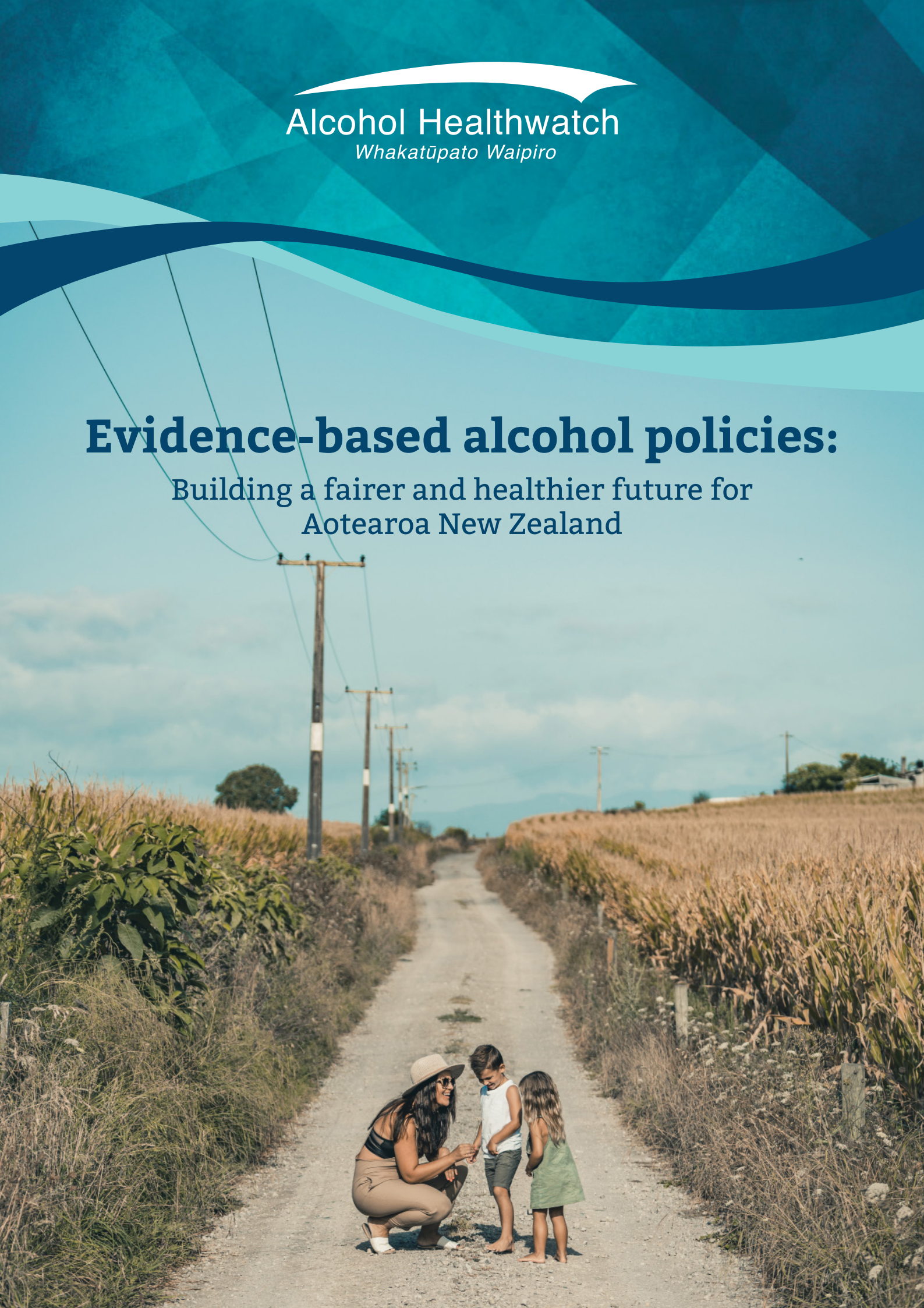
Alcohol Healthwatch
Whakatūpato Waipiro

Evidence-based alcohol policies:

Building a fairer and healthier future for Aotearoa New Zealand



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Introduction

Reducing the harm from alcohol can **improve the life of every person in Aotearoa New Zealand** – and especially, the lives of the most vulnerable in our communities. We can build healthier norms for drinking and leave a legacy for future generations to reap the benefits.

When less alcohol is consumed in our country, the benefits are huge and wide-ranging – for drinkers and others harmed by drinkers. The benefits include (but not limited to):

- Reduced social, economic and health inequities experienced by Māori;
- Reduced inequities in alcohol harm experienced by Pacific people and low income populations;
- Reduced family and sexual violence;
- Improved child wellbeing;
- Improved mental health;
- Reduced suicide;
- Lower rates of alcohol-related cancers (e.g. bowel and breast cancer);
- Safer communities for all;
- Safer and less stressful workplaces, particularly for Police staff and frontline health and social services staff;
- Lower rates of alcohol-involved road deaths and injuries (to drivers, passengers and other road users);
- Stronger economy, improved business productivity, lower unemployment; and
- Large cost savings, especially for ACC, and the justice, health, and welfare sectors.

Safer roads ❦ Fewer cancers ❦ Safer communities
Better health ❦ Cost-savings ❦ Happier families
Real connections ❦ Happier children

There is no doubt that these are crucial times for our health and economy. Actions to address the factors driving **longstanding health inequities** in our country are imperative and must remain at the forefront of the current pandemic response. Pro-equity alcohol policies are available and are urgently required to:

- Address the disproportionate impact that alcohol has on Māori; and
- Uphold and honour our collective obligations to Te Tiriti o Waitangi.

The strength of our action on alcohol will play an important role in the long-term recovery of our economy, as well as our public health preparedness for future pandemics. Alcohol use increases the risk of more than 200 health conditions, many of which weaken the body's defences against infections, including COVID-19.[1,2] The frequency of co-morbidity within persons with alcohol use disorders (including obesity with metabolic syndrome, chronic kidney disease, etc.) also heightens future risk.[2,3] Actions must be taken to reduce the cost burden to society from alcohol harm, estimated to be >$7 billion per year.

We commend successive Government budget commitments to increase funding for mental health and addiction services. However, a greater move towards the 'top of the cliff' is required, as effective prevention can avert long-term suffering to individuals, families and communities. Action is needed early in the life course given 70% of alcohol abuse and dependence cases in Aotearoa New Zealand are developed by the age of 25 years.[4] Prevention is therefore ethically and fiscally responsible.

Given the disproportionate harm from alcohol experienced by Māori, Pacific people and low income populations, evidence-based alcohol policies are also pro-equity. **Alcohol Healthwatch recommends adoption of the following pro-equity policies:**

- Amend the Sale and Supply of Alcohol Act 2012 to require it to give effect to Te Tiriti o Waitangi;
- Increase the price of alcohol via substantive (beyond CPI) increases to alcohol excise tax;
- Implement Minimum Unit Pricing (and implement s397(1d) of our alcohol Act to collect industry sales data);
- Amend the Sale and Supply of Alcohol Act 2012 to give communities greater control in licensing decision-making;
- Immediately fund the replacement of alcohol sponsorship of sports;
- Legislate greater controls on alcohol advertising;
- Increase funding for alcohol screening and brief interventions in health services;
- Increase funding to recognise FASD as a standalone disability;
- Increase funding so that best practice levels of roadside alcohol breath testing are attained; and
- Increase the legal purchase age for alcohol to 20 years.

Improving health, wellbeing and equity is an incredible legacy to leave behind. By taking an evidence-based alcohol harm reduction approach, we can take important and confident steps towards uncapping the potential of our amazing country. We were once leaders in tobacco control and saved many lives; we can, and must, do the same for alcohol control.

