NZMA
New Zealand Medical Association

# Reducing alcohol-related harm

New Zealand Medical Association
Policy Briefing

May 2015

ISBN 978-0-473-31919-9 (Print)
ISBN 978-0-473-31920-5 (Digital PDF)

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# Executive Summary

**While** alcohol is consumed and enjoyed by most New Zealanders, well over half a million New Zealanders consume alcohol in a hazardous way.

Despite its normalisation in society, alcohol is not an ordinary commodity. It is a toxin, an intoxicant and an addictive psychotropic drug. As such, its sale and supply is subject to regulation in virtually every country. The current regulatory environment for the sale and supply of alcohol in New Zealand is not doing enough to protect New Zealanders from alcohol-related harms. The easy availability of cheap alcohol and sophisticated marketing have contributed to what has been termed an 'alcogenic' environment.

Alcohol-related health and social harms constitute a significant burden in New Zealand. These harms are incurred by individual drinkers, those around them, as well as the wider society. Alcohol-related harms are disproportionately high in selected population groups, particularly Māori and the most socio-economically deprived.

Doctors regularly witness the negative impacts of the use of alcohol. The NZMA believes that doctors have a key role and an ethical responsibility to advocate for their patients, as well as for improved population health and health equity. Improved policies to reduce alcohol-related harms are central to securing better health outcomes for all New Zealanders. This policy briefing replaces the 2010 NZMA position statement on alcohol.

Policy responses to addressing the harms from alcohol should draw on the best available evidence, without undue influence or interference from commercial interests or ideology. The evidence base to formulate alcohol policy is substantial and growing. We know what works and what doesn't work. Where there are conflicts of interests between the public health of New Zealanders and the profits of private commercial entities, public health considerations should prevail.

The NZMA recommends that a suite of measures be considered as part of a comprehensive approach to reducing alcohol-related harms. While doctors and other healthcare workers have a key role to play, we consider that government is in the best position to implement the legislative, regulatory and policy measures needed to modify the existing environment and best protect New Zealanders from the health, social and economic harms of alcohol.

## Recommendations:

While this policy briefing is intended for a diverse audience, the following recommendations are directed primarily at doctors, policy makers and politicians.

1. Doctors and other healthcare professionals should take every opportunity to provide screening and/or brief interventions for patients with suspected harmful alcohol consumption. Funders need to ensure adequate resources and incentives to facilitate these interventions.

2. The government should introduce a specific health target that incorporates the provision of better help to address harmful drinking, like the target on advice for smoking cessation.

3. Treatment services for people with alcohol dependence need to be expanded across the country and available across diverse settings, including to people convicted of criminal offences.

4. The government should raise excise taxation on alcohol and introduce minimum unit pricing. A greater proportion of revenue gained from alcohol taxation should be utilised towards alcohol harm-reduction.

5. All forms of alcohol marketing, including sponsorship of sporting and cultural events, should be phased out. In the interim, restrictions on the content and quantity of alcohol advertising need to be supported by statutory regulation rather than industry self-regulation.

6. Women of childbearing age and those who are pregnant should receive advice on the harmful effects of drinking during pregnancy. Those already pregnant or considering pregnancy should be advised against drinking any alcohol. This should be part of an action plan developed to combat the harm caused by Fetal Alcohol Spectrum Disorder in New Zealand.

7. Local authorities should support calls by health professionals for restrictions in the density of alcohol outlets and reductions to maximum trading hours when developing their Local Alcohol Policies (LAPs). This may require changes to the terms of engagement between councils and industry, to ensure that harm minimisation remains at the forefront of LAPs.

8. When negotiating international trade agreements, the government should ensure that it retains the ability to implement best-practice public health policies for reducing alcohol-related harms.

9. Drink-drive countermeasures should be enforced in a rigorous and highly visible manner.

10. The minimum purchase age for alcohol should be raised to 20 years for on-licensed as well as off-licensed premises, with the minimum purchase age of alcohol viewed by parliamentarians as a health and social policy issue rather than a conscience issue.

**Importantly,** all measures to reduce alcohol-related harms should be rigorously evaluated and modified as and when necessary.

# Introduction

**Alcohol** is consumed and enjoyed by most New Zealanders and its use is deeply embedded in our culture. Nevertheless, alcohol should not be viewed as an ordinary commodity. Among its many properties, alcohol has three important characteristics that differentiate it from other beverages. It is:

i) an **intoxicant** that produces functional impairment in psychological and psychomotor performance
ii) a **toxin** that has direct and indirect effects (including as a carcinogen) on a wide range of body organs and organ systems
iii) an **addictive psychotropic drug** (though not all heavy drinkers develop dependence).[1]

These properties contribute to a wide range of health and social harms that accrue to individual drinkers, to those around them and to wider society. It is for these reasons that the sale and supply of alcohol is regulated in every country.

The Sale of Liquor Act 1989 saw the liberalisation of the environment in which alcohol was sold and supplied in New Zealand. The subsequent proliferation of alcohol outlets, extension of trading hours, lowering of the purchase age and increasingly sophisticated marketing techniques that encourage a culture of heavy drinking have resulted in what some researchers term an 'alcogenic' environment. Two decades on from the 1989 liberalisation, in the face of mounting concerns about alcohol-related harms, the government of the day entrusted the New Zealand Law Commission, led by Sir Geoffrey Palmer, to undertake a rigorous and comprehensive review of the liquor laws in 2009/2010.

The final report by the Law Commission 'Alcohol in our lives: curbing the harm' made 153 recommendations.[2] While several of these were adopted, in whole or in part, in the new Sale and Supply of Alcohol Act 2012,[3] some of the most effective recommendations to reduce alcohol-related harms were ignored. Despite this missed opportunity, the Law Commission's report remains an authoritative blueprint for change. The evidence it contains is as relevant and applicable today as it was in 2010.

[1] Babor T, et al. Alcohol: No Ordinary Commodity. Research and Public Policy. 2nd edition, 2010, Oxford University Press; Health Promotion Agency. Alcohol – the Body and Health Effects: A brief overview. August 2014
[2] New Zealand Law Commission. Alcohol in our lives: curbing the harm. Report 114, Wellington, April 2010
[3] Available from http://www.legislation.govt.nz/act/public/2012/0120/latest/DLM3339333.html

**"It may take decades to reverse the epidemics of alcohol abuse that emerge when industry-favourable policies trump public health initiatives"**

- editors of the leading journal *Addiction*[7]

Two additional reports published since the Law Commission's recommendations – one by the Office of the Prime Minister's Science Advisory Committee,[4] the other by the Parliamentary Health Committee[5] – are also highly relevant to informing alcohol policy. Both contained several recommendations for reducing the harms from alcohol to children and young people that have either been ignored or are yet to be fully implemented.

The evidence base to formulate effective alcohol policy is substantial and growing. New Zealand is also fortunate to have some of the world's leading experts in alcohol research. Yet translating the cumulative body of evidence into policy formation and implementation has remained challenging. It is worth noting here the caution expressed by the Prime Minister's Chief Scientific Advisor, that: "there have been too many examples where appealing to apparently confused science masks what is in fact an ideological issue".[6] We consider it vital to ensure that policies to reduce alcohol-related harm are based on the best available evidence, not on ideology or on the basis of lobbying by vested commercial interests. Where policies to reduce alcohol-related harm result in conflicts between protecting the public health of New Zealanders and protecting private commercial interests, we consider that public health considerations should take precedence.

Although this policy briefing has been developed for a wide audience, it is intended primarily for doctors and other health professionals, policy makers and politicians. It replaces the NZMA's 2010 position statement on alcohol.

[4] Office of the Prime Minister's Science Advisory Committee. Improving the Transition: Reducing Social and Psychological Morbidity During Adolescence: A report from the Prime Minister's Chief Science Advisor. May 2011

[5] Hutchison P (Chair). Inquiry into improving child health outcomes and preventing child abuse with a focus from preconception until three years of age. Report of the Health Committee. November 2013

[6] Gluckman P. The role of evidence in policy formulation and implementation: a report from the Prime Minister's Chief Science Advisor, September 2013

[7] Babor T, et al. Who is responsible for the public's health? The role of the alcohol industry in the WHO global strategy to reduce the harmful use of alcohol. Addiction. 2013 Dec;108(12):2045–7

KEY QUESTION

# Why has the NZMA developed a policy briefing on reducing alcohol-related harm?

**One in five presentations to emergency departments in New Zealand hospitals at 2:00am on 14 December 2013 were alcohol-related.[8]**

**Doctors** regularly witness many of the harmful effects of the use of alcohol during their work, whether dealing with the aftermath of alcohol-related road traffic crashes or treating patients with a range of non-communicable diseases (NCDs) for which alcohol is a well established risk factor.[9] Indeed, alcohol is causally linked to over 200 different diseases, conditions and injuries, as specified in the International Classification of Diseases, Revision 10 (ICD-10).

Doctors have an ethical responsibility to act in the best interests of their patients, and the population as a whole. The Consensus Statement on the Role of the Doctor in New Zealand, developed by the NZMA in 2011 and endorsed by several other medical organisations, is unambiguous in its position that doctors are advocates for improved population health and health equity for all people.[10] This statement also recognises that doctors have diverse roles, both within and outside the health sector, in promoting and maintaining both individual and population health. As leaders, doctors have a role in applying their intellectual and scientific skills in the development of policy. This is especially the case when it comes to health and social policies designed to address a complex issue such as alcohol-related harm.

Alcohol-related harms are disproportionately high in Māori, Pacific and lower socio-economic population groups. Alcohol harms may not simply be reflecting existing inequalities between ethnic groups but may actually be driving inequalities. A landmark report on the social determinants of health listed alcohol (and other drugs) as one of 10 major contributors to inequalities that can be influenced by public policy.[11] The NZMA position statement on equity,[12] developed in 2011, obliges our association to advocate for improved policies to reduce alcohol-related harms.[13]

[8] Egerton-Warburton D, et al. Survey of alcohol-related presentations to Australasian emergency departments. Med J Aust. 2014 Nov 17;201(10):584–7

[9] Parry C, et al. Alcohol consumption and non-communicable diseases: epidemiology and policy implications. Addiction. Oct 2011; 106(10): 1718–24

[10] New Zealand Medical Association. Consensus Statement on the Role of the Doctor in New Zealand, November 2011

[11] Wilkinson R & Marmot M (eds). Social Determinants of Health: The Solid Facts (2nd ed), Regional Office for Europe of the World Health Organization, 2003, Denmark

[12] New Zealand Medical Association. Position Statement on Health Equity. January 2011

[13] Clause 32 "Urges clinical doctors and public health specialists to work together more closely in shaping services and developing programmes to promote and protect people's health, prevent ill health and tackle health inequities, and address the broader social and environmental factors that are influencing individuals' health, choices and behaviour."

