**Response from:**

**Public Health – NHS Islington**

**Consultation Question 1:**
**Do you agree that this MUP level would achieve these aims?**
From a public health viewpoint we are extremely supportive of MUP, and see no disadvantage in establishing a minimum price. At a population level MUP is one of the most effective interventions in tackling a range of alcohol related harm. Introducing MUP (at an appropriate level) is likely to be among the most effective ways of reducing alcohol consumption, and prevent the high levels of discounting on alcohol - evidence shows how alcohol demand is price responsive. The evidence also suggests it is likely to specifically target those in whom consumption is causing the greatest harm (harmful and hazardous drinkers). Younger drinkers are also likely to be particularly responsive to price and this is another group that we feel it is important to target.

Compared to 1980 alcohol is now 45% more affordable. At the same time mortality from liver disease, strongly linked to alcohol consumption, has increased – an increase of 25% between 2001 and 2009. This contrasts with a decrease in many European countries.

Increasing the price of alcohol will reduce the rates of a range of alcohol-related harms, including violence and crime, alcohol related deaths and admissions, behavioural and mental disorders associated with alcohol use, and drink driving injuries and deaths. There is also likely to be economic benefits including reduction in absenteeism as well as substantial reductions in health and social care costs.

We would like the MUP to be higher than the proposed 45p. Modelling clearly shows that increases in levels of MUP result in very steep increases in effectiveness, in terms of reduced rates of hospital admissions, mortality and crime.

**Consultation Question 2:**
**Should other factors or evidence be considered when setting a minimum unit price for alcohol?**
It is essential that the MUP is kept under regular review and that alcohol does not become more affordable overtime.

We believe the Government should follow the example of Scotland and use a 50p MUP for alcohol. We do not believe the case for being different from Scotland has been made. With the increasing amount of alcohol related harm being seen in England and across the UK there seems to be clear justification for a higher MUP.

The cost of alcohol misuse to the UK is substantial - it has been estimated that the total annual costs of alcohol-related harm are £20 billion in England (including £1.7 billion in healthcare costs) and we feel this provides further evidence for MUP to be set at a minimum of 50p per unit.

**Consultation Question 3:**
**How do you think the level of minimum unit price set by the Government should be adjusted over time?**
It is essential that MUP is adjusted regularly to ensure that it continues to address affordability of alcohol. Inflation alone may not be a sensitive enough indicator and a broader indicator of affordability should be considered. For instances measures such as the Real Households Disposable Income (RHDI) index or the Alcohol Affordability Index, as used in the Statistics on Alcohol Series should be considered.

As the MPU will not be implemented immediately, introducing it at a price of more than 45p per unit should be considered to take account of future, as opposed to current, affordability.

**Consultation Question 4:**
**The aim of minimum unit pricing is to reduce the consumption of harmful and hazardous drinkers, while minimising the impact on responsible drinkers. Do you think that there are any other people, organisations or groups that could be particularly affected by a minimum unit price for alcohol?**

Underage drinkers are a particular group we are concerned about. Evidence suggests children who start drinking alcohol at an early age are more likely to develop alcohol problems in later life. Young binge drinkers are likely to be particularly sensitive to price because they have little money of their own. We would see this as another reason to be supportive of MUP.

MUP could have an impact on the practice of "pre-loading" (where drinkers consume cheaper alcohol from off-licences at home before visiting bars and clubs) as the price differential between on- and off-sales decreases. Anecdotal evidence from on-licencees locally suggests a high proportion of alcohol-related anti-social and violent behaviours is perpetrated by people whilst seeking to enter a bar or club, and after they have been refused entry.

**Consultation Question 5:**
**Do you think there should be a ban on multi-buy promotions involving alcohol in the off-trade?**
Yes

**Consultation Question 6:**
**Are there any further offers which should be included in a ban on multi-buy promotions?**
We are concerned that allowing other promotions such as half price and a third off could potentially lead to gaming whereby an off-licence could state an item is half price as long as you buy two drinks i.e. offers resulting in the equivalent of buy one get one free.

If some types of offers are allowed and others are banned, this could be hard to enforce from a practical perspective..

We do not think the evidence presented as part of the consultation shows why an individuals response (in terms of the amount of alcohol consumed) to a 'buy one get one free' offer would be different to a half price offer. We also feel that offers such as half price drinks would be attractive to younger / underage drinkers who are known to be particularly sensitive to price.
It would be essential that MUP continued to apply regardless of the offer. So even at half -price the cost per unit would need to be higher than MUP.

