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BMA

Alcohol Consultation
Drugs and Alcohol Unit
Home Office
4th Floor Fry Building
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Board of Science

1 February 2013

Dear Sir/Madam

Consultation on alcohol strategy

The British Medical Association (BMA) is an independent trade union and voluntary professional association which represents doctors and medical students from all branches of medicine throughout the UK. With a membership of over 150,000, we promote the medical and allied sciences, seek to maintain the honour and interests of the medical profession and promote the achievement of high quality healthcare.

The Association welcomes the opportunity to respond to this consultation. The scale of alcohol consumption in England represents a significant cause of medical, psychological and social harm, and is placing an unsustainable burden on our healthcare services. It has been estimated that the total annual costs of alcohol-related harm in England are £20 billion (including £1.7 billion in healthcare costs).[1] Our members witness first hand the damaging effects of alcohol, and have repeatedly called for stronger action to reduce the affordability and availability of alcohol. Through its Board of Science, the Association has published several reports on alcohol control, including *Reducing the affordability of alcohol* (2012)[2], *Under the influence: the damaging effect of alcohol marketing on young people (2009)*[3], *Alcohol misuse: tackling the UK epidemic (2008)*[4] and *Fetal alcohol spectrum disorders – a guide for healthcare professionals* (2007).[5] These reports outline a wide range of measures to reduce alcohol-related harm, and can be accessed via the BMA website at www.bma.org.uk/alcohol. The BMA is also a member of the UK Alcohol Health Alliance.

Our responses to the specific areas covered in the consultation are as follows.

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A minimum unit price for alcohol

The BMA strongly supports the Government's commitment to introduce a minimum price per unit, and agrees that this measure will reduce alcohol associated crime, health harms and excessive alcohol consumption, particularly among heavier drinkers and young people. Modelling has found that increasing the level of a minimum price per unit may lead to steep reductions in alcohol consumption and harm.[6,7,8,9,10] New research from the Canadian province of Saskatchewan has shown that increased minimum prices, introduced in 2010, led to a significant reduction in the consumption of cheap, high-strength alcohol. Larger increases in minimum prices for stronger drinks resulted in proportionately greater reductions in consumption of those products.[11] A minimum price per unit strategy is preferable to other pricing policies because those who drink within recommended guidelines are likely to be only marginally affected by the introduction of minimum pricing.[12] A 2012 study by Ludbrook et al concluded that heavier household purchasers of alcohol are most likely to be affected by the introduction of a minimum pricing in the UK, and that this policy is unlikely to be significantly regressive when the effects are considered for the whole population.[13] In the UK, alcohol is frequently used as a loss leader in the off-trade, in particular by supermarkets. This discounting encourages consumption and undermines the effectiveness of tax based approaches. The introduction of minimum pricing is only intended to affect the sale of alcohol at a very low cost, and will therefore prevent deep discounting in the off-trade.

Our members believe that the proposed level of 45p for the minimum unit price is too low. In 2012, the BMA Board of Science concluded that a minimum price for the sale of alcohol should be set at no less than 50p per unit (**Question 1**).[2] A 50p minimum unit price should reduce alcohol-related hospital admissions by 97,700, alcohol-related crimes by 42,500, and avoid 25,900 cases of unemployment per annum after 10 years of implementation.[7] Applying a 50p minimum price per unit for all alcohol types would be the most effective, evidence-based minimum pricing strategy. This would ensure consistency with The Scottish Government's legislation to introduce a minimum unit price set at 50p and would eliminate cross-border differences in the cost of alcohol. The level for minimum unit pricing should be regularly reviewed to reflect the best available evidence. This should ensure that alcohol does not become more affordable over time (ie in responding to rises in inflation), and should assess its effectiveness in reducing alcohol-related harm (**Question 3**). There also needs to be consideration for the impact that a minimum price per unit has on the illegal production and trade of alcohol.

In reducing the affordability of alcohol, the introduction of a 50p minimum unit price should be supported by stronger action on excise duty. In the UK, the affordability of alcohol increased by 70 per cent between 1980 and 2009.[14] This is because the level of household disposable income has increased much faster than alcohol prices, whilst excise duty levels have remained relatively static. Between 1997 and 2007, duty on beer and wine was only adjusted for inflation, while duty on spirits did not increase at all.[15] Since 2007, excise duty rates have only increased at two per cent above inflation annually.[16] The BMA believes that excise duty on alcohol should be significantly increased (in the region of 10%), with continued annual

increases above inflation. There is also a clear need to rationalise the taxation system of alcohol in the UK. This is required to ensure all products are taxed proportional to their alcoholic content, with the introduction of duty bands that favour the production of lower strength products.

A ban on multi-buy promotions in the off-trade

The BMA welcomes the commitment to introduce a ban on multi-buy promotions as a way of reducing irresponsible retailing in the off-trade (**Question 5**), and believes there should be no exemptions for different types of promotions (**Question 6**). This is a proportionate measure in light of the evidence that excessively cheap promotions can fuel heavy drinking and alcohol-related crime and disorder.[1,17,18,19] We note that the proposals in this consultation, and the provisions of the *Licensing Act 2003 (Mandatory Licensing Conditions) Order 2010*, do not prohibit multi-buy promotions in on-license venues such as pubs, clubs, bars and restaurants. The BMA believes that consideration should be given to extending the proposals in this consultation to prohibit multi-buy promotions in the on-trade.

Reviewing the mandatory licensing conditions

The BMA does not have a view on the effectiveness of the specific licensing conditions set by the government under the *Licensing Act 2003 (Mandatory Licensing Conditions) Order 2010*. We believe that the Mandatory Licensing Conditions should be extended to restrict promotions of all types that encourage excessive consumption, such as those promotions that cut prices for a specified time (eg happy hours) **(Question 10).** Our members also believe that a stronger stance is required at a national level with an overarching directive to reduce licensing hours for on- and off-licensed premises. This in line with the evidence that increased opening hours are associated with higher levels of alcohol consumption.[20,21,22,23,24] Longer hours of alcohol sales may also be linked to increased problems with alcohol-related crime and disorder.[25] There is also a need to prioritise the enforcement of alcohol licensing regulations. It is essential that regulations, such as penalties for breach of licence, suspension or removal of licences, the use of test purchases to monitor underage sales, and prohibiting the sale of alcohol to individuals who are intoxicated or those underage, are actively enforced.

Health as a licensing objective

In the UK, access to alcohol has increased significantly due to doubling of the number of on and off-licensed premises. In 1953 there were 61,000 on-licensed premises and 24,000 off-licensed premises in Great Britain.[26] In 2012, 35,500 premises were licensed for on-sales of alcohol only, 51,100 premises were licensed for off-sales or supply of alcohol only, and 82,900 premises were licensed for on- or off-sales or supply.[27] This causes particular concern given the strong evidence that a high density of outlets is associated with increased alcohol consumption and alcohol-related harm.[28,29,30,31] The BMA strongly supports the proposal to ensure that local authorities take account of the full range of alcohol-related health harms when making licensing decisions. Sources of evidence that should be considered include local and regional data on conditions wholly attributable to alcohol (eg alcohol use disorders; alcoholic liver cirrhosis), chronic conditions where alcohol is a contributory cause (eg liver disease; oropharyngeal,

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oesophageal and liver cancer), acute conditions where alcohol is a contributory cause (eg alcohol-related accidents and injuries) and data on local crime levels associated with alcohol.

I hope you find this information helpful, and look forward to hearing the outcome of your consultation.

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