KEY QUESTION

# How are we drinking?

**1/5**

of past-year drinkers had hazardous drinking patterns

**43%**

of past-year male drinkers aged 18–24 years had hazardous drinking patterns

**Alcohol** is the most commonly used recreational drug in New Zealand, with 80% of adults consuming alcohol in the past 12 months, according to data from the most recent New Zealand Health Survey.[14] Women were less likely to have consumed alcohol in the past 12 months (76%) than men (83%).

Of particular concern is the finding that one in five past-year drinkers (20%) had hazardous drinking patterns.[15] This is about 576,000 people and is broadly consistent with previous research that found that a quarter of all New Zealand drinkers over the age of 15 years had a sustained pattern of problematic drinking.[16] Among past-year drinkers, men were nearly twice as likely to have hazardous drinking patterns (26%) than women (14%). Young men aged 18 to 24 years had a particularly high rate of hazardous drinking, at 43%.[17]

While the proportion of adult Māori who consumed alcohol in the past year (81%) was similar to the national average (80%), over one in three Māori (38%) had hazardous drinking patterns compared with 20% of all past-year drinkers.[18] After adjusting for age and sex, Māori drinkers were 1.8 times as likely to have a hazardous drinking pattern as non-Māori drinkers. While Pacific adults were less likely to consume alcohol over the past year (56%) than other adults (80%), over one-third of those who did so had hazardous drinking patterns (35%). After adjusting for age and sex, Pacific drinkers were 1.4 times as likely to have hazardous drinking patterns as non-Pacific drinkers.

People living in the most socioeconomically deprived areas were less likely to have consumed alcohol in the past 12 months (70%) than those living in the most affluent areas (83%).[19] However, people living in the most deprived areas were twice as likely to have hazardous drinking patterns (30%) compared with those in the least deprived areas (16%). After adjusting for age, sex and ethnicity, people living in the most deprived areas were 1.5 times as likely to have hazardous drinking patterns as people living in the least deprived areas.

Māori and Pacific drinkers were

**1.8 & 1.4**

times as likely, respectively, to have hazardous drinking patterns compared with non-Māori and non-Pacific drinkers (in the past year)

[14] Ministry of Health. New Zealand Health Survey. Annual Update of Key Results 2013/14. December 2014.

[15] Hazardous drinking is defined as a score of 8 points or more on the 10-question Alcohol Use Disorders Identification Test (AUDIT) developed by the World Health Organization (Barbor TF, et al. 2001, The alcohol use disorders identification test: guidelines for use in primary care. Geneva: World Health Organization), which includes questions about alcohol use, alcohol-related problems and abnormal drinking behaviour. Hazardous drinking refers to an established drinking pattern that carries a risk of harming the drinker's physical or mental health, or having harmful social effects on the drinker or others.

[16] Wells JE, et al. Substance use disorders in Te Rau Hinengaro: The New Zealand Mental Health Survey. Final Report. Alcohol Advisory Council of New Zealand, 23 November 2006

[17] Ministry of Health. December 2014

[18] Ibid

[19] Ibid

Over
**1 in 3**
young people aged 12–16 years engage in binge drinking


**8 in 10**
people aged 16–17 years years had consumed alcohol in the past year

Alcohol is widely used and misused by children and young people in New Zealand, with estimates suggesting that over 1 in 3 young people aged 12 to 16 engage in binge drinking[20] and a similar fraction of young people aged 16 to 21 engage in hazardous drinking.[21] In a large survey, eight in 10 people aged 16 to 17 years had consumed alcohol in the past year, with 71% of these consuming a large amount at least once and 36% drinking at least weekly.[22]

These data are particularly alarming. Early initiation into alcohol use is a risk factor for alcohol-related harm in young people and for heavy drinking and alcohol dependence in adulthood.[23] Data from the Dunedin Multidisciplinary Health and Development Study showed that adolescents with no history of conduct problems exposed to alcohol and other drugs before the age of 15 years were two to three times more likely than non-early exposed adolescents at age 32 to be substance dependent, to have herpes infection, to have had an early pregnancy, and to have failed to obtain educational qualifications.[24] Early-exposed adolescents also had significantly more criminal convictions as adults than non-early-exposed adolescents.

Data from the latest New Zealand Health Survey suggest a slight decrease in the overall proportion of adults who consume alcohol between 2006/07 and 2013/14. However, the total per capita consumption of alcohol in New Zealand has fluctuated over the decades. New Zealand is currently positioned in the middle of the OECD countries with a per capita consumption of 9.2 litres of pure alcohol per adult per year according to the most recent data.[25] Nevertheless, total consumption figures provide only a partial insight into drinking patterns and harms. Drinking patterns and, in particular, the prevalence of binge drinking and drinking to intoxication are powerful predictors of levels of alcohol-related harm.

[20] Fortune S, et al. The health and wellbeing of secondary school students in New Zealand: suicide behaviours and mental health in 2001 and 2007. June 2010. Auckland: University of Auckland
[21] Wells JE, et al. 2006
[22] Ministry of Health. Alcohol Use in New Zealand – Key results of the 2007/08 New Zealand Alcohol and Drug Use Survey. October 2009. Wellington: Ministry of Health
[23] Zeigler DW, et al. The neurocognitive effects of alcohol on adolescents and college students. Prev Med. 2005 Jan;40(1):23–32
[24] Odgers CL, et al. Is it important to prevent early exposure to drugs and alcohol among adolescents? Psychol Sci 2008;19(10)1037–44
[25] OECD Health Data: Non-medical determinants of health: OECD Health Statistics

KEY QUESTION

# What is the burden of alcohol-related harm?

**Alcohol** is associated with a number of harmful health and social consequences. These harms accrue to individual drinkers as well as to those around them, including children and other family members, friends, co-workers and strangers.

Alcohol-related harms to health include an increased risk of a range of cancers (see Alcohol and Cancer), stroke, cirrhosis and neuropsychiatric disorders. Alcohol also contributes to death and disability through accidents and injuries, assault, violence, homicide and suicide. Fetal exposure to alcohol increases the risk of birth defects and intellectual impairment (see Alcohol and Fetal Alcohol Spectrum Disorder).

Worldwide, 3.3 million people die every year due to the harmful use of alcohol.[26] This represents 5.9% of all deaths. Alcohol is also estimated to account for approximately 5% of the global burden of disease and injury.[27] In New Zealand, 802 deaths in people aged less than 80 years were attributable to alcohol (5.4% of all deaths) in 2007, representing 13,769 years of life lost (YLL).[28] Given the conservative methods used to derive these figures, the net health harms of alcohol use in New Zealand may be even greater than these estimates.[29]

There are important gender and ethnic differences in alcohol-related harms, with men more likely to experience alcohol-related harms than women (though this may overlook harm from the drinking of others), and Māori more likely to experience alcohol-related harms than non-Māori. The standardised alcohol-attributable death rate for Māori overall was 2.5 times the rate for non-Māori.[30] Likewise, the age-adjusted alcohol-attributable YLL rate for Māori was 2.7 times the rate for non-Māori. Road traffic injuries were the most common cause of alcohol-attributable deaths in Māori and non-Māori males, while breast cancer was the most common cause of alcohol-attributable deaths in Māori and non-Māori females.[31]

There are no grounds to promote alcohol for health reasons, given the lack of clear evidence of overall cardiovascular benefit (see Alcohol and Cardiovascular Disease) and known significant cancer risks (see Alcohol and Cancer), plus the burden from other diseases and injuries (see Table).

[26] World Health Organization. Global status report on alcohol and health 2014
[27] Ibid
[28] Connor J, et al. The burden of disease and injury atrributable to alcohol in New Zealanders under 80 years of age: marked disparities by ethnicity and sex. N Z Med J. 2015 Feb 20;128(1409)15–28
[29] Wilson N. Blakely T. The high health burden from alcohol in New Zealand and the need for an appropriate government response. N Z Med J. 2015 Feb 20;128(1409):6–8
[30] Connor J, et al. 2015
[31] Ibid

***Table.***
**Top five causes of alcohol-attributed deaths in 2007 in New Zealanders aged less than 80 years[32]**

| Males | Percentage of alcohol-attributable deaths | Females | Percentage of alcohol-attributable deaths |
|---|---|---|---|
| **Māori** | **(N = 124)** | **Māori** | **(N = 62)** |
| Road traffic injuries | 32.1% | Female breast cancer | 19.0% |
| Other unintentional injuries | 13.1% | Road traffic injuries | 17.4% |
| Self-inflicted injuries | 10.2% | Ischaemic heart disease | 16.3%* |
| Alcoholic liver cirrhosis | 5.7% | Alcoholic liver cirrhosis | 6.5% |
| Drownings | 5.6% | Haemorrhagic stroke | 6.4% |
| | | | |
| **Non-Māori** | **(N = 414)** | **Non-Māori** | **(N = 203)** |
| Road traffic injuries | 15.8% | Female breast cancer | 29.3% |
| Alcoholic liver cirrhosis | 13.3% | Haemorrhagic stroke | 12.2% |
| Self-inflicted injuries | 10.6% | Alcoholic liver cirrhosis | 10.8% |
| Other unintentional injuries | 7.6% | Colon cancer | 8.5% |
| Oesophagus cancer | 7.4% | Road traffic injuries | 7.5% |

*Calculations for ischaemic heart disease used methods based on the association of ischaemic heart disease with average alcohol consumption, irregular heavy drinking occasions, and status as a former drinker. Ischaemic heart disease emerged as the third leading cause of alcohol-attributable deaths in this group due to the relatively high proportion of older Māori women who were former drinkers, who have an increased risk of ischaemic heart disease compared with abstainers.

