Alcohol Policy in Scotland and Ireland: European Trailblazers or Celtic Fringes?

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Learning
• Policy evaluation is (still) difficult!
• How to capture the interactions and softe
outcomes?
• Inform policy vs evaluate policy?
• Importance of relationships
• National vs local
• etc


Alcohol Policy in Scotland and Ireland:
European Trailblazers or Celtic Fringe?


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Price

Alcohol Policy in Scotland and Ireland: European Trailblazers or Celtic Fringes?

Wednesday 2nd March 2016, the Royal College of Physicians of Edinburgh

On 2nd March 2016, Scottish Health Action on Alcohol Problems (SHAAP), Alcohol Focus Scotland and Eurocare, held a joint event in the Royal College of Physicians of Edinburgh to explore and discuss alcohol policy in Scotland and Ireland. Governments in Scotland and Ireland are pushing forward policies that focus on increasing alcohol price and reducing availability and marketing, in the face of sustained opposition by global alcohol producers.

In the context of a refresh to the current Scottish Alcohol Strategy, ''Changing Scotland's Relationship with Alcohol'', and Ireland introducing a new Public Health (Alcohol) Bill, which includes Minimum Unit Pricing and is wide ranging in its provisions related to marketing and availability, the event provided an opportunity to hear from experts who are centrally involved in influencing alcohol policies. As well as providing an update on Scottish, Irish and European alcohol challenges and priorities, the findings of the latest MESAS (Monitoring and Evaluating Scotland's Alcohol Strategy) report, which was launched on 1st March 2016, were presented.

Chair: Dr Peter Rice, Chair of Scottish Health Action on Alcohol Problems (SHAAP)

Scotland and Ireland are interesting parts of the world, both in terms of their respective relationships with alcohol and policy approaches to tackle alcohol-related harm. Both are characterised by traditionally high levels of consumption and alcohol-related mortality, and both are also leading the way in implementing effective policy approaches to strategically tackle the problems they face. Alcohol policy does not stand still. It remains in a constant flux and Scotland and Ireland's relationships with alcohol exemplify this flux, and make them interesting and important test cases.

This year, SHAAP will be celebrating its tenth anniversary. It would have required a lot of foresight ten years ago to predict and understand how important the European dimension was going to be in relation to alcohol policy.

Europe and alcohol: challenges and opportunities

Mariann Skar, Secretary General of Eurocare, The European Alcohol Policy Alliance

The European Alcohol Policy Alliance was formed in 1990 with nine members, and the UK was one of these members. Today, Eurocare has 60 member organisations from 25 countries with a central secretariat in Brussels. Our main goal is to raise awareness of decision makers of the harms caused by alcohol (social, health, economic burden) ensuring that these are taken into consideration in all relevant EU policy discussions. We aim to ensure that alcohol, and more broadly health, is kept above all other interests. We are the link between members and the political institutions and as such are dependent on our members to provide us with up-to-date information to facilitate our engagement with the European Institutions. The second main goal of Eurocare is to promote the development and implementation of evidence-based policies, aimed at effectively preventing and reducing the burden of alcohol. Alcohol policy moves up and down the interest agenda in Brussels. Interest peaked in 2014. We are now on a downward trajectory but alcohol will move up the agenda again as things always change and continue to get better. Eurocare's motto is 'Less is Better', following the World Health Organisation (WHO) strategy.

The three main European Institutions with which Eurocare engages are the European Commission, European Parliament, and the European Council. For policy change, the European Commission is most important, but it is difficult to access. There is a tight timeframe in which we can come in and contribute. If we come in early at the planning stage of policy and legislation, our voice will be heard; if we come in later when the debate is on-going and the issue has already been lodged in Parliament, it is really challenging to achieve any sort of influence.

Eurocare is also involved with a number of projects including work on alcohol intervention programmes with young people and youth organisations; a workplace project to develop effective methods of engaging with workplaces, and their workforces, to raise awareness around alcohol and to bring about organisational and individual change which leads to safer alcohol consumption; and a project aimed at supporting Member States to take forward work on common priorities in line with the EU Strategy.

Participation in civil society is crucial to help ensure that public health is given priority in policies. Participation ensures our voices as public health advocates are heard in the same arena as the alcohol industry.

The EU Alcohol Strategy has a number of achievements. Ten countries adopted or revised a National Strategy after 2006. This was particularly effective at facilitating exchange of 'best practice'. It also proved highly effective in this context to list or rank countries, as no country likes to be at the bottom of this list, and so this incentivises change/action. Furthermore, around half of Member States have adopted restrictions on price promotions and have introduced a licensing system for on and off trade premises. All Member States actively engage in awareness raising, and the majority have introduced age limits.

So, where are we in 2016? We currently have no EU Alcohol Strategy. The European Health Minister, Vytenis Andruikaitis from Lithuania, is committed to the issue but we collectively need to try to get alcohol policy higher on the political and policy agenda. The most likely outcome is that we will get a Framework Convention for Non-communicable Diseases (NCDs). The European Institutions are moving towards this and it is our job to ensure alcohol is central in all necessary areas within the Framework. This is my realistic hope because to think we will get an alcohol strategy is highly doubtful. Significantly, in April last year, we were successful in getting Parliament to pass a Resolution on the Alcohol Strategy. This was difficult to get but we managed to achieve it. Although the Resolution has not had a direct impact, it is there and is important. There is good NGO collaboration on alcohol at European level, with all Member States now calling for a new strategy. Going forward, we will continue to argue for a new Alcohol Strategy and recommendations.

