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Health, Social Care and Sport Committee

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Session 6

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HEALTH, SOCIAL CARE AND SPORT COMMITTEE

10th 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:

Orlando Heijmer-Mason (Scottish Government)
Christina McKelvie (Minister for Drugs and Alcohol Policy)
Katherine Myant (Scottish Government)
James Wilson (Scottish Government)

CLERK TO THE COMMITTEE

Alex Bruce

LOCATION

The Sir Alexander Fleming Room (CR3)

Scottish Parliament

Health, Social Care and Sport Committee

Tuesday 26 March 2024

[The Convener opened the meeting at 09:17]

Decisions on Taking Business in Private

The Convener (Clare Haughey): Good morning, and welcome to the 10th meeting in 2024 of the Health, Social Care and Sport Committee. I have received no apologies.

Agenda item 1 is to decide whether to take items 5 and 6 in private and whether to consider in private at future meetings a draft report on the Abortion Services (Safe Access Zones) (Scotland) Bill. Do members agree to take those items in private?

Members *indicated agreement.*

Subordinate Legislation

Alcohol (Minimum Pricing) (Scotland) Act 2012 (Continuation) Order 2024 [Draft]

Alcohol (Minimum Price per Unit) (Scotland) Amendment Order 2024 [Draft]

09:18

The Convener: Agenda item 2 is consideration of two draft affirmative instruments, the first of which is the draft Alcohol (Minimum Pricing) (Scotland) Act 2012 (Continuation) Order 2024. The purpose of the order is to continue the effect of minimum unit pricing provisions that were inserted into the Licensing (Scotland) Act 2005 by the Alcohol (Minimum Pricing) (Scotland) Act 2012. In the absence of this order, those provisions would expire.

The policy note states that minimum unit pricing has had a positive impact on tackling alcohol-related harms in Scotland and should be continued, as evidence suggests that, if MUP were no longer in effect, alcohol consumption would increase, contrary to the policy aim of reducing alcohol-related harm.

The second instrument is the draft Alcohol (Minimum Price per Unit) (Scotland) Amendment Order 2024. The purpose of the instrument is to increase the minimum unit price, which is currently set at 50p per unit, to 65p per unit. The policy note states that evidence has found that MUP at 50p per unit has had a positive impact on health outcomes in Scotland and that, in order to derive greater health benefits, the current level should be raised to 65p per unit. I also note that the Delegated Powers and Law Reform Committee considered the instruments at its meeting on 27 February 2024 and made no recommendations in relation to them.

We will now have an evidence session on the instruments with the Minister for Drugs and Alcohol Policy and supporting officials. Once our questions have been answered, we will proceed to a formal debate on the motions.

I welcome to the committee Christina McKelvie, Minister for Drugs and Alcohol Policy and from the Scottish Government: Orlando Heijmer-Mason, drugs policy division; Katherine Myant, health and social care analysis; and James Wilson, population, health strategy and improvement. I invite the minister to make a brief opening statement.

The Minister for Drugs and Alcohol Policy (Christina McKelvie): Good morning, convener and colleagues. I am pleased to be in front of the

committee today to discuss minimum unit pricing and the two draft orders that were laid on 19 February. The Alcohol (Minimum Pricing) (Scotland) Act 2012 (Continuation) Order 2024 seeks to continue the effect of the minimum unit pricing provisions beyond the initial six-year period, while the Alcohol (Minimum Price per Unit) (Scotland) Amendment Order 2024 seeks to change the level from 50p per unit to 65p per unit.

Scotland is facing a growing burden of disease over the next 20 years. Non-communicable diseases are the leading cause of death and ill health in Scotland, and alcohol is one of the key contributors in that respect.

Committee members will know that, in September 2023, the Scottish Government published its report on the effect of minimum unit pricing in its first five years of operation. That report drew heavily on the studies included in Public Health Scotland's comprehensive evaluation of the policy, which was commended by internationally renowned public health experts, including Professor Sir Michael Marmot and Professor Sally Casswell. Public Health Scotland estimated that, over the study period, minimum unit pricing reduced alcohol-attributable deaths by 13.4 per cent—or 156 people a year—and was likely to have reduced hospital admissions that were wholly attributable to alcohol by 4.1 per cent, compared with what would have happened had minimum unit pricing not been in place.

Alongside consideration of the impact of minimum unit pricing, the Scottish Government undertook a review of the price per unit. The decision to lay regulations increasing the price per unit to 65p is underpinned by modelling carried out by the University of Sheffield. Its research suggests that, to maintain the value of the price per unit and, therefore, to continue to achieve the public health benefits at a level estimated by Public Health Scotland in the evaluation, the minimum unit price should be increased to at least 60p.

However, it is clear that Scotland is continuing to experience significant levels of alcohol harm, and as a result, the Scottish Government is proposing to increase the price per unit to 65p in order to further increase our policy's public health benefits. I expect—and the University of Sheffield's modelling predicts—that implementing the increase will save additional lives.

I know that some people do not agree with minimum unit pricing, but we have considered their concerns in reaching our position. At round-table meetings that were held in 2023, many business stakeholders told us that implementing any price change quickly might be difficult. That was echoed by the regulatory review group, which recommended that a six-month implementation period would be necessary to allow business to prepare for a price increase. I am pleased to say that we have listened and, should Parliament agree to increase the minimum unit price, it will be implemented from 30 September 2024.

I am clear that minimum unit pricing is a vital part of the Scottish Government's approach to tackling alcohol-related harm. However, it is not a silver bullet; no single intervention on issues as complex as alcohol harm would be. For a start, according to some findings in the Public Health Scotland evaluation, it was clear that some who were alcohol dependent had experienced additional challenges linked to the price of alcohol increasing. I know that specialist support and treatment are vital for those people, so, to that end, the Scottish Government has provided record funding of £112 million this year for Scotland's alcohol and drug partnerships. That funding supports the critical delivery of services to those affected by alcohol dependency, including outreach, psychosocial counselling, in-patient and community alcohol detox, access to medication, alcohol brief interventions, alcohol hospital liaison and alcohol-related cognitive testing.

In addition, residential rehabilitation offers programmes that aim to support individuals to attain an alcohol or drug-free lifestyle. Public Health Scotland's most recent interim report, which was published in December last year, showed that, of the 386 ADP-approved residential rehab placements, almost half—48 per cent—were for people with problematic alcohol use and 20 per cent were for people with both alcohol and drug issues. Moreover, in 2023-24, the Government provided £13 million in funding through the Corra Foundation in support of a range of projects helping those with substance addiction issues, including alcohol dependency, into treatment and recovery.

Minimum unit pricing is an important part of our approach to reducing alcohol harm and improving the health and wellbeing of our population. The decision to continue minimum unit pricing and to increase the price per unit to 65p will show that Scotland continues to be world leading in our policies to improve the health of people in Scotland. That position was recently supported by more than 80 third sector organisations, senior clinicians and leading public health academics from Scotland, the rest of the United Kingdom and further afield.

Convener, I look forward to discussing the issue further with you this morning, and I welcome questions from you and your colleagues.

The Convener: Thank you, minister, for that opening statement. As it has pre-empted what was going to be my first question, I will move on to my next.

You touched on claims from certain stakeholders that the conclusions that Public Health Scotland had reached in its evaluation of MUP were

"selective, biased, misleading or flawed."

How would you counter that? How would you respond to those claims?

Christina McKelvie: As I have said, not everybody agrees with minimum unit pricing, but Public Health Scotland's evaluation, the work that we have done, and the 80 organisations, including those at the front line, and individuals that I have mentioned tell a very different story.

In a letter to *The Lancet*, a number of leading public health officials, including Professors Michael Marmot and Sally Casswell, said:

"The concentration of the decrease in mortality in the lowest income groups is particularly welcome, as a narrowing of health inequalities was one of the key intentions of the policy and it has been achieved."

I know that some people do not agree with minimum unit pricing, but, as I have said, the professional judgment and experience of front-line organisations and people with lived and living experience tell a very different story. They see the value of minimum unit pricing, and they support its continuation and uprating.

The Convener: Thank you for that. I should also place on record a reference to my entry in the register of members' interests as a registered mental health nurse with a current bank contract with NHS Greater Glasgow and Clyde.

Briefly, one of the initial aims of MUP was to decrease the sales of high-alcohol-by-volume products, particularly strong ciders and so on. Has the Government done any research on whether there has been an impact on the sales of those products?

Christina McKelvie: Last week, I met the industry partnership group to discuss further proposals and how we might work together on the issue, which is something that I am very committed to doing. According to some of the analysis, particularly that carried out by academics and Public Health Scotland, there has been a definitive drop in the use of some of those more highly-potent and very cheap ciders and similar types of alcohol.

