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Quaker Action on Alcohol and Drugs

THE COST OF ALCOHOL:
QAAD BRIEFING ON PRICE AND ALCOHOL-RELATED HARM

THE COST OF ALCOHOL: QAAD BRIEFING ON ALCOHOL HARMS

1. Introduction and context

1.1. QAAD has produced this briefing paper because of our concern with the human costs of alcohol-related harm. It sets out the reasons that the price of alcohol needs to rise, and the specific arguments for the introduction of a minimum price per unit.

1.2. Raising the price of alcohol is perceived to be unpopular by policy makers. A number of faith-based groups (the Methodists, the Church of England, the Evangelical Alliance, the Salvation Army and CARE) are working together to demonstrate to M.P.s - and to government - that substantial numbers of people understand the need for such a policy, and would welcome it. QAAD hopes that this briefing (or a digest of it) will assist Friends and Meetings in considering the issue, and support them in engaging with their M.P.s to promote changes that will minimise harm.

Background and current situation

- The price of alcohol in relation to income has dropped significantly in the last forty years. Alcohol was 69% more affordable in 2007 than it was in 1980; some is available for less than 20p per unit, and much at less than 30p – and more cheaply than soft drinks.
- The last Labour administration reviewed alcohol policy because of its concerns about health and social costs, which have risen significantly. In order to consider the options, the Department of Health commissioned a study on alcohol and pricing from the Social Research and Health Centre at Sheffield University (which is known as the ScHARR report). The results were published in 2008, and indicated that minimum pricing per unit – set at an effective level – would bring substantial reductions in harm.
- Minimum price per unit has 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. 50p per unit is the level at which harms could be reduced substantially.
- Successive Westminster governments have so far rejected this policy. However, the Liberal Democrats favoured it in their election manifesto, and the Scottish National Party attempted to introduce it in Scotland in 2010 and are likely to do so again.
- The Coalition government has confirmed previous plans to increase the tax on alcohol at a rate 2% higher than the retail price index, and some cheap higher strength products will be taxed more. However, medical bodies and Alcohol Concern assert this will have a very limited impact. The government itself describes these measures as 'a first step'.
- Any rise in the price of alcohol is welcome, though a serious increase is necessary to make an effective difference. Other measures that would help are presented in the conclusion.
- Although progress is slow, there is a growing recognition of these problems, and some policy-makers are addressing them. We are encouraged by the proposed Bill to limit alcohol advertising that children are likely to see, which would mean on television and social media. This Bill will have its second Parliamentary reading on September 9th, 2011.

2. Why does the price of alcohol need to rise?

- International studies have consistently shown that consumption - both harmful and general - rises and falls with price[i].
- A steady rise in alcohol-related problems has occurred as prices have fallen over the last decades. In 2009/10, there were 1,057,000 alcohol related admissions to hospital. This is an increase of 12% on the 2008/09 figure (945,500) and more than twice as many as in 2002/03 (510,800).[ii] The UK is the only developed country showing an upward trend in liver disease, and the age at which people suffer from it is falling. Alcohol-related deaths rose from 4,144 in 1991 to 6,584 in 2009.[iii] Current healthcare costs are estimated at £2.7 billion per annum. [iv]
- These problems are not confined to a small minority. Approximately 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.[v]
- Over one million incidents of alcohol-related violent crime occur every year. A recent study showed that 49% of offenders have an alcohol problem relevant to their offending[vi], while a Parliamentary answer in November 2010 stated that 37% of offenders subject to community penalties have an alcohol issue.
- 18% of 11-15 year olds have drunk alcohol,[vii] although The Chief Medical Officer has recommended that children under 15 do not drink alcohol at all. The percentage in this age group who drink has fallen recently, but the average amount they regularly drink is concerning (11.6 units per week on average, and over 15 units for a minority)[viii].
- 1 in 10 15-16 year olds report having been drunk three times in the last month,[ix] and there are over 7,500 hospital admissions for 11-17 year olds every year[x]. Risky patterns tend to persist into adulthood, making people vulnerable to alcohol-related illnesses.
- Alcohol plays a part in a quarter to a third of cases of child abuse, and approximately 705,600 children are living with hazardous drinkers.[xi]
- Children, young people, risky and hazardous drinkers all tend to consume cheaper alcohol.
- Studies indicate that **general price increases reduce alcohol-related harms -** and that this is more effective than attempting to target particular groups of people or particular drinks. 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.