Current context of alcohol use

Any drinking in the past year

In 2019/20, **81.5% of adults** (aged 15 years and over) reported drinking alcohol in the past year.[5] Among the total population:

- Men (85%) were significantly ***more likely*** to drink than women (79%);
- Māori were ***as likely*** to drink as non-Māori;
- Adults living in the most socio-economically deprived areas (73%) were significantly ***less likely*** to drink when compared to those living in the least deprived areas (88%);
- 57.5% of 15-17 year olds consumed alcohol in the past year; and
- Pacific persons were significantly ***less likely*** to drink compared to non-Pacific persons.

Hazardous drinking

One in five adults (20.9%) were classified as hazardous drinkers in 2019/20.[5] This equates to **838,000** drinkers. Among the total population:

- Males (28.7%) were twice as likely as females (13.6%) to be hazardous drinkers;
- 44% of Māori men and 29% of Māori women reported hazardous drinking;
- 37% of males and 28% of females aged 18-24 reported hazardous drinking; and
- Hazardous drinking prevalence was high among those aged 25–34 (24%), 35–44 (22%) and 45–54 (27%).

Among drinkers:

- Adult drinkers in the most socio-economically deprived areas were 1.3 times ***more likely*** to consume 6+ drinks on an occasion at least weekly, when compared to adults in the least deprived areas (among women, 1.75 times); and
- Pacific drinkers were 1.4 times ***more likely*** to report hazardous drinking than non-Pacific drinkers.

Changes in drinking over time

Between 2006/07 and 2011/12, there were **significant reductions in hazardous drinking**. Most demographic groups (by age, sex, ethnicity) reduced their alcohol use during this time. The reasons and exact timing of the start of these declines is unknown. It is unclear if the decline commenced prior to the Global Financial Crisis.

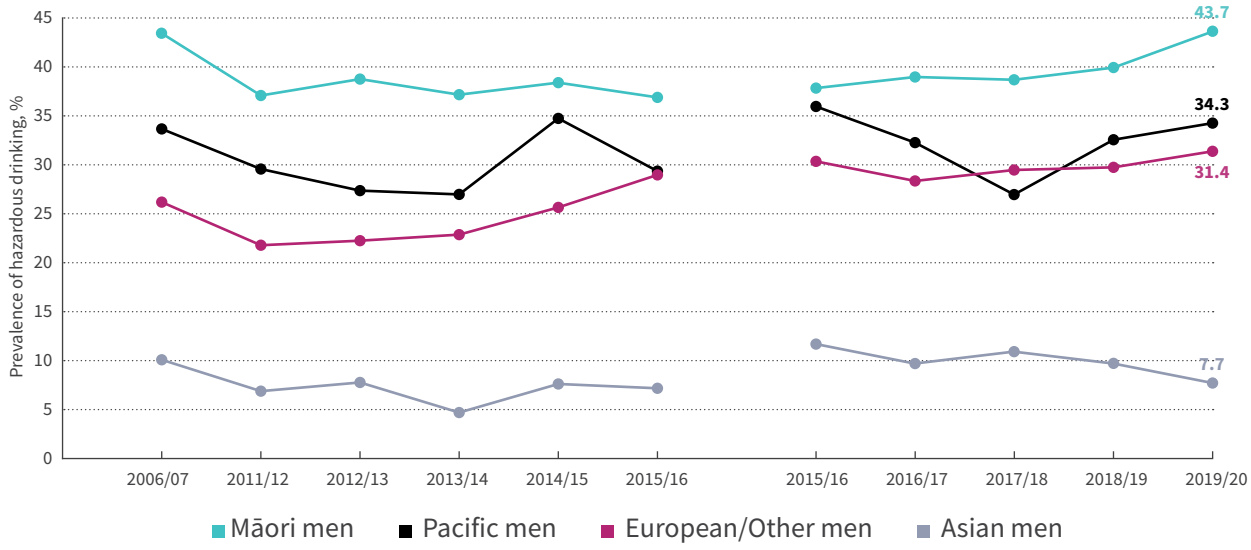
Among 15-17 year olds, these lower levels of hazardous drinking have largely been maintained over time.[6] In 2019/20, significant increases in hazardous drinking were found in this age group (from 6.3% in 2018/19 to 11.6%)[5], but changes to the survey arising from COVID-19 may explain this. Further surveys are needed to determine if this is a one-off increase.

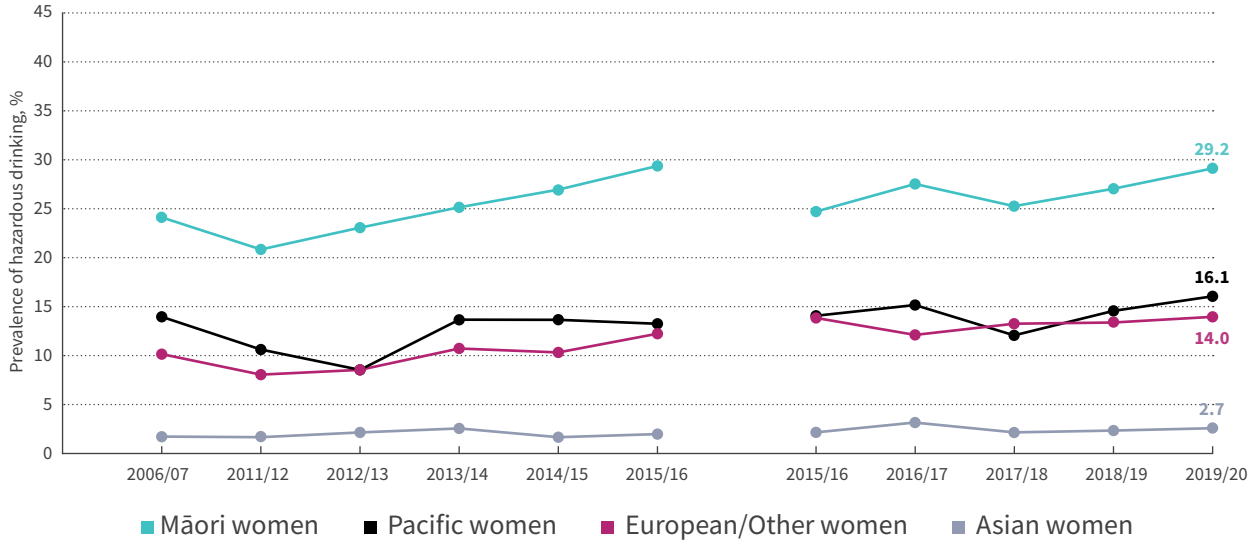
Inequities in drinking among rangatahi are stark and preventable – the New Zealand Health surveys from 2012/13 to 2015/16 found rangatahi Māori males and females were **two to three times *more likely*** to be classified as hazardous drinkers than non-Māori males and females.[7] The Youth'19 Health Survey found **22% of secondary school students reported binge drinking in the past month**, with the prevalence higher among rangatahi Māori (29%), 16 year olds (29%) and those aged 17 years or over (42%).[8]

Young adults aged 18 to 24 years remain Aotearoa New Zealand's most hazardous drinkers. The prevalence of hazardous drinking **significantly reduced** between 2006/07 and 2011/12, but has remained mostly stable since.[6]

Among older adults, especially those aged 35–74 years, **hazardous drinking significantly increased** between 2011/12 and 2015/16. The largest increases were found among Māori women (Fig 1). Since this time, hazardous drinking prevalence has remained at these high levels, and are particularly high among men of all age groups. It is important to note that the survey methodology changed in 2015/16 – this means that comparisons are only permitted between 2006/07 and 2015/16 and between 2015/16 to 2019/20. In the 2015/16 national survey, both the previous and new methods were used.

Figure 1. Trends in the prevalence (unadjusted) of hazardous drinking, by ethnicity and sex. New Zealand Health Survey.





Types of beverages consumed

In 2019, **491 million litres of alcohol** were available for consumption in Aotearoa New Zealand.[9] This measure is used as a proxy for alcohol consumption in the population and is derived from alcohol excise payments for alcohol available for sale in the domestic market.

Of this total volume:

- 298 million litres were beer (61% of total);
- 108 million litres were wine (22%);
- 70 million litres were RTDs (14%); and
- 15 million litres were spirits (3%).