That has been particularly the case among young people—that is, those under the age of 25. According to the health and wellbeing survey done in schools, the numbers of young people who would access that type of cheap high-alcohol product are declining quite quickly. At the time of the original debates on minimum unit pricing, it was called "pocket-money alcohol"; it is not that now. If there has been any impact on the industry at all, it has been on cider producers in Scotland, who are experiencing a real decline in the sale of that type of alcohol.

The Convener: Has there been an impact on the sales of other products, such as whisky and other spirits?

Christina McKelvie: According to our analysis, there seems to have been no impact on that type of alcohol, because its unit price in the off-trade was already well in excess of 65p, while the unit price in the on-trade sits at about an average of £2.04. We have not seen any impact on the off-trade. In any case, the policy was targeted not at that sort of product, but at the high-alcohol, low-price products that were available. We have not seen an impact on those other products at all.

The Convener: Tess White has a supplementary question.

09:30

Tess White (North East Scotland) (Con): The Public Health Scotland evaluation of MUP is riddled with holes, as are the Scottish Government's conclusions about its effectiveness. That is not my view; the Law Society of Scotland said:

"In our view, the study does not provide enough evidence that the introduction of MUP 'saved lives'",

and other stakeholders in the Scottish Government's consultation described the evaluation as

"selective, biased, misleading or flawed".

In your opinion, and ahead of the expiry of the sunset clause, how does that square with the robust evaluation that former health secretary Nicola Sturgeon promised during the parliamentary passage of the bill in 2012?

Christina McKelvie: I do not agree with that characterisation of the evaluation. The Scottish Government tasked Public Health Scotland with undertaking an independent evaluation of minimum unit pricing. There were two overarching evaluation questions. The first was:

"To what extent has implementing MUP in Scotland contributed to reducing alcohol-related health and social harms?"

and the second was:

"Are some people and businesses more affected (positively or negatively) than others?"

The evaluation plan for minimum unit pricing contains a portfolio of studies that were either undertaken by Public Health Scotland or which PHS commissioned external research bodies to undertake and which, through open procurement processes, were separately funded and led by

academic partners. A slew of information was taken into account and Public Health Scotland took a theory-based approach to the evaluation of minimum unit pricing, its implementation, compliance, the alcohol market, alcohol consumption and alcohol harms.

The outcome of the Public Health Scotland evaluation is that minimum unit pricing is estimated to have cut alcohol consumption and deaths attributable to alcohol and that it is likely to have reduced hospital admissions that were wholly attributable to alcohol. The evaluation of minimum unit pricing also told us that it reduced health inequalities, the biggest reduction being seen in the impacts on men and on people living in the 40 per cent most deprived areas.

I would argue that Public Health Scotland took a robust approach. There are people out there who do not agree with the policy and who will have a different opinion, which is absolutely fine. My opinion is based on the work that Public Health Scotland and the University of Sheffield have done for us and on the work of organisations working on the front line—including those made up of people with lived and living experience—who have seen the benefit of minimum unit pricing in the past few years.

Sandesh Gulhane (Glasgow) (Con): I declare my interest as a national health service general practitioner.

Minister, you spoke about underage drinkers. Can you point me to the evidence that shows that MUP has reduced underage drinking?

Christina McKelvie: There has been a pretty marked impact on underage drinking. We should look at that in more detail, because it surely demonstrates the benefits of doing the health and wellbeing survey with children at school, which is where some of the data came from.

The Health Behaviour in School-aged Children survey—all those things have big, long names—showed that levels of drunkenness in children aged 15

"have declined steadily and are now at their lowest in 32 years".

Some of the data has been picked up by curriculum for excellence work in schools and some comes from specific projects.

Sandesh Gulhane: Are you specifically saying that MUP has led to a decrease in underage drinking? That was my question.

Christina McKelvie: The Public Health Scotland evaluation did not find that and did not go into that detail, but the Health Behaviour in School-aged Children survey did. That gave us some additional information about young people, as did some of the evidence taken through the health and wellbeing strand of the curriculum for excellence. Some organisations are also doing work within schools. I was recently at Craigroyston community high school, which has worked very closely with Fearless, the youth wing of Crimestoppers, to look at ways in which young people can seek advice and get support, should they or their friends embark on hazardous drinking or drug use. That has allowed children to get the support that they need at that age, and they are taking that up.

Sandesh Gulhane: I am sure that that is the case, but the quote that you used was about underage drinking and Public Health Scotland said that it has found no evidence that MUP has reduced underage drinking. Is that correct?

Christina McKelvie: Public Health Scotland has said that, yes.

Carol Mochan (South Scotland) (Lab): Thank you, minister, for your opening statement. I am interested in some of the other measurements that we might look at around MUP. We have seen strong evidence and reports about how MUP impacts on health harms and affects the industry, but have you received any views or seen any evidence on some of the other indicators, both positive and negative, in relation to whether MUP helps to reduce crime and other social harms? Is there any evidence to suggest that people have moved to other addictive substances? Is there a need for more evidence in that area, or could you point us to some?

Christina McKelvie: There are a couple of things there. Public Health Scotland's analysis showed that the biggest impact was on men and on people in the 40 per cent most deprived areas. We should interrogate that piece of work further, so that is where I will go with that.

The other thing is the impact on women. We have seen different impacts on women, because women generally drink things that are above 65p or 50p per unit, so we need to do a bit more work in relation to them. Anecdotally, when I visited the Craigmillar project last week, I heard that many organisations—such as the Bothy, which deals with drugs and alcohol—have set up women's groups to look at the particular barriers that women face.

One of those barriers is stigma. The work that Professor Alan Miller is doing with the national collaborative on a rights-based approach to the issue is considering some of those intersections, which are sometimes the deepest when they overlap with other things. There are areas that we are working on where we are thinking about women in particular. I hear things anecdotally, but we need the evidence to back that up. I know that

the analysis has a much deeper, more detailed understanding.

Katherine Myant (Scottish Government): As the minister has said, the Public Health Scotland evaluation took a theory-based approach. One of the things that it did was to look at any potential unintended consequences of minimum unit pricing, which included the impact of minimum unit pricing on crime, which Carol Mochan has mentioned, on road traffic accidents and on switching to higher-strength alcohol or illicit substances.

The analysis did not find any really consistent evidence of minimum unit pricing having an impact on those things, with the exception of some negative impacts on dependent drinkers—particularly dependent drinkers on a low income—who had perhaps, on occasion, switched, and who had maybe not been able to buy food because of the increase in the price of alcohol. However, those occasions were few and quite difficult to attribute to MUP.

Christina McKelvie: The thing is that dependent drinkers were never the focus of this policy; the focus was always on the people who drink at harmful and hazardous levels. As I said in my opening remarks, dependent drinkers need a much more nuanced detailed approach; some of the work that we are doing around treatment and how to access it has been pretty successful, but it is still worth looking at that issue.

Carol, did you ask me about drug use and whether people might be changing to—

Carol Mochan: Yes, it had been suggested that that might happen, but there is some evidence—

Christina McKelvie: The front-line organisations that support people had that worry, but it has not materialised. They have been pretty open; I think that they have said in evidence to the committee in the past few weeks that they have not seen that happen.

Public Health Scotland found no evidence that people started to use drugs because of the increased price of alcohol. However, it was considering the group that drinks at harmful and hazardous levels and, as I said, a different approach is being taken to the work around dependent drinkers.

Carol Mochan: To be clear, as this is an important policy that we will be voting on, is the Government confident that it worked in the area that it should have worked in and is the Government committed to looking at some of the evidence around the issue and any work that we need to do in that other area?

Christina McKelvie: We are not committing to a huge Public Health Scotland review such as the one that we have just done. However, I am committed to reviewing the areas that we feel need a bit more focus, which is why I am focusing on dependent drinkers and women, and some of the other challenges that other people have had around the matter. The commitment is to keep the issue under review. The work of the committee is incredibly helpful in informing our work and challenging us on where we should be looking, and I welcome that.

Ivan McKee (Glasgow Provan) (SNP): Good morning, minister. I have a brief supplementary question following on from the conversation around Sandesh Gulhane's question. With regard to underage drinkers and the effect of MUP, I absolutely agree that, anecdotally, there seems to be a lot less alcohol consumption among people in that age group these days, whether that is due to MUP or other factors. I understand that we might not know why that is.

Has any work been done to analyse whether trends in Scotland on the reduction in consumption of alcohol among young people are significantly different to trends in the rest of the United Kingdom? That might point to policy choices here making more of an impact. That would be interesting data, if it is available.