'*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.*'[xii] Plant, M, (2009)

> *'The model results show that greater general price increases lead to larger consumption reductions. (ScHARR report, page 9)*

THERE IS STRONG EVIDENCE TO SUGGEST THAT YOUNG DRINKERS, BINGE DRINKERS AND HARMFUL DRINKERS TEND TO CHOOSE CHEAPER DRINKS. (SCHARR REPORT, PAGE 5)

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.' [xiii] Home Office review of evidence on pricing, 2011

3. Why is minimum pricing more effective than other pricing policies?

3.1. Rises in taxation or alcohol duty can be a help. However, these measures are mitigated by the economics of the supply chain, and therefore to have an uneven, and less effective, impact. A rise in taxation alone would not prevent discounting or 'on offer' bulk promotions, for example. Similarly, the amount that a drink costs to produce or sell (addressed in the recent 'no sale below cost price' policy) is not necessarily relevant to the key issue – the amount of alcohol it contains, and how that price relates to disposable income. A policy needs to be adopted that targets **all** forms of cheap alcohol, and prevents **any** being sold at too low a cost, in order to reduce 'switching' to other products or outlets.

3.2. The ScHARR study (commissioned by the Department of Health) analysed a large number of different pricing policies and various permutations between them, including:

a. A general price increase at different levels (namely 1%, 10%, and 25%)
b. minimum pricing per unit of alcohol, ranging from 15p to 70p per unit
c. a rise in the price of specific low-cost alcohol products
d. a reduction in various kinds of discounting and promotion ('on' and 'off-trade')

The modelled impacts took into account the fact that most cheap alcohol is sold 'off-trade' in supermarkets and off-licences, but some groups, particularly young people, also drink cheap 'on trade' alcohol in pubs and bars. It also took into account the 'price elasticity' and consumption patterns of different drinks and how they would respond to price changes.

3.3. Options (c) and (d) had relatively modest effects. Most measures showed reduced consumption of below 1%; even a total ban on all 'off-trade' discounting (the most effective of all these measures) only reduced consumption by 2.8%.

3.4. The other two policies showed substantial effects, as long as the level of increase was set high enough - but minimum pricing per unit is the more effective at reducing health harms. For example, a general price increase of 10% would result in a reduction of consumption of 4.4% - similar to the 4.5% that would be brought by a minimum price of 45p per unit. However, the estimated reduction in hospital admissions are 10,100 and 10,800 per annum respectively, and these benefits would be scaled up over ten years. Similarly, a general price increase of 10% would result in 1681 fewer deaths over ten years, as opposed to 2288 for a 45p minimum unit price. The main reason for the difference between the two is that minimum pricing targets risky and harmful drinkers more closely, by removing very cheap alcohol. When the price is 50p per unit, the reduction is 6.9%, and the benefits in reduced harms are considerable. [xiv] Of course there are even greater gains at higher levels, but 50p was deemed to be an achievable level by health bodies.

3.5. A further minimum pricing option that showed significant impact was the combination of a minimum price of 40p for the 'off-trade,' and £1 for the 'on-trade'. This showed 294 fewer deaths in the first year and 13,400 fewer hospital admissions. It also had a slightly stronger impact on reducing crime than a flat minimum price of 50 p per unit, largely because it had more of an effect on evening drinking in pubs and clubs, and the attendant crime that arises. At a lower level, a minimum price of 30p off- and 80p on-trade gives an estimated consumption change of -2.1%.

3.6. 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. 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 different kinds of harm. It also showed that these harms could occur at any level of drinking.[xv]

3.7. Minimum pricing would send out an education message that alcohol content is the key issue for all drinkers. Aside from the intrinsic benefit, this could also have an impact on the market. For example, women's drinking and harmful drinking has shown one of the steeper increases[xvi]. 57% of total women's consumption is in wine,[xvii] which has become stronger over recent years. A bottle of 10% proof wine contains 7.5 units, whilst a 14.5% contains 10.9. At 50p per unit they would cost £3.75 and £5.45; cheap wine would be more likely to mean weaker wine.

'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, page 6

'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) from a study of 15-16 year olds

4. What would be the effects of a minimum price of 50p per unit?

4.1. The ScHARR report estimated that a minimum price of 50p per unit would result in:

- Over 1600 fewer hospital admissions in the first year and 97,900 fewer in ten years' time
- 406 fewer deaths in the first year and 3,393 fewer in ten years
- 10,300 fewer violent crimes per annum
- An average reduction in consumption of 7.3% for drinkers aged 11-18 years
- 500 fewer hospital admissions in this age group per annum
- 2,200 fewer violent alcohol-related crimes in this age group per annum
- A 3% drop in consumption in the risk group of those aged 18-24
- Reduced absenteeism from work of 3.3% and a decrease in unemployment costs
- £66 million per annum savings in reduced health costs, and £49.6 million in crime costs in the first year.

