# Minimum Unit Pricing for Alcohol

## A CONSULTATION DOCUMENT

***February 2022***

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## Foreword from Robin Swann MLA
## Minister of Health

Alcohol use, and particularly the harm that alcohol can cause, has an impact on our whole society. While we often think about the impact high levels of alcohol consumption can have on an individual's health and wellbeing, even those who don't drink can be adversely affected – they may be subject to alcohol-related anti-social behaviour, they may have to wait longer at hospital due to pressures brought on by alcohol-related admissions, or may have to work more to cover alcohol-related absenteeism or colleagues feeling the effects of alcohol use. The harm caused by alcohol use negatively impacts our health, costs us money, reduces productivity, increases the risk of domestic or sexual violence, and increases crime. Its impact is felt by individuals, families and communities right across Northern Ireland.

The evidence is quite clear that price is a key factor in driving alcohol-related harm. Alcohol is 74% more affordable now than it was 30 years ago, and the availability of alcohol at very low prices is encouraging excessive and, most importantly, harmful consumption among some individuals.

When looking at the approaches that can be used to address the harms related to alcohol use, the Department has considered a wide range of potential options that have been put forward by academics, health professionals and other administrations. Based on these considerations, I am convinced the evidence shows that the introduction of legislation to set a Minimum Unit Price for Alcohol has the potential to be a key population-level health measure to address the harms related to alcohol consumption across Northern Ireland.

This consultation document makes the case that Minimum Unit Pricing is a proportionate and targeted solution to supporting a reduction in alcohol-related harm. It will help reinforce the fact that alcohol is not an ordinary commodity, and therefore it should be priced in a way that reflects its potential harm. Minimum Unit Pricing supports this by increasing the price of the cheapest, strongest alcohol products. These are primarily consumed by those hazardous and harmful drinkers who make up just 19% of the population but drink 67% of all the alcohol consumed in Northern Ireland. Non-drinkers and those who drink at low risk levels shouldn't worry – the impact on them in terms of consumption or increased spending is expected to be marginal.

I have been watching developments in Scotland, Wales and the Republic of Ireland very closely, where Minimum Unit Pricing has already been introduced, and am encouraged by the emerging evidence of the positive effect this policy can have. Depending on the outcome of this consultation, and a future decision by the incoming Executive, the intention is that the Department of Health will introduce legislation to the Northern Ireland Assembly to allow us to set a Minimum Unit Price for alcohol locally.

Therefore this consultation invites views from across society, on proposals to introduce legislation to enact Minimum Unit Pricing of Alcohol in Northern Ireland. I would encourage everyone with an interest to read this policy document and respond to the consultation. Often people who agree with the proposals in a consultation don't respond or provide feedback – as they believe policy is moving in a direction they agree with. However, it is vital that everyone responds, to express support for the proposals or to challenge them, to show the true level of opinion across society.

## Executive Summary

Alcohol misuse causes real and significant harm in Northern Ireland. The Health Minister believes that more has to be done to reduce the high levels of harm alcohol use causes to individuals, children, families and communities (as set out in **Section 2**).

It is important to note, a range of action is already being taken forward on alcohol and substance use more generally (see **Section 1**). However, in order to change behaviour, reduce consumption, and reduce harm, the Minister believes we need to directly address the availability of relatively cheap alcohol. There is a range of research that links price, consumption and harm. In particular, there is a growing consensus that Minimum Unit Pricing (MUP) for Alcohol (which sets the *minimum* price an alcoholic product can be sold at based on multiplying the number of units of alcohol – i.e. 10mls of pure alcohol – in a product by a set amount) is a targeted and proportionate way of ensuring that the price of alcohol reflects its potential harm. **Section 3** contains more information and research on MUP for Alcohol.

Given the targeted nature of MUP, compared to the alternatives set out in **Section 4**, the Minister believes it is the most proportionate and effective way of achieving our desired outcome of reducing alcohol-related harm – as it specifically targets hazardous and harmful drinkers, i.e. those that suffer the majority of the alcohol-related harm. In light of this, **Section 5** sets out how potentially MUP could be taken forward and how its implementation would be monitored should the decision be taken to proceed with the policy.

As part of this consultation, we are seeking your views on:

- the overall policy aim of reducing the harm alcohol causes;
- if, of the pricing options considered, MUP for alcohol is the most effective way of achieving the policy aim;
- what information or evidence should be considered when setting a MUP for alcohol and the level MUP should be set at initially;
- if the level of the MUP should be varied over time and, if so, how;

- the mechanisms for setting the MUP, including the formula and how it will be monitored; and
- any other information that you feel should be taken on board in respect of the policy or the various impact assessments?

# 1. BACKGROUND – ALCOHOL POLICY

## Introduction

1.1 Addressing the harms that are associated with the use of alcohol has been a key priority for the Department of Health for a number of years. This section outlines some of the wider approaches to address the harm related to alcohol use in Northern Ireland, the process to develop this consultation document, and the overall policy aims of this consultation.

## Context

1.2 The sale of alcohol has been regulated for many years, in recognition that alcohol is a psychoactive drug that has implications for health and social behaviours. There is a clear relationship between alcohol consumption and a range of health issues, and this led to the development of the low risk drinking guidelines by the four UK Chief Medical Officers[1].

1.3 In fact, research has estimated the cost to Northern Ireland of the use of alcohol, and more importantly the related harms, at up to £900 million[2]. However, this financial cost can never bring home the full impact that the harm related to alcohol use has on individuals, families and communities across Northern Ireland.

1.4 In addition, there has been a worrying increase in alcohol-specific deaths in recent years and the legacy these leave for families and communities. There were 351 alcohol specific deaths in 2020, up from 336 in 2019 and from 284 in 2018. Each and every one of these deaths is potentially preventable and therefore addressing this issue must be a key public health priority for the Department of Health and the Executive, but also for wider civic society and for the general public.

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[1] http://www.nhs.uk/change4life/Pages/alcohol-lower-risk-guidelines-units.aspx
[2] https://www.health-ni.gov.uk/sites/default/files/publications/dhssps/alcohol-and-drug-social-costs-of-misuse-ni-2008-09.pdf

## Substance Use Strategy

1.5 The new 10-year substance use strategy for Northern Ireland, "Preventing Harm, Empowering Recovery"[3], was approved by the Executive and launched by Minister Robin Swann MLA in September 2021.

1.6 Underscored by five population-level outcomes, the vision of *Preventing Harm, Empowering Recovery* is that "People in Northern Ireland are supported in the prevention and reduction of harm and stigma related to the use of alcohol and other drugs, have access to high quality treatment and support services, and will be empowered to maintain recovery".

1.7 The co-produced strategy took full account of the emerging evidence base, as well as direct input from service users, key stakeholders inside and outside Government, academics, family members, health professionals, and those in the justice sector.

1.8 The new strategy notes that substance use, and the related harm, is not just an issue of personal responsibility and people's behaviours. It is interlinked with wider health and social care outcomes, including health inequalities, and more widely with the economic, social and environmental circumstances in which people are born, grow, live, work and age.

1.9 While the strategy contains a range of measures around prevention and early intervention, harm reduction, treatment and support, recovery and governance, it explicitly acknowledges and references the evidence which shows the linkages between alcohol pricing and availability, and alcohol consumption and related harm.

1.10 The strategy therefore contains a commitment and action that a full public consultation would take place on the introduction of Minimum Unit Pricing for Alcohol (MUP) into Northern Ireland within one year of its publication.

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[3] Preventing Harm, Empowering Recovery - Substance Use Strategy | Department of Health (health-ni.gov.uk)

1.11 It should also be noted that the Licensing & Registration of Clubs (Amendment) Act (Northern Ireland) 2021, which achieved Royal Assent on 26 August 2021, contains a requirement for the Minister for Health to bring forward to the Assembly legislation to set a minimum price for the sale or supply of intoxicating liquor in Northern Ireland and to prohibit its sale or supply in Northern Ireland below that price within 3 years of the enactment of the whole Act or, if it is not reasonably practicable, to make a statement to the Assembly on why it is not reasonably practicable to do so.

**Policy Aims and Outcomes**

1.12 The overall aim of this pricing policy is to reduce the harm alcohol causes in Northern Ireland. However, we recognise that this needs to be done in a proportionate and targeted way that focuses on those who suffer most harm, without unnecessarily distorting the market place, or having a disproportionate impact on those who drink within the low risk guidelines.

1.13 The outcomes sought from the policy are primarily a reduction in the number of alcohol-related admissions to hospitals and alcohol-related deaths. Other quantifiable outcomes would be a reduction in alcohol-related crime and absences from work caused through alcohol consumption. In addition, it would also be expected that such a policy would have wider, unquantifiable societal benefits such as safer communities, improved mental health, improved inter-personal relationships, and happier families and, over time, a healthier attitude to alcohol consumption.

1.14 It is important to note the any pricing policy on its own will only be as effective as the wider strategy it sits within. This consultation compliments the wider policy framework in Northern Ireland, in particular the new 10-year substance use strategy, “Preventing Harm Empowering Recovery”, which was agreed by the Executive and launched in September 2021.

## Minimum Unit Pricing

1.15 Minimum Unit Pricing for Alcohol (MUP) is a piece of legislation that would set a minimum price that could be charged per unit (8 mg or 10ml) of alcohol. Every alcoholic beverage has a set number of units. The purpose of MUP ensures that a drink cannot then be sold for a price lower that the number of units multiplied by the MUP. MUP increases the price of drinks, such as own-brand spirits, high strength beers and white cider, which have high alcohol content but are usually very cheap. The more units a drink contains, the stronger it is and therefore the more expensive it will be.

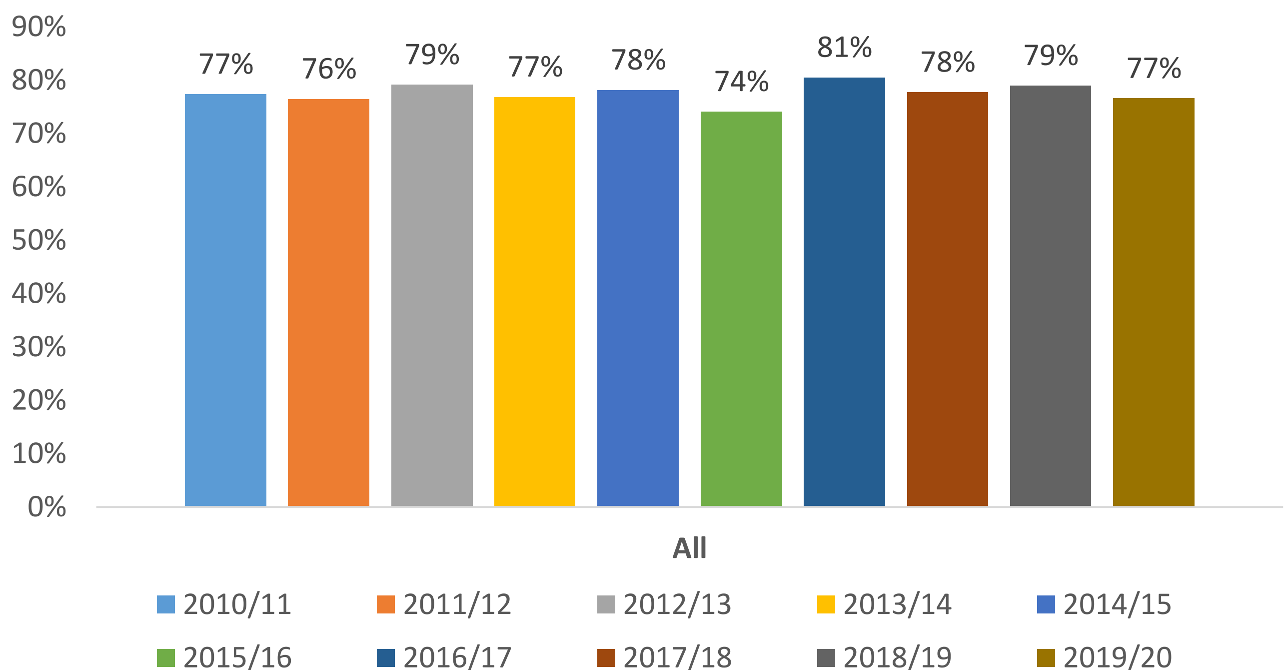
## 2. ALCOHOL USE AND RELATED HARM IN NORTHERN IRELAND

2.1 This section sets out in more detail some statistics relating to the use of alcohol and the harm it causes in Northern Ireland and provides more context for why action is needed.

### Alcohol Prevalence

2.2 According to the 2019/20 Health Survey Northern Ireland, around three-quarters of adults aged 18 and over drank alcohol (77%), with no significant change since 2010/11.

***Figure 1 – Drinking prevalence by year***




**Source: Health Survey Northern Ireland**

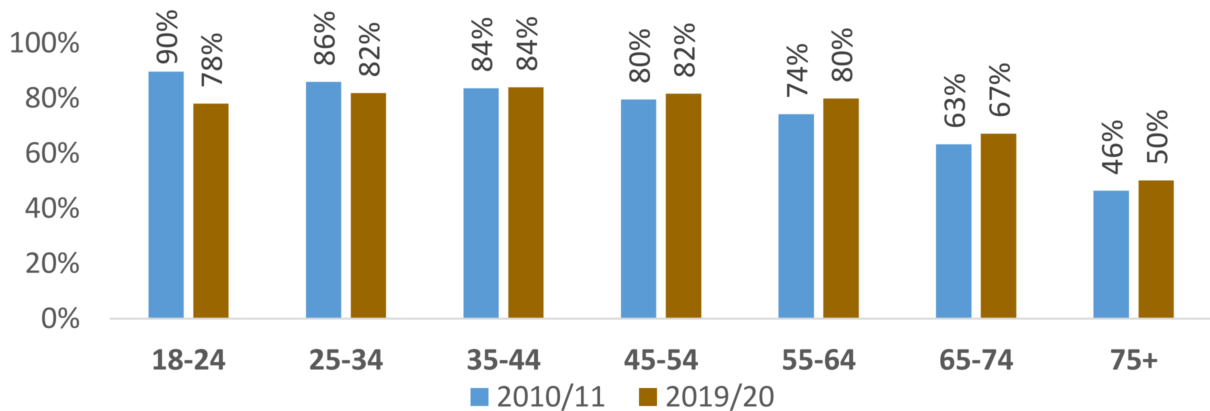
<u>Drinking Prevalence by Sex</u>

2.3 Males were significantly more likely to drink alcohol than females throughout the period from 2010/11 to 2019/20. In 2019/20 four-fifths (80%) of males drank alcohol compared with three-quarters (73%) of females.

