistency of effects seen in the literature on alcohol taxes and prices".[6]

[4] Model-based Appraisal of the comparative impact of Minimum Unit pricing and taxing policies in Wales
[5] Ibid
[6] 'Wagenaar, AC, Salios, MJ, Komoro, KA, 'Effects of beverage alcohol price and tax levels on drinking: a meta-analysis of 1003 estimates from 112 studies, Addiction, 104, 179-190, society for the study of addiction' (2009)

Further evidence suggests that consumers of alcohol increase their drinking when prices are low, and decrease their consumption when prices rise.[7] Therefore, public health can be protected and improved with the introduction of such a policy lever. This Bill presents a window of opportunity to do just that.

Conclusion

The introduction of MUP would have untold benefits for both our society and economy. Whilst we accept that the introduction of MUP will not, in itself, resolve Wales' alcohol-related problems, it is at least a step in the right direction. We see MUP as part of *a range of measures* aimed at improving the health and wellbeing of the Welsh people. And so we will continue to challenge the Welsh Government to invest in social programmes, to support families and create attitudinal change, which will together encourage positive choices about the role of alcohol in our lives.

The problem of alcohol misuse is not unique to Wales. It is a global issue. It is, therefore, positive to see the Welsh Government in the vanguard of countries that are developing innovative national policies to address this seemingly intractable problem. Addressing the price and availability of alcohol through legislation are consistently recognised as effective, public health interventions and we would encourage others to similarly follow suit.

We welcome the opportunity to feed into this consultation and look forward to engaging with further discussions on this matter.

Major Lynden Gibbs, Addictions Support Officer, The Salvation Army

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MPA 50

Bil Iechyd y Cyhoedd (Isafbris am Alcohol) (Cymru)

Public Health (Minimum Price for Alcohol) (Wales) Bill

Ymateb gan Bwrdd Iechyd Prifysgol Aneurin Bevan

Response from Aneurin Bevan University Health Board

Aneurin Bevan University Hospital Board

Response to the Health, Social Care and Sport Committee on the Public Health (Minimum price for Alcohol) (Wales) Bill

1. Introduction

Aneurin Bevan University Health Board (ABUHB) welcomes the opportunity to respond to the Health, Social Care and Sport Committee consultation on the Public Health (Minimum Price for Alcohol) (Wales) Bill.

ABUHB strongly support the implementation of the minimum unit pricing for alcohol in Wales and have articulated the same opinion in previous consultation submissions, which include a comprehensive response to the Public Health (Wales) Bill in 2015. ABUHB's position supporting the implementation of MUP in 2015 has been strengthened by further evidence which has since been published, and highlighted below.

As outlined in ABUHB's submission in 2015:

- There is evidence that excessive alcohol consumption significantly increases short and long term harms to health. Evidence indicates that increased consumption is linked to increased harm: there is a dose-harm response[1]. The UK Chief Medical Officers report reinforced this, concluding that the risk of developing health problems increases with the amount of alcohol consumed on a regular basis[2].

- There is clear evidence linking the affordability of alcohol with the quantity of alcohol consumed (and thus resultant alcohol harms). More than 100 international studies clearly demonstrates a link between the affordability of

[1] APoSM/Advisory Panel on Substance Misuse (2014) Minimum Unit Pricing: A review of its potential in a Welsh context

[2] UK Chief Medical Officers (2016) Low Risk Drinking Guidelines

alcohol and alcohol consumption[3]. Alcohol has become steadily more affordable in recent years, with there being a real term reduction in the cost of alcohol[4].

- There is strong evidence to support decreasing the affordability of alcohol to reduce consumption and thus reduce harm from alcohol[5]. When the price of alcohol increases consumption by most drinkers reduces including, critically, consumption by hazardous and harmful drinkers[6]. When alcohol consumption in the population declines, rates of alcohol related harms also decline[7]. The intervention for increasing affordability with the strongest evidence is Minimum Unit Pricing (MUP) of alcohol[8].

In conclusion robust evidence indicates that:

(i) alcohol consumption levels are linked with levels of harm
(ii) affordability is one of the key drivers of alcohol consumption, and
(iii) MUP is the most effective price mechanism to reduce the affordability of alcohol

Since the ABUHB consultation submission in 2015 there has been additional published evidence which provides further insight into the harms caused by alcohol. This includes an extremely comprehensive review of the evidence of the health harms associated with alcohol consumption resulting in new low risk drinking guidelines published in 2016: the UK Chief Medical Officers' Low Risk Drinking Guidelines, published in 2016. Other reports which ABUHB considered are: Public Health Wales (2015) 'Adverse Childhood Experiences and their impact on health-harming behaviour in the Welsh adult population', Alcohol Health Alliance (2016) 'Cheap Alcohol, the Price We Pay'.

2.1 Terms of Reference

The general principles of the Public Health (Minimum Price for Alcohol) (Wales) Bill and the extent to which it will contributed to improving and protecting the health and well-being of the population of Wales, by

[3] Alcohol Concern (2015) All Party Parliamentary Group on Alcohol Misuse Manifesto 2015

[4] Public Health Wales (2014) Public Health Wales NHS Trust Response to the Health and Social Care Committee Consultation on the Public Health (Wales) Bill

[5] Welsh Government (2014) Working Together to Reduce Harm. Substance Misuse Strategy Annual Report 2014

[6] Public Health Wales (2014) Public Health Wales NHS Trust Response to the Health and Social Care Committee Consultation on the Public Health (Wales) Bill

[7] Ibid. Public Health Wales (2014)

[8] University of Sheffield (2014) Model-based appraisal of minimum unit pricing for alcohol in Wales - An adaptation of the Sheffield Alcohol Policy Model version 3

providing for a minimum price for the sale and supply of alcohol in Wales and making it an offence for alcohol to be sold or supplied below that price.

ABUHB support the general principles of the Public Health (Minimum Price for Alcohol) (Wales) Bill after considering the following evidence:

Alcohol consumption linked to affordability

Evidence indicates that recent decades have seen increases in alcohol consumption and health harms associated with alcohol consumption in Wales. These increases in consumption and harms are associated with real terms reductions in the cost of alcohol (alcohol being more affordable). Introducing a MUP for alcohol would be a targeted measure of increasing the price (and therefore reducing affordability) of alcohol. This approach would target those at greatest risk of harm from their drinking: heaviest drinkers and those at particular risk from alcohol related harm such as young people.

There is strong evidence that alcohol affordability is one of the main determinants of alcohol consumption and resultant level of alcohol harms. More than 100 international studies clearly demonstrate a link between the affordability of alcohol and alcohol consumption[9]. There is overwhelming evidence to support policies which reduce affordability[10].

MUP is based on two fundamental principles:

1. When the price of alcohol increases, consumption, especially by the heaviest drinkers, goes down, and:
2. When alcohol consumption in the population declines, the rates of alcohol related harms decline[11].

Health harms from alcohol consumption

Drinking alcohol increases the risk of developing over 60 different health problems[12] as well as increasing the risk of causing a range of harms to others[13]. Worldwide, the harmful use of alcohol ranks amongst the top five risk factors for

[9] Alcohol Concern (2012) 2011-2012 public affairs briefing

[10] Ibid. APoSM/Advisory Panel on Substance Misuse (2014)

[11] Public Health Wales (2014) Public Health Wales NHS Trust Response to the Health and Social Care Committee Consultation on the Public Health (Wales) Bill

[12] World Health Organisation (2009) Evidence for the effectiveness and cost-effectiveness of interventions to reduce alcohol related harm

[13] Quigg et al (2016) Alcohol's Harms to others: the harms from other people's alcohol consumption in Wales

disease, disability and death[14]. Recent decades have seen increases in alcohol consumption and associated health harms across Wales[15]. These harms are preventable. Alcohol misuse is detrimental, not only to the drinker, but also in the harm to their family and local community. Alcohol misuse places an avoidable burden on public services. The estimated to cost the Welsh nation is £1 billion per year[16] (Alcohol Concern Cymru, 2013), with the cost to the NHS in Wales for alcohol related hospital admission in 2012-13 being £109m alone[17].

The anticipated benefits of MUP: the modelling

The OECD report[18] stated that *"approximately four in five drinkers would decrease their risk of death by cutting their alcohol intake by just one unit per week".* A model-based appraisal of MUP in Wales conducted by the Sheffield Alcohol Research Group for a MUP of 50p estimated that there would be a reduction in alcohol consumption for the overall population per person of 4% (30 units per drinker per year).

The Sheffield Alcohol Research Group, Sheffield University, applied the Sheffield Alcohol Policy Model (SAPM) in Wales and estimated that a 50p MUP would result in:

- 53 fewer deaths a year
- 1,400 fewer hospital admissions a year
- 3,684 fewer criminal offences a year
- 10,000 fewer absent days from work a year from heavy drinking

The SAPM indicates savings of £131 million over 20 years relating to direct costs to healthcare services over 20 years. The authors concluded that the societal value of these impacts totals £882 million over the 20 year period. This figure includes savings from healthcare costs, reduced crime and policing, reduced workplace absences and financial valuation of the health benefits measured in quality-adjusted life years[19].

MUP and the impact on crime and associated costs to health and well-being

[14] Public Health Wales (2014) Public Health Wales NHS Trust Response to the Health and Social Care Committee Consultation on the Public Health (Wales) Bill

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[16]

[17] WG (2015) Draft Public Health (Minimum Price for Alcohol (Wales) Bill Explanatory memorandum

[18] Sassi, F.(ed.) (2015), *Tackling Harmful Alcohol Use: Economics and Public Health Policy*, OECD Publishing, Paris.

[19] University of Sheffield (2014) Model-based appraisal of minimum unit pricing for alcohol in Wales - An adaptation of the Sheffield Alcohol Policy Model version 3

The Crime Survey for England and Wales reported that within the year 2011/12 there were 917,000 violent incidents where the victim believed the offender(s) to be under the influence of alcohol, accounting for 47% of violent offences that year. Alcohol routinely accounts for over 40 per cent of all violent crimes committed and, as well as youth violence, is strongly associated with domestic violence, child abuse and self-directed violence such as suicide[20].

The SAPM estimated that the cost of alcohol related crime would fall by £248 million over 20 years, with an estimated 3,684 offences a year resulting from a MUP of 50p. As well as reducing the harm to the individual who is drinking, it can also impact on the wellbeing of family members, friends and the wider society through reducing alcohol related crime, including anti-social behaviour and domestic violence.