The 491 million litres of alcoholic beverages contained **35.3 million litres of pure alcohol** (as each beverage listed above has a different alcohol content). An almost equivalent amount of pure alcohol was consumed in beer, wine and spirits:

- 13 million litres of pure alcohol were from beer (37% of total)
- 11 million litres of pure alcohol were from wine (32%)
- 11 litres of pure alcohol were from spirits or RTDs (31%).

There has been an **increasing contribution of spirits and spirits-based drinks** to Aotearoa New Zealand's pure alcohol intake over time, from 23% in 2004 to 31% in 2019.[9] In 2012/13, Māori were 2.1 times more likely, and Pacific people 1.5 times more likely, to drink RTDs on a typical occasion compared to non-Māori and non-Pacific drinkers. Individuals living in the most deprived neighbourhoods were two times more likely to consume RTDs than those living in the least deprived.[10] Māori, Pacific and low income drinkers were significantly less likely to consume wine than the relevant reference group.[10]

Impact of COVID-19 on drinking

It is clear that the global pandemic has had an immediate impact on alcohol consumption in Aotearoa New Zealand, and that it represents a picture of both good and bad news. During Level 4 lockdown and post lockdown Level 1, the Health Promotion Agency surveyed[11] drinkers about their alcohol use. Among those who had consumed alcohol in the past four weeks, key findings showed that **when compared to pre-lockdown:**

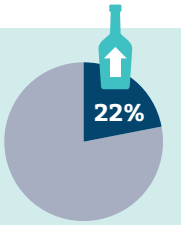
	↑ **increased** their consumption	= **no change** in consumption	↓ **decreased** their consumption
During Level 4 lockdown	19%	47%	34%
In Level 1	14%	64%	22%

Key findings by ethnicity and age (when compared to prelockdown) showed:

- 22% of Māori drinkers increased their consumption in Level 4 lockdown. This prevalence **did not** decrease once lockdown ended (22% had also increased consumption at Level 1);
- 20% of Pasifika drinkers increased their consumption in Level 4 lockdown, halving to 10% at Level 1;
- 51% of 18-24 year olds decreased their consumption in Level 4 lockdown, and 26% at Level 1; and
- 19% of 18-24 year olds increased their consumption in Level 4 lockdown, and 23% at Level 1.

Across all study participants, reasons given for drinking more included: 1) it helps me **relax/switch off**, 2) I have been feeling **stressed out/anxious**, and 3) I have been **bored**.[11]

Early findings show that 22% of Māori drinkers increased their consumption during Level 4 lockdown and this did not decrease following the end of lockdown



Reasons given for drinking less included: 1) haven't been able to, or haven't wanted to, socialise as much or go out/visit the pub etc., 2) money/cost, 3) haven't wanted to go out and buy alcohol, 4) physical health reasons (e.g. weight, health condition, to be healthier), and 5) the lockdown period was a good time to reduce how much I drink and I want to continue drinking less.[11]

It is imperative that we do everything we can to support Aotearoa New Zealanders who have maintained lower levels of drinking during, and after, Level 4 lockdown. This is the 'good news' of alcohol use during the global pandemic.

Some impacts of the pandemic on alcohol use will likely be immediate, whilst others will occur over a longer time period.[12] The longer term impacts are believed to include a **normalisation of home drinking**, reinforcing or introducing drinking as a way to **self-medicate symptoms** of stress, anxiety, boredom and an increased prevalence of newly diagnosed patients with alcohol use disorders (as well as **relapse** among persons with a disorder).[2,13–16]

Many people will **use alcohol to cope** with the on-going impacts of the pandemic. Research shows that individuals who drink for coping reasons are at a heightened risk of developing problems with alcohol.[17] Depression and anxiety have been found to be associated with drinking to cope.[17] Factors such as unemployment, time spent unemployed, redundancy, increased workloads and reduced workplace morale due to loss of staff are also likely to result in a heightened vulnerability to developing new, or exacerbating existing, alcohol-related problems.[18]

Alcohol harm to drinkers and others

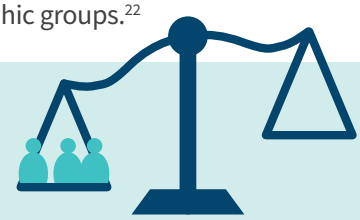
There is overwhelming evidence that alcohol-related harm in New Zealand is unacceptably high to both drinkers and others, and plays an undeniable role in the social, economic and **health inequities experienced by Māori.**

Pacific people and low income populations also experience disproportionately more harm from alcohol, as well as the following persons who are especially vulnerable:

- unborn babies;
- children and young people;
- people living with mental illness;
- homeless and vulnerably housed populations;
- people experiencing, or at risk of, family violence (especially women and children); and
- high risk drinkers and those experiencing alcohol dependence.

Of all drugs available in our society, alcohol is the most harmful.[19,20] More Aotearoa New Zealanders report being harmed by the drinking of others, than from their own drinking.[21] Wāhine Māori are shown to experience disproportionately more harms from the drinking of others than other demographic groups.[22]

Alcohol harm is inequitable – individuals and communities bear more of the burden than others



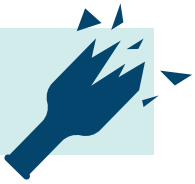
Death and disability	• Alcohol consumption is a component cause for more than **200 disease** and injury conditions.[23] • In 2007, it was estimated that there were over **800 deaths** from alcohol in Aotearoa New Zealand. This resulted in 13,769 years of life lost.[24] • Alcohol is the **leading behavioural risk factor** for death and Disability Adjusted Life Years lost among Aotearoa New Zealanders aged 15 to 49 years.[25]
Harm to Māori	• In 2007, the age-standardised premature death rate for Māori from alcohol was **2.5 times** the rate for non-Māori. The years of life lost due to alcohol were 2.6 times greater for Māori than non-Maori.[24] • Higher proportions of cancer among Māori are due to alcohol, with an average of 12.7 years of life lost from alcohol-attributable cancer for Māori compared to 10.1 years for non-Māori.[26] • Research estimates that 35% of the relationship between Māori ethnicity and hazardous drinking is explained by **experience of discrimination**.[27] • More Māori drinkers report harms to their financial position as a result of their drinking, when compared with European/Others. Māori drinkers have also been found to be 2.0 times more likely to be absent from their work because of their drinking.[10]

Exacerbates inequities	• Research shows that persons living in deprived communities experience ***more harm per drink*** when compared to those living in the least deprived communities with the same level of drinking.[28]
Injuries	• Injuries are the **leading cause of alcohol-related deaths** among males in Aotearoa New Zealand.[24]
Cancer	• Alcohol is a Group 1 carcinogen[29], causally associated with **seven types of cancer** (including bowel, female breast and liver cancer).[30] • Cancers account for 30% of all alcohol-attributable premature deaths in Aotearoa New Zealand.[24] • **Breast cancer is the leading cause** of alcohol-attributable death among females in Aotearoa New Zealand.[24] • More than one-third of these alcohol-attributable breast cancer deaths were attributed to an average consumption of **<2 standard drinks per day**.[26]
Poor mental health and suicide	• Mental health issues can fuel alcohol use, and alcohol use can fuel mental health issues.[31,32] • *Suicide:* Regular heavy drinking, as well as single occasion drinking (even at low levels),[33,34] has been shown to significantly increase the risk of suicide.[33–35] • Heavy drinking is understood to facilitate suicidal behaviour in those already at risk, possibly by increasing impulsivity, impaired judgment and aggression.[31] • In 2017, almost one-third (31.1%) of all Aotearoa New Zealanders who had completed suicide had alcohol in their system, and a further 26.2% had a trace of alcohol in either their blood or urine.[36] • *Dementia:* Alcohol use disorders have been found to be a **major risk factor** for the onset of all types of dementia, especially early-onset dementia.[37] • *Mental health harms to others:* Aotearoa New Zealand research[38] shows that persons with greater exposure to heavy drinkers in their life are **less satisfied with their life**, health, personal relationships, and have lower community connectedness. They also report experiencing more pain, discomfort, anxiety and depression.

