ChaMPs public health network

Liverpool Public Health Observatory

Alcohol: Minimum Pricing and Licensing Powers

Expected outcomes and recommended local actions for Merseyside

ISSUES

Liverpool Public Health Observatory
Issues series, no.10, February 2010

Janet Ubido and Paul Cordy

PROVIDING INTELLIGENCE FOR THE PUBLIC HEALTH

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Liverpool Public Health Observatory

Liverpool Public Health Observatory was founded in the autumn of 1990 as a research centre providing intelligence for public health for the five primary care trusts (PCTs) on Merseyside: Liverpool; St.Helens and Halton, Knowsley, Sefton and Wirral. It receives its core funding from these PCTs.

The Observatory is situated within the University of Liverpool's Division of Public Health. It is an independent unit. It is not part of the network of regional public health observatories that were established ten years later, in 2000.

Observatory ISSUES Series

In October 1994, Liverpool Public Health Observatory launched the ISSUES series. This was a response to the perceived need for timely reports reviewing theory and practice in areas of concern and controversy within public health. The intention is to target the audiences most closely involved with each issue covered. All ISSUES reports are sent to NHS directors of public health and chief executives within Merseyside and Cheshire. A full list of reports can be found on the Observatory website: http://tinyurl.com/yfv479u

Printed copies can be obtained by contacting Francesca Bailey at the Observatory on 0151 794 5570

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Introduction

Following the Liverpool Shadow Safer Healthier Communities Board meeting on 28th October 2009, the Board requested information on alcohol minimum pricing and utilising licensing powers, drawing upon national and regional learning. Liverpool Public Health Observatory was commissioned to do this work, resulting in a summary paper being presented to the Board on 13th January 2010. The paper sought to assist the Board's discussion and agreement on progressing alcohol minimum pricing, use of licensing powers and suggested next steps for Merseyside.

This paper details the information used for the summary paper sent to the Board. It focuses on specified recommended local actions and measurable expected outcomes, such as lives saved and reductions in hospital admissions. The paper has incorporated learning from Greater Manchester, Blackpool, Scotland, Our Life and Drink Wise NW.

Background

In his Annual Report for 2008, the Chief Medical Officer called for the introduction of minimum pricing (Donaldson, 2009). He outlined the harmful effects of alcohol, and the impact that minimum pricing could have (Box 1).

Box 1
From the annual report of the Chief Medical Officer, 2008

''The effects of passive drinking are far-reaching - much more so than those of passive smoking. They include 39,000 serious sexual assaults every year. They include the one and a quarter million instances of alcohol-related vandalism. Passive drinking leads to huge financial costs to society. Alcohol alone costs the NHS £2.7 billion per year.

***Cheap alcohol is killing people and it's undermining our way of life. In my report price and access are two crucial factors affecting alcohol consumption. I recommend action taken on both but particularly on price**.*

Introducing a minimum price of 50 pence per unit would mean that a typical bottle of wine could be sold for no less than £4.50 and a typical six-pack of lager for no less than £6. Research has shown that this would hardly impact upon those who drink at low-risk levels. It would significantly affect those who drink at high-risk levels, helping them to reduce their own drinking and reducing the harms of passive drinking. Within 10 years of introducing this 50 pence policy, there would be major benefits. We would expect to see over 3,000 fewer deaths a year, 46,000 fewer crimes, 300,000 fewer sick days and 100,000 fewer hospital admissions. The total benefit could be as high as over £1 billion per year.

I recommend:

- *Licensing laws should take the effects of passive drinking into account*
- *There should be a national campaign focussing on passive drinking*
- ***A minimum price per unit should be introduced as a priority**."*

[Sir Liam Donaldson, Chief Medical Officer (CMO) 2009]

The Directors of Public Health in the North West have been involved in lobbying for a 50p minimum price per unit of alcohol, most recently in a letter to the Daily Telegraph (see Appendix 1).

Alcohol affordability: In the UK, alcohol was 69.4% more affordable in 2007 than it was in 1980 (IAS, 2008). A consideration of 'affordability' takes into account the effects of income changes and price on alcohol consumption. A recent EU report noted that the affordability of alcohol increased since 1996 in all countries for which data was available, with the exception of Italy (Rabinovich et al, 2009). In 2004, increases in income accounted for 84% of the increase in alcohol affordability, and 16% was driven by changes in alcohol prices. The UK had one of the highest increases in affordability, and the 4th highest change in disposable income (50%).

Making alcohol less affordable will have a greater impact on young people than on the rest of the population (Rabinovich et al, 2009).

