COMITÉ PERMANENT DES MÉDECINS EUROPÉENS
STANDING COMMITTEE OF EUROPEAN DOCTORS

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On 27 April 2013, the CPME Board co-signed the 'BMA Letter on Minimum Alcohol Pricing' (CPME 2013/028 FINAL)

Letter on Minimum Alcohol Pricing

Please find below the letters addressed to Commissioners Borg and Tajani on minimum unit pricing of alcohol, co-signed by the British Medical Association and CPME.

British Medical Association

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Mr Tonio Borg
EU Commissioner
Health and Consumer Policy
European Commission

8 May 2013

Minimum Alcohol Pricing

The BMA is an independent trade union and voluntary professional association which represents doctors and medical students from all branches of medicine all over the UK. With a membership of over 150,000 worldwide, 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 BMA is registered on the EU Transparency Register.

The Standing Committee of European Doctors (CPME) represents national medical associations across Europe. We are committed to contributing the medical profession's point of view to EU and European policy-making through pro-active cooperation on a wide range of health and healthcare related issues.

Dear EU Commissioner Borg,

On behalf of the British Medical Association (BMA) and the Standing Committee of European Doctors (CPME) we are writing to express our gratitude for your recognition of the efficacy and legality of a minimum price per alcohol unit (MUP) scheme in Scotland, as a means of reducing the health harms associated with excessive drinking.

The Scottish Government's proposal to introduce a minimum unit price for alcohol is part of a wider alcohol strategy for Scotland, published in 2009, which reflects recommendations set out by the World Health Organisation (WHO) in its *Global strategy to reduce harmful use of alcohol.*

Despite the UK government's recent reduction of support for the introduction of MUP in England and Wales at the present time, we still support the adoption of such a scheme and will continue to support the Scottish Government's efforts to implement MUP in Scotland.

As you will be aware, Scottish Government's legislation on minimum unit pricing is currently being considered at EU level and, while we welcome the recognition of the major health benefits accruable through the introduction of minimum pricing for alcohol, we are concerned about the main conclusion of the consultations with other member states which invites Scotland to refrain from introducing such a scheme. As health advocates, we believe that the evidenced health gain achievable through the introduction of measures to affect pricing should take priority over trade considerations.

We are concerned about the main conclusions of the consultation which tend to demonstrate a discriminatory effect of minimum pricing against imported alcohol products. The opinion published last November addresses two main points: Whether minimum pricing is a measure of equivalent effect to a

quantitative restriction; and whether it can be justified under the terms of Article 36 Treaty on the Functioning of the European Union (TFEU). Both UK competition law and EU free trade law allow for the setting of a minimum price for the retail sale of alcohol for public health purposes by a government or public authority. Article 36 (formerly Article 30) of the EC Treaty states that restrictions on the free movement of goods (which a minimum pricing regime may bring into effect) can be justified if implemented on the grounds of public policy and the protection of health, providing such restrictions are shown to be proportionate and necessary and are not a disguised trade barrier. The European Court of Justice has accepted the right of member states to use pricing measures to control consumption and harm for public health objectives. It is also a matter of 'settled case-law' that, when considering compliance with the principle of proportionality in the field of public health, member states 'enjoy wide discretion' in determining the level at which they would like to protect public health. The opinion also suggests taking additional targeted measures to tackle health related harms concentrated within certain demographic groups as opposed to the whole population. In response, we would like to emphasise that academic literature concerning MUP stresses that the relationship between total consumption and consumption among various groups in the population is key (the higher the mean consumption in a population, the higher the consumption level for modest drinkers, heavy drinkers, the heaviest drinkers etc). To tackle the 'irresponsible few', it is essential to act at a population level.

While Scotland has one of the highest levels of alcohol consumption in Europe, the problems of alcohol related health harms are not isolated to Scotland. The WHO notes that at societal level, the EU is the heaviest drinking region in the world, with over one fifth of the European population aged 15 years and over reporting heavy episodic drinking (five or more drinks on an occasion, or 60g alcohol) at least once a week. Heavy episodic drinking is widespread across all ages and the whole of Europe, not only amongst young people or those from northern Europe as is commonly believed. The WHO European Region has the highest worldwide proportion of total ill health and premature death due to alcohol.

The scale of alcohol consumption throughout Europe, and especially in Scotland, represents a significant cause of medical, psychological and social harm, and is placing an unsustainable burden on our healthcare services. Alcohol is causally related to over 60 different medical conditions and is a contributory factor in domestic violence, child abuse, and criminal and disorderly behaviour. Since the 1960s, alcohol has become increasingly affordable and available due to a combination of deregulation, liberalisation of licensing laws and aggressive marketing. The more affordable alcohol has become, the more consumption has gone up and as consumption has increased, alcohol-related deaths have reached record highs.

