

Editorial

The price of a drink: the potential of alcohol minimum unit pricing as a public health measure in the UK

Peter Rice and Colin Drummond

**Summary**

The UK has seen a dramatic increase in alcohol consumption and alcohol-related harm over the past 30 years. Alcohol taxation has long been considered a key method of controlling alcohol-related harm but a combination of factors has recently led to consideration of methods which affect the price of the cheapest alcohol as a means of improved targeting of alcohol control measures to curb the consumption of the heaviest drinkers. Although much of the evidence in favour of setting a minimum price of a unit of alcohol is based on complex econometric models rather than empirical data, all jurisdictions within the UK now intend to make selling alcohol below a set price illegal, which will provide a naturalistic experiment allowing assessment of the impact of minimum pricing.

Declaration of interest

P.R. is a member of Scottish Health Action on Alcohol Problems, a group formed by the Royal Colleges and Faculties in Scotland, and previously a Board Member of Alcohol Focus Scotland, a campaigning charity. C.D. has received research grants on alcohol misuse from the Medical Research Council, Department of Health, National Institute for Health Research, Cabinet Office, European Commission, Alcohol Research UK, Scottish Government, Wales Office for Research and Development and the Home Office. He has received an educational grant from Alkermes in 2008, and has chaired a NICE guideline development group, a quality standards topic expert group, and a Commissioning Outcomes Framework and Quality and Outcomes Framework expert group on alcohol use disorder. C.D. is a member of the Independent Scientific Committee on Drugs.

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Alcohol pricing, particularly the price of the cheapest alcohol, has gained increasing attention in the UK over the past 5 years. In Scotland, legislation to introduce a minimum unit price of 50p per unit (8 g/10 mls) in Spring 2013 has been passed. Governments in Northern Ireland and Wales have, for some time, made clear their intention to do the same, and at the end of March 2012 the UK government in Westminster, which has responsibility for alcohol licensing in England and Wales and setting rates of excise duty and VAT (sales tax), announced their intention to introduce a minimum unit price.¹ The UK government is consulting on the level, but the strategy document gave examples of the effect of a minimum unit price of 40p. The chief medical officer in England has recommended a minimum unit price of 50p, the Northern Ireland Health Minister is considering 45–50p and the Scottish government has settled on 50p as the initial level. The UK government had previously considered a ban on sales below the cost of alcohol duty plus VAT, but this was shown to be ineffective as it would affect the price of only a small minority of alcoholic beverages². Why has the price of a drink become an issue of such importance in the UK?

Harm from alcohol is increasing

Alcohol-related harm has been increasing steeply in the UK. Alcohol-related hospital admissions have doubled in England between 2002 and 2009 and now exceed 1 million per year, and

deaths from liver disease have more than doubled in the UK since 1980, mostly due to alcoholic liver disease.³ In 2010, alcohol had become 44% more affordable than in 1980 and consumption has increased by more than 10% in the past 15 years.² The change in affordability has not been uniform across all outlets. The affordability gap between off-sales (liquor stores) and on-sales (pubs and restaurants) has steadily grown and consequently the increase in consumption has been seen in off-sales, whereas consumption in pubs has declined.^{3,4}

The UK experience over the past 25 years provides further evidence that increased alcohol affordability and accessibility leads to increased consumption producing greater levels of harm.⁵ There are, however, some early signs of downward trends in alcohol-related harm since 2008, a period when there has been a reduction in alcohol affordability due to economic recession, which is consistent with this model.^{5,6}

Historically, excise duty rates were seen as the key lever to control alcohol harm.^{7,8} In the UK, however, other mechanisms have been increasingly advocated for alcohol price control.⁸ There are two major reasons for this. First, successive UK governments from the mid 1980s until 2008 have been reluctant to increase alcohol excise duties.⁷ Second, there has been an increasing dominance within the UK off-sales sector by the major supermarkets. Unlike many other countries, in the UK all alcohol can be sold alongside other goods. This allows alcohol, including spirits, to be used as a 'loss leader' or 'footfall driver' where the retailer accepts a low profit (or even a loss) on alcohol to attract business and profits are made on other goods. Supermarkets in the UK advertise to their customers that they will absorb duty rises in order to maintain low alcohol prices. Discounting of alcohol in the off-sales sector is common, and following a ban on discounts for multiple purchases in Scotland, from October 2011 there was an immediate fall in consumption in line with the predictions from the University of Sheffield econometric model.⁹

Why minimum unit price?