## Alcohol and Cardiovascular disease

The relationship between alcohol and cardiovascular disease is complex. Alcohol has a number of physiological effects on the cardiovascular system. For example, moderate regular consumption increases high-density lipoproteins, and inhibits platelet activation and fibrinolytic factors[33] – effects that may contribute to a cardioprotective association. However, episodes of heavy drinking increase blood pressure, fibrinolytic factors and ventricular arrhythmias[34] – effects that increase the risks of cardiovascular disease and may counter any cardioprotective effects of low to moderate consumption.

Even the putative beneficial effects of low and regular levels of consumption of alcohol for cardiovascular health are controversial.[35] Firstly, it is likely that epidemiological studies have overestimated the apparent benefits of low to moderate consumption on the risk of ischaemic heart disease because they were influenced by uncontrolled confounders.[36] For example, people who only consume light to moderate amounts of alcohol also tend to have healthier lifestyles than heavy drinkers, while many abstainers do so because they already have health problems, not so they can avoid them. Another source of error is the systematic misclassification of ex-drinkers and occasional drinkers as abstainers, which negatively biases the health status of abstainers.[37]

*Continued page 11*

[32] Connor J, et al. The burden of disease and injury atrributable to alcohol in New Zealanders under 80 years of age: marked disparities by ethnicity and sex. N Z Med J. 2015 Feb 20;128(1409)15–28
[33] Brien SE, et al. Effect of alcohol consumption on biological markers associated with risk of coronary heart disease: systematic review and meta-analysis of interventional studies. BMJ. 2011 Feb 22;342:d636
[34] Puddey IB, et al. Influence of pattern of drinking on cardiovascular disease and cardiovascular risk factors-a review. Addiction. 1999 May;94(5):649–63
[35] Jackson R, et al. Alcohol and ischaemic heart disease: probably no free lunch. Lancet. 2005 Dec 3;366(9501):1911–2; Sellman D, et al. Alcohol cardio-protection has been talked up. NZ Med J. 2009 Sep 25;122(1303):97–101
[36] Chikritzhs T, et al. A healthy dose of scepticism: four good reasons to think again about protective effects of alcohol on coronary heart disease. Drug Alcohol Rev. 2009 Jul;28(4):441–4
[37] Ibid

*Alcohol and Cardiovascular disease continued:*

Secondly, any potential benefit of low to moderate consumption of alcohol is restricted to middle aged and older people. Yet even in these population groups, the overall effect of alcohol on the burden of disease is detrimental.[38] Thirdly, low to moderate levels of consumption do not seem to confer any cardioprotective association when combined with heavy drinking episodes.[39] At least in men, heavy drinking episodes appear to increase deaths from ischaemic heart disease.[40] Former drinkers also have a significantly higher risk of death from ischaemic heart disease than abstainers.[41]

## Alcohol and Cancer

Alcoholic beverages have been classified as a Group 1 carcinogen by the World Health Organization's International Agency for Research on Cancer (IARC) since 1988, along with substances such as asbestos and formaldehyde.

There is strong evidence that alcohol use increases the risk of cancers of the mouth, pharynx, larynx, oesophagus, bowel (in men) and breast (in women), and probable evidence that it increases the risk of bowel cancer (in women) and liver cancer.[42] The risk of developing these cancers appears to show a dose-risk response. Heavy consumption of alcohol appears to increase the risk of gastric and pancreatic cancer.

Breast cancer is the leading cause of alcohol-related death among New Zealand women for both Māori and non-Māori. Even low levels of consumption (eg, 1 standard drink per day) increase the risk of breast cancer in women. There is a 10% increase in the risk of breast cancer for each extra standard drink consumed per day, with no known safe threshold.[43] Consumption of more than 3 standard drinks per day is estimated to increase the risk of breast cancer by 40-50%.[44]

A meta-analysis concluded that moderate (2–3 standard drinks per day) and heavy (≥4 standard drinks per day) consumption of alcohol was associated with an increase in the risk of colorectal cancer of 21% and 52%, respectively.[45]

The Cancer Society of New Zealand recommends that people limit the amount of alcohol they consume or do not drink if they wish to reduce their risk of developing cancer.[46]

[38] Rehm J, et al. Global burden of disease and injury and economic cost attributable to alcohol use and alcohol-use disorders. Lancet. 2009 Jun 27;373(9682):2223–33

[39] Roerecke M, et al. Heavy drinking occasions in relation to ischaemic heart disease mortality—an 11-22 year follow-up of the 1984 and 1995 US National Alcohol Surveys. Int J Epidemiol. 2011 Oct;40(5):1401–10

[40] Ibid

[41] Roerecke M & Rehm J. Ischemic heart disease mortality and morbidity rates in former drinkers: a meta-analysis. Am J Epidemiol. 2011 Feb 1;173(3):245–58

[42] Chelimo C, Casswell S. Effect of alcohol consumption on cancer risk: A review of meta-analyses (2007-2013). Auckland 2013: SHORE & Whariki Research Centre, School of Public Health, Massey University; Secretan B, et al. A review of human carcinogens--Part E: tobacco, areca nut, alcohol, coal smoke, and salted fish. Lancet Oncol. 2009 Nov;10(11):1033–4; World Cancer Research Fund / American Institute for Cancer Research. Food, Nutrition, Physical Activity, and the Prevention of Cancer: a Global Perspective. Washington DC: AICR, 2007; International Agency for Research on Cancer. IARC Monographs on the Evaluation of Carcinogenic Risks to Humans. Volume 100E. A review of human carcinogens: Personal habits and indoor combustions. Lyon, France: International Agency for Research on Cancer 2012 41; Bagnardi V, et al. Alcohol consumption and site-specific cancer risk: a comprehensive dose-response meta-analysis. Br J Cancer. 2015 Feb 3;112(3):580–93

[43] Key J, et al. Meta-analysis of studies of alcohol and breast cancer with consideration of the methodological issues. Cancer Causes Control. 2006 Aug;17(6):759–70

[44] Seitz HK, et al. Epidemiology and pathophysiology of alcohol and breast cancer: Update 2012. Alcohol Alcohol. 2012 May-Jun;47(3):204–12

[45] Fedirko V, et al. Alcohol drinking and colorectal cancer risk: an overall and dose-response meta-analysis of published studies. Ann Oncol. 2011 Sep;22(9):1958–72

[46] Cancer Society of New Zealand. Position statement on alcohol and cancer risk. June 2014

## Harm to others – the 'second hand effects' of alcohol

The consumption of alcohol has a range of harms to people other than the individual drinker. This is variously described as the 'second-hand effects', 'collateral damage' or 'negative externalities' of drinking. Though there is a lack of systematic surveillance of these harms, available data suggests that a large proportion of New Zealanders experience physical, social, economic and psychological harms because of the drinking of others.[47] For example, in a large national survey, one in four respondents indicated they had at least one heavy drinker in their life, with most of these respondents experiencing a range of harms because of this person's drinking.[48]

Alcohol is a factor in a large proportion of criminal offending across New Zealand. Police data reveal that 31–46% of all offences are committed by persons affected by alcohol.[49] Alcohol is involved in one in three cases of violent offending and in nearly half of all homicides. Other data suggest that over 62,000 physical assaults (54% of all physical assaults) and 10,000 sexual assaults (57% of all sexual assaults) occur in New Zealand every year where the perpetrator has been drinking.[50]

Alcohol is also implicated in a large number of road-traffic crashes. For example, analysis of data from the New Zealand Transport Agency's Crash Analysis System (CAS) showed that alcohol was a factor in 28% of all road traffic injuries between 2003 and 2007.[51] Of these injuries, 43% were to someone other than the person who had been drinking; this equates to about one in eight of all road traffic injuries. In 2012, driver alcohol/drugs were a contributing factor in 82 fatal traffic crashes, 338 serious injury crashes and 941 minor injury crashes.[52] These crashes resulted in 102 deaths, 467 serious injuries and 1,347 minor injuries.

[47] Casswell S, et al. Alcohol's harm to others: self-reports from a representative sample of New Zealanders. NZ Med J 2011;124(1336)75–118; Connor J & Casswell S. Alcohol-related harm to others in New Zealand: evidence of the burden and gaps in knowledge. NZ Med J 2012;125(1360):11–27
[48] Casswell S, et al. 2011
[49] Stevenson R. National Alcohol Assessment. Wellington: New Zealand Police 2009 (Reported in Connor & Casswell 2012)
[50] Data from Health Behaviour Surveys (Reported in Connor & Casswell 2012)
[51] Data from the CAS available at http://www.nzta.govt.nz/resources/crash-analysis-system/ (Analysis reported in Connor & Casswell 2012)
[52] Ministry of Transport. Alcohol/drugs: crash statistics for the year ended 31 December 2012. Wellington: November 2013

Violence is a major alcohol-related harm experienced by women and children as a result of the drinking of others

Increasing evidence shows that violence is a major alcohol-related harm experienced by women and children as a consequence of the drinking of others, overwhelmingly men.[53] Children are particularly vulnerable to the impacts of others' drinking. A review of the literature for the Families Commission concluded that the health and wellbeing of children is adversely affected in families with caregivers who are heavy drinkers.[54] New Zealand research found that 17% of respondents with children reported that their children experienced harm because of the drinking of someone else.[55] Heavy alcohol use has been shown to be a risk factor for child abuse.[56] Children of heavy drinkers may also be at risk of unintentional injury, loss of educational opportunities, conduct disorders, poor mental health, drug and alcohol problems of their own, and developing poor models of behaviour and parenting.[57]

There is a clear need for improved public health surveillance on the alcohol-related harms to others. This will require interagency collaboration in the identification, systematic collection, analysis and interpretation of data.[58]

Alcohol is associated with considerable economic costs to society that are borne largely by the taxpayer. These include the burden on the police, the judicial system, the penal system, healthcare resources and the traffic safety agencies.[59] A study applying a methodology endorsed by the WHO estimated that harmful alcohol use in 2005/06 cost New Zealand an estimated $4.4 billion of diverted resources and lost welfare.[60] To put this figure in perspective, this was equivalent to almost two fifths of Vote Health. Other estimates of the social costs of alcohol harms have ranged from $765 million to $16.1 billion.[61]

