OFFICIAL REPORT
AITHISG OIFIGEIL

# Health, Social Care and Sport Committee

**Tuesday 6 February 2024**

Session 6

The Scottish Parliament
Pàrlamaid na h-Alba

# Tuesday 6 February 2024

## CONTENTS


| | Col. |
|---|---|
| **DECISION ON TAKING BUSINESS IN PRIVATE** | 1 |
| **SUBORDINATE LEGISLATION** | 2 |
| Community Care (Personal Care and Nursing Care) (Scotland) Amendment Regulations 2024 [Draft] | 2 |
| **ALCOHOL (MINIMUM PRICING) (SCOTLAND) ACT 2012 (POST-LEGISLATIVE SCRUTINY)** | 6 |


## HEALTH, SOCIAL CARE AND SPORT COMMITTEE

**4th Meeting 2024, Session 6**

**CONVENER**

*Clare Haughey (Rutherglen) (SNP)

**DEPUTY CONVENER**

*Paul Sweeney (Glasgow) (Lab)

**COMMITTEE MEMBERS**

*Sandesh Gulhane (Glasgow) (Con)
*Emma Harper (South Scotland) (SNP)
*Gillian Mackay (Central Scotland) (Green)
*Ruth Maguire (Cunninghame South) (SNP)
*Ivan McKee (Glasgow Provan) (SNP)
*Carol Mochan (South Scotland) (Lab)
*David Torrance (Kirkcaldy) (SNP)
*Tess White (North East Scotland) (Con)

*attended

**THE FOLLOWING ALSO PARTICIPATED:**

Dr Pete Cheema (Scottish Grocers Federation)
Alison Douglas (Alcohol Focus Scotland)
Dr Alastair MacGilchrist (Scottish Health Action on Alcohol Problems)
Tracey McFall (Scottish Recovery Consortium)
Justina Murray (Scottish Families Affected by Alcohol and Drugs)
Bob Price (National Association of Cider Makers)
David Richardson (Wine and Spirit Trade Association)
Clare Thomas (Scottish Government)
Maree Todd (Minister for Social Care, Mental Wellbeing and Sport)
Paul Waterson (Scottish Licensed Trade Association)

**CLERK TO THE COMMITTEE**

Alex Bruce

**LOCATION**

The Sir Alexander Fleming Room (CR3)

# Scottish Parliament

## Health, Social Care and Sport Committee

*Tuesday 6 February 2024*

*[The Convener opened the meeting at 09:00]*

## Decision on Taking Business in Private

**The Convener (Clare Haughey):** Good morning, and welcome to the fourth meeting in 2024 of the Health, Social Care and Sport Committee. I have received no apologies.

The first item on our agenda is to decide whether to take items 6 and 7 in private. Do members agree to take those items in private?

**Members** *indicated agreement.*

## Subordinate Legislation

### Community Care (Personal Care and Nursing Care) (Scotland) Amendment Regulations 2024 [Draft]

09:00

**The Convener:** Our second agenda item is consideration of the draft Community Care (Personal Care and Nursing Care) (Scotland) Amendment Regulations 2024, which is an affirmative instrument. The purpose of the instrument is to increase the value of payments for free personal care and nursing care by 6.68 per cent.

The policy note states that payment rates are being increased in line with inflation using the gross domestic product deflator, with rates increasing from £233.10 to £248.70 for personal care and from £104.90 to £111.90 for nursing care.

The Delegated Powers and Law Reform Committee considered the instrument at its meeting on 23 January 2024 and made no recommendations in relation to it.

We will have an evidence session on the instrument with the Minister for Social Care, Mental Wellbeing and Sport and supporting officials from the Scottish Government. Once all our questions have been answered, we will proceed to a formal debate on the motion.

I welcome to the meeting the minister, Maree Todd; Marianne Barker, who is the unit head in adult social care charging and support from home; and Clare Thomas, who is a policy manager in adult social care charging and support from home.

I invite the minister to make a brief opening statement.

**The Minister for Social Care, Mental Wellbeing and Sport (Maree Todd):** Thank you very much for the opportunity to speak to the committee about a proposed amendment to the Community Care (Personal Care and Nursing Care) (Scotland) Regulations 2002.

The draft regulations that are before the committee will make routine annual increases to the rates for free personal and nursing care. Those payments help to cover the cost of those services for self-funding adults in residential care.

This year, I am happy to propose an uplift based on the GDP deflator that will result in a 6.68 per cent increase in the current rates. The GDP deflator has been used historically as the inflationary measure to increase those rates. That

will mean that the weekly payment rates for personal care for self-funders will rise from £233.10 to £248.70 and the nursing care component will rise from £104.90 to £111.90. It is estimated that that will cost around £11.5 million in the next financial year. That will be fully funded by the Scottish Government with additional investment in the local government settlement, as outlined in the recent 2024-25 Scottish budget.

The most recent official statistics show that more than 10,000 self-funders receive free personal and nursing care payments. All of them should benefit from the changes.

I am happy to take any questions from the committee.

**The Convener:** Thank you very much, minister. We will move to questions.

**Paul Sweeney (Glasgow) (Lab):** Thank you for your opening statement, minister.

In increasing the rates above inflation for the past three years, the Scottish Government has effectively admitted that in-line-with-inflation uplifts are simply not enough to meet the rising costs of providing care. However, the statutory instrument puts the rate in line with inflation for the coming financial year. Who does the minister see meeting the gap between rising costs and the capacity to pay for them? What is covered in the local government settlement? Is it for the councils, which are already under significant financial pressures in the forthcoming budget settlement, to find that extra financial capacity rather than central Government?

**Maree Todd:** Given the challenging financial context that we face, I am happy that we have been able to increase the rates by 6.68 per cent. An additional £11.5 million is being invested through the local government settlement to do that. It is for local authorities to make decisions on how they spend their funding at the local level.

**Paul Sweeney:** Does the minister accept that over 80 per cent of local government finance is determined by central Government grants and that that constrains local government's capacity to meet the other side of the equation?

**Maree Todd:** Traditionally, since 2010, the payments have increased in line with inflation. In the first few years of their existence—up to 2007, when the Scottish National Party Government came into power—they were not increased at all. From 2007 to 2010, we and local authorities negotiated the payment rates, and from 2010 to 2020, they were increased using the GDP deflator.

As you said, there have been above-inflation rises in the past three years. Unfortunately, the financial context this year means that that cannot occur again. However, in the financial context that we are experiencing, I am pleased to be able to increase the payments in line with the GDP deflator, as stated.

**Paul Sweeney:** On the GDP deflator, what assessment has the Government made of the impact of the rate on the delivery of personal care? Can you guarantee that people will still be able to access the care that they need and that it will remain free at the point of use?

**Maree Todd:** We have not done an impact assessment because it is not a new policy; an existing policy is being continued. We have not done a full impact assessment, but we expect this to support everyone who is self-funding in the system, which we think is around 10,000 people.

**Carol Mochan (South Scotland) (Lab):** I want to follow up on the points that have been made about an impact assessment. You were concerned that the costs increased more in previous years. Do you have concerns that that will be the case again this year and that local authorities will need to meet the costs that are not in the agreed settlement?

**Maree Todd:** In the past three years, our ambition has certainly been to give above-inflation settlements. Unfortunately, the financial context that we find ourselves in this year does not enable us to do that. Local authorities will make their own decisions on their local priorities, as they are democratically elected to do.

**Carol Mochan:** I want to be clear. I suppose that, in your modelling, you anticipate that local government will need to make some contribution to costs because you think that there will be an increase in costs, as in the previous three years.

**Maree Todd:** I ask my official Clare Thomas to respond to that line of questioning.

**Clare Thomas (Scottish Government):** The free personal and nursing care rates are set out in the legislation. They are set rates. There should not need to be a contribution from local authorities. The contracts and the rates that self-funders pay are private arrangements between individuals and the provider.

**Sandesh Gulhane (Glasgow) (Con):** I want to pick up on what Paul Sweeney and Carol Mochan have asked about. On the £11.5 million cost, is that £11.5 million what central Government is putting into a budget that will allow local authorities to make their own choices? Is that an extra £11.5 million that central Government is putting in, or will local government have to find that £11.5 million?

**Maree Todd:** The £11.5 million is additional funding to fully fund the uplift.

**The Convener:** As I have not had any indications that any other members wish to ask

questions, we will move on to agenda item 3, which is the formal debate on the instrument on which we have just taken evidence. I ask the minister to speak to and move motion S6M-11853.

**Maree Todd:** I move,

That the Health, Social Care and Sport Committee recommends that the Community Care (Personal Care and Nursing Care) (Scotland) Amendment Regulations 2024 [draft] be approved.

**The Convener:** Thank you, minister. Members should not put questions to the minister during the formal debate, and officials may not speak in the debate.

**Paul Sweeney:** I have concerns about the statutory instrument being recommended to Parliament because the Scottish Government has set the rates above inflation for the past three financial years to help to redress the costs of providing personal and nursing care, which have increased significantly, and payments have not kept pace with that. By its own admission, the rate increase in line with inflation is insufficient to meet the rising real costs of delivering personal care.

The Scottish Government expects members to trust in its vision—which we have not yet seen—for a national care service that, in its own words, delivers "consistent and high standards", but the statutory instrument demonstrates an inability to adequately resource a basic tenet of social care. I will not vote against the statutory instrument, but I have concerns about recommending to Parliament the rate, which falls short of what local government needs to provide personal care.

**The Convener:** I have had no indications that any other members wish to speak. Minister, will you sum up and respond to the debate, please?

**Maree Todd:** As stated during questioning, the uprating is fully funded by the Scottish Government, and local authorities have additional income in their budget in order to ensure that it is paid. I am happy to put the matter to a vote with the committee.

**The Convener:** Thank you very much, minister.

The question is, that motion S6M-11853 be agreed to. Are we agreed?

*Motion agreed to.*

**The Convener:** That concludes consideration of the instrument. I briefly suspend the meeting to allow a changeover of witnesses for our next item.

09:10

*Meeting suspended.*

09:12

*On resuming—*

## Alcohol (Minimum Pricing) (Scotland) Act 2012 (Post-legislative Scrutiny)

**The Convener:** The next item on our agenda is the first of two oral evidence sessions as part of our post-legislative scrutiny of the Alcohol (Minimum Pricing) (Scotland) Act 2012. I welcome to the meeting Alison Douglas, who is the chief executive of Alcohol Focus Scotland; Dr Alastair MacGilchrist, who is the chair of Scottish Health Action on Alcohol Problems; Tracey McFall, who is the chief executive of the Scottish Recovery Consortium; and Justina Murray, who is the chief executive officer of Scottish Families Affected by Alcohol and Drugs.

