Agenda – Health, Social Care and Sport Committee

Meeting Venue:	For further information contact:
Committee Room 2 – Senedd	**Claire Morris**
Meeting date: 23 November 2017	Committee Clerk
Members pre-meeting: 09.15	0300 200 6355
Meeting time: 09.30	SeneddHealth@assembly.wales

Informal pre-meeting (09.15 – 09.30)

1 Introductions, apologies, substitutions and declarations of interest

2 Public Health (Minimum Price for Alcohol) (Wales) Bill – evidence session 1 – Public Health Wales and the health boards' Directors of Public Health

(09.30–10.15) (Pages 1 – 35)

Dr Kelechi Nnoaham, Executive Director of Public Health, Cwm Taf University Health Board

Fiona Kinghorn, Deputy Director of Public Health, Cardiff and Vale University Health Board

Conrad Eydmann, Head of Partnership Strategy and Commissioning, Cardiff and Vale University Health Board

Dr Julie Bishop, Director of Health Improvement, Public Health Wales NHS Trust

Break (10.15 – 10.20)

3 Public Health (Minimum Price for Alcohol) (Wales) Bill - evidence session 2 - BMA Cymru Wales, Royal College of Physicians and Royal College of Psychiatrists

(10.20 - 11.05) (Pages 36 - 50)

Dr David Bailey, Chair of the BMA Welsh Council

Dr Ruth Alcolado, Royal College of Physicians

Dr Ranjini Rao, Royal College of Psychiatrists

Break (11.05 - 11.15)

4 Public Health (Minimum Price for Alcohol) (Wales) Bill - evidence session 3 - Directors of Public Protection Wales and the Welsh Local Government Association

(11.15 - 12.00) (Pages 51 - 53)

David Riley, Chair of the Wales Heads of Trading Standards, and Head of Public Protection Services in Anglesey

David Jones, National Coordinator, Trading Standards Wales

Simon Wilkinson, Policy officer, Welsh Local Government Association

5 Paper(s) to note

5.1 Public Health (Minimum Price for Alcohol) (Wales) Bill - letter from the Committee to the Cabinet Secretary for Health and Social Services regarding stage 1 scrutiny

(Pages 54 - 57)

5.2 Public Health (Minimum Price for Alcohol) (Wales) Bill - letter from the Cabinet Secretary for Health and Social Services regarding stage 1 scrutiny

(Pages 58 - 74)

6 Motion under Standing Order 17.42 to resolve to exclude the public from the remainder of the meeting

7 Public Health (Minimum Price for Alcohol) (Wales) Bill – consideration of evidence

(12.00 – 12.15)

Agenda Item 2

Document is Restricted

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

Date: 10 November 2017	**Version:** 1

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

2 Stockwell and Thomas, (2013). Is alcohol too cheap in the UK? The case for setting a Minimum Unit Price for alcohol.. Institute of Alcohol Studies Report

3 Wagenaar AC, Salois MJ, and Komro KA (2009) Effects of beverage alcohol price and tax levels on drinking: a meta-analysis of 1003 estimates from 112 studies. Addiction, 104, 179-90

4 Wagenaar, A., Tobler, A. and Komro, K. (2010) Effects of alcohol tax and price policies on morbidity and mortality: A systematic review. American Journal of Public Health, published online September 23, 2010 at: http://ajph.aphapublications.org/cgi/content/abstract/AJPH.2009.186007v1

5 World Health Organisation (2009) Harmful Use of Alcohol [online] Available at: http://www.who.int/nmh/publications/fact_sheet_alcohol_en.pdf

6 Public Health England (2016) The Public Health Burden of Alcohol and the Effectiveness and Cost-Effectiveness of Alcohol Control Policies - An Evidence Review. [online] Available at: https://www.gov.uk/government/publications/the-public-health-burden-of-alcohol-evidence-review

7 UK Chief Medical Officers' Low Risk Drinking Guidelines. [online] Available at: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/545937/UK_CMOs__report.pdf

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[23] Women drinking less than 14 units a week and men drinking less than 21 units a week.

[24] Women drinking more than 35 units a week and men drinking more than 50 units a week

[25] Welsh Government, (2014) Model-based appraisal of minimum unit pricing for alcohol in Wales

An adaptation of the Sheffield Alcohol Policy Model version 3. [online] Available at: http://www.senedd.assembly.wales/documents/s42760/ASMAI%2033%20University%20of%20Sheffield.pdf

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THE WELSH NHS CONFEDERATION
CONFFEDERASIWN GIG CYMRU

	The Welsh NHS Confederation response to the Health, Social Care and Sport Committee consultation on the Public Health (Minimum Price for Alcohol) (Wales) Bill.
Contact	Nesta Lloyd – Jones, Policy and Public Affairs Manager, the Welsh NHS Confederation. [redacted] Tel: [redacted].
Date:	10 November 2017.

Introduction

1. The Welsh NHS Confederation welcomes the opportunity to respond to the Health, Social Care and Sport Committee consultation on the Public Health (Minimum Price for Alcohol) (Wales) Bill.

2. The Welsh NHS Confederation represents the seven Health Boards and three NHS Trusts in Wales. The Welsh NHS Confederation supports our members to improve health and well-being by working with them to deliver high standards of care for patients and best value for taxpayers' money. We act as a driving force for positive change through strong representation and our policy, influencing and engagement work.

3. We support the introduction of Minimum Unit Pricing (MUP) to reduce the substantial harm associated with excess alcohol consumption in Wales. There is overwhelming scientific evidence that excessive consumption of alcohol significantly increases risk to long-term health. Alcohol is a factor in a wide range of serious medical conditions, including liver disease and cancer, and leads to thousands of hospital admissions every year. We agree that one of the best, and proportionate, way to reduce ill-health and other related social costs of excessive alcohol consumption in Wales is to control the price of alcohol.

Terms of Reference

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 price.

4. We support the general principles of the Public Health (Minimum Price for Alcohol) (Wales) Bill. There is compelling evidence, both from across the UK and internationally, that introducing a MUP in Wales would lead to significant improvements in health and well-being of the population.

5. 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 MUP is a targeted measure that will impact beneficially on the heaviest drinkers and other groups particularly at risk from alcohol related harms. Moderate drinkers will experience relatively minor change in the amount they have to pay for alcohol.

6. MUP sets a floor price for a unit of alcohol, meaning that alcohol could not legally be sold below that price. This would not necessarily increase the price of every drink, only those that are sold below the minimum price e.g. cheap spirits, beer, ciders and wine. MUP is based on two fundamental principles[i] that are widely supported by evidence:
   - When the price of alcohol increases consumption by most drinkers goes down including, critically, consumption by hazardous and harmful drinkers (i.e. heavier drinkers); and
   - When alcohol consumption in a population declines, rates of alcohol-related harms also decline.

7. Alcohol has become steadily more affordable in recent years, with there being a real term reduction in the cost of alcohol.[ii] Whilst overall alcohol consumption has declined in the last few years, in the UK we are still drinking over 40% more litres per head of population than we were in 1970.[iii] Although the reasons behind this are complex and multi-factorial, affordability is a key factor, and more than 100 international studies clearly demonstrate a link between affordability of alcohol and alcohol consumption.[iv] Alcohol is 60% more affordable than it was in 1980[v] when compared with average household income, and channels for its availability have multiplied far beyond the local pub. The majority of alcohol is now sold in the off-trade (such as in off licences and supermarkets), where alcohol is routinely offered at reduced prices to attract people into their stores.

8. In Wales, one in five (20%) of adults in 2016 said that they had drank more than the recommended guidelines and almost a third (31%) of adults drank more than three units (women) or four units (men) on at least one day the previous week.[vi] Increased drinking over time has had a detrimental impact on the nation's health and well-being. Alcohol consumption accounts/ accounted for:
   - 504 alcohol-related deaths registered in Wales in 2016;[vii]
   - Around 30,000 hospital bed days in Wales. It is estimated that, on average, there is an alcohol-related hospital admission every 35 minutes;[viii]
   - 15,165 hospital admissions related to alcohol in 2016 – 17;[ix]
   - 10,081 individuals admitted with an alcohol specific condition in any diagnostic position in 2016-17, accounting for 13,512 admissions.[x] 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;[xi]
   - Estimated cost to NHS Wales is between £70 million and £85 million each year[xii] (the combined cost of alcohol-related chronic disease and alcohol-related acute incidents). National costs from alcohol related harms (health, social, economic and criminal justice) are equivalent to around £900 per family annually,[xiii] with the estimated to cost the Welsh nation £1 billion per year;[xiv]
   - 592,000 violent incidents where the victim believed the offender(s) to be under the influence of alcohol, accounting for 47% of violent offences that year. Alcohol routinely accounts for over 40% of all violent crimes committed[xv] and, as well as youth violence, is strongly associated with domestic violence, child abuse and self-directed violence (e.g. suicide);[xvi] and

- Increased risk of developing over 60 different health problems[xvii] 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;

9. Young people are especially vulnerable to harms of drinking alcohol.[xviii] They are also vulnerable to the harms from other people's drinking particularly their parents. The Public Health Wales NHS Trust Welsh Adverse Childhood Experience study in 2015 found long term impacts on children of parents who misused alcohol (and other negative experiences relating to alcohol misuse such as abuse, domestic violence and a family member being in prison). This results in a vicious cycle of harm – children who have four or more adverse childhood experiences are themselves four times more likely to grow up to be high risk drinkers themselves.[xix]

10. These harm, and the related costs, could be substantially reduced if MUP was to be introduced. Based on the evidence, highlighted below, we regard a level of 50p per unit MUP as an appropriate level at which to initially establish a MUP. It is estimated that a minimum price of 50p per unit would see 53 fewer deaths and 1,400 fewer hospital admissions in Wales per year.[xx]

11. Sufficient modelling has already been undertaken in England, and elsewhere, to estimate the benefits that a 50p MUP would have on alcohol consumption and related health harms. However, this is based on current levels of affordability of alcohol, 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 and the frequency of review should be based on the level of change in the retail price index.