The EU report noted that research has found that increases in affordability are associated with increases in consumption, which in turn are significantly related to increases in fatal traffic accidents, traffic injuries and liver cirrhosis (Rabinovich et al, 2009). In summary, a 1% increase in alcohol consumption is associated with an increase of:

- 0.86% in fatal traffic accidents
- 0.61% in traffic injuries
- 0.37% in chronic liver cirrhosis

As a 50p per unit minimum price for alcohol is expected to result in a 6.9% reduction in consumption (University of Sheffield, 2008), a significant reduction in these harmful effects on health would be predicted. Full details are given in section 3.

1) Utilising licensing powers

The mandatory code of practice for licensed premises proposed by the government has recently been passed by law (the Policing and Crime Act 2009, Part 3: Alcohol misuse). Once parliamentary approval is obtained, it is planned to introduce the code in April 2010. Any premises breaching the code may lose their licence, or have tough conditions imposed on their licence. The focus of the mandatory code is on the 'on-trade' (pubs and clubs) with little regard to the 'off-trade' (corner shops and supermarkets).

The code has 5 conditions, with the first 3 planned to come into effect on 6th April 2010 as follows:

- banning irresponsible promotions, such as 'all you can drink for £10' or 'women drink free' deals, that encourage people to drink quickly or irresponsibly
- banning 'dentist's chairs' where drink is poured directly into the mouths of customers, making it impossible for them to control the amount they are drinking
- ensuring free tap water is available for customers, allowing people to space out their drinks

Premises will have further time to prepare for the remaining 2 conditions due to come in on the 1st October 2010:

- ensuring all those who sell alcohol have an age-verification policy in place, requiring them to check the ID of anyone who looks under-18
- ensuring small measures of beers, wine and spirits are made available to customers

Additionally, from 29 January 2010, local councils will gain tough new powers to make it quicker and easier for them to tackle problem premises by calling for a review to restrict or remove licenses, without having to wait for the police or local residents to complain.

(Home Office 19th January 2010)

1.1) Problems with introducing the code of practice

a) It is ineffective and unfair to focus on the on-trade – restricting promotions will drive volume into the off-trade where there is no regulation of consumption (Noctis, 2009). A 2008 consultation on the code revealed supermarket 'loss-leading' as one of the main areas for concern. The British Beer and Pub Association have labelled the code 'lop-sided and unbalanced', reporting that nearly 70% of all alcohol is sold in supermarkets while the pub trade continues to suffer (Morris 2010)
b) It is estimated that 82% of people drinking in late night venues will 'pre-load' with alcohol at home (Noctis, 2009). When prices are much higher in the on-trade, this is more likely to happen
c) On average customers will enter late night venues around two hours later when there are no drinks promotions (Noctis, 2009)
d) Drinking hand-poured less accurate measures at home will encourage larger consumption (Noctis, 2009). A recent live experiment by Drink Wise found that the average home barman will pour twice as much as a standard single measure (Drink Wise NW, 2009).

2) Action on minimum pricing

The government has not included minimum pricing in the new mandatory code as they feel that measures around minimum unit price would punish unfairly the sensible majority of moderate and responsible drinkers.

However, they do commit to developing further the evidence base in this area (Home Office, 13th May 2009) and they have made a commitment to make funding available early in 2010 for research into the crime-related effects of alcohol pricing policies (Jones, 2009).

A recent House of Commons Health Select Committee inquiry into alcohol made strong calls for minimum pricing (House of Commons Health Committee, 2010), supporting the previous recommendations of the Chief Medical Officer (see Box 1). The cross-party Select Committee report concluded that minimum pricing would target problem drinkers who rely on cheap alcohol, and that increasing the price of alcohol was the most powerful tool at the disposal of the government.

'On trade' licensees would back the introduction of a 50p per unit minimum pricing campaign for alcohol, saying that this will not only stop supermarkets from selling alcohol as a loss-leader, but also encourage people to drink in the nation's pubs which mostly sell alcohol at responsible prices (Eley, 2008).

There are difficulties in introducing minimum pricing in the off-trade – supermarkets are unable or unwilling to do so, saying they would not be allowed to do this in collaboration with other supermarkets – and would lose business if they do it on their own. Tesco have stated that they are very prepared to play an active and constructive role in discussions on minimum pricing, but that frustratingly, the

industry would not be able to lead the way – government action is needed (North, 2009).