We will move straight to questions, starting with Sandesh Gulhane.

**Sandesh Gulhane:** Good morning. Thank you for coming in.

Alison Douglas, I will start with you. How accurate has the Sheffield model been in each of its iterations prior to its update?

**Alison Douglas (Alcohol Focus Scotland):** The Sheffield modelling predicted that there would be a 3.5 per cent decrease in consumption, or a three-year 3.5 per cent decrease in consumption, which is pretty much what we have seen in practice. With regard to the effect on consumption, it has been pretty accurate.

With regard to the effect on health outcomes, the estimate was a very conservative one. The effect that we have seen in the real world has been significantly higher. The modellers were probably quite deliberate in being cautious about the expected health benefits. As you know, minimum unit pricing was predicted to save 60 lives in the first year of operation. In practice, it has saved 156 lives. That is a significantly greater number than was predicted.

09:15

The key thing is that the theory of change that was behind the Parliament's support for minimum unit pricing has been fairly well borne out through the evaluation. The real-world evidence that we have been able to add, through that very comprehensive evaluation, to the evidence that came from other countries, but also from the Sheffield modelling, all paints a picture that minimum pricing is operating in the way that we expected it to. It is affecting high-strength low-cost drinks the most, thereby reducing consumption, particularly among those who drink above the low-

risk guidelines, and it is reducing alcohol harm. The way that we can measure that is through alcohol-specific deaths—deaths that are caused as a direct consequence of alcohol and through no other cause. That is the 156 lives saved that I alluded to.

In addition, minimum unit pricing is having an effect on a range of conditions, such as cancers and cardiovascular disease. It is estimated that an additional 112 lives have been saved each year due to minimum unit pricing. That is why more than 30 organisations and the directors of public health have endorsed the evidence that we and SHAAP have given to the committee. There is a widespread understanding among the medical community, public health professionals and children's charities that minimum unit pricing is working, but that it needs to be uprated.

**Sandesh Gulhane:** You said a number of things in that opening answer. You said that 156 lives had been saved as if it were a fact, but that is an estimate based on modelling that is under intense scrutiny. You talked about comprehensive evidence, but you were referring to only one out of the 30 papers that were evaluated.

The other issue that I want to get into here is that of dependent drinkers. How has MUP affected dependent drinkers? Before I come back to Alison Douglas, I would like to bring in Justina Murray.

**Justina Murray (Scottish Families Affected by Alcohol and Drugs):** I will pre-empt that with a slightly different comment. I am here to represent and speak on behalf of Scottish Families Affected by Alcohol and Drugs. Families are getting a bit frustrated that, so many years down the line, the issue is still being debated. You know that we have lost more than 11,000 people specifically to alcohol over the past decade, and the figure is many times more than that if we take account of alcohol-related conditions and other things that are linked to alcohol, such as violence, accidents and so on. Families do not understand why this is still being debated. They want to see action. They want to see action on other issues, such as marketing, availability and treatment, as well.

We are part not only of the public health community in Scotland but of the international public health community, and that community is united in believing and understanding the evidence that MUP saves lives. It is designed as a whole-population approach. We can see that it has reduced consumption, it has reduced hospital admissions and it has reduced deaths.

**Sandesh Gulhane:** I am sorry—can I ask you for the evidence that it has reduced hospital admissions, please?

**Justina Murray:** The evidence has all been presented to you.

**Sandesh Gulhane:** Was it statistically significant?

**Justina Murray:** The papers that we have shared show that hospital admissions have reduced by 13.4 per cent.

**Sandesh Gulhane:** Was it statistically significant?

**Justina Murray:** I am here as a charity CEO. I am not going to start arguing with you over statistical significance. I think that you should be focusing on the fact that MUP has saved lives. I am not sure, but I think that you are possibly the only person in the room who does not believe the evidence. I am standing firm with the public health community across the world in saying that price is the most effective mechanism for reducing harm and reducing deaths.

**Sandesh Gulhane:** I believe the evidence. I want to make that abundantly clear. That is why I am asking the questions. I asked you specifically what effect MUP has on dependent drinkers, which you have not answered yet.

**Justina Murray:** You are correct—I have not answered that. Many of the families that we support are families whose loved ones are drinking at hazardous, harmful and dependent levels, and price is one of many factors that they talk about when it comes to changing their loved one's behaviour. The evidence on dependent drinkers was never supposed to be what we pinned the success of MUP to. It is a whole-population measure, and it has worked as a whole-population measure.

We know that the needs of people who are dependent drinkers are very complex and very specific. One tool in the toolkit is never going to work for all dependent drinkers. Some drinkers have said that they have changed their behaviour based on MUP, but we also need to look at the other tools in the toolkit. Instead, we just focus on and talk about MUP all the time, but it must sit alongside availability, marketing and treatment.

**Sandesh Gulhane:** We will certainly come on to those questions, but, again, you have not answered my question about dependent drinkers, because—

**Justina Murray:** I said that their needs are very complex and specific, so price will not be the only thing that will impact their drinking. I think that that is an answer.

**Sandesh Gulhane:** The evidence shows that dependent drinkers are spending more on their alcohol consumption.

I will come back to Alison Douglas. What has been done to help dependent drinkers, who are spending more money, to come away from

alcohol? How have measures such as alcohol brief interventions worked for dependent drinkers who have sought treatment?

**Alison Douglas:** To come back to the question about whether minimum unit pricing has worked for dependent drinkers, I make it absolutely clear that it was not the purpose of minimum unit pricing to change the drinking of dependent drinkers. The purpose was to reduce consumption among people who drink above the low-risk guidelines.

To give you a sense of the scale of that, about 1 per cent of the Scottish population, roughly, is alcohol dependent. That is about 50,000 people or so. Some 23 per cent of us drink above the low-risk guidelines. That is well over a million of us. That is what we mean when we talk about a population-based measure. The effect has been greater on those who drink at higher levels.

When it comes to dependent drinkers, as Justina Murray has indicated, when people who are psychologically and physiologically dependent on alcohol wake up in the morning, the first thing that comes into their mind is not, "How much am I paying for my alcohol?"; it is, "I need alcohol now to get me through this morning." It is clear that people who are in that extreme position need more intensive support to help them to overcome their alcohol problem.

What I can tell you—I am sure that Tracey McFall will be able to add to this—is that, when I have spoken to people who are dependent on alcohol or, rather, who are in recovery from serious alcohol problems, they have made it very clear that minimum unit pricing would not have changed their dependence on alcohol. However, they whole-heartedly support minimum unit pricing as a preventative measure to ensure that people do not come along behind them and experience dependence and the severe problems that they and their families have had to contend with.

The message from people in recovery is, "Please get on with renewing minimum unit pricing and uprating the minimum price, because it's such an essential component of the wide range of things that we need to do to tackle the alcohol problem in Scotland."

**Sandesh Gulhane:** Sorry, I—

**The Convener:** I am sorry, but we will have to move on. You have had 12 minutes of questions and answers, and we have lots to get through. We will move on to questions from Tess White.

**Tess White (North East Scotland) (Con):** I will ask my question to Dr MacGilchrist initially and then other panel members may want to answer it.

Looking at the facts and the data, we can see that alcohol deaths are the highest now since 2008. The number of male deaths has remained unchanged, yet the data from 2022 shows that the number of female deaths has risen by 31, to 440. How does minimum unit pricing help to reduce the number of female deaths?

**Dr Alastair MacGilchrist (Scottish Health Action on Alcohol Problems):** The question about female deaths is quite a specific area, so we may get into quite close detail here. You will remember that 50p was first suggested in 2012, when Parliament set it at that level with unanimous agreement. By 2018, that was already on the borderline of being effective, because of the effect of inflation over that time. The modelling suggested that, at that 50p level, MUP is less effective in preventing female deaths than preventing male deaths.

It is interesting that 50p has been effective over the past five years, but it has probably not been consistently effective over those five years. It is becoming less effective as time passes, because of the effect of inflation: 50p now is not what it was in 2018 or what it was in 2012. It is reasonable to speculate that that very disappointing and interesting small increase in female deaths between 2021 and 2022 might reflect that MUP is becoming less effective, particularly in women. We do not really understand why that is; it is maybe because women drink a different pattern of products compared to men and are less likely to drink the cheapest end of the range, such as cider and so on, rather than wine. Wine is relatively unaffected by MUP at the 50p level.

I cannot let a couple of the previous comments go unchallenged, so would you mind if I took just two minutes to come back on a couple of points, convener?

**The Convener:** Please be brief, because we have to move on.

**Dr MacGilchrist:** I realise that. Very briefly, Dr Gulhane stated that only one out of 30 studies showed the effect. That is a very misleading statement, I am afraid. There was only one study that looked at population-level deaths on hard data—that is, national statistics on deaths and admissions—and it showed a clear difference between Scotland, where there is MUP, and England, where there is not. That was not modelling; it was looking at real-world data, so to suggest that the figure of 156 is based on modelling is incorrect—it is real-world data. It is an estimate, because we are talking about percentage differences, but it is not a model.

Dr Gulhane also asked about the significance of hospital admissions. Again, this gets very detailed but, when medical studies talk about statistical or clinical significance, they talk about a 95 per cent certainty that something could not have happened by chance. The data on hospital admissions

showed 94 per cent certainty, so p equals 0.06. Yes, it did not cross the 95 per cent certainty but you can draw your own conclusions about 94 per cent versus 95 per cent as to whether there was an effect.

Finally, before we go on to other matters, on the question about dependent drinkers, it is important that everybody understands what we are talking about here. Harmful drinkers—people who drink in excess of 35 units for women and 50 units for men—constitute probably around 5 per cent of the population, and dependent drinkers constitute 1 per cent. For those dependent drinkers who are already addicted—to use that term—to alcohol, MUP is not the solution. The whole point of MUP is to prevent people from getting to that point. It is a preventative measure.

**Tess White:** Can I go back to my question, please? We have gone off piste.

**Dr MacGilchrist:** Apologies.

**Tess White:** Can we go back on piste and talk about female deaths?

**Dr MacGilchrist:** Yes, I understand.

**Tess White:** It is statistically significant: an increase of 31 to 440 is huge. We are looking at no change in male deaths since 2008, but the figure on female deaths is dramatic. You talk about modelling and speculative figures, but the data from National Records of Scotland does not support what you are saying. You have confirmed that you just do not know whether MUP affects female deaths, so I would just like to say that there is no answer. I invite Alison Douglas in.