Fetal Alcohol Spectrum Disorder (FASD)	• Alcohol is the one of the **most dangerous drugs** to be consumed during pregnancy. It can lead to miscarriage, still birth, and organ and brain damage. The negative impacts on the brain and body of individuals prenatally exposed to alcohol means individuals with FASD experience significant challenges in their daily life and may require support with learning, memory, attention, emotional regulation, social skills, motor skills and physical health. • It is estimated that: – 48% of children diagnosed with FASD will have significant and permanent impairment in 6 or more brain domains (three being the minimum requirement for a confirmed diagnosis);[39] – an estimated **1,800 babies** are born each year with FASD in Aotearoa New Zealand[40], although this is likely to be underestimate; – around half of the children and young people in Oranga Tamariki care are affected by FASD;[41] – 10-20% of people in prisons and other correctional settings have an FASD;[42] – around 80% of adults with an FASD will not be able to live independently without some level of support;[43] and – children and adolescents with an FASD have a 95% lifetime likelihood to experience mental health issues[44]; individuals with FASD have a much higher risk of suicidal behaviour than the general population.[45–47]
Road deaths	• In 2018, **125 (33%) of the 378 road deaths** in Aotearoa New Zealand involved alcohol.[48] • In the years 2016-2018, for every 100 alcohol or drug-impaired drivers or riders who died on our roads, 30 of their passengers and 25 road users died with them.[49]
Domestic, family and sexual violence	• Aotearoa New Zealand research shows that alcohol use increases the **likelihood and severity** of domestic violence.[50] • Alcohol is involved in **one-third of all violence** (33%), one-third of all family violence (34%), and half of all sexual assaults (57%) and homicides (49.5%).[21,51] • Wāhine Māori, in particular, are more likely to experience violence committed by someone under the influence of alcohol.[52] • Family violence in Aotearoa New Zealand is estimated to account for 41% of a frontline police officer's time.[53]

Child maltreatment	• Children are at a high risk of death from maltreatment when they live with caregivers who abuse alcohol. • In a national study, almost one in five persons (17%) who had a heavy drinker in their life reported that their **children were negatively affected** (e.g., being verbally abused, witnessed violence) by this person's drinking.[54] • Children's exposure to violence has been shown to impact brain development. In a longitudinal study, children who had witnessed violence against their mother scored lower on cognitive measures, with the effects being strongest in those traumatised in the first two years of life.[55] • The long-term physical and mental health impacts of exposure to family harm are well documented elsewhere.[56]
Poor economic performance and productivity	• Economic growth is negatively associated with the level of alcohol consumption in a country.[57] • Lost output (e.g. **unemployment, premature death, lost productivity**) is the largest financial cost associated with alcohol-related harm.[58] • In 2019, the population level cost of lost productivity due to alcohol was estimated to be $1.65 billion.[59] • The more alcohol-related harms an adolescent experiences in Aotearoa New Zealand, the **less likely they are to complete high school**.[60] • The estimated annual societal cost of alcohol is estimated to be $7.85 billion – much higher than the level of Government revenue from alcohol excise tax ($1.07 billion in 2019).[61,62]
Harm to healthcare professionals and other staff	• A 2014 survey of Australasian Emergency Department (ED) staff found that 98% of staff in Australia and Aotearoa New Zealand reported experiencing alcohol-related verbal aggression and 92% reported **physical aggression** in the workplace, with 68% experiencing **verbal aggression** frequently.[63] • Alcohol-related presentations were perceived to negatively or very negatively affect waiting times, other patients in the waiting room, and the care of other patients. Alcohol-affected patients were perceived to have a negative or very negative impact on staff workload, wellbeing and job satisfaction.[63]
Lower rates of quitting smoking	• Heavy drinking is associated with **lower rates of quitting and making a quit attempt**,[64] compromising achievement of the Smokefree 2025 goal.

With less alcohol harm, we have the potential to improve everyone's lives



Give effect to Te Tiriti o Waitangi in alcohol legislation

There is compelling evidence of the unequal harm from alcohol/waipiro to Māori. The legacy of colonisation, and the inequalities and cultural alienation arising from it, are described as key drivers behind these unjust differences.[22,65] The impact of alcohol harm **further drives** the long-standing social, health and economic inequities between Māori and non-Māori.[22]

In Aotearoa New Zealand, the social, economic and physical environments are key determinants of inequities in drinking and harm for Māori. They must be urgently addressed to improve Māori health outcomes, equity and wellbeing.

Impact of discrimination. Studies show that experience of discrimination substantially increases the risk of hazardous drinking among rangatahi Māori[66] and among Māori adults.[27,67] Research estimates that **35% of the relationship** between Māori ethnicity and hazardous drinking is explained by experience of discrimination.[27]

Impact of deprivation. Non-Māori are more advantaged than Māori across all Census socioeconomic indicators.[68] Research shows that deprived communities experience **more harm per drink**, when compared to the least deprived communities with the same level of drinking. Research in Aotearoa New Zealand has also found there to be disproportionately more harm (i.e. dependence, alcohol-related disorder) per drink among drinkers unemployed or of low socio-economic status.[69] Studies show that increasing social welfare spending has the greatest impact on reducing alcohol-related mortality.[70]

Unequal exposure to, and harms from, alcohol risk environments. Māori are more likely to be exposed to key environmental risk factors that increase alcohol use and harm. These relate to low alcohol prices, high alcohol outlet availability and ubiquitous alcohol marketing and sponsorship. Māori have:

- Higher exposure to alcohol outlets when living in deprived areas;[71,72]
- Disproportionately higher risk of hazardous drinking (among young Māori males) when living in closer proximity to alcohol outlets;[73]
- Higher exposure to cheap alcohol (via price competition in areas with outlet proliferation) and higher likelihood of purchasing very cheap alcohol;[74] and
- Substantially higher exposure to alcohol advertising among tamariki, especially in their neighbourhood environments.[75,76]

These social, economic and physical environments play a large role in inequities in drinking patterns. As shown in Figure 1 (page 5), 43.7% of Māori men reported hazardous drinking in 2019/20 compared to 31.4% of European/Other men.[5] Among women, the differences were much larger, with 29.2% of wāhine Māori reporting hazardous drinking compared to 14.0% of European/Other women. Adjusted ratios showed Māori men were 1.57 times more likely to drink hazardously than non-Māori men and wāhine Māori were 2.22 times more likely than non-Māori women to report hazardous drinking. These differences translate to a doubling in the years of life lost due to alcohol for Māori, when compared to non-Māori.[24]

Figure 1 also shows the rapid and consistent increases in hazardous drinking among wāhine Māori between 2011/12 and 2015/16. Despite clear evidence of these substantial annual increases in drinking (and likely harm), no strong political action was specifically prioritised to reduce these inequities. The increase in harm went unchecked.

It is important to note that, until recently, Māori were significantly **less likely** than non-Māori to drink alcohol. The 1996/97 New Zealand Health Survey found that 27.4% of Māori adults reported no alcohol use in the past year[77], compared to 12.9% of European/Other adults. By 2006, this gap had substantially reduced to 15.7% of Māori compared to 12.1% of European/Other adults.[78]

The COVID-19 pandemic has already given rise to **increased inequities**. During Level 4 lockdown, 22% of Māori drank more than usual, compared to 20% of Pasifika and 18% of Non-Māori/non-Pasifika drinkers.[11] Post lockdown in Level 1, 10% of Pasifika were drinking more than usual and 13% of Non-Māori/non-Pasifika drinkers. In contrast, 22% of Māori drinkers continued to drink more than usual.[11] The overall increase in consumption indicates that it may be heavy drinkers that have increased their consumption during the pandemic[11], as found elsewhere.[79] It must be noted that many Māori have reduced their consumption since the pandemic[11] and these positive changes need to be supported and maintained.