Given the situation we have, and the political situation across Europe, I think that we have to focus on cross-border issues, including price, marketing, information to consumers, drink-drivers, and monitoring. It is these issues which offer potential for influence and are the main areas where we can get the European Commission to move forward. If we look at one of these areas in more detail – marketing or advertising – there have been positive developments across Europe. A large majority of Member States have legislation which bans alcohol advertising on TV and on radio. However, there also remains a number of very striking areas where action is needed. The majority of Member States have little or no statutory regulation on internet or social media advertising.

A more detailed examination of regulations on alcohol advertising across Europe shows there is widespread variation. In all Member States there is a mix of statutory and voluntary regulation. The stand out example is

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France with the Loi Evin which heavily regulates alcohol advertising and bans sports sponsorship. Other examples include Sweden, which only permits adverts which focus on the product itself, and Finland which introduced legislation in 2015 to ban alcohol advertising in digital games and gaming apps on consoles, tablets and mobiles. Product placement in video games is also banned. This legislation is significant as it impacts on social media. We are hoping for a good evaluation of this legislation in the coming years to see how or if it has worked and how easy it would be to implement in other Member States.

The price of alcohol is a problematic issue in Europe. There has been a decrease in the price of alcoholic beverages, due largely to on-going decline in the EU minimum excise duty since 1992. This has not been adjusted to reflect inflation and there is currently zero duty on wine products. Overall, alcohol in Europe has become more affordable, although this trend is not uniform across countries. In contrast, age regulation is an area where Europe has done well. Most Member States now have a minimum age of 18 for purchasing alcohol products.

Consumer labelling (e.g. nutrition information and health warnings) of alcoholic beverages is a policy area where there needs to be change. We are in an absurd situation where if you buy a bottle of milk, all necessary and relevant information is provided on the label; if you buy a bottle of vodka, or any other alcohol product, you get zero information. Consumers have a right to know what is in the bottle. Some sectors within the alcohol industry, like beer and spirits, are more accepting of this and have taken steps towards providing the necessary information to consumers. The wine industry, however, remains firmly opposed to any such labelling. There is obviously a reason for this and it suggests that there are 'bad' ingredients that they really do not want consumers to know about.

Eurocare is calling for all alcoholic beverages to contain details of ingredients, substances with allergic effect, relevant nutritional information like calories, alcoholic strength, and health and safety information. To demonstrate how easy it is to put all of this information onto product labels, Eurocare developed a series of mock labels. Labels which are easy to do are messages around drink driving, pregnancy warnings, and age restrictions i.e. over 18. These are already heavily undertaken by the industry, although we need external and independent regulation to ensure an appropriate font size and colour for the information on labels. This is presently absent. The industry are less supportive of nutritional/ingredient labelling and stronger messaging relating to cancer, for example, which are known to be more effective.

Drink-driving is another area of difficulty for policy makers in Europe. There is large-scale variance in permitable blood alcohol limits across Member States, ranging from zero in Hungary, Romania and the Czech Republic to 0.5 in Germany, France, Austria and Denmark for example. This is most common limit across the EU, with 18 countries having this as their limit. The UK (excluding Scotland) and Malta, are the only two members with a higher drink-driving limit of 0.8. A harmonised limit across Europe needs to be enforced. Eurocare recommends that zero-tolerance to drink driving should inform policy decisions; there should be a ban on the sale of alcohol at petrol stations; a harmonised penalty system of licence suspension across Europe; and drink-driving warnings on all alcoholic beverages.

Finally, improved data gathering, better data monitoring, and the development and maintenance of a common base both in Member States and for the EU as a whole would make a profound and significant contribution to influencing policy makers on alcohol. The very good data available in Scotland as part of the MESAS evaluation demonstrates this. Some of the current data in use in Europe is from 2004 and this is not very helpful for NGOs when putting forward policy arguments. The data needs to be updated to be effective.

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Monitoring and Evaluating Scotland's Alcohol Strategy (MESAS) 2016: evaluating Scottish alcohol policy

Clare Beeston, NHS Health Scotland

MESAS: Monitoring and Evaluating Scotland's Alcohol Strategy is a programme which was established in 2009 when the Scottish Government commissioned NHS Health Scotland, in partnership with the Information Services Division (ISD), to plan and undertake evaluation of the new approach to tackling alcohol harm in Scotland.

Scotland has a multi-component alcohol strategy. Policy evaluation is difficult. As we all know, implementation is varied with multiple components, different implementation dates, in different places and in different ways with limited or even no ability to control for many factors. In such cases it is only possible to assess contribution to outcomes, we can't attribute outcomes wholly to the strategy.