**Dr MacGilchrist:** I am sorry—I perhaps need to finish my answer if I did not clarify it to you. I am saying that MUP at 50p is less effective on women than it is on men, and the data is bearing that out. If you want to solve the problem of its being less effective on women, the clear answer is to uprate MUP.

**Tess White:** I dispute that.

I ask Alison Douglas to respond.

**Alison Douglas:** In relation to deaths as a whole, what we saw was—

**Tess White:** Sorry, but the question is about women.

09:30

**Alison Douglas:** I will get there.

Deaths as a whole doubled between the 1970s and the 2000s. Women are still much less likely than men to die. However, because of a number of changes in society, women are drinking at higher levels than previously. In Scotland and across the United Kingdom, we have seen an increase in the consumption of wine in particular, and wine is often favoured by female drinkers. We have seen increasing social acceptability of women drinking, the increased availability of wine and the increased acceptability of wine drinking. I think that, over time, those things have contributed to an increase in female deaths.

We talked earlier about alcohol-specific deaths. Three quarters of those would involve alcoholic liver disease, and Dr MacGilchrist can speak to the fact that clinicians are seeing very young women presenting, when they had not seen that previously. Many alcohol-related conditions can take 10 to 20 years to manifest themselves—for example, that is the case with alcohol-related cancers such as breast cancer. Part of what we are seeing is probably that the increased drinking among women is flowing through into increased deaths.

**Tess White:** Nobody is disputing those facts; I am just disputing the question of the effect of MUP on female alcohol-related deaths. Thank you.

**Carol Mochan:** Dr MacGilchrist, I am interested in the medical community that works in this area. I am sure that you discuss MUP as part of that whole package. Are the medics who work in the area generally quite convinced that MUP has helped and that we should uprate it?

**Dr MacGilchrist:** Yes, there is no doubt that MUP has perhaps not unanimous but near unanimous support from the medical community and from the health community in general.

Without taking advantage of your indulgence too much, convener, the background to this is that my clinical career has been spent as a liver doctor. As you have heard, not only are most alcohol-specific deaths due to liver disease, but it works the other way round, too—most liver deaths are due to alcohol. I have lots of folk on my ward who are dying of liver disease. Last week, I was in the infirmary speaking to my colleagues, and it was just a usual week: 18 out of the 19 patients with liver disease on the ward had liver disease due to alcohol. That is the scale of the problem. The most recent death that they had at the weekend was a 40-year-old who had two young kids.

It is frustrating that the disease becomes apparent to you when it is at an irreversible stage—cirrhosis is silent until you have advanced disease. The need to have a preventative mechanism is why I became interested in this stuff in the first place. We need to prevent people from getting it in the first place. I came to the public health stuff a bit later on and, from reading the evidence, it is clear that we have known what to do for a long time. We have known what is effective—it is measures on price, availability, and

attractiveness through marketing, which we have spoken about a little. The medical community is delighted to have this targeted and progressive policy that reduces health inequalities.

We are not seeing the effect on the ward yet, to be honest. With some of the deaths that Ms White has referred to, it is important to realise that we are still seeing the aftermath of the Covid pandemic, which had a major effect on everything, including alcohol and liver deaths. Therefore, it is more important than ever that we use effective measures such as MUP at a proper level.

**The Convener:** We have a lot to get through this morning, so I ask committee members and witnesses to keep their answers concise.

**Dr MacGilchrist:** Sorry.

**Emma Harper (South Scotland) (SNP):** Good morning, everybody. Over the weekend, I was reading about minimum unit pricing policies that have been implemented in other European countries. I declare an interest as a registered nurse and former liver transplant nurse. Other countries are adopting MUP in some form or another. Other European countries have some form of taxation on alcohol, anyway. There is a report called "No place for cheap alcohol: the potential value of minimum pricing for protecting lives". I would be interested to hear about what we can learn from other countries. The impact of the pandemic would then be a second question.

**Dr MacGilchrist:** Shall I take that?

**Justina Murray:** I am happy to come in on the pandemic, but I will leave the issue of other countries to you.

**Dr MacGilchrist:** The international community's eyes are on Scotland, because it was the first country in the world to introduce MUP, having known for a long time that pricing is effective. Pricing regulation is generally done by taxation. The attraction of MUP is the idea that you target the cheaper drinks that the heavier drinkers take.

Prior to the introduction of MUP in Scotland, a number of provinces in Canada had something similar. There is now one province in Australia, the Northern Territories, and two other areas in the British Isles—Ireland and, I think, Jersey in the Channel Islands. The ones in Europe in general are slightly different. They often target one particular drink—in Russia, it is vodka and, interestingly, in Ukraine it is specifically spirits.

We are lucky in Scotland that we have very good evaluation and good data. Few other areas have such good data, which is why others are interested in watching what is happening here. That is one reason why the industry is so worried, if you like, because if MUP is seen to be effective, other countries will adopt it. You are still only talking about a handful of countries, and you could ask yourself why that is. Maybe it is the power of the industry. Most countries just rely on taxation, which is a much blunter tool.

**Justina Murray:** In December 2020, when we thought that the pandemic was tailing off, Scottish Families Affected by Alcohol and Drugs produced our report "Lockdown and Beyond", in which we talked about the impact of the pandemic on families. We do not get involved as a charity where there is alcohol or drug use in a family; it is where there is harm. During the pandemic, for a lot of families, we saw that use becoming harm. In the report, we talk about new families and existing families. Before the pandemic, there were already families who knew that there was an issue with alcohol, for example, but during the pandemic the alcohol use increased. It was more likely to happen in the home, because of the closure of hospitality and the stay-at-home rules, and the other members of the household were also more likely to be at home.

There were also new families, where the other family members were not aware that there was an issue, but it was hard to hide during the pandemic when everybody was at home. None of the things that families normally do to keep themselves well—going to work, to school, to college, to meet friends or going for a swim or to the gym or whatever—was available, so everybody was stuck in the house with this alcohol use increasing. It really was what we call a pressure cooker situation.

Alongside that, there was the closure of a huge number of treatment and support services, which could no longer be accessed. People who were concerned about their drinking were phoning the Scottish Families Affected by Alcohol and Drugs helpline. They were trying to contact services, and nobody answered the phone, or they left a voicemail message but nobody got back to them. It was a perfect storm.

Once that box has been opened, we cannot just say, "The pandemic is over now. We will just pretend it never happened." That harm is on-going, and we are not seeing the pick-up in treatment and support services that we need.

**Emma Harper:** Has the pandemic affected our ability to capture further evidence? It obviously informed the way in which some evidence was gathered. As Justina Murray described, there were higher levels of drinking during the pandemic. Do we need to continue with minimum unit pricing in order to get further robust evidence? I see that Alison Douglas has her hand up.

**Alison Douglas:** As Justina Murray said, the scale of the problem has increased. As in so many areas, whether it be cancer, mental health or

alcohol, there is a Covid hangover or unfortunate legacy on our health. There are on-going effects of Covid, because people who started to drink more during the pandemic do not appear, unfortunately, to have reverted to their previous patterns of drinking, which means that we have an even greater public health emergency with alcohol than we would otherwise have had. I fear that we could be heading back to record levels of deaths if we do not do something. Part of the response needs to be to uprate the minimum unit price, but we also need to do a range of other things.

On your point about the evidence base, in its study on deaths and hospital admissions, Public Health Scotland used not only gold-standard data but what would largely be accepted as the best possible methodology for statistical analysis. It used a range of controls. That included looking at whether there was a material change in the data following the pandemic. Using England as a comparator, Public Health Scotland found that the same changes in the number of deaths were evident—there was the same direction of travel, with the number of deaths having gone up significantly—but, although the number of deaths went up by 22 per cent in Scotland, the number went up by 30 per cent in England. Public Health Scotland concluded that the only plausible explanation for that was the introduction of minimum unit pricing.

**Emma Harper:** Thank you.

**Paul Sweeney:** Do any of the witnesses have concerns that there might have been unforeseen negative impacts on health-related outcomes that have not been picked up by the Public Health Scotland evaluation? Are there any other aspects that you would have liked to have been measured or that you have found it difficult or impractical to evaluate? For example, I have concerns about potential substitution with benzodiazepines—so-called street Valium.

**Dr MacGilchrist:** I will start, and others can chip in. One of the points to note about the Public Health Scotland-led evaluation is how comprehensive it was. For the past few years, if you spoke to people at international meetings, they would say that they had never seen a measure that had undergone such scrutiny, which includes what we are doing in this room. The people involved in the evaluation looked at substitution in relation to three issues: other products such as benzos, illicit alcohol—although, to be honest, that is not really a problem in the UK—and cross-border trade. They found no significant evidence of issues in that regard.

About a year or two after the introduction of MUP, there was a little bit of press about a couple of examples of people who had taken benzos. However, there was no evidence that anybody who had not been using street drugs or non-prescription drugs had started to do so, although some people who were using both perhaps changed the emphasis of what they were doing. I am not too concerned about the illicit alcohol issue, because it has not proved to be a big problem.

**Tracey McFall (Scottish Recovery Consortium):** On a practical community-based level, I have, over a number of years, worked and engaged with communities who use both alcohol and drugs. There is the evidence base, and there was a concern that, in real-life communities, there would be substitution. We have not seen that in the communities that we work with. We need to keep a close eye on that, but we have not seen that in the real-life communities that we engage with day to day.

09:45

**David Torrance (Kirkcaldy) (SNP):** Good morning. I know that all the witnesses have touched on this slightly, but I want to ensure that the evidence is on the record for the committee. What would you say to people who have concluded from the available evidence that minimum unit pricing is not working in targeting problem drinkers?

**Tracey McFall:** I will make a broader point. This is not only about minimum unit pricing; this is about the other things that we need to wrap around it. We need to think about early intervention, prevention, education, access to treatment, employment opportunities and what happens after treatment. We need to look at the issue more broadly. From speaking to recovery communities and on the basis of my experience in the sector, I think that minimum unit pricing is one tool among the suite of tools that are needed.

I will make another very broad point. We are talking about alcohol consumption but, just before Christmas, I was at a cross-party group meeting at which we were talking about drug deaths. There are connections across alcohol, drugs, mental health, justice, homelessness and domestic violence. From a policy perspective, we need to be joining the dots and to be doing so locally.

