



11th January 2009

Dear Jackie Baillie MSP and Richard Simpson MSP,

Thank you for your detailed response to our recent letter. We recognise and are encouraged by the fact that Labour supports most parts of the Alcohol Bill and note that the only significant element preventing wholehearted support is the provisions pertaining to minimum unit pricing. We will address the individual points you raise in your letter under six broad headings:-

- Scientific Evidence
- International Precedent
- Sheffield Review and Modelling Study
- Pensioners and Poorer Communities
- Buckfast and Caffeinated Alcohol Products
- Legal Issues

Scientific Evidence

The scientific rationale for proposing the policy measure of minimum unit pricing of alcohol is based first on a comprehensive international evidence base from a number of studies from more than one country which clearly establish a link between alcohol price, consumption and harm. The data from Finland is one of the most recent studies confirming this link but is not, as you suggest in your letter, “the main basis of the broad link between price, consumption and harm”. We are nevertheless pleased that Labour accepts the scientific evidence linking price, consumption and harm as this link is now accepted by all credible medical and scientific opinion. Indeed the only people who

refuse to acknowledge this comprehensive evidence base are representatives of the alcoholic beverage industry and their trade bodies who have stated publicly on numerous occasions that there is no evidence that price impacts on consumption and harm.

Given this evidence base, legislators must consider which pricing policy lever would be most effective in reducing alcohol-related harm. A number of pricing policy measures have been examined by a wide range of experts including the WHO; leading international alcohol scientists; the House of Commons Health Committee; the Scottish and UK Medical and Nursing Royal Colleges; the BMA; the four Chief Medical Officers of the UK; and the National Institute for Clinical Excellence (NICE). All have concluded that statutory minimum unit pricing is a pricing policy measure that government/s should consider implementing to reduce the growing burden of harm caused by alcohol. This is why we state in our letter that Labour's decision to reject minimum pricing is contrary to all credible medical and scientific opinion. We are not, as you suggest, conflating the impact of minimum unit pricing with alcohol pricing more generally but are merely stating that given the significant evidence linking price, consumption and harm, the international medical and scientific consensus is that minimum pricing would be an effective policy measure for governments to implement to reduce both consumption and harm. We remain deeply concerned that opposition politicians have dismissed minimum unit pricing in the face of such widespread scientific and medical consensus and that this decision has been taken prior to hearing the evidence through due Parliamentary process.

International Precedent

You are correct to assert that minimum unit pricing has until recently not been tested in other countries. Traditionally, taxation has been the favoured pricing policy lever to reduce consumption and indeed the report *Alcohol Price, Policy and Public Health* published by SHAAP in 2007 recommended both measures. However, there has been a growing concern at the very low unit cost of alcohol available for sale in the UK and the fact that tax increases are not always passed on to the consumer thereby negating its impact as a mechanism to reduce both consumption and harm. In the UK, despite two tax increases in 2008, it was still possible to buy a range of cheap alcohol products. Minimum pricing is a measure which focuses on the cheapest alcohol which is favoured by the heaviest drinkers whereas tax increases are more general in their impact. It is estimated that 64% of low cost alcohol (below 40p a unit) is drunk by individuals consuming more than 50/35 units weekly. For these reasons, the international and UK medical and public health community have identified both increases in duty and minimum unit pricing as necessary to reduce consumption and harm.

You refer to the 'social reference' pricing system in Canada which is a pricing control measure which establishes a floor price. To state that there is no published evidence of it having had any significant beneficial effect is not entirely correct in our opinion. It would be more accurate to acknowledge that the impact of social reference pricing on rates of alcohol-related harm has not been evaluated separately from the effects of other federal and provincial taxes and mark-ups that apply to alcoholic beverages in Canada. It is worth noting, however, that public authorities in Canada exercise a far greater level of control over alcohol pricing and retailing than in the UK and that levels of alcohol consumption and harm are significantly lower than in the UK.

