Druglink page for December 2012/January 2013

ALCOHOL LICENSING, PRICE AND TAXATION

For later policy developments see these hot topics on pricing policy and controlling alcohol-related disorder including licensing law and allied developments.

For England and Wales the 2012 national alcohol strategy represented what may prove to be a turning point in the politics of UK alcohol policy – acceptance that drink-related harm is spread across much of the population and that the counter-measures too must affect the population as a whole, even if it inconveniences them or makes bigger alcohol-related holes in their pockets – and even if it may lose votes. In opposition Conservative party plans were focused on binge drinking youngsters, now they have grasped a nettle which might alienate most adult voters.

The nettle concerned was to set a uniform minimum price per unit of alcohol across all drinks which might substantially raise the costs of the cheaper products. A step closer to this was taken when in November 2012 a consultation was announced on setting a minimum per unit price. The Home Office at first gave £0.40 as an example but later upped this to £0.45 in line with the consultation document, though some health campaigners say £0.50 is needed. The consultation also proposed a ban on off-licence promotions offering discounts contingent on buying several drinks at once.

The same nettle had already been grasped in Scotland, which has also moved further to making unit pricing a reality. As long ago as 2009 the Scottish national alcohol strategy committed the government to a minimum price per unit of alcohol and included plans to ban the sale of alcohol as a loss-leader. At first the parliament rejected the minimum pricing element but another attempt was made which in June 2012 became law in the form of the Alcohol (Minimum Pricing) Scotland Act. This enables the government to issue regulations setting a minimum unit price, which it intends to set at £0.50.

Scientific and expert support for such moves includes guidance from the World Health Organisation, whose possible impact was recently modelled for Australia. That exercise confirmed that in countries such as the UK where hazardous drinking is common, raising alcohol taxes has the greatest yet least resource-intensive impact on public health. Next most cost-effective were licensing controls. Britain has substantially contributed with modelling exercises based on data from England (study 1) and Scotland (study 2) which on public health grounds supported setting a relatively high minimum price per unit of alcohol. With these analyses available to them, Britain's National Institute for Health and Clinical Excellence (NICE) argued that price rises and licensing changes to reduce the number of outlets were the key public health levers.

Despite scientific backing, the stuttering and in some political quarters reluctant progress to accepting a minimum unit price in the UK illustrates the difficulty democratic administrations face in imposing major (rather than incremental) price rises on majority-drinking populations, and also in facing up to the power of sections of the alcohol industry opposed to such rises. The new Scottish law and the plans for the rest of the UK may yet be derailed by arguments that they contravene UK devolution and/or European Union free trade laws. Unless renewed after five to six years, the Scottish provision falls by default. The plan for England and Wales is not to be implemented until October 2014 subject to an impact assessment and consultation. Even if it survives the politics, it too may face legal challenges. Most pertinent is the detailed opinion of the European Commission on the Scottish proposals, which suggests they may constitute a disproportionate restriction on free trade and competition, and also that they could counter-productively increase the incentive for the alcohol industry to market the affected products due to higher profit margins gifted them by a high minimum price. That margins and industry revenue will increase is acknowledged by impact assessments for Scotland and England, though how much extra profit will remain after costs and which sector of the industry will benefit most is unclear. The Conservative party also faces the uncomfortable prospect of being hoist on its own petards of deriding the 'nanny state', rolling back state control of the market, and its previous stress that the majority drinking public should not be punished for the antics of the minority of rowdy binge drinkers. Government impact assessments (1 2) acknowledge that those 'punished' most will be the poorest regular drinkers, though they too stand to gain in health terms if they respond as expected by cutting their drinking.

While tax and unit pricing have been at the forefront of political debate, regulating availability and minimising harm through licensing are also major tactics. The Licensing Act 2003 seemingly has not made things much worse, but as detailed in this Findings analysis, neither did it give local authorities in England and Wales the power to make things much better, though in Scotland licensing authorities have greater scope. A potentially far-reaching innovation made in Scotland was to include prevention of health harm among the objectives which must be considered while making licensing decisions. For England and Wales the much more modest innovation was from April 2012 to give local health bodies the power to make representations to licensing authorities, but only in in respect of impacts related to existing licensing objectives such as crime and disorder and public safety, not health as such. A further but still modest step consulted on at the end of 2012 would enable (but not oblige) licensing authorities to take alcohol-related health harms into consideration when making decisions about cumulative impact policies. These policies can be used to refuse or restrict licensing applications in areas where the high density of outlets is leading to adverse impacts within the terms of licensing law objectives. Added to these for this purpose only – not for licensing decisions in general – would be health.

One fly in the ointment rarely highlighted in public health studies is that health – the focus of most research-based policy recommendations – has little to do with why most Britons drink. The 'benefits' drinkers themselves feel they get are rarely valued in to cost-benefit calculations.