4.2 As is apparent from some of the figures, the benefits would increase over time; this policy would be a preventative measure as well as one that addresses current problems. Over 10 years, £1.37 million in health care costs would be saved, with an immeasurable benefit in quality of life for the individuals and families involved.

5. Objections to minimum pricing:

5.1 The majority of responsible drinkers should not be penalised for the minority

- A quarter of the population is drinking riskily - too large a proportion for small-scale measures. A recent European report indicates that in the UK 1 in 10 of male cancers and 1 in 33 female cancers are caused by alcohol.[xviii]
- The effect on moderate drinkers of a 50p minimum price per unit is estimated to be about £15 per annum, whereas for hazardous drinkers, the figure is £93.11. There might be differential effects on individuals depending on the cost of the alcohol that an individual favours (an average strength bottle of wine containing 9 units would need to be sold at £4.50, for example, and a bottle of spirits containing 28 units would need to cost at least £14.00) - but the average effect on moderate drinkers overall would be relatively light. The 10 million people who drink over recommended limits account for 73% of total alcohol consumption[xix]
- The overall costs of alcohol harms are estimated to be three times the amounts raised in revenue duty.[xx] Focusing only on the price a person pays to buy alcohol disregards the costs they pay in taxation for the NHS and criminal justice services.
- 'Softer' benefits in terms of greater safety and amenity would also be experienced by the moderate drinker. The environmental ill-effects are felt particularly in poorer areas.
- It is worth noting that even drinking within recommended limits is not risk-free. Current limits mean that approximately 1 in 100 people who drink within these levels have a lifetime risk of dying from an alcohol-related condition. Cheap alcohol also 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. [xxi]

5.2 Minimum pricing per unit would penalise those on lower incomes

- People in the most deprived groups are actually more likely not to drink at all. (In a recent study only 33% of households on the lowest income band purchased alcohol in the last week, as opposed to 70% in the highest).[xxii]
- The study also showed that the purchasing of cheaply-priced alcohol is distributed across income groups.
- People on lower incomes are more likely to drink 'on-trade' in pubs, for example, where prices would be less affected by 50 p minimum pricing per unit.
- People in less advantaged socio-economic groups are more likely to suffer alcohol-related harm if they do drink – perhaps because health and social problems seem to exacerbate each other (as the recent book 'The Spirit Level'[xxiii] 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, and women are three times as likely.[xxiv]

'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, for example, 30 per cent of men drank more than 4 units and 14 per cent 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 per cent and 26 per cent respectively. The difference for women was even more marked. In households with income of £200 or less per week, 17 per cent of women exceeded 3 units and 8 per cent exceeded 6 units on their heaviest drinking day. These proportions rise to 43 and 19 per cent respectively in households with income in excess of £1,000 per week'[xxv]

'*The tendency for middle and higher income groups to buy more low price alcohol is more noticeable in the price bands at 30p to 40p and 40p to 50p than in the price band below 30p. This may suggest that higher values for a minimum price (40p or 50p rather than 30p) will spread the effect more evenly across income groups*.'[xxvi]

'There was limited evidence around the impact of increasing alcohol price on different income groups. Findings are limited to two studies; one of which indicated that low socio-economic groups may be more responsive to changes in alcohol affordability than others. Findings from the second study, examining purchasing patterns of alcohol, suggest all income groups purchased low price off sales alcohol, although low income groups were less likely to purchase off sales alcohol at all'. [xxvii] Home office review, 2011

5.3. Hazardous and problem drinkers would be unlikely to change their behaviour because they are dependent

- The vast majority of people drinking over recommended limits are not 'addicted' - but they are drinking enough to damage their health. 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.
- There is relatively little research on the most heavily dependent group. Some have argued they are less price-responsive, but if the increase is sufficiently serious, they will be affected at least to some degree. It is true the policy could present difficulties for some, but treatment and support (rather than cheap alcohol) needs to be the response.
- Minimum pricing per unit would mean fewer people become severely dependent. Cheap alcohol plays a significant role in initiating and sustaining early problematic drinking that continues into adulthood.