Christina McKelvie: We have analysed that cross-border comparison of what is happening here compared with other parts of not just the whole of England, but England and Wales and parts of England. You may have seen the letter that the committee received from the Association of Directors of Public Health of north-east England about its analysis on the issue. There is always work that we can continue to do in the area. We have not fully realised the impact of Covid, so we still have a bit of work to do on the impact of Covid, and that will play out as we move forward.

I have a son who will not even put processed food in his body, never mind alcohol, and I know a lot of families who are like that. We are looking at the under-25 age group but that does not mean that we are taking the focus off problematic and harmful drinking in younger age groups. That is why the health and wellbeing study of 15-year-olds is incredibly important; that gives us real-time information and data on how we can target that focus. That is why organisations such as Crimestoppers, the GIVIT and others are working in schools. The education part of the issue is incredibly important.

Ivan McKee: To be clear, I assume that data is available on alcohol consumption rates in Scotland versus the rest of the UK. What does that show for young people?

Katherine Myant: The Health Behaviour in School-aged Children survey is a multicountry

survey, so we can compare Scotland with other countries. Those trends are also observed in other countries. I am not sure of the extent to which Scotland is showing a greater decline than other countries. As the minister said, it is not something that we attribute to minimum unit pricing. There are other interventions and things happening in schools.

Emma Harper (South Scotland) (SNP): Thank you for being here this morning. I am interested in how the pandemic impacted alcohol consumption. I have a wee brief in front of me from Alcohol Focus Scotland, which talks about 156 lives being saved and 499 hospital admissions being averted per year, on average. Did the pandemic impact on the data that was being measured by Public Health Scotland?

Christina McKelvie: Public Health Scotland took information from a range of sources. Some of those studies—seven or eight, I think—included analysis of the Covid years. We can get you more detail of the deep analysis of that via Public Health Scotland. Are you talking about the blog?

Emma Harper: I think that it is from there.

Christina McKelvie: Yes. I spotted that as well. I spotted that coming over the airwaves and had a good look at it. Although we realise that harmful drinking increased during the Covid pandemic, we have still not been able to completely analyse that and understand what it means for recovery going forward. That includes an uptick in people suggesting that they have increased their drinking habits; that was mostly among people in the harmful and hazardous category who are now looking for ways to reduce their drinking. We need to keep doing work in that area.

We are nowhere near understanding the impact of Covid on many things, never mind social isolation and loneliness, and some people may become more alcohol dependent to escape that social isolation and loneliness. We treat social isolation and loneliness as a public health issue—indeed, as a public health emergency. Looking at the data that has come through, about eight of the studies had information that included the Covid years, and we can get you much more detailed analysis on that.

Katherine Myant has been much embedded in all of that work, and she will be able to pick up on that.

09:45

Katherine Myant: There are two parts to your question, Ms Harper. The first is about the impact of Covid on people's drinking habits and what we might expect for the future. The other is about whether Covid impacted on the evaluation.

To reiterate what the minister has said about drinking habits during Covid, it is still early days, and data takes a while to come through, so we do not fully understand the impacts, but the data that we have shows that consumption changed during the pandemic and became more polarised. People who were already drinking a lot were drinking even more, and people who did not drink a lot were drinking even less. As part of the price review work that the University of Sheffield did for us on the modelling, it considered what might happen over the next 20 years with health harms caused by changes in drinking patterns. Even in the most optimistic scenario—even if drinking patterns go right back to pre-pandemic levels, which we do not know yet—it is expected that increased health harms will be caused by the pandemic and the drinking during that time. That gives us further impetus to do more work in this area.

On the second part of the question, on whether the pandemic impacted on the evaluation and the ability to evaluate minimum unit pricing properly, Public Health Scotland adjusted for Covid where it had an impact. As the minister said, only eight of the 40 papers included data collected during the pandemic. The method that Public Health Scotland used in many of its studies was to compare Scotland with England. As the pandemic was also obviously happening in England, that acted as a sort of control. We are confident that Covid did not interfere with the ability of the evaluation to determine the impact of MUP.

The Convener: We move to questions from Paul Sweeney, who joins us remotely.

Paul Sweeney (Glasgow) (Lab): I want to ask a question about the discussion in the 2018 study. There was a business and regulatory impact assessment—a BRIA—on price elasticity of demand, which found that alcohol is generally quite an inelastic product; in other words, as price increases, consumer behaviour does not change very much. Basically, that means that a rent is created that flows to the retailer or vendor of the product at the expense of the consumer. It was observed that there were points where the price becomes more elastic, such as with off-trade cider. We have seen evidence of some of the particularly potent ciders reducing in popularity as a result of minimum unit pricing.

The most recent study by Public Health Scotland did not seem to address the analysis around price elasticity of demand. Might the minister or her colleagues be able to narrate what they have found in that regard? I know that the University of Sheffield model found that heavier drinkers were more responsive to price change. Nonetheless, people with alcohol dependence are more likely to continue to consume alcohol,

although they will perhaps find themselves in a more financially distressed position as a result.

Christina McKelvie: That is a smashing question—thank you so much. Mr Sweeney and the committee will be keen to know that we have published an up-to-date BRIA, which goes into some depth. I had been in the job for only about three days when my lovely officials presented me with a 70-page document to work my way through. It goes into some detail, and we are happy to make it available to the committee.

Mr Sweeney is right to say that the elasticity in prices has impacted on high-alcohol, low-price products. People who are involved in the cider market will tell you that their market has collapsed in Scotland—although not too much, we would argue. That has been where some of the biggest impact of MUP has been noticed from a business point of view.

We take the World Health Organization's approach in relation to accessibility and availability and how to tackle those. Setting a minimum price is one of the tools that the World Health Organization suggests that we use. That goes along with the work of Public Health Scotland and the University of Sheffield, and our commitment to on-going review. We will keep the issue under review, because we want to ensure that we are being as responsive as possible.

Work was done on analysing the price point that the MUP should be set at, and researchers at the University of Sheffield thought that it should be set at around 60p or 62p. Tying that in with inflation and all of those issues, we felt that 65p would be the level at which the MUP would create the circumstances to drive down some of the sales, and to drive down hazardous and harmful drinking.

We have taken all those things into account, including the World Health Organization's recommendations.

Paul Sweeney: That is helpful. Have there been any reports back from the on-trade? I know that, in the Sheffield model, an elasticity was observed in spirits being traded in on-trade bars relative to beer. Was that feedback that came from the industry? Did it observe a change in on-trade consumer behaviour?

Christina McKelvie: You have stumped me there, Mr Sweeney. I do not have information on the comparison between spirits and beer in my head or in my folder. However, we can certainly look at the analysis that has been done and provide the committee with an update on that. If that information exists, we will get it to you.

Paul Sweeney: That is helpful.

I noted from the 2018 study the estimated impact on consumer spending of a minimum unit price of 50p. The study highlighted that, on average, there would be a small impact for the consumer, especially moderate drinkers, but the largest impact would be on those who were most likely to buy the products that were liable to be affected—basically, people who were on low incomes who drank at harmful levels. The study also indicated that the dynamic of minimum unit pricing was to transfer income from individual consumers who were problematic drinkers who were perhaps in poverty to retailers. Has the Government made any effort to look at ways to mitigate the effect of that on the household income of those consumers, whether through money advice or targeted interventions?

Christina McKelvie: The BRIA has additional details about the impact on the industry. You have hit the nail on the head on the reason for taking this approach. Minimum unit pricing is only one tool. People are experiencing an impact not just because of minimum unit pricing; the cost of living crisis is having an impact on everyone. Additional support is being given to ADPs. This year, record funding of £112 million is being provided, and we have made a commitment to provide £250 million over the whole parliamentary session—in other words, for the next two years. All those supports are contained within that.

One way in which we approach the matter is through a whole-family approach. That involves looking at some of the challenges that people have in their lives—homelessness, debt and all of that. All that advice is factored into the supports, and that approach has proven to be incredibly supportive and helpful for people who are in the categories that Paul Sweeney has mentioned.

I refer members to the managed alcohol programme that has been undertaken in Glasgow with the Simon Community Scotland, particularly with people who are homeless. I can make available to the committee a wonderful case study that involves a particular individual who has taken part in the Simon Community's pilot project. That individual is now in a supported tenancy. They have had income maximisation work done because they were not claiming anything and they did not know that they were entitled to anything, and they have had all the other social supports that they need. That includes the ability to access other types of therapy and support that they need. That person has now become a peer mentor.

Members can see the real benefit of taking a whole-family or person-centred approach. We are really interested in the outcome of the Simon Community's pilot, particularly for a very vulnerable cohort of our population who are involved in harmful use of alcohol, who are unemployed and homeless, and who have very little family support. That is the person-centred

aspect. The other aspect is the whole-family approach, which involves looking at what the family as a whole is entitled to and where we can engage with families to ensure that they get holistic support.