Those are the two broad points that I would like to get across. This is not just about minimum unit pricing, because, if it is, it will not work. We need there to be access to treatment, to recovery and to opportunities. All of this is underpinned by poverty and inequality, which we need to focus on, too.

**Dr MacGilchrist:** At the risk of slightly repeating what has been said, I talk about problem drinkers all the time—it is common parlance—but we have to be careful about what we are talking about here. As I said, dependent drinkers are a small

proportion of harmful drinkers. MUP has had the least effect on dependent drinkers, and it has had the biggest effect on people who drink at a hazardous or harmful level.

I will make two points in that regard. First, we should remember that sales data is more robust than survey data. People can be asked questions in a survey about how much they drink, but their recall might not be very good, they might not always be entirely honest and surveys might not reach the people we need to reach. Sales data showed not only that sales from off-sales had fallen but that, based on data collected from till receipts, the biggest change had been in households that bought the most alcohol. That is encouraging.

For my second point, I will, again, put on my liver disease hat. The deaths that happen in England but which do not happen in Scotland, when we might expect them to, are all liver deaths. All my liver patients are very heavy drinkers, so there is no way that there would be that difference between Scotland and England unless heavy drinkers were being influenced by MUP.

**David Torrance:** Convener, my other questions have been answered.

**The Convener:** Okay. I call Ruth Maguire.

**Ruth Maguire (Cunninghame South) (SNP):** Good morning. I thank the witnesses for being with us.

When I heard Justina Murray talk about the 11,000 people lost to alcohol, I thought about the families and children around them, so I will ask about them. I hear the frustration that we are just talking about minimum unit pricing; that is the legislation that we are scrutinising, but feel free to add any extra comments.

My questions are for Justina Murray and Tracey McFall, because I think that they will have rich evidence from families. The Public Health Scotland evaluation report says that researchers

"felt unable to determine if"

minimum unit alcohol pricing

"had positive or negative impact on the lives of children and young people affected by"

parental drinking, and it says that

"there was no evidence of change in any parenting outcomes".

I think that we probably all intuitively understand the harm that drinking causes, but could you say a bit about the impact on children and families?

**Justina Murray:** One of the issues for children and young people, as well as for adult family members, is that so much of this is hidden. There was a question earlier about needing more research or evaluation. We know that there is so much stigma, shame and secrecy around alcohol use within a family, so we can be quite confident that most of the harm is hidden. Outwardly, people might have a nice house, a nice car and a great job, but there might be a lot of drinking behind the scenes.

There is very little support for families. There is the best support for children when there is opioid use by family members, particularly when a single parent or both parents use opioids. A lot of families are affected by alcohol use, but it might not be on anybody's radar because the children attend school, the young people attend college and so on.

We need to talk more openly about what is going on. We have a very contradictory approach to alcohol in Scotland. We use it to mark every occasion—hatches, matches and dispatches—but, if anybody develops a problem, we do not really want to know about it. The main issue for families is that so much of the harm is hidden, so the support is not there for them.

**Tracey McFall:** I agree with Justina Murray. A huge amount of stigma is attached to alcohol use. While it is hidden, it is very difficult for family members to come forward and access treatment services, which has an impact on children. The reality is that there are fewer treatment services to support those with alcohol issues than there ever have been in Scotland. If families identify that there is an issue, where do they go? That is why, as Justina Murray said, there are calls to the helpline. Families struggle to know where to get help when they identify that there is an issue.

There is a massive stigma attached to alcohol use. There are parallels with the work on drugs and the national mission, so we could learn from that in relation to tackling stigma. We do not need to start with a blank piece of paper. Again, that is why we need to take a cross-portfolio approach. I agree with Justina Murray on that.

If families identify an issue, they need to be able to access treatment. We need to do more research, but we need to use organisations such as Scottish Families Affected by Alcohol and Drugs and the Scottish Recovery Consortium to access those families, because it is more than likely that they will first phone those organisations before accessing treatment services.

**Ruth Maguire:** We are carrying out post-legislative—that is my least favourite word to say, because I find it difficult to do so—scrutiny, but, when legislation moves through the Parliament, we often talk about the other things that are needed. I am sure that, when the Alcohol (Minimum Pricing) (Scotland) Bill was being considered in 2012, which was a bit before my

time in the Parliament, the need for treatment and additional interventions would have been discussed. Has there been progress on those things?

**Justina Murray:** That perhaps relates to the frustration that you are hearing today. In Scotland's alcohol framework and in "Rights, Respect and Recovery", there are multiple commitments on price, availability, marketing, treatment and support. There has been so much focus on MUP, and so much funding for research has gone towards it—that was quite right, because the policy has been well evaluated—but what about everything else? That is the point. Families are reaching breaking point, so all the other stuff needs to be looked at, too.

We are talking a lot about costs this morning. When we talked to families when cost of living issues were first hitting the press, such issues were not even in the top 10 things that families were worried about and that were keeping them awake at night. That is not to say that those families do not have cost of living worries, but we have talked about the cost of loving. That is the cost that they face. It is relentless—every day. There are financial, practical and health costs. Life is chaotic. Within that, price is a factor, but all the other things also need to be addressed.

**Ruth Maguire:** Thank you.

**Ivan McKee (Glasgow Provan) (SNP):** Good morning, panel. This is a hugely important subject and many of us have probably had family members or friends who have succumbed to alcohol harm and passed away earlier than they should have done.

I want to focus a wee bit on the economics of this. I am sorry, but I will be a bit geeky to kick off. Dr MacGilchrist, I am trying to get my head round what the labels are on the axes in the chart in your submission. Do you have it to hand?

**Dr MacGilchrist:** Yes.

**Ivan McKee:** I am assuming that the left-hand side is units of alcohol per person per year, but what do the numbers on the right-hand side relate to?

**Dr MacGilchrist:** I am not sure that I know. The slide is from a very old piece of data, from the 1970s and 1980s, which first drew attention to the fact that there is an absolutely clear relationship between how much we drink and how affordable alcohol is, so it is about consumption, not harm.

The right-hand axis shows "Price relative to income", which is the affordability of alcohol. Alison Douglas has alluded to the fact that there has been a huge increase in alcohol deaths in many countries but particularly in Scotland and in the UK. I graduated in 1979. At that point, deaths were at a bad level but much more manageable. They have increased hugely over the past 30 years. The primary reason for that is that alcohol is much more affordable. Alcohol goes up a little bit in price, but our income and our disposable income goes up by much more.

It was about 2007 when the crisis really hit the public eye. A famous headline in the *Sunday Mail* was: "Alcohol is cheaper than water"—and it was at that point. It is not quite as bad as that now.

That is what that graph is trying to tell you—that there is a clear relationship between price and consumption. If you make alcohol cheaper, more people will drink and more people will die. If you make alcohol more expensive, less people will be drunk and more people will live.

**Ivan McKee:** I understand what it is trying to tell us, and thanks for laying that out—

**Dr MacGilchrist:** It is an old graph.

**Ivan McKee:** —but it would just be nice to know what the numbers mean. It would be helpful if you could dig out that information. It would also be nice to know whether there is any data since then—I think that you said that the data in the graph goes up only to 2007. Anything beyond that, for the past 15 years or so, would be really helpful to see.

**Dr MacGilchrist:** I could show you many graphs, and I am happy to provide that data to you, but the point is that that relationship holds good at any time in any country when it has been looked at.

**Ivan McKee:** That is fine.

I will move on. In terms of the effect on the industry, I have a couple of data points on which I again seek clarification, as we will be speaking about those with our next panel.

A study by the Institute for Fiscal Studies says that there are £383 million of "windfall gains" from MUP to the alcohol sector a year. I am not sure whether that is increased revenue, increased profit, net profit or something else. There is also the Sheffield modelling, which gives a figure of £140 million, which is a revenue number. Clearly, that will not translate through to profit.

I do not know whether anyone on the panel is on top of any of those numbers. If not, it is not a problem.

**Dr MacGilchrist:** Alison Douglas is.

**Alison Douglas:** I would not go so far as to say that I am on top of them. However, they all use different approaches to estimate the revenue increase to the supply chain. Fraser of Allander Institute did a calculation for us that came out at £30 million a year. As you have alluded to, the IFS's figure is an order of magnitude greater than

that per year. You are right to say that revenue does not equate to profit.

**Ivan McKee:** Is the IFS number a Scotland number or a UK number? It must be a Scotland number, I suppose.

**Alison Douglas:** I think that it is Scotland, yes.

**Ivan McKee:** We also have a number in our submission of savings to national health service costs, which is just short of £1 million a year. I understand how that has been calculated and it is good to see that saving. Are you aware of, or do you have any data on, the cost of alcohol harm to the overall economy?

**Dr MacGilchrist:** I can answer that. We commissioned the Social Market Foundation to update some UK-wide work that it had done some years ago specifically for Scotland. It depends on what parameters you use. The figures are always estimates. You can take account of the healthcare costs that we have spoken about, the social costs, the policing costs of dealing with disorder and so on, but it is more of a challenge if you include calculations on years of life lost. One of the things about alcohol is that it kills people in their middle years, unlike most other conditions that kill people once they are beyond their working life. If you want to be brutally honest, you are losing productive people. The estimate is somewhere between £5 billion and £10 billion. That is a big estimate—

**Ivan McKee:** Is that at a UK level or a Scotland level?

**Dr MacGilchrist:** That is in Scotland: the estimate is £5 billion to £10 billion—

**Ivan McKee:** Of economic activity?

**Dr MacGilchrist:** Yes, that is right. That is the cost, including years of life lost.

**Ivan McKee:** That is helpful, and it puts some of the other numbers that we are talking about today into context. Thanks very much.

The last thing that I want to focus on is the uprating of MUP. What is your perspective on that? What should the mechanism be? Should it be automatic? Should it be based on inflation or affordability? I am going back to the graph that we have just discussed. I am keen to get anyone's perspective on how we should progress that.

10:00

**Dr MacGilchrist:** I will comment on that briefly and then pass on to others. We touched on affordability. In an ideal world, we would have an instantly available measure of affordability. Affordability might change year on year, depending on whether we are in a recession or a booming economy. In an ideal world, you would uprate MUP in relation to affordability, and it might go up and down year on year. In reality, the data on affordability always lags behind by several years. For example, we do not have affordability data since 2021 and we have had the cost of living crisis since then.