Drinking Prevalence by Age

2.4 Drinking prevalence decreased with age; in 2019/20, around four-fifths of adults aged 18-64, two-thirds of those aged 65-74 and half of those aged 75 reported that they drank alcohol. For most age-groups, there was no significant change since 2010/11; however drinking prevalence for those aged 18-24 decreased from 90% to 78% and drinking prevalence for those aged 55-64 increased from 74% to 80%.

***Figure 2 – Drinking prevalence by Age-group (2010/11 & 2019/20)***

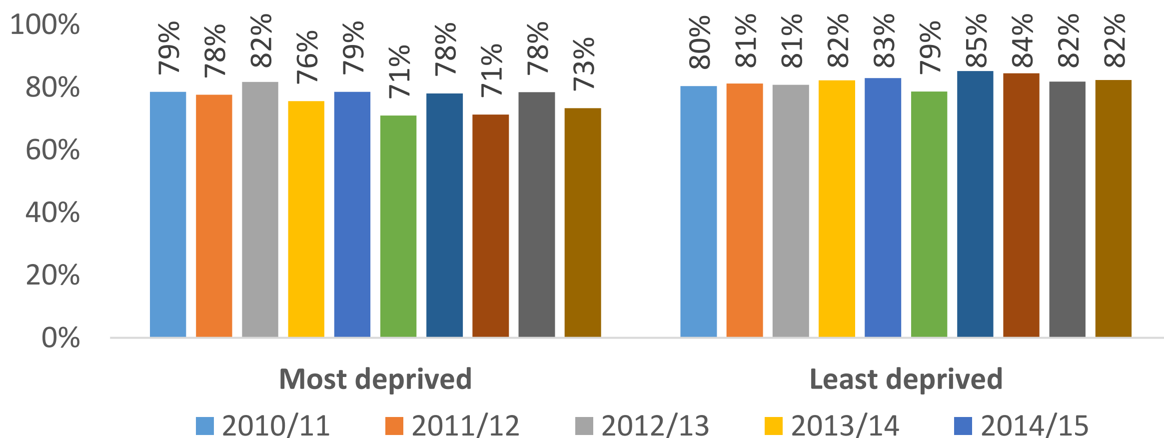



**Source: Health Survey Northern Ireland**

Drinking Prevalence by Deprivation Area

2.5 In 2010/11, there was no significant difference between the drinking prevalence of those living in the most deprived areas and the least deprived areas. In 2019/20, those living in the most deprived areas were less likely to drink alcohol (73%) than those living in the least deprived areas (82%).

***Figure 3– Drinking prevalence by Deprivation (Most and Least Deprived compared)***




**Source: Health Survey Northern Ireland**

Drinking Prevalence by Urban-Rural Area

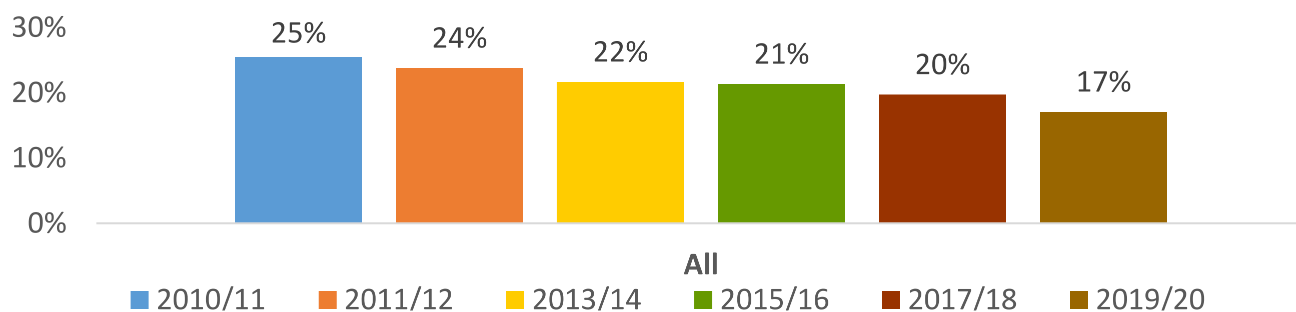
2.6 From 2010/11 through to 2016/17, those living in rural areas were less likely to drink alcohol than those living in urban areas. In 2019/20, there was no significant difference in the drinking prevalence between those living in rural areas and urban areas.

**Drinking above recommended weekly limits**

2.7 The UK Chief Medical Officers' guidelines for low risk alcohol consumption[4] is not to exceed 14 units weekly, for both men and women. All information presented below is based on this level.

2.8 In 2010/11 Health Survey Northern Ireland data showed that a quarter (25%) of adults drank alcohol above the recommended weekly limits. In 2019/20, this had fallen to 17%.

***Figure 4 – Drinking above recommended weekly limits***




**Source: Health Survey Northern Ireland**

Drinking above recommended weekly limits by Sex

2.9 Males were significantly more likely to drink alcohol above recommended weekly limits than females throughout the period from 2010/11 to 2019/20. In 2019/20, 26% of males drank alcohol above weekly limits compared with 9% of females.

[4] https://www.gov.uk/government/publications/alcohol-consumption-advice-on-low-risk-drinking

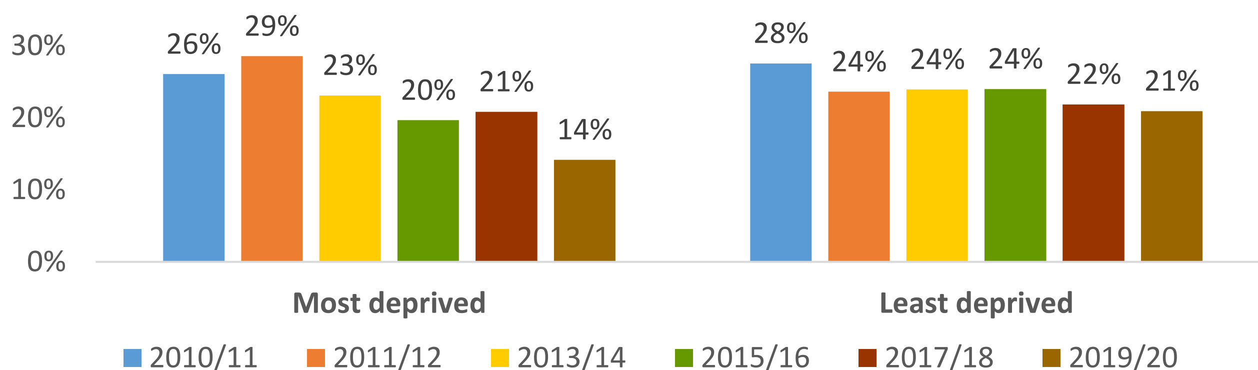
Drinking above recommended weekly limits by Age

2.10 Those aged 75+ were least likely to drink alcohol above recommended weekly limits. Between 2010/11 and 2019/20, the proportion of those aged 18-54 who drank alcohol above recommended weekly limits decreased significantly. There was no significant change for those aged 55 and over.

Drinking above recommended weekly limits by Deprivation Area

2.11 In 2010/11, with regards to drinking above recommended weekly limits, there was no significant difference between those living in the most deprived areas and the least deprived areas. In 2019/20, those living in the least deprived areas (21%) were more likely to drink alcohol above recommended weekly limits than those living in the most deprived areas (14%).

***Figure 5 – Drinking above recommended weekly limits by Deprivation (Most and Least Deprived compared)***

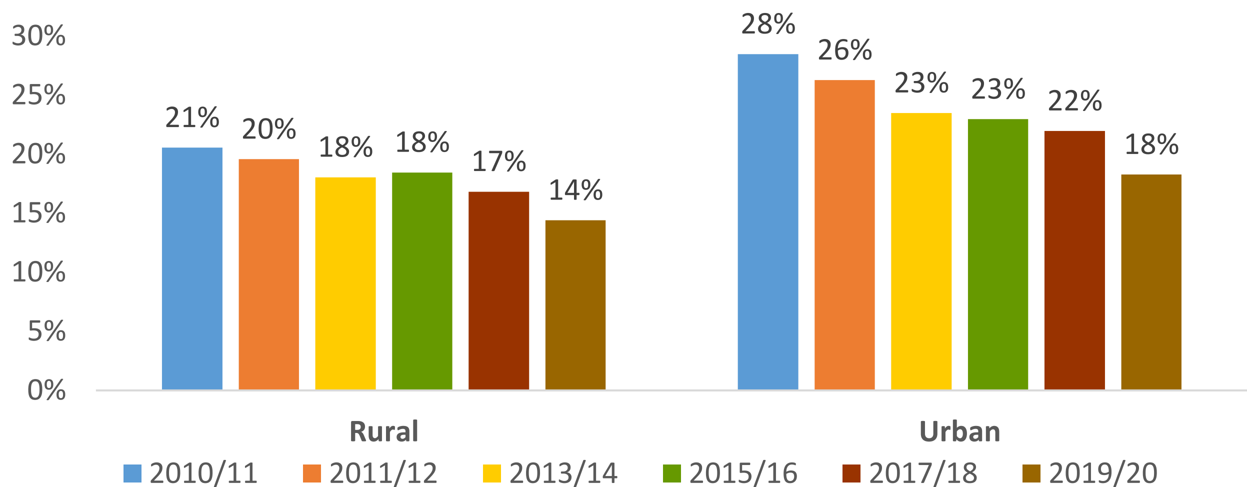



**Source: Health Survey Northern Ireland**

Drinking above recommended weekly limits by Urban-Rural Area

2.12 For all years, those living in rural areas were less likely to drink alcohol above recommended weekly limits than those living in urban areas. Between 2010/11 and 2019/20, the proportion drinking alcohol above recommended weekly limits decreased significantly for those living both in urban areas and in rural areas.

***Figure 6 – Drinking above recommended weekly limits by Urban-Rural area***

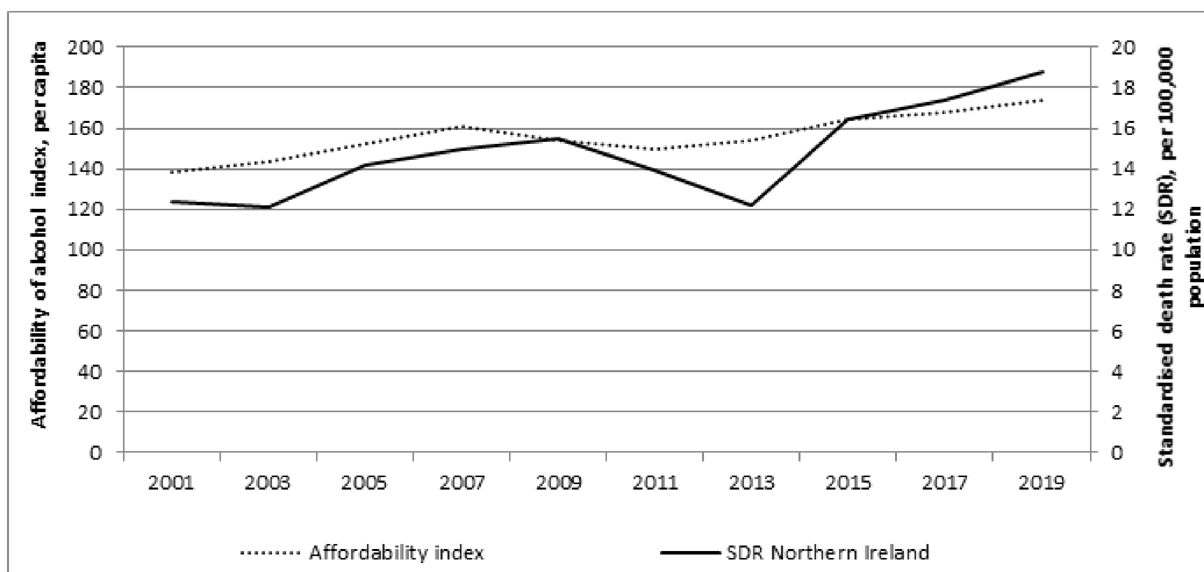



**Source: Health Survey Northern Ireland**

## Affordability

2.13 UK disposable income has risen faster than alcohol taxation, meaning that alcohol is more affordable than it was in the past. The availability of alcohol at such low prices helps to encourage irresponsible, excessive and, most importantly, harmful consumption.

**Figure 7 – Alcohol Affordability Index and Crude Alcohol Death Rate**




Source: NHS Digital 'Statistics on Alcohol - England, 2020', Table 4 and 'research matters'

2.14 The increasing affordability is not uniform across all sectors. While on-sales (e.g. pubs) prices have generally increased over the last 20 years, off-sales prices have remained more static. This is due largely to supermarkets and larger retailers being able to heavily discount prices. The relatively low price of off-sales alcohol is likely to be contributing to the move to home drinking – this trend is noticeable in recent surveys.

**Potential impact of COVID-19**

2.15 The most recent Northern Ireland Retail & Nutrition material published by the Food Standards Agency[5] showed increases in the volume purchased for flavoured alcoholic beverages and spirits, beer & lager, wine etc. during 2020. The volume of alcohol purchased has risen from 2019 to 2020 by: 40% for beer and lager; 29.4% for flavoured alcoholic beverages; 23.8% for wine; and 19.2% for spirits.

**Cost of Alcohol Related Harm**

2.16 It is widely recognised that excessive alcohol use has serious consequences not only for the individual but also for their family, community and indeed for wider society. Research has shown that the full social costs to the NI economy of alcohol-related harm could be as high as £900m per year with up to £250m directly borne by the Health sector alone and a further £383m borne by the Justice sector[6].

**Problem Drinking**

2.17 In 2019/20, 6% of those aged 18 and over who drink alcohol scored two or more on Cutdown, Annoyed, Guilty and Eye opener (CAGE)[7] question analysis indicating they may have a problem with alcohol.

[5] https://www.food.gov.uk/research/research-projects/northern-ireland-take-home-food-and-drink-purchases-2016-2019-2020
[6] https://www.health-ni.gov.uk/sites/default/files/publications/dhssps/alcohol-and-drug-social-costs-of-misuse-ni-2008-09.pdf
[7] Problem drinking is assessed using the CAGE substance use screening tool – CAGE stands for Cut down; Annoyed; Guilty; and Eye opener.

2.18 Male drinkers (8%) were more likely than female drinkers (5%) to score two or more. Drinkers living in urban areas (8%) were more likely than drinkers living in rural areas (5%) to score two or more.