MUP would target those experiencing most harm from alcohol consumption

MUP operates at a population level to reduce alcohol consumption and primarily targets drinkers who tend to drink alcohol which is cheap relative to its strength. The modelling undertaken by the Sheffield Alcohol Research Group[21] demonstrated that the implementation of MUP in Wales would have a small impact on moderate drinkers, and the greatest impact on hazardous and harmful drinkers as they tend to favour the under priced/discounted alcoholic drinks which will be mostly affected by the implementation of a 50p MUP. These are the drinkers who are causing most harm to themselves and society.

MUP would target those living in poverty who consume alcohol

The SAPM estimated that the greatest positive health improvement impact would be experienced by adult drinkers living in poverty. Sheffield Alcohol Research Group estimated that people living in poverty who are hazardous drinkers would reduce their consumption by 6.2% or 84.3 units per year as compared to those hazardous drinkers not in poverty who would reduce their consumption by 1.2% or 17.7 units per year. When comparing harmful drinkers it was estimated there would be a reduction of 13% (or 487.3 units) a year for harmful drinkers living in poverty compared to a reduction in consumption by 5.8% (or 243 units) for harmful drinkers not in poverty. This would have a greater health impact on those drinkers living in poverty with a 50p MUP estimated to result in 5 fewer deaths and 120

[20] British Crime Survey for England and Wales (2014)

[21] University of Sheffield (2014) Model-based appraisal of minimum unit pricing for alcohol in Wales - An adaptation of the Sheffield Alcohol Policy Model version 3

hospital admissions per 100,000 drinkers in poverty compared to 2 and 50 for those drinkers not in poverty[22].

For those people living in poverty the financial costs of MUP will be higher but the potential health benefits are more significant.

MUP would target young people – a group particularly vulnerable from alcohol consumption

Comprehensive reviews have clearly highlighted that the consumption of alcohol by children and young people is linked with significant harm[23]. A wide range of potential harms have been outlined by the Chief Medical Officer for Wales and include: a range of developmental problems, increased risk taking behaviour, inappropriate sexual activity and violence[24]. There is evidence that regular consumption of alcohol at this critical development time will lead to significant changes to brain chemistry and structure which will set a pattern for continued heavy use, and may affect brain functioning into adulthood. The introduction of MUP would potentially have a beneficial impact in preventing this.

Evidence demonstrates that young people are more vulnerable than adults to the adverse effects of alcohol due a range of physical and psycho-social factors[25]. There is evidence to indicate that children who begin drinking at a young age will drink more frequently and in greater quantities than those who delay drinking and therefore experience greater harm. This overwhelming evidence has led to the recommendation by the previous Chief Medical Officer for England, which is supported by the Chief Medical Officer for Wales and ABUHB, that an alcohol-free childhood is the healthiest and best option for all[26].

However, despite legislation restricting the sale of alcohol to minors, many young people drink alcohol, and some drink to a level that causes harm. Although drinking

[22] University of Sheffield (2014) Model-based appraisal of minimum unit pricing for alcohol in Wales - An adaptation of the Sheffield Alcohol Policy Model version 3

[23] Donaldson, L. Department of Health (2009) *Guidance on the consumption of alcohol by children and young people.* [Online] London: DH Available at http://www.cph.org.uk/wp-content/uploads/2013/09/Guidance-on-the-consumption-of-alcohol-by-children-and-young-people.pdf [Accessed 20 January 2015]

[24] Jewell, T. Welsh Assembly Government (2010) *You, your child and alcohol: Guidance on the consumption of alcohol by children and young people.* [Online] Cardiff: WAG Available at: http://www.healthchallengecardiff.co.uk/attributes/100602_YourChildAndAlcohol_en.pdf

[25] Newbury-Birch D, Gilvarry E, McArdle P, Stewart S, et al (2009). *The impact of alcohol consumption on young people: Systematic Review of Published Reviews.*[Online] Available at: http://dera.ioe.ac.uk/11355/1/DCSF-RR067.pdf. [Accessed 3 March 2015]

[26] Donaldson, L. Department of Health (2009) *Guidance on the consumption of alcohol by children and young people.* [Online] London: DH Available at http://www.cph.org.uk/wp-content/uploads/2013/09/Guidance-on-the-consumption-of-alcohol-by-children-and-young-people.pdf [Accessed 20 January 2015]

prevalence amongst children and young people is decreasing, Wales has the highest alcohol consumption among 15 year olds in the UK[27].

ABUHB anticipate that a 50p MUP would (i) reduce alcohol consumption of children and young people and (ii) protect them from the harms caused as a result of other adults, children and young people drinking.

ABUHB believe that the introduction of MUP would not only be beneficial to children and young people who drink, from their reduced consumption, but to children and young exposed to harms from adults who drink. These harms could be direct or indirect as a result of adults, particularly parents/carers, drinking at a harmful level (e.g. increased risk of domestic violence).

2.2 Whether there are any unintended consequences arising from the Bill

ABUHB acknowledge that the modelling assumes that drinkers will behave rationally, and that not all drinkers will respond the same way to price increases. ABUHB acknowledge that although the largest positive health impact is envisaged for harmful drinkers living in poverty, MUP could negatively impact on them and their families if they were unable to restrict their consumption, and therefore their spending on alcohol. ABUHB acknowledge that heavy and/or dependent drinkers may continue to drink at the same level and for those living in poverty will have less disposable income to spend on other items.

ABUHB acknowledges the potential unintended consequences on a small number of people within the local population. We would welcome guidance on how these consequences might be mitigated and support Welsh Government's proposal to evaluate the impact of introducing MUP. This should include an assessment of unintended consequences and immediate priority should be given to ensuring access to alcohol services and support families in need and those that are most vulnerable.

Although there may initially be greater demand on local primary care services and specialist treatment services, we envisage there being a long-term savings to the local Emergency Departments and other ABUHB secondary care services. As MUP reduces the level of problematic drinking in future generations ABUHB acknowledges that unintended consequence should become less of an issue over time.

[27] Currie C et al. eds. *Social determinants of health and well-being among young people. Health Behaviour in School-aged Children (HBSC) study: international report from the 2009/2010 survey.* Copenhagen, WHO Regional Office for Europe, 2012 (Health Policy for Children and Adolescents, No. 6)

2.3 The financial implication of the Bill (as set out in Part 2 of the Explanatory Memorandum)

There are no additional costs that we are aware of that have not been considered within the financial implications of the Bill set out in Part 2 of the Explanatory Memorandum.

ABUHB welcome the inclusion of £350,000 for the evaluation of the Bill to ensure it leads to the expected outcomes it aims to achieve.

2.4 The appropriateness of the powers in the Bill for Welsh Ministers to make subordinate legislation (as set out in Chapter 5 of part 1 of the Explanatory Memorandum)

ABUHB support the powers for Welsh Ministers to make subordinate legislation to specify the MUP. Based on the evidence in 2014 ABUHB regarded 50 pence per unit MUP as an appropriate level. However, ABUHB consider that MUP should be linked to an inflationary measure to ensure it remains an effective measure to reduce alcohol health harms.

ABUHB recommend that a range of other evidence based measures should be considered to reduce the harms caused by alcohol to Welsh citizens. ABUHB believe there is sufficient evidence to support complementary approaches:

- Licensing authorities being empowered to tackle local availability of alcohol in their localities, by supporting licensing and enforcement partners working in partnership

- Sufficient resourcing of the prevention of underage, intoxicated and proxy sales and ensuring sanctions are applied to businesses breaking the law

- The legal limit for blood alcohol concentration for drivers should be reduced to 50mg/100ml

- All health and social care professionals should be trained to provide early identification and brief alcohol advice

- People who need support for alcohol problems should be routinely referred to specialist alcohol services for assessment and treatment. These services need to be adequately funded and resourced

- Alcohol advertising should be strictly limited to newspapers and other adult press while its content should be limited to factual information

Conclusion

There is a dose-response relationship between the volume of alcohol consumed and the likelihood of harm[28] and therefore any policy which is successful in reducing consumption of alcohol would be welcomed by the ABUHB. The evidence to support the introduction of MUP is strong, consistent and robust and compelling that the introduction of MUP in Wales would lead to significant improvements in the health and well-being of the population.

[28] APoSM/Advisory Panel on Substance Misuse (2014) Minimum Unit Pricing: A review of its potential in a Welsh context

Response to Welsh Assembly inquiry into Public Health (Minimum Price for Alcohol) (Wales) Bill

December 2017

Promoting · Supporting · Influencing

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1. **The Royal College of Midwives' response to Welsh Assembly inquiry into Public Health (Minimum Price for Alcohol) (Wales) Bill**

2. The Royal College of Midwives (RCM) is the trade union and professional organisation that represents the vast majority of practising midwives in the UK. It is the only such organisation run by midwives for midwives. The RCM is the voice of midwifery, providing excellence in representation, professional leadership, education and influence for and on behalf of midwives. We actively support and campaign for improvements to maternity services and provides professional leadership for one of the most established clinical disciplines.

3. The RCM welcomes the opportunity to respond to this call for evidence and our views are set out below.

4. We support the general principles of the Public Health (Minimum Price for Alcohol) (Wales) Bill and believe that it will make a contribution to improve and protect the health and well-being of the population of Wales.

5. However we do not believe that a minimum pricing strategy alone will be sufficient to address what is a major public health problem. We would urge the Health, Social Care and Sport Committee to look at how minimum pricing can be made more effective by other, simultaneous initiatives.

6. According to Health First, an evidence-based alcohol strategy for the UK which the RCM supports, we must tackle the primary drivers of alcohol consumption if the vision of a safer, healthier and happier world where the harm caused by alcohol is minimised. The report states that there is clear evidence that the most effective way to reduce this harm is to reduce not only the affordability but also the availability and attractiveness of alcohol products.[1] Targeting support to vulnerable individuals who consume large amounts of alcohol needs to address the underlying causes of their vulnerability, for example housing, social support, financial pressures, employment and mental health. Strong referral pathways need to be in place to ensure that wherever vulnerable alcohol abusers seek help in Wales, professionals and volunteers can address these underlying issues.

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[1] Health First: an evidence-based alcohol strategy for the UK (2013). University of Stirling, https://www.stir.ac.uk/media/schools/management/documents/Alcoholstrategy-updated.pdf

7. At the moment alcohol is freely available for sale and heavily marketed and advertised. Alcohol producers and public health professional and charity organisations will have competing interests but small advances have been made in recent years with labelling and restrictions on price promotions. However, the harms from alcohol continue and it is therefore up to government to put measures in place, either through legislation or public health policy to minimise harm.

8. In addition to minimum pricing, measures could include reducing the availability of alcohol, reducing the amount of advertising and targeted advertising, more strident information about alcohol harms on packaging and plain packaging (as has happened with cigarettes) and the reduction of allowed blood alcohol concentration in drivers. We would encourage the Committee to challenge the Welsh Government to think big and take a zero-tolerance approach to alcohol harm.