12. Numerous studies have shown that the price of alcohol, and more particularly its price relative to income, is one of the main factors in determining levels of consumption. Both US and UK data show that the heaviest drinkers gravitate towards the cheapest alcohol.[xxi] 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 and the evidence, both in the UK and internationally, has led several countries to consider MUP policy.

13. A 2005 review[xxii] by the World Health Organisation (WHO) of 32 European alcohol strategies found that the most effective measures to curb alcohol related health harms include changes to price and availability. In 2011, researchers at Bangor and Glyndŵr Universities[xxiii] came to the following conclusion: "*Within the international literature on reducing alcohol consumption and the harm related to alcohol, the finding with the strongest evidence base is that consumption of alcohol is highly sensitive to changes in price (or, to be more accurate, affordability). When the price of alcohol drops, more is consumed; when alcohol becomes more expensive, less is consumed*."

14. In 2014, research by Sheffield University[xxiv] on the impacts of introducing a 50p minimum unit price estimated the following:
    - A 50p MUP would result in 53 fewer deaths and 1,400 fewer hospital admissions in Wales per year;
    - A 50p MUP would save the Welsh NHS more than £130m over 20 years, by reducing impacts on health services, such as Accident and Emergency;
    - It would reduce workplace absence, which is estimated would fall by up to 10,000 days per year;
    - Crime is estimated to fall by 3,700 offences a year overall. A similar reduction is seen across the three categories of crime – violent crimes, criminal damage and robbery, burglary and theft;
    - The total societal value of these reductions in health, crime and workplace harms is estimated at £882m over the 20-year period modelled.

15. Recent modelling in England[xxv] suggests that a 50p MUP would result in:
- A harmful drinker drinking 368 fewer units per year;
- A moderate drinker drinking 11 fewer units per year; and
- An annual reduction in alcohol related deaths of 12.3% and in alcohol related hospital admissions of 10.3%.

16. Work in Scotland suggests that an MUP of 50p per unit would reduce alcohol-related hospital admissions in Scotland by 8,900 annually and would reduce alcohol related criminal offences by 4,200, with a total value of an estimated saving of £1.3 billion over 10 years.[xxvi]

17. In Wales, modelling[xxvii] 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; and
    - An annual reduction in alcohol related deaths of 12.3 per cent and in alcohol related hospital admissions of 10.3 per cent.

18. MUP in Canada has proved a successful measure for reducing alcohol-related harms; including reducing alcohol-related deaths. In British Columbia,[xxviii] with a population of 4.6million, a 10% increase in the average minimum price of all alcoholic beverages was associated with a 9% decrease in acute alcohol-attributable admissions and a 9% reduction in chronic alcohol-attributable admissions two years later. It was estimated from this that a 10% (approximately 6p) increase in average minimum price was associated with 2% (166) fewer acute admissions in the first year and 3% (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.

19. Although the explanatory memorandum says MUP is not massively regressive, the evidence is still unclear on this point. However, what is clear from the evidence is that if MUP is regressive, this regressivity is not unfair when considered against the social pattern of alcohol related harm. By comparison to MUP 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.

20. Based on evidence from Canada and elsewhere, MUP would help substantially in reversing these health harming trends relating to alcohol consumption in Wales.

Any potential barriers to the implementation of the provisions and whether the Bill takes account of them;

21. One of the significant barriers to implementation of the Bill is the outcome of the Supreme Court case, Scotch Whisky Association and others (Appellants) v The Lord Advocate and another (Respondents) (Scotland), which we are still waiting judgement on.

22. While the Alcohol (Minimum Pricing) (Scotland) Act 2012 was passed in June 2012, the legislation has not yet been implemented due to a legal challenge led by the Scotch Whisky Association. The Supreme Court hearing took place in July 2017 and the judgement due imminently (15th November 2017).

23. Another barrier, which is highlighted in more detail below, is the ability of Local Authorities to enforce the MOU. The receipt of penalty notice payments should mitigate but upfront costs could still present a barrier.

Whether there are any unintended consequences arising from the Bill;

24. There are some consequences arising from the Bill that should be considered, but should not prevent the Bill being passed by the Assembly.

Consumers/ the public;

25. Moderate drinkers are unlikely to change their habits. For harmful and hazardous drinkers, if they are able to make a rational decision, it is possible that alcohol consumption will fall. However, a proportion of people in these categories will be addicted to alcohol and will need help to reduce their drinking. Many middle-class people whose drinking exceeds the recommended limits are likely to continue to do so, as it is a lifestyle choice which they will remain able to afford.

26. Concerns around the possibility of a hard-hitting impact on those with low incomes have been a critical consideration of MUP debate.[xxix] Many of health harms related to alcohol misuse disproportionately on most deprived communities – alcohol related deaths in Wales increase as levels of deprivation increase (quintiles).[xxx] Research shows that people on a low income or who are living in deprived areas are more likely to suffer from a long-term illness as a result of drinking too much. A recent annual statistical report[xxxi] on alcohol and drug use in Wales highlights that the proportion of all patients admitted for alcohol specific conditions living in the most deprived areas was 3.8 times higher than those from the least deprived areas. However, MUP can potentially reduce levels of harmful drinking in these groups, meaning the risk of alcohol-related harm would be reduced.

27. The impact on low income drinkers will depend on whether they are alcohol dependent (alcoholic) or heavy drinkers by choice. The impact on alcoholics will further depend on whether or not appropriate treatment and support services are available to help them to quit. It is possible that NHS costs could increase in the short term, as additional services for alcoholics who wish to quit may be required.

28. The modelling report for Wales in 2014[xxxii] estimates that moderate drinkers (62% of the population) consume on average 5.5 units per week, spending £310 per year on alcohol. High risk drinkers (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.

29. There is a potential impact upon young people, who are often the consumers of high strength, low price alcohol, in that they may turn to other substances which are lower cost e.g. legal highs, solvents or illegal drugs. The population level consumption data suggests that young people are drinking less than they used to, which is a positive trend, but care should be taken to observe whether there is a shift to use of other substances and this should be tracked as the MUP Act is implemented. Those professionals who work with and educate young people should be aware of a potential shift. The Bill and the evidence behind it could be communicated through substance misuse education programmes in children and young people's settings, as it provides an opportunity to raise awareness of the implications of hazardous and harmful drinking amongst this population group. It could also raise children and young people's understanding of the signs of alcohol withdrawal which could be affecting their family members.

30. There will be a need for public awareness work to ensure that the wider population are aware of the signs of withdrawal from alcohol where individuals who are unknowingly dependent and consume less following introduction of the Bill, may be at risk of harm through withdrawal.

Retailers;

31. It is possible that retailers will see a reduction in sales. Supermarkets should be able to compensate for reductions in alcohol sales by promoting other lines, but small off-licences are likely to be hardest hit.

Public sector

32. The burden of inspection and control will fall on Local Authorities, adding to their costs, which have been considered within the financial impact of the Bill. 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.

33. The health service in Wales should ultimately benefit, as there should be fewer admissions for alcohol related conditions, but it may be difficult to attribute reductions to the introduction of MUP, as alcohol consumption at most ages, but particularly in young people, has already begun to decline. There may be greater demands on primary care from people trying to reduce their alcohol intake. 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. Health Boards need to develop and promote non-abstinent harm reduction treatment and support programmes for alcohol users that focus on reducing consumption to less harmful levels, rather than eliminating consumption. There may be a perception among the general public that all alcohol treatment and support has a default expectation of achieving abstinence – this may discourage harmful drinkers seeking to support in order to reduce and control their alcohol consumption levels.

34. The inclusion of impacts of MUP on crime is an important health and well-being consideration. As well as harm to the individual who is drinking, alcohol consumption can also improve the well-being of wider society through reducing alcohol-related crimes, including those relating to violent, anti-social and disorderly behaviour, acquisitive crime and criminal damage. It is possible that there could be some cost reduction for Local Authority social services if reductions in alcohol intake result in reduced rates of domestic violence and family breakdown attributable to alcohol.

35. Finally, there is a need to ensure that those professionals who are working with and supporting people who are living in the most deprived communities are aware of the introduction of this Bill and the potential implications. As highlighted, it is the areas of highest deprivation that experience the highest levels of alcohol related harms, suggesting that many people in these communities are drinking at hazardous levels. It is possible that people who are dependent on alcohol, or heavy drinkers by choice, may sacrifice other expenditure, such as food or paying bills, in order to continue to buy alcohol at the higher prices. This could have implications for their families and their own well-being, and professionals should be alert to this and raise concerns if they feel this is happening.

The financial implications of the Bill (as set out in Part 2 of the Explanatory Memorandum);

36. 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.

37. As highlighted within the Explanatory Memorandum, the key costs will be for Local Authorities in relation to the compliance costs and the funding required for additional inspection and enforcement, including training. The costs within these areas seem reasonable and the challenging financial environment within which Local Authorities are currently managing their services means the need to ensure that any additional duties come with adequate funding.