**Binge Drinking**

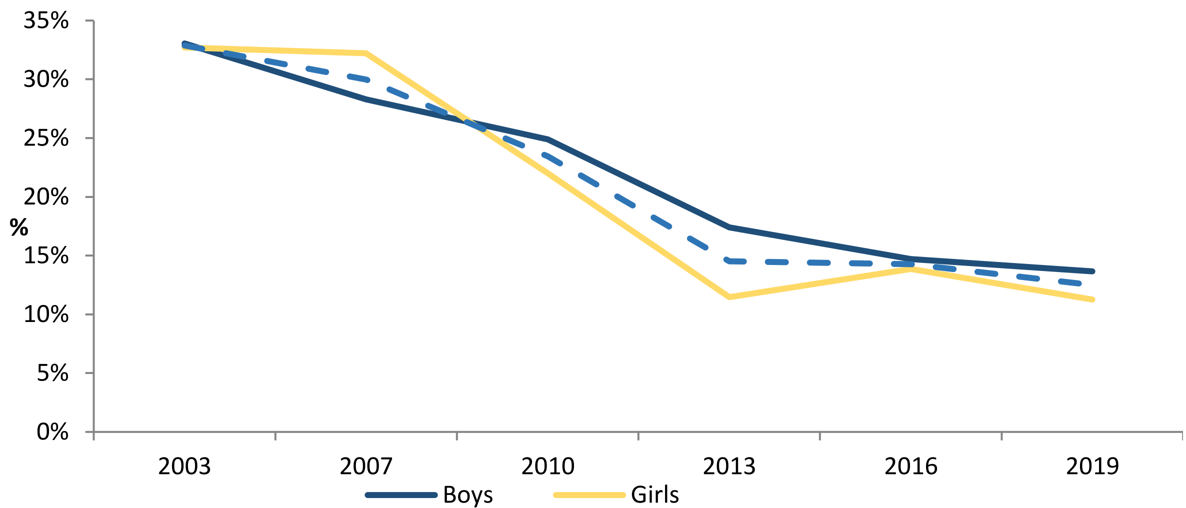
2.19 Patterns of consumption are also important, with those who drink large volumes of alcohol in one sitting putting themselves at a higher risk. The most recent figures show that around 31% of adults binge drink[8] but this has fallen from 38% in 2005.

2.20 Over a third of males (35%) and more than a quarter of females (27%) had engaged in at least one binge drinking session in the week prior to the survey. Younger adults (18-29 year olds) were more likely to binge drink than older adults (60-75 year olds).

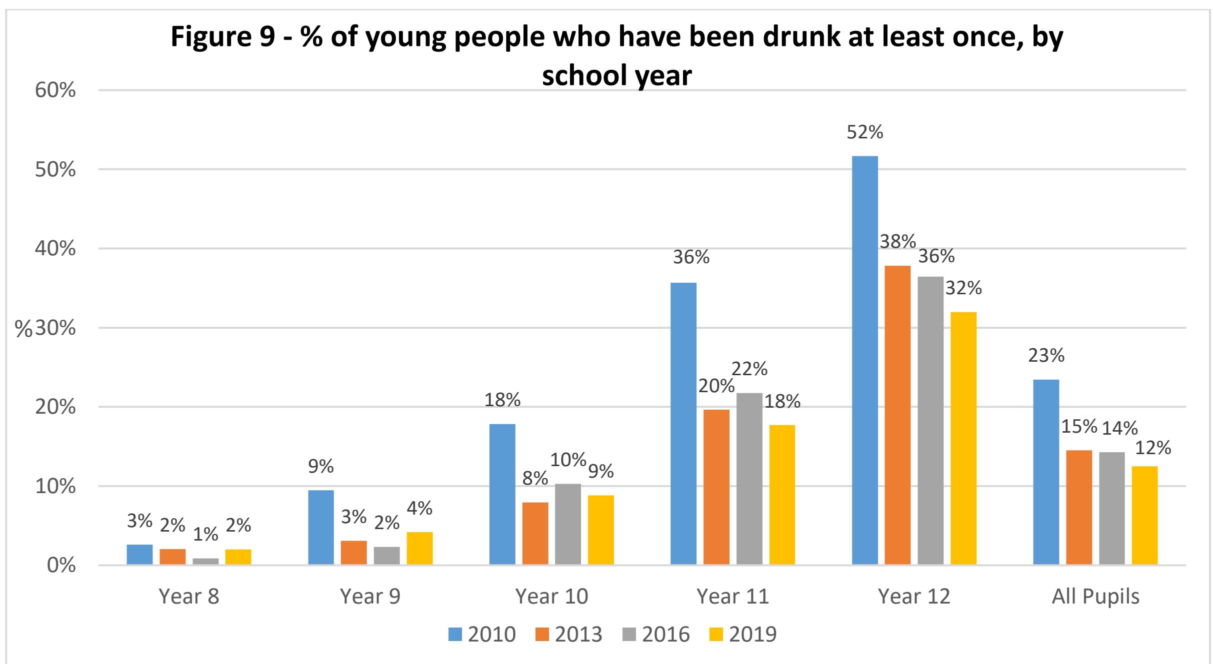
**Young People's Drinking**

2.21 According to the Young People's Behaviour and Attitude Survey[9] progress has been made in relation to young people's drinking, with the proportion of young people[10] who reported getting drunk at least once decreasing from 33% in 2003 to 12% in 2019. The charts below set out the trend and the breakdown by age and gender.

[8] https://www.health-ni.gov.uk/publications/adult-drinking-patterns-northern-ireland-survey-2013
[9] https://www.health-ni.gov.uk/articles/young-persons-behaviour-attitudes-survey
[10] i.e. those aged 11-17




Source: Analysis of Young People Behaviour and Attitudes Surveys, 2003-2019, DoH



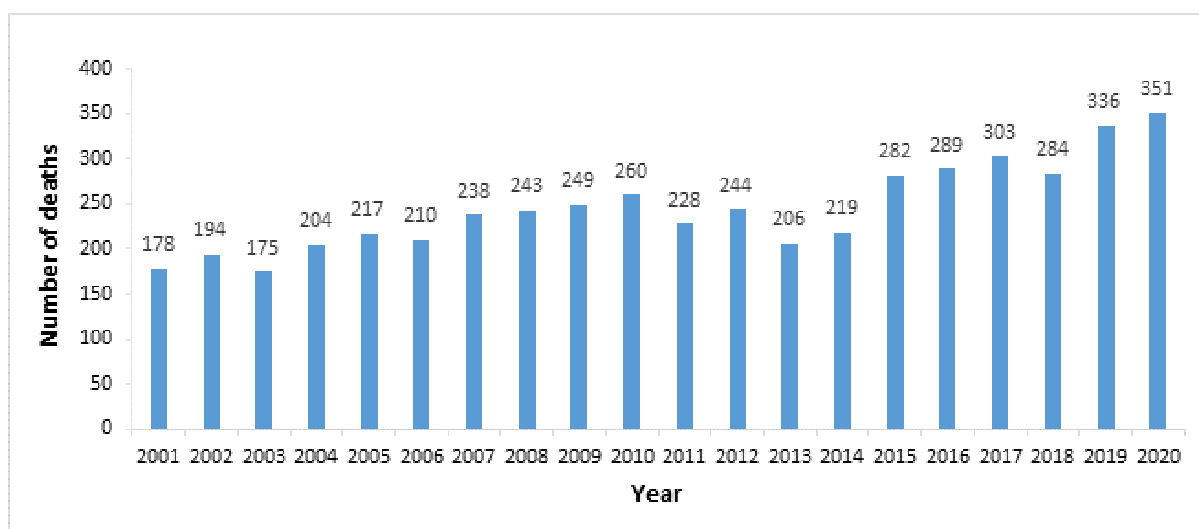

Source: Analysis of Young People Behaviour and Attitudes Surveys, 2010-2019, DoH

2.22 Despite having improved in recent years, consumption of alcohol among our young people remains an issue of concern, with this having the potential to impact on a young person's immediate wellbeing, academic achievement, and longer term health and wellbeing as an adult.

## Alcohol-Specific Deaths

2.23 However, while progress is being made on some of the indicators above, when looking at measures that describe alcohol-related harm, the figures are not as encouraging. For example, the number of Alcohol-Specific Deaths has been increasing – in 2013 figures[11] indicated 206 people died directly as a result of alcohol misuse, increasing to 351 in 2020. The chart below sets out the trend from 2001 to 2020[12].

**Figure 10 – Number of Alcohol-Specific Deaths**




Source: General Register Office, NISRA

2.24 We also need to be aware of the longer term impacts and how alcohol impacts on people as they get older. The proportion of those who died from alcohol-specific causes aged 55-64 has increased in recent years; in 2020 this age group accounted for over a third of such deaths (37%), while those aged 45-54 accounted for 28% of the total.

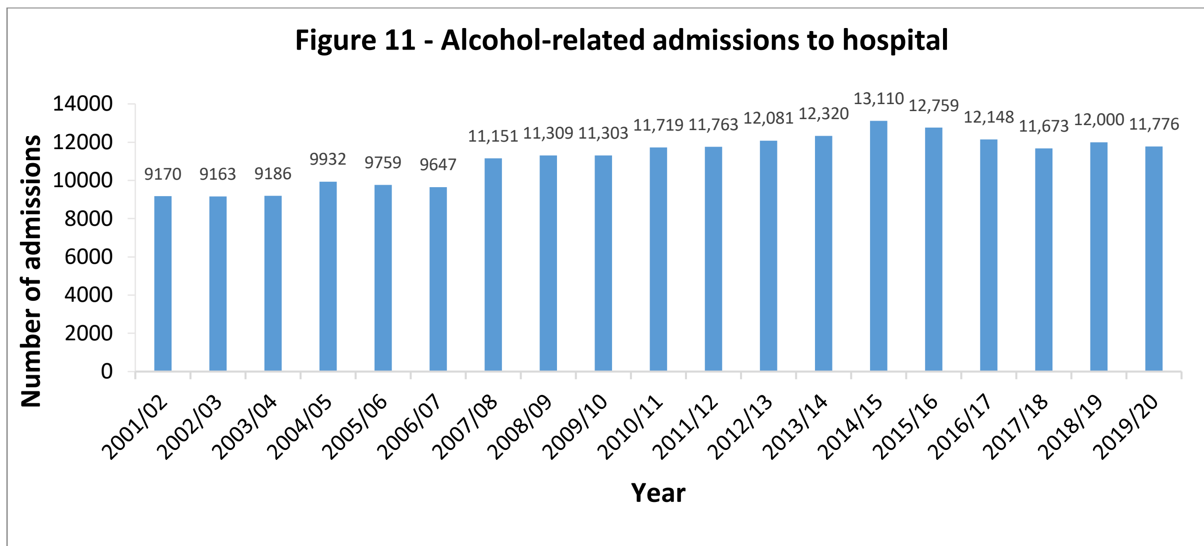
## Alcohol-Related Admissions to Hospital

2.25 Alcohol-related admissions to hospital have decreased from their peak of 13,110 in 2014/15 to 11,776 in 2019/20. However, compared to historical data

[11] https://www.nisra.gov.uk/node/2556

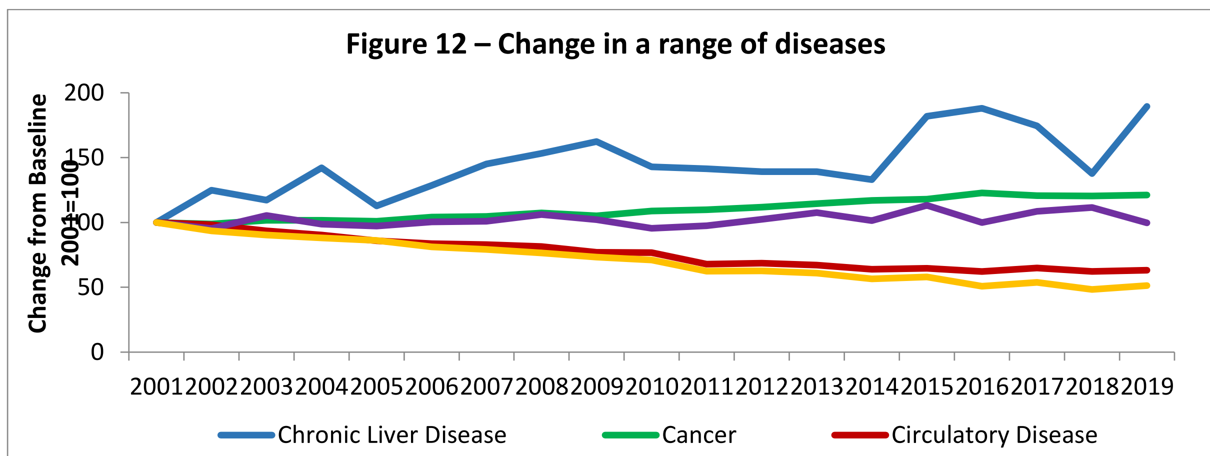
[12] Note: In 2017 the methodology for selecting alcohol deaths was revised following a consultation led by ONS. Alcohol-Specific deaths are now reported instead of Alcohol Related Deaths. The above data is for Alcohol-Specific Deaths only.

admission levels remain higher than those reported prior to 2011/12. The chart below sets out the trend from 2001/02 to 2019/20.




Source: Information and Analysis Directorate, Hospital information Branch

2.26 Figure 12 shows the change in cases of liver disease, and other conditions, over time compared to 2001. This clearly demonstrates the rise in liver disease compared to many other diseases which have remained largely static or declined. However, these figures should be interpreted with caution, as they show the percentage change relating to these diseases – rather than the absolute disease burden.