9. There must be a well-funded and accessible specialist alcohol service across Wales so that appropriate assessment and treatment can take place. In addition all health professionals should be able to give brief advice on alcohol consumption, be able to refer appropriately when required. There must be a robust a referral pathway that is known to and understood by those who work across health and social care, local authorities and charities.

10. Measures such as this are even more important now that we have more evidence on the harm from alcohol to women and babies, and clear the advice from the four UK Chief Medical Officers in regards to minimising drinking. The RCM endorses this advice:

    a. "If you are pregnant or think you could become pregnant, the safest approach is not to drink alcohol at all, to keep risks to your baby to a minimum. Drinking in pregnancy can lead to long-term harm to the baby, with the more you drink the greater the risk."

11. It continues:

    a. "The risk of harm to the baby is likely to be low if you have drunk only small amounts of alcohol before you knew you were pregnant or during pregnancy. If you find out you are pregnant after you have drunk alcohol during early pregnancy, you should avoid further drinking. You should be aware that it is unlikely in most cases that your baby has been affected. If you are worried about alcohol use during pregnancy do talk to your doctor or midwife."[2]

12. This advice is in keeping with the aims of minimum pricing, which seeks to reduce heavy drinking by increasing the price of high-strength alcohol and making frequent drinking less attractive.

13. However, it is also important to note that midwives cannot and should not be cast as social police in enforcing women's behaviour and this is not the message of the Chief

[2] UK Chief Medical Officers' Low Risk Drinking Guidelines (2016). Department of Health (UK), Welsh Government, Department of Health (Northern Ireland), Scottish Government. http://www.gov.scot/Resource/0050/00504757.pdf

Medical Officer, though this is often misinterpreted. 'Policing' does not encourage women to practice self-care and can make engaging with services less likely. It also will do nothing to help women with co-morbidity issues like domestic abuse or mental health, where early engagement is absolutely critical to improving clinical outcomes.

14. Rather, the midwife's skill is in conveying relevant, evidence based information, in a format that will be understood by the women, while offering support to those who consume alcohol when pregnant. This is especially important as not all pregnant women will be drinking the alcohol that is captured by minimum pricing. Women who drink in pregnancy are not a homogenous group and so our response to this concern must not be a one-size fits all approach. It is a myth that Fetal Alcohol Syndrome (FAS) and Fetal Alcohol Spectrum Disorders (FASD) happens to 'one' kind of family.

15. Alcohol also creates indirect harms to women and their unborn children through its relationship to violence against women and girls (VAWG). Research shows that 30 per cent of cases of domestic abuse begin in pregnancy and 40-60 per cent of women experience domestic abuse while they are pregnant.[3] In England and Wales 36 per cent of domestic violence incidents are committed by people who have been drinking.[4]

16. A 2016 study found that overall, domestic violence doubled the risk of preterm birth and low birth weight. This risk was increased further for women who experienced two or more types of domestic violence during their pregnancy.[5] Pre-term birth is a significant contributor to neonatal death, and poor long term health outcomes.[6]

17. The risk continues into the postnatal period where research has found that 'after the birth of their first child 23 per cent of parents continued to drink as much as before their baby was born and 17 per cent increased the amount they consumed. Overall around three in ten parents drank more than the recommended units per week.[7] Parents may be putting their new born babies at risk because they are under the influence of alcohol.

18. In summary, the RCM, while supporting minimum alcohol pricing, believes that the Welsh Government must take a whole-system approach to reducing the harms of alcohol to mothers and babies. This must take into account the 'trusted' role midwives have in public health in the relationships they build with women, their ability to refer to other services, the relationship between vulnerability, co-morbidities and alcohol use, and the relationship between alcohol and VAWG. We would encourage the Committee to press

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[3] Lewis, G (ed) 2007. The Confidential Enquiry into Maternal and Child Health (CEMACH). Saving Mothers' Lives: reviewing maternal deaths to make motherhood safer - 2003-2005. The Seventh Report on Confidential Enquiries into Maternal Deaths in the United Kingdom. London: CEMACH. http://www.publichealth.hscni.net/sites/default/files/Saving%20Mothers%27%20Lives%202003-05%20.pdf

[4] ONS (2015). Violent Crime and Sexual Offences - Alcohol-Related Violence. https://www.ons.gov.uk/peoplepopulationandcommunity/crimeandjustice/compendium/focusonviolentcrimeandsexualoffences/2015-02-2/chapter5violentcrimeandsexualoffencesalcoholrelatedviolence

[5] Donvan et.al. (2016). Intimate partner violence during pregnancy and the risk for adverse infant outcomes: a systematic review and meta-analysis. BJOG, 123, 8. http://onlinelibrary.wiley.com/doi/10.1111/1471-0528.13928/full

[6] WHO (2015). WHO recommendations on interventions to improve preterm birth outcomes. http://apps.who.int/iris/bitstream/10665/183037/1/9789241508988_eng.pdf

[7] 4Childern (2012) Over the Limit: the truth about families and alcohol. http://www.fairplayforchildren.org/pdf/1351833639.pdf

the Welsh Government on how minimum alcohol pricing will be supported by other evidence-based initiatives to reduce alcohol harm.

MPA 52

Bil Iechyd y Cyhoedd (Isafbris am Alcohol) (Cymru)
Public Health (Minimum Price for Alcohol) (Wales) Bill
Ymateb gan Swyddfa Ffederal Iechyd y Cyhoedd, Swistir
Response from Federal Office of Public Health, Switzerland

Dear Ms Sargent, dear Dr. Dai Lloyd,

Many thanks for your letter. Congratulations to the work on the Minimum Price-Bill you have started.

Concerning the evidence on price changes and corresponding changes in alcohol consumption in Switzerland, we are happy to share the following information with you:

In 1999 the price for imported spirits fell in Switzerland up to 50% (30%-50%), due to the accession of Switzerland to the WTO general agreement on Tariffs and Trade (GATT), which forced the country to liberalize spirit imports and cut import-taxes.

The Swiss Alcohol Board initiated a research-project in order to accompany this change of practice scientifically and to monitor possible changes in alcohol consumption. Please find the study published 2003 in the "Addiction"-Journal attached.

In order to assure the quality of the research, the project-proposal was submitted to the American National Institute on Alcohol Abuse and Alcoholism (NIAAA). It received an excellent evaluation and was even supported by the NIAAA. In addition, a supervisory group consisting of renowned alcohol-policy researchers was put in place to accompany the project.

The study consisted of two surveys: One was conducted before the implementation of the new regime in spring 1999 (price change was introduced on 1st of July 1999). 4000 randomly selected inhabitants of Switzerland (age 15 and older) were interviewed on their alcohol consumption. In autumn 2001, the same people were interviewed a second time, where 73% responded.

The survey proved a significant rise of spirit consumption after the introduction of the new regime. Spirit consumption rose by 39% (+0.27 Gramm of pure alcohol on average per person per day). The consumption of wine also rose, but to a much smaller extent (8.6%). The rise in wine consumption can partly be explained by age effects. The consumption of beer did not significantly change. Overall, alcohol consumption rose significantly, largely due to the rise in spirit consumption. The share of spirit consumption on overall alcohol consumption rose by 24%.

Highest changes in spirit consumption occurred among young people. In the group of the 15-29 years old, spirit consumption rose by 60%, compared to an increase of 34% among the 30-59 year old. Among young men (age 15-29), spirit consumption rose by 75% (women 15-29y: +44%).

The increase in spirit consumption was higher among persons with an initially low consumption than among people with an already high consumption. This confirmed the results of the scientific literature.

Thus, the increase in spirit consumption was higher among women (+49%) than among men (+31%).

Please find more detailed results in the article attached.

A further effect of the accession to the WTO-GATT was, that import prices of sweetened premixed alcoholic beverages (alcopops) - mainly consumed by young adults and minors - decreased significantly as well. This led to an rise in import and consumption by adolescents, peaking in 2002. Based on demand for more youth protection, an excise tax on alcopops was introduced on February 1st, 2004, rising the price of alcopops

significantly. Thus, already in 2003, the import quantities started to decrease, leading to a decrease in sold alcopop quantities to one fifth of the quantity of alcopops sold in 2002 (source: Swiss Alcohol Board).
As important substitution effects to sweetened beer and self-mixing with cheap import wodka occurred, the overall alcohol consumption of young adults and minors did not decrease significantly.
Pleas find attached a factsheet and a graphic (in German, showing alcopop imports), as well as a link to a study from Germany (in English: http://onlinelibrary.wiley.com/doi/10.1111/j.1360-0443.2010.02956.x/epdf), reporting a very similar development.

We hope, that this information will support your work.

In case of further questions, please do not hesitate to contact us.

Yours sincerely,

Marc Raemy
Scientific advisor

Changes in alcohol consumption following a reduction in the price of spirits: a natural experiment in Switzerland

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ABSTRACT

Aims To discover what changes in alcohol consumption had occurred in subgroups defined by age, sex, volume of drinking and drinking occasions, following a reduction in the price of spirits in Switzerland in July 1999.

Design Quasi-experimental. Longitudinal general-population survey with baseline 3 months before and follow-up 3 months after price change.

Participants Probabilistic telephone sample of 1347 individuals with at least monthly consumption on average in the previous 6 months at both interviews. The response rate at baseline was 74,8% and the attrition rate from baseline to follow-up 20.2%.

Measurements Alcohol consumption was assessed by means of a beverage-specific graduated-frequency measure. High volume of drinking was defined as 40 + g/day for men and 20 + g/day for women. Binge drinking was defined as six + drinks on an occasion for men and four + drinks for women.

Findings Spirits consumption increased significantly (by 28.6%) in the total sample, and specifically in young males and in individuals who were low-volume drinkers at baseline. Consumption of alcohol overall, or of wine or beer, did not change significantly. No indication of effects of substitution was found.

Conclusions Spirits consumption showed price-responsiveness in the early postintervention period. This finding is of particular interest, as (a) the increase in spirits consumption took place at a time of generally declining consumption of alcohol in Switzerland; and (b) in contrast to the findings of most studies, the intervention, namely price reduction, increased availability.

KEYWORDS Longitudinal study, price changes, spirits consumption, taxation.