In Scotland, Greater Manchester and Blackpool, there have been attempts at action on introducing minimum pricing. There have been questions raised about the legality of imposing minimum pricing. 'Our Life'[1] is commissioning lawyers to provide a legally robust guide to the implementation of a minimum price per unit of alcohol across a local authority or city region. The advice will also cover the legality in European terms of establishing a minimum price, the legality in terms of UK competition law and legality in terms of the Licensing Act. 'Our Life' will disseminate the advice across the region as soon as it is available. The lawyers have advised 'Our Life' that local areas should postpone any implementation until guidance has been produced, although in the meantime, advocating in principle for a minimum price per unit as a course of action for the city region would be very helpful (Giles, 2009).

2.1) Scotland

The Scottish government is aiming to introduce a minimum price of 50p per unit of alcohol for the on and off-trade. This is currently being blocked by opposition parties, who say it might contravene European competition laws. Although there has been no action on minimum pricing yet, there are other changes introduced by the Licensing (Scotland) Act 2005 that came fully into force on 1st September 2009.

These include:

a) Alcohol will be displayed in separate areas within shops and supermarkets, rather than around the store
b) Irresponsible promotions such as happy hours and 'buy one get one free' offers in pubs and in clubs will be banned
c) All bars must provide customers with free tap water
d) There is now more scope for people to have a greater say in how alcohol affects their community as anyone can ask a licensing board to review the licence of any premises
e) All staff working in licensed premises have to be trained before serving alcohol, including all part time and casual staff
f) Shops, supermarkets and off-licences will only be allowed to sell alcohol between 10am and 10pm.

(Alcohol Focus Scotland, 2009)

Problems: Some loopholes in these requirements have emerged, mainly with some pubs now offering 'happy days' rather than 'happy hours'. The new rules aimed to prevent 'happy hour' offers by forcing publicans to keep drinks at the same price for a period of 72 hours. But rather than abandon their drinks offers, bars have been extending them to last for 72 hours or more (Edinburgh Evening News, 5th September 2009). It is also reported that, for example, cider is still available from outlets for as little as 90p per litre (8 units of alcohol) (The Journal, 13th September 2009).

2.2) Greater Manchester: Oldham

In Greater Manchester, they are exploring the possibility of using their city region networks to introduce minimum pricing for alcohol. So far, this has been piloted for

[1] Our Life: a movement for social change in the north west

the on-trade in the borough of Oldham, with the off-trade the next target. The City Region Board is made up of 7 strategic commissions (covering housing, the environment, health etc.), three of which have agreed to support the call for minimum pricing in the on and off-trade. As yet, the Board has no formal powers it can use regarding minimum pricing. In the meantime, the Board will continue to lobby national government and meet with licensing chairs and other bodies to build up support for the policy.

In Oldham, all 22 bars and clubs selling cut-price drinks have had their licences reviewed. They have been asked to set a minimum price for alcohol of 75p per unit (£1.88 for a pint of strong lager) – if they don't comply, they will be asked to change the way they operate – with e.g. a post office-style queuing system (not popular), only allowing the purchase of two drinks at a time, providing extra door staff, and paying for police officers to watch over the bar. Any premises refusing to co-operate could lose their licences. The scheme was featured in a recent BBC Panorama programme (Bilton, August 2009).

Panorama reported that so far, 16 bars have either accepted the proposal or a version of it and 5 are still in discussion. One bar has successfully fought the move, after complaining that it was unfair to condemn them for violence that happens elsewhere. Oldham council hope the new conditions will not be needed at all because bars will agree to stay above 75p per unit.

The council is trying to work with the law (Bilton, August 2009). In order to reduce the chances of legal challenges, the on-trade measures in Oldham are not described as minimum pricing (Irving, 2009).

Evidence on the impact of the scheme in terms of crime and disorder is expected soon, and is expected to be positive (Irving, 2009).

2.3) Blackpool

In Blackpool the NHS Trust recently produced a report on alcohol modelling, recommending that the single most effective policy, in terms of reducing alcohol related hospital admissions and their associated costs, would be to introduce a minimum price of 50p per unit of alcohol as soon as possible, and to maintain that policy for as long as possible (Gisborne et al, 2009). In addition to reduced hospital admissions, it was noted that there are likely to be considerable other savings to the health service over the medium to long term, such as in primary care, A&E, community mental health services and community drug and alcohol services.

The report looked at various treatment packages such as brief interventions, as well as pricing policies. More details of their work, including a table comparing the costs of different interventions, are included in Appendix 2. It was noted that unlike other interventions, the minimum pricing intervention produces no additional intervention cost, since the model assumes that the pricing policy is cost free to the health service (Gisborne et al, 2009). The only costs to the health service would be the time spent lobbying etc. There will be some costs to the local authority of enforcement of the policy.