Source: Public Health Information & Research Branch, HSCIMS (deaths sourced from VARS, NISRA)

## Alcohol-Related Brain Injury (ARBI)

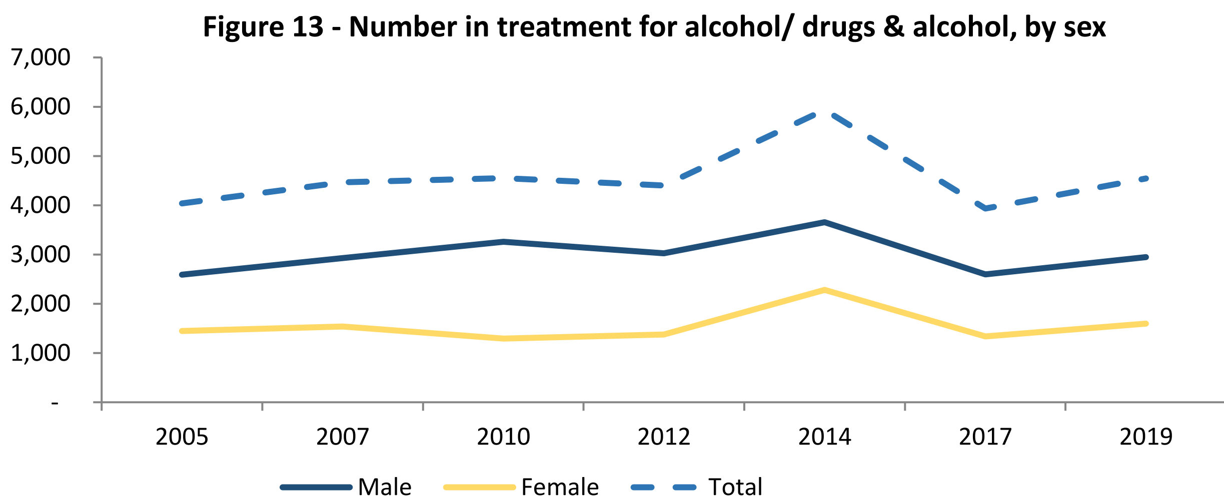
2.27 One of the long-term harms that can be caused by excessive drinking is Alcohol-Related Brain Injury (ARBI). This is a prolonged cognitive impairment

due to changes in the structure and function of the brain linked to chronic, excessive alcohol consumption on a regular basis over a long period of time.

2.28 ARBI differs from dementias in that with abstinence from alcohol there tends to be some measure of recovery in up to 75% of cases, no deterioration of functioning in the remaining 25% and it also tends to have a lower age of onset. Although the prognosis for ARBI can be positive, optimal recovery requires a wide range of professional involvement and co-ordinated service provision. It can be difficult to get robust figures on the issue, however a research project in the Western Health & Social Care Trust area found that the overall prevalence rate of the condition in that area was found to be 9.4/10,000, which lies at the higher end of prevalence estimates across the UK.

**Treatment**

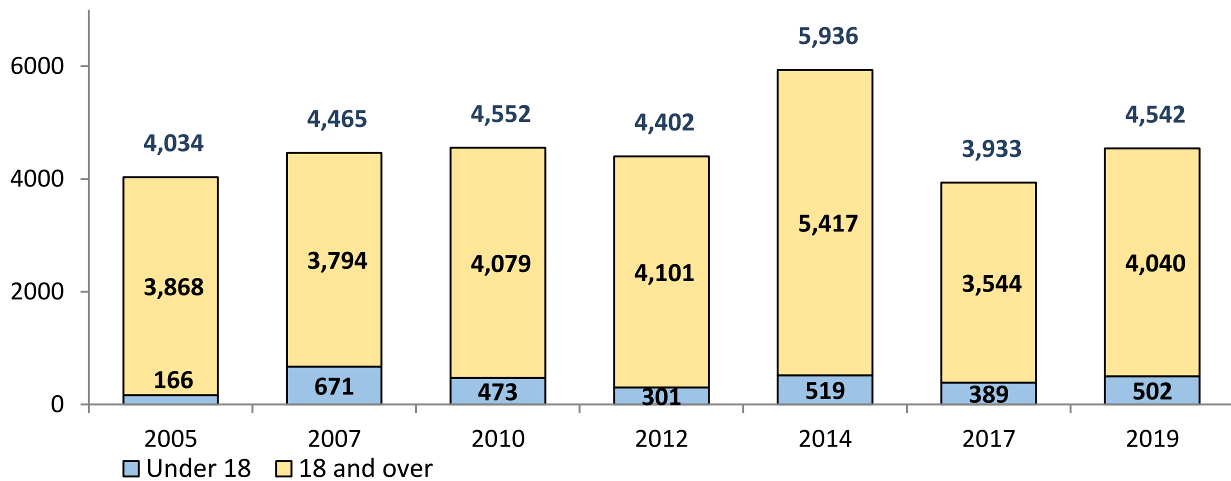
2.29 The number of people in treatment[13] for alcohol use, or a combination of drugs and alcohol use, has increased from 4,034 at 01 March 2005 to 4,542 individuals in treatment at 30 April 2019. The charts below set out the trend:




Source: Analysis of Treatment Census, 2005-2019, DoH

[13] https://www.health-ni.gov.uk/publications/census-drug-and-alcohol-treatment-services-northern-ireland-30th-april-2019

**Figure 14 - Number in treatment for alcohol/ drugs & alcohol, by age**




Source: Analysis of Treatment Census, 2005-2019, DoH

## Justice System

2.30 People who suffer from alcohol-related harm are more likely to come into contact with the justice system, have more complex issues such as higher rates of poor mental health, and may have other long-term conditions or a history of trauma.

2.31 Since 2012/13 around one in five crimes recorded by police have been flagged with an alcohol motivation. Around half of all violence with injury offences (between 49 and 58 per cent) and two fifths of violence without injury offences (between 37 and 43 per cent) have been given an alcohol motivation. The proportion of violence against the person offences with an alcohol motivation has fallen from 47 per cent in 2012/13 to 34 per cent in 2019/20.

2.32 Overall the number of vehicle collisions of all categories involving substances have fallen in 2020, but the proportion of collisions that are alcohol or drug related has remained consistent over the years.

*Youth Justice Agency (YJA)*

2.33 All children who are referred to YJA are assessed using the Youth Justice Agency Assessment (YJAA) Tool. One of the key factors of this tool explores drug and alcohol use in association with offending. There was a moderate to

strong association between drug and/or alcohol use and offending in one third of children referred in 2020/2021.

**Economy**

2.34 As has been mentioned previously, there is a significant cost for society associated with the use of alcohol. The Social Costs of Alcohol report estimated the costs to the wider economy – through presenteeism at work, absenteeism, unemployment, and premature mortality for those of working age – to be up to £258m every year[14].

**Public Opinion**

2.35 In the 2013 Adult Drinking Patterns Survey[15], respondents were asked to rate the statement "Availability of cheap alcohol is harmful to society" on a scale of 1 to 5, with 1 representing a strong agreement with the statement and 5 representing a strong disagreement. In total over 65% of people agreed or strongly agreed that the availability of cheap alcohol is harmful to society.

[14] https://www.health-ni.gov.uk/sites/default/files/publications/dhssps/alcohol-and-drug-social-costs-of-misuse-ni-2008-09.pdf
[15] https://www.health-ni.gov.uk/publications/adult-drinking-patterns-northern-ireland-survey-2013

## 3. PRICING POLICY, MINIMUM UNIT PRICE AND RESEARCH

3.1 Evidence in recent years has increasingly shown that price plays a key role in levels of consumption. For example, the World Health Organisation SAFER initiative[16] states that: “Alcohol taxation and pricing policies are among the most effective and cost-effective alcohol control measures” and an evidence review by Public Health England in 2016[17] stated that: “taxation and price regulation policies affect consumer demand by increasing the cost of alcohol relative to alternative spending choices. Policies that reduce the affordability of alcohol are the most effective, and cost-effective, approaches to prevention and health improvement”.

### Units

3.2 Units of alcohol are used to express the amount of pure alcohol in a drink – this enables people to track how much they are drinking and to keep within the recommended guidelines. One unit equals 10ml or 8mg of pure alcohol, which is around the amount of alcohol the average adult can process in an hour. This means that within an hour there should be, in theory, little or no alcohol left in the blood of an adult, although this will vary from person to person. The number of units in a drink is based on the size of the drink as well as its alcohol strength.

3.3 The following table sets out the number of units in a range of products:

**Table 1 – Units in Alcohol Products**

| Drink and Volume | Strength (ABV) | No. of Units |
|---|---|---|
| Vodka (35ml) | 37.5% | 1.3 |
| Gin (700ml) | 38% | 19.6 |
| Super Strength Lager (500ml) | 9% | 4.5 |
| Lager cans (440ml) | 4% | 1.8 |
| Pint (568ml) | 4.5% | 2.6 |
| Bottle of Wine (750ml) | 12.5% | 9.4 |
| Glass of Wine (175ml) | 12.5% | 2.2 |
| Bottle of Cider (2L) | 6% | 12 |
| Ready to Drink (250ml) | 5% | 1.3 |

[16] https://www.who.int/initiatives/SAFER
[17] https://www.gov.uk/government/publications/the-public-health-burden-of-alcohol-evidence-review

**Minimum Unit Price (MUP)**

3.4 Minimum Unit Price (MUP) is a mechanism that would introduce a floor price for an alcohol product based on the number of units it contains, meaning it cannot be sold for lower than that level in on or off trade licensed premises. It increases the price of drinks, such as own-brand spirits, high strength beers and white cider, which have high alcohol content but are usually relatively cheap. The more units a drink contains, the stronger it is and therefore the more expensive it will be.

3.5 This is important as a systematic review[18] reported that there is evidence that harmful drinkers tend to show a preference for relatively cheaper alcoholic drinks. Therefore, MUP is a targeted approach, in that it seeks to reduce harm by focusing on drinks which are relatively cheap compared to their high strength. MUP achieves this by having a progressively greater effect in terms of consumption and alcohol related harm for those who drink the most.

**Evidence**

3.6 A firm knowledge base now exists on the relationships between pricing controls, reduced access to alcohol, reduced consumption of alcohol and reduced alcohol-related harms. Recent research in the United Kingdom, Republic of Ireland and Europe shows a relationship between price and consumption – as the price of alcohol has fallen, consumption has risen.

3.8 The seminal work on reducing alcohol related harm, *Alcohol: No Ordinary Commodity*[19], reviews the most effective alcohol policies and summarises that these include alcohol control measures, including minimum unit pricing, drink driving laws, and brief interventions. In addition, the National Institute for Clinical Excellence (NICE) in their guidance on *Alcohol-use disorders: preventing harmful drinking*[20] include consideration of MUP as part of effective approaches to this issue.

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[19] Babor, T., et al (2010) Alcohol: No Ordinary Commodity. 2nd edtn. Oxford: Oxford University Press
[20] https://www.nice.org.uk/guidance/ph24

**Local Research**

3.9 The Department of Health previously commissioned specific research to model the potential impact of various different levels of minimum unit prices, and other pricing options, for alcoholic products in Northern Ireland[21]. The research was undertaken by the University of Sheffield's School of Health and Related Research (ScHARR) and was published in December 2014[22].

3.10 It is important to note that this research indicated that hazardous[23] and harmful[24] drinkers only make up 19.4% of the total adult[25] population, yet they account for 67% of all alcohol consumption and 56% of all spending on alcohol. Harmful drinkers alone (just 5.8% of the total population) are responsible for 39% of all consumption and 29% of all spending. This is the group that drinks the most, and the cheapest, alcohol. It is also the group that suffers the most alcohol-related harm and it is this group that MUP specifically targets – they are likely to reduce consumption the most and therefore benefit from the greatest reductions in alcohol-related harms.

3.11 The report also demonstrated that alcohol is available at relatively low prices in Northern Ireland, particularly in the off-trade. For example, 47% of all beer and 52% of all cider sold in the off-trade was sold below a price of 40p per unit – this compares to only 4% of on-trade beer and 0% of on-trade cider.

3.12 Any pricing policy needs to act in a proportionate way in tackling the harm which results from alcohol consumption. While some low risk drinkers will be affected by any pricing policy, a MUP set at a proportionate level will target those who drink to hazardous and harmful levels the most. The ScHARR report considered a range of MUP levels from 35p to 75p per unit. At the lower range the effects of MUP are modest while at the upper range all drinkers are more likely to feel

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[21] To ensure consistency and value for money this research was commissioned jointly with the Dept of Health in the Republic of Ireland, then separate reports were developed for the two jurisdictions.

[22] https://www.health-ni.gov.uk/sites/default/files/publications/dhssps/alcohol-and-drug-mup-ni-report-from-university-of-sheffield.pdf

[23] Defined as drinking 21-50 units per week for men and 14-35 units per week for women, please note this is this is analogous with the term "Increasing Risk" used in the ScHARR report.

[24] Defined as drinking 50+ units per week for men and 35+ units per week for women, please note this is this is analogous with the term "High Risk" used in the ScHARR report.

[25] In this case measured as those aged 16+

the effects of the policy. A 50p per unit was been used as a "worked example" by the researchers.

**Findings**

3.13 The ScHARR research showed that MUP is an effective and targeted policy. At a 50p MUP, 39% of all products purchased would be affected. For moderate drinkers[26], only 22% of the units they purchase would be affected by the policy, compared to 37% for hazardous drinkers and 49% for harmful drinkers.

3.14 Table 2 below summarises the impacts of a 50p MUP, more detailed information is then provided in subsequent paragraphs:

**Table 2 – Impacts of a 50p MUP**

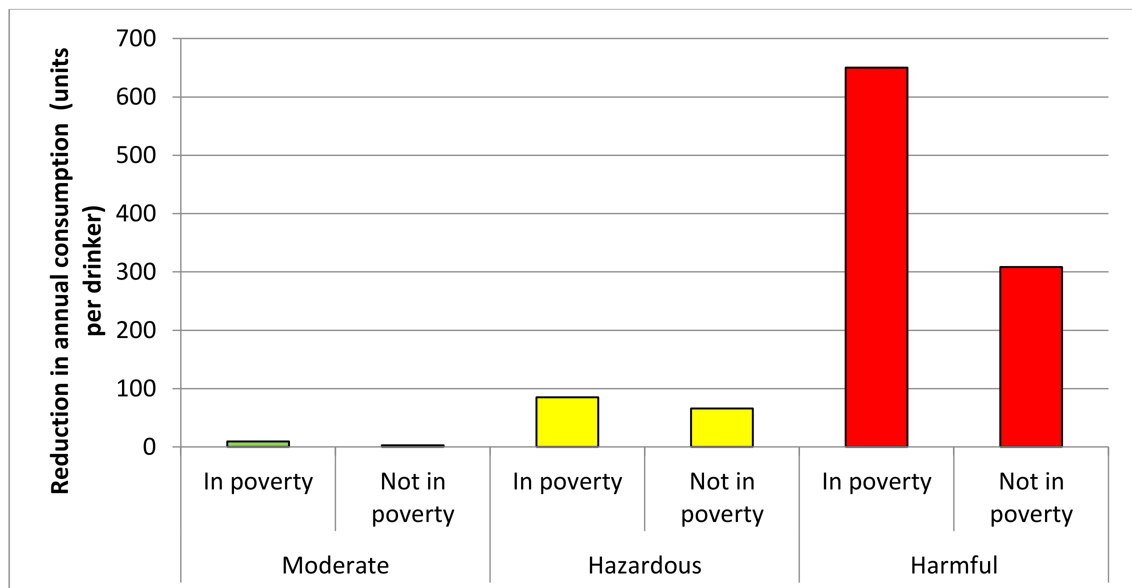
| 50p minimum price per unit | | |
|---|---|---|
| Overall reduction in consumption | 5.7% | |
| **Annual health savings in year 20** | | |
| Reduction in Deaths | 60 | |
| Reduction in Hospital admissions | 2,400 | |
| **First year reductions** | | |
| Crimes | 5,300 | |
| Days absent | 35,000 | |
| **Total cost reduction over 20 years (discounted)** | | |
| Health | £59m (direct) | £0.6bn (QALY[1]) |
| Crime | £0.3bn (direct) | |
| Workplace absence | £46m | |
| **Total** | **£1.0bn** | |
| **Revenue changes** | | |
| Retailers | +£22m (off-trade) | +£3m (on-trade) |
| Exchequer (Duty + VAT) | -£9m (off-trade) | +£1m (on-trade) |

Source: University of Sheffield, 2014

[26] For the purposes of the research defined as drinking less than 21 units per week for men and less than 14 units per week for women.