INTRODUCTION

The control of alcohol availability has become a serious public-health issue because of the well-established harmful effects of alcohol consumption on health, manifested in increased morbidity, premature mortality and personal injury, as well as for its negative social consequences (Bruun *et al*. 1975; *Addiction* 1993; Holder & Edwards 1995). Control measures that affect alcohol availability, especially taxation, have been shown to reduce health impairment and other adverse effects of alcohol consumption (Edwards *et al*. 1994). Alcohol research has been concerned especially with the relationship between economic access to alcohol and consumption. Evidence about price-sensitivity of alcoholic beverages indicates that an increase in price is followed by a decline in consumption, and a fall in price by increased consumption (for overviews see Ornstein 1980; Ornstein & Levy 1983; Godfrey 1988; Leung & Phelps 1991; Österberg 1995; USDHHS 1997; Österberg 2001).

Changes occurring within a short period in specific aspects of alcohol availability have been referred to as 'natural experiments' (Wagenaar & Holder 1991). The advantage of 'natural experiments' is that they serve as a quasi-experimental means of identifying particular determinants of alcohol consumption, while other determinants are expected to remain unchanged. The effect of an intervention can thus be isolated, as confounding factors are viewed as negligible. This is often not possible with time-series analysis, the usual method of identifying such determinants: time-series usually span longer periods (e.g. decades of annual sales statistics) and hence time-series analysis estimates of effects will reflect, and be confounded with, long-term cultural and structural changes rather than only short-term economic changes (Simpura 1995).

A recent 'natural experiment' in Switzerland has been the reform of taxation on spirits, which came into effect on 1 July 1999, in accordance with the World Trade Organization agreement on the elimination of discriminating duties on foreign spirits. Previously the tax rate per litre of pure alcohol for domestic spirits was Swiss francs 26.00 and for foreign spirits between Swiss francs 32.00 and 58.00, according to type of beverage and alcohol content (EAV 1998). The highest rates applied to popular liquors such as whisky and gin. The new regulation introduced a uniform tax rate of Swiss francs 29.00 for domestic and foreign spirits.

The fiscal reform also liberalized the import of spirits. Restrictions on the number of companies permitted to import bottled spirits were eased. Increased competition among importers led to lower profit margins. The result was, combined with decreased taxes, a reduction of 30–50% in the retail price of foreign spirits. Prices of domestic spirits, however, did not change: the industry compensated for the modest increase in taxes by reducing its share of profits to avoid loss of customers. The Swiss Alcohol Board has estimated that in 1998, before the intervention, imports accounted for about 53% of the total domestic consumption of spirits, expressed in grams of pure alcohol (SFA 1999).

With regard to availability, the reform affected only price; it brought no structural change in the market, such as in outlet density, opening hours, advertising rules or legal drinking age. Earlier research with 'natural experiments' concerned mainly the privatization and deregulation of alcohol monopolies in the previous two decades in the European Union (Nordic Studies on Alcohol and Drugs 1999) and in North America (see Her *et al.* 1998, 1999; Wagenaar *et al.* 1999). The effect of those processes was to extend the alcohol distribution system, with resultant changes in both economic and structural availability (Gruenewald 1993). An inherent difficulty of earlier research was that of disentangling economic and structural effects. The present study does not have these problems of multiple effects and can investigate the pure effect of price reduction on alcohol consumption. Findings of an overall increase in spirits consumption after a 28 month follow-up were recently reported (Kuo *et al.* 2003). The present study deals with short-term changes in spirits consumption in different subgroups, defined by volume and heavy occasional drinking, 3 months after the price of foreign spirits decreased. In addition, a more detailed analysis of potential regression towards the mean effects is provided.

Most empirical studies on price effects have used time-series analysis of per capita consumption, i.e. analysis at the aggregate level. As per-capita data are often available on an annual basis only, and many time-points are needed for efficient estimation (Rehm & Gmel 2001), such data usually reflect historical interest more than actual economic impact (but note exceptions using monthly data, e.g. Wagenaar & Holder 1995). Little is known therefore about individual-level effects, particularly short-term effects, of change in economic availability, such as substitution of one beverage for another or addition of an easier available beverage to previous consumption (Mäkelä, Room & Single 1981a) or altered drinking patterns. Relatively few studies have been carried out with individual-level data and they date mainly from the 1980s (see Österberg 1995); the lack of such studies has been widely commented on in the literature (Godfrey 1997; Chaloupka, Grossman & Saffer 1998; Her *et al.* 1999). In particular, there is little evidence from natural experiments, derived from individual-level data, about effects of price changes.

Earlier studies raise two issues. First, the evidence base on which one society determines alcohol policies is considered to be transposable to other societies, irrespective of the specific context of each society. The pertinence of this principle to an effective alcohol policy has been questioned, however. New studies on price effects in modern societies are needed in order to adjust for societal changes (e.g. Plant, Single & Stockwell 1997; Rehm, Gmel & Her 2000). Instances of such changes are the long-term trends in alcohol consumption since the 1980s (Room 1991; Smart 1991); homogenization of alcohol consumption owing to the globalization of trade; and factors that promote cultural uniformity (Pyörälä 1990; Hupkens, Knibbe & Drop 1993; Edwards *et al.* 1994; Simpura 1995; Simpura, Paakanen & Mustonen 1995). Even within the European Union, countries differ in these respects (Gmel, Rehm & Frick 2001b). Secondly, aggregate-level studies cannot address effects by subgroups, for example the differential effects of price responsiveness among different types of drinkers (heavy, moderate or light) or among different age groups. The limitations of aggregate-level studies have long been discussed in the

literature (e.g. Cook & Campbell 1979; Rehm & Strack 1994; Morgenstern 1998; see also Rehm & Gmel 2001 for a discussion of time-series analysis in the alcohol field).

Evidence on price-sensitivity in heavy drinkers is central to primary and secondary prevention (Whitehead 1998). Heavy drinkers are considered to be more price-responsive than light or moderate drinkers (Becker & Murphy 1988; Becker, Grossman & Murphy 1991; Grossman 1993). However, empirical evidence is not conclusive. The assumption that heavy drinkers are at least as responsive or more responsive as moderate drinkers (see Edwards *et al.* 1994; Österberg 1995) has been supported mainly by older studies in the United States (Grossman, Coate & Arluck 1987; Coate & Grossman 1988) and in Scotland (Kendell, de Roumanie & Britson 1983) or by indirect evidence, such as the association between price-responsiveness and liver-cirrhosis mortality at the aggregate level (Sloan, Reilly & Schenzler 1994; Chaloupka *et al.* 1998). A more recent publication, based on data of the early 1980s (Manning, Blumberg & Moulton 1995), however, suggests that heavy drinkers may be even less price-responsive than other drinkers. Kenkel (1996) found that heavy drinkers who were well informed about the health effects of alcohol consumption were price-responsive whereas less-informed heavy drinkers were not. The evidence from individual-level studies for the higher price-responsiveness of heavy drinkers has certain limitations. The US study (Grossman *et al.* 1987; Coate & Grossman 1988) was based on young people aged 16–31 years. Extrapolations to general populations may be misleading, as price responsiveness may be related to a lack of money specific to this subgroup or to an age-specific drinking pattern. The results of the Scottish study (Kendell *et al.* 1983) may have regression to the mean as alternative explanation. According to this phenomenon, measurement of consumption contains a time component, and as a consequence second measurement of respondents with extreme values tend to be closer to the mean (see also below).

The present study used a quasi-experimental, longitudinal design with individual data to investigate the effect of a price decrease consequent to taxation reform. Changes in consumption were determined from assessment of the alcohol consumption of the same individuals before and after the intervention. The changes examined were related to overall and beverage-specific consumption of spirits, wine and beer, and particularly to the association between changes in overall consumption and in consumption of spirits. In accordance with recent findings that adverse consequences of alcohol consumption are associated with both heavy drinking and heavy-drinking occasions (Rehm *et al.* 1996; Godfrey 1997; Klingemann & Gmel 2001), both these aspects of heavy drinking are examined separately and conjointly, as well as in subgroups defined by sex, age and alcohol consumption. The study adds further knowledge derived from individual-level data and the impact of a clear intervention related to prices of spirits in particular, while other aspects of availability (e.g. outlet densities) remained unchanged. It is novel in that it is concerned with an increase in availability following a decrease in price, whereas most 'natural experiments' have been in the form of public health measures designed to decrease availability.

METHODS

Sample

The data were obtained from a longitudinal study on changes in alcohol consumption in the resident population of Switzerland aged 15 years or more. They were collected at baseline, in March 1999, 3 months before the intervention and at follow-up, 3 months after, in October 1999. The method used was computer-assisted telephone interviewing. Respondents who could not be interviewed in German, French or Italian, or participate for health reasons, were excluded. The study used a two-stage random sample stratified by linguistic regions (germanophone, francophone, italophone). First, a random sample of households was drawn from the Swiss telephone directory. Secondly, a household roster was established during the first telephone contact and a target person was selected at random. The final sample size was 4007 at baseline, and the response rate was 74.8%. The response rate at baseline was similar to response rates of health surveys in the Swiss general population or even higher (BFS 1994, 1998, Fahrenkrug & Müller 1989, Gmel 1996). Individuals who could not be reached because of incorrect telephone numbers, or whose numbers were business numbers, or addresses were holiday dwellings, as well as people not matching the sample specifications (relating to language or health) were regarded as neutral non-respondents. Non-neutral non-responses were due to refusals and time restrictions. Time restriction arose because interviews had to be completed within a short period—about 1 month—in order to distinguish the consumption before the intervention from the consumption after the intervention. Individuals who could not be contacted during this period were considered as non-respondents. The study had two special features. First, owing to budget constraints the study was restricted to current drinkers, defined as people having had at least six alcoholic drinks during the 6 months preceding the interview ($n = 2902$). Secondly, although all participants were interviewed by telephone at baseline, the sample was split randomly into two subsamples for follow-up. One

subsample ($n = 1061$) received a written questionnaire including a weekly drinking diary and questions related to brands, purchasing and stocking of spirits in order to collect detailed information. This subsample was followed-up by the written questionnaire only. The second subsample ($n = 1841$), which received no additional diary at baseline, was followed-up by telephone. Only the latter is analysed in the present study.

At follow-up the survey included 1470 participants (attrition = 20.2%). Forty-three neutral non-responses occurred because of address errors; 17 individuals could not be interviewed, for health reasons; 115 could not be re-contacted within a month; and 196 refused further participation. A number of current drinkers at baseline had become non-drinkers at follow-up; the inverse change (i.e. non-drinkers had become drinkers) could not be observed, however, as the study design excluded non-drinkers at baseline. To ensure parallelism with baseline, and thus avoid downward bias of changes in consumption, the analysis was restricted to individuals who satisfied the consumption criterion (at least six drinks in the preceding 6 months) at both baseline and follow-up ($n = 1347$). To counterbalance the exclusion of non-drinkers who eventually became drinkers, drinkers who became non-drinkers were also excluded.