The Crown has a duty to uphold and honour its obligations to Te Tiriti o Waitangi by addressing the disproportionate exposure to risk and impact that alcohol has on Māori.

David Ratuu's (Ngaati Te Ata Waiohua, Waikato, Ngaati Maniapoto) claim [Wai2624] to the Waitangi Tribunal's Health Services and Outcomes Kaupapa Inquiry [Wai2575] clearly articulates the alcohol-related prejudice to Māori as a result of the Crown's legislative failings. Numerous examples of case law demonstrate the consistent failure of the Sale and Supply of Alcohol Act 2012 to incorporate the Treaty or its principles. This failure has significant implications across all aspects of alcohol control, especially in relation to guaranteeing Māori representation in alcohol licensing decisions that affect the wellbeing of current and future generations.

The Sale and Sale Supply of Alcohol Act 2012 must be amended to ensure proper recognition of the Treaty and the special status of Māori. This is supported in the report of the New Zealand Health and Disability System Review.[80] Structural and cultural shifts are also required, through addressing racism and discrimination in Aotearoa New Zealand and enabling a fully empowered commissioning authority to plan and fund kaupapa Māori services that prevent and reduce alcohol harm to Māori. A proportion of alcohol excise revenue should be earmarked to sufficiently provide for this.

Recommendation #1.

Amend the Sale and Supply of Alcohol Act 2012 to ensure proper recognition of the Treaty and the special status of Māori

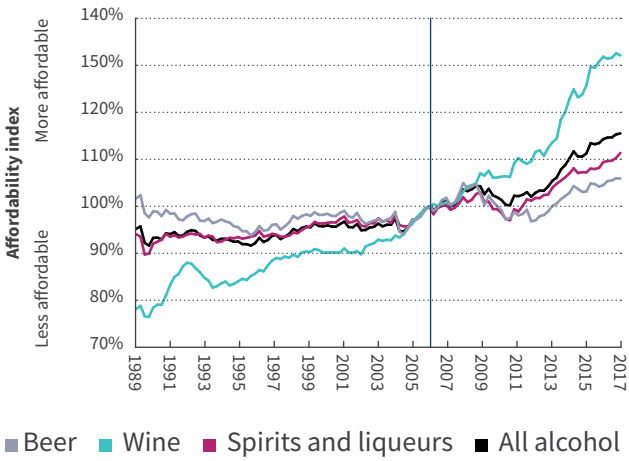
Reduce the harm from cheap alcohol

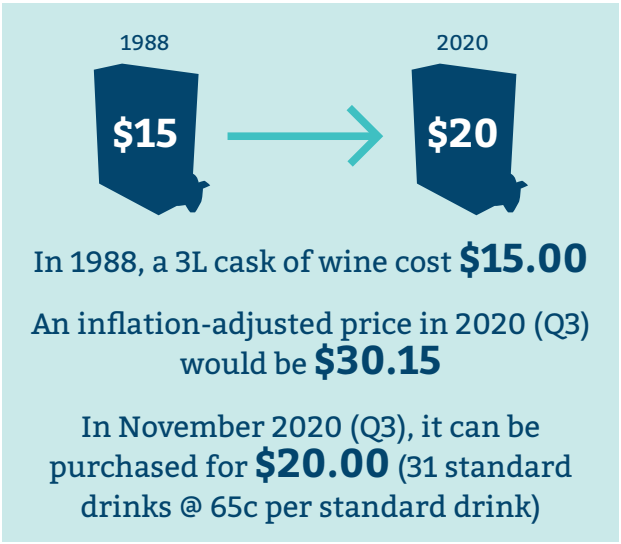
The real price of alcohol and its affordability (price relative to income) **are strong drivers** of alcohol use.[81,82] Research in Aoteaora New Zealand has shown that when incomes increase and the real price of alcohol decreases, consumption levels go up.[83]

The affordability of alcohol in Aotearoa New Zealand has substantially increased over time (Figure 2).[84] **In 2017, alcohol was more affordable than ever before**. This has been particularly driven by wine, which has increased in affordability by more than 20% since 2012.

Today, wine is the cheapest alcohol product (by standard drink) sold in Aotearoa New Zealand – cask wine is the cheapest, sold for as little as 65c per standard drink. Bottled wine is the second cheapest, sold for around 85c per standard drink. It is therefore unsurprising that in a study of dependent drinkers in Auckland, almost half exclusively drank wine.[85]

Figure 2 Changes in affordability of alcohol products in New Zealand (1988-2016). Source: Health Promotion Agency. (2018)



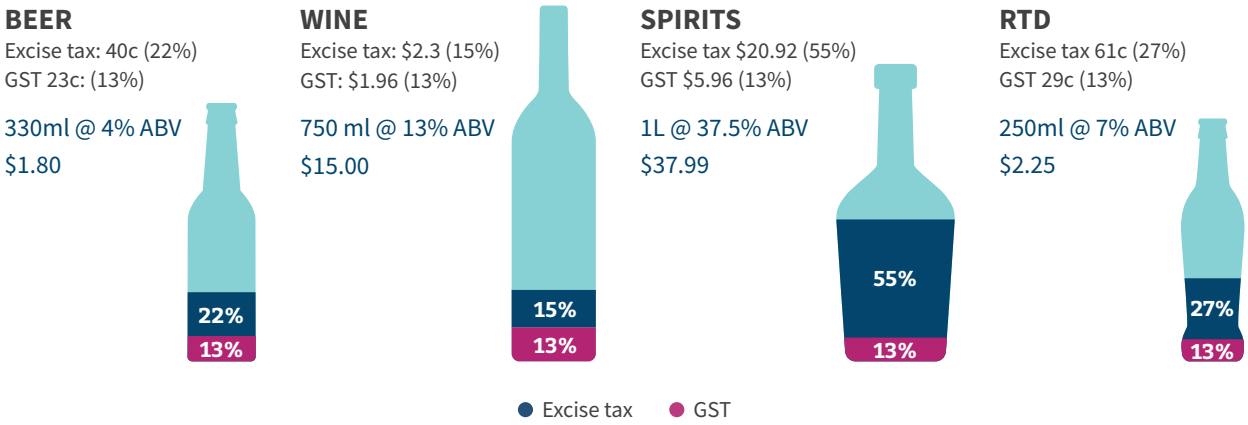


As shown above, the price of cask wine has not kept pace with inflation in Aotearoa New Zealand. In part, wine is the cheapest product because **it is taxed as if it is 10% alcohol** – in reality, it is likely to be in the range of 12.5% to 14.5% alcohol content. Australian estimates are that an average white wine contains 12.2% alcohol, whilst a red wine contains 13.4%.[86] While the alcohol content of wine has increased over time, Aotearoa New Zealand's excise tax structure has not kept pace. The under-taxing of wine amounts to a >20% tax reduction and an unlevel playing field when compared to beer.

1) Increase alcohol excise tax rates

Currently, around **15-25% of the price** of mainstream beers, wines and Ready to Drinks (RTDs) is excise tax. Due to the higher tax rate on high-strength spirits, around half of the price of a bottle of spirits is excise tax.

In comparison, tax comprises ~66% of the price of cigarettes. In 2019, alcohol excise tax raised $1.07 billion in Government revenue.[62]



To reduce alcohol harm, the Law Commission recommended that the alcohol excise tax rates increase by 50% – this would, on average, **increase alcohol prices by around 10%** and reduce overall consumption by 5%.[22] A 50% tax increase would raise the price of a 12-pack of beer by <$3, a bottle of wine by $1.30, a bottle of spirits by $12 and a 12-pack of RTD by $4 (as at July 2020).

The Ministry of Justice examined the effects of an 82% excise tax increase[87] and estimated that:

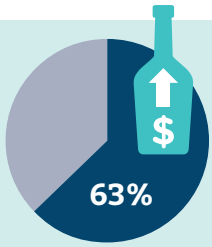
- Harmful drinkers would reduce their annual consumption the most, by around 13.1%;
- Low-risk drinkers would pay an additional $1.77 per week, increased risk drinkers $5.87 per week, and harmful drinkers $13.65 extra per week; and
- Net cost savings to society from reduced harm were estimated to be $339 million in the first year, and $2.45 billion over ten years. The majority of these savings were from reduced costs to ACC, the justice sector and health system.