We are surprised that the fact that minimum unit pricing has not as yet been widely implemented is given as one of the reasons for rejecting the policy given the Labour

Party's history in introducing innovative health and social policies. Indeed some of the most effective public health policies were introduced as new and innovative policies and Scotland in particular has a long tradition of being a pioneer in introducing public health measures. The utility of minimum unit pricing as an additional price control measure to limit the damage caused by alcohol consumption is increasingly being recognised. Russia has just introduced a minimum unit price for vodka that more than doubles the cost of the cheapest vodka on the market. The Russian President has stated that the aim of the measure is to reduce the number of alcohol-related deaths in Russia. In Australia, a health taskforce has recently recommended new policy measures to reduce harmful alcohol consumption, including the means to regulate a minimum price. In the UK, the Welsh Government Assembly has called for minimum unit pricing to be considered as has the Health Minister of the Government of Northern Ireland. A few days ago, the UK Health Select Committee's Alcohol Inquiry chaired by Labour MP Kevin Barron published its findings which included a recommendation that the Westminster government should implement minimum unit pricing. The World Health Organisation's draft global strategy to reduce the harmful use of alcohol similarly recommends minimum unit pricing as one of a number of price controls governments should apply. The draft strategy will be presented to the World Health Assembly in May 2010. As governments are forced to confront the impact of the increasing burden of alcohol harm on populations, minimum unit pricing may well become a mainstream policy lever used in conjunction with taxation to reduce consumption and harm.

Sheffield Review and Modelling Study

You raise a number of points relating to the recent academic work undertaken by the University of Sheffield for both the Department of Health and the Scottish Government which appear to conflate the systematic review of the evidence (Phase 1 of the Sheffield study) with the findings of subsequent modelling work. Phase 1 of the Department of Health study reviewed pricing mechanisms and concluded that in the UK context, minimum unit pricing was one of the most promising potential mechanisms open to government which is why it was then considered in more detail in Phase 2.

Your letter expresses concern that the Sheffield modelling suggests a minimum unit price would only reduce and not eliminate harmful drinking, and that it would not significantly alter the consumption levels of hazardous drinkers. To understand the model properly, however, you need to look at the impact on consumption in conjunction with the impact on alcohol-related harm. For example, the model predicts that a 40p minimum price in Scotland would lead to a reduction in consumption in hazardous drinkers of 1.9%. Whilst this may not appear to be a significant reduction, it is estimated that this reduction will save the lives of 64 hazardous drinkers and 1,900 hospital admissions per year, once the full effect of the policy has been realised. As moderate and hazardous drinkers make up the bulk of the drinking population, even apparently small reductions in consumption in these drinking groups will lead to significant health gains at the population level and significant cost savings to our society. A point highlighted by Kevin Barron MP, the chair of the Health Select Committee who stated "Even small reductions in the number of people misusing alcohol could save the NHS millions". Small reductions in consumption also have the potential to prevent moderate drinkers from slipping into the hazardous category and hazardous drinkers slipping into the harmful category. For harmful drinkers, the model predicts that a 40p minimum price would reduce the number of deaths by 141 and hospital admissions by 2,200 per year. No-one would argue that any one policy intervention could completely eliminate harmful

drinking. However, a measure that can effectively and cost-effectively *reduce* the level of harm is surely worthwhile considering.

To have a greater impact on hazardous and harmful drinkers, a higher level of minimum pricing could be set as the Sheffield model demonstrates. The Sheffield study states: "As the minimum price threshold increases, alcohol-related hospital admissions and deaths are estimated to reduce: for example, -3,600 admissions per annum (once the full effect on the risk of harm has been realised) for a 40p threshold compared to -8,900 per annum for a 50p threshold". Harm occurs in middle or older age groups at significant risk of developing and potentially dying from chronic disease. As the minimum price threshold increases, healthcare costs are reduced: for example health and social care costs avoided due to reduced illness and admissions are estimated to be approximately £60m for the 40p threshold and £160m for the 50p threshold (in total over 10 years). The value of health-related quality of life gains represents the largest component of health savings: estimated at £290m for 40p and £730m for 50p. In our view, those are crucial benefits to the population and to the costs of the NHS.