There has been particular interest in mechanisms which affect the price of the cheapest alcohol. The reasons for this will be obvious to clinicians who are familiar with the histories of patients who drink heavily, who change their choice of beverages to achieve maximum 'bang for their buck'. A UK study of people in treatment for alcohol problems has shown that 83% of the alcohol they consumed is under 50p and 70% under 40p per unit.¹⁰ The potential value of a minimum unit price has been increasingly advocated by health professionals because compared with a general increase in tax on alcohol, setting a minimum unit price would have a targeted effect on the heaviest drinkers.¹¹

Assessing the potential impact of minimum pricing requires complex econometric models. A study using sales data from Sweden predicted that price changes focused on the most expensive drinks, such as that produced by a VAT rise, led to increased consumption due to consumers moving to cheaper brands and increasing their consumption.¹² Price increases focused on the cheapest alcohol, as envisaged by minimum pricing, were predicted to be most effective in reducing consumption and harm. A major study commissioned by the UK Department of Health from the University of Sheffield used UK sales data to estimate the effect of a range of price mechanisms such as general price increases through excise duty, a ban on discounts for bulk purchases, and introduction of a minimum unit price ranging from 20 to 70p per unit.¹³ This modelling exercise showed minimum unit price as the best targeted approach to influence the consumption of the heaviest and most problematic drinkers, with significant beneficial effects starting from 40p per unit.

Research in Australia and Canada, where forms of minimum unit pricing have been introduced, showed a reduction of between 16% and 19% in alcohol consumption, accompanied by reductions in alcohol-related hospital admissions and alcohol-related offending.^{14,15}

Conflict between health and industry interests

Minimum unit price has been strongly supported by a range of UK health organisations, including the Royal College of Psychiatrists (e.g. www.rcpsych.ac.uk/press/pressreleases2012/alcoholstrategy.aspx), and by the chief medical officers in England, Scotland, Wales and Northern Ireland. Minimum unit pricing also attracts support from the police, children's charities, the pub industry and most small, and some large, producers. Opposition to the policy has come from large retailers and organisations representing multinational alcohol producers. In Scotland, Wales and Northern Ireland where minimum unit price was a significant electoral issue, the elections were won by parties supporting the policy.

Some opponents of minimum unit pricing are concerned that the policy will generate revenue for retailers and not for the public purse. However, the policy is advocated as a public health measure and governments have a range of mechanisms to generate tax revenues, including raising alcohol duties, with which minimum pricing is compatible.

These recent debates in the UK have focused attention on the role of the alcohol industry in policy development. The industry has been shown to favour ineffective approaches such as public information campaigns and school-based education and to oppose regulatory approaches on price and availability of alcohol which are most effective in reducing harm.¹⁶ A number of health

agencies, including the British Medical Association and Royal College of Physicians, refused to sign the UK government's 'Responsibility Deal' because they felt it had been too influenced by the industry. The Scottish government has come under considerable pressure from the whisky industry to drop its minimum price proposals, which it has resisted. Among the claims put forward by industry lobbyists is the potential for a detrimental impact on employment in the alcohol industry. However, in other countries a decline on overall consumption of cheaper alcohol combined with a shift to the more labour-intensive on-sales sector has been shown to have a net beneficial effect on employment and profitability.¹⁷

Turning problem into action

The minimum price concept in the UK has now developed considerable momentum and it is difficult now to conceive that it will not be implemented. The details of the implementation are not yet clear, in particular whether the price level will vary across the UK. Great Britain may follow the example of Northern Ireland and Ireland where health ministers have agreed that a cross-border differential is undesirable. Although the legality and real-life effect of minimum price remain to be tested, to have reached this point is a significant achievement for the public health community in the face of concerted political lobbying by parts of the alcohol industry, which is reminiscent of the tobacco policy landscape in the UK 30 years ago. It is not surprising that UK alcohol retailers have been advised to start contingency planning for the introduction of minimum unit pricing.¹⁸