Inflation is the next best measure that we have. One of the striking things about inflation in the past few years has been how alcohol inflation has been much lower than food inflation or general inflation. Alcohol prices have not gone up, so it has become relatively cheaper compared with other products.

If I had my way, there would be a regular uprating of MUP. An automatic uprating would be best, because that would take the heat out of the situation. However, if you do not have a regular uprating mechanism, you are consigning MUP to be less effective year on year. That is one of our endless discussions. We are almost six years into the measure and its effect is reducing.

If possible, MUP should be by uprated automatically; if not, that should be done regularly. Uprating it in relation to affordability would be the gold standard, but I think that doing so in relation to inflation is a good second best.

**Alison Douglas:** It is clear from the Sheffield modelling that, if we leave the price at 50 pence, harm will go up. If we were to raise it to 65 pence per unit, over five years, 800 lives would be saved, 10,000 hospital admissions would be averted and £12 million would be saved in hospital costs. That gives you a comparator for the two price levels over the next five years.

**Justina Murray:** We are very much in favour of uprating the MUP and for that then to be automatic. It makes no sense whatsoever to put all our eggs in the basket of this policy. As Alastair MacGilchrist said, the price was fixed in 2012, so people should not be wondering why it is having less and less impact over time. If we are once again to become world leaders in the field of alcohol policy, we have to look at a reasonable price point for MUP.

**Ivan McKee:** That is interesting. You will have seen our first agenda item this morning, which was on upgrading social care payments. That is done by a percentage increase, and the process is relatively painless.

**Gillian Mackay (Central Scotland) (Green):** Good morning to the panel. If MUP was to continue, would witnesses support the introduction of a levy to recoup the additional revenue from retailers as outlined in the Scottish budget? Justina Murray is nodding so I will go to her first.

**Justina Murray:** Something that families really support is the polluter pays idea—that is, if

someone is making money from alcohol, some of that should definitely be put back into treatment. I am very much in support of such a levy.

**Tracey McFall:** I agree with what Justina Murray said, and I am very much in support of a levy, too.

**Alison Douglas:** A wide range of organisations support uplifting MUP and the introduction of a levy. The likelihood is that, if you raise the price of MUP, there will be additional profits. It has not been possible to quantify what that translates into profit wise, but it is pretty clear that the producers think that the retailers are making more money, and, in a commonsense analysis, we are buying less alcohol, but we are paying more for it, so the likelihood is that shops are making more money.

There was a public health supplement in Scotland between 2012 and 2015 that applied to large supermarkets who sold both alcohol and tobacco. There has been discussion about whether that might be reintroduced. We would strongly support its reintroduction. It is unfair that shops and supermarkets should profit from minimum unit pricing, but it also unhelpful that it should be more profitable to sell alcohol as that could encourage other shops that currently do not sell alcohol to start selling it.

**Gillian Mackay:** Would witnesses prefer a levy to take the form of a public health supplement or for it to be a social responsibility levy? What should that revenue be put back into?

**Alison Douglas:** I think that everybody on the panel supports an alcohol harms prevention levy, which is a form of the public health supplement, that would apply to retailers who sell alcohol. That would be levied on non-domestic rates as the public health supplement was. A 13p rate would bring in £57 million a year.

We believe that the levy could be used at local level for improving treatment. We have heard that treatment services are inadequate. We have seen a 40 per cent reduction in treatment services over the past 10 years. People in recovery are saying that their recovery groups are struggling financially. Investing at local level in those recovery groups and in support would be extremely helpful, as it would be for preventative activity. Currently, projects at taking place around Scotland involving communities, children and parents that aim to get more sustainable change in alcohol consumption at local level. Investment in those and similar activities would be very welcome.

**Justina Murray:** In relation to drugs, we have the national drugs mission and a huge investment of £250 million over five years as part of that. However, alcohol causes more harm and causes more deaths. It seems to me a very obvious mechanism to use—that is, to identify funds that we could then put into communities, treatment support and recovery services. Doing that would be really important.

**Gillian Mackay:** What would be the total benefit of minimum unit pricing and bringing back the public health supplement or having a social responsibility levy? What would be the impact of the public health benefit of minimum unit pricing—we have seen that make a difference—and the additional revenue going back into treatment and preventative services? What does that whole bundle look like?

**Dr MacGilchrist:** It is a win-win situation, or a win-win-win situation if you like. Perhaps one of the lessons that we have learned compared with when MUP was first introduced, relates to concerns about the effect on dependent drinkers—that 1 per cent of the population—and how we need to support them. Continuing MUP and, I hope, uprating it to an appropriate level, is the ideal time to focus on improving services for treatments. That takes money and resources, so it is a win-win situation to plough that windfall or increased revenue into the public purse and for that to be put into alcohol services.

**Carol Mochan:** I have a short follow-up question for Justina Murray. The alcohol industry often says that it already puts money into funding services. Do you think that the MUP model or the levy model might allow us, in a better way, to put money into public services and use that across Scotland to support the harms that you have spoken about? How do you see that working?

**Justina Murray:** That is preferable for a number of reasons. First of all, it focuses on large-scale retailers, so there is a direct link between how much money is raised and the amount of money that is coming through alcohol sales. There is also local decision-making. Through the levy, money would go back to local areas, and the use of that funding would be community orientated.

We want it to be the case that people in every local area have a choice. Some people will need hospital treatment, but others might want community-based counselling or a recovery community. We also need family support in every area. That lets local communities determine how the funds are spent. In that way, there is not such a direct link to the alcohol industry, which might be trying to get some public relations out of sponsoring a community project and having its branding, for example, on show.

**Carol Mochan:** That is helpful—thank you.

**Paul Sweeney:** Thank you, convener. I want greater clarity on each panellist's view of the benefits of a public health supplement over a social responsibility levy. Ms Douglas, you said

that the public health supplement might be your preference. Are there any other particular views on that distinction?

**Dr MacGilchrist:** I am not a legislator, but I can give you an educated guess as an outsider. We know that the public health supplement is readily implementable and we know that it worked. How easily the social responsibility levy can be implemented and the effect it would have are a bit more uncertain. Because of the practicalities, I would prefer the supplement.

**Paul Sweeney:** Are there any other strong or particular views?

**Tracey McFall:** Yes, I agree with Alastair MacGilchrist. This is about making sure that we look at the easiest option, whatever form it takes. Let us get money to where it needs to be in local communities to reduce the harm that is caused by problematic drinking, and do it in the easiest way possible so that communities can make decisions. In my experience, local communities understand the problems; they have their own solutions, and they can drive those solutions. That is where the money needs to go in the easiest way possible, which would be through the public health supplement approach.

**Justina Murray:** I agree.

**Paul Sweeney:** That is great. You talked about local communities having a degree of democratic oversight of the proceeds of that supplement. Would that money flow to a health and social care partnership, or would it reside with a different organisation?

**Justina Murray:** I will turn to Alison Douglas for the mechanics, but my understanding is there will be local control over spend.

**Alison Douglas:** We have seen with the drugs mission that there was a political commitment to an extra £50 million per year. We would probably like to see that commitment to the public health supplement, which could then be scrutinised by the Parliament. The money would go back to local authorities, which are key partners in the local alcohol and drug partnerships that are used to looking at how best to deploy the money that is available. That is therefore where the decisions should be made.

**Paul Sweeney:** Have you any modelling evidence of what scale the public health supplement could be set at relative to MUP and the overall split price share?

**Alison Douglas:** The Fraser of Allander Institute research that was published yesterday uses a poundage rate that is equivalent to the previous public health supplement of 13 pence in the pound, which would raise total revenue of £57 million across Scotland. It models where the money would come from—local areas—but I do not think that it models how it would be returned to those local areas. The modelling would use a pre-existing formula for local allocations.

**Paul Sweeney:** That is great and very helpful. Thank you.

**Emma Harper:** My question is about your thoughts on alcohol advertising. I read an article in *The Lancet* that basically said that one third of the people on the planet die because of fossil fuels, alcohol, ultra-highly processed food and tobacco. What needs to happen with advertising to reduce the harm from alcohol?

**The Convener:** Can the witnesses please be extremely brief as we have one and a half minutes to go?

**Alison Douglas:** It is abundantly clear from the international evidence that alcohol marketing drives consumption of alcohol. There is a causal link between the exposure of young people and children to alcohol marketing, initiation of drinking, increasing drinking in those who are already drinking and the likelihood of them going on to develop an alcohol problem in the longer term. People in recovery also tell us how alcohol marketing affects their daily lives and risks them maintaining their recovery.

We are all are affected by marketing, frankly. We might think that only other people are affected by marketing, but we see it in all sorts of decisions that we make, and alcohol marketing is part of that because it encourages us to think that alcohol is glamorous, that it is the way that we connect with friends and family, that it is an integral part of our lives, and that it is something that we should be using weekly or daily. However, as we have heard today, alcohol causes immense harm, so tackling marketing has to be part of the wider mix of measures that we take in Scotland.

**The Convener:** Thank you. Sandesh Gulhane has a declaration of interest.

**Sandesh Gulhane:** Thank you, convener, and apologies. I declare an interest as a practising NHS general practitioner.

**The Convener:** Thank you. I thank the witnesses for their attendance today and I suspend the meeting.

10:15

*Meeting suspended.*

10:22

*On resuming—*

**The Convener:** We continue our post-legislative scrutiny of the Alcohol (Minimum Pricing)

(Scotland) Act 2012 with a second panel of witnesses. I welcome to the committee Dr Pete Cheema OBE, who is the chief executive of the Scottish Grocers Federation; Bob Price, who joins us online, is the director and policy adviser of the National Association of Cider Makers; David Richardson, who also joins us online, is the regulatory and commercial affairs director of the Wine and Spirits Trade Association; and Paul Waterson, who is the honorary president and former CEO of the Scottish Licensed Trade Association.

We move straight to questions, and I will kick off. In the earlier evidence session, we heard from alcohol health charities. I will paraphrase slightly here, because I do not have the *Official Report* in front of me. One of the panel members spoke about minimum unit pricing being one of the most scrutinised public health measures that there has been. Previously, there were robust challenges to its introduction from sections of the alcohol industry. To what extent do witnesses contest Public Health Scotland's conclusion that its evaluation of MUP showed strong evidence that the policy had reduced the number of chronic alcohol deaths and hospital admissions? Who would like to start?

**Dr Pete Cheema (Scottish Grocers Federation):** I will kick off. I think that the Covid-19 pandemic and fluctuations in behaviour, particularly in increasing costs in hospitality and online consumption, mitigate really significant skews in any data collected since March 2020.