38. 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.

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).

39. We support the powers for Welsh Ministers to make subordinate legislation to specify the MUP. As previously highlighted, based on present evidence we regard a level of 50p per unit MUP as an appropriate level at which to initially establish a MUP in 2014. However, the initial MUP should be adjusted to account for inflationary trends up to the point of its introduction and the frequency of review of the MUP level should be based on the level of change in the retail price index.

40. As part of the Bill, or as part of subordinate legislation or other policies, we recommend other evidence based measures could be considered in order to reduce the harms caused by alcohol to Welsh citizens. 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. We would support the following:[xxxiii]
    - 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;
    - 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 and further investment in these services provided; and
    - 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.

41. Introduction a MUP and the measures highlight above have successfully improved health elsewhere and can do the same in Wales. However, we also need to empower individuals in Wales to make the right choices about their own drinking. Too many drinkers fail to

recognise how even moderate drinking can increase their risks of developing diseases such as cancer. The Government, public health professionals and the wider public sector professionals must rise to the challenge of informing the public about these risks in an environment dominated by advertising intent on increasing consumption of their products. Our experience with tobacco suggests that sustained and population wide messages about harms were only possible once legislation stipulated prominent health information on all advertisements and products. The risks related to alcohol use are now clear, what is needed is the policy to allow them to be communicated at scale to the public.

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[i] Stockwell and Thomas, 2013. Is alcohol too cheap in the UK? The case for setting a Minimum Unit Price for alcohol Institute of Alcohol Studies Report

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[vii] Public Health Wales, 2017. 'Data mining Wales: The annual profile for substance misuse 2016-17' [online] Available at: http://howis.wales.nhs.uk/sitesplus/documents/888/FINAL%20profile%20for%20substance%20misuse%202016-17%20%282%29.pdf

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[x] Ibid

[xi] 'Alcohol specific conditions' are commonly defined as those conditions, such as alcoholic liver disease, which are 100% attributable to the use of alcohol. Recently, additional measures related to 'alcohol-attributable conditions' have become more frequently reported in literature evaluating alcohol harms. Alcohol-attributable measures include those conditions which have been evaluated as partially, but not completely, caused by alcohol consumption when considered across the whole population. Alcohol-attributable figures therefore add a further dimension to analysis of alcohol harms. Both alcohol specific and alcohol attributable hospital admissions can be described in 'person based' measures (the number of individuals admitted in a given time period, with each counted only once) or 'admission based' measures (where all admissions of all individuals are included, as often one individual may be admitted on more than one occasion in a given year).

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http://www.ons.gov.uk/ons/taxonomy/index.html?nscl=Crime+in+England+and+Wales

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HSCS(5)-32-17 Papur 3 / Paper 3

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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

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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]

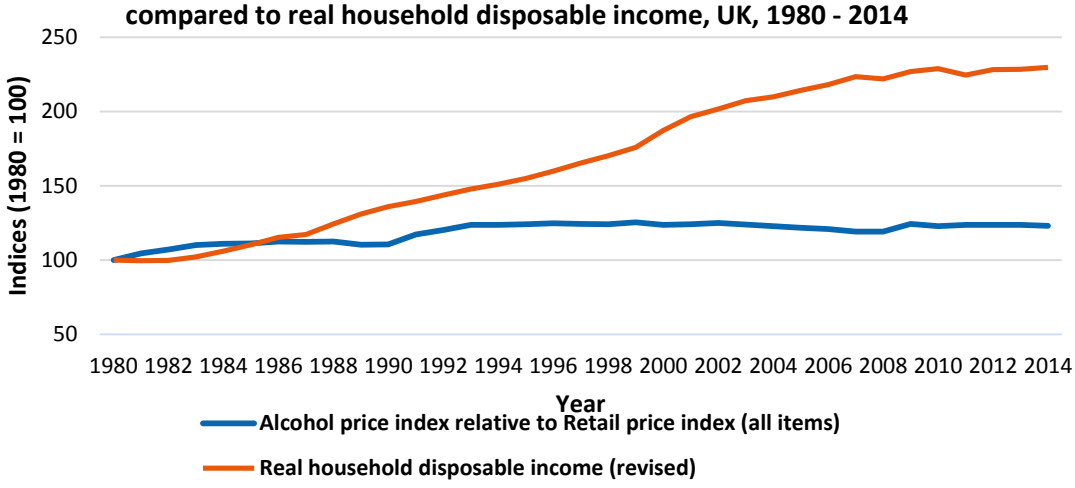
Costs of alcohol-related harm

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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Health, Social Care and Sports Committee inquiry into the general principles of the Public Health (Minimum Price for Alcohol) (Wales) Bill

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The Royal College of Psychiatrists is the professional medical body responsible for supporting psychiatrists throughout their careers, from training through to retirement, and in setting and raising standards of psychiatry in the United Kingdom.

The College aims to improve the outcomes of people with mental illness, and the mental health of individuals, their families and communities. In order to achieve this, the College sets standards and promotes excellence in psychiatry; leads, represents and supports psychiatrists; improves the scientific understanding of mental illness; works with and advocates for patients, carers and their organisations. Nationally and internationally, the College has a vital role in representing the expertise of the psychiatric profession to governments and other agencies.

RCPsych in Wales is an arm of the Central College, representing over 550 Consultant and Trainee Psychiatrists working in Wales.

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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 price.

1. The Royal College of Psychiatrists in Wales welcomes the proposals as set out in the Public Health (Minimum Price for Alcohol) (Wales) Bill and we are pleased to respond to the Committee's inquiry. The Bill is a clear indication of the Welsh Government's commitment to tackling problem drinking as a public health issue for individuals, their families, and the wider public.

2. The aim of this important piece of public health policy is to reduce, in particular, the consumption of harmful and hazardous drinking. Minimum unit pricing (MUP) of alcohol will not affect moderate drinkers but will have a significant impact on reducing alcohol related deaths, hospital admissions, and will result in fewer crimes.

3. The College has always supported MUP and pressed for all governments in the UK to adopt legislation. Our members across the UK see the harmful impact of low cost alcohol daily in their clinical practice, not just on drinkers, but on their families. Alcohol is a huge burden on our society, affecting the health of individuals and those around them and often hitting those hardest in deprived and poor communities.

4. We are pleased that the Welsh Government has pressed ahead with this policy, following the lead of the Scottish Government, and despite the many barriers that Scotland has faced. The Supreme Court's ruling is especially welcomed, which means that we can now pave the way for Wales to make real improvements to people's lives.

5. We believe that the general principles of the Bill will go a long way to addressing the concerns around problem drinking and youth drinking, and this is supported by robust evidence.[1] [2] [3] [4] We would hope that the Bill proceeds quickly through the Assembly given the overwhelming evidence that supports the benefits of MUP and the positive feedback from stakeholders received through previous consultations.

[1] Booth A, Meier P, Stockwel T et al (2008) *Independent review of the effects of alcohol pricing and promotion. Part A: systematic reviews.* School of Health and Related Research, University of Sheffield.
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Why MUP works

6. The most notable in-depth studies into the impact on reducing alcohol related harm when applying a minimum unit price for alcohol have been conducted by Sheffield Hallam University. Their evidence shows that MUP is the most effective means of improving the health and wellbeing of individuals and those they are close to. The Sheffield Alcohol Research Group has gathered a wealth of international evidence on the impact that MUP has on people's drinking habits. They were commissioned by the Welsh Government to conduct a study into the impact in Wales for the purposes of the Bill and concluded that there would be a reduction in the consumption by those considered to be in the high-risk category of 7.2% and a reduction of 2.2% for moderate drinkers.[5] [6] Their research shows that an MUP set at 50p would result in 53 fewer deaths per year, 1400 fewer hospital appointments per year and save the public purse by £882m in 20 years. Their evidence also shows that an increase in MUP correlates with a decrease in harm – so that the benefits increase with an increase in the floor price. An MUP of 60p would have even more health and social benefits.

7. Countries that have adopted a floor price for alcohol are reporting benefits. British Columbia, Canada, has seen a marked reduction in harmful drinking[7], hospital admissions[8], deaths and crime[9].

8. A survey in 2011 showed that 70% of the units of alcohol consumed were under 40p and 83% under 50p highlighting that the price influences the choices we make when buying alcohol.[10] This is consistent with College members' observations in clinical practice, who noticed the popularity of 'super lagers' in the 1990s was supplanted by white cider and vodka by 2000s as these drinks became cheapest.

9. The UK Government has already recognised the importance of pricing to reduce alcohol related harm through its ban on the sale of alcohol below the total of VAT and excise duty. However, this policy has been found to affect only around 1% of the alcohol sold in the UK, and even then to have raised

[5] Meng Y. et al. (2014); Sheffield: ScHARR, University of Sheffield.

[6] The Meng Model (2010) class moderate drinkers as men/women who consume no more than 21/14 U.K. units per week, hazardous drinkers as consuming between 21/14 and 50/35 units per week, and harmful drinkers as consuming more than 50/35 units per week, respectively.

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[9] Stockwell T, Zhao J, Martin G et al (2015) *Relationships Between Minimum Alcohol Pricing and Crime During the Partial Privatization of a Canadian Government Alcohol Monopoly*. Journal of Studies on Alcohol and Drugs, 76(4), 628–634 (2015).

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prices only slightly.[11] Minimum alcohol pricing affects the floor price and is thus targeted at the retail practices which are most likely to result in harm. An MUP would effectively ban the offering of price reductions for larger quantities of alcohol sales – multibuys for example. For this reason, the College continues to support minimum unit pricing as one of the most effective measures to prevent alcohol-related harm.