We all understand that approaching one issue with one response will never work in these circumstances, so it has to be a whole-family approach. That is where the third sector, the charity sector, our ADPs and all the professionals who are working in this field become incredibly important, as they enable us to take a multi-agency approach with such individuals.

Paul Sweeney: It is important that you have highlighted those examples of interventions that are showing promise. Are you engaged with local integration joint boards and health and social care partnerships to highlight the fact that, given the potential financial pressures that they face in the coming financial year, they should not take decisions that might undermine or impact on those programmes, which target support at people who are facing such problems?

Christina McKelvie: Yes, most definitely. I think that I have been in this role for about eight weeks. I have tried to continue with as much of Elena Whitham's diary as possible to maintain continuity and to ensure that the regular things still happen with the regular people. At the same time, I have also tried to learn the portfolio and to engage with some of the key stakeholders. I have done quite a lot of work on that over the past few weeks. We have held a number of round-table events and have engaged in other ways of gathering evidence from stakeholders.

One issue that arises time and again is a worry about IJBs. When the First Minister appointed me to this post, he told me that my budget is protected, which, I must say, is a very privileged place to be in at any level of Government. Over the next weeks and months, I have planned events to discuss with IJBs and boards how that money should be spent. I am absolutely clear that the money that is coming from my budget for ADPs and for front-line services through IJBs and boards is to be spent on those subjects. I will make that clear when I meet them. Circumstances are tough for everybody right now, and I want to be as supportive as possible, but I am absolutely clear that that money is to be spent where we have agreed that it should be spent.

Paul Sweeney: I am conscious of the need not to try the convener's patience, but I just want to ask—

The Convener: We need to move on, Mr Sweeney, because lots of other members are keen to ask questions. I call Sandesh Gulhane.

Sandesh Gulhane: Minister, you said that dependent drinkers were never the focus of the policy. Is that your position?

Christina McKelvie: The minimum unit pricing policy was always about hazardous and harmful drinking. We always knew that a nuanced different approach, along with additional support, would be needed for dependent drinkers.

Sandesh Gulhane: When the Scottish Government was in court, one of the things that the lord ordinary said was:

> "In contrast, minimum alcohol pricing will ... target the really problematic drinking to which the Government's objectives were always directed".

To me, that sounds like dependent drinkers.

Christina McKelvie: It depends on how you define "problematic", does it not?

Sandesh Gulhane: The reference was to "really problematic" drinking.

Christina McKelvie: I would define problematic drinking as hazardous drinking, and that is the focus of this work. MUP impacts on dependent drinkers as well, but there has always been a clear understanding that that group of people, who are more vulnerable and more stigmatised, need a nuanced and more detailed support structure around them. That is the work that we are doing.

I said in my opening remarks that MUP is not a silver bullet; it is not the answer for everyone. However, it gives some of the answers for most people, and we have developed other answers for some of those other people as well.

Sandesh Gulhane: You referred to problematic drinkers. We could certainly have a discussion about what that means. However, "really problematic drinking"—which is the term that was used in the court's findings—goes further than that, does it not?

Christina McKelvie: In the court's findings?

Sandesh Gulhane: In the court's summary.

Christina McKelvie: In the summary—so, not in the findings.

Sandesh Gulhane: In the court's summary judgment.

Christina McKelvie: My approach is that MUP is to target all drinkers, but we know that dependent drinkers need a different and more nuanced supportive approach.

Sandesh Gulhane: So, the Scottish Government's position in court was that the policy was to target all drinkers.

Christina McKelvie: Public Health Scotland's analysis over the past six years has demonstrated

to us that it is much more nuanced than that, so our approach is to ensure that that support is in place.

10:00

Sandesh Gulhane: I am sorry, minister, but, in court, the Scottish Government's position was that the policy was meant to target all drinkers. Is that right?

Christina McKelvie: Yes.

Sandesh Gulhane: Okay.

On problematic drinking, we heard from Paul Sweeney that dependent drinkers are spending more money on alcohol; indeed, they are often choosing to spend money on alcohol instead of on heating their homes or eating. In Glasgow and Edinburgh, the money for drug and alcohol treatments has been cut. How does that square with your objective of trying to help those people?

Orlando Heijmer-Mason (Scottish Government): Could you clarify which financial year you are talking about?

Sandesh Gulhane: Going forwards.

Orlando Heijmer-Mason: Well, we have not seen a cut yet, but there are such proposals. We discuss the spending patterns of ADPs and health and social care partnerships closely with them, and that spending is in the power of local areas, in order to respond to local need. However, the minister was clear in her answer just now that the investment that goes to ADPs is earmarked for that purpose, and her expectation is clear that it is spent on that. I am sure that she will be able to say that the level of investment in ADPs is at record levels.

Sandesh Gulhane: So, should we expect to see a reversal of the proposals in Glasgow and Edinburgh?

Orlando Heijmer-Mason: You should ask Glasgow and Edinburgh about that.

Sandesh Gulhane: I am sorry; I did not catch that.

Orlando Heijmer-Mason: Those are decisions for Edinburgh and Glasgow, but we are clear in our discussions with Edinburgh and Glasgow that we expect the money to be spent for the purposes for which we give them the money.

Sandesh Gulhane: The proposed cut will surely harm dependent drinkers, because they will not be able to be helped in the same way by treatment services, and we know that MUP is causing them problems. How can we ensure that dependent drinkers get the help that they need as part of what you said was a nuanced approach?

Christina McKelvie: For clarity, are you talking about the 2023-24 budget and the 2024-25 budget?

Sandesh Gulhane: Yes.

Christina McKelvie: Are you talking about proposed cuts to ADPs?

Sandesh Gulhane: I am talking about cuts to drug and alcohol services.

Christina McKelvie: I am absolutely clear that the budget that we have provided for ADPs—which has gone up this year to a record amount—should be spent on ADPs. If I have to go as far as to give a direction, it will be that that money should be spent on ADPs and the work that they have to do, including the detailed work that they do with dependent drinkers. That ties into Mr Sweeney's question about my contact with IJBs and boards with regard to the work that they are doing, because this is a shared responsibility across health and social care. However, my direction is that that money is to be spent on ADPs and the work that they do on the front line.

Emma Harper: I want to return to the issue of the targeting of minimum unit pricing. I know that some people have said that it is a flagship policy and a silver bullet—you referred to that view earlier—but I am keen to clarify how we support the most vulnerable people in society. The north-east of England branch of the Association of Directors of Public Health sent us a letter, in which it said:

"we need similarly proactive and enlightened public health policies to reduce alcohol harm and protect the most vulnerable in our communities."

So, the public health experts in the north-east of England support the action that has been taken in Scotland, because their region has similar levels of alcohol harm to that which we see in Scotland. Can you say more about how minimum unit pricing is designed to target a specific group and is not just a silver bullet for everybody?

Christina McKelvie: The policy has never been a silver bullet, and it has never existed in isolation as the only thing that we are doing. The paragraph that jumped out at me in the letter from the north-east of England branch of the Association of Directors of Public Health concerned the proportionately higher positive health impacts on people who experience the deepest health inequalities.

The letter said:

"The positive health impact of the policy, compared to what would have happened without MUP, can be seen both in annual death statistics before the pandemic struck, and when comparing the rise in alcohol deaths in Scotland to England, since. In the first full year after MUP was implemented, there was a 10% reduction in alcohol-specific

deaths and a small reduction in hospital admissions from liver disease."

One of the key areas is the high incidence of liver disease in Scotland and how we can tackle that to reduce the harms.

The letter went on to say:

"Changing drinking habits during the pandemic, combined with reduced access to services, led to a tragic rise in alcohol-specific deaths in Scotland between 2019 and 2021".

We recognise that and are focusing work on it. However, the letter went on to say:

"this was substantially lower than the rise experienced in England and particularly the rise in the North East".

The north-east of England branch of the association analysed the difference between not having minimum unit pricing in England, including in the north of England, and having it in Scotland and came to the conclusion that, in its professional judgment, minimum unit pricing targeted the areas where the biggest inequalities were, particularly in relation to hospital admissions and deaths. On the 156 lives that are saved, if one of those people was in your family, they would be a precious person. All 156 of those people continue to be precious.

Earlier, I made points in response to the question about the impact on women and other groups. I want to pick up and look at that, too.

Emma Harper: I forgot to remind everybody that I am a registered nurse and a former liver transplant nurse.