3.15 The research set out that a 50p MUP is estimated to reduce overall consumption by 5.7% (or 0.88 units per drinker per week). However, those who drink at moderate levels are affected marginally by the policy i.e. moderate drinkers are estimated reduce their consumption by 1.6% (or 0.1 units per week) compared to a reduction of 5% (1.3 units per week) for hazardous drinkers and a reduction of 8.6% (7.4 units per week) for harmful drinkers. Figure 15 summarises the estimated breakdown in the consumption of units across drinker categories. This shows that 85% of the total consumption reduction is in high risk drinkers and depicts the targeted nature of the measure.

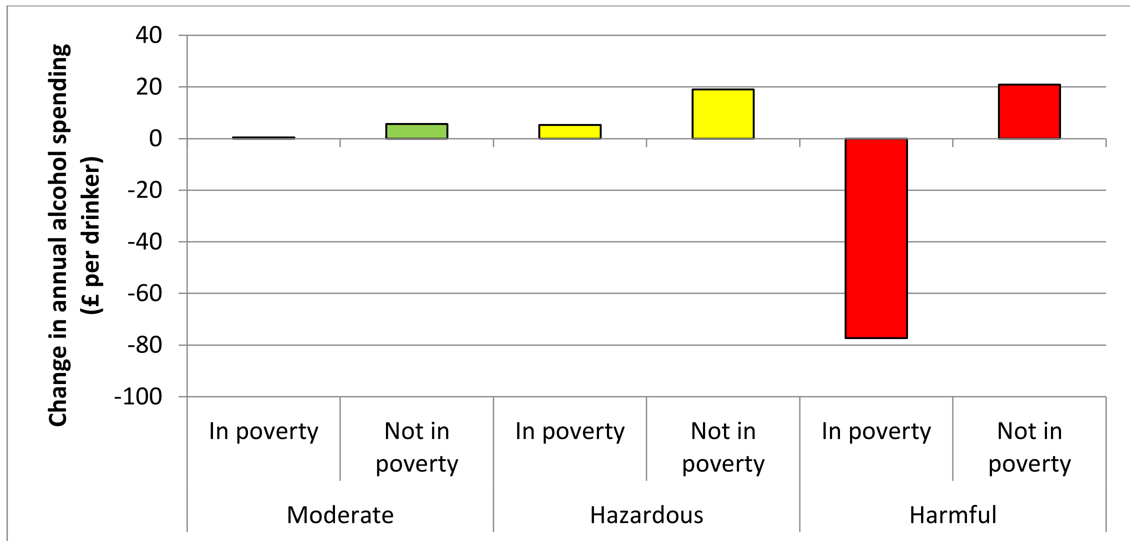
**Figure 15- Reduction of consumption of a 50p MUP by drinker category**




Source: University of Sheffield, 2014

3.16 Overall spending on alcohol is estimated to increase by 0.8% (or £6.30 per drinker per year). Moderate drinkers could increase their spending by 1.3% (or £4.70 per drinker per year), hazardous drinkers increase their spending by 1.2% (or £16.50 per drinker per year), while harmful drinkers could decrease their spending marginally (just above 0% or £1.50 per drinker per year). Figure 16 below again breaks down changes in spending by drinker category:

**Figure 16 – Change in spending by drinker category**




Source: University of Sheffield, 2014

3.17 The impact on health and societal harms are estimated to be substantial – with a reduction of 63 alcohol-related deaths per year (after 20 years when the full effect of the policy will be felt) and a reduction of 2,460 alcohol-related admissions to hospital. Crime is estimated to fall by 5,293 offences per year (from year 1), and work place absence is estimated to be reduced by 35,000 days per year.

3.18 The total societal values of these reductions in harms is estimated at £956m[27] over the 20 years modelled – savings in health costs of £59m, savings in crime costs of £292m, savings in workplace costs of £46m, and Quality Adjusted Life Years (QALY)[28] gains of £559m.

3.19 It should be noted the model only applies to those aged 16+. However, it is likely that any increase in price would also limit the ability of those aged under 16 to purchase alcohol, and is therefore likely to have an impact on reducing underage drinking and harm suffered by those in this age group.

[27] All costs and benefits are discounted at 3.5%.
[28] Assuming a QALY is valued at £60,000.

3.20 The impacts on consumption, spending, health harms, crime harms, workplace harms and societal costs, of all the policies modelled was summarised in a range of tables and is available online. [29]

3.21 The Department of Health is aware that this modelling was undertaken some time ago. Therefore, if the outcome of this consultation is that we progress with MUP, then we will update the research.

**Broader issues**

3.22 As with all polices, MUP could have unintended consequences as there is uncertainty around how the local alcohol industry and consumers might respond. The sections below give some consideration to the wider issues in relation to MUP and will also examine the position in rest of the UK and in the Republic of Ireland.

**Modelling**

3.23 It is important to note that the ScHARR report is based on a complex mathematical model. Such models do not always reflect "real" life – this is even more the case when dealing with an addictive and psychoactive drug such as alcohol. *Individual* human behaviour is hard to predict with any certainty. The ScHARR model uses sales data, hospital admissions, crime figures and many more inputs to assess how price changes can affect purchases and consumption of alcohol products at a *population level*. This model has been peer reviewed and published in various academic and medical journals.

3.24 However, alcohol sales data[30] in Scotland showed that in the 12 months following the implementation of MUP, off-trade alcohol consumption at a population level fell in Scotland while it rose in England & Wales. The combined effect the changes resulted in the smallest difference in per-adult off-trade

[29] https://www.health-ni.gov.uk/sites/default/files/publications/dhssps/alcohol-and-drug-mup-ni-report-from-university-of-sheffield.pdf
[30] Sales-based consumption - Outcome areas and studies of evaluation of MUP - Evaluation of minimum unit pricing (MUP) - Alcohol - Health topics - Public Health Scotland

alcohol sales between Scotland and England & Wales in the time series available.

### Substitution

3.25 Some commentators have suggested that increased alcohol prices could increase consumption of other drugs and illicit substances (i.e. some people would shift from consuming alcohol to drugs). There is no clear evidence that this would be the case and evidence to date from Scotland does not seem to indicate that MUP has led to people increasing consumption of other substances[31][32], and in general the research that does exist indicates that alcohol and illicit drugs are complements rather than substitutes.

### Impact on Vulnerable Individuals

3.26 Some emerging evidence from Scotland[33] has indicated that some people who are dependent on alcohol may have reduced daily living expenditure due to spending more on alcohol. When those in the study in Scotland were asked about their behaviours since MUP was introduced, the most common behaviour (reported by over two-thirds of participants) was 'drank about the same as before'. The study also found that people with alcohol dependence expressed a need of support to prepare for price rises before MUP was implemented but were not aware of any being available.

3.27 Should a decision be taken to proceed with MUP, additional resources will need to be made available so that more direct support can be provided to this more at-risk group.

### Local Industry Reaction

3.28 There is a risk that any net increase in spending by consumers will be used by the retailers/producers to further promote alcohol consumption, for example through advertising.

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[31] https://www.ncbi.nlm.nih.gov/books/NBK574742/
[32] https://www.publichealthscotland.scot/media/8200/interim-report-on-the-impact-of-mup-among-people-who-are-alcohol-dependent-and-accessing-treatment-services.pdf
[33] https://publichealthscotland.scot/news/2021/june/initial-report-published-on-the-impact-of-mup-on-people-who-are-dependent-on-alcohol-and-accessing-treatment/

3.29 It is possible that retailers will remove some of the most affected products from the market rather than increase the retail price. This would result in less alcohol being produced on the market with subsequent effects on producers, manufacturers, wholesalers and consumers. Alternatively, it is also possible that producers could produce lower strength alcohol products as these would retail more cheaply. This may help reduce alcohol consumption and associated harms.

**Cross-Border Trade**

3.30 There is a long history of cross-border consumer shopping between Northern Ireland and the Republic of Ireland, and alcohol has been part of this process. The Irish Government decided to proceed with MUP from 01 January 2022.

3.31 Following this implementation, the Department of Health has been working closely with colleagues in the Republic of Ireland on this policy with a view to minimising any potential impact on cross-border trade. Obviously if Northern Ireland also introduced MUP, the impact on cross-border trade is likely to be minimised, but will be impacted by the minimum prices set in the two administrations and the currency exchange rate.

3.32 There is also a small potential for criminal gangs to seek to take advantage of any price differential to encourage cross-border smuggling, illicit production and “bootlegging‟ of alcohol. This could have an impact on the criminal justice system. However, there is no evidence to suggest that this would be the case. Any difference in price is likely to be relatively small and unlikely to make people travel significant distances to achieve a saving.

**Developments in Other Jurisdictions**

*Scotland*

3.33 In 2012, the Scottish Parliament passed the Alcohol (Minimum Pricing) (Scotland) Act 2012[34] which allowed Scottish Ministers to introduce a system of minimum unit pricing for alcohol. The aim of the act was to save lives, reduce hospital admissions and, ultimately, have positive impacts across the whole health system in Scotland and for wider society.

3.34 The legislation was challenged in court by some parts of the alcohol industry, which delayed implementation, but in November 2017 the UK Supreme Court confirmed the legislation was lawful.

3.35 Scotland concluded that a 50 pence per unit minimum price struck a reasonable balance between public health, social benefits and intervention in the market after taking the responses to the consultation and other factors into account. The legislation on the price was laid on 01 March 2018, and unanimously approved by full Parliamentary vote on 25 April 2018. A minimum price of 50p per unit has been implemented in Scotland from 01 May 2018.

3.36 Minimum unit pricing legislation contains a 'sunset clause' which requires the Scottish Government to evaluate the policy's effect five years after it comes into force. This funded evaluation programme includes a programme involving research in a number of areas including:

- price and product range;
- alcohol sales and consumption;
- alcohol-related harm; and
- economic impact on the industry.

3.37 The evaluation programme seeks to answer two questions:

- has minimum unit pricing contributed to reducing the health and social harms related to alcohol?

[34] Alcohol (Minimum Pricing) (Scotland) Act 2012

- are some people and businesses more affected (positively or negatively) than others?

Further Information on the programme is available at: http://www.healthscotland.scot/health-topics/alcohol/evaluation-of-minimum-unit-pricing-mup/overview-of-evaluation-of-mup/why-we-are-evaluating-mup

*Wales*

3.38 The Public Health (Minimum Price for Alcohol) (Wales) Act 2018 (the Act) gives effect to the Welsh Government's determination to provide a legislative basis for addressing some of the long-standing and specific health concerns around the effects of excess alcohol consumption in Wales. The regulations to introduce an MUP for alcohol of 50p were approved by the National Assembly for Wales on the 12 November 2019 and an MUP of 50p was introduced from 02 March 2020.

3.39 The ultimate aim of minimum pricing in Wales is to tackle alcohol-related harm, including alcohol-related hospital admissions and alcohol-related deaths, by reducing consumption amongst hazardous and harmful drinkers.

3.40 To support the production of the report on the operation and effect of the legislation, the Welsh Government has commissioned an independent evaluation including:

- Contribution analysis;
- Research into the impact on retailers;
- Qualitative work with services and service users; and
- Assessment of impact of introducing minimum price for alcohol on wider population of drinkers. Reports relating to baseline research and modelling to inform the legislation can be found at https://gov.wales/research-minimum-pricing-alcohol .

3.41 The legislation has been implemented in Wales since March 2020. Trading Standards Officers are enforcing the legislation and providing advice to retailers

and businesses on compliance with the legislation if this is not being adhered to when the first inspection has taken place. Inspections have been delayed due to COVID-19 but Trading Standards have now inspected over 90% of Welsh retailers and businesses, and to date no fixed penalty notices have been issued.

*England*

3.42 At present, the UK Government has no plans to introduce MUP in England. The UK Government's intention remains to increase alcohol duties in line with RPI inflation at each fiscal event to protect the value of the tax and maintain relative price, although decisions on alcohol duty must also consider the impacts on cost of living, economic growth and community life. The UK continues to have some of the highest alcohol taxes in the world, but where particular issues are identified, such as with 'white cider', they are ready to act with taxation levers.

3.44 To better support public health, the UK Government intends to move to a new system that taxes all products in reference to their alcohol content for the first time. This will help to target problem drinking by taxing higher-strength products associated with alcohol-related harm a higher rate of duty. A consultation on these reforms ran until 30 January 2022. Subject to the outcome of the consultation, the new duty structure will take effect from 01 February 2023.

3.45 The UK Chief Medical Officers' low risk drinking guidelines have been developed on the basis that people have a right to accurate information and clear advice about alcohol and its health risks.

3.45 The UK Government is working with industry to deliver a significant increase in the availability of alcohol-free and low-alcohol products by 2025. Increasing the availability of these products should help nudge drinkers to lower strength alternatives.

*Republic of Ireland*

3.46 The introduction of a legislative basis for minimum pricing per gram of alcohol was recommended by the National Substance Misuse Strategy published in

2012. In October 2013, a Government Decision approved the drafting of legislation to address alcohol as a public health issue and agreed a comprehensive suite of measures, including MUP, to reduce excessive patterns of alcohol consumption and resultant social, economic and health harms as set out in the National Substance Misuse Strategy.