Why MUP is important

10. Overconsumption of alcohol can lead to many social problems, such as increased crime particularly violent crime. ONS figures from 2005 – 2016 show a fluctuation between 562,000 and 1.1m violent incidents recorded in England and Wales where the victim believed the offender to be under the influence of alcohol.[12] This translates into 39% and 55% of all violent crimes.

11. Overconsumption of alcohol also often increases the likelihood of accidents and it contributes to a multitude of health problems such as premature death, cirrhosis of the liver, heart disease, cancer, alcoholism, and mental health conditions. This places a huge cost on the NHS. In Wales, in 2016 there were 54,000 admissions to hospital for alcohol related harm[13] and around 10,300 patients admitted to hospital in 2014 for a specific alcohol specific condition. Of those 10,300 patients, 66% had mental health and behavioural disorders (70.1% in males and 58.5% in females).[14]

12. According to the Welsh National Database for Substance Misuse, there were 9,127 referrals for alcohol and drug misuse treatment between January and March – up 1,827 on the same period in 2012-13.[15] The latest figures by Welsh Government also show that 504 people died last year in Wales due to alcohol, which is an increase of 8.9% from 2015 to 2016.[16]

13. World Health Organisation data for OECD (Organisation for Economic Co-operation and Development) countries in 2015 show that the UK is ranked at number six by alcohol consumption per capita (at 12l).[17] In the Government's Alcohol Strategy (2012) they recognised that Alcohol was one the three biggest lifestyle risk factors for disease and death in the United Kingdom, after smoking and obesity.[18]

[11] Brennan A, Meng Y, Holmes J et al. (2014) *Potential benefits of minimum unit pricing for alcohol versus a ban on below cost selling in England 2014: modelling study.* The BMJ 349: g5452

[12] Crime Survey for England and Wales, Office for National Statistics

[13] Public Health Wales (2016) *Piecing the puzzle: The annual profile for substance misuse*. NHS Wales.

[14] Public Health Wales (2014) Alcohol and Health in Wales 2014: Wales Profile. pg. 22.

[15] http://www.infoandstats.wales.nhs.uk/page.cfm?orgid=869&pid=41017

[16] Welsh Government (2017) Substance Misuse Strategy: Working Together to Reduce Harm Annual Report.

[17] World Health Statistics data visualizations dashboard http://apps.who.int/gho/data/node.sdg.3-5-viz?lang=en

[18] HMGovernment (2012). The Government's Alochol Strategy. CM8336

14. A recent AHA review of prices found 3-litre bottles of 7.5% ABV cider, which contain the same amount of alcohol as 22 shots of vodka, being sold for just £3.50, or 16p per unit.[19]

How MUP should be set

15. We agree with current proposals that the price should be set in regulations, and not defined in the Bill, so that the rate can be adjusted in line with changes in the market. It is important that the MUP level reflects the growing affordability of alcohol, and affordability should be considered when MUP levels are under review in the future. We agree to monitoring the impact of the legislation to determine the reduction in harm.

16. The College feels that the MUP should be set at 50p initially and that a review of the price should take place annually, as it is the case in Canada and Australia. After the recent announcement by the Supreme Court, the Scottish Government will launch a consultation on the appropriate level of MUP and if the level of 50p, which was set five years ago, will have the desired impact.

Any potential barriers to the implementation of the provisions and whether the Bill takes account of them;

17. This is not our area of expertise; however, we would just like to raise a few points for the Committee to consider when speaking with other witnesses:

    1) Local Authorities would be responsible for enforcing the Act and with ever decreasing budgets, will they have the resources to meet their statutory obligations?

    2) The Assembly should consider the possibility of an increase in cross-border importation of alcohol and whether this increase could offset the advantages of a MUP. We would, however, hope that England will follow the devolved nations and themselves introduce an MUP so cross-border trade would not be an issue.

    3) The Supreme Court Ruling on 15 November should pave the way for other UK nations to adopt similar public health legislation without legal challenges by the drinks industry.

Whether there are any unintended consequences arising from the Bill;

18. It is possible that the number of referrals to Community Mental Health Teams as well as Community Drug and Alcohol Teams would rise initially as a result of the legislation. This would be welcomed as it would indicate that the legislation was meeting its objectives and that people were instead seeking

[19] Alcohol Health Alliance (2016). *Cheap Alcohol: the price we pay*. Available at http://12coez15v41j2cf7acjzaodh.wpengine.netdna-cdn.com/wp-content/uploads/2016/11/AHA-price-survey_FINAL.pdf

help and treatment. We would need to ensure that CMHTs and CDATs could cope with a possible increase in patients seeking help.

The financial implications of the Bill (as set out in Part 2 of the Explanatory Memorandum);

19. The Explanatory Memorandum takes evidence from the study commissioned to Sheffield University, which concluded that a MUP of 50p is estimated to be worth £882m to the Welsh economy in terms of reductions in illness, crime and workplace absence over a 20-year period. The cost in hospital admissions alone from alcohol related illnesses in Wales is currently £120m. The financial and societal burden of alcohol related harm is a major public health issue. We are pleased that the Welsh Government is seeking to address this through legislation and would urge robust evaluation of the policy post implementation.

20. We would like the Welsh Government to explore the possibility of working with retailers and alcohol producers to annex a portion of the retailers anticipated profits and ring fence the money for treatment services – services that are currently stretched, and likely to experience an increase of referrals as a result of the legislation.

END

Agenda Item 4

The Public Health (Minimum Price for Alcohol) (Wales) Bill 2017

Evidence to the National Assembly for Wales, Health, Social Care and Sport Committee from The Directors of Public Protection Wales, The Wales Heads of Trading Standards and the Welsh Local Government Association.

13th November 2017

1. We welcome the opportunity to provide information to the Committee in relation to the proposed Bill.
2. It is envisaged that local Government will be provided powers and duties to act to ensure compliance with the minimum unit price of alcohol requirements.
3. We believe that local government is well placed to receive these duties and powers, and the framework, as currently presented will allow the new requirements to become embedded into the wider public protection and regulatory functions of our services.
4. In the preceding months, we have welcomed the opportunity to discuss with policy officials the overarching principles, which will engage local authority staff once the Bill is enacted.
5. We have limited our evidence to the compliance and enforcement provisions within the Bill, recognising that others are more qualified and better placed to discuss the wider policy drivers around the health and social need, and the factors which have arrived at the practical minimum price point of alcohol.
6. However, we record that we are supportive of the intention to reduce the harmful effects of excessive drinking, and the wider comprehensive strategies surrounding this.
7. Local authority public protection officers have long-standing advice, education and enforcement experience, and act as a critical interface between government and businesses, where the primary intention of the relationship is to encourage compliance with legislation.
8. In this regard, there are a number of critical factors which should be considered in framing new legislation, to ensure that the policy goals can be achieved via compliance or regulatory interaction.
9. Local Authority experience of enforcing new legislation suggests that early compliance is more likely when:
    - The new legislation is seen as necessary, reasonable, easy and cheap to comply with
    - The Trade has a clear understanding of what is required of them, and advice and education of the requirements is provided to them
    - The enforcing authority has capacity to check compliance early in the new regime

- This is made easier if the legislation is unequivocal and simple with absolute offences that do not need to be argued through the Courts (this limits case preparation time and frees officer time for more checks to be made)
- Certain and quick enforcement outcomes (like Fixed Penalty Notices, with appropriate appeal mechanisms) where appropriate, also maximises efficiency

10. The Committee will be aware that local authority regulation budgets have suffered dramatically over the last period. It is regrettable, that as Local Authority regulatory services continue to be cut, it is no longer realistic to expect proactive, consistent enforcement activity across Wales.
11. New legislation such as this, adds to the existing burden and will compete for officer time with existing enforcement activities. Since public protection services activity is prioritised on the basis of risk to the public, initiatives to change behaviour are unlikely to be prioritised unless extra provision is made.
12. The Wales Heads of Trading Standards have been engaged in dialogue with Welsh Government regarding the new burden which will be placed on local government. There is a common desire to establish an efficient and successful regime which will ensure broad compliance.
13. The proposed legislation appears clear and easy to understand, and is generally framed in a manner which is familiar to officers when dealing with other enforcement matters.
14. The engagement of the trade at the earliest opportunity is essential and we are pleased to note that this is acknowledged. Public protection officers already provide advice on a vast range of complex legal and technical legislation, and the existing skills of those officers can be utilised during the implementation of the Bill. e
15. We welcome the broad range of powers which are available, and believe these are sufficient to enable compliance to be achieved.
16. The fixed penalty enforcement mechanism is an appropriate and efficient mechanism for minimum unit pricing. Although not extensively used, enforcement officers are familiar with exercising this method of enforcement activity.
17. We welcome the acknowledgment of a training need for officers, and would be pleased to work with officials on how to most effectively deliver this.
18. The provision to review the policy after five years is welcomed. Local authorities will however need to invest to amend their current databases. It will be essential that codes and

definitions are agreed to be able to record and analyse data consistently to ensure efficient reporting in due course.