We are puzzled by your comment about gender impact. The Sheffield study certainly took gender differences in drinking habits into account although the impacts are not reported separately.

Pensioners and Poorer Communities

The extra health and social burden borne by the most disadvantaged communities is a major public health concern. It is clear that alcohol has a disproportionately damaging effect in our most deprived communities. This indicates that poorer communities are already being 'penalised' by our current alcohol policies. Almost two thirds of all alcohol-related deaths in Scotland in 2007 were amongst the most deprived members of society. People living in the most deprived areas are eight times more likely to be admitted to a psychiatric unit with an alcohol-related disorder than people living in the least deprived area. Children, families and the wider community are also affected by problem alcohol use with alcohol implicated in acts of violence, public nuisance and family breakdown. Contrary to claims that raising the price of alcohol penalises poorer people, all the evidence indicates that preventing the sale of cheap alcohol will have the greatest health benefit for Scotland's most deprived communities. It is worth noting that in Finland, the increase in mortality which immediately followed the policy decision to reduce the price of alcohol adversely affected the most vulnerable groups with the poor, unemployed and pensioners' disproportionately represented in the increased deaths due to alcohol. Improving the health and quality of life of the poorest communities is a priority and minimum pricing may go some way towards this.

It is possible that some pensioners who drink at low-risk levels may have to pay slightly more for their alcohol under a minimum pricing regime. However, we know from survey data that there are currently a high percentage of abstainers in the oldest age groups which suggests that in absolute terms the number of pensioners potentially affected by minimum pricing will be relatively low. For example, the Scottish Health Survey shows 76% of women in the 65-74 age group either do not drink at all or drink less than seven units a week and this rises to 87% in the 75+ age group. It should also be noted that given the significant percentage of NHS and Social Work services and expenditure currently required to deal with alcohol-related problems, pensioners in Scotland are already losing out as they are more likely to use and need these services. A reduction in the high levels of alcohol-related harm in Scotland would free up valuable resources

which could be used to increase access to essential services for pensioners and other vulnerable groups.

Buckfast and Caffeinated Alcohol Products

Buckfast has been cited by opponents of minimum unit pricing as a reason for opposing the measure yet Buckfast makes up less than 1% of the volume of alcohol sold in Scotland. This means that from the point of view of the health of the population, Buckfast is something of a red herring. Your letter cites the findings of the McKinlay report which is based on drinking habits reported by Young Offenders. However, the most disturbing finding of the report was the increasing role that alcohol plays in violent crime and the main message of the study was the steady increase in alcohol consumption by young offenders (most strikingly shown by the increase in the number of daily drinkers) at the survey points in the late 70s, the mid 90s and 2007. The number reporting the use of spirits prior to the offence is 42%, similar to the level of Buckfast (43.4%). Buckfast was bought mostly in smaller off-licence premises and favoured by very young drinkers from the western end of the central belt of Scotland. It is perhaps worth noting that not a single young offender from Dundee or Lothian reported consuming Buckfast. Similarly, recent data shows that just 7% of all alcohol seized by police in Tayside from under 18s is wine of any type and these volumes are dwarfed by cider and spirits. Focusing on Buckfast is therefore misleading. It is similarly our view that the added hazard associated with caffeinated products represents another diversion when the health of the population is at stake. It calls to mind the tobacco companies claims that particular types of cigarettes were dangerous and by inference others "harmless". The effect of caffeinated alcoholic drinks on health is a valid scientific question, but given the proportion of the alcohol market this type of drink makes up, it should not be our central concern.

Legal Issues

There have been competing claims regarding the legality or otherwise of minimum unit pricing. SHAAP commissioned two legal opinions to inform publication of the report *Alcohol Price, Policy and Public Health* in 2007. The legal opinions confirmed that fixing minimum drinks prices is possible under both UK and EU law with some caveats. Namely, minimum unit pricing must be imposed on licensees by law, or by a public body exercising public functions imposed on it by enactment and must not constitute a trade barrier. On the latter point, it should be noted that EU law allows exceptions to the free movement of goods rule on the grounds of public health, provided it can show that the prices set did not constitute a disguised trade barrier and were proportionate to addressing the problem of alcohol-related harm.