Measures

A graduated frequency (GF) instrument was used to measure alcohol consumption. It is recognized that measurement with a GF instruments gives higher values for volume of alcohol intake than with a quantity–frequency (QF) instrument (for an overview see Rehm 1998), and GF instruments are recommended for surveys of alcohol consumption (WHO 2000). Whereas QF asks about the usual quantity and usual frequency of drinking, GF enquires about the frequency at which several quantities of alcohol are consumed. Thus, instead of assessing only a single typical quantity and a single typical frequency in the QF, variability of different drinking occasions is more accurately captured with GF. GF has been shown especially to yield higher proportions of heavy drinkers and lower proportions of light drinkers (Midanik 1994) than QF. It has been argued that GF captures variability of consumption better than QF and therefore requires less averaging of consumption on the part of respondents (Hilton 1989); they may tend to focus less on the mode of the respondent's distribution of drinking occasions. QF, compared with GF, may therefore insufficiently assess infrequent heavy-drinking occasions (Kühlhorn & Leifman 1993).

The questions asked were beverage-specific for beer, wine and spirits. For each type of beverage, respondents were asked whether they had drunk it during the past 7 days; and, if so, on how many days; and on how many of the days they had had 11 or more (or 9–10, 7–8, . . . , 1–2) standard drinks. Respondents with no weekly consumption were asked similar questions about their consumption during the previous 6 months. For the same gradations of quantities, respondents reported the associated frequency of drinking, with response categories of once a week, twice or three times a month, once a month, less often than once a month and never. For each type of beverage, volume of drinking was obtained by converting quantities and related frequencies into grams of pure alcohol a day. The volume percentages used for beer (volume percentage = 4.8%), wine (volume percentage = 11.0%), and spirits (volume percentage = 40.0%), were those determined by the Swiss Alcohol Board (Maurer, Blanchard & Helfer 1996). Beverage-specific volumes of drinking were totalled to determine total consumption. For analysis by subgroups, three age categories were used: 15–29, 30–59 and 60 years or older. This categorization was chosen instead of a continuous measure of age because of the distribution of alcohol consumption in Switzerland, which is approximately inversely U-shaped by age (Rehm & Arminger 1996). In accordance with common definitions of risky alcohol intake (English *et al*. 1995; WHO 2000) high-volume drinking was defined as drinking 40 g of pure alcohol a day or more for men and 20 g or more for women, which is about four standard drinks a day for men and two standard drinks for women. Heavy-drinking occasions ('binge drinking') were defined for men as drinking six drinks or more, and for women four drinks or more, at least once during the 6 months preceding the interview.

Statistical analysis

Analysis of survey data should take into account the complex sampling design to yield correct standard errors—i.e. correct significance tests and correct confidence intervals (Rehm & Bondy 1996; Korn & Graubard 1999). The estimation therefore incorporated probability inclusion weights (reflecting household size and disproportional sampling of regions) and stratification by linguistic regions. Statistical analysis used STATA for parameter estimation of the complex survey design (StataCorp 1999). Tests were derived by means of sample design-based survey estimators. All estimators used robust estimation of standard errors.

T-statistics were used to test changes in mean consumption between baseline and follow-up in the total sample and in subgroups. Multiple-regression models were used to measure the conjoint influence of the variables, with dummy coding for the combinations of ages (15–29 years, 30–59 years, 60 years or older) and sex (male/female), high-volume drinking (40 +/20 + g/less), and binge drinking (at least once in the past previous 6

months/none). In addition, combinations of drinking categories at baseline and follow-up for both volume-drinking and binge-drinking were constructed, as follows:

- stable high-volume drinking (stable binge-drinking): high-volume drinking (binge-drinking), at both baseline and follow-up;
- increased high-volume drinking (increased binge-drinking): high-volume drinking (binge-drinking), at follow-up only;
- decreased high-volume drinking (decreased binge-drinking): high-volume drinking (binge-drinking), at baseline only;
- stable low-volume drinking (stable non-binge drinking): low-volume drinking (non-binge drinking), at both baseline and follow-up.

Combinations of those drinking categories at baseline and follow-up were also used as one means of accounting for effects of regression to the mean. Regression to the mean may be misinterpreted as an intervention effect. Correction formulas, and use of control groups or of multiple measurement points, are common approaches applied to disentangle effects of intervention and of regression to the mean (Yudkin & Stratton 1996). These approaches, however, rely on restrictive statistical assumptions (e.g. multivariate–normal distributions) and on additional empirical data such as longitudinal data not affected by an intervention. In the present study, the use of combinations of drinking categories at baseline and follow-up was designed to weaken the effects of regression to the mean. Regression to the mean is assumed to occur because an individual's consumption fluctuates by chance in a limited range. The use of combinations of the drinking categories for measurements at baseline and follow-up makes it possible to capture approximately the individual's range of fluctuations. If most individuals are not too close to the category cut-offs, chance fluctuations are unlikely to change an individual's allocation to a category. Thus, without real changes in consumption, most drinkers should stay consistently within their category. For example, the consumption of most stable low-volume or high-volume drinkers should fluctuate within the low or the high drinking categories. Chance fluctuations occur because especially at baseline some drinkers are at the lower end of their individual drinking range while others are at the upper end. If changes are due solely to chance fluctuations, decreases from baseline to follow-up should compensate increases and vice versa. Similarly, for drinkers close to the cut-offs, changes in categories will be compensated. For instance changes from high-volume drinking to low-volume drinking will be compensated by changes from low-volume drinking to high-volume drinking.

In the present study, however, the intervention effect is expected to increase the consumption of spirits. For drinkers close to the cut-offs, the counterbalancing effect of chance fluctuations for individuals changing their drinking category may therefore be attenuated. At follow-up, because of the upward shift in consumption due to intervention, there will be more drinkers with a high drinking status than drinkers with a low drinking status. The following remarks address how intervention affects the allocation to the drinking categories compared with regression to the mean without intervention.

- Stable high-volume drinkers with intervention: this group includes stable high-volume drinkers without intervention, as intervention is supposed to result in an upward shift of consumption at follow-up. Thus, the drinking status does not change at follow-up. In addition, stable high-volume drinkers with intervention may include some decreased high-volume drinkers without intervention, who were close to the cut-off at baseline, especially those with downward chance fluctuations to follow-up. The intervention keeps them in the stable high-volume drinkers' category. Because the effects of regression to the mean are not counterbalanced in this group, they contribute to an underestimation of the intervention effect in classified stable high-volume drinkers.
- Increased high-volume drinking with intervention: this group includes increased high-volume drinkers without intervention. Because of the intervention effect, the drinking status at follow-up does not change. In addition, this group may include some stable low-volume drinkers without intervention close to the cut-off at baseline, especially those with upward chance fluctuations to follow-up. Regression to the mean and intervention would therefore put them in the increased high-volume drinkers' category. As chance increases are not counterbalanced in this group, the increase due to the intervention may be overestimated.
- Decreased high-volume drinking with intervention: this group includes only partly decreased high-volume drinkers without intervention. Some decreased high-volume drinkers without intervention close to the cut-off at follow-up, especially those with downward chance fluctuations from baseline, may counterbalance decreases of consumption due to regression to the mean by the intervention. Thus, they became stable high-volume drinkers. As chance decreases are lost, the increase due to the intervention may be overestimated.
- Stable low-volume drinkers with intervention: this group only includes partly stable low-volume drinkers without intervention. Some individuals close to the cut-off at baseline, especially those with upward chance fluctuations, may become increased high-volume drinkers. As chance increases are lost, the

increase due to the intervention may be underestimated.

In general, under and overestimation depends on the number of individuals close to the cut-off of 40 g of pure alcohol a day (men) or 20 g a day (women) and the effect of the intervention. Assuming that alcohol consumption close to the cut-off is defined as 37–43 g of pure alcohol a day in men and 17 and 23 g in women, only 2.2% of men and 3.3% of women consumed within these boundaries. The departure of 3 g from the cut-off correspond to almost the 10-fold of the change of total alcohol consumption (– 0.32 g, see Results)

To assess effects of substitution across beverages, changes in consumption of non-spirits were tested in the total sample and in subgroups. Cross-price elasticity of non-spirits was calculated by dividing the percentage changes in the consumption of non-spirits by percentage changes in the prices of spirits.

RESULTS

Table 1 summarizes changes in overall and beverage-specific consumption in the total sample in the 6 months between baseline and follow-up. Consumption of spirits increased significantly while that of beer and wine, as well as overall consumption, decreased, although not significantly. In grams of pure alcohol per day, the increase for spirits was 0.28 (28.6%); and the decrease for wine and beer together was non-significant at – 0.60 (CI: – 1.28; 0.07, percentage decrease 6.2%). Given the 30–50% range of price reduction for foreign spirits, price elasticity of spirits was at least between –0.56 and –0.94, and cross-price elasticity of non-spirits between 0.12 and 0.21. Almost zero values of cross-price elasticity indicated that the increase in spirits consumption was only marginally, if at all, offset by decreases in consumption of other alcoholic beverages.

As Table 2 shows, the drinking distribution remained fairly stable over the 6-month interval between baseline and follow-up. As measured by volume at both time-points, around 90% remained high-volume or low-volume drinkers, and 70–80% either binge or non-binge drinkers. Consequently, the percentages of high-volume drinkers or binge drinkers changed little between the two waves. Women in the middle-age group accounted for the most marked changes: a decrease of about 4.5% in heavy drinkers and about 5.2% in binge drinkers. In older men, binge drinkers decreased by 4.6%. Stable high-volume drinking was highest in older men and lowest in young men. Stable binge drinking and increased binge drinking declined with age in men and women.

Table 3 shows changes in spirits consumption by subgroup. Consumption increased significantly in men, by about 0.42 g of pure alcohol a day (36.9%). Women showed a non-significant increase of about 0.13 g (14.8%). Increases in spirits consumption were most pronounced in high-volume increasers and in young males. Effects in women were not significant. Lack of significance in subgroups may be due to small sizes.

In men, spirits consumption was found to have increased in those who were low-volume drinkers at baseline, and also in the low-volume drinking category at follow-up. In absolute numbers, most marked changes were found in high-volume increasers at follow-up. Spirits consumption decreased significantly in those who were high-volume drinkers at baseline. Thus, spirits consumption increased among stable low-volume drinkers, and increased even more among high-volume increasers, but declined among high-volume decreasers. Given the different sample sizes of the combinations of drinking categories, most of the overall changes were attributable to stable low-volume drinkers whereas the other drinking-category subgroups offset one another. Except for binge-decreasers, spirits consumption increased among all groups defined by binge-drinking status. Increasers were of similar magnitude, indicating that changes in spirits consumption were largely independent of binge-drinking categories. This was also true of women, who showed no significant changes. Significant increases in spirits consumption among women were found among high-volume drinkers at follow-up and therefore also among high-volume increasers. The same as with men, female high-volume decreasers reduced their consumption significantly but less so than the high-volume increasers.