MESAS is underpinned by a Theory of Change (TOC) model, which assesses how planned activities or actions may result in a series of outcomes, and is an example of the link between policy and evaluation. TOC maps how the strategy is expected to lead to a change in alcohol related harms

MESAS TOC hypothesised that the alcohol strategy could lead to a reduction in alcohol-related harms by impacting on a number of intermediate outcomes, such as reduced availability and affordability, changed attitudes and social norms, improved support, and a safer environment. By impacting on these intermediate outcomes, the Strategy may then lead to a reduction in alcohol consumption at population level and shift towards safer drinking patterns, which in turn could lead to a reduction in alcohol related harms such as deaths, hospital stays, and crime.

For theory based evaluations we must also consider any other impacts the intervention may have. These are termed unintended consequences and they can be both positive and negative and can include issues such as the economic impact on the alcohol industry and substitution effects.

It is also important to understand and measure other factors external to the programme, and usually out with your control, which may be having an impact on the key outcomes you seek to change and on the delivery of your strategy and these therefore impact on the success of the strategy. External factors can include changing economic context or variation in the delivery of an intervention.

The MESAS evaluation studies were designed to test the TOC. Given the size of the strategy we could not examine every element in detail, but prioritised the elements based on criteria such as the likelihood they would have an impact; the feasibility and cost of a robust evaluation; and importance of the question. Based on this, we chose to evaluate the impact of the Licensing Act; Framework for Action and related actions; the Alcohol Act; and Minimum Unit Pricing (MUP). The analyses are underpinned by issues relating to affordability as an external influencing factor rather than a policy driver because without MUP the strategy was not expected to change affordability. Patterns of population consumption and alcohol-related harms, and attitudes and social norms are also important.

Now let's explore some of the key findings from MESAS[1]. In 2014, 10.7 litres of pure alcohol were sold per adult in Scotland, equivalent to 20.5 units per adult per week. This represents a flattening of the recent downward trend seen until 2012. Much of this downward trend was driven by falls in consumption by the heaviest drinkers, and an increase in the rate of abstinence in young adults. By market sector, in 2014, off-trade sales accounted for 72% of all alcohol sold, compared to 28% in the on-trade. Cheap vodka made up the majority of off-trade sales of spirits. In 2014, 52% of all off-trade alcohol sold in Scotland was sold below 50p per unit. Since 2008, per adult alcohol sales have been 18-20% higher in Scotland than in England and Wales. The majority of this difference is due to higher per adult off-trade sales in Scotland.

Alcohol-related mortality rates in Scotland rose rapidly in the early 2000s, and then falling away in the middle of the decade. In England and Wales, mortality rates are much steadier and rise and fall much less rapidly. Over the same time period, they show a much shallower decline than in Scotland. In Scotland in 2014 alcohol-related mortality was 49% higher than in 1981. Since 1981, male alcohol-related mortality has remained approximately twice the female mortality rate. Mortality rates have been consistently highest amongst adults aged 55-64 in Scotland and were eight times higher in the 10% most deprived than in the least deprived areas in 2014, a clear persistence of health inequalities. The increase and decline has been primarily driven by those in the most deprived areas. Compared to England and Wales, mortality rates remain significantly higher in Scotland.

1 NHS Health Scotland (2016) Monitoring and Evaluating Scotland's Alcohol Strategy, Final Annual Report **http://www.healthscotland.com/uploads/documents/26884-MESAS__Final%20annual%20report.pdf**

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In terms of morbidity, this can be measured in three ways – by hospital stays, by unique patients within a given year, and new patients who have never accessed a service due to alcohol. Across each of these measures, there has been a steady decline in the rate of people presenting. For hospitalisations, there has been a fall of 11.8% compared to a 12.3% rise in England; the number of new unique patients within a given year fell by 13.8% and rose in England by 1.5%; and for completely new patients, there was a 21.1% decrease, compared to a decline of 7.1% in England. Overall, however, rates of alcohol morbidity remain higher than in England and Wales.

In terms of specific components of the Strategy, the Licensing Act (2009) introduced a Test Purchasing scheme, Licensing Standards Officers, and provided licensing policy statements and licensing objectives. Although this legislation is believed to have led to change in practice, the impact on decision making remains unclear. We found this was partly due to it being difficult to operationalize health objectives and policy statements in practice. There was also uncertainty over how it impacts on availability.

The Framework for Action published in 2009 contained a commitment to a national roll-out of Alcohol Brief Interventions (ABIs). These have been delivered across a range of settings including A&E, primary care, and antenatal care. Since 2008, over 500,000 ABIs have been delivered. This is 45% above the national target. Of this figure, it is estimated that 25% are repeat interventions and that the programme has successfully reached 43% of hazardous and harmful drinkers since 2008. There have also been similar successes in terms of investment in treatment and care. Waiting times for alcohol treatment have reduced and approximately 25% of dependent drinkers accessed specialist alcohol treatment in 2012. Staff also reported an improvement in the quality, availability and access to alcohol treatment services. Both channels of activity have contributed to alcohol support for those most in need.

The Alcohol Act (2011) introduced further restrictions including a ban on multi-buy discounts and restrictions on in-store alcohol displays. Since the introduction of the Act, off-trade sales have fallen by 2.6%, primarily driven by a 4% reduction in wine sales. This is equivalent to 4.5 million fewer bottles of wine sold in the year following implementation. However, there has been no short-term change in alcohol-related mortality and hospitalisation indicators. This is likely to be because we measured only those outcomes wholly attributable to alcohol (such as alcoholic liver disease) rather than wider alcohol-attributable outcomes (such as accidents). Also, only measuring short-term impacts increases the potential that some longer-term impacts were missed.