David Torrance (Kirkcaldy) (SNP): What evidence led the Scottish Government to conclude that going above a unit price of 65p would be too high for Scotland? Some people would argue that, if we increased the price above 65p per unit, that would decrease the harm from alcohol and reduce deaths.

Christina McKelvie: I will bring in Katherine Myant to give the detail on the analysis and decision making, because that happened before I was in post. I do not have the benefit of hindsight and of remembering that, but Katherine was immersed in it, so she can give you a much more detailed answer.

Katherine Myant: In order to come to a decision on the price and to inform that work, we commissioned the University of Sheffield alcohol research group to do some modelling for us. That modelling looked at the impact of new price points on alcohol-related health harms and on the industry. We were looking for a balance: we wanted to be able to see the impact that we want on health harms—to save lives and reduce hospital admissions—but to be careful about the impact on industry.

The figure of 65p was judged to be the right balance and where we would see increased effects. Sorry—this gets a bit complicated, but 50p in 2019 would be 60p today, due to inflation. We wanted to go a little further than that and see increased benefits for health, so 65p was judged to be the point at which we saw the benefits for health and did not interfere too much with industry.

James Wilson (Scottish Government): There is a point about targeting the policy on alcohol that is cheap relative to strength. The further we raise the unit price, the clearer it is that we start to affect types of alcohol that might not reasonably be defined as that, so we start to drift away from the policy intention.

David Torrance: I have no further questions, convener, because, in her opening statement, the minister answered the ones that I was going to ask.

The Convener: Thank you, Mr Torrance. We will go back to Paul Sweeney for a supplementary.

Paul Sweeney: We discussed earlier some of the challenges about financing public services, particularly those that are targeted at harm reduction in communities through integration joint boards and so on. We discussed the dynamics of minimum unit pricing as being basically a rent for private sector retailers, which creates an extra income for them. That juxtaposition jars with me. I realise that there are policy limitations, but is the Government looking at opportunities to capture some of the revenue to bolster the public finances?

Christina McKelvie: Mr Sweeney will know that some in the sector have asked the Scottish Government to consider a public health levy, which we have considered in the past. In the most recent budget statement, the Deputy First Minister intimated a willingness to re-look at that.

I go back to the response that Katherine Myant gave to David Torrance about getting the balance right. My conversations with the business sector and the public health sector about getting that balance absolutely correct have become really important.

I do not know whether we will ever be able to negate any negative or positive outcomes on either side of the argument, but the commitment is to review whether a public health levy is something that we should consider. We are at the very early stages of that—it was announced only a few weeks ago, in the budget. In future weeks and months, I would be happy to give the committee an update on that work and on our intentions.

As you will know, we consulted on marketing last year. Some of the points came through in that consultation. We are committed to doing more of

that work over the next year or so. That is one of the ways in which we will consult with both the industry and the people who are working on the front line to deliver public health measures. I will be happy to update the committee when we have more detail on that.

Paul Sweeney: That is a helpful indication from the minister.

Gillian Mackay (Central Scotland) (Green): Good morning, minister. This is the first time that we have uprated MUP. Due to the length of time between its being introduced and now, some people feel that it is quite a jump. Has the Government considered whether we require legislation for the automatic uprating, or something similar, of minimum unit pricing?

Christina McKelvie: That has been raised with me already over the past few weeks, particularly when the budget statement included a commitment to look again at a public health levy.

You have heard from Katherine Myant about the detailed work that went into setting the uprating at the level that we think will be most effective. Some areas of the sector have asked about having an annual uprating, for instance, and I am committed to looking at that. That piece of work is at an early stage—we have not developed it much further than making that commitment, but it will be valuable to consider whether we can set an annual uprating into legislation at a future date. We are at the very early stages, but I really want to look into that. The work of the committee and the work and understanding of the sector will be really helpful in that. There may come a time when regular uprating is included in legislation.

Gillian Mackay: I appreciate that that work is at an early stage, but have the minister and the Government considered how that approach would work in practice? Would it be linked to an inflationary index or some other index? Would there be an implementation period, as there is this year, between the uprating being announced and the change on the shelves, to reflect the call from industry and businesses that they need that time in order to make the changes?

Christina McKelvie: To be absolutely honest, I am open-minded about how to do it. We are looking at many ways in which we can tackle it. Every official in the department has different experience, so they come with all that information as well. We will look at whether inflation is the right measure; then we will have an argument about whether it should be the consumer price index or the retail price index. We will work that out.

My mind is open, and you are absolutely right about giving businesses the opportunity to be ready. We listened to their calls. If the uprating to 65p goes through, it will be September before that is implemented. That is the amount of time that businesses thought that they needed. Some people were looking for 12 months, which was stretching it a wee bit; we think that six months is time enough. If it becomes a regular thing, that opportunity will be there.

You will know that the First Minister set a new deal with business. That is why, just last week, I met the alcohol business partnership group to talk about some of its concerns and challenges. I am trying to take as balanced a view as possible. I am not here to make life more difficult for our producers. We have a world-leading food and drinks industry. Its global impact is huge. I would not want to diminish any of that, but we have to get the balance right.

Gillian Mackay: Recently, inflation has been much higher than it has been at other times. The impact of the uprating of minimum unit pricing will depend on the economic outlook. I am also quite interested in how we put lived and living experience, which has been so important the whole way through, at the heart of any analysis of uprating. Obviously, we are speaking in hypotheticals, but, if there is ever a case for making that uprating higher, for good reason, that experience, which has been so integral and useful so far, must be put at the heart of what we do.

10:15

Christina McKelvie: I am a policy person who does not make policy without ensuring that the people who will be impacted by the policy are sitting at the table. That is the approach that I have taken in all my ministerial and parliamentary roles. Even in my past professional life, I did not make any policy decisions without such people sitting at the table, because their lived and living experience is absolutely key.

My answer to your first question—that I am open-minded—is the exact answer to your question about the process of uprating. Inflation might be a crude measure for doing it, given the economic impacts that we have had—a sharp inflation rise and then a drop in inflation. Therefore, that might not be the measure that we use.

As I said, my mind is open, and, if colleagues on the committee have ideas on how we can do it, please let me know. I am keen to work with the Parliament, stakeholders and across the Government to ensure that we get it right.

Tess White: Minister, I have a question about uprating, but I would like to go back to harmful drinking. If you remember, the bill's financial memorandum emphasised that minimum pricing would

"reduce the consumption of alcohol by harmful drinkers".

However, if we look at the facts, we see a 25 per cent increase in the number of alcohol-related deaths over the past three years alone and, over the past 10 years, the number of people accessing alcohol treatment services has gone down by 40 per cent. Do you agree that harmful and hazardous drinkers are the ones who need the greatest help?

Christina McKelvie: Straight off, that is a yes—obviously. Public Health Scotland's evaluation found that the evidence points to minimum unit pricing having a

"positive impact on health outcomes"

for harmful and hazardous drinking, and the work that we have done on that is incredibly detailed. My answer is yes—those people need the most support.

The point that you made about a 40 per cent drop in the number of people accessing services has confounded us, and we are doing a bit of work to understand why it has happened. This is anecdotal, but, from conversations that I have been having across the board, I know that there are particular groups of people who, because of stigma, will not access services, which is why Professor Alan Miller and lots of organisations are doing work on stigma. Women are pretty significant in that category, which is why I am looking at the impact of minimum unit pricing on women and at the support that they need.

I am concerned that, if people with an alcohol dependency are shunned socially in the way that people who have a drug dependency are, it will be much more difficult for them to come forward for treatment. We are taking a public health approach to the issue because we hope to create circumstances in which people feel confident about coming for treatment.

As I said, we are a bit confounded by the 40 per cent drop, and we are doing detailed work to analyse it and try to understand how to pivot services to address it. Orlando Heijmer-Mason has been really involved in that work, so he can give you more detail.

Tess White: Earlier, you said that the MUP will impact all drinkers. However, it will hit social drinkers, in particular, in their shopping basket. Rather than the MUP targeting harmful drinking, it will hit everybody in the social drinker group.

Christina McKelvie: Due to the cost of living crisis, it is really difficult to know whether that is completely accurate. Some of the biggest impacts on people right now are from the cost of living crisis and its impact on their shopping bills, their energy bills and everything else in their life, so it is a bit more nuanced than just this one approach. There are other influences on the issues that people are facing, and the cost of living crisis is a huge one.

Tess White: Do you recognise that there are massively differing opinions on the issue? Many people think that, rather than being a silver bullet, MUP is a blunt instrument with massive holes in it.

Christina McKelvie: Others argue the complete opposite. Even in the consultation, the ideas and understanding that were expressed were pretty polarised.