Table 1 Changes in overall and beverage-specific consumption in the total sample in g/day.

	March 1999 estimates	*October 1999 estimates*	*Changes*				
			Estimates	*SE*	t	P	*95% CI*
Overall	10.67	10.35	– 0.32	0.38	– 0.84	0.40	– 1.06, 0.42
Spirits	1.00	1.29	0.28	0.09	3.14	< 0.01	0.11, 0.46
Wine	5.96	5.61	– 0.35	0.23	– 1.50	0.13	– 0.80, 0.11
Beer	3.71	3.46	– 0.25	0.23	– 1.12	0.26	– 0.70, 0.19

Table 2 Proportions of respondents (SE) within drinking subgroups

	Males				*Females*			
	15–29 years (n = 135)	*30–59 years (n = 417)*	*60 years + (n = 141)*	*Overall (n = 693)*	*15–29 years (n = 126)*	*30–59 years (n = 370)*	*60 years + (n = 158)*	*Overall (n = 654)*
Volume drinking								
*t*1 low (*n* = 639/589)	91.4% (0.03)	94.4% (0.01)	93.6% (0.02)	93.5% (0.01)	97.1% (0.01)	91.2% (0.02)	94.2% (0.02)	93.2% (0.01)
*t*1 high (*n* = 54/65)	8.6% (0.03)	5.6% (0.01)	6.4% (0.02)	6.5% (0.01)	2.9% (0.01)	8.8% (0.02)	5.8% (0.02)	6.8% (0.01)
*t*2 low (*n* = 646/620)	92.4% (0.03)	95.0% (0.01)	92.3% (0.02)	93.9% (0.01)	96.6% (0.01)	95.7% (0.01)	97.4% (0.01)	96.2% (0.01)
*t*2 high (*n* = 47/34)	7.6% (0.03)	5.0% (0.01)	7.7% (0.02)	6.1% (0.01)	3.4% (0.01)	4.3% (0.01)	2.6% (0.01)	3.8% (0.01)
Binge drinking								
*t*1 no (*n* = 388/426)	42.9% (0.05)	49.6% (0.03)	69.8% (0.05)	51.4% (0.02)	47.4% (0.05)	63.0% (0.03)	89.3% (0.03)	64.0% (0.02)
*t*1 yes (*n* = 305/228)	57.1% (0.05)	50.4% (0.03)	30.2% (0.05)	48.6% (0.02)	52.6% (0.05)	37.0% (0.03)	10.7% (0.03)	36.0% (0.02)
*t*2 no (*n* = 395/432)	40.9% (0.05)	52.8% (0.03)	74.4% (0.04)	53.6% (0.02)	43.4% (0.05)	68.2% (0.03)	89.5% (0.03)	66.1% (0.02)
*t*2 yes (*n* = 298/222)	59.1% (0.05)	47.2% (0.03)	25.6% (0.04)	46.4% (0.02)	56.6% (0.05)	31.8% (0.03)	10.5% (0.03)	33.9% (0.02)
Changes of volume drinking								
Low to low (*n* = 619/573)	86.6% (0.04)	91.8% (0.02)	91.0% (0.02)	90.3% (0.01)	94.8% (0.02)	89.2% (0.02)	92.6% (0.02)	91.2% (0.01)
Low to high (*n* = 20/16)	4.7% (0.03)	2.6% (0.01)	2.6% (0.01)	3.1% (0.01)	2.3% (0.01)	2.0% (0.01)	1.5% (0.01)	2.0% (0.01)
High to low (*n* = 27/47)	5.8% (0.03)	3.3% (0.01)	1.3% (0.01)	3.6% (0.01)	1.8% (0.01)	6.5% (0.01)	4.7% (0.02)	5.0% (0.01)
High to high (*n* = 27/18)	2.9% (0.02)	2.4% (0.01)	5.1% (0.02)	3.0% (0.01)	1.1% (0.01)	2.3% (0.01)	1.1% (0.01)	1.8% (< 0.01)
Changes of binge drinking								
No to no (*n* = 307/344)	25.8% (0.05)	40.8% (0.03)	60.7% (0.05)	40.4% (0.02)	32.4% (0.05)	51.1% (0.03)	81.4% (0.04)	52.1% (0.02)
No to yes (*n* = 81/82)	17.1% (0.04)	8.9% (0.02)	9.1% (0.03)	11.0% (0.01)	15.0% (0.04)	11.8% (0.02)	7.9% (0.03)	11.9% (0.02)
Yes to no (*n* = 88/88)	15.2% (0.04)	12.0% (0.02)	13.7% (0.04)	13.1% (0.02)	11.0% (0.03)	17.1% (0.02)	8.1% (0.03)	14.0% (0.02)
Yes to yes (*n* = 217/140)	42.0% (0.05)	38.3% (0.03)	16.5% (0.04)	35.4% (0.02)	41.6% (0.05)	20.0% (0.02)	2.5% (0.01)	22.0% (0.02)

The *ns* in the first column refer to the unweighted group sizes for males/females. Volume drinking: low = less than 40 g/day for men and less than 20 g/day for women, high = 40 + g/day men and 20 + g/day women. Binge drinking: no = no occasion of six (men)/four (women) drinks or more in the 6 months preceding interview; yes = at least one occasion of six (men)/four (women) drinks or more in the 6 months preceding interview.

Table 3 Changes in spirits consumption in subgroups in g/day.

	Males				*Females*				*Overall*			
	March 1999 estimates	*Oct. 1999 estimates*	*Change*		*March 1999 estimates*	*Oct. 1999 estimates*	*Change*		*March 1999 estimates*	*Oct. 1999 estimates*	*Change*	
			Estim. (SE)	*95% CI*			*Estim. (SE)*	95% CI			*Estim. (SE)*	*95% CI*
Age												
15–29 years (n = 135/126)	1.28	2.21	0.93*(0.38)	0.19; 1.68	1.29	1.32	0.03 (0.32)	– 0.59; 0.65	1.29	1.81	0.52* (0.26)	0.02; 1.03
30–59 years (n = 417/370)	1.01	1.24	0.23* (0.11)	0.01; 0.45	0.67	0.89	0.22 (0.17)	– 0.11; 0.55	0.85	1.07	0.22* (0.10)	0.03; 0.42
60 years + (n = 141/158)	1.35	1.65	0.30 (0.24)	– 0.17; 0.77	0.86	0.82	– 0.04 (0.20)	– 0.43; 0.34	1.12	1.25	0.14 (0.16)	– 0.17; 0.44
Volume drinking												
*t*1 no (n = 639/589)	0.95	1.49	0.55* (0.12)	0.31; 0.78	0.74	0.91	0.17 (0.13)	– 0.09; 0.43	0.85	1.22	0.37* (0.09)	0.19; 0.55
*t*1 yes (n = 54/65)	3.86	2.48	– 1.38* (0.67)	– 2.69; – 0.07	2.38	1.92	– 0.46 (0.56)	– 1.56; 0.64	3.15	2.21	– 0.94* (0.45)	– 1.82; – 0.06
*t*2 no (n = 646/620)	0.99	1.32	0.32* (0.11)	0.11; 0.53	0.81	0.70	– 0.11 (0.09)	– 0.28; 0.07	0.91	1.03	0.12 (0.07)	– 0.02; 0.26
*t*2 yes (n = 47/34)	3.36	5.27	1.91 (1.11)	– 0.27; 4.09	2.00	8.05	6.05* (2.19)	1.75; 10.35	2.89	6.24	3.36* (1.07)	1.27; 5.46
Binge drinking												
*t*1 no (n = 388/426)	0.79	1.28	0.49* (0.12)	0.24; 0.73	0.63	0.76	0.13 (0.11)	– 0.09; 0.35	0.71	1.01	0.30* (0.08)	0.14; 0.47
*t*1 yes (n = 305/228)	1.50	1.85	0.35* (0.22)	– 0.08; 0.78	1.24	1.36	0.12 (0.30)	– 0.46; 0.70	1.40	1.66	0.26 (0.18)	– 0.09; 0.61
*t*2 no (n = 395/432)	0.79	1.09	0.31*(0.11)	0.09; 0.52	0.68	0.60	– 0.08 (0.09)	– 0.26; 0.11	0.73	0.84	0.11 (0.07)	– 0.04; 0.25
*t*2 yes (n = 298/222)	1.54	2.10	0.55* (0.23)	0.09; 1.01	1.19	1.72	0.53 (0.33)	– 0.13; 1.18	1.40	1.94	0.54* (0.19)	0.16; 0.92
Changes of volume drinking												
Low to low (n = 619/573)	0.87	1.30	0.42* (0.10)	0.23; 0.62	0.74	0.70	– 0.04 (0.09)	– 0.21; 0.13	0.81	1.02	0.21* (0.07)	0.07; 0.34
Low to high (n = 20/16)	3.08	7.09	4.02* (1.68)	0.71; 7.32	0.81	10.61	9.80* (3.68)	2.59; 17.0	2.26	8.35	6.09* (1.73)	2.69; 9.49
High to low (n = 27/47)	4.02	1.74	– 2.28* (0.97)	– 4.19; – 0.37	2.04	0.78	– 1.26*(0.48)	– 2.20; – 0.32	2.92	1.21	– 1.72* (0.52)	– 2.74; – 0.70
High to high (n = 27/18)	3.67	3.36	– 0.31 (0.80)	– 1.88; 1.27	3.35	5.17	1.82 (1.36)	– 0.85; 4.48	3.56	3.98	0.42 (0.75)	– 1.04; 1.89
Changes of binge drinking												
No to no (n = 307/344	0.70	1.11	0.41* (0.13)	0.15; 0.67	0.58	0.61	0.02 (0.09)	– 0.15; 0.20	0.64	0.85	0.21* (0.08)	0.05; 0.36
No to yes (n = 81/82)	1.13	1.90	0.78* (0.32)	0.14; 1.41	0.85	1.45	0.60 (0.48)	– 0.34; 1.53	1.00	1.68	0.69* (0.29)	0.13; 1.25
Yes to no (n = 88/88)	1.04	1.02	– 0.02 (0.21)	– 0.42; 0.39	1.04	0.58	– 0.46 (0.29)	– 1.03; 0.11	1.04	0.81	– 0.23 (0.18)	– 0.58; 0.12
Yes to yes (n = 217/140)	1.67	2.16	0.48* (0.29)	– 0.09; 1.05	1.38	1.86	0.49 (0.44)	– 0.38; 1.36	1.57	2.05	0.49 (0.24)	– 0.01; 0.96
Overall (n = 693/654)	1.14	1.56	0.42* (0.12)	0.18; 0.66	0.85	0.98	0.13 (0.13)	– 0.13; 0.38	1.00	1.29	0.28* (0.09)	0.11; 0.46

The *ns* in the first column refer to the unweighted group sizes for males/females.