An examination of the price distribution of alcohol sold in the off-trade in Scotland between 2009 and 2014 shows the change in price of the alcohol people are buying. In 2009, 77% of off-trade sales were below 50p per unit; by 2014, this had fallen to 52%.

We also examined knowledge about and attitudes to alcohol, and how these have changed over time. Amongst the Scottish population there is increased agreement that alcohol is the drug that causes the most harm in Scotland. In 2013, 60% identified alcohol as the drug causing the most harm. This view was not shared by those living in the most deprived communities. Other than this, there was no consistent change in knowledge and attitudes measured.

We then looked at external factors to establish what else might be playing into what we are seeing. Firstly, we examined the combined effects of deprivation and changing income. In Scotland, and England and Wales, disposable incomes fell for individuals in the lowest income group from 2003. This had an impact on the affordability of alcohol for that group. Also, a higher proportion of the Scottish population live in deprived circumstances than in England and Wales, and a greater proportion of alcohol-related deaths in Scotland are found in deprived communities than in England and Wales. The combined effects of these country-specific differences explains part of the greater rise and fall in alcohol mortality in Scotland compared to England and Wales. This only offers a partial explanation of what is going on. Another part of the explanation is the idea of the vulnerable generation. The theory hypothesises that a vulnerable generation appeared at a time when alcohol was becoming increasingly affordable and available. This led to an increase in alcohol-related deaths (from the mid-1990s) which is now tailing off as these individuals have died. Remaining generations are less vulnerable to alcohol-related harms.

The MESAS evaluation approach has a number of strengths. Evidence was gathered from a wide range of sources which examined both the strategy and the wider context in which it operates. It also made use of robust data and was able to provide information on long-term trends of alcohol sales, mortality and morbidity. The evaluation also compared Scotland and England and Wales to further illustrate some of these trends. However, comparison with England and Wales is also a weakness as England and Wales are very different from Scotland and so are not easy to compare. Other weaknesses include only being able to study selected components of the strategy and as such some changes and interactions which have an important impact on outcomes are likely to have been missed as they were not measured. Such a narrow focus meant we were unable to pick up and analyse the effect and interaction between the elements measured. There were also data limits and outcomes cannot be clearly attributed.

Going forward, we would recommend a review and refresh of the strategy and an improvement in implementation, particularly around MUP and availability. There is also a need for increased monitoring and evaluation and further research.

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Overall, there are a number of conclusions we can draw from the evaluation. There has been a decline in population consumption between 2009 and 2012, and alcohol-related death rates and hospitalisations have both fallen since their peaks in the mid-2000s. Perhaps the most significant conclusion is that implementation of the Alcohol Strategy has led to some positive change in intermediate outcomes. However, and worryingly, consumption is flattening and there has been no decline in mortality or morbidity in the last two years.

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Whisky galore? Policy challenges and priorities in Scotland

Alison Douglas, Chief Executive, Alcohol Focus Scotland

Whisky Galore? The title of this presentation should instead be 'Vodka Galore', as that is really a more accurate picture of where we are today in Scotland. More than twice as much vodka was sold per adult in supermarkets and off-licences in Scotland than in England and Wales.

In terms of our alcohol consumption, 18% more alcohol is sold per adult in Scotland than in England and Wales, and almost all of this (94%) is because of higher sales in supermarkets and off-licences. One of the critical things we must understand is the range of harms experienced. Yes, health harms are crucial but alcohol is undermining our society in a multitude of ways, and those impacts are going far beyond the drinkers. It is affecting their families, children, colleagues, communities, and fundamentally it is costing Scotland dearly in terms of lost potential and the broader economic cost. This is something we can frankly ill-afford, particularly in these difficult financial times.

Showing the implementation of this strategy visually can help us understand the opportunities and challenges faced. Alcohol can be represented as a river running through society. The river in Scotland has grown stronger, deeper, and wider over the years. We have found ourselves in a situation where alcohol flows freely through our society, and the impact of this can be seen across our communities but particularly in our poorest communities. We need to rebalance the place of alcohol in our society.

Commodities such as alcohol should be controlled in such a way that the harm caused to individuals, families, communities and the nation as a whole is limited. When policies are not strong enough to stem the flow we get out of balance – alcohol begins to flow more freely to the point where harm begins to increase to levels that are completely unacceptable.

The alcohol river is flowing too fast and being fed by heavy marketing, cheap prices, and the fact that alcohol is so readily available. This imbalance is saturating our communities and efforts to encourage positive choices and attitudes and our efforts to protect our children and families are compromised by the strength of the river. For those individuals who are swept away, recovery is an upstream battle as the river continues to flow freely and does not support them in their recovery.

Furthermore, when we look at the cost effectiveness of interventions, we can see that the three 'Best buys'[1] are the most effective and cost-effective policy choices. If we do not take action upstream on price, availability and marketing, we will continue to eat up resources further down the river. Early intervention and preventative action are critical if we are serious about tackling harm. However the three 'Best Buy' "sandbags" have serious challenges which could stop them from doing their job. The power and resources of the alcohol industry to fight against them is formidable. They often deploy arguments about the importance of alcohol production and retailing to the national and local economy in order to influence decision-makers.