[53] Connor J, et al. Alcohol-related harm to others: A survey of physical and sexual assault in New Zealand. NZ Med J 2009;122(1303):10–20; Connor JL, et al. Alcohol involvement in aggression between intimate partners in New Zealand: a national cross-sectional study. BMJ Open. 2011 Jun 29;1(1):e000065

[54] Girling M, et al. Families and Heavy Drinking: Impacts on Children's Wellbeing – Systematic Review. Wellington: Families Commission; June 2006. Blue Skies Report No 6/06

[55] Casswell S, et al. 2011

[56] Walsh C, et al. The relationship between parental substance abuse and child maltreatment: findings from the Ontario Health Supplement. Child Abuse Negl. 2003 Dec;27(12):1409–25

[57] Girling M, et al. 2006; Lynskey M, et al. The effect of parental alcohol problems on rates of adolescent psychiatric disorders. Addiction 1994;89:1277–86

[58] Connor J & Casswell S, 2012

[59] Ibid

[60] Slack A, et al. Costs of harmful alcohol and other drug use. Report to Ministry of Health and ACC. July 2009. BERL

[61] New Zealand Law Commission. Alcohol in our lives: an issues paper on the reform of New Zealand's liquor laws. Wellington 2009, p168

## Alcohol and Fetal Alcohol Spectrum Disorder

Fetal Alcohol Spectrum Disorder (FASD) is a range of physical, cognitive and behavioural impairments caused by exposure to alcohol during fetal development. These impairments pose major challenges for individuals with FASD across the lifespan, as well as for their families and a broad range of service providers.

In developed countries, FASD is recognised as the leading preventable cause of developmental disabilities, but there is a paucity of reliable data in New Zealand. Nevertheless, based on international data and patterns of drinking in this country, it has been estimated that 600 to 3,000 babies a year or more are born with FASD in New Zealand.[62]

There is no known safe level of alcohol consumption at any stage of pregnancy. Since 2006, the Ministry of Health has recommended that women who are pregnant or planning to become pregnant do not consume alcohol. Worryingly, about one in four women who were pregnant (28.7%) reported drinking alcohol while pregnant.[63]

The Ministry of Health has funded the development of a pregnancy and alcohol cessation toolkit,[64] an online guide for health professionals which has been endorsed by the New Zealand College of Midwives and the Royal New Zealand College of General Practitioners. The NZMA recommends that all women of childbearing age and those who are pregnant should receive advice on the harmful effects of drinking during pregnancy. This should be part of the action plan that is being developed to combat the harm caused by FASD in New Zealand.

[62] Sellman D, Connor J. In utero brain damage from alcohol: a preventable tragedy. NZ Med J 2009,122(1306):6–8

[63] Ministry of Health. Alcohol Use in New Zealand – Key results of the 2007/08 New Zealand Alcohol and Drug Use Survey. October 2009. Wellington: Ministry of Health

[64] Available online at https://akoaotearoa.ac.nz/download/ng/file/group-6285/pregnancy-and-alcohol-cessation-toolkit.pdf

## BY THE NUMBERS
### — the second-hand effects of alcohol in New Zealand

**Alcohol is involved in:**

**31–46%** of all criminal offences[65]

Over **62,000** physical assaults annually[66]

Over **10,000** sexual assaults annually[67]

**28%** of all road traffic injuries

of which **43%** involved people who were not the drink driver[68]

**Domestic violence** including **child abuse** and **neglect**

An estimated **600** to **3000** babies a year or more born with Fetal Alcohol Spectrum Disorder[69]

**In addition:**

**84%** of university students experienced at least one harm during the previous month because of another student's drinking[70]

**5.7%** and **5.3%** of people aged between 12–65 years reported being physically assaulted and sexually harassed, respectively, by someone who had been drinking[71]

[65] Stevenson R. 2009
[66] Connor J & Casswell S, 2012
[67] Ibid
[68] Ibid
[69] Sellman D, Connor J. In utero brain damage from alcohol: a preventable tragedy. NZ Med J 2009,122(1306):6–8
[70] Langley JD, Kypri K, Stephenson SC. Secondhand effects of alcohol use among university students: computerised survey. BMJ 2003;327(7422):1023–4
[71] Ministry of Health. Alcohol use in New Zealand: Analysis of the 2004 New Zealand Health Behaviours Survey — Alcohol Use. Wellington, March 2007.

KEY QUESTION

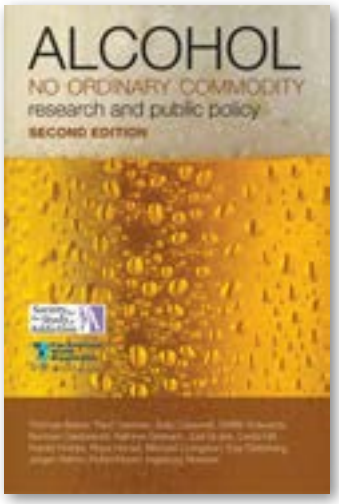
# How should we respond?

**Given** the enormous and ongoing health, social and economic harms resulting from the use of alcohol in New Zealand, the NZMA considers that further measures to reduce alcohol-related harms are essential and should be a high priority for legislators, policy makers and health professionals. The Sale and Supply of Alcohol Act 2012, though an improvement on earlier legislation, failed to implement several critical recommendations by the Law Commission. We believe these shortcomings need to be addressed to ensure the comprehensive approach to addressing alcohol-related harms envisaged by the Law Commission.

While doctors and other health professionals have an important role to play, the NZMA considers central government to be a key actor because only it has the ability to enact legislation, policies and regulations to change the existing environment that promotes and normalises drinking at harmful levels. Given that New Zealand has endorsed the WHO global action plan for the prevention and control of noncommunicable diseases, we suggest that the government commit explicitly to the voluntary target in this plan for an at least 10% reduction in the harmful use of alcohol.[72]

It important to ensure that all measures to address alcohol-related harms draw on the best-available evidence without undue influence from ideology or vested private commercial interests. We also consider that resources for reducing alcohol-related harms should be allocated where they will have the greatest effect (and away from where they are having minimal effect). There is good evidence that certain interventions to reduce alcohol-related harms are cost-effective, and even cost-saving to government, while other interventions that continue to receive funding are ineffective.[73]

The second edition of the publication *Alcohol: no ordinary commodity: research and public policy*[74] is widely considered to be the definitive evidence-based resource for alcohol researchers and policy makers. This publication systematically evaluated a range of strategies and interventions to reduce alcohol-related harm. Accordingly, this resource, together with the final report by the Law Commission, forms the basis for many of the recommendations in this briefing.




Alcohol: no ordinary commodity: research and public policy. Second edition. Babor T, et al. 2010

[72] World Health Organization. Global status report on noncommunicable diseases 2014. Geneva.
[73] World Health Organization (WHO). Evidence for the effectiveness and cost-effectiveness of interventions to reduce alcohol-related harm. 2009. WHO Regional Office for Europe: Copenhagen; Cobiac L, et al. Cost-effectiveness of interventions to prevent alcohol-related disease and injury in Australia. Addiction. 2009 Oct;104(10):1646–55; Chisholm D, et al. Reducing the global burden of hazardous alcohol use: a comparative cost-effectiveness analysis. J Stud Alcohol. 2004 Nov;65(6):782–93
[74] Babor T, et al. Alcohol: No Ordinary Commodity. Research and Public Policy. 2nd edition, 2010, Oxford University Press

## Screening, early intervention and treatment

There is good evidence to show that brief interventions in a primary care setting, consisting of one or more sessions of advice and feedback from a health professional, can significantly reduce drinking and alcohol-related problems.[75] The feasibility of routine screening for alcohol use and brief intervention in a primary care setting has been demonstrated in the Whanganui region.[76] However, such interventions require time and a level of training that is not always available across all primary care settings. Many people experiencing the greatest harms from alcohol may also not have frequent enough contact with a primary healthcare provider.

The NZMA recommends that doctors and other healthcare professionals take every opportunity to provide screening and/or brief interventions for patients with suspected harmful alcohol consumption, but this approach alone is insufficient to effect population-wide change. To support brief interventions and screening, we recommend that funders of primary healthcare services ensure that adequate resources and incentives are available to providers of these services. We also suggest that the government introduces a specific health target that incorporates the provision of better help to address harmful drinking, like the target on advice for smoking cessation.

There is good evidence to support the effectiveness of detoxification treatments,[77] but the unmet need for alcohol dependence treatment services across New Zealand is considerable. Around 32,000 people (1.2% of the population aged 16–64 years) want help to reduce their alcohol use every year but do not receive it.[78] Notably, those in the most deprived neighbourhoods were over four times more likely to report unmet need for help with their alcohol use than those living in the least deprived areas.[79]
Furthermore, only a small proportion of people with drinking problems seek help or are ever diagnosed, suggesting that the actual unmet need for treatment services is very large indeed.

Under resourcing of addiction treatment means that opportunities to reduce alcohol harm are being missed. Currently, the courts are able to call for alcohol and drug assessments and direct offenders into treatment as part of the sentencing process. A lack of available treatment programmes, however, means this is often not possible. The NZMA recommends that treatment services for people with alcohol dependence be expanded across the country and made available across diverse settings, including to those convicted of criminal offences.

### Toolkit for screening

The Royal New Zealand College of General Practitioners has developed a Clinical Effectiveness Module toolkit to guide general practices through the necessary steps to establish the ABC approach to alcohol screening and brief intervention.[80] Completing this toolkit will qualify participating general practices for CORNERSTONE® practice accreditation points and participating general practitioners can also obtain individual recertification (CPD) points.