Blackpool Council has recently agreed on a motion to introduce minimum pricing. The Council now has an agreement with pubs that they will keep to a minimum price of £1.50 per drink from Thursday through to Sunday evening. Pubs are happy to cooperate as long as they are all doing the same. It may not be legally possible to include supermarkets in the Blackpool scheme – the council and the NHS are looking into this (see 2.1).

3) Outcomes of introducing 50p minimum price per unit
(on and off-trade, England and Merseyside)

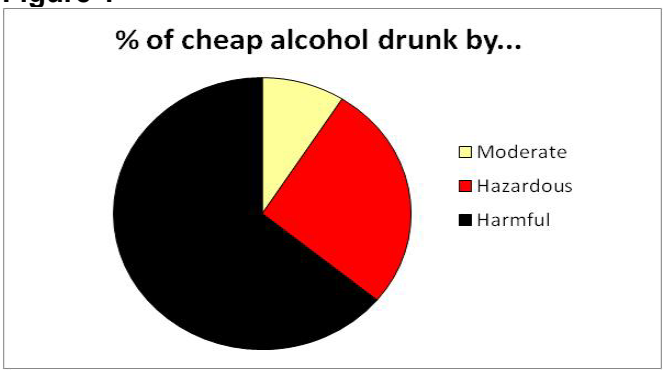
The University of Sheffield was recently funded by the Department of Health to carry out a study with the aim of quantifying the potential impact of policies targeting pricing and promotion of alcohol on alcohol related harm in England (University of Sheffield, 2008). They analysed the effects of a range of possible scenarios, including increasing the general price of alcohol by different percentages, banning off-trade promotions, minimum pricing ranging from 15p to 70p (on and off trade) and differential combinations of on and off trade minimum pricing (e.g. 40p off and £1 on trade).

Reductions in harm and consequent savings increase steeply the higher the minimum price per unit. The outcomes presented here focus on 40p and 50p minimum pricing for the on and off-trade.

Who would be affected?
Minimum pricing affects cheap alcohol more than would an increase in the price of all drinks by a set percentage. Minimum pricing and discount bans target cheap alcohol (i.e. only part of the market).

- 64% of all cheap off-trade alcohol is consumed by harmful drinkers (and only 9% by moderate drinkers) (Figure 1)
- approximately 27% of off-trade alcohol consumption is purchased for less than 30p per unit, compared to 9% in the on-trade.

Figure 1



Source: University of Sheffield 2009a

A single minimum price is not likely to affect the on-trade, because prices there are already much higher than in the off-trade.

Harmful drinkers: A 50p minimum price would affect harmful drinkers more - they would consume 10.3% less alcohol (compared to a 5% reduction in consumption for moderate drinkers). The alternative policy of increasing alcohol prices by 10% would have a much smaller effect on harmful drinkers, reducing their consumption by 5%. The 50p minimum pricing policy would cost harmful drinkers £15 extra per month, with a small impact on sensible drinkers of around £1 extra per month.

In summary, the Sheffield study notes that price policies target harmful drinkers because harmful drinkers

- buy 15 times more alcohol than a moderate drinker
- spend 10 times as much on alcohol than a moderate drinker
- prefer cheaper drinks, and pay 40% less per litre of pure alcohol

11-18 year olds: A 40p minimum price would be estimated to result in a 4% decrease in consumption by those aged 18 and under. A 50p minimum would lead to a 7.3% reduction.

Minimum prices targeted at particular beverages are less effective than all-product minimum prices

A total ban on off-trade discounting is estimated to reduce consumption by 23 units per year, which would give an estimated change in consumption of -2.8%. This would have a similar effect to a 40p minimum price policy for the on and off trade (-2.6%).

(University of Sheffield 2009a and 2009b)

Scotland: The Scottish government commissioned the University of Sheffield to apply their model on the effects of minimum pricing to the Scottish population. There was a need to allow for differences in drinking habits etc – but results were only slightly different to those for England (University of Sheffield, 2009b).

3.1) Consumption

The Sheffield model predicted that overall, there would be a steep increase in effectiveness as the minimum price increases, with a 40p minimum price per unit leading to an estimated 2.6% reduction in alcohol consumption, a 50p minimum price resulting in a reduction of 6.9% and a 70p minimum price giving an estimated 18.6% reduction. A 50p minimum pricing policy would be more effective than a policy of increasing alcohol prices by 10%, which would be estimated to result in a 4.4% decrease in alcohol consumption (University of Sheffield, 2008).

3.2) Spending

Estimated reductions in consumption do not match the increase in prices, so that overall, spending increases. The increase in spending becomes higher as the price increases – so that for a minimum price policy of 50p, there would be an increase in spending of £56.31 per year per person (£21.52 for a 40p minimum price policy) (University of Sheffield, 2008).