Unless we fundamentally change the role of alcohol in our society, challenge social norms, and help people to make more positive choices, we are simply going to keep ploughing in more money without tackling the problems and issues at hand. We can't afford to do this, particularly when there are significant cuts to service provision. Direct Government funding to Alcohol and Drugs Partnerships has been cut by 22%.

We know that consumption drives harm. Would a national target to reduce alcohol consumption be helpful in providing a clear and concerted focus for action across all agencies in Scotland? This is something they have done in Ireland with the new Alcohol Bill. Why do I suggest this? Firstly, it is a clear declaration of intent; a clear statement of our aspirations. It is also an approach with a proven track record as targets or 'stretch aims' have already been used by the Scottish Government to drive improvement in other areas. The existing strategy recognises that the current levels of consumption are too high. Establishing a target as part of the new strategy would be a logical next step.

We are all very familiar with some of the things that are driving consumption and harm - the price, availability, and marketing of alcohol. These three elements are mutually reinforcing and need to be considered as such. For example, if you have a highly competitive market with multiple suppliers, that drives down price. If you have huge investment in alcohol marketing, that drives availability, which in turn drives price. Price is also an important element of how alcohol is marketed. We need to be thinking about the three 'Best Buys' collectively; they are not separate.

Price is still an acute problem and we cannot lose our focus on it as an issue. The majority of shop-bought alcohol is sold below 50p per unit. We have to persist with making the case for minimum unit price as a highly effective evidence-based policy to tackle alcohol-related harm. Industry have actively obstructed the implementation of minimum unit price (MUP), putting their profits above the health of the public. I hope and fully expect a positive result

1 http://www.who.int/nmh/publications/who_bestbuys_to_prevent_ncds.pdf

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from the MUP court case and to see the implementation of MUP in Scotland.

Turning to availability, and in particular the density of outlets, there is twice the concentration of alcohol outlets in the most deprived communities as in the least. Indeed, despite reports of the high number of pubs closing, the number of on-sale outlets has actually increased in the last few years. To me, there is question mark here about our national policy on availability – what it is we are aiming to achieve? This links to my earlier point about developing targets around consumption. There seems to be a huge disconnect between our national Alcohol Strategy and the operation of Local Licensing Boards in local areas. The current system gives these Boards far too broad a scope to determine how alcohol is sold locally. There is a gap in terms of national strategy or direction.

The licensing system is devolved to local level to enable communities to influence decisions and to ensure they are appropriate for local circumstances. In practice there is little opportunity for communities to participate or have their voices heard. There is thus a huge democratic deficit. Part of the challenge is how we connect licensing better to community planning. Alcohol Focus Scotland launched its Community toolkit on alcohol licensing last week. It has received a lot of interest and we are working hard to try to strengthen local voices. There needs to be a re-examination at national level about how we bolster community involvement in licensing. It just is not acceptable that Licensing Boards are not fulfilling their statutory duty around publishing statements on overprovision.

Turning to marketing: it is remarkable how little information or cues we need to be able to understand and recognise brands once we are sensitised to them. Children and young people are far more susceptible to brands than us as adults. The greater children's exposure to alcohol marketing, the more likely they are to drink, to start younger, and drink more. Recent research evidence showed that 95% of 10 and 11 year olds surveyed in Scotland recognised the brand Fosters, and that this level of recognition was greater than, for example, a leading ice-cream brand; the kind of product we think of as traditionally being targeted at children2[2]. This is a huge issue and we are like 'innocents abroad' when dealing with it due to our limited understanding of the sophisticated methods employed, particularly in relation to digital marketing. We are always a few steps behind the industry. There is a question here about how we protect children from marketing exposure, taking a precautionary approach. There is also a fundamental question about the regulatory regime we have and why the industry are able to play such a strong role in that regulation. Surely regulation should be organised around protecting the public and their interests? Labelling and health warnings should be on all products, as a matter of course.

I wanted to return to 'Whisky Galore' and link this back to the issue of price. In my view it is unacceptable that we underwent a democratic process which determined that Scotland should have a MUP and that the big producers, hiding behind an umbrella body, have obstructed its implementation. Alcohol continues to take a huge toll on the lives of people in Scotland, and it is likely that a large number of lives would have been saved if we had been able to put MUP in place following the passage of the legislation in 2012.

The Scottish Government has been trying to put public health and the broader interests of the public at the forefront of policy. The UK government does not seem prepared to do this, relying on softer 'responsibility deal' arrangements with industry. At the international level, free trade agreements could potentially restrict future action to protect health. As advocates, we need to be doing much more to challenge this and to challenge the industry's influence on alcohol policy – influence which the World Health Organization recognises is inappropriate.

But the alcohol industry does have a role to play in helping to support efforts to reduce and prevent alcohol-related harm. It is a unique role as only they know how much alcohol they are selling and only they know how much they are investing in marketing. That is my call to the industry – if you are serious about helping to prevent alcohol-related harm; let us see your data.