[75] Whitlock EP, et al. Behavioral counseling interventions in primary care to reduce risky/harmful alcohol use by adults: a summary of the evidence for the U.S. Preventive Services Task Force. Ann Intern Med. 2004 Apr 6;140(7):557–68; O'Donnell A, et al. The impact of brief alcohol interventions in primary healthcare: a systematic review of reviews. Alcohol Alcohol. 2014 Jan-Feb;49(1):66–78
[76] Gifford H, et al. Is routine alcohol screening and brief intervention feasible in a New Zealand primary care environment. N Z Med J. 2012 May 11;125(1354):17–25
[77] Babor T, et al. 2010. Chapter 14. Treatment and early intervention services
[78] Ministry of Health, 2009
[79] *Ibid*
[80] Royal New Zealand College of General Practitioners. Implementing the ABC Alcohol Approach in Primary Care: To record alcohol intake and provide brief advice and counselling for patients whose alcohol behaviours may be harmful. July 2012. Available from www.rnzcgp.org.nz/assets/documents/News--Events/CGP4044-Clinical-Effectiveness-Modules-Template-v2-LR.pdf

## Pricing and taxation

**"One of the consequences of alcohol being promoted and sold at pocket-money prices is that we risk losing sight of its status as a legal drug, capable of causing serious harm to others"**

- Sir Geoffrey Palmer

The NZMA considers that an end to the availability of extremely cheap alcohol must be a central element of a comprehensive strategy to reduce alcohol-related harms. The current widespread availability of cheap alcohol products contributes to the excessive and harmful consumption of alcohol. Cheap alcohol products are favoured by heavy, as well as young, drinkers. Alcohol in New Zealand became more affordable over the 10 years between 1999 and 2009, with heavily discounted alcohol cheaper than averagely priced bottled water.[81]

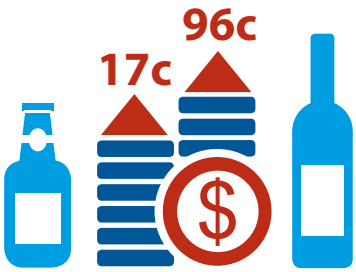
Raising alcohol prices is internationally recognised as the most effective and cost-effective way to reduce alcohol-related harms. Raising prices preferentially reduces consumption in high-risk groups such as heavy drinkers – about 1% for each percentage rise in price – and the young. It also reduces the likelihood of young or moderate drinkers becoming heavy drinkers. The evidence for this is clear and extensive.[82]

Widespread availability of cheap alcohol contributes to excessive and harmful consumption

Accordingly, we recommend that the government adopt the recommendations on pricing made by the Law Commission following the Commission's detailed review of the evidence and commissioning of independent economic analysis on the pricing and taxation of alcohol.[83]

Specifically, we recommend an increase in alcohol excise tax by 50% to achieve a 10% average increase in retail prices. Because excise tax is levied on the amount of pure alcohol in a product, those who drink the most alcohol pay the most tax, both proportionately and absolutely. Furthermore, excise tax forms a substantially larger proportion of the price of cheap alcohol products. So any increase in excise tax will make relatively little difference to prices paid by consumers in pubs and bars, but will significantly affect the prices of cheap alcohol favoured by heavy drinkers and the young.


[81] Imlach Gunasekara F & Wilson N. Very cheap drinking in New Zealand: Some alcohol is more affordable than bottled water and nearly as cheap as milk. NZ Med J 2012;123(1324):97–101
[82] Anderson P, et al. Effectiveness and cost-effectiveness of policies and programmes to reduce the harm caused by alcohol. Lancet. 2009 Jun 27;373(9682):2234–46; University of Sheffield. Independent review of the effects of alcohol pricing and promotion: Part B. Modelling the Potential Impact of Pricing and Promotion Policies for Alcohol in England:Results from the Sheffield Alcohol Policy Model. Sheffield, 2008; Wagenaar AC, et al. Effects of beverage alcohol price and tax levels on drinking: a meta-analysis of 1003 estimates from 112 studies. Addiction. 2009 Feb;104(2):179–90; WHO Regional Office for Europe. Evidence for the effectiveness and cost-effectiveness of interventions to reduce alcohol related harm. Copenhagen, 2008. World Health Organization Regional Office for Europe; Wagenaar AC, et al. Effects of alcohol tax and price policies on morbidity and mortality: a systematic review. Am J Public Health. 2010 Nov;100(11):2270–8;
[83] New Zealand Law Commission, 2010. Chapter 18. Alcohol Pricing Policies; Marsden Jacob Associates. The benefits, costs and taxation of alcohol: Towards an analytical framework. A report prepared for the New Zealand Law Commission. Marsden Jacob Associates, Melbourne, 2009




A modest rise in the retail price of alcohol due to proposed higher excise taxes would not penalise responsible drinkers

Fears about penalising 'responsible' drinkers are unfounded. The modest rise in excise taxes proposed by the Law Commission would not have a significant impact on low or moderate drinkers. For example, the average price of a 330 ml beer would rise by just 17 cents and an $11 bottle of wine would increase by just 96 cents.[84] A rise in excise tax of 50% to achieve a 10% average increase in retail prices would also have likely net economic benefits to New Zealand of around $72 million each year, via reductions in alcohol-related harms.[85]

**Population-based approaches have little impact on the moderate drinker, except to reduce their risk of harm from the drinking of others.[86]**

We also suggest that a greater proportion of revenue from the excise tax on alcohol be used for prevention, treatment and rehabilitation services, and to replace alcohol sponsorship of sporting and cultural events. Earmarking a greater proportion of excise tax for mitigating alcohol-related harms should help make the increase in price more acceptable. This has been demonstrated for tobacco products in the New Zealand setting.[87]

The NZMA also believes there is a compelling case for developing and implementing a minimum pricing system, in addition to a raise in excise tax. Fixing minimum unit prices for alcohol can achieve goals that raising alcohol taxes alone cannot by preventing below-cost selling and the deep discounting of alcohol by some retailers. The key benefit of a minimum price system would be to raise the retail price of the alcohol products that provide the cheapest forms of absolute alcohol. Unlike a raise in tax, there is no opportunity for its effect to be diluted by being absorbed by producers, wholesalers, distributors and retailers. The evidence to support minimum unit pricing comes from modelling studies in the UK as well as from real-world data from Canada.[88]

Increases in the minimum price of alcohol in British Columbia between 2002 and 2009 were associated with significant immediate and delayed decreases in alcohol-attributable mortality.[89] The introduction of minimum alcohol pricing in Saskatchewan also looked promising for reducing the public health burden associated with hazardous alcohol consumption.[90] Notably, there was a shift in consumption patterns toward beverages with lower alcohol content.

[84] Marden Jacob Associates, 2009
[85] Ibid
[86] Connor J. The knock-on effects of unrestrained drinking. NZ Med J 2008;121(1271):11–14
[87] Wilson N, et al. Smoker support for increased (if dedicated) tobacco tax by individual deprivation level: national survey data. Tob Control. 2009 Dec;18(6):512; Wilson N, et al. Characteristics of smoker support for increasing a dedicated tobacco tax: national survey data from New Zealand. Nicotine Tob Res. 2010 Feb;12(2):168–73
[88] University of Sheffield 2008; Holmes J, et al. Effects of minimum unit pricing for alcohol on different income and socioeconomic groups: a modelling study. Lancet. 2014 May 10;383(9929):1655–64; Stockwell T, et al. The raising of minimum alcohol prices in Saskatchewan, Canada: impacts on consumption and implications for public health. Am J Public Health. 2012 Dec;102(12):e103–10; Zhao J, et al. The relationship between minimum alcohol prices, outlet densities and alcohol-attributable deaths in British Columbia, 2002-09. Addiction. 2013 Jun;108(6):1059–69
[89] Zhao J, et al. 2013
[90] Stockwell T, et al. 2012


The introduction of minimum price levels has strong potential to reduce the public health burden associated with excessive alcohol consumption and reduce socioeconomic and ethnic disparities in health

Economic modelling in the UK has shown that setting a minimum price of 50 pence per unit would likely increase the average weekly spend on alcohol of moderate drinkers by only 23 pence per week, but would decrease the consumption by underage and heavy drinkers by 7.3% and 10.3%, respectively.[91] More recent modelling published in the Lancet demonstrated that the greatest reductions in consumption with a minimum price of 45 pence per unit occurred in harmful drinkers in the lowest socioeconomic group.[92] This group clearly had the most to gain in terms of reduced morbidity and mortality related to alcohol.

While a recent report by New Zealand's Ministry of Justice concluded that a minimum price of either $1 or $1.20 per unit would result in substantial net savings to society ($318 and $624 million over ten years, respectively), it recommended against minimum pricing in New Zealand for reasons that included increased profits to the alcohol industry, impacts on non-harmful consumers and challenging implementation issues.[93] It also suggested waiting for the results of evaluations from the experience of minimum pricing in other jurisdictions.

The NZMA considers that the public health benefits of minimum pricing, particularly its pro-equity impact, and savings to the tax payer, outweigh the risks identified in the Ministry of Justice report. We also consider that there is already robust evidence (from modelling and real-world experience) to support minimum pricing. As such, we recommend that the government develops, implements and evaluates a minimum pricing scheme without delay. We note that some countries that have sought to implement minimum pricing have faced legal challenges from the alcohol industry. As is the case with standardised packaging of tobacco, the NZMA takes the view that the government must prioritise the health and wellbeing of New Zealanders over possible threats by private commercial vested interests, including the threat of litigation.

**"Those who enjoy alcohol socially and drink in a low-risk manner will be little affected... our [pricing] reforms are firmly targeted at reducing the harms associated with heavy drinking and drinking to intoxication"**

- Sir Geoffrey Palmer

[91] University of Sheffield, 2008
[92] Holmes J, et al. 2014
[93] Ministry of Justice. The Effectiveness of Alcohol Pricing Policies: Reducing harmful alcohol consumption and alcohol-related harm. Wellington, 2014

# Availability

## Physical availability

In New Zealand, the number of outlets licensed to sell alcohol more than doubled from 6,296 in 1990 to 14,424 in 2010.[94] The relationship between outlet density and alcohol-related harm is complex and context specific. Nevertheless, for some areas, a higher density of outlets is associated with increased consumption, particularly among young people, higher levels of harmful drinking as evidenced by more alcohol-related crime or anti-social behaviours, or a variety of secondary harms that can undermine community wellbeing.[95]

New Zealand research has demonstrated that higher outlet density is more common in lower socio-economic neighbourhoods than in higher socio-economic neighbourhoods.[96] Unsurprisingly, higher outlet density is associated with lower alcohol prices and longer opening hours. Where there are several outlets in one area, particularly off-licence outlets, alcohol discounting is one commonly used means for outlets to compete with each other. Lower prices can stimulate demand and facilitate heavier consumption. Regulating the physical availability of alcohol is, therefore, a major tool available to reduce alcohol-related harms.