A significant proportion of the Scottish population consumes alcohol above recommended healthy amounts. This is particularly worrying given the dose-response relationship that exists with alcohol consumption, where increased consumption is directly related to an increased risk of premature death, cancer, and cardiovascular disease. In 2011, the alcohol-related death rate in Scotland was more than twice that of 1982 and double the current rate in England and Wales. Alcohol related hospital admissions have more than quadrupled in the past few decades and Scotland now has one of the highest cirrhosis mortality rates in Western Europe.

In the UK, two-thirds of alcohol consumed is purchased through the off-trade with large supermarkets accounting for 84% of all alcohol sold through the off-trade. Supermarkets have a dominant market position in alcohol sales due to their ability to cross subsidise products across their vast range of produce. Supermarkets admit selling alcohol as a loss leader to attract customers and to absorbing increases in excise duty to maintain low retail prices. Today alcohol is available for as little as 15 (€0.19) price per unit (ppu) in Scotland. A two litre bottle of cider (5%abv) can cost just £1.89 (€2.34). A man can drink at the recommended limit for daily alcohol consumption for as little as 60p (€0.74) and the weekly limit for £3.15 (€3.90). A woman can drink at her daily limit for 45p (€0.56) or her weekly limit for £2.10 (€2.60)

Increasing excise duty, as the aforementioned opinion suggests, does not adequately reduce alcohol consumption. Simply increasing taxation is ineffective and should be accompanied by the introduction of a minimum unit price, creating a 'floor price' and preventing the sale of alcohol at dangerously cheap prices. The cost of alcohol misuse in the UK is substantial. It has been estimated that the total annual costs of alcohol-related harm are £3.6 billion in Scotland (including £267.8 million in healthcare costs).

Given the scale of the problem in Scotland, there is a demonstrable need for stronger action on alcohol misuse and it is widely acknowledged that central to any comprehensive alcohol strategy are measures to tackle the affordability of alcohol. There is strong and consistent evidence that increases in the price of alcohol are associated with reduced consumption and alcohol-related harm at a population level. Heavy drinkers and young drinkers are known to be especially responsive to price. Economic modelling conducted by the University of Sheffield has estimated that an initial minimum price of 50p per unit, as proposed by the Scottish Government, would save 60 lives in its first year after implementation, rising to 300 lives per year after 10 years of implementation. This modelling also showed that those who drink to excess would be affected more than those who drink modestly.

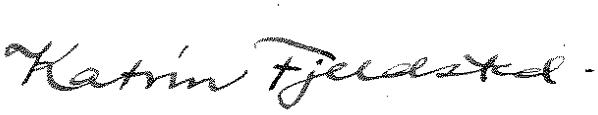
Canada operates a scheme called 'social reference pricing' (SRP). SRP, introduced in 1990, has both a public health and a government revenue rationale and which, with other policy measures, forms the Canadian model of alcohol control. Evidence from a recent study of minimum pricing in the Canadian province of British Columbia suggests that a 10% increase in the minimum price of an alcoholic beverage reduces consumption of all alcoholic drinks by 3.4%[1]. As observed in this study, price changes may have different effects on different alcoholic beverages. A 10 per cent increase in the minimum price resulted in a reduction in the consumption of spirits and liqueurs by 6.8%; wine by 8.9%; alcoholic sodas and ciders by 13.9%; and beer by 1.5%. The results of another study show that a 10% increase in the average minimum price for all alcoholic beverages was associated with a 32% reduction in wholly alcohol attributable deaths in British Columbia.

We strongly support the introduction of a minimum price per unit as an effective way of tackling the excessive discounting of alcohol by large retailers, which is known to encourage consumption and undermine the effectiveness of tax-based approaches to tackling this issue.

We have also written to your colleague, Commissioner Tajani, to advise as to our views on this matter and to request that he work with colleagues to reassess the efficacy and legality of MUP in reducing alcohol consumption and minimising the health harms associated with excessive drinking, in both Scotland and across the EU.

We look forward to hearing from you and would be delighted to provide further information upon request.

Yours sincerely



Terry John
Head of the BMA CPME delegation

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CPME President

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Mr Antonio Tajani
EU Commissioner
Industry and Entrepreneurship
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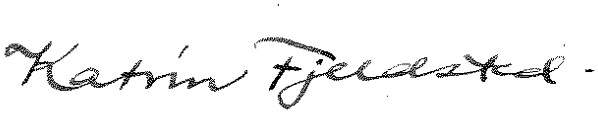

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