2 http://www.alcohol-focus-scotland.org.uk/media/62890/Children_s_Recognition_of_Alcohol_Marketing_Briefing.pdf

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Finding the right measure? Policy challenges and priorities in Ireland

Suzanne Costello – Chief Executive, Alcohol Action Ireland

Alcohol Action Ireland is the national charity for alcohol-related issues. Our work is to inform and educate the public about alcohol harm; to protect young and vulnerable people from alcohol harm; to advocate for the burden of alcohol harm to be lifted from society; and to campaign for the implementation of evidence-based policy measures to reduce alcohol harm.

Back in the 1960s, contrary to popular opinion, Irish people did not really drink an awful lot. Over the years, consumption rose steadily until it peaked in 2001. This was during the 'Celtic Tiger' period in Ireland (from 1997-2007) when expenditure on alcohol exploded.

More than half (54%) of drinkers in Ireland are classified as harmful drinkers, which equates to 1.35 million people. Binge-drinking is a real problem in Ireland. A lot of people are not drinking at all during the week and are instead saving it all up for the weekend. Ireland has the second highest binge drinking rate in the EU. Although consumption has grown enormously over the years, the Irish have never really properly embraced the idea of 'drinking and eating'; these activities tend to remain largely separate and this is particularly true amongst men.

In terms of alcohol harm, alcohol is responsible for 88 deaths in Ireland every month. One in four deaths in young men aged 15-39 in Ireland is due to alcohol and alcohol is a factor in half of all suicides, and a third of cases of deliberate self-harm. There have been a number of large scale campaigns with lots of investment targeted at reducing road deaths, and these have been very successful. What we need now is a similar level of investment in approaches to reduce alcohol-related harms. Ireland has the fifth highest rate of young male suicide in the EU. There has been a lot of discussion in Ireland around issues of stigma, pain, loss and heartache associated with suicide and we know binge drinking is a driver of depression in young men. In order to have a significant impact on these preventable deaths we need to consider a more integrated approach to substance misuse and mental health services.

As we know, the impact of alcohol goes beyond the user. It is a significant contributory factor in many cases of child neglect, with parental drinking identified as a key child welfare issue; it is a factor in one in three fatal road collisions; and is a contributory factor in many assaults and cases of domestic violence. When discussing the harm to others agenda, it is important to view it in the context of austerity inflicted upon Ireland in the last few years. It is difficult for people outside of the country to understand the impact on services. The impact has been horrendous. In terms of healthcare, the effect on the most vulnerable groups and the young is appalling. There have been deep cuts to primary care services with emergency departments being placed under increased pressure from alcohol and drug use/misuse.

One of the challenges of reducing alcohol harm is addressing Ireland's drinking 'culture'. A recent survey of attitudes reflected a real sense of pride in some drinkers in Ireland's reputation as 'good drinkers'. For some it seemed part of national identity and pride. This was reflected quite widely across the age range. Beliefs and attitudes about and to alcohol seem to have been shaped by and reflect alcohol advertising. This is not surprising, alcohol advertising and the alcohol industry makes a significant contribution to Irish life and some brands are seen as intrinsic to Irish culture. Challenging these attitudes is difficult - and one of the biggest barriers is the high levels of tolerance for alcohol harm. Irish people will sometimes reference a family member who may have had an alcohol problem; and historically we would have been accepting of this; it can be remarkably difficult to be a non-drinker in Ireland, despite the fact we have quite high levels of non-drinkers in the population - usually around 20% of the population.

From an environmental perspective, a real change in how alcohol was purchased, sold and consumed came with the abolition of the Groceries Order (Ban on below cost selling) in 2006 - with the aim of reducing the price of food the greatest price drop came in alcohol and saw a shift from drinking in pubs and restaurants to drinking at home with alcohol bought in supermarkets where it was much cheaper.

In addition to making changes to pricing and availability we much too often take our foot off the accelerator of alcohol promotion. Advertising and sports sponsorship in particular reaches children and young people. The current advertising codes around alcohol advertising in Ireland are voluntary and self regulated - we feel that this is ineffective and statutory regulation of alcohol advertising is necessary.

The Public Health (Alcohol) Bill marks the first time that alcohol misuse has been addressed as a public health issue by an Irish Government. This bill is part of a comprehensive suite of measures to reduce excessive patterns of alcohol consumption as set out in the Steering Group Report on a National Substance Misuse Strategy. It is also one of the measures being taken under the Healthy Ireland Public Health framework. The aim is to reduce

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alcohol consumption in Ireland to 9.1 litres per person per annum (the OECD average) by 2020, and to reduce the harms associated with alcohol.

The Bill contains a range of measures including a minimum unit price for alcohol, set at one Euro for a 'standard drink', and regulation around alcohol advertising. Sports sponsorship has been particularly controversial in this context. A review committee, established by the previous government, found no evidence of an association between sport sponsorship and alcohol consumption. This was very disappointing. However, some measures restricting 'on pitch' advertising and pitch side advertising where children's sports are played are contained in the Bill. This is a significant step forward as the three main sporting organisations in Ireland – football, rugby, and horse racing – were strongly opposed to the restrictions and lobbied heavily. They even lobbied directly on behalf of the industry. Such restrictions will have an important part to play in the overall health of the country.