Restrictions on maximum trading hours and curbing outlet density are key ways to reduce alcohol-related harms.[97] The NZMA welcomed legislation allowing local communities to have their say on outlet density and maximum trading hours by way of local alcohol policies (LAPs). When developing their LAPs, we recommend that local authorities support calls by public health professionals for restrictions in the density of alcohol outlets and reductions to maximum trading hours. While public health interests have called for reductions to both trading hours and outlet density in LAPs, these provisions have frequently been appealed by segments within the industry. It is our view that local authorities need to be further empowered to ensure that the harm reduction objectives of the Sale and Supply of Alcohol Act 2012[98] take precedence over other interests. This may require alterations to the terms of engagement between councils and industry during the LAP process.

Curbing outlet density and restricting trading hours are key ways to reduce alcohol-related harms

[94] New Zealand Law Commission. 2009. Chapter 2. The Context for Reform. Information provided by the Liquor Licensing Authority

[95] Babor T, et al. 2010, p131; Anderson P, et al. 2009; Connor JL, et al. Alcohol outlet density, levels of drinking and alcohol-related harm in New Zealand: a national study. J Epidemiol Community Health. 2011 Oct;65(10):841–6; Donnelly N, et al. Liquor Outlet Concentrations and Alcohol-related Neighbourhood Problems. Alcohol studies bulletin 2006, no. 8

[96] Hay GC, et al. Neighbourhood deprivation and access to alcohol outlets: a national study. Health Place. 2009 Dec;15(4):1086–93; Cameron MP, et al. The impacts of liquor outlets in Manukau City. Summary Report – Revised. Alcohol Advisory Council of New Zealand, January 2012

[97] Popova S, et al. Hours and days of sale and density of alcohol outlets: impacts on alcohol consumption and damage: a systematic review. Alcohol and Alcoholism 2009; Sep-Oct;44(5):500–16; Connor JL, et al. Alcohol outlet density, levels of drinking and alcohol-related harm in New Zealand: a national study. J Epidemiol Community Health 2011; Oct;65(10):841–6; Day P, et al. Close proximity to alcohol outlets is associated with increased serious violent crime in New Zealand. Aust N Z J Public Health. 2012 Feb;36(1):48–54; Miller P, et al. Dealing with alcohol-related harm and the night-time economy. December 2012. Monograph Series No. 43; Wicki M, Gmel G. Hospital admission rates for alcoholic intoxication after policy changes in the canton of Geneva, Switzerland. Drug Alcohol Depend. 2011 Nov 1;118(2-3):209–15

[98] Available from www.legislation.govt.nz/act/public/2012/0120/latest/DLM3339340.html

Raising purchase age is shown to reduce access to alcohol and reduce harmful drinking by adolescents

## Minimum purchase age

Raising the minimum purchase age of alcohol is another way to limit the availability of alcohol. Drinking at a young age is a risk factor for alcohol-related harms as a young adult and later in life.[99]

Lowering the purchase age in New Zealand from 20 to 18 in 1999 has been associated with increased assaults resulting in hospitalisation among young males aged 15 to 19,[100] and increased likelihood of alcohol-involved crashes among drivers aged 18 to 19 years.[101]

The Law Commission considered the idea of a split purchase age (20 for off-licences, 18 for on-licences) but rejected it as there was no robust evidence that on-licences provide a lower-risk drinking environment. On the contrary, the evidence from overseas and New Zealand suggests that a considerable proportion of alcohol-related harms, particularly violent crime, occur in and around on-licensed premises (see On-licences and alcohol-related harm).

Strong international evidence demonstrates that raising the purchase age reduces adolescent access to alcohol, reduces harmful youth drinking and raises the age at which young people start drinking.[102] Furthermore, it is increasingly recognised that the adolescent brain continues to mature well into the twenties. Alcohol use during mid-to-late adolescence is associated with deviations in neurodevelopment across several brain tissue classes.[103]

On the basis of the cumulative body of evidence, the NZMA considers that the minimum purchase age for alcohol should be raised to 20 for on-licensed as well as off-licensed premises, as part of a suite of measures to reduce the availability of alcohol and reduce its harms to young people. We also suggest that the minimum purchase age of alcohol be treated by Parliament as a health and social policy issue (guided by the evidence) rather than a conscience issue, as recommended by the Law Commission.[104]

[99] Zeigler DW, et al. 2005; Odgers CL, et al. 2008
[100] Kypri K, et al. Effects of lowering the minimum alcohol purchasing age on weekend assaults resulting in hospitalization in New Zealand. Am J Public Health. 2014 Aug;104(8):1396–401
[101] Huckle T & Parker K. Long-Term Impact on Alcohol-Involved Crashes of Lowering the Minimum Purchase Age in New Zealand. Am J Public Health. 2014 June; 104(6): 1087–1091
[102] Babor TF, et al. 2010. Chapter 9; Wagenaar AC & Toomey TL. Effects of minimum drinking age laws: review and analyses of the literature from 1960 to 2000. J Stud Alcohol Suppl. 2002 Mar;(14):206–25
[103] Luciana M, Collins PF, Muetzel RL, Lim KO. Effects of alcohol use initiation on brain structure in typically developing adolescents. Am J Drug Alcohol Abuse. 2013 Nov;39(6):345–55
[104] New Zealand Law Commission. Review of regulatory framework for the sale and supply of liquor: Part 1: Alcohol legislation and the conscience vote. Report 106, May 2009

## On-licenses and alcohol-related harm

- New Zealand research has shown an association between access to alcohol from on-licensed premises during adolescence and heavy consumption.[105]
- Australian research found that the largest proportion of alcohol-related assaults (over a third) took place in licensed premises, followed closely by assaults occurring on the street.[106]
- North American research showed that the risk of injury associated with alcohol consumption was higher in licensed premises than other public places.[107]
- Of people involved in incidents attended by police in New Zealand, almost all those who cited a licensed premise as their last place of drinking were moderately or seriously intoxicated.[108]
- A significant proportion of all violent assaults in New Zealand occur on licensed premises.[109] Where violence occurred on licensed premises, it was more likely to have been committed by a stranger. In fact, 18% of all violent victimisations (perpetrated by a person not well known to the victim) and 9% of all threats of violent victimisation occurred in a pub, club or nightclub. Roughly 75% of these incidents resulted in injury.
- Licensed premises were reported as the last place of drink in up to 33% of police apprehensions in the Auckland region.[110] The most commonly reported offences reported in the Last Drink Survey data were drink-driving, violence and disorder offences. Alleged offenders who named a licensed premise as their last place of drink were more likely to be extremely intoxicated than those whose last place of drink was not a licensed premise, or where the location was not specified.

[105] Casswell S & Zhang JF. Access to alcohol from licensed premises during adolescence: a longitudinal study. Addiction. 1997 Jun;92(6):737–45
[106] Teece M & Williams P. Alcohol-related assault: Time and place. Trends and Issues in Crime and Criminal Justice 2000;169:1–6
[107] Borges G, et al. Risk of injury after alcohol consumption: a case-crossover study in the emergency department. Soc Sci Med. 2004 Mar;58(6):1191–200
[108] Wiggers J, et al. Strategies and outcomes in translating alcohol harm reduction research into practice: the Alcohol Linking Program. Drug Alcohol Rev. 2004 Sep;23(3):355–64
[109] Morris A, et al. (2003) The New Zealand national survey of crime victims 2001. Ministry of Justice, Wellington
[110] Sim M, et al. The Impact of Enforcement on Intoxication and Alcohol-related Harm. Wellington: Accident Compensation Corporation, 2005

## Marketing

**Generally, there is a dose-response relationship between young people's exposure to alcohol marketing and the likelihood that they will start to drink or drink more. The greater the exposure, the greater the impact. The evidence thus suggests that limiting the kind and amount of alcohol marketing would reduce drinking initiation and heavy drinking among young people.**

- World Health Organization (WHO)[111]

The relationship between alcohol marketing and consumption is complex, but several systematic reviews of longitudinal studies offer compelling evidence that alcohol marketing has a powerful effect on young people.[112] It has been found to influence the age at which drinking commences, the volume and frequency of drinking, and alcohol-related beliefs and attitudes. Further, these effects have been found to be cumulative, becoming more pronounced as the volume of advertising and promotions increases. Recently published research generally appears to confirm earlier findings.[113]

"They'll drink bucket loads of the stuff and still manage to last the duration"

From the Creative Brief for a well known UK brand of fruit flavoured sparkling wines

"...used to crank up the evening, accelerate the process of getting drunk with less volume of liquid"

Industry proposal for positioning a shot product designed to be drunk like a chaser

Interestingly, an analysis of internal alcohol industry advertising documents confirms that young people are a key target for marketing.[114] Furthermore, a key aim of alcohol marketing is to increase the amount of alcohol being drunk, not merely to build brand awareness as is often claimed.[115]

"The brand should talk at the level of the target audience - young people. Funny is the most important thing,...not take itself too seriously, fresh, witty, a funny brand that doesn't take itself too seriously"

Creative Brief of UK alcohol brand

"Having a laugh and getting a bit pissed is a big part of their life"

Creative Brief of UK alcohol brand

Excerpts from internal alcohol industry marketing documents[116]

[111] World Health Organization (WHO). Evidence for the effectiveness and cost-effectiveness of interventions to reduce alcohol-related harm. 2009. WHO Regional Office for Europe: Copenhagen
[112] Anderson P, et al. Impact of alcohol advertising and media exposure on adolescent alcohol use: a systematic review of longitudinal studies. Alcohol Alcohol. 2009 May-Jun;44(3):229–43; Smith LA & Foxcroft DR. The effect of alcohol advertising, marketing and portrayal on drinking behaviour in young people: systematic review of prospective cohort studies. BMC Public Health. 2009 Feb 6;9:51; Booth A, et al. Independent review of the effects of alcohol pricing and promotion. Part A: systematic reviews. 2008. School of Health and Related Research: Sheffield
[113] Grenard JL, et al. Exposure to alcohol advertisements and teenage alcohol-related problems. Pediatrics. 2013 Feb;131(2):e369–79; Jones SC & Magee CA. Exposure to alcohol advertising and alcohol consumption among Australian adolescents. Alcohol Alcohol. 2011 Sep-Oct;46(5):630–7; Lin E-Y, et al. Engagement with alcohol marketing and early brand allegiance in relation to early years of drinking. Addict Res Theory 2012; 20(4):329–38
[114] Hastings G. "They'll drink bucket loads of the stuff": an analysis of internal alcohol industry advertising documents. 2009. The Alcohol Education and Research Council.
[115] Ibid
[116] Ibid

The NZMA contends that if New Zealand's drinking culture is to change, we need to address the environment in which our young people are continually bombarded by sophisticated marketing messages that blatantly associate alcohol with social, sporting and sexual success, and encourage a culture of heavy drinking. We believe that existing mechanisms to regulate alcohol marketing, such as the self-regulated Code for Advertising Liquor, are not working, especially in protecting children and young people from the marketing of alcohol in New Zealand (see Young people and alcohol marketing in New Zealand — a snapshot of the evidence).

