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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]

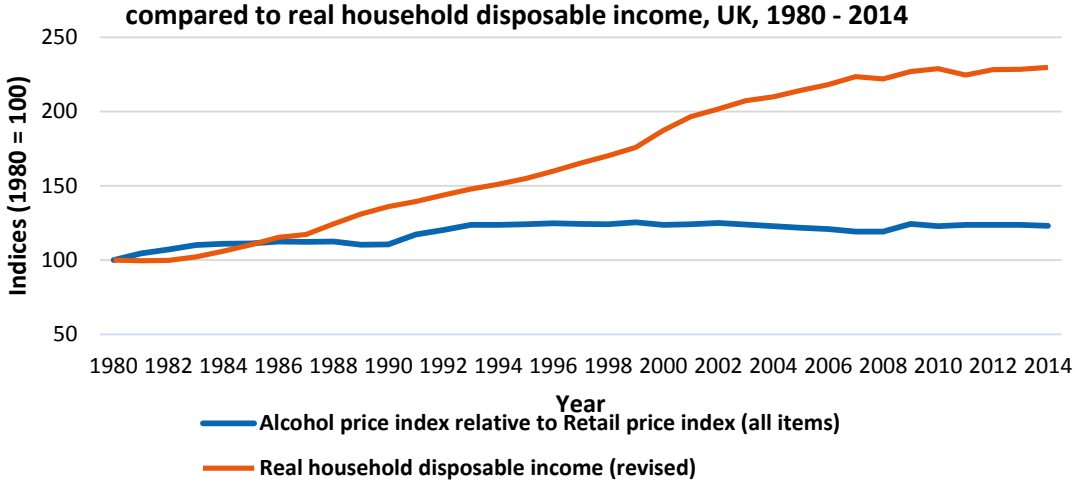
Costs of alcohol-related harm

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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