In the recent past at least one UK government analysis has also argued that drinking produces social and business benefits for society as a whole due to "alcohol's capacity to act as a catalyst in social interactions and leisure experiences ... promoting social cohesion", but then as now there is no study on which estimates of these benefits could be based, so they are omitted from calculations.

Neglect of benefits from drinking was one of the criticisms (study 3) made by a prominent alcohol expert and sociologist of attempts to establish a total cost (or cost reduction due to policy changes) to society of alcohol-related harm. He argued that though the constituents such as lives saved, crimes not committed, and illnesses avoided, may in themselves be good enough reasons to curtail the availability of alcohol, amalgamating these 'apples and pears' and attaching a monetary value to them is such a value-laden and imprecise exercise that it is of propaganda value only in determining policy. The British exercises in particular were dominated by productivity gains due to less drink-related unemployment, calculations which, it was reasoned, unrealistically assumed no countervailing benefits. Yet in the absence of full employment, vacancies left by drinkers will usually be filled by someone else, ending perhaps via a chain of job changes in someone currently unemployed gaining a job.

Other critics too have attacked the modelling exercises for England (study 1) and Scotland (study 2) as so subject to error and questionable assumptions that they cannot be relied on as guides to policy. For example, it was argued that the degree to which drinkers cut consumption of one type of beverage when it increases in price is not a guide to how far they will cut back when alcohol prices overall increase. In the former scenario they can switch to other drinks, in the latter they cannot so may opt instead to maintain consumption by paying more. When the Home Office itself valued the costs and benefits of minimum per unit pricing, they accepted that "The costs of lost productivity due to alcohol misuse are substantial", but excluded these from their calculations while consulting to see if more secure estimates can be made. Partly for this reason their estimate of the net benefit to society of a £0.45 unit price was £352 million over ten years, just £35 million a year, much less than in UK modelling exercises which included

productivity gains. The Home Office also accepted that drinkers gain benefits from their drinking and that to a degree these will be countered or eroded as drinkers are forced to pay more for these benefits and/or forgo them. There will be some countervailing gains for the alcohol industry, but the result would, it was said, be a "decrease in net social welfare".

Whether as predicted consumption will fall when minimum per unit prices are imposed has been assessed in real-world studies, of which two from Canada have been influential. The most relevant (study 4) estimated that a 10% increase in minimum price across all beverages had been significantly associated with an 8.4% reduction in total consumption. However, in the Canadian studies the provincial governments had a direct influence on the alcohol market via government alcohol distribution monopolies. Similarly, whether health really will improve as alcohol rises in price is best assessed directly, but the data is very limited. A comprehensive review widely relied on found just one study capable of addressing net health harm/benefit, because it related tax to *overall* mortality, whatever the cause. In this study, US state alcohol taxes were weakly related to fewer deaths overall, but not with sufficient strength or consistency to eliminate the possibility that the relationship was due to chance rather than to a real link with tax levels.

The possible prize in purely public health terms – health improvement among the largest achievable by any feasible means – is great, but so too are the uncertainties and the obstacles, not least a British public consisting overwhelmingly of people who drink and many who drink a lot, and politicians who need their votes. Run this search for the evidence and debate on this truly hot topic.

MAJOR SOURCE STUDIES **Click blue titles to download the Findings analysis**

1 Independent review of the effects of alcohol pricing and promotion. Meier P. *et al*. University of Sheffield, 2008.

Commissioned by the English health department, the first study to model the impacts of alcohol policies by integrating data on pricing, promotion, purchasing, consumption and harm found that raising price or banning promotions can bring major benefits. The findings helped persuade government to introduce a minimum per unit price for alcohol.

2 Model-based appraisal of alcohol minimum pricing and off-licensed trade discount bans in Scotland. Meier P. *et al*. University of Sheffield, 2009.

Estimates that a £0.40 minimum price per unit of alcohol plus a ban on discount promotions would cut drinking by 5.4% in Scotland, saving a life every day once the policy fully takes effect, and over the first ten years saving £millions in public and private sector costs.

3 Cost-of-alcohol studies as a research programme. Mäkelä K. *Nordic Studies on Alcohol and Drugs*: 2012, 29, p. 321–343.

Prominent alcohol expert argues that estimates that drinking imposes billions of pounds of costs on society are so value-laden and imprecise that their main value is as propaganda. Policies like increasing the price of drink may be justified on other grounds, but not by a misleadingly appealing total cost or cost reduction figure.

4 The raising of minimum alcohol prices in Saskatchewan, Canada: impacts on consumption and implications for public health. Stockwell T., Zhao J., Giesbrecht N. *et al*. *American Journal of Public Health*: 2012, 102(12), p. e103–e110.

The Canadian province of Saskatchewan offered a confirmatory real-world test of whether plans in Britain to impose high minimum price for a unit of alcohol really will reduce consumption, first step in the chain expected to lead to improved public health and productivity and reduced crime.