Cynulliad Cenedlaethol Cymru
Y Pwyllgor Iechyd, Gofal Cymdeithasol a Chwaraeon
National Assembly for Wales
Health, Social Care and Sport Committee

Vaughan Gething AM
Cabinet Secretary for Health and Social Services

8 November 2017

Dear Vaughan

Public Health (Minimum Price for Alcohol) (Wales) Bill – Stage 1 scrutiny

Following the cancellation of this week's Health, Social Care and Sport Committee meeting at which you were due to provide evidence on the Public Health (Minimum Price for Alcohol) (Wales) Bill ("the Bill"), I'm writing to seek your views on a number of issues which would have been discussed during the meeting.

<u>Public health case for the Bill</u>

1) What public health outcomes does the Welsh Government expect to see from the introduction of minimum pricing for alcohol in Wales?

2) What measures will be used to evaluate the effectiveness of the legislation? Will an evaluation after five years give us a clear enough picture, given that some of the health impacts may only be seen in the longer term?

<u>Competence</u>

3) Can you explain, for the record, your position on the National Assembly's competence to pursue this Bill, the reasons for the Bill being introduced now, and your intentions following the pending Supreme Court judgment on the relevant Scottish legislation?

<u>The minimum unit pricing (MUP) approach</u>

4) How will the level of MUP be decided? What further work is needed before the relevant regulations are made, and what are the timescales for that work?

5) What is the Welsh Government's intention regarding reviewing the level of MUP in the future - how frequently, for example, and by what mechanism will the MUP be reviewed/altered?
6) What is the evidence base underpinning the proposals? How has the link between alcohol price, consumption and harm been demonstrated? In particular, what evidence shows that those who drink at hazardous/harmful levels will reduce consumption under a minimum unit pricing policy?
7) Have other strategies to reduce the affordability of alcohol been looked at? Why does the Welsh Government consider that minimum unit pricing will be the most effective approach?

Wider impact on consumers

8) One of the criticisms of minimum unit pricing is that it won't just target those drinking at harmful levels, but that it will impose additional costs on a majority of people who drink responsibly. What impact does the Cabinet Secretary expect the Bill to have on moderate drinkers?
9) The Explanatory Memorandum acknowledges that minimum unit pricing is likely to affect dependent drinkers. What assessment has been made of the need for additional services to support those who are dependent on alcohol?
10) What is your response to the concern that minimum unit pricing is a regressive measure that will impact most on those in poverty?
11) How will the impacts of the Bill on low income and vulnerable groups be monitored and mitigated?

Substitution effect

12) What is known about the consumption of unrecorded alcohol in Wales? Does Sheffield University's modelling work take account of this? ('Unrecorded alcohol' might include home-made or informally produced alcohol (legal or illegal), smuggled alcohol, alcohol intended for industrial or medical uses, and alcohol obtained through cross-border shopping (which is recorded in a different jurisdiction)).
13) What level of risk is there that the introduction of minimum unit pricing could result in an increase in consumption of illegal or dangerous alternatives? How will this be monitored?

Impact on local authorities

14) How have you assessed the capacity of local authorities to enforce the minimum unit pricing regime? What additional support do you intend to provide (including financial support and guidance) to ensure local authorities are able to carry out the functions imposed on them by this Bill?

15) Section 16 of the Bill allows an authorised officer of a local authority (authorised by a warrant under section 14) to enter a dwelling with additional persons and equipment. What safeguards are in place to prevent abuse of the section 16 power when an authorised officer of a local authority enters a dwelling by warrant and may take such other persons and equipment as the officer considers appropriate?

Impact on retailers, including cross-border issues

16) The Regulatory Impact Assessment describes a 'degree of uncertainty' about what the alcohol industry's response to the introduction of minimum unit pricing might be. Is there a risk that, if the introduction of minimum pricing results in increased profits for the alcohol industry (as predicted by the Sheffield model), this could undermine the policy intentions of the Bill?

17) Can you clarify whether/how minimum unit pricing would apply where a person living in England orders alcohol products that are delivered from within Wales – both from a retailer based only in Wales, and also from larger UK-wide retailers?

18) What assessment has been made of the impact on UK-wide retailers who will have to operate a different pricing regime in Wales to that in England and elsewhere in the UK?

19) Is the introduction of minimum unit pricing likely to encourage consumers to cross the border to buy alcohol in England, and will this have a negative impact on Welsh businesses, particularly in border areas?

20) Will the introduction of minimum unit pricing have a disproportionate impact on smaller businesses, who may face higher implementation costs for example?

21) What guidance and support does the Welsh Government intend to provide to retailers, and why this is not set out on the face of the Bill?

It would be helpful if you were able to provide this information by 15 November.

These issues, and other points raised by our stakeholders during scrutiny of the Bill, will be discussed with you further during our meeting on 11 January 2018.

Yours sincerely,

Dr Dai Lloyd AM
Chair, Health, Social Care and Sport Committee

Agenda Item 5.2

Vaughan Gething AC/AM
Ysgrifennydd y Cabinet dros Iechyd a Gwasanaethau Cymdeithasol
Cabinet Secretary for Health and Social Services

Llywodraeth Cymru
Welsh Government

Ein cyf/Our ref MA-L/VG/0755/17

Dr Dai Lloyd AM
Chair of the Health, Social Care and Sport Committee

14 November 2017

Dear Dr Lloyd,

Thank you for your letter of 8 November following the cancellation of the Health, Social Care and Sport Committee meeting, where I was due to provide evidence on the Public Health (Minimum Price for Alcohol) (Wales) Bill.

I am writing with the Welsh Government's response to the questions you have posed regarding the Bill.

I look forward to attending the scrutiny session scheduled for 11 January.

Yours sincerely,

Vaughan Gething AC/AM
Ysgrifennydd y Cabinet dros Iechyd a Gwasanaethau Cymdeithasol
Cabinet Secretary for Health and Social Services

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Rydym yn croesawu derbyn gohebiaeth yn Gymraeg. Byddwn yn ateb gohebiaeth a dderbynnir yn Gymraeg yn Gymraeg ac ni fydd gohebu yn Gymraeg yn arwain at oedi.

We welcome receiving correspondence in Welsh. Any correspondence received in Welsh will be answered in Welsh and corresponding in Welsh will not lead to a delay in responding.

Public Health (Minimum Price for Alcohol) (Wales) Bill

To note:

The Public Health (Minimum Price for Alcohol) (Wales) Bill (the Bill) proposes that the minimum unit price (the MUP) for the purposes of the Bill would be specified in regulations to be made by the Welsh Ministers. However, for the purpose of illustrating impacts and the associated costs and benefits, the below responses, like the Explanatory Memorandum which accompanies the Bill uses a 50p MUP as an example. Where research or analysis has used an alternative MUP (for example, 45p), this is highlighted. The specified MUP may be higher or lower than these amounts.

A definition for moderate, hazardous and harmful drinkers are outlined below:

Moderate drinkers are those who drink less than 21 units per week for men and 14 for women. As defined in the Meng et al. (2014) report: *Model-based appraisal of minimum unit pricing for alcohol in Wales*.

Hazardous/increasing-risk drinkers – Men who regularly drink more than three to four units a day but less than the higher-risk levels. Women who regularly drink more than two to three units a day but less than the higher-risk levels. As defined in the Meng et al. (2014) report: *Model-based appraisal of minimum unit pricing for alcohol in Wales*.

Harmful/high-risk drinkers – Men who regularly drink more than eight units a day or more than 50 units of alcohol per week. Women who regularly drink more than six units a day or more than 35 units of alcohol per week. As defined in the Meng et al. (2014) report: *Model-based appraisal of minimum unit pricing for alcohol in Wales*.

The responses below are based on the current case law at the date of response. When delivered, the Welsh Government will consider the detail of the Supreme Court judgment in the matter of *Scotch Whisky Association and others* v *The Lord Advocate and another*. This judgment is due to be handed down on 15 November 2017.

Public health case for the Bill

1) What public health outcomes does the Welsh Government expect to see from the introduction of minimum pricing for alcohol in Wales?

The Bill is aimed at reducing hazardous and harmful drinking in Wales and associated harm by introducing a minimum price for alcohol, thereby reducing the availability of cheap, high-strength alcohol.

We are expecting to see a reduction in alcohol-related deaths and a reduction in alcohol-related hospital admissions because hazardous and harmful drinkers tend to consume greater amounts of low-cost and high-alcohol content products.

All alcohol-related deaths are avoidable deaths, demonstrating the urgency for further action and further progress. We consider that the introduction of a minimum price for alcohol can make an important contribution to addressing the devastation caused by this preventable issue.

The Welsh Government previously commissioned the Sheffield Alcohol Research Group at the University of Sheffield to model the potential impact in Wales of a range of alcohol pricing policies. On 8 December 2014, the report, *Model-Based Appraisal of Minimum Unit Pricing for Alcohol in Wales*[1], was published. The modelling undertaken by the University of Sheffield concluded that minimum unit pricing 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. For example, it was estimated that introducing an MUP would reduce alcohol-related deaths by more than 50 per year and reduce alcohol-related hospital admissions by more than 1,400 per year, if the MUP was specified as being 50p.

2) What measures will be used to evaluate the effectiveness of the legislation? Will an evaluation after five years give us a clear enough picture, given that some of the health impacts may only be seen in the longer term?

The Bill commits Welsh Ministers to laying before the National Assembly and subsequently publishing – after a period of five years from the commencement of the minimum pricing regime – a report about the operation and effect of the Act during that period. My officials are currently developing an evaluation plan and will commission work to support a full evaluation and review of MUP in Wales.