I take to heart the expertise of Public Health Scotland, the University of Sheffield, front-line workers and public health directors in the work that I must do to make a difference, rather than listening to people who might be sitting on the sidelines criticising the policy without any real idea about how to approach it themselves.

I reiterate that I do not believe that this is a silver bullet—no one is saying that it is a silver bullet, because it is not. It is just one of the tools that we have in the box for tackling the issues that we face.

Tess White: We will talk later about uprating. Public Health Scotland agrees that the data was based on modelling, rather than actual statistics.

Katherine Myant: Public Health Scotland conducted a number of studies that estimated the impacts that would have happened if minimum unit pricing had not been in place.

Tess White: You are confirming that that was modelling, not statistics.

I will go back to the uprating question. Minister, you talked about whether we might use RPI or CPI in the future. Do you intend to come back to Parliament when there is a review so that there can be a robust analysis that is based on facts, not modelling?

Christina McKelvie: I think that all analysis should be taken into account. Modelling is a recommended and respected way of getting the information that we need to tackle societal issues and move policy forward. I would not underestimate the impact of the modelling work that has been done by the University of Sheffield and Public Health Scotland. I take your point about data and facts, because we all face issues with getting information.

You asked about coming back to Parliament. As I said to Gillian Mackay, my mind is completely open regarding uprating. We are working right now on some of the information about the best way to do that. I will bring that back to the committee if that is what members wish and I am also happy to come to Parliament with that. I suspect that

another change to legislation would be needed, so we would have to go through that process anyway.

Tess White: Let me check that, minister. You are open-minded about coming back to the committee, hopefully when you have some facts rather than models, which would be a good opportunity to come and have another review and to discuss and debate the policy.

Christina McKelvie: I am happy to come back when I have considered all the evidence, including facts and modelling.

Ivan McKee: I have some specific questions, but I just want to go back to a couple of things about facts and modelling, so that we can get your responses on the record. It is my understanding that the analysis has been based on facts and statistics but also addresses a counterfactual, because of other variables in the mix. It would therefore be incorrect to say that it is not based on facts. Is that the correct analysis?

Katherine Myant: Yes. The statistics and data on alcohol-specific deaths and hospital admissions are impacted by a huge number of different factors across society. We have already talked about Covid and the cost of living crisis, which are two things that have happened since the implementation of MUP. Public Health Scotland needed to find a way of disentangling all of that in order to get down to the impact of minimum unit pricing, and it did so by comparing Scotland with a counterfactual—in this case, with England, which has a similar culture and economy and has also been through the pandemic and the cost of living crisis. When Public Health Scotland looked at the differences, it concluded that minimum unit pricing had led to a decrease in alcohol-specific deaths and that it was likely to have led to a decrease in hospitalisations, too.

That data was put together with all the other work that Public Health Scotland did. The evaluation comprised a huge portfolio of studies on different aspects of a theory of change; it looked, for example, at compliance with minimum unit pricing, at what happened to the price of alcohol and at consumption, and it found all aspects of that theory of change to be met. There was compliance with minimum unit pricing, the price of alcohol increased and consumption decreased. That helped increase confidence that the decrease in alcohol-specific deaths and hospitalisations was due to the impact of MUP.

Ivan McKee: So, the data is based on facts, with a robust statistical analysis to isolate the different variables.

Christina McKelvie: Yes. That was recognised in the letter to *The Lancet* from Professors Michael Marmot and Sally Casswell, who said:

> "This summary of research on minimum unit pricing is comprehensive, including interviews with individuals who fear the policy will be detrimental to them personally or financially. The Public Health Scotland approach of emphasising population-level findings is the right one for assessing population-level interventions, such as minimum unit pricing."

They were absolutely clear about the value of that analysis.

Ivan McKee: Thank you.

Moving on to the second point that I want to touch on, I wonder whether you will clarify something for me. Maybe I missed this, but I want to be clear about it. As far as uprating is concerned, your options are to come back in a year—or in two or three years—with a similar process to the one that we are in today, and talk about the next hike, or to put in place a process for automatic uprating. Would primary legislation be required for the latter? What would need to be done legislatively to prevent you from having to come back every year or two to work through the process again?

James Wilson: As we explore things, we will need to look at what the right approach is. Clearly, if it is to be automatic, we will take legal advice on that. There is an opportunity to uprate through regulations, as we have done in this case. I think that we would be keen to continue to explore with a wide range of people and the committee what the right approach is, and then come back to the committee with a clear plan.

Ivan McKee: I am just trying to identify the process here. If you decided to put it up each year by, say, the retail prices index or the consumer prices index, that would require a change to primary legislation. Is that correct? Would that require an amendment to the act?

James Wilson: We could amend the regulations. There is a range of things that we could do. The uprating process now allows us to lay an order—

Ivan McKee: Okay, so that would also be an automatic process.

James Wilson: It depends on what you mean by automatic, I suppose—

Ivan McKee: "Automatic" means that you would not have to come back here every year and argue for another 5p or 10p. It would just happen.

James Wilson: We will take legal advice on that as we move forward but, at the moment, there is a wide range of options.

Christina McKelvie: We will look for the best option that will allow Parliament to scrutinise any decisions that are made, but also ensure that we can continue the policy's benefits.

Ivan McKee: Of course, we are talking about increasing the price, but the reality is that we are just standing still. A decision not to increase it is, in real money, a decision to reduce it. It is important to recognise that.

Christina McKelvie: Yes. The modelling found that inflation would take it from 50p up to 60p or 62p, and we decided on 65p, which takes it one level further. We also looked at modelling for 70p and other prices per unit, but we felt that 65p gave us the right balance between the impact on industry and the impact on public health.

Ivan McKee: And that view was based on the situation in 2018, not in 2012, when the 50p price was first proposed.

Christina McKelvie: Yes.

Ivan McKee: There has been much higher inflation over that period cumulatively, of course. I will move on, though, as I want to unpick some other things a wee bit.

First, I have a brief question on the time that businesses have to prepare. This is not an exact analogy, but when the chancellor puts up alcohol duty, it happens almost immediately, whereas in this case you are giving businesses quite a lengthy time to prepare. Is that correct?

Christina McKelvie: Yes, absolutely.

Ivan McKee: Next, I want to focus on the points that Paul Sweeney made. The public health supplement applied before minimum unit pricing, so it is important to separate the two; they were not dependent on one another, although they are potentially related. Something that has danced around us in the evidence sessions and that we have struggled to get our arms around is whether retailers or producers have seen an increase in revenues as a consequence of MUP. We heard in evidence from cider producers that there was an increase of 300 per cent or thereabouts in the retail price of their product, but an 80 per cent reduction in the volume of sales. That would suggest that they have seen, perhaps, a 20 per cent reduction—not an increase—in retail revenues, because the reduction in the volume sold has outweighed any increase in price.

Do you have any data on that, other than what we have managed to piece together through that evidence? I would expect His Majesty's Revenue and Customs to have some pretty robust data on that, even if the industry itself is unable to provide us with anything. Do you have data on that so that we can put the issue to bed once and for all?

10:30

James Wilson: At the moment, there is no clear data on that, only anecdotal information. We will follow this up with HMRC, but I am not aware of a clear link between the volume sold and the increase in price. We have a lot of information, but we are keen to continue to consider the differential spread. For instance, producers might be providing a different view to that of retailers on where the revenue is being held in the supply chain.

Christina McKelvie: It is different for different retailers. Those in the off-licence trade—that is, bottle shops—can see the difference pretty clearly, but it has become difficult for supermarkets to separate sales, because people will buy alcohol along with whatever else is in their shopping. That said, HMRC might have some data on that, so we will follow that one up.

Ivan McKee: Having worked in the sector, I know that HMRC keeps a very close watch on how much alcohol people are selling.

Christina McKelvie: It will know, based on the alcohol duty.

Ivan McKee: On the different products, yes. If you get anything, it would be helpful if you could give to us, so that we can put the issue to bed. Do you have any other data on this?

James Wilson: We have access to sales data, but it does not provide information on revenue. It tells us the volume of sales; it does not give the cost of those sales, but it is useful in looking at alcohol purchase rates in Scotland. Public Health Scotland will continue to monitor that as part of its work on alcohol harm and alcohol-related statistics.

Ivan McKee: My concern is that we are all chasing a golden pot of money, when there is a possibility that such a thing does not exist in reality. It would be nice to put the issue to bed once and for all.

Moving on to the public health supplement, you have already indicated that you will have a look at that. Can you say anything more about what you might do in that respect, when you might come back with a perspective on it and who might be impacted? In the past, it was the larger retailers and supermarkets that were impacted.