3.3) Health outcomes: Hospital admissions

North West Public Health Observatory (NWPHO) data on alcohol-related hospital admissions uses the same definitions as in the Sheffield study. This makes it possible to apply the Sheffield outcomes model to local data.

Policies targeting only cheap alcohol, or lower minimum prices such as 20p per unit, have very small effects on alcohol-attributable hospital admissions. Policy options with greater price rises begin to have larger effects. For example:

b) **in England**, a 40p minimum price gives an estimated reduction of around 40,000 admissions per annum (-5.2%), and a 50p minimum price is estimated to reduce admissions by 98,000 each year (-12.4%).

c) **in Merseyside,** there would be a reduction of an estimated 5,021 admissions each year with a 50p minimum price. Table 1 provides predictive outcomes across Merseyside (see Appendix 3 table B for Cheshire):

Table 1

Merseyside:
Hospital Admissions for Alcohol-related Harm
Estimated reductions in admissions with a 50p per unit alcohol minimum pricing policy

PCT	*Number of Admissions 2008/2009**	*Estimated Cost (£)***	*Estimated Annual Reduction in Admissions****	*Estimated Saving (£)***
Halton and St Helens	7889	2.3M	978	281,664
Knowsley	4169	1.2M	517	148,896
Liverpool	13054	3.8M	1619	466,272
Sefton	6697	1.9M	830	239,040
Wirral	8686	2.5M	1077	310,176
Total	*40495*	*11.7M*	*5021*	*1,446,048*

* NWPHO 2009. NI39 http://www.nwph.net/alcohol/lape/download.htm

** based on NHS Wirral tariff (£288) for patients over 19 and less than 69 with mental health as primary diagnosis (Wirral PCT)

*** based on 2008/9 admissions - full effect per annum after 10 years of the policy, rather than 1st year effect. Applying the Sheffield model of a 12.4% reduction with a 50p minimum unit price of alcohol, on and off trade (University of Sheffield, 2008)

3.4) Health outcomes: Deaths

The NWPHO holds data on alcohol-attributable deaths for Merseyside. The Sheffield model has been applied here to Merseyside data.

As prices increase, then more deaths attributable to alcohol are avoided. For example, a move from a 40p to a 50p minimum price per unit would change the estimated avoided deaths in:

a) **England** in year 1 from 157 (-4.5%) to 406 (-11.6%). By year 10, the full effects of chronic disease risk reductions will have come into effect, so that the deaths per annum avoided are 8 times higher in year 10 compared to year 1 (3,393 deaths avoided each year in England by year 10 with a 50p minimum price).

b) **Merseyside** from 71 (11.3%) to 174 (27.8%) per annum. These are the estimated full effects after 10 years of minimum pricing, by which time chronic disease risk reductions will have come into effect, so that the deaths per annum avoided are higher in year 10 compared to year 1 (table 2) (see Appendix 3 table C for Cheshire).

Table 2

Merseyside:
Deaths from alcohol attributable conditions, all ages, 2007
Estimated reductions with 40p and 50p per unit alcohol pricing policy

Local Authority	*female deaths*	*male deaths*	*total deaths*	*40p minimum price: full effect of deaths avoided per annum (11.3%)**	*50p minimum price: full effect of deaths avoided per annum (27.8%)**
Knowsley	23.37	35.41	58.77	6.64	16.34
Liverpool	61.42	146.48	207.9	23.49	57.80
Halton	18.15	28.01	46.16	12.83	12.83
St Helens	32.91	39.37	72.28	8.17	20.09
Sefton	31.29	66.75	98.04	11.08	27.26
Wirral	42.95	98.81	141.77	16.02	39.41
Total	*210.09*	*414.83*	*624.92*	*70.62*	*173.73*

source: results from University of Sheffield study (2008) on estimated deaths avoided, applied to data on deaths from NWPHO 2009 (http://www.nwph.net/alcohol/lape/download.htm)

*the full effects of chronic disease risk reductions on deaths are modelled to take 10 years to have full effect (University of Sheffield, 2008)

*[**Note:** The Sheffield study is based on a smaller number of total deaths (12,196 in England, compared with 15,070 using NWPHO data). This is probably because their model allowed for the protective effects of consuming alcohol on CHD and type 2 diabetes. Also, their data was one year older (2006). In addition, there may have been slightly different methods used to calculate the attributable fraction (Purshouse, 2010). This means that in this respect, the figures produced for Merseyside may be overestimated – but this may be offset by allowing for differences in drinking patterns, which if higher on Merseyside compared to England, may lead to an underestimation of effects.]*

3.5) Crime outcomes

The harmful effects of crime will reduce as prices increase. A minimum price of 40p would be estimated to reduce total crimes in England by around 16,000 each year (-0.8%), and for a 50p minimum, the reduction would be 45,800 (2.4% fewer alcohol-related crimes). With a 50p minimum price, violent crimes in England would reduce by 10,300, criminal damage by 17,100 and thefts, robberies and other crimes by 18,500 (University of Sheffield, 2008).