Raising the price of alcohol is the **most cost-effective** measure to reduce alcohol consumption[88] (in terms of cost per health life-years gained). Increasing the price of alcohol has been shown to be associated with reductions in alcohol-related disease and injury outcomes, alcohol-impaired driving, motor vehicle crashes and injuries, death from cirrhosis, alcohol dependence, sexually transmitted infections, suicide, and violence (including rape, robbery, and violence towards children).[89,90]

Whilst increases in alcohol excise tax are suggested to be mildly financially regressive, they are less regressive than cigarette and petrol excise taxes and GST. From a health and social justice perspective, **disadvantaged populations have the greatest potential to benefit from tax increases** given the disproportionate harms they experience from their own drinking and the drinking of others. Otago University research[91] found that alcohol excise tax increases would be associated with a reduction in traffic injuries, with males and Māori disproportionately benefitting. Directing additional excise revenue to fund targeted programmes (e.g. by Māori, for Māori) can further enhance the equity impacts of alcohol pricing policies.

UMR public opinion polling[92] in February 2019 found that almost two-thirds (61%) of persons polled supported increasing the price of alcohol if the revenue was earmarked for the funding of mental health and addiction services.

63% of New Zealanders support raising the price of alcohol if the extra revenue was used to fund alcohol and mental health services



Recommendation #2.

Increase the price of alcohol via substantive increases to alcohol excise tax

2) Implement Minimum Unit Pricing:

Many countries and jurisdictions throughout the world have adopted legislation to set a floor price (minimum price) that alcohol can be sold. It makes common sense that our most harmful drug should not be sold at pocket money prices.

Minimum Unit Pricing (MUP) specifically targets the harm from the **cheapest alcohol sold** in Aotearoa New Zealand, mostly purchased from bottle stores, supermarkets, and the internet. In Aotearoa New Zealand, most large alcohol producers sell a range of products at the budget end of the market; beers, wines and spirits are commonly sold for under $1.00 per standard drink, with the cheapest RTD sold for ~$1.15 per standard drink (although cheaper when bought in multi-buy promotions). This budget end of the alcohol market in Aotearoa New Zealand has moved very little in price over the past few decades.

Cheap alcohol is more likely to be purchased by **heavy drinkers and frequent drinkers**, including young heavy drinkers. Pacific people have also been found to be more likely than other ethnic groups to purchase the cheapest alcohol; as are Māori drinkers, but to a lesser extent.[74]

Research is demonstrating the **positive impacts of Minimum Unit Pricing**, especially on equity.[93,94] In the first year of MUP in Scotland, purchases of alcohol reduced the most among low income, heavy drinking households.[94] Because the policy has the greatest impact on the purchases of very cheap alcohol (i.e. especially by low-income heavy drinkers), the positive impacts on health from MUP are considerably large, given the disproportionate harm that these drinkers experience. In particular, MUP is shown to be the **most pro-equity** alcohol pricing policy – having the potential to narrow socio-economic, alcohol-related health inequities the most.[95,96] In a United Kingdom modelling study, it was estimated that 90% of the lives saved from MUP would be from lower-socio-economic groups.[95] Closer to home, Australian modelling found that MUP policies were estimated to result in greater reductions in consumption by heavy drinkers and low-income drinkers.[96]

On average, the financial impacts on drinkers from MUP have been demonstrated to be negligible, as households (including low income households) have shown **no significant increase in spending** following MUP in Scotland.[94] In Aotearoa New Zealand, the Ministry of Justice estimated that the additional weekly spend resulting from a minimum price of $1.20 per standard drink would be $0.40 for a low-risk drinker, $1.04 for an increased risk drinker and $2.35 for a harmful drinker.[87] All else remaining the same, heavier drinkers would be able to buy less alcohol for the money they currently spend. In addition, alcohol producers may also respond by reducing the size of their products (e.g. from an 18-pack to a-15 pack) to maintain the same price point. This has been shown to occur in Scotland.[97] MUP would have **little to no effect on bar and pub prices**, as drinks are commonly sold above the minimum price.

Finally, we recommend that s397(1d) of the Sale and Supply of Alcohol Act 2012 is implemented. This section states:

for the purpose only of any investigations to be undertaken in relation to the possibility of introducing minimum pricing schemes for alcohol, requiring persons who sell alcohol to give the chief executive information relating to the quantities of alcohol they have sold over any period and the prices at which they have sold it:

In 2010, the Government at the time recommended that alternative approaches be explored before using s397(d) to regulate the obtaining of this information. One year was provided to review the information before determining whether regulation was required.[98] During a global public health pandemic, this information is more important than ever before.

Recommendation #3.

Reduce the harm from cheap alcohol by implementing Minimum Unit Pricing

Reduce the harm from high alcohol availability

1) Increase community control in local alcohol licensing processes

In 2020, there were more than 11,000 businesses that sold alcohol in Aotearoa New Zealand:

- 1641 sports club and other club licences;
- 6628 on-licences (bars, restaurants, cafés, etc); and
- 2904 off-licences (including 942 bottle stores, 341 grocery stores, 327 supermarkets, 233 tavern off-licences, 92 brewers, 58 chartered clubs, 16 distilleries, 150 hotels, 266 mail order only, 234 wine makers, 242 other).

There are **more places to buy alcohol in our most socio-economically deprived communities**.[71,72] In response to strong community concern regarding their inability to influence important local decisions about where alcohol is sold, a priority objective of Aotearoa New Zealand's liquor law reforms in 2012 was to "**improve community input into local alcohol licensing decisions**".[99]

Eight years later, this objective has been far from realised. **Alcohol licences have not become "harder to get and easier to lose**". Communities continue to take time out of their busy lives to object to liquor licence applications in their neighbourhood, rarely achieving success.

The 2019 Alcohol Regulatory and Licensing Authority annual report noted the following[100]:

"MINIMAL NUMBER OF LICENCE REFUSALS: The Authority notes that the number of applications refused for new licences is very low compared to the number of applications being granted. The same can be said for applications for licence renewals and new manager's certificates. The reasons why there are so few refusals may be worthy of some investigation by policy officials to see if this is consistent with what was envisaged at the date of commencement of the Act"

Amendments are required to our liquor laws to ensure licences are harder to get and easier to lose.

Also, the COVID-19 pandemic has immediately impacted the alcohol retail landscape. Overnight, there was an **expansion of bottle stores commencing online sales during Level 4 lockdown**. However, as there is no accurate list of who is selling online, compliance checking and enforcement is challenging. In Australia, it has been argued that the licensing system has not kept pace with the changes in the market, with online sales operating under **much lower levels of scrutiny** than physical stores.[101] This statement equally applies to the Aotearoa New Zealand context. Given the explosion of online alcohol sales, a thorough review is required. Especially with regards to the rapid delivery (in under 2 hours) of alcohol and the lack of identification requirements when alcohol is being delivered to private homes.

Also, Aotearoa New Zealand's legislated default national trading hours (in the absence of a Local Alcohol Policy) also increase the risk of harm to communities. On-licence hours (8am to 4am) and off-licence hours (7am to 11pm) render alcohol being available for many hours of the day. **Reducing the national trading hours** can reduce harm and **save lives**.[102,103]

Recommendation #4.

Amend the Sale and Supply of Alcohol Act 2012 to give communities greater control of licensing decision-making and reduce the default national trading hours

2) Overhaul the highly legalistic Local Alcohol Policy process

In 2012, the Sale and Supply of Alcohol Act devolved policy-making on alcohol availability to local government. Each local Council is enabled to develop a Local Alcohol Policy (LAP), permitting them to control the number and location of premises in a district, the clustering of premises and trading hours. These legislative provisions **offered Councils much hope to implement best practice measures** to reduce alcohol harm.