'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, p 124

'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 Scottish health committee.[xxviii]

'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....' [xxix] 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.[xxx]

5.4 Alcohol consumption has reduced over the past couple of years, so problems will begin to fall without such drastic measures.

It is true that there has been a fall in consumption and risky consumption recently, from a high-point in 2007/8, though women's drinking has scarcely decreased. 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: in England they were 1.1.million in 2009/10, an increase of 12% on 2008/9.[xxxi] 70% of peak time attendances to Accident and Emergency Departments are alcohol-related. Even if these figures fall, they are far too high. The economic climate may be linked with the downturn in drinking, but whatever the reasons, the price of alcohol needs to be rebalanced to reduce harm - and this needs to be done on the rational basis of alcohol content.

5.5. The government is acting to stop sales of alcohol to under-aged drinkers: won't that be enough to tackle problems among the young?

It is certainly welcome that the penalty for sale of alcohol to under-age drinkers is to be increased. Identity/proof of age schemes are also useful: a Scottish study of 2001 suggests that the under-age drinkers with the most problematic patterns tend to be those who buy from several outlets. Many female drinkers had also been served in clubs despite being under-age. However, later Scottish evidence suggested 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. [xxxii] 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 effective if combined.

5.6. Minimum pricing would contravene European law

Minimum pricing per unit has not yet been tried, nor has there been a direct parallel within the EU. Opponents of minimum pricing per unit - particularly in the drinks industry - have emphasised the doubts in this area. Article 34 of EU law forbids measures that favour the producers of a member state and/or work against free flow of goods. Article 36 allows a public health defence for breaches of this, but the onus is on the member country to prove that measures are proportionate and not arbitrary. The Scottish Parliamentary Select Committee thought that the 'proportionality' argument might rest on the level of minimum price per unit that was chosen, but the law did not get as far as being passed in the last Parliament. The Westminster Parliamentary Select Committee also recommended minimum pricing per unit, though it had considered the European dimension.

There is some ambiguity that might only be resolved by action, but it is apparent that there is a valid public health case to be mounted, and as a member state, we should be advancing it. We would be joining with others in the EU concerned about alcohol-related problems: for example, a 2006 World Health Organisation European Report[xxxiii] urged action on price.

5.7. The ScHARR report is based on modelling, and not 'real world' evidence

This is the argument adduced by opponents of minimum price per unit in the Scottish Parliament. Minimum pricing has not yet been tried elsewhere, so data had to be extrapolated in a model. However, the report was commissioned by the Department of Health and its recommendations were based on detailed 'real world' statistical data, as well as a review of hundreds of studies from many countries. It has been peer reviewed and widely quoted in international literature, with which it is consistent.

6. Conclusion and possible ways forward

6.1. The evidence indicates that health bodies argued for the most effective practicable policy option to reduce harm - namely minimum pricing at 50p per unit. However, the rejection of it by politicians has left rather a hiatus. There is obviously some ground between the policy goal of 50p per unit and the current position – and this needs to be explored if we are to move into more effective territory.

6.2. Steps on the way to minimum pricing at 50p per unit could include:

- A total ban on off-trade discounting (which would result in a reduction in consumption of 2.8%)
- A general price increase of 10% (-4.4% consumption)
- The acceptance of the principle of minimum price per unit, but set at a lower level which could then be moved up: (45p per unit gives an estimated 4.5% reduction in consumption, as opposed to 6.9% for 50p, for example)
- An off-trade price of 40p minimum per unit combined with £1 minimum price for on-trade (- 5.4% consumption)

6.3. The recent Scottish election result is likely to put minimum pricing per unit back into the policy arena, spur further debate, and perhaps test EU law. Faith groups can play a useful part in engaging with M.P.s and policy makers in a dialogue that brings the whole issue of price up the agenda, by demonstrating public understanding and support. Liaison with health bodies and with Alcohol Concern particularly would be part of this.

6.4. In addition to minimum pricing per unit, other measures that QAAD supports are tax or other incentives to favour lower alcohol drinks (wines and beers have got stronger, but lower strength versions could be taxed less, for example); the banning of promotions/discounting (such as bulk discounts and 'two for one' offers); the pending Parliamentary Bill to prevent advertising that affects children; an increase in licensing controls; and a lowering of the blood alcohol limit for legal driving to 50 m.g. We also support Alcohol Concern's campaign 'Making alcohol a health priority' [xxxiv]and its suggested programme of investing in prevention and treatment.

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