Turning to price-based promotions, there has been legislation in place in Ireland for a number of years to prohibit these, and the current administration is keen to re-focus on this. Measures contained within the Bill include prohibiting or restricting the selling or supplying of alcohol products free of charge or at a reduced price to a particular category of people; selling or supplying alcohol products during a limited period (three days or less) at a price less than was being charged for those same products the day before the offer began; selling or supplying alcohol products free of charge or at a reduced price to someone because they have bought a certain quantity of alcohol products or any other product or service; and promoting a business or event in a way that it intended or likely to cause people to drink in a harmful manner. Such restrictions are really important.

With regards to availability, retail outlets must ensure that alcohol products are separated from the rest of the premises by a physical barrier through which alcohol products and advertisements are not readily visible to members of the public; and members of the public do not have to pass through the area where alcohol is on sale to gain access to or purchase any other products.

Under the Bill, product labels will have to contain a health warning to inform the public of the dangers of alcohol consumption; a similar warning about consumption during pregnancy; the quantity of grams of alcohol within the product; and calorie information. Most interestingly, in addition to the above information, all alcohol product labels will contain a link to the public health website which will provide information on alcohol and related harms. This is very important as every alcohol product label in Ireland will have to contain this link to the website which offers comprehensive health information about alcohol harm in Ireland, everything from drinking guidelines through to information on referral pathways to access support services. Alcohol product labels are being used as the platform for providing comprehensive public health information. This is a highly significant approach being taken by the Department of Public Health and its influence and effectiveness will grow over the years. Crucially, it will help the public health message to remain at the forefront of people's minds in a way it has not before.

Key to the progression of the Public Health (Alcohol) Bill was the interest of the minister holding the health portfolio. Ireland has had a succession of Health Ministers who have been strong advocates of alcohol policy. In 2015, the current Minister for Health Leo Varadkar took the role of alcohol from the junior to the senior ministry and got right behind the legislation. He has been a tremendous asset to the Bill ever since. There have been some barriers for the Bill, however. Alcohol is seen as the sole preserve of the health ministry. Much emphasis is placed on the contribution of the alcohol industry to the economy in Ireland, especially for jobs and tourism. While acknowledging this contribution to the economy, the significant health and social costs cannot be ignored.

The recent elections in Ireland have led to a change in the political landscape which is now much more favourable to health issues.

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Questions from the floor and Discussion

Peter Rice (SHAAP): Would it be fair to say, in relation to areas like rates of Liver Disease mortality and morbidity for example, that the overall Scottish trajectory of price, consumption and harm is being understood in a way which is different from in England?

Clare Beeston (NHS Health Scotland): It is tricky. The relationship between price, consumption and harm is stronger in Scotland than in England (and Wales). The industry response to this is that it is all about culture in the respective countries. At a general level, the relationship holds over time and this is the main challenge for us with regards to price and consumption when England behaves differently.

Colin Shevills (Balance North-East): In the North of England, we behave much more closely to Scotland than the rest of England in terms of some of these relationships. I would suggest we should perhaps view some of these relationships in the context of deprivation as a potential explanation for some of the difference.

Niamh Shortt (University of Edinburgh): I would like to ask the speakers where we can go with some of this and what other angles we might take. In the alcohol public health field, do we focus enough on inequalities? I think a good example of this is the alcohol harm paradox. What can we do to raise the issue of inequalities, so we can bring people along with the idea?

Alison Douglas (Alcohol Focus Scotland): I totally agree. Inequality is something we need to make a stronger argument about and be more vocal about where the harm is actually felt and experienced. In relation to availability, data from CRESH (Centre for Research on Environment Society and Health at the University of Edinburgh) shows that there are 40% more alcohol outlets in the most deprived compared to the least deprived areas in Scotland and that does feel like targeting to me. There is a real lack of regard for the impact of this on those communities. Licensing is one way we can combat this but there needs to be a message within a wider conversation about what we want our communities to look like. It's about developing 'healthy communities' and how we get into discussions of shaping them. We also need to balance economic arguments, which usually take precedence, with arguments about health promoting communities. There is a lot of traction in Scotland around the inequalities argument and that has to sit within a wider understanding that it is structural inequalities and power inequalities that need to be addressed as well as some of the issues around availability. I think it is a combination of all of this.

Suzanne Costello (Alcohol Action Ireland): When it comes to health inequalities, it is an effective message to communicate but we have to gauge the middle ground of the public debate for anything to happen. Trying to promote MUP, for example, is difficult as a lot of people think it is a tax. It comes down to clarity of message around health inequalities and very strong advocacy from effected communities. We are currently not sufficiently equipping people to deal with complex messages and we need real clarity around what the issues are.

Mariann Skar (Eurocare): At the European level, health inequalities are very high on the agenda and are one of the areas where the Commission is working well. We have not been so good on alcohol inequalities specifically and we want to change that with the upcoming European Alcohol Policy Conference in November, where the theme for the first day is Alcohol and Health Inequalities.