Sadly, these hopes have been far from realised. LAPs have become **legal nightmares for Councils**, with communities standing no chance of upholding their wishes against well-resourced legal teams of alcohol retailers. The **vast majority of LAPs have ended up in legal appeals**, particularly led by the supermarket duopoly. The Medical Officer of Health and Police have appealed on fewer occasions, against policies they believe will not minimise alcohol-related harm.

The legal fight has been lengthy and costly. In Auckland, a four-week public hearing before the Alcohol Regulatory and Licensing Authority in February 2017 has since proceeded to judicial review before the High Court. It is scheduled to be heard at the Court of Appeal in 2021. It is therefore unsurprising that in 2018 and 2019, two Local Government NZ remits were passed **calling for urgent change**.

In 2021 (seven years after Councils were given the power to adopt LAPs), **41 of 67 (61%) Councils have an adopted policy**. However, the majority of policies have been watered down as they proceeded through the legal appeals process. Sixteen Councils have chosen not to proceed to developing a LAP. Our four largest population centres – Wellington, Hamilton City, Christchurch and Auckland – **have no LAP in place**. Christchurch City Council aborted their policy after spending more than $1 million fighting it, Hamilton City have aborted too, as has Far North District Council.

As LAPs focus on new licences, they are limited in their ability to address existing outlet proliferation. This leaves a substantial onus on communities to object to renewal applications to reduce outlet density, with objections to renewals often unlikely to succeed.

Recommendation #5.

Amend the Local Alcohol Policy (LAP) process; consider repealing the appeals provision or remove LAPs altogether and include location and density provisions in the Sale and Supply of Alcohol Act 2012

Reduce the harms from alcohol advertising

1) Legislate effective controls on alcohol advertising

Aotearoa New Zealand has a vision of being the best place in the world for children and young people.[104] A place where children live in healthy, sustainable environments.[104] In reality, our environments expose children and young people to alcohol advertising multiple times per day. Alcohol advertising exposure is highly inequitable, with **tamariki Māori having disproportionately higher levels of exposure** (5.4 times greater) than European children.[75]

Reviews of longitudinal studies show exposure to alcohol advertising is causally associated with **earlier drinking initiation** among adolescents and **heavier drinking** among adolescents who drink.[105–108] The World Health Organisation considers restricting alcohol advertising and sponsorship as one of the most cost-effective measures to reduce alcohol harm.[109]

The ubiquity of alcohol advertising in our environment also serves to **normalise drinking** and maintain our country's heavy drinking culture. It places **vulnerable persons** (e.g. those with a history of dependence) at a heightened risk given their susceptibility to alcohol marketing.[110] The pervasiveness of alcohol advertising compromises the ability of many drinkers to cut down their drinking, seek help, or remain sober.

Whilst tobacco advertising and sponsorship has been prohibited in Aotearoa New Zealand for decades, controls on alcohol advertising remain weak despite **strong public support** for increasing restrictions.[111] The main mechanism is a voluntary code of practice, known as the Advertising Standards Authority (ASA) Code for Advertising and Promotion of Alcohol. The ASA is a self-regulatory body comprising advertisers, agencies and the media. The process relies on the public's knowledge of the Code as well as time to submit a complaint. By the time a decision is made, the advertising campaign has usually ended. Evidence has shown that self-regulatory approaches are ineffective at reducing harmful exposure of alcohol advertising.[112]

Of particular concern is the **increased use of digital media** as a key channel to uniquely target individuals with alcohol marketing.[113–115] The granular access to personal information means it is possible for **vulnerable consumers to be targeted**. The delivery of these advertisements by social media algorithms means it is impossible to identify advertisements (they are less visible to the public and ephemeral) in order to assess Code compliance.

There is a long history of Government-commissioned reports and inquiries into alcohol advertising and sponsorship. The New Zealand Law Commission made strong recommendations in 2010[22], followed by the Ministerial Forum on Alcohol Advertising and Sponsorship in 2014[116] and the Mental Health and Addiction Inquiry Panel.[117] The recommendations for stronger restrictions have yet to be adopted.

Recommendation #6.

Replace ineffective self-regulation of alcohol advertising with legislative controls

2) Replace alcohol sports sponsorship

Sport is a primary vehicle for the promotion of alcohol in Aotearoa New Zealand. International alcohol companies utilise sponsorship of sporting, cultural and social events as a key advertising strategy.[118] Sponsorship in these settings may include naming rights; mentions in sports commentaries; signage; labelling on clothing apparel; exclusive rights to sell alcohol, and other innovative activations linking brands, rights holders and their audiences.

In a study that utilised digital cameras on children in the Wellington region, alcohol-sponsored sports merchandise was one of the most **dominant forms of children's exposure to alcohol marketing**.[75] Research shows that exposure to alcohol sports sponsorship is associated with **higher levels of drinking**.[119]

In 2014, Sport New Zealand conducted a survey among its members to determine the value of alcohol sports sponsorship. It was estimated that **$21 million per year** was received from alcohol companies in the form of sponsorship, of which 65% was direct cash payments and 35% was non-cash payments.[120] Only 7% of national-level sponsorship funding of sports was received from alcohol companies. As such, global alcohol companies can spend relatively little on sponsorship in Aotearoa New Zealand and yet achieve significant marketing reach. Sponsorship is increasingly moving into the digital domain.

There remains a **high level of public support** for ending alcohol-related sponsorship of events.[111]

Two-thirds (68%) of New Zealanders support banning alcohol-related sponsorship at events that people under 18 may attend

Ideally, funding from alcohol sports sponsorship would be replaced as occurred with tobacco sponsorship buyout in the 1990s. **Replacing alcohol sports sponsorship** could be achieved through increasing the **existing Health Promotion Agency levy** that is placed on all alcohol products sold in Aotearoa New Zealand (for the purposes of undertaking activities to reduce alcohol harm). Funding the replacement of alcohol sports sponsorship would add as little as 6 cents to a bottle of wine, 2 cents to a can of beer, 2 cents to an RTD, and 7 cents to a bottle of spirits. Such little cost for a large public health benefit.

In Western Australia, alcohol sponsorship of community-level Australian Rules has been replaced as a strategy to improve men's health.[121]

Recommendation #7.

Urgently replace alcohol sports sponsorship utilising the existing Health Promotion Agency levy on alcohol sold

Support health and disability services to reduce alcohol harm

1) Provide screening and brief intervention for hazardous drinking

Like blood pressure monitoring and cholesterol screening, screening for hazardous drinking is an equally important preventative service that should be a routine part of all visits to primary, secondary and community-based health services.

Screening, brief intervention and referral to treatment is **cost effective**.[109] It is estimated that approximately 1 in 5 to 1 in 8 individuals who receive a brief intervention for alcohol use is likely to benefit in terms of reduced alcohol consumption.[122] In Aotearoa New Zealand, an investment of $1 in a brief intervention in general practice is estimated to produce a return of $1.74 over three years, and $2.48 in Emergency Departments.[123]

District Health Boards (DHB) need to be supported to roll out alcohol screening and brief interventions throughout their services. These measures are a particularly important complement alongside measures that increase the price of alcohol. Routine screening may also serve to positively change our national conversation around alcohol – to more openly question and consider our consumption and its impact. As such, it plays an important role in enabling social permission to **drink less**.

Recommendation #8.

Integrate screening for hazardous drinking into routine health services practice

2) Prevent FASD and reduce harms arising from FASD

Population-based interventions to reduce alcohol use (including increasing price, reducing availability and restricting marketing) are essential to the prevention of FASD. **Diagnosis and early intervention** are also critical to positively impact the developmental trajectory of individuals affected by FASD. However, many individuals with FASD are unable to access appropriate diagnosis and intervention supports. This denies the individual and their whānau the knowledge on which to build strength-based early intervention, exacerbating existing inequities and challenges.