Of the predicted reduction in crime, nearly half (43%) will be a reduction in crimes committed by 11-18 year olds (19,500 fewer crimes committed by those aged 11-18, of the 45,800 total annual crimes reduction - 50p minimum price scenario). Crime harms reduce particularly for the under 18s because they are disproportionately involved in alcohol-related crime. They are also more affected by targeting price rises at low-priced products, which is the effect of a minimum price (University of Sheffield, 2008).

3.6) Employment

Absence: a minimum price of 40p is estimated to reduce days absent from work by around 100,000 (-1.1%). For 50p, the reduction is estimated at 296,000 (-3.1%). The majority of absence reductions occur amongst hazardous and harmful drinkers (as opposed to moderate drinkers).

Unemployment: With a 40p minimum price, there would be 12,400 avoided unemployment cases each year (-11.6%), compared to 27,100 for a 50p minimum (-25.3%) (University of Sheffield, 2008).

3.7) Financial outcomes

The financial value of harm reductions becomes larger as prices are increased. There is an overall £5,418m reduction in harms over 10 years for a 40p minimum price. This figure more than doubles with a 50p minimum price, with harms reduced by £12,950m (University of Sheffield, 2008).

Healthcare costs are reduced as prices are increased. NHS costs avoided due to reduced alcohol-related illness and admissions are estimated to be £546m for the 40p minimum price, and £1,373m for the 50p minimum, over a 10 year period.

The financial value of mortality and morbidity avoided using the Health QALY measure[2] also improves as prices are increased. The value of QALY loss avoided changes from -£1,938 for the 40p minimum price, to £4,909 for the 50p minimum, over 10 years.

Reductions in morbidity and consequent health savings are likely to be underestimated. This is because hospitalisation rates are used as a proxy for the prevalence of disease, but not all people with alcohol-attributable disease will be hospitalised in any one year.

Crime costs are also estimated to reduce as prices increase. With a 40p minimum price, the costs of crime would fall by £140m over 10 years, and by £413m with a 50p minimum price.

The crime QALY is a measure of the impact of crimes on the victim's quality of life. With a 40p minimum price, this would be reduced by £196m, and a 50p minimum price would lead to an estimated reduction of £616m in the crime QALY.

Unemployment reductions form the largest component of overall harm reductions. With a 50p minimum price, just under half of overall estimated harm reductions are unemployment-related (£5,402m of the total £12,951m over 10 years). This is because minimum pricing hits harmful drinkers disproportionately and harmful drinkers are more likely to be unemployed (University of Sheffield, 2008).

(Note: these are 10 year cost savings / value of harm reductions - data on 1st year cost savings also available – see table 35, Sheffield report, University of Sheffield, 2008)

[2] Quality Adjusted Life Years – a measure that summarises improvements in quality of life and survival

3.8) Impact on Teenage Pregnancy

The University of Sheffield study did not consider impacts on teenage pregnancy. A study in the US by Sen (2003), examined the effects of increasing beer taxes on teenage pregnancy and found that increased beer taxes have statistically significant and negative effects on abortion rates and therefore by implication pregnancy rates. Effects on birth rates are not significant – suggesting that taxes help to prevent some unwanted pregnancies that would typically be terminated with abortion, rather than resulting in a live birth. The effects would be quite small, with a 100% increase in beer taxes leading to a 7-10% decrease in teenage abortion rates.

4) Recommended action on minimum pricing for Merseyside

In the summary paper for the Safer, Healthier Communities Board (see Introduction, p.2), the Board was requested to:

4.1) Note the findings outlined in this paper

4.2) Endorse and introduce the discretionary local actions in Merseyside

4.3) In line with CMO recommendations agree in principle to the introduction of a minimum price of 50p per unit in Merseyside and work closely with 'Our Life' who will inform any future policy decision by the production of legal guidance

Learning from action taken in Greater Manchester (Jones, 2009), additional recommendations are made as follows:

4.4) *Mobilise local organisations,* with regular meetings of NHS/LA alcohol leads, local licensing chairs and other bodies such as trading standards and planning committees, to ensure all the structures are in place in anticipation of minimum pricing. Involve the local community to encourage them to back the policy

4.5) *Continue lobbying* national government to introduce minimum pricing for alcohol in the on and off-trade, with more letters from the DsPH etc.(see Appendix 1)

4.6) *Local action*: for the time being, carry out initiatives in smaller 'hotspot' areas, similar to the scheme in Oldham, Greater Manchester, to deter sales of cheap alcohol in the on-trade.