Lesley Graham (ISD and SHAAP): Inequalities offer both opportunity and problems in the criminal justice setting. For example, ISD Scotland has done work in Scotland which shows that three out of four prisoners have an alcohol use disorder. There is a huge prevalence of alcohol problems in the prison community. We do not know the rates in Police Custody settings. The NHS in Scotland took over delivery of healthcare in prisons in 2011, and in police custody in 2014. There is a high prevalence of alcohol use in these populations but these settings provide an opportunity to access those that are normally hard to reach, predominantly young males who tend not to be in contact with health services. In addition, these are people who are coming from the most disadvantaged backgrounds and experiencing wider (health) inequalities. Going forward for the Alcohol Strategy in Scotland, we need to address the treatment gap in justice settings. Only one in five people with alcohol problems in the justice system are actually accessing treatment and I am worried that this treatment gap is only going to widen.

Alison Douglas (Alcohol Focus Scotland): A Public Health Working Group, which the Cabinet Secretary for Health and Wellbeing chairs, has been set up in Scotland. The Working Group recognises the interplay between different policies from a health perspective and promotes the wider view of 'alcohol in all' policies.

Fiona O'May (Queen Margaret University): I was wondering about the differences between men and women and the effect of this on policies – how do we account for this?

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Deborah Shipton (NHS Health Scotland): MESAS actually did a piece of work on the gender impact of population level interventions and found it is very difficult to determine the impact of gender on alcohol policies and interventions. When looking at interventions, we are not just thinking of gender issues and we have a long way to go on this. There were some interesting findings with regards to gender in terms of drink-driving and promotion, particularly around the different types of media used to target the genders.

Peter Rice (SHAAP): SHAAP has supported some work with Edinburgh Napier University looking at alcohol mortality among a cohort of heavy drinkers in different parts of Scotland (Glasgow and Edinburgh). It was not surprising that in Glasgow, morbidity, multi-morbidity, and mortality was greater than in Edinburgh, across both genders.

Eric Carlin (SHAAP): It seems that we now have an understanding with other European countries on what will be effective action for reducing alcohol-related harm, that is action on price, availability and marketing which effect the whole population. However, we are failing in relation to implementation. We have the regulations in place but do not have the outcomes in terms of delivery, in terms of effect of alcohol use within different populations for example. A suggested solution to this is the use of national targets. I am not sure how much political will there will be to do that and could be quite problematic. Suzanne, do you have any ideas – are you thinking about implementation, are you thinking not just about the policy but how to implement it and how to get past some of the obstacles that both Ireland and Scotland have had for example?

Alison Douglas (Alcohol Focus Scotland): The Licensing Act in Scotland pre-dates the whole population approach and is fundamentally not about reducing population consumption so I do not necessarily agree there might not be political will for national targets. The point of having a target is that you then have a system-wide aspiration and thinking about how the policy and implementation collectively are at that national and local level, helping as a driver towards achieving that target. At the very least it promotes a discussion about how the bits of the jigsaw join up. So fundamentally our licensing policy, for example, is not about reducing availability. It does not enable Licensing Boards, even if they were minded to do so, to reduce availability. We do not even know how much availability there is, due to data limitations, so we need to be asking ourselves that bigger question about are we serious about reducing availability and what are the mechanisms that we are going to use to do that? For me, there is a deficit, a gap both at national level in terms of policy but also in how the community can help shape the profile of alcohol availability in their community. We are pretending that communities can be fundamentally affecting this but when Licensing Boards are completely unaccountable to their local community it does not happen.

Colin Shevills (Balance North-East): It might not be helpful for the Scottish Government, or any other government, to talk about how much more alcohol we are consuming or how much more alcohol is being sold. If we want the debate to focus around industry and arguments of sales and consumption falling, we need to somehow change that debate. Talking about targets and comparing it to where we were in the 1960s, for example, actually reframes the whole sales and consumption debate with the industry.

Suzanne Costello (Alcohol Action Ireland): Targets can be quite controversial but in terms of the issues we are talking about and to be able to change things, we have to be able to identify where we are going. We have targets for virtually everything else so it would seem strange to remain so vague when discussing alcohol. The whole issue is bedevilled by vague statements and ideas, and it would be much more influential if we could add figures to it.

Mariann Skar (Eurocare): We already have targets for alcohol across the world. With the Sustainable Development Goals, we actually have a target for reducing alcohol consumption – by 10% by 2020. At least that is a starting point.

Suzanne Costello (Alcohol Action Ireland): The Public Health (Alcohol) Bill in Ireland forces the Minister for Health to make reference to data on harms when justifying any action or decision. That is a significant development.

Lesley Graham (ISD and SHAAP): With regards to implementation, we thought about this with MESAS but also with the Alcohol Brief Interventions (ABIs) implementation programme. What we found was it is difficult to ascertain the full effect of a national programme. We did not have outcome data and not enough information on reach. It's not just about policy modelling and where it is all meant to go, it is also about building in data collection that is going to be useful for answering questions, but that sometimes has to be a pragmatic political decision. In terms of implementation guidance, we need a much better understanding about overprovision, for example, what it is and what it actually means.

Niamh Shortt (University of Edinburgh): A lack of data in many areas makes evaluation of many of the areas discussed near impossible. At the national and local level, are we thinking about inequalities and what this means for communities? The data is there, the industry just choose not to share it.

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Price is still an acute problem…
…some drinks 20p per unit
TAURUS


Ireland's famous drinking 'culture'


Conclusion
Tackling Scotland's alcohol problem

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