Currently, a standalone diagnosis of FASD (without co-occurring intellectual disability) does not result in provision of specific health, disability or education services despite children experiencing severe neurological impairments. Funding is urgently required to support early identification of FASD across DHB child health and mental health services. FASD must be **recognised as a standalone disability** so that individuals and whānau can be supported.

Recommendation #9.

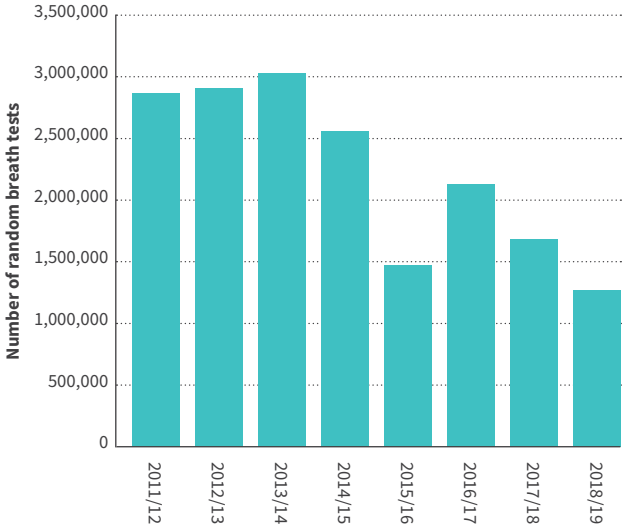
Increase FASD diagnostic capacity, recognise FASD as a standalone disability and increase support for individuals and families affected by FASD

Reduce alcohol harm on our roads

In 2018, **125 (33%) of the 378 road deaths** in Aotearoa New Zealand involved alcohol.[48] In the years 2016-2018, for every 100 alcohol or drug-impaired drivers or riders who died in road crashes, 30 of their passengers and 25 road users died with them.[49] Our drinking culture places everyone at risk of the harms from drink driving.

Overall, Aotearoa New Zealand has made no recent progress towards decreasing the rate of alcohol-related deaths and serious injuries on our roads. In some areas of the country, the rate of alcohol-involved crashes has been increasing.[124]

Figure 3. Number of random breath tests carried out by NZ Police. Data obtained from Police Annual Reports.



A Vision Zero approach to road deaths cannot be achieved without strong action on alcohol. Adequate enforcement of drink driving legislation, through roadside breath testing, is essential.

Of huge concern, the **number of random breath tests in Aoteaora New Zealand has reduced** from around 3 million tests in 2013/14 (about 1 test per driver per year – which is best practice) to below 2 million tests in 2018/19.[125] If best practice levels of enforcement were adhered to, there would be over 3 million tests carried out every year (in 2015 there were 3,384,395 Aotearoa New Zealanders who had a driver licence). We are cognisant that technological differences in reporting explain much of the lower number of tests carried out in the 2015/16 period.

We understand that changes in the way in which road policing is structured in a number of Police districts has resulted in the disestablishment of dedicated impairment testing teams. This may have also contributed to a reduction in test volumes. We also recognise that there has been a more targeted, intelligence-based approach to testing.

Alcohol Healthwatch supports an intelligence-based approach to testing but wishes to see an associated reduction in the rate of alcohol-related deaths. We believe that **increasing the overall volume of tests** is required, particularly to increase the public's perception of being caught.

Recommendation #10.

Increase funding for random breath tests to enhance enforcement of drink driving laws

Increase the legal purchase age for alcohol

The longer a young person delays drinking, the more they are protected from alcohol harm. A large population-based study[4] found that the majority of cases of alcohol abuse and dependence in Aotearoa New Zealand were developed in adolescence and young adulthood. Almost 50% were found to develop by the age of 20 years and 75% by the age of 25. Each year a young person delays drinking, they are estimated to reduce their risk of becoming dependent on alcohol by 9–21%.[126]

Other harms from drinking include:

- Being less likely to finish high school;[60]
- Increased health risks, including sexually transmitted infections, major depression, suicide, and victimisation;[127]
- Irreversible impairment of brain functioning;[128] and
- Death or injury.[127]

In one study, secondary school students of Māori and Pacific ethnicity and/or living in socio-economic disadvantage were more likely to report experiencing alcohol-related harms.[129]

As noted earlier, there have been **positive declines in past-year drinking, hazardous drinking and binge drinking** among adolescents. The New Zealand Health Survey 2019/20[5] found that 54% of 15-17-year-old males and 62% of 15-17-year-old females reported consuming alcohol in the past year. In 2019, **22% of all secondary school students reported binge drinking** (5+ drinks in four hours) in the past month. This prevalence was higher among 16 year olds (29%) and students aged 17 years and over (42%).[8]

Whilst these declines are very positive, we still have a long way to go to protect young people from harm. New Zealand's low-risk drinking advice recommends young people **delay alcohol use for as long as possible**.[130]

These guidelines are underpinned by evidence that young people experience **many more harms from their drinking** when compared to other age groups.[131] In part, this is due to the high amounts of alcohol that they drink in an occasion as well as their immature bodies being unable to cope with the damaging effects of alcohol. **Children under 15 years of age are at a very high risk of harm from drinking**.[131]

Empirical studies have shown that the 1999 law change in Aotearoa New Zealand that lowered the purchase age from 20 to 18 years was associated with an increase in a number of alcohol-related harms for young people, including alcohol-related hospitalisations[132], prosecutions for driving with excess alcohol and disorder[133], and traffic crashes[134–135].

Increasing the legal purchase age is a recommended strategy in the World Health Organization's SAFER Framework to prevent and reduce alcohol-related harms.[136] Given the inequities in consumption[7] and harm experienced by rangatahi Māori[129], increasing the legal purchase age should be considered as **pro-equity**.

Recommendation #11.

Increase the legal purchase age for alcohol to 20 years

Conclusion and recommendations

We recognise the **endless possibilities** for our county with **less alcohol harm**. Everything we care about will start to improve - better mental wellbeing, reduced suicide, safer roads and communities, less family harm, improved child wellbeing and better physical health (e.g. fewer injuries and cancers).

As stated earlier, these are critical times for our health and economy. Whilst some Aotearoa New Zealanders will reduce their use of alcohol during a pandemic (due to a range of reasons), a proportion of the population are likely to drink more heavily. It is clear that the impacts of the pandemic will be felt for years to come and that our young generations will be paying the financial cost.

Inequities in alcohol harm have been long-standing and must be addressed. It is **unjust that Māori lose more years of life** as a result of alcohol. The Crown's obligations to honour te Tiriti o Waitangi require that Māori health is protected. The impact of the global pandemic heightens the risk for inequities to widen.

The **evidence-base is extensive, strong and consistent**. In the past decade, recommendations for stronger legislative action have been repeatedly made – by the Law Commission[22], Ministerial Forum on Alcohol Advertising and Sponsorship[116] and the Mental Health and Addiction Inquiry Panel[117].

Vulnerable drinkers (and others) experience greater harm from the sale of cheap alcohol, high levels of alcohol availability and ubiquitous exposure of alcohol advertising and sponsorship. Adoption of the following pro-equity policies will make a tangible difference to drinkers and others (particularly vulnerable persons and communities), in this generation and the next:

- Amend the Sale and Supply of Alcohol Act 2012 to require it to give effect to Te Tiriti o Waitangi;
- Increase the price of alcohol via substantive (beyond CPI) increases to alcohol excise tax;
- Implement Minimum Unit Pricing (and implement s397(1d) of our alcohol Act to collect industry sales data);
- Amend the Sale and Supply of Alcohol Act 2012 to give communities greater control of licensing decision-making;
- Immediately fund the replacement of alcohol sponsorship of sports;
- Legislate controls on alcohol advertising;
- Increase funding for alcohol screening and brief interventions in health services;
- Increase funding to recognise FASD as a standalone disability;
- Increase funding so that best practice levels of roadside alcohol breath testing are attained; and
- Increase the legal purchase age for alcohol to 20 years.

There is a solid evidence base to take action

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