None of the age or sex subgroups showed significant changes in consumption of non-spirits (results not shown). This may indicate that non-spirits were not being substituted for spirits. Similarly, stable low-volume drinkers showed the most changes in the consumption of spirits, reducing non-spirits consumption by 0.31 g a day (= 3%). Thus, cross-price elasticity resulting from a decrease of 30–50% in the price of spirits ranged from 0.06 to 0.1. In most subgroups, the increase or decrease in the consumption of spirits was accompanied by increases or decreases in non-spirits consumption, indicating additive effects of alcoholic beverages rather than substitution of spirits for beer or wine.

Multivariate regression analysis (Table 4) included combinations of gender and age as well as drinking status defined by volume and binge drinking at baseline and follow-up. It widely confirmed bivariate findings. Because the subgroups defined by sex and age differed widely in their changes in spirits consumption, the six combinations of the sex and age variables were coded as five dummy variables. Young men increased their spirits consumption the most, even when consumption was adjusted for combinations of volume-drinking and binge-drinking status. High-volume increasers showed a significantly higher increase in spirits consumption than stable low-volume drinkers. High-volume decreasers showed a decrease, although less than the amount of increase in high-volume increasers. The effects for binge-drinking status were less than the effects for volume status. Drinkers defined by binge-drinking status changed less than those defined by volume status. Binge-decreasers showed a significant change by comparison with stable non-bingers, the reference subgroup).

DISCUSSION

This study used longitudinal individual data and a before/after-intervention design to examine initial effects on alcohol consumption of a reduction of 30–50% in the price of imported spirits in Switzerland. The main findings were an increase of almost 30% in consumption of spirits, and no significant change in that of wine or beer, or in total alcohol consumption. Analysis of subgroups showed that the increase in spirits consumption was associated mainly with the variables sex, age and volume of drinking. The association with sex was central. Females showed no significant change; males showed an increase of about 38% in spirits consumption, young men showing the highest increase. In the total sample, most of the excess consumption over the baseline measure occurred in stable low-volume drinkers. In high-volume drinkers at baseline, spirits consumption showed no increase. Spirits consumption had increased markedly, however, in those found at follow-up to have become high-volume drinkers.

In intervention analysis of longitudinal data, effects of regression to the mean may be confounded with the intervention effect. In the present study, the use of combinations of drinking status at baseline and follow-up made it possible to control partly for the effect of regression to the mean by distinguishing stable low-volume or stable high-volume drinkers from those who had changed drinking status (i.e. either decreasers or increasers). The intervention led to a significant increase in spirits consumption in stable low-volume drinkers. High-volume decreasers reduced their consumption of spirits significantly. High-volume increasers drank significantly more spirits. The increase in spirits consumption across all

Table 4 Regression analyses of changes in spirits consumption in g/day.

	Coefficients	*Standard errors*	t	p	*95% CI*
Constant	– 0.01	0.19	– 0.05	0.96	– 0.38; 0.36
Age/sex	0				
(ref.women 60 + years)					
Men, 15–29 years	0.82	0.33	2.50	0.01	0.17; 1.47
Men, 30–59 years	0.19	0.23	0.82	0.41	– 0.27; 0.66
Men, 60 + years	0.23	0.31	0.74	0.46	– 0.38; 0.84
Women, 15–29 years	– 0.03	0.33	– 0.10	0.92	– 0.70; 0.63
Women, 30–59 years	0.30	0.24	1.26	0.21	– 0.17; 0.77
Volume	0				
(ref. low to low)					
Low to high	5.73	1.70	3.36	< 0.01	2.39; 9.07
High to low	– 2.01	0.55	– 3.61	< 0.01	– 2.39; – 0.92
High to high	0.11	0.79	0.14	0.89	– 1.43; 1.65
Binge	0				
(ref. no to no)					
No to yes	0.20	0.26	0.77	0.44	– 0.31; 0.72
Yes to no	– 0.50	0.19	– 2.65	0.01	– 0.87; – 0.13
Yes to yes	– 0.01	0.19	0.04	0.97	– 0.37; 0.39

combinations of either binge drinking or volume of drinking at baseline and follow-up was highest for high-volume increasers in both sexes, and particularly higher than the decrease in high-volume decreasers. This could mean that regression to the mean, if it occurred, was weakened by the intervention effect in high-volume decreasers and exaggerated in high-volume increasers. Given the pattern of results, although regression to the mean may have accounted for some effects, it is unlikely to be the only explanation. First, although changes in consumption of spirits were analysed, groups designated by volume of drinking or binge drinking were constructed for overall consumption, not for spirits only. Hence, with regard to the use of groups defined by extreme values at baseline, mostly accounting for effects of regression to the mean, the extreme values did not necessarily refer to consumption of spirits. For example, the proportion of spirits in total consumption usually declines with increasing total consumption (Gmel & Schmid 1996). In the present study, the correlation between consumption of non-spirits (i.e. beer and wine) and the consumption of spirits was 0.20 at baseline and 0.26 at follow-up. Secondly, coupled with the hypothesis that individual measures vary in a narrow range rather than from one end of the spectrum to the other (Yudkin & Stratton 1996), strong changes from low to high volume of drinking can be expected not to be attributable exclusively to regression to the mean.

The present study has shown that changes in consumption of spirits were associated with changes in overall drinking status, specifically from low-volume to high-volume drinking. Such a finding contradicts the assumption of substitution of alcoholic beverages, which is consistent with previous findings (Mäkelä *et al.* 1981b; Österberg 1995; Österberg 2001).

The study confirms the findings of previous research (Ornstein 1980; Ornstein & Levy 1983; Godfrey 1988; Leung & Phelps 1991; Österberg 1995) that, for the total sample, spirits are price-elastic, on the whole, like common consumption goods. The findings draw attention to three factors:

- First, changes in the social environment, such as those in life-style and consumption, have brought a long-term downward trend in the consumption of alcohol, including spirits, in most established market economies since the 1980s (Simpura 1995). In Switzerland between 1980 and 1998, for instance, the decrease for alcohol overall was 17.8% and for spirits 32.8% (Blanchard 2001).
- Secondly, most studies on price effects have analysed the effects of rising prices. Hence, expected decreases in consumption following price increases occurred in a period of generally declining consumption, and effects may have been confounded. The present study shows that price-elasticity of alcoholic beverages holds true for falling prices even in a period of declining consumption.
- Thirdly, the use of individual-level data in this study permitted an examination of short-time variation in spirits consumption. Price sensitivity is usually analysed on the basis of aggregated data, often long-term time-series of national sales statistics. The use of sales data to determine the level of alcohol consumption in a population is controversial, however, as changes in sales data may not be congruent with consumption changes in individuals (Rehm 1998; see also Mulford & Fitzgerald 1988). Effects of stocking or variation in cross-border purchases, for instance, may especially bias short-term consumption changes inferred from sales data. This study found an immediate reaction in spirits consumption to price decrease.

Related to the increase in consumption of spirits is the central issue of addition or substitution effects. This issue is crucial, as drinkers can respond to a price decrease in two essentially different ways: they increase their consumption of the beverage concerned and either do not change their use of other beverages or offset their increased consumption of the beverage by reducing their consumption of other beverages (Mäkelä *et al.* 1981a). It is a common finding that, with increased availability of an alcoholic beverage, drinkers usually increase their intake of it but do not decrease their consumption of others (Österberg 1995; Österberg 2001). Thus, changes in drinking patterns have a cumulative rather than an interchangeable character. Findings of the present study do not support substitution effects. The decrease in consumption of wine and beer was not significant and may reflect more the general trend of decreasing consumption in Switzerland. It should be noted, however, that because of the larger quantity of alcohol consumed in beer and wine compared to spirits, beer and wine consumption decreased absolutely at twice the rate at which the consumption of spirits increased. Therefore, the price changes of spirits may not have resulted in an overall increase in alcohol consumption in Switzerland. According to Swiss Alcohol Board sales data (Blanchard 2001), the consumption of beer, wine and spirit decreased steadily since the 1980s. The present study indicates that this trend may have been reversed for the consumption of spirits. Cross-price elasticity resulting from those non-significant decreases were small, and the strongest effects of increased or decreased spirits consumption were found among those individuals who also increased or decreased their consumption of alcoholic non-spirits. Beverage-specific substitutions have so far been scarcely studied at the individual level, but research on cross-elasticity with aggregate data has similarly indicated only weak and mostly insignificant substitutions of one beverage for

another (for overviews see Edwards *et al.* 1994; Nelson & Moran 1995; Österberg 2001).

Price responsiveness is known to be related inversely to the integration of a beverage in a drinking culture (Labys 1976; Godfrey 1989; Sparrow *et al.* 1989; Godfrey 1990). Thus, the less a beverage is consumed, the more price-responsive it will be. The present findings are consistent in this respect as, according to data of the Swiss Alcohol Board for 1999, the proportions of spirits, beer and wine in total consumption in Switzerland were, respectively, 16.1%, 31.1% and 52.9% (Blanchard 2001). Spirits should accordingly be price-responsive. In the present study, price elasticity could not be exactly determined as reduction in prices varied between 30% and 50%. Price decreases attributable to tax changes and lower profit margins of importers varied with type of spirits. Moreover, the price decrease applied only to imported spirits, or about half of all spirits consumed in Switzerland before the reform (SFA 1999). These findings therefore indicate a conservative price elasticity of −0.6 to −1.0, which is well within the range of price elasticity of spirits in other studies (Clements, Yang & Zheng 1997; for an overview see Österberg 1995).