The Welsh Government will be monitoring a range of different indicators where we expect to see change, including, for example, the number of hospital admissions as a result of alcohol misuse and reductions in alcohol-related deaths. We will also be monitoring price data for different alcohol products, as well as the overall consumption of alcohol across the population and among different sub-groups, including hazardous and harmful drinkers who are the target of this legislation. Further consideration will be given to the content of the evaluation and review over the coming months, with a view to learning lessons from the evaluation and review being implemented in Scotland.

There is likely to be a time lag between the introduction of MUP and changes in individual behaviour. The Welsh Government considers that a five-year review is the earliest point at which the policy would be embedded and there would be sufficient data to assess its effectiveness.

[1] http://gov.wales/docs/caecd/research/2014/141208-model-based-appraisal-minimum-unit-price-alcohol-en.pdf

However, while some of the health impacts may need a longer period to be demonstrated, the Welsh Government considers that a review into the operation and effect after five years is proportionate and that there should be some indication of impact of the legislation at this point.

Competence

3) Can you explain, for the record, your position on the National Assembly's competence to pursue this Bill, the reasons for the Bill being introduced now, and your intentions following the pending Supreme Court judgment on the relevant Scottish legislation?

The Welsh Government is content that the Bill is within the National Assembly's competence on the basis of the current case law.

We welcomed the most recent judgment in the litigation surrounding the Scottish minimum pricing legislation, which rejected the Scotch Whisky Association and others' arguments that the Alcohol (Minimum Pricing) (Scotland) Act 2012 was incompatible with EU law. It was in accordance with this case law that the Welsh Government introduced the Bill to the National Assembly.

Although we were still awaiting the outcome of the appeal by the Scotch Whisky Association and others at the point of introducing the Bill to the Assembly, we did not want to lose any time in including the Bill in this year's legislative programme.

The Welsh Government has a window of opportunity to introduce this Bill under the existing Wales Act regime; this will change when the Wales Act 2017 comes into force in April 2018. By introducing legislation on minimum pricing in Wales now, we can realise change at the earliest opportunity and deliver health and wider societal benefits. We are taking action now by introducing legislation which we believe will save lives.

The National Assembly for Wales has legislative competence on a wide range of public health matters and this Bill is specifically concerned with the protection of life and health.

Members will be aware, however, that the Supreme Court has announced its intention to deliver its judgment in the matter of *Scotch Whisky Association and others (Appellants)* v *The Lord Advocate and another (Respondents) (Scotland*) on 15 November. When the judgment is received, careful consideration will be given to it and any implications for the Bill, by the Welsh Government.

The minimum unit pricing (MUP) approach

4) How will the level of MUP be decided? What further work is needed before the relevant regulations are made, and what are the timescales for that work?

The policy rationale for minimum unit pricing is well developed in Wales –two consultations have taken place. We first consulted on this issue as part of the Public Health White Paper *Listening to you: Your health matters* in 2014 and we undertook a five-month consultation on a draft Public Health (Minimum Price for Alcohol) (Wales) Bill in 2015. We have continued to engage with external stakeholders and the alcohol industry in the two years after the draft Bill was published. This engagement work will continue as the Bill progresses through the National Assembly and ahead of any decision taken in relation to the level of the MUP.

The Bill, like the draft Bill published for consultation in 2015, provides that the MUP for the purposes of the Bill will be specified in regulations to be made by Welsh Ministers, with the approval of the National Assembly, if the Bill is enacted. The Welsh Government's previous consultations have been on the basis of a MUP of 50p.

The University of Sheffield is currently updating its analysis of the modelled impacts of MUP in Wales and the full report, which will consider a range of possible levels of MUP, will be published in January 2018. Proposals about the level at which the MUP should be specified will be developed using this updated evidence and other factors, such as alcohol sales data; the affordability of alcohol and data about alcohol-related harm in Wales.

The Welsh Government is aware that the amount of MUP to be specified is a matter of considerable interest to both Members and stakeholders more widely. Consequently, there are a number of safeguards built into the proposals for specifying the amount, not least that the regulations to be made will require the National Assembly's approval.

At present, the Welsh Government is continuing to use an example MUP (mainly 50p) in the supporting documentation for the Bill, including the Explanatory Memorandum and Regulatory Impact Assessment. These documents also make it clear that the MUP which will ultimately be specified in regulations may be higher or lower than this amount. The Statement of Policy Intent sets out the policy intention for the subordinate legislation that Welsh Ministers would be empowered or required to make, under the provisions of the Bill.

As set out in the Explanatory Memorandum, the proposal is that the minimum pricing regime will come into force 12 months from the date of Royal Assent of the Bill. Ahead of that time, work will be undertaken to ensure that the price specified in the

regulations is appropriate and set at the level most likely to achieve the policy aim of reducing hazardous and harmful drinking in Wales.

5) What is the Welsh Government's intention regarding reviewing the level of MUP in the future – how frequently, for example, and by what mechanism will the MUP be reviewed/altered?

We will keep the level of the MUP under review to ensure it is set at the most appropriate level to secure the public health objectives of the Bill. We intend to undertake an internal review of the level of the initially-specified MUP after the first two years following the date of the bringing into force of the minimum pricing regime proposed by the Bill. If it is felt that the level of the MUP needs to be adjusted, any regulations amending this amount would be subject to the affirmative procedure.

The formal review after five years will focus on the operation and effect of the Act during that period. It will be informed by an ongoing programme of monitoring and evaluation.

6) What is the evidence base underpinning the proposals? How has the link between alcohol price, consumption and harm been demonstrated? In particular, what evidence shows that those who drink at hazardous/harmful levels will reduce consumption under a minimum unit pricing policy?

An MUP specifically targets those who are drinking at hazardous and harmful levels, as these are the drinkers who tend to consume cheap, high-strength alcohol.

Hazardous and harmful drinkers are also those individuals who have the poorest health outcomes – in relation to alcohol-related harm – and have the most to gain from this legislation. Evidence on the targeted effect of MUP is provided in the 2014 report on the impacts of MUP, undertaken by the University of Sheffield. This reported that across the whole population, if the MUP was specified at 50p, 38.4% of units purchased would be affected but this differed according to drinker type. For harmful drinkers, 46.4% of units were affected; 35.9% of units for hazardous drinkers and 23.5% of units for moderate drinkers.

The analysis by the University of Sheffield also showed that reductions in consumption differ by drinker type. It was estimated that harmful drinkers would reduce their consumption by 7% (293.2 units per year) with reductions of 2% for both hazardous (28.8 units per year) and moderate drinkers (6.4 units per year).

More generally, there is strong evidence to support the link between alcohol price and consumption and on the direct link between consumption and harms and this

evidence is summarised in the Explanatory Memorandum.[2] As alcohol becomes more affordable, consumption increases. As consumption increases, harm increases. The Welsh Government therefore considers that if we increase the price of the cheapest drinks, we can have an important impact on reducing levels of consumption and reducing alcohol-related harm.

As is highlighted in the Explanatory Memorandum, the demand for goods and services is strongly influenced by price and this is a relationship which extends to alcohol. The majority of research and analysis about alcohol and price suggests there is a causal relationship between the price of alcohol, the quantity of alcohol consumed and adverse health outcomes. Increasing the price of alcohol therefore provides a mechanism through which health improvement can be achieved.[3]

The Explanatory Memorandum also highlights a number of systematic reviews of the evidence base on the impacts of price on consumption which support this conclusion. For example, paragraph 104 of the Explanatory Memorandum, cites the systematic review by Wagenaar et al. (2009) examining the relationship between measures of beverage alcohol tax or price levels, and alcohol sales or self-reported drinking.[4] This found a total of 112 studies demonstrating alcohol tax or price effects and specifically highlighted that these effects are large compared to other prevention policies and programmes.

In 2014, the Advisory Panel on Substance Misuse (APoSM) published a report reviewing minimum unit pricing and its potential to deliver change and reduce consumption in Wales. In summary, upon reviewing the MUP literature and taking into account the expert evidence presented to it, APoSM recommended that minimum unit pricing should be introduced to address alcohol-related harm in the vulnerable groups most affected by hazardous and harmful levels of drinking. It considered that while MUP (and the evidence for it) has been criticised, nevertheless the evidence base is extensive, and the modelling of the effects of MUP in a UK context is well-founded and robust. APoSM considered that the effects of MUP would be different for different subgroups of the population: therefore MUP enables those drinking alcohol more harmfully or hazardously to be targeted, with smaller effects on moderate drinkers, particularly those with low incomes.

[2] See section on "Evidence related to price and alcohol" – beginning on page 27 of the Explanatory Memorandum.

[3] Hobday, M., Gordon, E., Meuleners, L., Liang, W. and Chikritzhs, T. (2016) The effect of price increases on predicted alcohol purchasing and decision and choice to substitute. Addition Research and Theory. Volume 24.

[4] Wagenaar, A., Salois, M., and Komro, K., (2009) Effects of beverage alcohol price and tax levels on drinking: a meta-analysis of 1003 estimates from 112 studies. Addiction, Volume 104. Pages 179–190.

7) Have other strategies to reduce the affordability of alcohol been looked at? Why does the Welsh Government consider that minimum unit pricing will be the most effective approach?

Yes. The 2014 Sheffield Model, as commissioned by the Welsh Government, considered the estimated impact of the ban on selling alcohol for below the cost of duty plus the VAT payable on that duty. It concluded this ban would have a negligible impact on alcohol consumption or related harms.

The Explanatory Memorandum also specifically looks at the evidence on taxation and explores the extent to which taxation could target hazardous and harmful drinking, as compared with the introduction of an MUP.

