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

[ii] Public Health Wales, 2014. Public Health Wales NHS Trust Response to the Health and Social Care Committee Consultation on the Public Health (Wales) Bill

[iii] History and Policy, 'The Highs and Lows of Drinking in Britain', http://www.historyandpolicy.org/opinion-articles/articles/the-highs-and-lows-of-drinking-in-britain

[iv] Alcohol Concern, 2015. All Party Parliamentary Group on Alcohol Misuse Manifesto 2015

[v] 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

[vi] Welsh Government, National Survey for Wales 2016.

[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

[viii] Public Health Wales Observatory, Alcohol and Health in Wales 2014: Wales Profile.

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

[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).

[xii] Welsh Assembly Government, 2008. Working Together to Reduce Harm, The Substance Misuse Strategy for Wales 2008-2018

[xiii] Alcohol Concern Cymru, 'A drinking nation? Wales and alcohol', p.11.

[xiv] Welsh Government, 2015. Draft Pubic Health (minimum price for alcohol) (Wales) Bill Explanatory Memorandum

[xv] British Crime Survey, ONS; http://www.ons.gov.uk/ons/taxonomy/index.html?nscl=Crime+in+England+and+Wales

[xvi] World Health Organisation (2006) Interpersonal violence and alcohol. http://www.who.int/violence_injury_prevention/violence/world_report/factsheets/pb_violencealcohol.pdf

[xvii] Public Health England, 2016. The Public Health burden of alcohol and the Effectiveness and Cost-Effectiveness of Alcohol Control Policies – an Evidence Review.

[xviii] Donaldson L Department of Health, 2009. Guidance on the consumption of alcohol by children and young people.

[xix] Public Health Wales, 2015. Adverse Childhood Experiences and their impact on health harming behaviours in the Welsh adult population.
[xx] NHS Wales, 2017, http://www.wales.nhs.uk/news/46467.
[xxi] Kerr, W. C. and T. K. Greenfield, 2007. "Distribution of alcohol consumption and expenditures and the impact of improved measurement on coverage of alcohol sales in the 2000 National Alcohol Survey." Alcoholism: Clinical and Experimental Research, 31, 1714-1722.
[xxii] WHO fact sheet. 2005. www.parpa.pl/download/fs1005e2.pdf
[xxiii] https://www.glyndwr.ac.uk/en/AboutGlyndwrUniversity/Newsandmediacentre/Newsarchive/Pressreleases2011/Alcoholindustryresponsibledrinkingmessagesfailingtoaddresstherealissues/
[xxiv] Meng, Y. et al. (2014); Sheffield: ScHARR, University of Sheffield.
[xxv] Sheffield Alcohol Research Group, 2014. Potential benefits of minimum unit pricing for alcohol versus a ban on below cost selling in England 201$; modelling study.
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[xxix] Hansard. House of Commons Debate 14 March 2013. Hansard 2013; 560: 451–91.
[xxx] Public Health Wales, 2017. Data Mining Wales: The annual profile for substance misuse 2016-17
[xxxi] Public Health Wales NHS Trust, 2017. Data mining Wales: The annual profile for substance misuse 2016-17
[xxxii] Welsh Government, 2014. Model-based appraisal of minimum unit pricing for alcohol in Wales.
[xxxiii] 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