**Consultation Question 7:**
**Should other factors or evidence be considered when considering a ban on multi-buy promotions?**
Currently the aim is around promotions which could encourage people to buy more. Another factor which should be taken into account in regards to promotions is the effect this could potentially have on younger/underage drinkers. This group are known to be particularly affected by price of drinks. It is important that any restriction of multibuys is seen in conjunction with MUP. We would not see the ban on multi buys as an alternative to MUP.

**Consultation Question 8:**
**The aim of a ban on multi-buy promotions is to stop promotions that encourage people to buy more than they otherwise would, helping people to be aware of how much they drink, and to tackle irresponsible alcohol sales. Do you think that there are any other groups that could be particularly affected by a ban on multi-buy promotions?**
Young/underage drinkers

**Consultation Question 9:**
**Do you think each of the mandatory licensing conditions is effective in promoting the licensing objectives (crime prevention / public safety / public nuisance / prevention of harm to children)?**

No comment

**Consultation Question 10:**
**Do you think that the mandatory licensing conditions do enough to target irresponsible promotions in pubs and clubs?**
No comment

**Consultation Question 11:**
**Are there other issues related to the licensing objectives (prevention of crime and disorder / public safety / prevention of public nuisance / protection of children from harm) which could be tackled through a mandatory licensing condition?**

No comment

**Consultation Question 12:**
**Do you think the current approach, with five mandatory licensing conditions applying to the on-trade and only one of those to the off-trade, is appropriate?**
Irresponsible promotions could be applied to both on and off licence premises – irrespective of the proposed ban on multi-buy promotions

**Consultation Question 13:**
**What sources of evidence on alcohol-related health harm could be used to support the introduction of a cumulative impact policy (CIP) if it were possible for a CIP to include consideration of health?**
As a public health department we believe it is essential that a wider range of health data be taken into account as part of licensing. Locally public heath are using the powers of being a Responsible Authority to support our partners in police and licensing. However we feel currently our potential impact in this area is limited by health not being included as a specific objective of the licensing policy. We feel that having a fifth objective focused on health would enable us to put together more rigorous joint objections to premises in problem areas.

We would also like more explicit national guidance around how acute health data can be used within the current licensing framework. For instance guidance around how health data (including that related to ambulance call-outs, alcohol-specific hospital admissions and data from accident and emergency departments) can be considered under the Public Safety Objective. We feel this data can be used effectively to make representations under the Public Safety Objective, because this objective can take account of the wider effects of alcohol e.g. considering public safety to be wider than violence and encompassing the effects of intoxication in relation to alcohol related harm. However we are concerned about challenges against this.

In terms of evidence we would like to use within cumulative impact policy, this should include alcohol specific and attributable admissions, ambulance call-outs for alcohol related incidents and A&E data. All of which demonstrate important and different characteristics of alcohol related harm. Generally this is routinely collected data.

**Consultation Question 14:**
**Do you think any aspects of the current cumulative impact policy process would need to be amended to allow consideration of data on alcohol-related health harms?**
Size of areas maybe different because health data is usually collated using geographical based areas. In some instances at smaller levels e.g. LSOA the number of health events maybe too low to demonstrate any clear patterns and so ward level data is used instead.

As part of the local review of the licensing policy we have already assessed how health data would map to newly proposed cumulative impact areas. Generally areas where there are concerns around alcohol health impact there are also concerns in relation to other detrimental impacts. Consequently changes allowing consideration of more health

data would strengthen existing policy and enable more robust evidence to support representations.

**Consultation Question 15:**
**What impact do you think allowing consideration of data on alcohol-related health harms when introducing a cumulative impact policy would have if it were used in your local area? Please provide evidence to support your response.**
It would make it much easier for public health to put in objections to licence applications within cumulative impact areas. We would be very supportive of this as currently we feel our (public health) potential impact in this area is limited by health not being included as a specific objective of the licensing policy.

It would enable us to take a wider selection of evidence to licensing committee. We believe the approach would enable a stronger case to be put to licensing committee and thus hopefully enable greater success in preventing new premises open or extending hours of existing premises in areas of the borough where we are most concerned about the detrimental effect of alcohol.

Our current approach is that health does not put in objections as a single organisation but does so when other organisations (namely police and licensing) are also putting in applications. We would not envisage this approach changing. Consequently we would not expect the proposed changes in national policy resulting in a higher number of objections but rather a more robust provision of evidence for representations that are already being made.

**Consultation Question 16 - 35 – no public health comment**