Evidence suggests that higher taxation would not be as effective at tackling the Bill's objective as introducing MUP. The Welsh Government considers that taxation alone (as it currently stands in the UK) will not target and reduce levels of hazardous and harmful drinking in the same way as introducing an MUP for alcohol.

Minimum unit pricing aims to increase the price of very cheap and strong alcohol, therefore limiting its affordability amongst hazardous and harmful drinkers who tend to consume the cheapest alcohol. Higher taxation will not guarantee a minimum price for alcohol as retailers can absorb tax increases by off-setting them against the cost of other products. An MUP on the other hand, will guarantee that alcohol is not sold below a certain level. While taxation does increase the price of alcohol, it does not provide the same opportunity to reduce levels of hazardous and harmful drinking as MUP. Furthermore, taxation (if passed on to consumers) would increase the price of all alcohol. Therefore, moderate drinkers would also be impacted by an increase in taxation.

The 2014 Sheffield modelling suggests that harmful drinkers purchase more of their alcohol below an example MUP of 50p per unit at all income levels (harmful drinkers in poverty buy 42% of their alcohol below 50p per unit compared to 21% for moderate drinkers in poverty, harmful drinkers not in poverty buy 28% of units below 50p compared to 14% moderate drinkers not in poverty). Thus MUP would change the price of approximately a fifth of the alcohol purchased by moderate drinkers in poverty, whereas an increase in taxation would affect the price of all.

As part of their updated analysis of the impacts of MUP, the University of Sheffield are also considering the increase in the level of taxation that would be needed to deliver the same health outcomes amongst hazardous and harmful drinkers as a 50p MUP.

Alcohol duty is set at a UK level by the UK Government. It is not devolved and the Welsh Government is not seeking the devolution of powers to set alcohol duty.

Wider impact on consumers

8) One of the criticisms of minimum unit pricing is that it won't just target those drinking at harmful levels, but that it will impose additional costs on a majority of people who drink responsibly. What impact does the Cabinet Secretary expect the Bill to have on moderate drinkers?

Research estimates that there will be a minimal impact on moderate drinkers as a result of introducing an MUP for alcohol. The modelling work undertaken by the University of Sheffield in 2014 for example, estimated the impact of MUP on moderate drinkers will be minimal. The Sheffield Alcohol Research Group research showed that moderate drinkers constitute 74% of the drinker population, but consume only 28% of all alcohol.

Specifically, the introduction of an MUP targets specific drinks – namely, cheap, high-strength products. These types of products are more likely to be drunk by those drinking at hazardous and harmful levels, as the evidence cited in answer to question seven demonstrates.

The University of Sheffield also showed that spending changes would differ across the population, with harmful drinkers estimated to spend an extra £32 (1.1%) per year but moderate drinkers' spending increasing by £2 per year (0.8%) based on a 50p MUP. Furthermore, consumption changes would differ across the drinker population. Based on a 50p MUP, analysis in 2014 estimated that harmful drinkers will consume 293 fewer units per year but moderate drinkers will only reduce their consumption by six units per year.

9) The Explanatory Memorandum acknowledges that minimum unit pricing is likely to affect dependent drinkers. What assessment has been made of the need for additional services to support those who are dependent on alcohol?

This Bill is targeted at protecting the health of hazardous and harmful drinkers who tend to consume the greater quantities of low-cost and high-alcohol content product. Dependent drinkers are only a small proportion of these drinker groups.

Nevertheless, we acknowledge the concerns raised by some that for those drinking at particularly harmful levels (and who are consuming cheap, high-strength alcohol products affected by an MUP) the risk of withdrawal will potentially be greater – particularly if they only have a set amount of money to spend on alcohol. We are working closely with alcohol treatment service providers in Wales and will also draw lessons from the planned evaluation of similar legislation in Scotland, which involves a specific study of the impacts of MUP on harmful drinkers.

We would also emphasise that MUP is only one part of the Welsh Government's wider and continuing strategic approach to tackle alcohol-related harms. Alcohol

policy in Wales involves a variety of approaches, which taken together, aims to educate people about the dangers of excessive alcohol consumption and to drink responsibly.

The details of other existing and policy actions by the Welsh Government are detailed in the Explanatory Memorandum and form part of the Welsh Government's 10-year substance misuse strategy for tackling the harms associated with the misuse of alcohol, drugs and other substances – *Working Together to Reduce Harm*.

10) What is your response to the concern that minimum unit pricing is a regressive measure that will impact most on those in poverty?

People living in poverty are disproportionately likely to abstain from alcohol or drink very low amounts – and people living in poverty who abstain from alcohol or are moderate drinkers will be minimally affected by the introduction of an MUP for alcohol.

People living in poverty drink less on average than those above the poverty line. Moderate, hazardous and harmful drinkers in poverty drink 4.9; 25.9 and 71.7 units per week respectively, compared to 5.6; 28.2 and 79.8 units per week for those not in poverty. MUP will have an impact on hazardous and harmful drinkers living in poverty.

As an illustrative example, in 2014 the University of Sheffield estimated that for harmful drinkers in poverty, 42% of all units purchased are purchased below 50p, compared to 28% for those not in poverty. For moderate drinkers, the figures are 21% for those in poverty and 14% for those not in poverty.[5]

For those drinking at hazardous and harmful levels, people on a low income or who are living in deprived areas are more likely to suffer from a long-term illness, as a result of drinking too much. An MUP for alcohol can potentially reduce levels of hazardous and harmful drinking in these groups, meaning the risk of alcohol-related harm would be reduced.

People in the lowest socioeconomic groups who are harmful drinkers will accrue the greatest health benefits from the policy, as a result of anticipated reductions in the consumption of alcohol.

A 50p MUP was previously estimated by the University of Sheffield to have greater reductions in deaths and hospital admissions per 100,000 drinkers for those in poverty than those not in poverty: five fewer deaths and 120 fewer hospital admissions per 100,000 drinkers for those in poverty, compared to two fewer deaths and 50 fewer hospital admissions per 100,000 drinkers for those not in poverty.

[5] http://gov.wales/docs/caecd/research/2014/141208-model-based-appraisal-minimum-unit-price-alcohol-en.pdf

11) How will the impacts of the Bill on low income and vulnerable groups be monitored and mitigated?

We understand and have noted the concerns raised by some regarding potential adverse impacts, which could arise as a result of the proposals set out in the Bill. For example, there have been concerns expressed that low-income households which consume low-cost alcohol will be unable to trade down and that household budgets could be affected if harmful and hazardous drinkers continue to consume alcohol at the same level as before MUP was introduced. We are also aware that some stakeholders have raised concerns that as some vulnerable groups reduce their consumption (in light of an increase in the price of alcohol) they may experience withdrawal and may need to access support services or hospital treatment to relieve and help manage the symptoms of withdrawal.

While these concerns are understood, within the Explanatory Memorandum we highlight that we do not expect large numbers of people to be accessing services in light of withdrawal from alcohol. For harmful drinkers, an MUP of 50p is estimated to reduce mean weekly consumption by 7.2% – or an estimated 5.6 units per week. It is unlikely that this type of reduction would result in a significant number of people requiring treatment for withdrawal. Nonetheless, even if we do see an increase in the number of people accessing substance misuse services as they reduce their levels of consumption, what we also expect to see is a reduction in alcohol-related deaths. This is something that we intend to monitor closely.

It is also important to recognise that MUP is not intended or expected to work in isolation. We will work with relevant stakeholders to signpost relevant services ahead of the implementation of MUP. We need to ensure people are accessing the support and services which are already in place. We will be working closely with Area Planning Boards to ensure local services are as responsive as possible to the needs of low income and vulnerable groups. Substance misuse treatment services are readily available with an improving trend for waiting times in this area.

The impacts of MUP on low income and vulnerable groups is an issue we will continue to consider both as the Bill proceeds through the National Assembly and as MUP is implemented.

Substitution effect

12) What is known about the consumption of unrecorded alcohol in Wales? Does Sheffield University's modelling work take account of this? ('Unrecorded alcohol' might include home-made or informally produced alcohol (legal or illegal), smuggled alcohol, alcohol intended for industrial or medical uses, and alcohol obtained through cross-border shopping (which is recorded in a different jurisdiction).

We are not aware of any evidence that suggests the introduction of minimum unit pricing specifically will lead to an increase in the consumption of unrecorded alcohol (including home-made or informally-produced alcohol, smuggled alcohol, alcohol intended for industrial or medical uses and alcohol obtained through cross-border shopping) but this is something we intend to monitor closely.

We do not consider that any increase in price resulting from the introduction of MUP is likely to be sufficient to incentivise these kinds of activity, which are not currently a significant problem in Wales.

The Advisory Panel on Substance Misuse (ApoSM), in its 2014 review of the potential of MUP in a Welsh context, concluded that "individual production is deemed unlikely for the most vulnerable groups of drinkers, not least because of the time required for the fermentation process and the cost of the necessary equipment."

13) What level of risk is there that the introduction of minimum unit pricing could result in an increase in consumption of illegal or dangerous alternatives? How will this be monitored?

The Welsh Government acknowledges the concerns raised by some that there is a risk that consumers could potentially switch to illegal drugs or new psychoactive substances, following an increase in the minimum price of alcohol.