Christina McKelvie: Yes, they were, but as you have said, that was before MUP. In a recent statement, the Deputy First Minister stated our intention to consider the matter again, and we are now in the very early stages of doing so. Indeed, stakeholder organisations such as Scottish Health Action on Alcohol Problems, Alcohol Focus Scotland and others have called on us to have a look at the issue again, too, and to consider whether we could raise the levy and ring fence the money raised so that it can be spent in those areas.

It is a perfectly reasonable ask, but we need to balance any such move with the impact on business. You have illustrated very clearly the difficulties of measuring the impact of that and how we ensure that we direct any additional money to the places where it needs to go. That is why I said to Gillian Mackay that I am very open minded on the matter.

If, from your experience in the industry, you have anything that you can tell us, please share it with us. I am really keen to work across Parliament and Government to get this right. It might be that getting it right means not having a levy—but it might also mean that there is a levy. In fact, Alcohol Focus Scotland and others have suggested that it should be around 16p. Some ideas are already being suggested, and we will interrogate all of them and factor them into our thinking on how we move forward.

The Convener: I appreciate that we have already gone over time, but I believe that Sandesh Gulhane has a question. If we could have a brief question and a short answer, that would be wonderful.

Sandesh Gulhane: Minister, I want to come back to modelling. When we did our modelling, we were clear that it was an estimate of the number of people that MUP had saved. I want to look at the difference in age-standardised alcohol-specific deaths per 100,000 people in England versus Scotland. In 2006-07, Scotland did better than England in that respect, and that was the case, too, in 2008-09 and 2011-12; in other words, Scotland had reduced the number of alcohol-specific deaths compared to England during those years.

There was no MUP then. In 2018-19, when MUP was brought in, there was still a difference; it was not as good as it was in 2006-07, but there was a reduction in Scotland. In 2019-20, however, England did better than Scotland, and the same thing happened in 2020-21. Can you explain that to me?

Christina McKelvie: That timeline runs over 17 or 18 years—which is a lot of time. In that time, there have been a lot of interventions, and a lot of work has been done to reduce drug and alcohol-related deaths and hospital admissions. We took the decision to continue to implement minimum unit pricing, because we saw the benefit not just in the short term but in the long term. That is why I am committed to continuing the policy and uprating MUP; we can see the definite change that is happening.

Have we been doing this long enough to understand that change at a population level? Probably not. That is why the reviews, the work and the modelling that are being done are incredibly important. Yes, we are talking estimates—but they can be only estimates, because it is a bit more difficult to disentangle health outcomes, particularly with regard to people who do not factor into the death statistics but who factor into the reduction in hazardous and harmful drinking. That is why the modelling and the analysis are being done in the way that they are, and it will also help us understand how we move forward. We want to uprate precisely because the differential has increased and we want to make sure that it increases again.

The director of public health in north-east England says that this policy works, and we can see that it works. We have made the comparison between Scotland and the north-east of England, and its recommendation is minimum unit pricing for England and Wales. That is an important point.

Sandesh Gulhane: You have said that we are seeing the benefit not just in the short term. I know that I am being cheeky asking another question, but would you commit to doing another review in five years?

Christina McKelvie: We will keep the scheme under continuous review. Whether we do a full review in five years will probably be for other people to decide, but my commitment is to keep the scheme under continuous review to ensure that we can be fleet of foot with any changes. For example, we might well see some of the pandemic's impacts playing out over the next couple of years, and we will need to respond to that.

A policy such as this will always benefit from being reviewed. No doubt academics and others out there will be continuously reviewing it anyway, but the Government is committed to reviewing all of this work and will continue to do so.

James Wilson: I will add one thing with regard to Mr Gulhane's earlier question. The Scottish Government's court submission referred to hazardous and harmful drinkers, so when the court was talking about problematic drinkers, it was referring to the submission that we provided. I think that it was taken in that context. I just thought that it would be helpful to note that factual correction for the committee.

The Convener: Item 3 is the formal debate on the instruments on which we have just taken evidence. I remind the committee that officials may not speak in the debate.

The minister will speak to and move motions S6M-12220 and S6M-12221.

Christina McKelvie: I am happy to move the motions. There is not much more to say, other than my key opening remarks that we believe, following the review, that now is the time to

continue with the policy and to uprate the minimum unit price to 65p. I commend both sets of regulations to the committee and hope that it will support them.

I move,

That the Health, Social Care and Sport Committee recommends that the Alcohol (Minimum Pricing) (Scotland) Act 2012 (Continuation) Order 2024 [draft] be approved.

That the Health, Social Care and Sport Committee recommends that the Alcohol (Minimum Price per Unit) (Scotland) Amendment Order 2024 [draft] be approved.

The Convener: Thank you, minister. One member of the committee wishes to speak.

Carol Mochan: I confirm that Scottish Labour supports continuation of the MUP and its uprating to 65p.

We also support Public Health Scotland's work on the issue. As we have heard, the data that has been produced is complicated, but we believe that it is clear that the MUP worked while 50p was an effective price and that lives were saved, as a result. That is undoubtedly significant, and it is only right that we continue the policy and look more at the impacts that an uprated MUP will have on public health. The MUP is, however, not and will never be effective on its own, so I welcome the minister's acknowledgement of that.

In relation to dependent drinkers, as we have discussed this morning, Public Health Scotland concluded that

"There is limited evidence to suggest that MUP was effective in reducing consumption for those people with alcohol dependence. Those with alcohol dependence are a particular subgroup of those who drink at harmful levels and have specific needs. People with alcohol dependence need timely and evidence-based treatment and wider support that addresses the root cause of their dependence."

Scottish Labour supports that statement.

The long-term underfunding of alcohol and drug partnerships, the cutbacks to health services and council budgets, and the real-terms cuts to investment in this year's budget suggest that the Government could become overreliant on MUP as a unitary method of tackling alcohol harm. That will not work—experts tell us as much—so I hope that the Government will now outline what further commitment it will make to services that offer support in our communities. We believe that we cannot continue MUP for much longer without ensuring that the profit that it creates for larger companies is reinvested in publicly funded public health initiatives. We feel that that is only right, and we would seek to work with colleagues to achieve that.

The continuation of MUP is, in my view, a positive step, and it has Scottish Labour's support. Once again, I urge colleagues to ensure that work is undertaken by the Government to properly fund and support services that will save lives, and that the Government commits to vital services in areas of highest deprivation. If we do not do that and act with purpose, we will quickly see the benefits of MUP fade, which is not something that any of us want. I know from today's debate that that is the minister' position, so I hope to work with her to put those things together.

Tess White: MUP is a blunt instrument to tackle a very complex problem, and the Public Health Scotland evaluation is riddled with holes. Alcohol-specific deaths are at their highest since 2008. Moderate drinkers are being penalised and will be penalised even more by the price increase. Other approaches in treatment of alcohol addiction are underfunded and underresourced.

Sandesh Gulhane: In Public Health Scotland's report, civil servants decided to intervene and change the wording. For example, the wording was supposed to be "consistent", but civil servants decided to write "strong and consistent", which is the wording that appeared, not in the draft, but in Public Health Scotland's final report.

We can see, as Tess White said earlier, that a 40 per cent reduction in alcohol treatment has occurred. Although the minister has said many times that that is not the silver bullet, that the issue is nuanced, and that lots of other things need to be done, the fact is that nothing else is being done. This is the Government's silver bullet; this is the only thing that it seems to be doing when it comes to alcohol. We simply need to see more treatment happening, because that has been proved to reduce people's dependence on alcohol, to reduce deaths, and to improve and save lives.

We also need to look at the fact that a policy that increases the price of alcohol will affect dependent drinkers disproportionately. The whole point about being a dependent drinker is that you drink to the exclusion of other things—it is your primary focus and you are dependent on that substance. It is absolutely awful that the MUP policy has increased the price of alcohol, which the Government must have known would affect dependent drinkers, and that, over time, nothing has been done to help those dependent drinkers to ensure that they did not spend more money on alcohol and that they actually came away from it. We should have known—the Government and the 25 civil servants who worked on the policy should have known—that that would happen.

I want to speak about the outrageous profits that are being made by retailers because of MUP. It is simply unacceptable that a policy that is designed to help people is creating huge amounts of money, but that money is not being reinvested in alcohol programmes or in helping the people whom the policy was designed to help.

10:45

It was made clear in court that the policy is not supposed to be a population-level approach. That is not what the Government said in court. The minister told me, however, that that was the point. That does not make sense to me.

Turning to other evidence, a Taiwanese group wrote in *The Lancet* that the modelling that was done was simply not accurate, and that the policy is not doing what we think it is doing.

The fact is that the number of people who have died because of alcohol has increased by 25 per cent. That is the figure. Saying that we have saved 156 lives in modelling suggests that, had we not had MUP, we would have had the highest number of deaths ever.