Alcohol advertising also has a negative impact on those with an existing drinking problem. Problem drinkers report that television advertisements make it more difficult to abstain.[117] A Ministry of Health report referred to people in recovery describing how alcohol advertising acts as a constant reminder that abstinence is not normal; it offers promises of companionship, good times and association with famous people/groups.[118]

Our counterpart associations in Australia and the United Kingdom – the Australian Medical Association and the British Medical Association – have both called for greater restrictions on alcohol marketing, including sponsorships, as well as a shift away from self-regulation towards independent statutory regulation of alcohol advertising.[119] The NZMA believes a similar stance is warranted in New Zealand.

**"After seven years I can still be triggered into thinking drinking would be a good idea by advertising in all its forms"**

- recovering alcoholic[120]

[117] Thomson A, et al. A Qualitative Investigation of the Responses of In-Treatment and Recovering Heavy Drinkers to Alcohol Advertising on New Zealand Television. Contemporary Drug Problems 1997;24(1)

[118] Litmus (for the Ministry of Health). Review of the Regulation of Alcohol Advertising. Summary of the Results of the Consultation Process. February 2007

[119] British Medical Association. Under the influence: the damaging effect of alcohol marketing on young people. September 2009; Australian Medical Association. Alcohol marketing and young people: time for a new policy agenda. 2012.

[120] Litmus (for the Ministry of Health). Review of the Regulation of Alcohol Advertising. Summary of the Results of the Consultation Process. February 2007


Alongside television and radio, social media and other digital platforms are now popular formats used to advertise alcohol

We have previously supported a ban on all alcohol advertising on television or radio before 10:00pm, however, much advertising now occurs via social media and other digital platforms. We have also previously suggested that clear and transparent rules around the content of alcohol advertisements be developed and applied to all media, including digital media. Given the rapid innovations in new forms of advertising, however, we recommend that the restrictions recommended by the Law Commission—advertising that communicates objective product information only, including the characteristics of the beverage, the manner of its production and price—be adopted as the first step in a phased approach to the eventual complete cessation of all forms of alcohol advertising. Until then, we believe that restrictions on the content and quantity of alcohol advertising need to be supported by statutory regulation rather than self-regulation, which has been shown to be largely ineffective.

## Young people and alcohol marketing in New Zealand – a snapshot of the evidence

- 90% of children aged between 5 and 17 years are exposed to alcohol advertising on TV each week.[121]
- An average of one scene every nine minutes of regular television depicts alcohol.[122] Scenes depicting uncritical imagery outnumber scenes showing possible adverse health consequences of drinking by 12 to 1.
- Young people aged 10 to 17 years feel that alcohol advertising encourages teenagers to drink. This is especially the case among 10 to 13-year-old boys, who are the most likely to accept the portrayals in alcohol advertising as realistic.[123]
- In the Dunedin Multidisciplinary study, the number of alcohol advertisements recalled at age 15 predicts heavier drinking among males at 18.[124] Those who responded positively to alcohol advertising at age 18 were heavier drinkers and reported more alcohol-related aggression at age 21.[125]
- Alcohol marketing has an active interaction with youth culture—via social media, direct promotions at events, sponsorship of concerts and musicians, and free music.[126]
- Social networking sites provide young New Zealanders with the opportunity to create and share 'intoxigenic social identities' and digital spaces that further contribute to the normalisation of youth consumption of alcohol.[127]

[121] McCreanor T, et al. Creating intoxigenic environments: Marketing alcohol to young people in Aotearoa New Zealand. Social Science & Medicine 2008;67(6):938–946
[122] McGee R, et al. Alcohol imagery on New Zealand television. Subst Abuse Treat Prev Policy. 2007 Feb 1;2:6
[123] Wyllie A, et al. Responses to televised alcohol advertisements associated with drinking behaviour of 10-17-year-olds. Addiction. 1998 Mar;93(3):361–71
[124] Connolly GM, et al. Alcohol in the mass media and drinking by adolescents: a longitudinal study. Addiction. 1994 Oct;89(10):1255–63
[125] Casswell S & Zhang JF. Impact of liking for advertising and brand allegiance on drinking and alcohol-related aggression: a longitudinal study. Addiction. 1998 Aug;93(8):1209–17
[126] McCreanor T, et al. Youth drinking cultures, social networking and alcohol marketing: Implications for public health. Critical Public Health 2013;23(1):110–20
[127] Griffiths R & Casswell S. Intoxigenic digital spaces? Youth, social networking sites and alcohol marketing. Drug Alcohol Rev. 2010 Sep;29(5):525–30

Marketing messages that blatantly associate alcohol with social, sporting and sexual success, and encourage a culture of heavy drinking need to be addressed if New Zealand's drinking culture is to change







**"We aren't just developing campaigns for the people who we send them to – we are developing them for the friends of those friends"**

- Heineken's global head of digital media[128]






**"We believe that the current level of exposure of young people to alcohol advertising and sponsorship is unacceptable and that this exposure can be reduced"**

– report by the Ministerial Forum on Alcohol Advertising & Sponsorship[129]

[128] Woods A. Procter & Gamble, Heineken and Diageo: who wins and who loses in direct brand deals with Facebook? Marketing; 2012, 6 March

[129] Lowe G, et al. Ministerial Forum on Alcohol Advertising & Sponsorship. Recommendations on alcohol advertising and sponsorship. October 2014.


Sponsorship of musicians and music festivals targets young drinkers, promoting not only alcoholic products, but an identity and lifestyle to take up

The NZMA also recommends that there should be an end to alcohol sponsorship of sporting and cultural events. Ending alcohol sponsorship of our sporting icons is particularly important if we are to see a shift in the culture of drinking in New Zealand. Sponsorship of concerts, DJs, musicians and free music festivals targets young drinkers in ways that are relatively invisible to older segments of the population. New Zealand research shows that alcohol brand images and lifestyle marketing are providing young people with brand identities to take up, along with the alcoholic products.[130]

We suggest that a proportion of the revenue from the alcohol excise tax could be used for sponsorship until alternative sponsors can be found. We believe that there are important lessons to be learned from the cessation of tobacco sponsorship. Contrary to predictions at the time, the Benson and Hedges Cricket series and the Rothmans rally did not collapse following the ending of tobacco sponsorship. Given the popularity of the All Blacks, it is difficult to envisage a scenario in which a replacement sponsor to the well known alcohol brand that sponsors the team could not be found.

We are also aware that the marketing of alcohol is increasing transnational, particularly with the shift to online content. The infrastructure that supports and allows alcohol marketing is global and requires a global response.[131] Accordingly, the NZMA supports calls by the World Medical Association for the consideration of a Framework Convention on Alcohol that would facilitate a more effective global response to reducing alcohol harms.[132]


Finding non-alcohol sponsorship for our major sports teams should not be difficult due to their profile and popularity

**"A strong move to restrict alcohol marketing will send a message that the New Zealand community acknowledges alcohol, like tobacco, is no ordinary commodity. In turn, this may increase the acceptability of other effective policies, such as price increases. This is a major reason why the alcohol industry is so focused on preventing any form of regulation of alcohol marketing"[133]** - Professor Sally Casswell

[130] McCreanor T, et al. 2005
[131] Casswell S. Current status of alcohol marketing policy – an urgent challenge for global governance. Addiction 2012;107:478–85
[132] WMA Statement on Reducing the Global Impact of Alcohol on Health and Society. 2005
[133] Casswell S. Profits or people? The informative case of alcohol marketing. N Z Med J. 2014 Nov 28;127(1406):87–92

## Drink-driving countermeasures

Alcohol is a major risk factor for road traffic crashes (see 'Harm to others – the second-hand effects of alcohol'). The evidence indicates that laws setting a reasonably low level of blood alcohol concentration (BAC) at which one may drive legally, combined with well-publicised enforcement, significantly reduce drink-driving and alcohol-related driving fatalities.[134] Frequent highly visible, non-selective testing can have a sustained effect in reducing drink-driving and the associated crashes, injuries and deaths.[135]

Until recently, New Zealand had an adult legal BAC limit of 80 mg per 100 mL of blood, which allowed people to become significantly impaired and still legally drive. The NZMA welcomed the recent lowering of the adult legal BAC limit to 50 mg per 100 mL of blood. This measure will save lives. There is clear evidence that the lower the BAC level, the lower the risk of crashing.[136] Lowering the BAC limit has also been shown to change driver attitudes and behaviour towards drinking, with drivers consuming less alcohol before driving.[137]

Frequent testing can have a sustained effect in reducing drink-driving and the resulting injuries and deaths from crashes

Setting a low BAC level at which people may legally drive is shown to significantly reduce alcohol-related fatalities

The Ministry of Transport has previously estimated that a BAC limit of 50 mg per 100mL could prevent between 15 and 33 fatalities and 320 to 686 injuries every year, with an estimated annual social cost saving of between $111 million and $238 million.[138] A more recent analysis indicates that, conservatively, an average of 3.4 fatalities and 64 injuries per year could be saved with this lowered limit, and that the policy would have a positive net present value of $200 million over 10 years.[139]

Along with the lower BAC limit, a greater focus on directing recidivist drink drivers to appropriate treatment programmes is needed. Repeat drink driving infringements and offences are a sign of an underlying drinking problem. Around 30,000 drink drive convictions occur each year, around a third of which are for repeat offenders,[140] yet only a small proportion of these people are referred to treatment programmes.