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Appendix 1
North West DsPH letter to the Daily Telegraph

Letters to the Editor
The Daily Telegraph
111 Buckingham Palace Road
London
SW1W 0DT

14 January 2010

Sir,

Time for decisive action on alcohol harm

As Directors of Public Health in the North West we welcome the comments from the Health Secretary (Telegraph, 14th January, Cost of cheap alcohol will double to curb binge drinking) and the report of the Health Select Committee last week on alcohol pricing. We call on all politicians to support the proposals for a minimum unit price for alcohol.

We know that politicians will be concerned about public opinion and the impact on people's pockets. However, they should also be aware that the public are very much aware of the effect of pocket money prices on consumption. In a major survey of 30,000 people across the North West 80% thought that low prices and discounts increased consumption. Only 36% felt that information on alcohol-related harm on its own would decrease consumption.

The alcohol business continues to tell the Government that information is all that is necessary. However as the Health Secretary, the Chief Medical Officer, the World Health Organisation and the public have all recognised there is also a link between price, consumption and harm that can no longer be ignored.

A minimum price of 50p per unit of alcohol would put a stop to the 2 litre bottles of cider for £1.21 and 15-packs of lager for £5 which are fuelling extreme levels of drinking at home. However, because a minimum price per unit is not a tax you could still get a pint for £1.50 in the pub and a bottle of wine in the supermarket for around £4. That doesn't seem much when you consider that we all have to shoulder our share of a £20bn cost to society from alcohol harm.

If the politicians are brave enough to make the case then we believe public support will be forthcoming.

Sincerely,

The North West Directors of Public Health
Dr Paula Grey, Liverpool PCT
Dr Arif Rajpura, Blackpool PCT
Fiona Johnstone, Halton and St Helens PCT
Dr Diana Forrest, Knowsley PCT
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Maggi Morris, Central Lancashire PCT
Dr Heather Grimbaldeston, Central and Eastern Cheshire PCT
Dominic Harrison, Blackburn with Darwen PCT
Marie Armitage, Wirral PCT
David Regan, Manchester PCT

Appendix 2

The Blackpool model

In Blackpool, the NHS Trust developed a model to test and demonstrate the most effective strategies for driving down alcohol-related hospital admissions (Gisborne et al, 2009). They looked at various treatment packages, and at pricing policies. The Blackpool study did consider also including an analysis of enforcement policies such as test purchases with follow-up action. However, because of a lack of strong evidence of the impact on alcohol-related hospital admissions, this policy was not considered in their analysis.

NHS outcomes: The Blackpool model was broadly based on the study by the University of Sheffield (2008), predicting that introducing a minimum retail price of 50p per unit of alcohol sold in any retail outlet would result in the following:

- a reduction of alcohol-related hospital admissions of 111 per year (-3.6%) by year 7 (**NOTE**: this is a much smaller % reduction than in the Sheffield model)
- a saving in occupied bed costs of £222,000 per year by year 7, with a cumulative net saving of £1,474,000 over a 9 year time period
- after 9 years, a reduction in occupied bed days (OBD) of 744 per year (approximately 2 hospital beds) and a cumulative reduction by year 10 of 4,914 OBDs

(Gisborne et al, 2009)

The model only calculates cost savings through occupied bed days associated with alcohol-related hospital admissions. As noted by Gisborne et al (2009), there are likely to be considerable other savings to the health service over the medium to long term, such as in primary care, A&E, community mental health services and community drug and alcohol services.

Value for money/ cost of interventions
The Blackpool Draft report noted that the minimum pricing intervention produces no additional intervention cost, since the model assumes that the pricing policy is cost free to the health service (Gisborne et al, 2009). The only costs to the health service would be the time spent lobbying etc. There will be some costs to the local authority of enforcement of the policy.