**The Convener:** Sorry—I did not quite catch that.

**Dr Cheema:** The Covid-19 pandemic and the subsequent fluctuations in behaviour, in particular the increased costs in hospitality and online unlicensed consumption, mitigate any significant skews in data collected since March 2020. It is our view that it is essential that MUP remains at 50p, but I do not think there has been a real opportunity to assess the impacts of the policy because of the pandemic.

**The Convener:** Therefore, you are challenging what Public Health Scotland has said.

**Dr Cheema:** I think that the data is skewed, and we have to assess it for a longer period of time to make sure that the data is correct.

**The Convener:** In what way are you challenging the data, because that is quite a challenge to Public Health Scotland? What evidence do you have?

**Dr Cheema:** We challenge it because, as you will understand, under Covid-19, a lot of stores closed, and people were not allowed to go out and had to stay in. There were behavioural changes that were really quite different to what we are experiencing now and what we normally experience in day-to-day running, so we need to see the data for a longer period of time than the period that was assessed.

**The Convener:** On what scientific or evidential basis are you asking for that?

**Dr Cheema:** Well, the scientific basis in front of you is very clear: there was such a behavioural change during that period that the data has to be skewed.

**The Convener:** So, in essence, the Scottish Grocers Federation does not, on the basis of anecdote, accept Public Health Scotland's evaluation of minimum unit pricing.

**Dr Cheema:** That is right.

**The Convener:** Okay. Thank you.

**Sandesh Gulhane:** I declare an interest as a practising NHS GP.

Can I come back to you, please, Dr Cheema? We looked at Public Health Scotland's modelling—it was modelling, because we all know that the number of deaths has gone up—and saw that it modelled against England. If it had modelled against Wales, we would have seen no difference, which is what Wales has found. If we had modelled against Northern Ireland, we would have seen that MUP exacerbated the number of deaths. Therefore, the way that the data was collected is a bit of a concern. What are your thoughts about that?

**Dr Cheema:** It is very difficult to assess when we have had such unprecedented times, so, in reality, we need a longer period of time to collect data to make sure that everything is correct.

**Sandesh Gulhane:** I turn to the witnesses who are online. I want to look at the eight studies on health outcomes that have been produced by Public Health Scotland. One study showed some changes, but it was clear that dependent drinkers did very badly. Women drinkers also did rather badly. What are your thoughts about that, and how can we help those groups?

**David Richardson (Wine and Spirit Trade Association):** Perhaps I could come in here. Thank you for the opportunity to give evidence to the committee. It is always challenging to challenge data that has been painstakingly collected by a number of different groups over a period of time.

My main point is that the evaluation report that was produced by the University of Sheffield said that there was no significant change in the proportion of drinkers consuming at harmful or moderate levels after the introduction of MUP,

which I think reflects the point that you have just made.

10:30

Our view of how you get to groups that do not do very well under MUP is not to have a population measure or a measure that penalises the moderate responsible drinker, but to have targeted measures.

There are various ways of targeting measures, but the one that we would promote is called community alcohol partnerships, which has a long track record of tackling and reducing underage drinking and does so in collaboration with retailers, regulators and local authorities in the area in which it works. It does not come with alcohol sponsorship badging; it comes with the community alcohol partnership badging. It is a clear programme that has a track record of success in targeting a particular group—underage drinkers. We would very much recommend that sort of targeted response as opposed to population measures.

**Sandesh Gulhane:** We heard from the previous panel members that money has been generated, although we are not sure how much. It could be between £90 million and £200 million over the three years. It is clear that money has been generated from MUP, but who has that money? Where is it physically going? Whose pocket has it ended up in?

**David Richardson:** That is an extremely good question. I am very concerned about that, because what I am hearing from other witnesses and various committees that I have sat on is that people conflate turnover revenue with profit and how much money people have. If prices go up but consumption goes down, it does not automatically follow that turnover goes up. If a retailer's turnover goes up, it does not automatically follow that their profit goes up, because they have other costs such as responding to Covid, the national minimum wage and an energy crisis—I am sure that we could list other costs—all of which affect profit. We do not know what conversations have gone on between retailers, wholesalers and producers of alcoholic products about the price at which retailers get the products in their hands. There is also the issue that, even if some of the increased turnover goes to wholesalers and producers, again, it does not necessarily translate into profit.

I cannot say absolutely to you that nobody has made a profit out of MUP, because I am sure that we could comb through accounts and find somebody who has. However, you would need a lot more evidence about what has happened to people's turnover as a result of MUP and what has happened to profit as a result of that before you could draw any sustainable conclusions about how much money has been made and exactly where it has gone.

**Sandesh Gulhane:** My big concern is that MUP should not be generating profit—that should not be what it does. It should be helping people. It would be very helpful to know where the money is so that we can use it to help the people who need it, especially those who are most dependent on alcohol.

From a retailer's point of view, what else could we be doing to help people who are drinking to harmful levels and dependency? We have spoken about community alcohol partnerships, but what else could we do? In the earlier evidence session, Tracey McFall said that we need a suite of tools, but there do not seem to be any others. We also heard Justina Murray say, "What about everything else?", when it comes to measures to help. Does the industry have some ideas about what else we could be doing?

**David Richardson:** Are you talking specifically about advertising?

**Sandesh Gulhane:** I am talking about anything.

**David Richardson:** There are a lot of measures in terms of industry voluntary codes around marketing. The Portman Group code of practice is well known for challenging and for taking off the shelf products that have a particular appeal to children or that are promoted on the basis that they will make someone a more appealing human being. Those measures are effective and known to work. However, I think that you are looking at a series of voluntary codes and education around responsibility. It is always tempting for a government to legislate, but we would suggest that you can get at least a large part of the result that you want through co-operation and discussion.

**The Convener:** Before we move on, I will declare an interest—thank you for reminding me, Dr Gulhane—in that I am a registered nurse with a bank contract with NHS Greater Glasgow and Clyde. We move to Ivan McKee.

**Ivan McKee:** Good morning. I just want to dig a bit deeper into the question that Dr Gulhane asked about revenue and where it is going. Maybe "concerned" is too strong a word, but I am perplexed as to why we do not have better data. The estimates of the additional revenue that has been flowing into the system range widely, as Dr Gulhane said, from £30-odd million to £300-odd million per year. I thought that the sector would have a better handle on the numbers.

I absolutely take the point that has been made that the whole point is to reduce consumption, so if you double the price but sell half as much, the

revenue does not go up at all. It is quite clearly possible that there has not been any extra revenue, but it could be quite significant, based on those numbers.

As was rightly said, the profit calculation is even more complicated because of the various layers within the supply chain and what they charge each other. Again, common sense says that if you are selling less, the unit price and the cost of producing, distributing and selling will increase.

I am just throwing this out there. Does anybody on the panel have any reliable data that we can talk about and put on the record about money that has additionally been coming through retailers and where it may have ended up?

**Paul Waterson (Scottish Licensed Trade Association):** Getting data from supermarkets must be one of the hardest things to do. We had the public health supplement a number of years ago, which added 13p, depending on rateable values, and was meant to be used, I think, for the same purpose. It was stopped after a couple of years: I do not know why. The supplement kicked in at rateable value of over £300,000; it was targeted at supermarkets, which paid that money. I think that over the three years of its lifespan it raised about £95 million. There is money there. That £300,000 ceiling could be brought down to £100,000, which would still protect smaller shops. The supermarkets should be targeted. Such a thing was in place previously and there are figures relating to that.

**Ivan McKee:** With respect, I say that that is very different to what we are talking about. That was a tax that raised a revenue. You are right that there is data on that, but there is no data specifically on the additional revenue that has flowed through retailers and up the supply chain directly as a consequence of MUP.

**Paul Waterson:** I get that, but it is a model that has been used before, and we know what the figures are. Is there more profit? We will never know, will we? It is as simple as that. You will never get the data because the supermarkets used alcohol as a loss leader for years, and are now using something else.

**Ivan McKee:** There are four industry experts in the room. I was hoping that one of you at least might have some data. Does anyone else want to comment?

**David Richardson:** It is genuinely very hard to get that data. Let us take a product that was previously sold below MUP and is now subject to MUP. You can see what happens to the volumes of that product. You do not necessarily know if some customers for that product trade up to a different product or keep buying the same product. It becomes quite hard, therefore, to associate activity with the measure that is in place. In a more general sense, I think that the challenge that MUP faces is causation versus association.

As for industry data, you can get the published accounts of supermarkets quite easily through Companies House, but I am afraid that you will not get data that drills down into management accounts to see how lines have performed, and how lines have competed against or worked with one another. Supermarkets and brand owners are not going to give that information to us, as a trade association.

**Ivan McKee:** Okay. I will leave it there, but I find it strange, having been in business, that people whose day job it is to know such numbers do not have a perspective on the matter.

I will move on to talk about uprating. The SGF's submission comments that you did not think there was any reason to increase the 50 per cent rate because wage inflation had not kept pace with price inflation. I am not sure how true that is according to recent wage inflation data, but does it mean that you would be comfortable with an increase that reflected wage inflation rather than price inflation, and that it is the inflation calculation that you are disputing rather than the concept of uprating?

**Dr Cheema:** I think that what is important is that our industry has suffered quite a lot. We have a cost of living crisis. We have not had the same rates relief as our English and Welsh counterparts, despite the Scottish Government having been given the £568 million in Barnett consequentials, which has never been passed on to the retail, convenience or hospitality sectors, so we are at a considerable disadvantage. We all know about the rates of inflation and interest, and we are also aware of the increased costs that we have to incur.

I want to go back to what you asked about where all the profit is going. No business takes just one sector into account. Profits are determined from the overall basket spend in the store. You must also remember that convenience stores are now, for the very first time, able to play on a level playing field with supermarkets, which could traditionally reduce the price of alcohol to encourage footfall. Putting that to one side, we honestly believe that the MUP should stay at the current level and that it should not be increased, because first, we do not have the proper data and secondly, there are, in the federation's view, no specific data to show why it should be increased because there is currently no correlation saying that an increase in MUP will reduce the number of deaths from alcohol.

That said, if you are going to increase the MUP we should be given a minimum of 12 months to

react and to adjust prices throughout the supply chain and prices of the stock that we hold, to replace shelf-edge and in-store labelling and to reprogramme tills, payments systems, formulas and so on. That is where the federation stands.