[134] Babor TF, et al. 2010. Chapter 11 Drinking-driving prevention and countermeasures
[135] Ibid
[136] Frith B & Strachan G. Road safety impact of establishing blood alcohol concentration levels at 0.05. Land Transport Safety Authority of New Zealand. 2002 (revised June 2008)
[137] Ibid
[138] Ministry of Transport. Safer Journeys Discussion Document. August 2009, p13.
[139] Reported in the Regulatory Impact Statement accompanying the Land Transport Amendment Bill. Available from www.transport.govt.nz/assets/uploads/about/documents/RIS-safer-journeys-lowering-legal-alcohol-limits-for-driving.pdf
[140] Waters G (2013). Drink/Drug Driving Data 2009-2012 and Preliminary Report on Interlock Uptake in New Zealand. Report compiled for the New Zealand Automobile Association.

# Other considerations

## Ineffective measures to reduce alcohol-related harms

A focus on educating and persuading the individual drinker to change his or her behaviour without changing the broader environment cannot be relied upon as an effective approach to reducing alcohol related harms.[141]

An awareness of what doesn't work when considering measures to reduce alcohol-related harms is as important as understanding what does work. Despite being among the most popular approaches to preventing alcohol-based problems, education programmes, including school-based alcohol education programmes, do not work in terms of changing long-term drinking behaviour.[142] Mass media campaigns by government agencies and NGOs addressing responsible drinking, the dangers of drink driving and related topics also generally have little to no effect on changing drinking behaviour over the long term.[143] All too often, resources have been diverted towards these types of programmes, despite the absence of evidence for their effectiveness. Mass media campaigns to publicise changes to legislation, such as lowering the BAC, and interventions such as random breath testing, are considered to increase the effectiveness of such changes.

## The role of the industry

Various sectors in the alcohol industry play an important part of the environment in which drinking patterns are learned and practised. The alcohol industry is increasingly transnational, with a handful of large multinational corporations now managing most of the world's leading brands. The size of these companies supports integrated marketing on a global scale. Their size also allows considerable resources to be devoted, directly or indirectly, towards promoting policy measures that favour the industry. Recent literature has revealed the extent to which the alcohol industry has attempted to influence policy, often under the guise of corporate social responsibility.[144]

The transnational producers of alcohol have waged a sophisticated and successful campaign during the past three decades, including sponsorship of intergovernmental events, funding of educational initiatives, research, publications and sponsoring sporting and cultural events.[145]

[141] Babor TF. Alcohol: No Ordinary Commodity – a summary of the second edition. Addiction 2010;105:769–79

[142] Babor TF, et al. 2010. Chapter 13 Education and persuasion strategies

[143] Ibid

[144] McCambridge J, et al. Vested interests in addiction research and policy. The challenge corporate lobbying poses to reducing society's alcohol problems: insights from UK evidence on minimum unit pricing. Addiction. 2014 Feb;109(2):199–205; Casswell S. Vested interests in addiction research and policy. Why do we not see the corporate interests of the alcohol industry as clearly as we see those of the tobacco industry? Addiction. 2013 Apr;108(4):680–5; Babor TF, Robaina K. Public health, academic medicine, and the alcohol industry's corporate social responsibility activities. Am J Public Health. 2013 Feb;103(2):206–14; Babor TF. Alcohol research and the alcoholic beverage industry: issues, concerns and conflicts of interest. Addiction. 2009 Feb;104 Suppl 1:34–47; McCambridge J, et al. Alcohol Harm Reduction: Corporate Capture of a Key Concept. PLOS Medicine Dec 2014;11(12)

[145] Casswell S, 2013

Media campaigns addressing the dangers of drink driving have been shown to have little to no effect on changing long-term drinking behaviour

Health professionals have a responsibility to advocate for effective public health policies based on the evidence. The NZMA reiterates the caution by the World Medical Association for all National Medical Associations and doctors to *"Be aware of and counter non-evidence-based alcohol control strategies promoted by the alcohol industry or their social aspect organizations."*[146]

**"In the view of WHO, the alcohol industry has no role in the formation of alcohol policies, which must be protected from distortion by commercial or vested interests"**

– Dr Margaret Chan,
Director-General of WHO

## International trade agreements

International trade agreements are another area that could affect alcohol policy.[147] We note that the WMA has recommended that, to protect current and future alcohol control measures, anything affecting the supply, distribution, sale, advertising, promotion or investment in alcoholic beverages be excluded from international trade agreements.[148] The NZMA considers it essential for the government to consult with public health experts and undertake comprehensive health impact assessments before committing to any final agreements. It is important to ensure that the government retains the ability to implement best-practice public health policies, including those designed to reduce alcohol-related harms.

[146] WMA Statement on Reducing the Global Impact of Alcohol on Health and Society. 2005
[147] Zeigler DW. The alcohol industry and trade agreements: a preliminary assessment. Addiction. 2009 Feb;104 Suppl 1:13–26
[148] WMA Statement on Reducing the Global Impact of Alcohol on Health and Society. 2005

# Key recommendations

**"Unless a comprehensive approach is taken to addressing the problems that alcohol poses for New Zealand society, those problems will not be solved"**

- Sir Geoffrey Palmer

**The NZMA** believes that a comprehensive suite of measures is necessary to address alcohol-related harms in New Zealand. While doctors have an important role to play at the coalface, government is in the best position to enact the legislative, regulatory and policy measures necessary to modify the current environment that promotes alcohol consumption.

This briefing is intended for a wide audience, but the following recommendations are directly primarily at doctors and other health professionals, politicians and policy makers.

1. Doctors and other healthcare professionals should take every opportunity to provide screening and/or brief interventions for patients with suspected harmful alcohol consumption. Funders need to ensure adequate resources and incentives to facilitate these interventions.

2. The government should introduce a specific health target that incorporates the provision of better help to address harmful drinking, like the target on advice for smoking cessation.

3. Treatment services for people with alcohol dependence need to be expanded across the country and available across diverse settings, including to people convicted of criminal offences.

4. The government should raise excise taxation on alcohol and introduce minimum unit pricing. A greater proportion of revenue gained from alcohol taxation should be utilised towards alcohol harm-reduction.

5. All forms of alcohol marketing, including sponsorship of sporting and cultural events, should be phased out. In the interim, restrictions on the content and quantity of alcohol advertising need to be supported by statutory regulation rather than industry self-regulation.

*Key recommendations continued:*

**6** Women of childbearing age and those who are pregnant should receive advice on the harmful effects of drinking during pregnancy. Those already pregnant or considering pregnancy should be advised against drinking any alcohol. This should be part of an action plan developed to combat the harm caused by Fetal Alcohol Spectrum Disorder in New Zealand.

**7** Local authorities should support calls by health professionals for restrictions in the density of alcohol outlets and reductions to maximum trading hours when developing their Local Alcohol Policies (LAPs). This may require changes to the terms of engagement between councils and industry, to ensure that harm minimisation remains at the forefront of LAPs.

**8** When negotiating international trade agreements, the government should ensure that it retains the ability to implement best-practice public health policies for reducing alcohol-related harms.

**9** Drink-drive countermeasures should be enforced in a rigorous and highly visible manner.

**10** The minimum purchase age for alcohol should be raised to 20 years for on-licensed as well as off-licensed premises, with the minimum purchase age of alcohol viewed by parliamentarians as a health and social policy issue rather than a conscience issue.

**Importantly,** all policy measures to reduce alcohol-related harms should be rigorously evaluated and modified as and when necessary.

# Conclusion

**While** the use of alcohol is deeply ingrained in New Zealand society, the health and social harms arising from the use of alcohol are substantial. These harms affect individual drinkers as well as those around them including children and represent a considerable burden to society.

Changing the way we drink is particularly difficult given the current environment which is characterised by the widespread availability and promotion of extremely cheap alcohol. Changing New Zealand's drinking culture will require changes to the regulatory environment.

When formulating policies to mitigate alcohol-related harms, it is important to keep in mind that alcohol is not an ordinary commodity; it is a toxin, an intoxicant and an addictive psychotropic drug. There is a wealth of evidence to draw on when formulating responses to alcohol-related harms. Recent legislative changes to the sale and supply of alcohol represent a missed opportunity.

While health professionals have an important role to play, government is in the best position to help change the existing environment by way of the legislative, regulatory and policy measures that have been identified in this briefing. Raising the price of alcohol, reducing its availability and phasing out its promotion should comprise the central tenets of an integrated response to reducing the harms from alcohol.

We hope this policy briefing will provide decision makers with a robust evidence-based resource with which to help build an effective and comprehensive response to reducing the harms from alcohol in New Zealand.

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# About the NZMA

**The NZMA is the country's largest voluntary pan-professional medical organisation with over 5,000 members. Our members come from all disciplines within the medical profession and include general practitioners, doctors-in-training, specialists and medical students.**

**Statement of purpose**
The NZMA aims to provide leadership of the medical profession, and promote:
- professional unity and values, and
- the health of all New Zealanders.

**The key roles of the NZMA are:**
- to provide advocacy on behalf of doctors and their patients
- to provide support and services to members and their practices
- to publish and maintain the Code of Ethics for the profession
- to publish the New Zealand Medical Journal.

The NZMA works closely with many other medical and health organisations, and provides forums which consider pan-professional issues and policies.

This policy briefing replaces our earlier 2010 position statement on Alcohol. It has been developed following extensive consultations with our Board. We have also sought feedback from various other public health experts in alcohol policy and harm reduction.

NZMA
New Zealand Medical Association

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- professional unity and values, and
- the health of all New Zealanders.

www.nzma.org.nz