The Blackpool model considered the relative costs and benefits of various interventions, including brief proactive interventions, reactive treatments, and combinations of interventions. Table A summarises the results. It would appear that the most effective strategy in terms of reducing admissions is to increase the use of multiple interventions (which would include a 50p per unit minimum price policy). The second most effective strategy in **reducing admissions** would be a 50p minimum price alone. The most effective strategy in terms of **reducing costs** is to implement the pricing policy alone. Increasing the Alcohol Nurse Service interventions would be reasonably effective in reducing admissions and is cost effective (Gisborne et al, 2009). The savings in occupied bed costs per year increase over time as the effects of the policy impact on the population's drinking and its subsequent health

Gisborne et al (2009) note that the policy involves changing the drinking behaviour of Blackpool's residents. They point out that the interventions are likely to work best and for longer if supported by a wide range of social inclusion support, such as housing, employment and education.

Table A
Summary of all policy tests conducted as part of the Blackpool model:

Intervention	Annual % change in alcohol related admissions by Year 10	Cumulative change in occupied bed days after 10 years	Annual change in costs (£000s) by Year 10	Cumulative change in costs (£000s) after 10 years
1. Change nothing	0	0	0	0
2. Increase intervention and brief advice (+1000 pa)	-0.4	-329	9	161
3. Increase brief intervention (+200 pa)	-0.5	-530	59	622
4. Increase extended brief intervention (+100 pa)	-0.5	-549	41	456
5. Increase Alcohol Nurse Service interventions (+50% pa)	-1.8	-2174	-67	-251
6. Increase T3 treatments* (+100 pa)	-0.8	-1059	105	1050
7. Increase T4 treatments* (+100 pa)	-0.8	-1079	229	2153
8. Minimum Price 50p per unit**	**-3.6**	**-4914**	**-223**	**-1474**
9. Multiple interventions (2, 3, 4, 5, 8)	-6.5	-8870	-207	-989

Source: Gisborne et al, 2009 DRAFT
*reactive interventions designed to identify and treat people who are drinking at hazardous levels, with the intention of moderating or stopping their alcohol consumption
**note: based on a lower % reduction than in the Sheffield model, which predicted 12.4%

Appendix 3.
Merseyside and Cheshire – alcohol related hospital admissions and deaths

Table B
Hospital admissions for alcohol-related harm

Estimated reductions with a 50p per unit alcohol minimum pricing policy

Local authority	number of admissions 2008/9*	estimated annual reduction in admissions **
Knowsley	4169	517
Liverpool	13054	1619
St. Helens	4660	578
Sefton	6697	830
Wirral	8686	1077
Halton	3229	400
Warrington	4615	572
Cheshire	13743	1704

*NWPHO 2009. NI39. http://www.nwph.net/alcohol/lape/download.htm

** based on 2008/9 admissions - full effect per annum after 10 years of the policy, rather than 1st year effect. Applying the Sheffield model of a 12.4% reduction with a 50p minimum unit price of alcohol, on and off trade (University of Sheffield, 2008

Table C
Deaths from alcohol attributable conditions, all ages, 2007

Estimated reductions with a 50p per unit alcohol pricing policy

Local Authority	*female deaths*	*male deaths*	*total deaths*	*deaths avoided in year 1 (11.6%)*	*full effect of deaths avoided by year 10 (27.8%)**
Knowsley	23.37	35.41	58.77	6.82	16.34
Liverpool	61.42	146.48	207.9	24.12	57.80
St Helens	32.91	39.37	72.28	8.38	20.09
Sefton	31.29	66.75	98.04	11.37	27.26
Wirral	42.95	98.81	141.77	16.45	39.41
Cheshire East	45.65	78.57	124.22	14.41	34.53
Halton	18.15	28.01	46.16	5.35	12.83
Warrington	27.3	44.46	71.76	8.32	19.95
Cheshire West and Chester	38.88	77.57	116.44	13.51	32.37
TOTAL Merseyside & Cheshire			*937.34*	108.73	260.58
England	**5043.3**	**10026.5**	**15069.78**	**1748.09**	4189.40

source: results from University of Sheffield study (2008) on estimated deaths avoided, applied to data on deaths from NWPHO 2009 (http://www.nwph.net/alcohol/lape/download.htm)

*the full effects of chronic disease risk reductions on deaths are modelled to take 10 years to have full effect (University of Sheffield, 2008)

University of Sheffield (2008) 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. Part B.

http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_091364.pdf

*[**Note:** The Sheffield study is based on a smaller number of total deaths (12,196 in England, compared with 15,070 using NWPHO data). This is probably because their model allowed for the protective effects of consuming alcohol on CHD and type 2 diabetes. Also, their data was one year older (2006). In addition, there may have been slightly different methods used to calculate the attributable fraction (Purshouse, 2010). This means that in this respect, the figures produced for Merseyside may be overestimated – but this may be offset by allowing for differences in drinking patterns, which if higher on Merseyside compared to England, may lead to an underestimation of effects.]*