3.47 This informed that primary policy objectives of the Public Health (Alcohol) Act 2018 which were developed in recognition that alcohol causes harms to health, with significant costs to the Exchequer and that alcohol consumption in Ireland remains high.

3.48 Section 11 of the Public Health (Alcohol) Act 2018 provides for a minimum unit price for alcohol products. The minimum unit pricing (MUP) provision which specifies a minimum price per gram of alcohol of 10c was commenced 10 May 2021 and came into effect on 4 January 2022.

3.49 In this Government Decision, it was agreed that MUP would be introduced simultaneously with Northern Ireland to allay concerns about negative impacts on cross-border trade.

3.50 As it became clear that Northern Ireland would not be in a position to bring forward legislation on MUP within the current Assembly mandate a revised government decision to commence MUP without its simultaneous introduction in Northern Ireland was agreed. This revised Government Decision was agreed in recognition of the urgent need to reduce the health harms of alcohol use through preventing the sale of strong alcohol products at very low prices.

3.51 *The Public Health Alcohol Research Group* was convened by the Department of Health in Ireland in 2019 and is charged with ensuring that the measures implemented under the Public Health (Alcohol) Act 2018 are comprehensively evaluated to assess their effectiveness in meeting the policy objectives of the legislation.

**Licensing Legislation in Northern Ireland**

3.52 The Licensing and Registration of Clubs (Amendment) Act (NI) 2021[35] became law on 28 August 2021. The changes brought about by the Act will come into effect in phases with the first phase having commenced on 01 October 2021.

3.53 The first phase of commencement saw the following changes come into effect on 01 October 2021:

- removal of additional restrictions at Easter;
- removal of restrictions on late opening for on-sales on Sunday;
- introduction of an occasional additional late opening hour for certain licensed premises;
- extension of drinking-up time;
- the alignment of the alcohol and entertainment licensing systems;
- the sale of alcoholic drinks on a Sunday at licensed race tracks;
- Minimum price for alcohol;
- Independent Review of licensing system including surrender principle;
- Annual publication of the number of licences;
- Guidance; and
- Review.

3.54 Phase 2 is scheduled to commence on 06 April 2022 and will include:

- Power for the Department to designate an event as a major event and varied permitted hours;
- Ability for cinemas and local producers of alcoholic drinks to apply for a liquor licence;
- Prohibition of home deliveries of alcohol to under 18s;
- Removal of requirement for children's certificates (all conditions remain);
- Underage functions in certain licensed premises;
- Attendance of young people at private functions beyond 9pm;
- Requirement for place of dispatch to be licensed for online/telephone/app sales;

[35] Licensing and Registration of Clubs (Amendment) Act (NI) 2021 - Guide | Department for Communities (communities-ni.gov.uk)

- Requirement for restaurants to place notice stating licence conditions;
- Ability for police to request conditions to be placed on an occasional licence;
- Requirement for changes to body corporate licence holders to be notified to the courts and police;
- Attendance of young people in sporting clubs until 11am in certain circumstances;
- Ability for sporting clubs to use their outside space for functions in certain circumstances; and
- Minor easement on registered clubs advertising restrictions.

3.55 Outstanding changes will be commenced later in 2022 and into 2023. These are:

- Ability for licensed local producers to apply for authorisation to sell for consumption on the premises in certain circumstances;
- Prohibition on self-service and sales by vending machines;
- Restrictions on off-sales drinks promotions in supermarkets;
- Prohibition of loyalty schemes;
- Code of practice; and
- Consent for alterations to club premises.

## 4. ALTERNATIVE OPTIONS CONSIDERED

4.1 This section looks at what other pricing policy options, aside from minimum unit pricing, were considered in tacking the harms caused by alcohol use.

### Do Nothing

4.2 A "do nothing" option as required for economic appraisals, was considered by the Department, however given the problems caused by excessive alcohol consumption (set out in Section 2) the Department does not believe this is a viable option at this stage.

### Taxation

4.3 One potential way of protecting and improving public health by reducing alcohol consumption through price mechanisms is via increasing alcohol duty and taxation. Taxes on alcohol explicitly signal that alcoholic beverages are to be treated differently from other consumer goods. However, alcohol duty and taxation is currently reserved to the UK Parliament.

4.4 Two indirect taxes are charged on alcohol in the UK; the standard rate of value added tax (20%) and excise duty that is levied at production at different rates according to the type of alcohol. Table 3 summarises the current UK-wide duty rates:

**Table 3 – Tax on alcohol**

| Alcohol type | Rate per hectolitre per cent of alcohol in the beer |
|---|---|
| Beer - General Beer Duty | £19.08 |
| Beer - high strength:<br>Exceeding 7.5% abv - in addition to the General Beer Duty | £5.69 |
| Beer - lower strength:<br>Exceeding 1.2% - not exceeding 2.8% abv | £8.42 |
| Still cider and perry:<br>Exceeding 1.2% - less than 6.9% abv | £40.38 |

| Alcohol type | Rate per hectolitre per cent of alcohol in the beer |
|---|---|
| Still cider and perry:<br>At least 6.9% - not exceeding 7.5% abv | £50.71 |
| Still cider and perry:<br>Exceeding 7.5% - less than 8.5% abv | £61.04 |
| Sparkling cider and perry:<br>Exceeding 1.2% - not exceeding 5.5% abv | £40.38 |
| Sparkling cider and perry:<br>Exceeding 5.5% - less than 8.5% abv | £288.10 |
| Spirits | £28.74 |
| Spirits-based: Ready-to-drinks | £28.74 |
| Wine and made-wine:<br>Exceeding 1.2% - not exceeding 4% abv | £91.68 |
| Wine and made-wine:<br>Exceeding 4% - not exceeding 5.5% abv | £126.08 |
| Still wine and made-wine:<br>Exceeding 5.5% - not exceeding 15% abv | £297.57 |
| Wine and made-wine:<br>Exceeding 15% - not exceeding 22% abv | £396.72 |
| Sparkling wine and made-wine:<br>Exceeding 5.5% - less than 8.5% abv | £288.10 |
| Sparkling wine and made-wine:<br>8.5% and above - not exceeding 15% abv | £381.15 |
| Wine and made-wine:<br>Exceeding 22% abv | £28.74 |

Alcohol Duty Rates from 1 February 2019 - HMRC

4.5 In October 2021, the UK Government published a consultation on a "New alcohol duty system[36]". The consultation sets out proposals to reform duties as follows:

36 https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/1028702/20211026_Alcohol_Duty_Review_Consultation_and_CFE_response.pdf

- All products across all categories will be taxed in reference to the litres of pure alcohol they contain, as is currently the case for spirits.
- All categories will move to a standardised series of bands for the rates, with rates for products between 1.2-3.4% ABV, 3.5-8.4% ABV, 8.5-22% ABV, and above 22% ABV.
- For the 8.5-22% ABV and above 22% ABV bands, all products across all categories will pay the same rate of duty.

4.6 Full details are set out in the consultation, however it is unclear if the proposals will apply to Northern Ireland. The UK Government has stated that it will continue to discuss the application of these reforms to Northern Ireland with the EU during the consultation period of the review.

4.7 Modelling of taxation policies was outside the scope of the research conducted by the ScHARR in Northern Ireland – however it did rehearse some of the key principles in terms of the difference in targeting between MUP and general tax rises. Firstly, it is expected that a tax increase (most likely through increased duty rates) would increase the price of all alcohol sold in the market because alcohol duties are levied on either ethanol content or product volume. The likelihood is therefore that moderate drinkers would be much more affected by a general tax rise than a MUP policy targeted at relatively cheaper alcohol.

4.8 Secondly, there is the issue of whether and how retailers pass the tax increases on to customers. A study[37] showed that when duty increases in the UK, supermarkets have tended to increase the price of more expensive alcohol more than the tax increase and increase the price of cheaper alcohol less than the tax increase. This in turn is likely to reduce the impact of the tax policy on increasing and high risk drinkers and drinkers who prefer cheaper alcohol.

4.9 Though MUP and alcohol taxes both reduce alcohol-related harm, they operate in quite different ways, and so can be seen as complements rather than substitutes.

[37] http://onlinelibrary.wiley.com/doi/10.1111/add.12590/abstract

**Below Cost Sales**

4.10 Below-cost selling is where a retailer sells a product for less than the costs incurred in its production, distribution and retail. Below-cost selling allows alcohol to be sold very cheaply and undermines the potential effectiveness of alcohol duty in curbing problem alcohol consumption and harm.

4.11 There is a real difficultly in determining what would constitute a product's "cost price". Some countries have previously tried to do this by using invoice prices but this is likely to benefit large retailers over small retailers. Problems with introducing this type of legislation are evident from experiences in the Republic of Ireland. The Restrictive Practices (Groceries) Order 1987 (the Groceries Order) banned below invoice price selling of products, including alcohol. Some of the difficulties experienced in monitoring and enforcing this piece of legislation included:

- Prosecutions for below-cost sales required knowledge of the wholesale price to the retailer but in practice the unit cost to the retailer could vary depending on a range of factors;
- The level of discounts resulting from agreements between the wholesaler and retailer for bulk purchasing, marketing agreements, product placement and product promotions proved difficult to quantify;
- The level of discounts were generally not factored into the original sales invoices from the wholesaler which meant that they could show a higher price compared with actual price when all discounts were taken into account;
- Special terms could also vary from one retailer to another depending on the quantity purchased and the retailer's relative market position; and
- A further complicating factor was that there could be a significant time lag between the original order and subsequent discounts.

4.12 The difficulties experienced in monitoring compliance and in securing convictions for below-cost selling led to the repeal of the Groceries Order in March 2006.

4.13 Based on local pricing data and modelling, the research[38] conducted by ScHARR in Northern Ireland stated that "*a policy to ban below-cost selling has virtually no impact on consumption and alcohol-related harms because most alcohol sold in the market would not be affected by the policy*".

**Ban on Promotions**

4.14 Significant amounts of alcohol are sold on promotion in Northern Ireland. Information from the off-trade demonstrates that 40% of all units sold are sold on promotion, with a mean discount of 26%. This effectively reduces the price and encourages people to purchase and potentially consume more alcohol than they had intended to – especially in the case of volume based discounts.

4.15 The objective of this option is to enable customers to buy the amount of alcohol they had originally intended rather than having to buy multiple products to achieve cost savings. This policy is not necessarily an alternative to MUP; the two policies complement each other and help ensure that retailers cannot simply offer straight discounts at very low prices to get round the aim of the regulations.

4.16 A power to ban irresponsible promotions which encourage customers to drink more than normal or consume alcohol quickly was included in the Licensing & Registration of Clubs (Amendment) Act (Northern Ireland) 2011 – this banned "all you can drink for a set price" promotions. Legislation was further updated in 2021[39], with additional restrictions on advertising off-sales drinks promotions in supermarkets and on the prohibition of loyalty schemes due to come into effect in 2022/23.

4.17 Going further than the current measures, this option would look at banning all volume based discounts in both the on-trade and off-trade. For example, this option would prevent retailers offering "special deals" (such as buy-one-get-one-free, 3 for £10 or happy hours) on alcohol sales both in the off-trade and

[38] www.dhsspsni.gov.uk/mup_ni_report_from_university_of_sheffield.pdf
[39] Licensing and Registration of Clubs (Amendment) Act (NI) 2021 - Guide | Department for Communities (communities-ni.gov.uk)

on-trade sectors. Currently many supermarkets and a wide range of pubs and nightclubs offer customers deals which encourage the purchase of strong alcoholic drinks at a low cost (for example, either as "loss leaders" or as promotional gimmicks to attract customers to their premises).

4.18 Table 4 summarises the effects of a ban on promotions, more detailed information is then provided in subsequent paragraphs:

**Table 4 – Effects of a Ban on off-trade promotions**

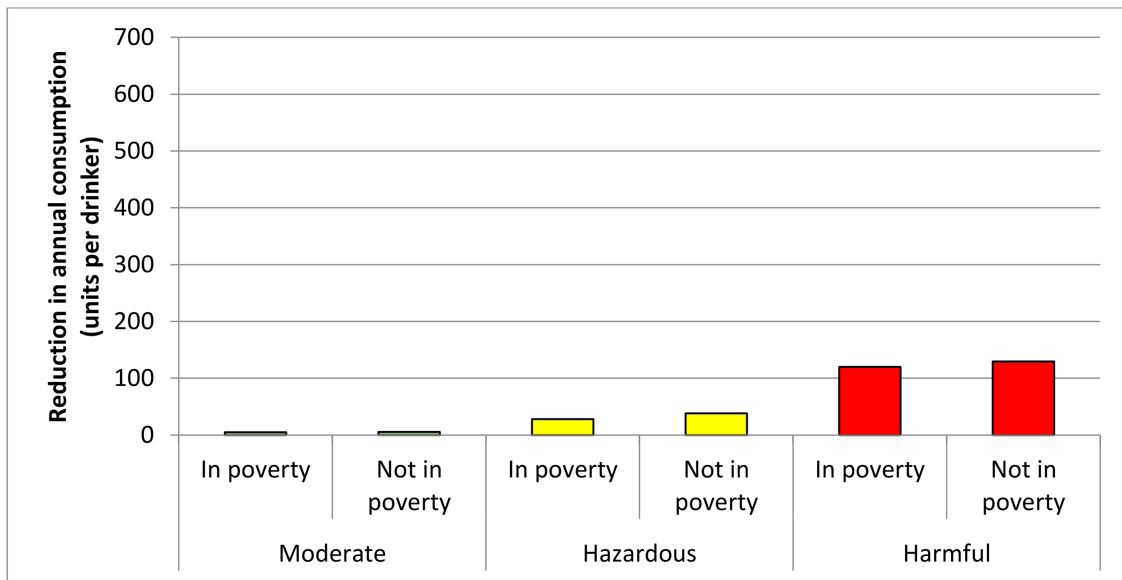
| Ban on Promotions | | |
|---|---|---|
| Overall reduction in consumption | 2.5% | |
| **Annual health savings in year 20** | | |
| Deaths | 25 | |
| Hospital admissions | 1,040 | |
| **First year reductions** | | |
| Crimes | 2,300 | |
| Days absent | 17,100 | |
| **Total cost reduction over 20 years (discounted)** | | |
| Health | £2m (direct) | £0.2bn (QALY[1]) |
| Crime | £0.1bn (direct) | |
| Workplace absence | £22m | |
| **Total** | **£0.4bn** | |
| **Revenue changes** | | |
| Retailers | +£23m (off-trade) | +£0m (on-trade) |
| Exchequer (Duty + VAT) | +£1m (off-trade) | -£4m (on-trade) |

Source: University of Sheffield, 2014.