Indeed the European Commission has stated in two recent written responses to questions from Catherine Stihler MEP (July 2009) and Charles Tannock MEP (November 2009) that Council Directive 92/83/EEC (covering excise duties on alcohol) "does not prohibit Member States from setting minimum retail prices for alcoholic beverages". The Commission confirms that minimum pricing is permissible under EU trade law providing it applies to domestic and imported products alike and does not constitute a barrier to trade. If the prices set were shown to be a barrier to the free movement of goods there would need to be a public policy justification. To be justifiable, the measure would have to be shown to be necessary to achieve the policy objective and the objective couldn't be achieved by any less trade-restrictive measure. In effect, if minimum pricing was subject to a legal challenge then the Government would have to argue that the public health case for the measure was both necessary and proportionate.

With the UK and international consensus increasingly moving towards viewing taxation and minimum unit pricing as *complementary* pricing policy measures given that taxation alone is unlikely to achieve the same health benefits, the case for demonstrating both the necessity and proportionality of the measure becomes stronger. The combination of the scientific evidence and the legal advice to date would certainly justify a decision by legislators to proceed with minimum unit pricing. In our view, the prospect of a legal challenge from representatives of the alcoholic beverage industry does not in itself provide sufficient grounds for rejecting an evidence-based, cost-effective policy which is likely to have a significant impact on reducing the burden of alcohol-related harm.

Finally, with regards to your comments about increased profit margins for retailers, we believe that this concern is overstated. One of the reasons supermarkets are able to offer cheap alcohol is because it is sold at a loss and they are able to do this by increasing the profit-margin on other essential goods. If supermarkets are prevented from using alcohol as a loss-leader through minimum unit pricing, the incentive to use other goods to cover the loss of profit on alcohol sales is removed. As stated earlier, we see increases in duty and minimum pricing as *complementary* policy measures and support the recommendation of the UK Health Committee that alcohol duty should continue to rise year on year and that duty increases should be directed at stronger alcoholic drinks such as spirits. However, minimum unit pricing offers an effective and cost-effective means of addressing a specific concern society has about low-cost, high volume alcohol sales and would be supplementary to the existing taxation system. An added attraction for legislators is that the introduction, monitoring and enforcement of a minimum unit price for alcohol is relatively straightforward and could be implemented at little additional cost to the public purse. The same cannot be said about the introduction of additional alcohol tax regimes.

Opposition politicians will need to have weighty reasons for opposing a policy measure which is informed by a significant scientific evidence base and has the backing of the UK and international public health community; the Westminster Health Committee; the UK's four Chief Medical Officers; the Directors of Public Health from all fourteen of Scotland's Health Boards as well as faith groups and other organisations. Having carefully considered the reasons you provide in your letter for opposing minimum unit pricing, regrettably, we find that they do not withstand robust analysis or detailed scrutiny.

We must trust that your opposition is based on good faith and a desire to find an evidence-based pricing policy measure which will deliver demonstrable health benefits and does not require the investment of significant bureaucratic or financial resources. You may find it helpful to know that in reaching our decision to call for the introduction of minimum unit pricing, the Scottish Medical and Nursing Royal Colleges, the BMA and colleagues in WHO have considered other approaches (see for example SHAAP Price report (2007) and Briefing on Limiting the Damage of Low Cost Alcohol (2009)). We believe that minimum pricing would be the most cost-effective policy lever open to the Scottish Government and that for the Labour Party's Commission to be credible, minimum pricing would have to be considered along with any other pricing policy measures which will be examined. Equally, we must assume that should the Commission not identify a "better way" then the Parliamentary Labour Group will support the minimum unit pricing proposal given your acceptance of the link between price, consumption and harm.

The search for an alternative should not be a means of delaying action.

Yours sincerely,

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