**Ivan McKee:** This is my final question. Again, I am quite perplexed. In effect, this is an opportunity for retailers, convenience stores and grocers to increase prices without increasing costs. I am not clear about why you see the increase as such an economic challenge, unless you can answer the earlier question and unpick who is charging who more, and what data is telling you about reduced revenue and profits, if that is the consequence.

10:45

**Dr Cheema:** Look, I think I answered that question quite adequately just a few moments ago. What I do not understand about this line of questioning is this. Is "profit" such a rude word for business? Are we not here to make a profit? Are we all here to make a loss so that there is no business? Why do you want to destroy a business—Scotch whisky and so forth—that is so highly regarded in the world? Why do you want to destroy something like that if it is doing well? We should be commended if our industry in Scotland is doing well. We should be encouraging that sector, not saying, "No, we want to absolutely destroy it. It's making too much profit, so we should be reducing it." Is that the way the economic world works, in your eyes?

**Ivan McKee:** You are asking the wrong person. I was in business for 30 years before I came into politics, and have run a lot of very profitable businesses.

**Dr Cheema:** That is why I am asking you the question.

**Ivan McKee:** The question I am asking you is about—

**The Convener:** Dr Cheema, you, not committee members, are here to answer the questions.

**Ivan McKee:** The question that I am asking is about basic economics. If somebody had said to me, when I was running a business, "You have the opportunity to increase prices without increasing costs", I would have seen that as positive, not negative. I am trying to understand why you see it as an economic challenge rather than an economic opportunity.

**Dr Cheema:** It is because our stores are embedded in communities. We know each and every one of our customers. If people are drinking too much, we try to discourage those people from drinking, which is the essence of MUP. We know the issues; we know the problems. Our stores are the first ports of call, and you must remember that during the Covid-19 pandemic, our stores were considered to be the fourth emergency service.

**David Torrance:** I have just a quick supplementary question. I find it odd that from everybody who is represented here, nobody can tell me where the profit went.

Everybody who sells alcohol needs an operating plan. I spent the last few weeks going through Fife Council's licensing papers and new applications. The majority of them, especially from small grocers, were for extensions for sales of alcohol. So, you tell me—if they were not making a profit, would they be extending the areas for selling alcohol? So, bigger retailers and smaller grocers are getting their profits. You could go through the licensing papers and check that in every local authority. I would bet that the number of people who are putting in for extensions to sell alcohol shows that they are making greater profit from it.

**Dr Cheema:** Convenience retailers offer a wide range of services. To remain viable, they have to share the additional costs of being a smaller business across their products and services. A reduction in the viability of one product area means there will have to be increases elsewhere across the range, which ultimately adds to inflation and to the cost of living crisis for customers. We do not want it to be the case that Mrs Smith cannot enjoy her Saturday night tipple.

**David Torrance:** Is it not the case that you would expand the area to sell a particular good if you are making greater profit from it?

**Dr Cheema:** I cannot really comment on one area in Fife where people may have applied for additional licensing.

**David Torrance:** The number of applications to extend areas to sell alcohol was over several licensing boards, which shows that those shops are making greater profit from alcohol, because they would not change an area if sales—

**Dr Cheema:** Could it not be because of the fact that convenience stores are finding it very difficult to sell dry goods—for example, foods—because of the increase in the numbers of supermarkets and discounters? So, they might be trying to decrease areas for selling those products. Could it not be that convenience retailers see that expanding the areas for alcohol is the only viable opportunity for them to make a profit?

**David Torrance:** I would argue against that. The small paper shop that I go to every day does not sell alcohol at all. It has been there for 20 years and is very successful.

**Dr Cheema:** There are different types of stores. There have traditionally been newspaper stores that sold nothing but newspapers, magazines and sweets. Some have always sold alcohol. There

are different types of stores and that is always going to be the case—there will always be different types of businesses.

**David Richardson:** I want to go back to Mr McKee's earlier point about the opportunity to increase prices without increasing costs and whether that is a good thing for retailers. I argue that it is not necessarily so because, first, increasing prices might not attract customers and, secondly, it is not just the cost to the retailer that matters; the cost to the rest of the supply chain also matters.

If there is consumer resistance to a particular product, producers might want to look at how to repackage or reformulate it to change the alcohol by volume. We saw in the first year of implementation of MUP that costs to industry increased generally across the supply chain because of what people had to achieve to deliver MUP. In fairness, that became business as usual and MUP became more or less embedded. However, it is not a cost-free exercise.

**Ivan McKee:** If I may, I will come back on that very briefly, convener.

You are absolutely right, and of course I understand that those are all factors. The point that I am trying to make is that we have already established through earlier questions that you do not have the data to understand where the revenue and the profit are, where they are flowing up and down the supply chain and what the impact on volume and revenue has been. Without that data to back it up, I am struggling to understand how such a strong case is being made that this is a bad thing for retailers. It may well be a good thing, depending on exactly what the numbers are that nobody seems to know.

**Bob Price (National Association of Cider Makers):** Can I come in at this point, please? I represent the National Association of Cider Makers. Cider is not a mainstream product in Scotland. At the moment, only 10 per cent of the cider that is made in the UK makes its way to Scotland; England is by far the largest market.

Since MUP was introduced, the data that we have has pointedly shown that cider sales in Scotland have fallen by 60 per cent. The sales of strong cider, which was the principal target of MUP in the first place, have dropped by 82 per cent. At the end of the day, there is very little strong cider—anything above 5.5 per cent alcohol by volume—being sold. Sales of mainstream cider—4.5 to 5.5 per cent ABV—have also fallen, by 33 per cent.

From the cider makers' point of view, no money at all is being made in Scotland. There is a residual market that is being fed by companies, but it is a market that is in serious decline and almost being put out of existence in Scotland. No profit or revenue is being made in Scotland by our industry.

**Ivan McKee:** Thank you very much for the helpful data points. Can you clarify whether that is by value or volume?

**Bob Price:** Volume.

**Ivan McKee:** Right. So the reduction in value will not be as dramatic, because the price will have more than doubled in many cases. Thank you very much for that data.

**Paul Sweeney:** Clearly, the impact on retail revenue is difficult to ascertain given the lack of data that has just been described by panel members. We have also just heard from the representative of the Association of Cider Makers. I am keen to understand more about the secondary impacts on manufacturing. Is there any evidence from brewers and distillers that the feared consequences for their industries following the introduction of MUP have come about, such as reduced revenues for manufacturers or the discontinuation of certain products? Can the panellists point to any specific instances of effects on firms or products?

**The Convener:** No one? I think that that answers your question.

**Paul Sweeney:** That is fine.

Is there any indication that minimum unit pricing has contributed to a levelling of the playing field for the on-trade and the off-trade? In particular, has there been any benefit to the on-trade?

**Paul Waterson:** The whole point of MUP was to see the Government getting involved in pricing, which was revolutionary. The relationship between low prices, and increased consumption and potential misuse is as obvious as it is dangerous.

If we go back a while, after the Licensing (Scotland) Act 1976 was passed there was an explosion in the number of licences for the on and off-trades, but towards the end of the 1980s and through the 1990s, we saw a lot of irresponsible promotions and so on from the on-trade—happy hours, drinking games and so on—which made people drink more and faster than they would normally. The SLTA was very clear when we moved towards the 2006 act that we had to do something about that. Extra competition was forcing prices down and that was leading to alcohol abuse, so we had to try to stop those drinks promotions. We managed to get those promotions stopped and we do not see them now at all in the on-trade, but little did we know that another group would be around to exploit that—supermarkets.

If you are chasing profit, it should not be achieved at any cost. We are licensed for a very good reason. Trends will come and go, and supermarkets will come and go, but one thing remains constant, and that is that alcohol is potentially dangerous and must be respected. When you are giving alcohol away, you are making no profit out of it but are using it as a loss leader to get people into stores to make a profit from other things. That is fine for some goods but not for licensed products, because it creates abuse. Eventually, the Scottish Government of the day decided that it should stop some of the promotions for alcohol in supermarkets and other shops, but it could not be prescriptive enough, because supermarkets kept getting around it. That is why we needed MUP, to bring standards up again among those who were not taking their responsibilities seriously—we have already heard about that this morning. For them, it was profit and nothing else; there was no responsibility and no adherence to licensing laws. If they did not like the licensing laws, supermarkets would challenge them, and they would challenge their local boards and usually win.

How did we do it? We did it through minimum unit pricing, which I think was the right way to go. We have supported MUP for many years. The legislation on MUP must be one of the most scrutinised acts that we have ever had in this country. I might be wrong about that but, certainly, there have been 40-odd studies looking at every aspect of it—taking into account Covid—in tremendous detail, and those studies have shown that MUP has been very positive. The SLTA is very clear that we support minimum unit pricing and have always done so.

Looking at the current level of MUP, I think that we should be have some sort of mechanism for putting the level up, or down, if it is not proportionate to the problem—that is why it was brought in: to be proportionate to the problem. Certainly, we support the level going up, but we think that the decision about what the level should be left to others.

**Paul Sweeney:** You mentioned the public health supplement, which was introduced and then discontinued. Do you support its reintroduction?

11:00

**Paul Waterson:** Absolutely. My problem with that is how the money raised can be hived off for what it is intended for. How do we make sure that it is ring fenced? It is very difficult to ring fence money if it is given back out to councils. How are they going to use it? We all know that councils are strapped for cash. Certainly, however, we would protecting smaller shops below a certain rateable value. One way of looking at it would be to have a ceiling of about £100,000, and anything with a rateable value above £100,000 should pay the supplement.

**David Torrance:** The previous witnesses and all the charities dealing with alcohol-related diseases and problems have called for an alcohol levy, as there was until 2015. I ask each of you to say whether you are in favour of the alcohol levy and for the money raised by it to be put back into the organisations that support people with alcohol addictions and their families and so on.

**Paul Waterson:** We would support it if we could guarantee that it was used for that purpose and that it applied to the off-trade for rateable values over £100,000. We would certainly support it. The public health supplement made—what was it?—£95 million over two years. I am sure that that would not make that big a dent in supermarkets' profits.

**David Torrance:** Are the other witnesses in favour of an alcohol levy?

**David Richardson:** I am very much in favour of targeted measures to help people who need help. I am not convinced that a levy—an extra business tax—is necessarily the right way to go about it when more can probably be done through voluntary and co-operative measures.

**Dr Cheema:** It is a very difficult question, but our view would be much the same as Paul Waterson's: we support it as long as the convenience sector is protected. That is very important, because we have been fairly disadvantaged to date. If that money is ring fenced for that purpose and we are protected, I have no problem with it at all.