4.19 The ScHARR modelling estimates that a ban on alcohol promotions would result in a reduction in alcohol consumption of 2.5% (2.8% for harmful drinkers and 2.6% for moderate drinkers). In addition, spending would increase on average by £5.30 per drinker per year, although there are significant differences within each category of drinker, by gender and by socio-economic group.

4.20 Figure 17 below summarises the breakdown in the consumption of units across drinker categories. When compared to the impact of a 50p MUP (figure 15) it is clear a ban on promotions has less impact and is less targeted.

**Figure 17 – Reduction in consumption of a ban on promotions by drinker category**




Source: University of Sheffield, 2014

4.21 The impact of such a ban on health is significant. Sheffield University estimates that alcohol-related deaths would reduce by 25 per year after 20 years, with admissions to hospital down by 1,040. The total societal value of these reductions in health, crime and workplace harms is estimated at £401m over the 20 year period modelled. This includes direct healthcare costs (£26m), crime costs (£128m), workplace costs (£22m) and a financial valuation of the QALY gain (£224m).

**Self-Regulation**

4.22 Because of the limitations imposed by the Competition Act 1998, the alcohol industry or industry organisations cannot set a minimum price for alcohol; nor include any provisions relating to pricing (for example, to outlaw the sale of alcoholic products in package that is cheaper than the sum of the products individually) via self-regulation.

**MUP plus a Ban on Promotions**

4.23 A final option would be to combine MUP with a ban on promotions. This was an option originally considered in Scotland and was included in the research undertaken by ScHARR in Northern Ireland.

4.24 The ScHARR research shows that this option would have a significant impact on alcohol consumption and harm. Using a 50p MUP as a worked example, this level of MUP plus a ban on promotions would result in a reduction in alcohol consumption of 7.5% (10.2% for harmful drinkers and 3.5% for moderate drinkers). Spending would increase, on average, by £7.30 per drinker per year, although there are significant differences within each category of drinker, by gender and by socio-economic group.

4.25 The impact on health of such a 50p MUP plus ban is significant. The ScHARR modelling estimates that alcohol-related deaths would reduce by 80 per year after 20 years, with admissions to hospital down by 3,080. The total societal value of these reductions in health, crime and workplace harms is estimated at £1,229.6m over the 20-year period modelled. This includes direct healthcare costs (£74m), crime costs (£386.4m), workplace costs (£62.4m) and a financial valuation of the QALY gain (£705.7m).

4.26 However, it could be considered that introducing two new regulatory burdens at the same time may add additional complications for the alcohol industry generally. It would also make it difficult to disaggregate the impact of each measure separately in terms of effectiveness.

## 5. THE WAY FORWARD

5.1 As set out in Section 1, our overall aim is to reduce the harm alcohol causes in Northern Ireland. However, this must be done in a proportionate and targeted way that focuses on those who suffer most harm, without unnecessarily distorting the market place, or impacting on those who drink at low risk levels.

**Consultation Question 1**

Do you agree with the overall policy aim of reducing the harm alcohol causes?

5.2 Weighing up this body of evidence, it is the view that MUP is the preferred option to help reduce the harm caused by excessive alcohol consumption. MUP, along with other policy measures, can be an effective tool in achieving the draft Programme for Government outcome "We all enjoy long, healthy, active lives" and help to develop better relationships within families and communities. It also offers the opportunity to make significant financial savings within the health, justice and employment sectors.

**Consultation Question 2**

Do you believe that introducing MUP for alcohol into Northern Ireland will have an impact on reducing alcohol-related harm?

**Consultation Question 3**

Do you foresee the introduction of MUP into Northern Ireland as impacting negatively upon any specific groups?

**Consultation Question 4**

Do you believe that of the pricing options considered, that MUP for alcohol is the most effective way of achieving the policy aim of reducing harm? Are there other pricing policy options that should have been considered?

5.3 The rest of this section sets out how MUP could be implemented, subject to the outcome of the consultation and final decisions by Ministers and the Executive.

5.4 It is important to note that MUP is not seen as a “silver bullet” that will prevent and address all alcohol-related harm. It is potentially an effective part of the solution but is only one part of the overall range of actions and commitments set out in our new Substance Use Strategy “Preventing Harm, Empowering Recovery”. It will complement and build on these actions, but it does not replace the need for the overall strategy.

**MUP Level**

5.5 It is proposed that primary legislation would be brought forward that would enshrine in law the *principle* that those holding alcohol licenses will have to sell alcohol at no less than a minimum price, as established by the formula set out at paragraph 5.8, but it will not establish the level of the unit price.

5.6 At this stage the Department has deliberately chosen not to recommend a price level at which to set the MUP – we want to take the views of those responding to the consultation. However, a 50p per unit price has been used as a “worked example” by the researchers. This is also the current minimum unit price per unit used in both Scotland and Wales. The Republic of Ireland has gone for a slightly different approach and has introduced a minimum price 10 cents per gram of alcohol.

**Consultation Question 5**

Do you have any opinion on the level on which MUP should be set initially and why?

**Changing the MUP over time**

5.7 It is recognised that over time any minimum unit price will need to be reviewed as inflation will erode its effectiveness. A mechanism will need to be agreed on how these revisions to the MUP will be set. This could be achieved in two ways:

- The MUP should be set initially, and subsequently varied at regular intervals (such as every 3-5 years), by the Health Minister through secondary legislation – subject to the normal procedures and controls of the Northern Ireland Assembly. This would ensure appropriate oversight

and would provide opportunity for regular debate on this issue. It would also provide certainty on the level of the MUP for a set period.

- An alternative would be for the Health Minister to set the initial level of the MUP but then it would be automatically varied each year by an appropriate measure of inflation. This would ensure the level of the MUP was consistent over time and could come into effect on a regular date each year, e.g. 01 April, allowing businesses to plan ahead for price increases with some degree of certainty. However, this option may lead to less clarity on the exact level the MUP is set at and may create a greater regulatory burden for businesses and enforcers in that prices would automatically have to be amended every year.

**Consultation Question 6**

Do you agree that the level of the MUP should be varied over time? If so, what other information or evidence do you think should be considered when amending the MUP?

**Consultation Question 7**

If the MUP rate is to be varied over time, what do you believe would be the best method of achieving this?

**How the price would be calculated**

5.8 The total minimum price of any alcoholic product would be set according to its strength (the ABV divided by 100), volume, and the minimum price per unit[40]. This could be determined for any product using the formula below:

Minimum Price = MPU * S * V *100

Where MPU = Minimum Price Per Unit, S= Strength[41], and V = volume in litres.

**Consultation Question 8**

Do you agree with the use of the formula for setting the total Minimum price for a product?

[40] Results should be rounded to the nearest penny.
[41] Measured as ABV divided by 100.

5.9 For example, if the MUP was set at 50p per unit of alcohol the minimum price of a range of products would be as set out in Table 5:

**Table 5 – MUP Examples**

| Product | MUP | * ABV/100 | * Volume (in Litres) | * 100 | = Minimum Price |
|---|---|---|---|---|---|
| 700ml bottle of vodka at 37.5% ABV | £0.50 | * 37.5/100 | * 0.7 | * 100 | **= £13.13** |
| 35ml measure of 37.5% ABV spirit | £0.50 | * 37.5/100 | * 0.035 | * 100 | **= £0.66** |
| 500ml super-strength (9%) can of beer | £0.50 | * 9/100 | * 0.5 | * 100 | **= £2.25** |
| case of 24 x 440ml cans of 4% beer | £0.50 | * 4/100 | * 0.44 | * 100 | **= £0.88 per can; or**<br>**= £21.12 per case** |
| pint (568ml) of beer at 5% | £0.50 | * 5/100 | * 0.568 | * 100 | **= £1.28** |
| 750ml bottle of wine at 12.5% | £0.50 | * 12.5/100 | * 0.750 | * 100 | **= £4.69** |
| 2lt bottle of 6% cider | £0.50 | * 6/100 | * 2 | * 100 | **= £6.00** |
| 275ml pre-mixed ready to drink spirit and mixer (such as a alcohol-pop) at 5% | £0.50 | * 5/100 | * 0.275 | * 100 | **= £0.63** |

5.10 For the purposes of defining the strength of an alcohol product, pre-packaged drinks generally have to state on the label the drink's alcoholic strength by volume. Various labelling regimes make this a requirement. For example, regulation 30 of the Food Labelling Regulations 1996 (SI 1996/1499) requires pre-packaged alcoholic drinks, other than EU controlled wine, that have a strength of more than 1.2% to be marked or labelled with an indication of the drink's alcoholic strength by volume to one decimal place and expressed as a

percentage. This is referred to as the “declared ABV”. Certain positive and negative tolerances are permitted (for example, beers of not more than 5.5% ABV have a tolerance of plus or minus 0.5%) and these are set out in Schedule 5 to the Regulations. These tolerances mean that it is possible for the strength of alcohol to be different to the declared ABV of that product. Where pre-packaged alcohol is required by certain labelling provisions to indicate a declared ABV it is the declared ABV that should be used in calculating the minimum price of the product rather than the actual strength of the product.

5.11 Where different alcohol drinks are mixed, for example in a cocktail, the declared ABV must be used for any alcohol to which relevant labelling provisions apply and the ABV for any other alcohol. The minimum price for each alcoholic component of the drink will need to be calculated and then added together to provide a minimum price for the whole drink.

5.12 Where pre-mixed alcoholic drinks are sold, for example a gin and tonic, the relevant labelling provisions will apply to these and so they will be marked or labelled with the declared ABV and the declared ABV is to be used in order to determine the minimum price of the drink.

**Enforcement and Penalties**

5.13 The legislation would create a new condition of licensed premises whereby the selling of alcohol below the MUP would become an offence under the Licensing (Northern Ireland) Order 1996. If an offence has been, or is being committed then:

a) a notice may be issued to the holder of the licence requiring such action to be taken to remedy the breach as may be specified in the notice; or

b) an application can be made to a county court to attribute penalty points in line with offences punishable with a level 5 fine on the standard scale.

**Consultation Question 9**

Do you agree with the enforcement proposals and sanctions that would be added to the necessary legislation?

### Appeals

5.14 As per Article 83 of the Licensing (Northern Ireland) Order 1996 – without prejudice to Articles 61 and 65 of the [1980 NI 3.] County Courts (Northern Ireland) Order 1980 – any party to the proceedings who is dissatisfied with a decision of a county court on an application made to it under this Order may appeal from that decision as if the decision had been made in exercise of the jurisdiction conferred by Part III of that Order of 1980 and the appeal were brought under Article 60 of that Order of 1980.

### Outcomes, Indicators and Monitoring

5.15 Indictors and outcomes will be set to enable the impact of MUP to be measured and to evaluate its ability to achieve the overall aim of reducing alcohol related harm. The Department believes the main outcomes would be in relation to a percentage reduction in alcohol related deaths, and a percentage reduction of alcohol related hospital admissions, after 5 and 20 years of the policy implementation. However, the level at which these targets would be set will be very much influenced by the level at which an MUP is set and how it is varied over time.

5.16 In addition to these indicators, the new Substance Use Strategy is overseen by a formal Programme Board chaired by the Chief Medical Officer and a range of other supporting bodies. These groups, with the support of the Public Health Information and Research Branch, monitor progress against a range of alcohol indicators set out in the new Substance Use Strategy. These include:

- Alcohol prevalence (including drinking over daily and weekly guidelines);
- Alcohol-related deaths;
- Alcohol-related admissions to hospital;
- Numbers in treatment;
- Alcohol-related crime; and
- Drink driving.

5.17 Given the research base, it would be expected that MUP would lead to a reduction in all the indicators above and that the Department will use these measures to help monitor and evaluate the ongoing efficacy of the policy.

**Consultation Question 10**

Do you agree with the proposed targets and monitoring arrangements?

## 6. HOW TO RESPOND TO THIS CONSULTATION

6.1 This consultation seeks views on whether Minimum Unit Pricing for Alcohol should be introduced into Northern Ireland, and if so how that should be accomplished.

**Scope of this consultation:**

6.2 We are keen to hear the views of all those with an interest in this issue including:

- members of the public;
- community and voluntary sector organisations;
- those who use alcohol and alcohol related services;
- health bodies;
- health professionals;
- justice agencies;
- local councils;
- business and industry bodies;
- academics; and
- other Government Departments and agencies.

**Geographical Scope:**

6.3 As evidenced by the introduction of Minimum Unit Pricing into Scotland and Wales, this policy falls within the scope of the Northern Ireland devolved administration. We will continue to work closely with UK Government, the other devolved administrations, and the Government in Ireland on any policy proposals arising from this consultation.

**Body/Bodies Responsible for the Consultation:**

6.4 This consultation is being undertaken by the Health Development Policy Branch in the Department of Health.

**Duration:**

6.5 This consultation will be open for 12 weeks from 22 February 2022 to 17 May 2022.

**Enquiries:**

6.6 For any enquiries about the consultation, please e-mail the Department at: HDPB@health-ni.gov.uk or write to:

Minimum Unit Pricing in Northern Ireland: A Consultation
Health Development Policy Branch
Department of Health
Room C4.22, Castle Buildings
BELFAST BT4 3SQ
Tel: (028) 9052 0540

**How to Respond:**

6.7 Online: You can respond online by accessing the consultation documents on the 'Citizen Space' web service and completing the online survey there. The online version can be accessed at the following link:

www.health-ni.gov.uk/MUP-consultation

6.8 Alternatively you can respond via the e-mail or office address above, however we would much prefer responses by Citizen Space.

6.9 When you reply, it would be very useful if you could confirm whether you are replying as an individual or submitting an official response on behalf of an organisation. If you are replying on behalf of an organisation, please include:

- your name;
- your position (if applicable);
- the name of your organisation;
- an address (including postcode); and
- an e-mail address.

**Consultation Response:**

6.10 We will consider the responses received and publish an outcome report on the Department's website.

**Accessibility:**

6.11 Alternative formats of this consultation document and the questionnaire (such as other languages, large type, Braille, easy read and audio cassette) may be made available on request. Please contact the Department (at the address below) to discuss your requirements.

**Consultation Principles:**

6.12 This consultation is being conducted in line with the Fresh Start Agreement – (Appendix F6 – Eight Steps to Good Practice in Public Consultation-Engagement).[42] These eight steps give clear guidance to Northern Ireland departments on conducting consultations.

