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

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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.

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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

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