We have heard from the minister that there are confounders, and that the biggest confounder is simply the cost of living. There has also been Covid. We must see, with a full evaluation, what happens in five years' time, when, I hope, we will not have those confounders. That could give us a really good indication of what is going on.

The minister has said that we are looking to increase the amount that is spent on treatment of drug and alcohol problems. I welcome that, and I ask the minister to back the Conservatives' proposed right to addiction recovery (Scotland) bill, which would give people the right to treatment, which would force our health and social care partnerships to invest at that level.

In summary, I say that the evaluation has not proved that MUP has done what we set out that it would do, which was that it would help the heaviest drinkers in our society. We need to ensure that, if MUP continues, we use the money that is generated to help those people. Otherwise, it is an absolute travesty.

Emma Harper: I have written notes based on what we have received in evidence, and I reiterate the intention behind the minimum unit pricing policy. I will restate some of the content of the correspondence that the committee received from the Association of Directors of Public Health north-east on 20 March. ADPH north-east said:

"As partners based in the North East of England—the region which suffers from the worst alcohol harms in England",

the public health directors there

"have watched the positive impact of MUP in Scotland with huge interest and admiration. At a time when alcohol deaths in England and especially here in the North East are at an all-time high,"

ADPH north-east is asking for

"similarly proactive and enlightened public health policies to reduce alcohol harm and protect the most vulnerable in our communities."

The directors of public health in the north-east of England

"are hugely supportive of Scottish Ministers' proposal to continue and uprate MUP and agree with the level of at least 65 pence per unit."

According to ADPH north-east,

"The evidence is clear that the policy has achieved its aim of reducing alcohol-related harm by both reducing population consumption and by targeting the consumption of people drinking at higher levels. It has also contributed to reducing alcohol-related health inequalities."

It also says that

"The evidence from Scotland is clear—MUP works by targeting the cheapest, most harmful alcohol and we hope that the Scottish Government will see fit to continue and uprate MUP, as part of its enlightened evidence-based approach to public health."

In addition, we received a letter that has been signed by more than 80 medical faith organisations and charities, calling for cross-party support to continue MUP. As I flicked through the letter, I noted their comment that the policy has meant that

"an estimated 156 families each year ... have been spared the loss of a loved one. Alcohol can have a serious impact at every stage of life, with the impact in pregnancy having a lifelong effect on the child. Hospital admissions are down by an estimated 4.1%, reducing the pressure on our NHS."

I will read the final sentence from that letter, which I will tweak a wee bit to highlight that I agree with it. It says that

"Now that it has been seen to work,"

those organisations—and I—support

"the continuation of this policy ... to uprate MUP to save more lives."

Gillian Mackay: The committee has recently heard about the impact of MUP from people with lived and living experience. For me, that has added, to the evaluation, a real-world context such as we have welcomed in many other areas of the committee's work. Those voices need to be amplified and to continue to be involved. I am pleased that the minister has indicated her willingness to continue to put that at the heart of policy development, as we move forward.

We need to ensure that there is an appropriate mix of support and treatment for people who require them, and that we tackle barriers for groups who currently have difficulty in accessing treatment. I accept and trust the minister's assertion that minimum unit pricing is not a silver bullet. One of the most important actions that we need to take is to tackle the alcohol environment that we have in Scotland. For me, that should include our examining how advertising affects children and young people and at-risk adult drinkers, as well as our implementing a public health levy. I am pleased that provision for such a

levy was included in the budget as a result of discussions between the Government and my party. Tackling alcohol harm must take a multipronged approach and must address all the barriers to services that people face.

I will be pleased to support both instruments.

The Convener: Minister, would you like to sum up and respond to the debate?

Christina McKelvie: Yes, thank you.

That discussion was really helpful. I thank Scottish Labour, Scottish National Party and Scottish Green members for their support for the policy. Everyone's comments on the work that is still to be done, the way in which we fund the sector, and the analysis and work that we must do on a public health levy are not lost on me. I will take them all away as action points.

I want to reassure members on funding. There is record funding of £112 million. I am absolutely committed to ensuring that it will be spent in exactly the right places.

I also want to respond to Tess White's and Sandesh Gulhane's remarks querying who might support the policy. We have seen the letter in *The Lancet* and the comments of the Association of Directors of Public Health north-east that Emma Harper referenced. We have seen the views of the 80 organisations that work with people and support them day in and day out. We have seen case studies such as those that have been carried out by the Simon Community Scotland. We have also seen modelling numbers that tell us that the lives of 156 people have been saved. That is not an insignificant number; it represents 156 loved ones. We should never forget that those are not just numbers; there are people behind them.

I turn to the point about treatment. The 40 per cent drop that we have experienced here has also been experienced in England, and the UK Government is looking at the reasons for that.

It is just not true to say that nothing else has been done on the matter. I will give the committee a list of actions that we are currently progressing to tackle the issues, whether they concern harmful, hazardous or dependent drinkers. We are working with the UK Government to produce new clinical guidelines on alcohol treatment for the whole UK. There is an alcohol brief intervention review and there are national specifications on alcohol and drugs. All ADPs already offer psychological counselling, in-patient alcohol-detox services and access to medication, and most offer community detox, ABIs and alcohol hospital liaison. It is therefore just not true to say that nothing is being done, because all those measures are already in place.

As for the proposed right to addiction recovery bill, for months I have been asking to see details of it, but we have not received them. I generally do not respond to social media comments on Government business, but just last week I did so to our colleague Annie Wells, who asked me whether I would support such a bill. I said that I would be happy to meet her to discuss it. We now have a date for that in the diary. I will be happy to discuss the bill then, but we still need to see the detail to understand what it would do.

I am glad to see that many members here support consideration of a public health levy. Mr Gulhane—some of your colleagues might be a bit disgruntled about your having said that you support that, because many of them do not. I am keen to work with you on all such aspects.

All the organisations that have written to us agree that minimum unit pricing works. They also agree that it is not a silver bullet. It has achieved its aim. Gillian Mackay is right: at the heart of the matter are the people whose lives will be made immeasurably better, and that is why lived and living experience is at the heart of all the work that I will do.

I ask the committee to support the Alcohol (Minimum Pricing) (Scotland) Act 2012 (Continuation) Order 2024 and the Alcohol (Minimum Price per Unit) (Scotland) Amendment Order 2024, which seeks to change the level from 50p per unit to 65p per unit. I thank the committee for its deliberations. None of what has been said is lost on me and all of it will inform my work.

The Convener: The question is, that motion S6M-12220 be agreed to. Are we agreed?

Members: No.

The Convener: There will be a division.

For

Haughey, Clare (Rutherglen) (SNP)
Harper, Emma (South Scotland) (SNP)
Mackay, Gillian (Central Scotland) (Green)
Maguire, Ruth (Cunnninghame South) (SNP)
McKee, Ivan (Glasgow Provan) (SNP)
Mochan, Carol (South Scotland) (Lab)
Torrance, David (Kirkcaldy) (SNP)
Sweeney, Paul (Glasgow) (Lab)

Against

Gulhane, Dr. Sandesh (Glasgow) (Con)
White, Tess (North East Region) (Con)

The Convener: The result of the division is: For 8, Against 2, Abstentions 0.

Motion agreed to.

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Members: No.

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Against

Gulhane, Dr. Sandesh (Glasgow) (Con)
White, Tess (North East Region) (Con)

The Convener: The result of the division is: For 8, Against 2, Abstentions 0.

Motion agreed to.

The Convener: That concludes consideration of those instruments.

Regulation of Care (Social Service Workers) (Scotland) Order 2024 (SSI 2024/56)

The Convener: The next item on our agenda is consideration of one negative instrument—the Regulation of Care (Social Service Workers) (Scotland) Order 2024. The instrument relates to registration of social workers and its purpose is to reduce the number of parts in the register from 23 to four by creating only two categories of social services worker, rather than having 21.

The policy note states that the objective of the instrument is

"To make registration, and being registered, straightforward and easy to understand."

It also states that

"The current Register structure has developed over time since the introduction of registration for social workers in 2003 ... the structure of the Register needs to change to reflect changing and emerging roles, as well as changes in the way services are delivered."

The Delegated Powers and Law Reform Committee considered the instrument at its meeting on 5 March 2024 and made no recommendations on it. No motion to annul has been lodged in relation to the instrument.

If members have no comments, does the committee agree to make no recommendations in relation to the order?

Members *indicated agreement.*

The Convener: At our next meeting, on 16 April, we will consider a negative instrument and a draft stage 1 report on the Abortion Services (Safe Access Zones) (Scotland) Bill.

10:59

Meeting continued in private until 11:57.

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