We consider this risk to be low, as illegal or untested substances are qualitatively different to the legal consumption of alcohol and most people would not consider them a valid substitute. Nonetheless, this is something we intend to explore further with the Advisory Panel on Substance Misuse (APoSM). The panel has previously commented: "Some consumers may substitute other psycho-active products for alcohol". APoSM also states that: "Evidence of the extent of such behaviour is scarce, although it suggests only a very small proportion of problematic drinkers, who already have other substance misuse issues, would respond in this way."[6]

[6] Welsh Government Advisory Panel on Substance Misuse (APoSM) (2014) Minimum Unit Pricing: A Review of its Potential in a Welsh Context. Report Published July 2014.

Research published by Alcohol Research UK in 2015, which was based on a longitudinal study of dependent drinkers in Scotland, found that there was very little evidence of substituting other substances (such as drugs) for alcohol or the consumption of illicit alcohol, when household income had reduced following the introduction of changes to the welfare system.[7]

This is an issue we will continue to consider as MUP is implemented**.**

Impact on Local Authorities

14) How have you assessed the capacity of local authorities to enforce the minimum unit pricing regime? What additional support do you intend to provide (including financial support and guidance) to ensure local authorities are able to carry out the functions imposed on them by this Bill?

We have worked closely with local government to date about the local authority-led enforcement regime set out in the Bill. This regime will build on existing structures to ensure the best use is made of local knowledge and expertise, which is already in place across Wales.

The Welsh Government understands it will be important to ensure that local authorities are appropriately resourced when it comes to the enforcement of the Bill, particularly in terms of local authorities undertaking inspection and enforcement activities over and above that which would be taking place as part of existing inspection regimes.

As a result, within the Explanatory Memorandum, we have indicated that the Welsh Government will provide £150,000 to local authorities for this "over and above" inspection and enforcement activity during the first year of implementing the legislation; £100,000 during the second year and £50,000 during the third year.

Welsh Government officials are currently in discussion with the Welsh Heads of Trading Standards about the resourcing implications for the enforcement of the legislation, particularly in the early stages of implementation and I will provide a further update to the committee as these discussions progress.

15) Section 16 of the Bill allows an authorised officer of a local authority (authorised by a warrant under section 14) to enter a dwelling with additional persons and equipment. What safeguards are in place to prevent abuse of the section 16 power when an authorised officer of a local authority enters a dwelling by warrant and may take such other persons and equipment as the officer considers appropriate?

[7] http://alcoholresearchuk.org/downloads/finalReports/FinalReport_0128.pdf

The Welsh Government considers the proposed enforcement regime would achieve a fair and proportionate balance between the rights of anyone affected by any powers of entry and the effective enforcement of the proposed MUP regime. We are satisfied that the enforcement regime proposed by the Bill is compatible with the European Convention on Human Rights or is capable of being exercised in a manner that is compatible.

Section 16 of the Bill makes supplementary provision about powers of entry. Consequently, an authorised officer could only exercise the power under section 16(1) to take other persons and equipment with him or her as the officer considered appropriate if entry was permitted under sections 13, 14 and 15 of the Bill and was in a matter consistent with the objectives of the Bill's enforcement provisions. There are various safeguards built into sections 13, 14 and 15.

Section 14 of the Bill makes provision about warrants to enable local authority authorised officers to enter dwellings. However, a warrant may only be issued where a Justice of the Peace is satisfied there are reasonable grounds to believe an offence under section 2 of the Bill has been committed and it is necessary to enter the premises for the purpose of establishing whether such an offence has been committed.

There are also safeguards built into section 16, including, if the occupier of the premises entered by virtue of a warrant is present, then the authorised officer must inform the occupier of the officer's name, produce evidence of his or her authorisation and supply a copy of the warrant to the occupier.

In addition to the various safeguards built into the legislation, the enforcement powers given to authorised officers will operate in the context of various other existing safeguards such as the Human Rights Act 1998. Likewise, the Police and Criminal Evidence Act 1984 Code B, to which those charged with the duty of investigating offences, will be required to have regard. This code also provides well-established general guidance which further places clear emphasis on acting in accordance with the Convention rights.

Impact on retailers, including cross-border issues

16) The Regulatory Impact Assessment describes a 'degree of uncertainty' about what the alcohol industry's response to the introduction of minimum unit pricing might be. Is there a risk that, if the introduction of minimum pricing results in increased profits for the alcohol industry (as predicted by the Sheffield model), this could undermine the policy intentions of the Bill?

As the committee notes, the Sheffield model estimates that under all modelled policies considered in 2014, revenue to retailers was estimated to increase. However, that same model concluded that 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.

Therefore, the Welsh Government does not consider this will undermine the policy intentions of the Bill, which is primarily to reduce hazardous and harmful drinking in Wales through a reduction in the availability of cheap, high-strength alcohol.

17) Can you clarify whether/how minimum unit pricing would apply where a person living in England orders alcohol products that are delivered from within Wales - both from a retailer based only in Wales, and also from larger UK-wide retailers?

This is a public health measure concerned with hazardous and harmful alcohol consumption in Wales. Consequently, the section 2 offence would apply to the supply of alcohol from qualifying premises in Wales and to the authorisation of the supply of alcohol from qualifying premises in Wales, to a person in Wales.

To summarise, this means that where alcohol purchases are delivered to a customer and the licence for the qualifying premise is held in Wales, the Bill's provisions would apply to all sales delivered to Wales, but would not apply to sales delivered to an address in England.

18) What assessment has been made of the impact on UK-wide retailers who will have to operate a different pricing regime in Wales to that in England and elsewhere in the UK?

The Regulatory Impact Assessment for the Bill contains an assessment about the impact on retailers. This assessment acknowledges there are likely to be compliance costs for retailers in relation to implementing the MUP regime. Estimated total compliance costs for retailers in the off-trade include: £756,400 in the first year to fully familiarise with the requirements of the legislation and changing prices, plus £75,000 annually for ongoing compliance and familiarisation (see table two, part two, Regulatory Impact Assessment).

In addition, paragraph 285 of the Regulatory Impact Assessment highlights the fact that larger businesses which operate UK-wide may incur costs associated with a different pricing and promotion regime in Wales. The cost of re-pricing and labelling at the point of implementation is not considered to be excessive, as these stores regularly re-price their products, including in response to changes in alcohol duty at short notice. However, these costs are unknown.

It will ultimately be for each UK-wide retailer to consider how they will comply with the minimum pricing regime proposed by the Bill. However, as the Bill proceeds through the National Assembly and as it is implemented, we will work closely with the alcohol and retail industry, particularly through the Welsh Government's Alcohol Industry Network, to raise awareness and to discuss this further.

19) Is the introduction of minimum unit pricing likely to encourage consumers to cross the border to buy alcohol in England, and will this have a negative impact on Welsh businesses, particularly in border areas?

Cross-border shopping already exists but we believe the impacts of introducing an MUP will be minimal.

It is recognised that different regimes in Wales and England may have an effect on consumer behaviour, depending on the willingness and ability to travel, along with the price differential compared to the costs of transport. But, for the majority of the Welsh population, purchasing alcohol in England would incur both a time and travel cost. This cost is likely to outweigh any savings on the price of alcohol.

We also know that the majority of hazardous and harmful drinkers are not living in areas close to the Wales-England border. A 2015 analysis shows that cross-border shopping in Wales occurs more in rural areas in the central border region, rather than the urban areas in the north and south border regions, where drinking patterns are heavier. This analysis is included as part of the Competition Assessment in the Explanatory Memorandum.

Minimum unit pricing targets the proportion of drinkers who consume hazardous or harmful quantities of alcohol, who are more likely to be purchasing alcohol for immediate consumption. It is considered this will reduce the incentive to travel further than they would normally, to avoid paying more for their alcohol as a result of an MUP.

Nonetheless, we recognise that in some areas of Wales, there may be people who decide to cross the border and purchase alcohol in England. But we anticipate this would be small in scale and would not undermine the overall effectiveness of the Bill as a public health population measure. For example, the estimated impact of a 50p MUP on moderate drinkers (74% of the drinker population in Wales) in terms of spend, in 2014, was an increase of £2 per year. We consider this amount is unlikely to change shopping habits significantly.

The Welsh Government will nevertheless be providing guidance to both retailers and enforcement officers about the proposed new regime. We are already engaging with retailers and the alcohol industry through the Welsh Government's Alcohol Industry Network and my officials will also be meeting with representatives of the Welsh Retail Consortium.

20) Will the introduction of minimum unit pricing have a disproportionate impact on smaller businesses, who may face higher implementation costs for example?

We accept there will be some implementation costs associated with the introduction of an MUP but we believe a large amount of retailers will be able to absorb these costs with the overall benefit from an increase in revenue. The modelling undertaken by the University of Sheffield estimated that revenue to retailers would increase across all policies considered, with an increase in revenue to retailers of £27m per year if the MUP was specified at 50p.

The Welsh Government will work with all retailers, including small businesses, during the implementation of the proposed MUP system to minimise costs, wherever possible.

21) What guidance and support does the Welsh Government intend to provide to retailers, and why this is not set out on the face of the Bill?

The Welsh Government will be issuing guidance regarding the Bill to assist an understanding of the proposed new regime. This guidance will not be set out on the face of the Bill as it will form part of the implementation process. The Welsh Government will rely on its existing, general powers to issue that guidance.

As set out in the Explanatory Memorandum, the Welsh Government will also be investing more than £100,000 in communications during the first year of implementation. We are planning to issue supporting materials, such as an online minimum price calculator and publicity materials, which will help retailers understand the legislation and its implications in terms of the alcohol products they sell.

In addition, plans are in place to provide training for local authority staff, which will focus on the requirements of the legislation and its enforcement in Wales.