**Feedback on the Consultation Process:**

6.13 We value your feedback on how well we consult. If you have any comments about the consultation process (as opposed to comments about the issues which are the subject of the consultation), including if you feel that the consultation does not adhere to the values expressed in the Eight Steps to Good Practice in Public Consultation Engagement or that the process could be improved, please address them to:

Health Development Policy Branch
Department of Health
Room C4.22, Castle Buildings
Stormont Estate
BELFAST BT4 3SQ
Email: HDPB@health-ni.gov.uk

**Equality and Rural Screening:**

6.14 As per the Department of Health's Equality Scheme[43] and in order to comply with the Rural Needs Act (Northern Ireland) 2016[44], this policy has been

[42] https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/479116/A_Fresh_Start_-_The_Stormont_Agreement_and_Implementation_Plan_-_Final_Version_20_Nov_2015_for_PDF.pdf
[43] https://www.health-ni.gov.uk/doh-equality#toc-0
[44] https://www.legislation.gov.uk/nia/2016/19/contents

screened for both Equality/Human Rights and Rural Needs impacts. These screening documents are both available at www.health-ni.gov.uk/MUP-consultation.

6.15 These screenings have indicated that there are no adverse impacts in relation to the policy proposals.

6.16 As part of this consultation, we welcome comments on these screening documents or inputs on areas where those responding may feel we should take further information into consideration in any future screening.

**Consultation Question 11**

Do you agree with the outcome of the Impact Assessment Screenings? Have you any comments on either the Equality/Human Rights or Rural screening documents? Have you anything you believe we should be considering in future Equality/Human Rights or Rural screenings or future impact assessments?

**Regulatory Impact Assessment**

6.17 Given that this policy, if agreed to, would lead to the creation of legislation to enact MUP, the Department has also drafted a Regulatory Impact Assessment of what the impact of the introduction of such legislation would be. This is available at: www.health-ni.gov.uk/MUP-consultation.

6.18 As part of this consultation, we would welcome comments on this Regulatory Impact Assessment or comments on areas where those responding may feel we should take further information into consideration in any future regulatory impact assessments.

**Consultation Question 12**

Do you agree with outcome of the Regulatory Impact Assessment? Have you any comments on the Regulatory Impact Assessment? Have you anything you believe we should be considering in future regulatory impact assessments?

**Privacy, Confidentiality and Access to Consultation Responses:**

6.17 For this consultation, we may publish all responses except for those where the respondent indicates that they are an individual acting in a private capacity (e.g. a member of the public). All responses from organisations and individuals responding in a professional capacity may be published. When doing so, we will remove email addresses and telephone numbers from these responses; but apart from this, we may publish them in full. For more information about what we do with personal data please see the link to our consultation privacy notice at paragraph 1.19.

6.18 Your response, and all other responses to this consultation, may also be disclosed on request in accordance with the Freedom of Information Act 2000 (FOIA) and the Environmental Information Regulations 2004 (EIR); however all disclosures will be in line with the requirements of the Data Protection Act 2018 (DPA) and the General Data Protection Regulations (GDPR).

6.19 If you want the information that you provide to be treated as confidential it would be helpful if you could explain to us why, so that this may be considered if the Department should receive a request for the information under the FOIA or EIR.

6.20 DoH is the data controller in respect of any personal data that you provide, and DoH's Privacy Notice, which gives details of your rights in respect of the handling of your personal data, can be found at: https://www.health-ni.gov.uk/articles/health-development-policy-branch-and-health-improvement-policy-branch-steering-groups-privacy-notice.

# ANNEXES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**ANNEX I**

**Summary of impact of a 50p MUP by consumer type**

Non Drinkers

- Obviously, the policy will not directly affect non-drinkers in terms of consumption or spending.
- However, they will benefit from reduced levels of crime in the community, increased productivity, and reduced pressure on the health service.
- In addition, there is some evidence that supermarkets subsidise "loss-leader" alcohol products through increasing the price of other products. Therefore, their spending could fall.

Moderate Drinkers

- The research shows that moderate drinkers (i.e. for the purposes of the research defined as men who drink less than 21 units a week and women who drink less than 14 units a week) drink an average of 5.3 units per week (i.e. approximately three 330ml bottles of 5% beer) and spend £377 per year on alcohol.
- Overall, a 50p MUP would mean they would drink 5.2 units (again approximately three 330ml bottles of 5% beer) less per year.
- They would spend an additional £4.70 per year on alcohol.
- There would be no fewer alcohol-related deaths among moderate drinkers, but there would be 70 fewer alcohol-related admissions to hospital.
- Overall, moderate drinkers would commit 382 fewer criminal offences per year and suffer 2,700 fewer absent days from work.
- As per non drinkers – moderate drinkers would benefit from reduced levels of crime in the community, increased productivity, and reduced pressure on the health service.

Hazardous Drinkers

- The research shows that hazardous drinkers (i.e. men who drink between 21-50 units a week and women who drink between 14-35 units a week) drink an

average of 26.8 units per week (i.e. approximately 15 330ml bottles of 5% beer) and spend £1,344 per year on alcohol.

- Overall, a 50p MUP would mean they would drink 67.6 units (approximately 40 bottles of 5% beer) less per year.
- They would spend an additional £16.50 per year on alcohol.
- There would be 19 fewer alcohol-related deaths and 670 fewer alcohol-related admissions to hospital among hazardous drinkers.
- Overall, hazardous drinkers would commit 2,214 less criminal offences per year and suffer 16,600 fewer absent days from work.
- As per other categories – hazardous drinkers would benefit from reduced levels of crime in the community, increased productivity, and reduced pressure on the health service.

Harmful Drinkers

- The research shows that harmful drinkers (i.e. men who drink 50+ units a week and women who drink 35+ units a week) drink an average of 86.5 units per week (i.e. approximately 15 330ml bottles of 5% beer) and spend £3,471 per year on alcohol.
- Overall, a 50p MUP would mean they would drink 384.8 units (approximately 226 330ml bottles of 5% beer) less per year.
- They would spend £1.50 less per year on alcohol.
- Per year, there would be 43 fewer alcohol-related deaths and 1,680 fewer alcohol-related admissions to hospital among harmful drinkers.
- Overall, harmful drinkers would commit 2,697 fewer criminal offences per year and suffer 15,700 fewer absent days from work.
- As per other categories – harmful drinkers would benefit from reduced levels of crime in the community, increased productivity, and reduced pressure on the health service.

In Poverty[45]

- The research shows that those in poverty (approximately 20% of the population) who drink consume an average of 11.6 units per week (i.e. approximately seven 330ml bottles of 5% abv beer) and spend £703 per year on alcohol.
- It should be noted, that 32% of those in poverty don't drink at all, and those would not be directly impacted by the policy.
- Overall, a 50p MUP would mean those in poverty who drink would consume 83.2 units (approximately fifty 330ml bottles of 5% abv beer) less per year.
- They would spend £6.10 less per year on alcohol.
- Per year, the death rate per 100,000 would fall by 9.6 and hospital admissions per 100,000 would fall by 317.
- As per other categories, those in poverty – whether they drink or not – would benefit from reduced levels of crime in the community, increased productivity, and reduced pressure on the health service.

Not In Poverty

- The research shows that those not poverty (approx 80% of the population) who drink consume an average of 11.5 units per week (i.e. approximately seven 330ml bottles of 5% abv beer) and spend £814 per year on alcohol.
- It should be noted, that 24% of those in poverty don't drink at all, and those would not be directly impacted by the policy.
- Overall, a 50p MUP would mean those not in poverty who drink would consume 36.4 units (approximately 21 x 330ml bottles of 5% abv beer) less per year.
- They would spend £9.20 more per year on alcohol.
- Per year, the death rate per 100,000 would fall by 3.0 and hospital admissions per 100,000 would fall by 132.
- As per other categories, those in poverty – whether they drink or not – would benefit from reduced levels of crime in the community, increased productivity, and reduced pressure on the health service.

[45] Defined as those individuals who have an equalivised household income below 60% of the population median.

**ANNEX II**

## Full List of Consultation Questions

### Consultation Question 1

Do you agree with the overall policy aim of reducing the harm alcohol causes?

### Consultation Question 2

Do you believe that introducing MUP for alcohol into Northern Ireland will have an impact on reducing alcohol-related harm?

### Consultation Question 3

Do you foresee the introduction of MUP into Northern Ireland as impacting negatively upon any specific groups?

### Consultation Question 4

Do you believe that of the pricing options considered, that MUP for alcohol is the most effective way of achieving the policy aim of reducing harm? Are there other pricing policy options that should have been considered?

### Consultation Question 5

Do you have any opinion on the level on which MUP should be set initially and why?

### Consultation Question 6

Do you agree that the level of the MUP should be varied over time? If so, what other information or evidence do you think should be considered when amending the MUP?

### Consultation Question 7

If the MUP rate is to be varied over time, what do you believe would be the best method of achieving this?

### Consultation Question 8

Do you agree with the use of the formula for setting the total Minimum price for a product?

**Consultation Question 9**

Do you agree with the enforcement proposals and sanctions that would be added to the necessary legislation?

**Consultation Question 10**

Do you agree with the proposed targets and monitoring arrangements?

**Consultation Question 11**

Do you agree with the outcome of the Impact Assessment Screenings? Have you any comments on either the Equality/Good Relations or Rural screening documents? Is there anything you believe we should be considering in future Equality/Good Relations or Rural screenings or future impact assessments?

**Consultation Question 12**

Do you agree with the outcome of the Regulatory Impact Assessment? Have you any comments on the Regulatory Impact Assessment? Is there anything you believe we should be considering in future regulatory impact assessments?

**ANNEX III**

## Table 6 - The potential impacts of a 50p MUP on a range of drinks.

| Product | Current Price | MUP | Strength (ABV/100) | Volume (in litres) | Min Price with t MUP | Diff |
|---|---|---|---|---|---|---|
| **Beer** | | | | | | |
| Budweiser 20 pack (300 ml) | £14.00 | 0.5 | 0.045 | 6 | £13.50 | No Impact from MUP |
| Fosters 18 pack (440ml) | £11.99 | 0.5 | 0.04 | 7.92 | £15.84 | £3.85 |
| John Smiths Extra Smooth (18 x 440ml) | £15.00 | 0.5 | 0.036 | 7.92 | £14.26 | No Impact from MUP |
| Blue Moon Wheat Beer (330ml) | £1.80 | 0.5 | 0.054 | 0.33 | £0.89 | No Impact from MUP |
| Bavaria (500ml) | £1.00 | 0.5 | 0.043 | 0.5 | £1.08 | £0.08 |
| Guinness Draught cans (15 x 440ml) | £12.99 | 0.5 | 0.041 | 6.6 | £13.53 | £0.54 |
| Triple Karmelite Beer (750ml) | £5.00 | 0.5 | 0.084 | 0.75 | £3.15 | No Impact from MUP |
| Heineken Lager Beer (4 x 440ml) | £4.75 | 0.5 | 0.05 | 1.76 | £4.40 | No Impact from MUP |
| **Cider** | | | | | | |
| Tesco Apple Cider 4 pack (440ml) | £2.20 | 0.5 | 0.04 | 1.76 | £3.52 | £1.32 |
| Magners Original 10 pack (440ml) | £7.99 | 0.5 | 0.045 | 4.4 | £9.90 | £1.91 |
| Kopparberg Mixed Fruit Cider (12 x 330ml) | £13.00 | 0.5 | 0.04 | 3.96 | £7.92 | No Impact from MUP |
| Westons Wyld Wood Organic Cider (3L) | £7.35 | 0.5 | 0.06 | 3 | £9.00 | £1.65 |
| Crofters (2L) | £2.05 | 0.5 | 0.05 | 1.76 | £4.40 | £2.35 |
| Strongbow Original 18 pack (440ml) | £10.99 | 0.5 | 0.045 | 7.92 | £17.82 | £6.83 |
| **Wine** | | | | | | |
| Tesco Zesty White Wine Bag in a Box (3L) | £14.50 | 0.5 | 0.11 | 1 | £5.50 | No Impact from MUP |

| | | | | | | |
|---|---|---|---|---|---|---|
| Tesco Medium Dry Fiortified British Wine (1L) | £5.50 | 0.5 | 0.15 | 1 | £7.50 | £2.00 |
| Blossom Hill Californian Red (750ml) | £5.00 | 0.5 | 0.12 | 0.75 | £4.50 | No Impact from MUP |
| Lambrini Bianco (750ml) | £1.80 | 0.5 | 0.075 | 0.75 | £2.81 | £1.01 |
| Tesco Finest English Sparkling Wine (750ml) | £21.00 | 0.5 | 0.12 | 0.75 | £4.50 | No Impact from MUP |
| **Spirits** | | | | | | |
| Tesco Imperial Vodka (700ml) | £11.50 | 0.5 | 0.375 | 0.7 | £13.13 | £1.63 |
| Smirnoff Red Label Vodka (1L) | £22.50 | 0.5 | 0.375 | 0.7 | £13.13 | No Impact from MUP |
| Scots Club Blended Scotch Whisky (700ml) | £10.99 | 0.5 | 0.4 | 0.7 | £14.00 | £3.01 |
| Johnnie Walker Red Label Whisky (1L) | £22.00 | 0.5 | 0.4 | 1 | £20.00 | No Impact from MUP |
| Tesco Dry London Gin (1L) | £15.38 | 0.5 | 0.357 | 1 | £17.85 | £2.47 |
| Bombay Sapphire Dry Gin (700ml) | £21.00 | 0.5 | 0.4 | 0.7 | £14.00 | No Impact from MUP |
| **RTD** | | | | | | |
| Tesco Vodka Lime & Lemonade 4 pack (250ml) | £4.00 | 0.5 | 0.06 | 1 | £3.00 | No Impact from MUP |
| Wkd Blue Lagoon Ready to drink cocktail (700ml) | £5.00 | 0.5 | 0.04 | 0.7 | £1.40 | No Impact from MUP |
| Vk Mix Pack (10 x 275ml) | £10.00 | 0.5 | 0.04 | 2.75 | £5.50 | No Impact from MUP |
| House of cocktails Mojito (250ml) | £0.75 | 0.5 | 0.04 | 0.25 | £0.50 | No Impact from MUP |
| Hooch lemon (700ml) | £2.85 | 0.5 | 0.04 | 0.7 | £1.40 | No Impact from MUP |

Based on prices @ Tesco.com 20 January 2022