However, although cultural embedment of a beverage may be one explanation of price responsiveness in the sample as a whole, it does not sufficiently explain differences between subgroups. In the whole sample, for instance, the share of spirits in total consumption is roughly the same across all age-groups and both sexes (ranging between 11% and 15%); larger-scale surveys in Switzerland have also confirmed a relatively stable proportion of spirits in total consumption (Gmel & Schmid 1996). Spirits consumption increased significantly only in men, however, and most in the youngest age-group, and in low-volume more than high-volume drinkers. One possible explanation at the subgroup level is that the level of alcohol consumption is determined by a combination of economic and cultural or structural factors, including drinking patterns (Simpura 1995). Economic factors may be the most influential in the short term and cultural factors in the long term (Treno, Parker & Holder 1993; Österberg 1995). If cultural and normative drinking styles are highly dominant, changes in prices of spirits may affect mainly the young, who have not yet adopted such culturally determined drinking styles. For instance, in an 8-year follow-up study in Switzerland, Gmel and colleagues (Gmel, Truan & François 1999) were able to show that beverage preferences remained highly stable and changed only at younger ages. Mainly, young people changed their 'youth drinking style' to the predominant drinking style of their region.

It is of interest that information about the price responsiveness of heavy drinkers has been derived mainly from studies with young people in the United States (Grossman *et al.* 1987; Coate & Grossman 1988). Young people are commonly the group most affected by prices as they have the least money to spend on drink (Edwards *et al.* 1994). The combination of unstabilized drinking patterns and financial constraints, not heavy drinking *per se*, is likely to determine their price responsiveness. We would argue, then, that consumption varies mainly with economic factors, if integration in a drinking culture is not yet completed.

Cultural norms or greater social acceptance may be also a factor in explaining why young women in the present study were not price-responsive, contrary to findings of studies in the United States (Chaloupka & Wechsler 1996; Kenkel 1996). According to social theories of 'diffusion of innovations' (Rogers & Shoemaker 1971; Rogers 1995), socio-economic groups show differential adoption processes and do not adopt innovations equally fast. For instance, women often lag several years behind men in adopting new consumption styles (for the 'smoking epidemic' see Peto *et al.* 1994; Graham 1996). Adoption processes generally take time, often several years. This study needs to be continued to discover whether women in Switzerland are generally not affected by the price change of spirits or simply will catch up with men later.

Contrary to other studies, mainly in the 1980s (Coate & Grossman 1988; Kendell *et al.* 1983; Grossman *et al.* 1987), the present study found that high-volume drinkers were not price-responsive or less so than moderate drinkers. This accords with recent findings that heavy drinkers are less price-responsive than light drinkers, and that most heavy drinkers are almost insensitive to price change (Manning *et al.* 1995; Kenkel 1996). However, the direction of the change in price (a decrease) may explain why drinkers who were high-volume at baseline were the least price-responsive. As high-volume drinkers are at the upper end of the consumption distribution a further increase is unlikely, whereas a decrease in consumption with increasing prices is still possible. Hence, high-volume drinkers may be price-responsive when prices rise but not when they fall. In addition, because of the high price of spirits, high-volume drinkers in Switzerland drank other beverages before the price change, and this pattern may have persisted.

On binge drinking the study gave mixed findings. Although stable male bingers and male binge increasers increased spirits consumption, these effects were no longer significant in the multiple regression model controlling for age, sex and volume. This may indicate that effects of binge drinking are already captured by age and low-volume drinkers, as binge drinking decreases with age (Table 2) and most Swiss binge-drinkers are low-volume drinkers (Gmel *et al.* 2001a). In contrast to volume of drinking, however, increases in spirits consumption

were found in male subgroups defined by binge-drinking status at baseline and follow-up except for binge decreasers, hence for bingers and non-bingers. Volume of drinking is probable, therefore, to be more predictive of change in spirits consumption than binge drinking.

Some shortcomings of the present study must be acknowledged. As for Kendell *et al.* (1983) it was restricted, for budgetary reasons, to respondents who took alcohol at least monthly during the 6 months before interview. This excluded abstinent respondents and very light drinkers. The increase in spirits consumption could have been underestimated, therefore, if the very light drinkers were more price-responsive than average or if abstainers began to drink above average. Some findings indicated, however, that very light drinkers were less price-responsive than moderate drinkers (Manning *et al.* 1995). As usual, self-reported consumption was lower than the sales data (Rehm 1998), but under-coverage can be expected to have a limited impact on change in consumption, as it occurs in a similar way in the baseline and follow-up surveys.

In line with the intervention, the findings showed a rapid increase in spirits consumption, mainly in men and light drinkers. The evolution of the consumption of spirits requires further investigation. Impulsive consumption due to presumed bargain opportunities may have been responsible for the early increase. Although drinking patterns and preferences may change, established drinking habits are likely to limit the increase, at least in middle-aged or older men. Evidence of a decrease in consumption from the 'gin epidemic' in England in the 18th century indicated that the effect of price changes was short term, lasting only a year (Warner *et al.* 2001). The rise in consumption may be followed by a decrease therefore also in Switzerland. This seems especially likely in conditions of decreasing consumption over a longer period, as changes in prices may be widely independent of changes in cultural factors. Results from the 'gin epidemic' study may be inapplicable to the present case, as it was an aggregate-level study in a very different time and context. For instance, because of the continuing decrease in alcohol consumption, an alternative hypothesis for further research could be that the price reduction in Switzerland brought about a permanent increase in the proportion of spirits within total consumption despite a continuing downward trend in total consumption. This could mean in the long and medium terms a relative, not an absolute, increase in consumption of spirits.

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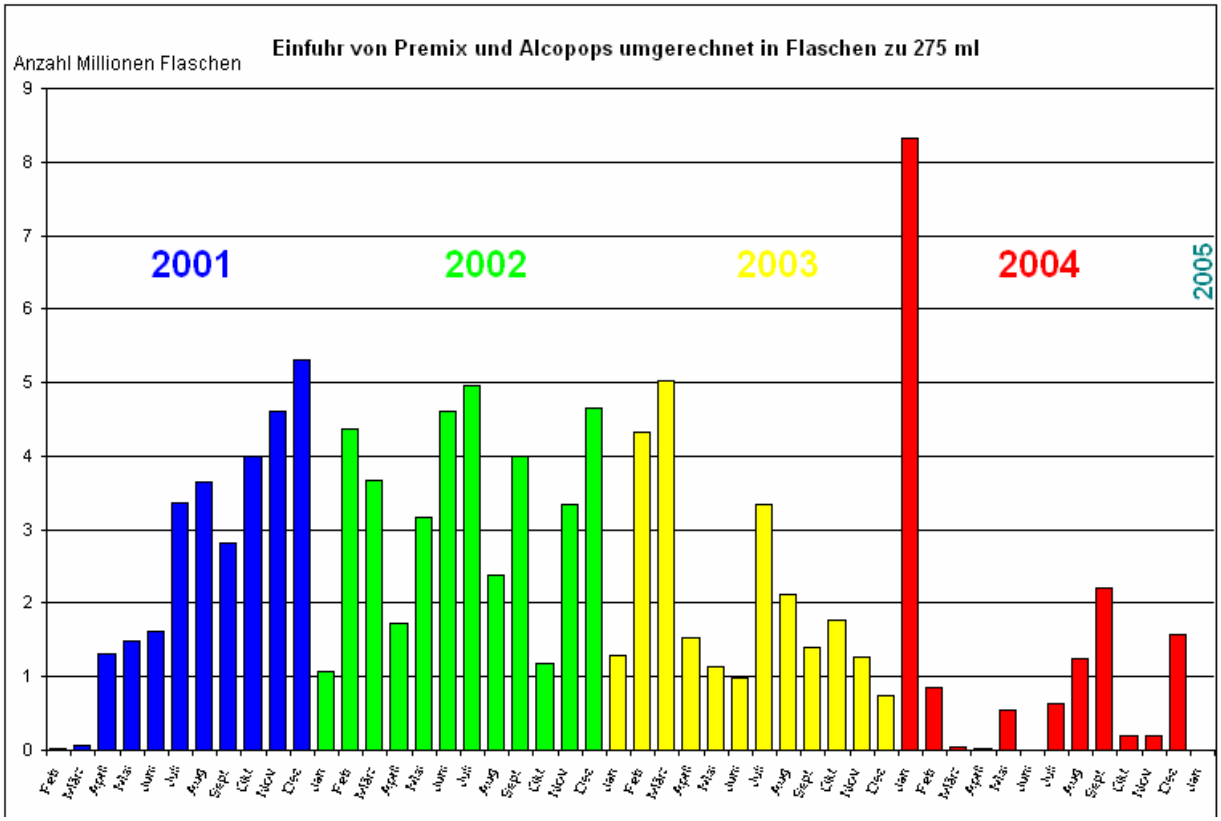
Several studies have confirmed how alcohol consumption can be influenced by playing on the price/demand fluctuation. This kind of prevention must be even more effective when it is aimed at children and juveniles who do not have the same financial resources as adults do. The Swiss special tax on alcopops is once again proof of this effect.

In 2004, imports declined to 16 million bottles, while 2002 was a record year with 40 million bottles of alcopops. It is due to this special tax, that the traditional alcopops which tasted very sweet have disappeared from the market.

The largest quantity of alcopops sold nowadays in bars, restaurants or by retailers, are products having a new recipe with less sugar (for which they are not specially taxed), but also less sweet in taste. These substitutes are definitely not a market success.

Import of premix and alcopops calculated in bottles of 275 ml, 5,6 % vol
Millions of bottles



This graph shows quite clearly the influence of tax on the alcopops market. The special tax rate came into effect on 1 February 2004. Previously it was 45 centimes, and after 1 February 2004, it was fixed at CHF 1.80 for a bottle containing 275 ml and 5.4% by volume of alcohol. Therefore the industry cleared its stock during December 2003, and restocked it with over 8 million bottles only in January 2004, knowing well that the price has a great impact on the market. Hence, they did not have to produce alcopops for the months ahead. In summer 2004, the alcohol industry introduced new alcopops (with less sugar) on the market. That way they could avoid paying the special tax. (See also the enclosed relevant special tax law article at the end of this text).

However, as you can see on the graph above (including the alcopops with less sugar), and as it is also evident from newspapers reports, these products did not have the same success as the originally-launched alcopops.

So we can see that the special tax did have an effect on the market, but the market nevertheless tries to find loopholes in the law.

Taxation

According to Article 23bis paragraph 2bis of the Alcohol Law (SR 680), alcopops are subject to a special tax. The tax is raised by 300 percent for sweet alcoholic drinks containing less than 15 percent by volume of alcohol and at least 50 grams sugar per litre, expressed as invert sugar, or an equivalent sweetening and reach the market mixed and ready-for-consumption in bottles or other containers. The special tax is CHF 116 per litre of pure alcohol.

Einfuhr von Premix und **Alcopops** (Hektoliter reinen Alkohols) in den Jahren 2000 bis 2015

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Quelle: Eidgenössische Alkoholverwaltung (EAV) (2016). *Jahresbericht 2015.*