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References

- 1 HM Government. *The Government's Alcohol Strategy*. HM Government, 2012.
- 2 Adams J, Beenstock J. Price discounts on alcohol in a city in northern England. *Alcohol Alcohol* 2012; **47**: 187–90.
- 3 NHS Information Centre. *Statistics on Alcohol: England, 2011*. Health and Social Care Information Centre, 2011.
- 4 Scottish Government. *Alcohol (Minimum Pricing) (Scotland) Bill. Policy Memorandum*. Scottish Government, 2011.
- 5 Babor T, Caetano R, Casswell S, Griffith E, Giesbrecht N, Graham K, et al. *Alcohol: No Ordinary Commodity (2nd edn)*. Oxford University Press, 2010.
- 6 Beeston C, Robinson M, Craig N, Graham L. *Monitoring and Evaluating Scotland's Alcohol Strategy. Setting the Scene: Theory of change and baseline picture*. NHS Health Scotland, 2011.
- 7 Institute for Fiscal Studies. *Alcohol Pricing and Taxation Policies*. Institute for Fiscal Studies, 2011.
- 8 Meier PS, Purshouse R, Brennan A. Policy options for alcohol price regulation: the importance of modelling population heterogeneity. *Addiction* 2009; **105**: 383–93.
- 9 Chick J. 16 for the price of 10: effects of a ban on multi-buy alcohol. *Alcohol Alcohol* 2012; **47**: 83.
- 10 Black H, Gill J, Chick J. The price of a drink: levels of consumption and price paid per unit of alcohol by Edinburgh's ill drinkers with a comparison to wider alcohol sales in Scotland. *Addiction* 2010; **106**: 729–36.

- 11 Scottish Health Action on Alcohol Problems. *Alcohol: Price, Policy and Public Health: Report on the Findings of the Expert Workshop on Price Convened by SHAAP*. Scottish Health Action on Alcohol Problems, 2007.
- 12 Gruenewald P, Ponicki W, Holder H, Romelsjö A. Alcohol prices, beverages quality, and the demand for alcohol: quality substitution and price elasticities. *Alcohol Clin Exp Res* 2006; **30**: 96–105.
- 13 Brennan A, Purshouse R, Taylor K, Rafia R, Meier P, Booth A, et al. *Independent Review of the Effects of Alcohol Pricing and Promotion: Part B. Modelling the Potential Impact of Pricing and Promotion Policies for Alcohol in England: Results from the Sheffield Alcohol Policy Model. Version 2008 (1-1)*. University of Sheffield, 2008.
- 14 Gray D, Siggers S, Atkinson D, Sputore B, Bourbon, D. Beating the grog: an evaluation of the Tennant Creek liquor licensing restrictions. In *Indigenous Australian Alcohol and Other Drug Issues: Research from the National Drug Research Institute* (eds D Gray, S Siggers): 17–28. National Drug Research Institute, 2002.
- 15 Stockwell, T, Auld CM, Zhao J, Martin G. Does minimum pricing reduce alcohol consumption? The experience of a Canadian province. *Addiction* 2012; **107**: 912–20.
- 16 Drummond, DC. An alcohol strategy for England: the good, the bad and the ugly. *Alcohol Alcohol* 2004; **39**: 377–9.
- 17 Anderson P, Baumberg B. *Alcohol in Europe*. Institute of Alcohol Studies, 2006.
- 18 Arnot R. Alcohol pricing: will health lobby hold sway? *The Grocer*, 18 February 2012.

poems
by
doctors

Care in the Community

Raymond Miller

Most often I spot them way off in the distance:
something in the gait and the weight of their symptoms
bears the stamp of repeat prescriptions.
Sets alarm bells screeching and I turn on a sixpence
To cross roads inventing a previous engagement,
catch a flower arrangement, bend to tie laces,
bury my head in shop windows replete
with cheap trinkets. I treat light on my feet
but dejected spirits make cock-crow visits,
patches of ice combine with the rain
to throw me off-balance; I clutch at displacement
when meeting ex-patients again.

Or else my elbow shudders at the finger
As "Hello stranger!" wraps round my shoulder.
I spin to a name that I can't remember;
a drug, a diagnosis or simply disorder.
The furrowed flesh of distress and despond;
failure to bond and exasperation;
the trial separation from errant husbands;
scars and bruises borne by the infant;
the rooted abhorrence roared at the parents
have eroded my epithets of empathy,
I've shovelled that dirty laundry
into yellow plastic bags for waste disposal;
I no longer dance to the non-judgemental.
What's once contemplated can't be unthought;
they take me at face value; I sell them short.

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