**Bob Price:** If you imposed a levy on the cider industry, you would be applying it to manufacturers. Manufacturers are getting no benefit whatsoever from MUP, so you would just be taking more money away from manufacturers, which have already lost money through MUP. Pricing is the prerogative of retailers, not manufacturers. Manufacturers are not allowed to set selling prices; only retailers can do that. You would just be taking extra money that we have not been able to get from the marketplace, so I cannot see that that achieves any benefit other than driving the industry out of Scotland.

**David Torrance:** Just to give an example, Diageo, which is located in my constituency and Jenny Gilruth's constituency, made £4.6 billion in profit alone last year from its alcohol sales. I know that both Paul Waterson and Dr Cheema have agreed that, if a levy were targeted, they could go there. Mr Price and Mr Richardson, do you think that the taxpayer should pay for all the damage that alcohol causes and for all the costs of the NHS and the various treatments and charities?

Should businesses not contribute something back that would be targeted to help?

**Paul Waterson:** You know the answer to that is that all businesses pay taxes and that the on-trade in Scotland pays exorbitant rates.

We could be talking about two different things. The SLTA would like to see the same model as the public health supplement, which was very much for the off-trade; it was very much about supermarkets and protecting the smaller operators. It was not for producers—I do not see the relationship there. At the time it was introduced, it was identifying where the problems stemmed from. The vast majority of alcohol in this country—you might have heard these figures previously—is sold by about seven or eight operators. It appears to me that, if you have a problem with alcohol, and you know who the seven or eight operators are who are the most responsible for selling it and who are always trying to keep the price down so that they can sell more, it is quite simple to say who should be targeted—it should be the supermarkets.

The supermarkets caused a lot of the problems by having ridiculously low prices, not adhering to the licensing acts and not being under the moral obligations that licence holders should be under. Supermarkets caused a lot of the alcohol problems in this country. Knowing that and knowing where the problems are coming from, I think that the levy should be on those businesses, not the smaller operators or pubs that are severely bounded by licensing in who they can sell to, when they can sell, the age of the buyers, and all the other licensing restrictions that we rightly have. It should not be the smaller operators, the pubs or the bars, or the hotels and restaurants that pay any levy; it should be those who are mainly responsible for causing the problems in the first place and, to a certain extent, keeping them going. We know who is selling the most alcohol.

**David Torrance:** Thank you for that.

**Sandesh Gulhane:** I was speaking to a small business owner—a retailer—who told me that, when she sells alcohol, she listens to the conversations that are going on. She does that because she knows that—I will name the brand—Dragon Soop is very popular with children because of how sweet it is, and that parents are buying it for their kids. When she hears a parent calling their kid to ask which one they want, she refuses to sell it to them. That diminishes her profits, but she does it because she feels that it is the right thing to do. Therefore, convenience stores do a lot of good in this area.

When we are looking at ways of raising money via a levy or at using the money that is generated by MUP—we have agreed that we do not know where that money is; perhaps we need to find out where it is—would it not be useful to consider putting that money back into education, palpable brief interventions and targeted help for people in order to reduce harms?

**Dr Cheema:** I mentioned in my opening remarks that convenience stores are embedded in society, and we know our customers. When we see outright abuse of alcohol, we try to stop it. I think that you have made that point quite adequately. As far as responsible retailing is concerned, we are there. It was the SGF that introduced challenge 25 almost 30 years ago. That has now been implemented across the UK.

We have supported the Scottish Government with MUP, and we are glad that it has levelled the playing field. As Paul Waterson neatly explained, it was the large supermarkets that were causing the issues. They were the ones that were selling alcohol, at times, for the same price as water, which caused problems. The introduction of MUP at 50p was very much warranted, and our sector has welcomed it.

The SGF has always emphasised the importance of education over everything—it is absolutely key. However, given the rising costs in our industry and our sector, we would find it very difficult to contribute any further. I think that the question of where the money will come from is one for the Scottish Government to take on.

**Sandesh Gulhane:** Do you think that we should have the supermarkets appear before us so that we can ask them similar questions?

**Paul Waterson:** I hope that you get an answer out of them. That is very difficult.

Mr McKee talked about getting data. I do not think that it is a job for any of us to get that data. I know that the Scottish Government has tried to get it in the past but has not been able to. Yes, the supermarkets should come before the committee to answer for themselves on what they have done over the past number of years—of course, we should remember that they were open when businesses such as ours were closed because of Covid and their profits went through the roof, for want of a better phrase.

If we could ring fence the money—which is very difficult to do—it might help groups that have not been helped as much through MUP, such as people who are suffering from alcoholism, which is a scourge; fundamentally, it is a health problem. If it would help those groups, we should do that, but as I have said before, it is difficult to ring fence the money. The Government would have to come up with a way of making sure that that money was spent on alcohol problems for the groups that, as one of the studies shows, have not been helped by MUP.

**Emma Harper:** Good morning. I want to pick up on what Dr Pete Cheema said about education being the way forward. I have been looking at the work of Henry Dimbleby and Chris van Tulleken on the problems that are caused by ultra-processed foods and how education is not the only answer, because we need to tackle stigma and to support people to lose weight.

In relation to alcohol dependence, what opportunities are there for supermarkets—I am thinking of the big ones that are not here today—to change their model of selling to one that is similar to what goes on in Ireland, for instance, where there are shop-inside-the-shop off-licences? Would that give us an opportunity to look at how we support people?

**Paul Waterson:** The shop-inside-the-shop model was how alcohol used to be sold. At the time, Alcohol Focus Scotland said—I think it was AFS, although I could be wrong—that, as soon as alcohol was moved into the main store, sales increased by 40 per cent. We have always advocated going back to the shop-within-a-shop model. We see that model in other countries—for example, in America, where the supermarkets in many states can sell only beer and wine, not spirits.

Going back to that model would be a way forward that would allow more control. It might also help us to get more data because, in that model, the data on alcohol sales went through a different till. That might help us to get more data on the amount of alcohol that is sold.

**Emma Harper:** The issue is not just one of education. For example, we had to introduce laws on the wearing of seat belts in cars in order to get people to wear them. Should regulation not be part of the process of tackling alcohol harm in Scotland?

11:15

**Dr Cheema:** The SGF runs two very successful programmes on behalf of the Scottish Government: the Healthy Living Programme, which we have been running since 2004; and the go local programme, which is now in its fourth or fifth year. Those programmes have been very successful.

Education is definitely the way forward. The SGF is part of the Scottish Alcohol Industry Partnership, and we have been involved in the community alcohol partnerships. It is interesting that the supermarkets do not seem to get involved. If you tried to hive off alcohol into a different section of the shop in convenience stores, that would involve additional costs that some of them would not be able to swallow, and it would put them out of business. I am sure that the Scottish Government would not want to see that happening, but if that model was implemented in the larger supermarkets—let us face it; they have huge sections—it might well help. However, in small convenience stores, having to adopt that model would simply put them out of business.

**Gillian Mackay:** So far, in talking about a public health levy, we have focused on the big retailers and rateable values. However, in some communities, small shops might be the only ones there, and they will sell alcohol to the community around them. Given that, as you correctly identified, it is the amount that people drink that causes them harm, what is your view on a public health levy being linked to the volume of sales—and, therefore, the harm that a shop might be doing to the community around it—rather than the rateable value of premises?

**Paul Waterson:** It is a matter of being pragmatic, getting the data and finding out who is selling the most. That is a difficult thing to find out. The easiest way to impose a levy would probably be through rateable values. That would protect the smaller shops, which I do not think cause the problems here. If the rateable value of premises that had to pay the levy was set at £100,000, that would take the smaller shops out of it; they would not have to pay the levy.

The levy could be applied on a sales volume basis, but it is very difficult to get the figures on volume and who is selling the most. In the smaller villages where there are no supermarkets, the convenience store owners know everyone. In their involvement in the sale of alcohol, they take their responsibilities seriously. They simply would not sell if they thought that there was a big problem there. Pete Cheema will know that better than I do.

**Dr Cheema:** Alcohol accounts for just under 16 per cent of total sales in convenience stores. I think that that is important. We must also remember that convenience stores are the hubs of their communities.

**Gillian Mackay:** Is 16 per cent the average?

**Dr Cheema:** Yes, it is the average proportion of the total basket spend. Therefore, alcohol is not the biggest segment.

It is important to remember that convenience stores sell a range of services on top: Post Office services, which do not make money; the lottery, which does not make money; payment services, which do not make money; and ATMs, which do not make money. Most of those services are sold at a loss, and most of them are simply not available in supermarkets. If they are available, there is a cost implementation. We have all seen the huge problems that our sector has faced in running post offices. As you can probably imagine, their larger counterparts focus only on those

products that make them a profit. As Paul Waterson said, the only way to impose a levy on them is through rateable value.

**The Convener:** I want to check the figure that you mentioned. You said that alcohol accounts for 16 per cent of sales in convenience stores, on average—

**Dr Cheema:** Just under 16 per cent.

**The Convener:** Does that take into account every other service or every other item that is sold?

**Dr Cheema:** It does not include services; it relates only to products.

**The Convener:** So things such as cigarettes, tobacco and newspapers are included.

**Dr Cheema:** Yes. Groceries, chilled products and fruit and vegetables are all included.

**The Convener:** Mr Torrance wants to come in. You must be very brief, because we need to finish.

**David Torrance:** Does that average figure include convenience stores that do not sell alcohol? Does it cover every convenience store in Scotland?

**Dr Cheema:** It covers convenience stores that sell alcohol.

**David Torrance:** Okay. Thank you.

**Ivan McKee:** I have a brief question about that data point of 16 per cent. Has that number gone up or gone down since the introduction of MUP?

**Dr Cheema:** That is a very good question, and I do not know the answer.

**The Convener:** Perhaps you could write to the committee to clarify that.

**Dr Cheema:** Sure.

**The Convener:** Thank you.

**Dr Cheema:** What I can supply you with is a survey that we conducted—I can leave the report here.

**The Convener:** The easiest way to do that would be through email correspondence with the clerks.

I thank our witnesses for joining us today. At our meeting on 20 February, we will hear from participants in the committee's recent informal engagement as part of its post-legislative scrutiny of the Social Care (Self-directed Support) (Scotland) Act 2013.

That concludes the public part of our meeting.

11:20

*Meeting continued in private until 12:18.*

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