Alcohol Position Statement

Nelson Marlborough Health (NMH) is the main provider of health services in the Nelson, Tasman and Marlborough regions, and our vision is that all people live well, get well, stay well – Kaiao te tini, ka ora te mano, ka noho ora te nuinga. NMH will work with the people of our community to promote, encourage and enable their health, wellbeing and independence and this includes working together to reduce the wide range of alcohol-related harm in the region.

Alcohol use is a major behavioral risk factor for numerous health conditions, injuries and social problems. Alcohol-related harm costs the health sector significant money, time and resources. It is a key driver of health inequities, as harm is disproportionately borne by demographic and population subgroups.

NMH believes that the implementation of strategies that aim to reduce alcohol-related harm in Nelson Marlborough is an essential component of improving local population wellbeing. NMH will undertake to reduce alcohol-related harm experienced by people within the Nelson Marlborough district by:

- Facilitating access to health services including
    - screening
    - early and brief intervention
    - treatment including addiction services
- Investing into target approaches for vulnerable populations including Maori
- Having a series of actions aimed at reducing alcohol-related harm identified in the NMH Annual Plan
- Increasing staff awareness of the short and long-term risks associated with alcohol use.
- Supporting and encouraging research and evaluation of alcohol interventions to ensure that they are effective and equitable.
- Obtaining and utilising NMH alcohol-related harm data in a consistent, high-quality manner
- Advocating the importance of harm reduction with cross sector forums
- Working closely with key agencies to reduce alcohol related harm locally
- Supporting and assisting Councils to implement strategies to reduce harm (e.g. through Local Alcohol Policies, District Plan rules, and bylaws e.g. relating to alcohol signage, alcohol advertising on Council infrastructure and alcohol bans in public places).
- Advocating for the following evidence-based policies and interventions to reduce alcohol-related harm:
    - Increasing alcohol prices (through excise taxes and pricing policies)
    - Strengthening restrictions on alcohol availability (including raising the purchase age / reducing trading hours / restricting density and location of alcohol outlets)
    - Strengthening restrictions on alcohol advertising, sponsorship and promotion
    - Advancing and reinforcing drink driving measures

SUMMARY OF EVIDENCE

Alcohol-related harm

Alcohol use is a major risk factor for more than 200 acute and chronic health conditions, including heart disease, injuries, cancer, psychiatric and neurological conditions, gastrointestinal disease, and birth defects including fetal alcohol spectrum disorder (FASD).

Approximately 5.9% of all deaths worldwide[1] and 5.4% of all premature deaths in New Zealanders under 80 years old are attributed to alcohol.[2]

It is estimated that alcohol accounts for approximately 4% of total health loss in New Zealand.[3] Alcohol alters the mood and impairs memory and psychomotor function. People who consume alcohol are less inhibited and therefore more likely to take risks and behave aggressively, which could lead to motor vehicle crashes, falls, drowning, poisoning, assault, self-inflicted injury, suicide and homicide. For almost all conditions, heavier alcohol use means higher risk of disease or injury.[4,5] It also contributes to diabetes, sleep disorders, and infectious diseases such as pneumonia and tuberculosis.

Children and young people experience significant harms from their own drinking and the drinking of others. Alcohol exposure during pregnancy increases the risk of a child being born with physical and developmental disabilities associated with FASD. Alcohol use by young people can also alter brain development, making young people more vulnerable to a range of negative social and educational outcomes.

In addition to health harms, significant social harm results from alcohol use: 12.2% of New Zealand adults in a national survey reported experiencing harmful effects from their own drinking on friendships, social life, home life, work/study/employment opportunities, financial position, legal problems or difficultly learning.[6] Overall, more New Zealanders report being harmed from the drinking of others than from their own drinking, with women and young people disproportionately affected by others' drinking.[7]

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[1] World Health Organisation (2018) Alcohol Fact Sheet 5 February 2018. Retrieved from http://www.who.int/news-room/fact-sheets/detail/alcohol

[2] Connor, J.,Kydd,R.,Shield,K.,Rehm, J. (2013). Alcohol-attributable burden of disease and injury in New Zealand: 2004 and 2007, Research report commissioned by the Health Promotion Agency. Wellington: Health Promotion Agency.

[3] Ministry of Health. (2017) Health and Independence Report 2016. *The Director-General of Health's Annual Report on the State of Public Health*. Wellington: Ministry of Health. Retrieved from https://www.health.govt.nz/system/files/documents/publications/health-independence-report-2016-apr17.pdf

[4] Rehm, J., Baliunas, D., Borges, G. L., Graham, K.,Irving, H., Kehoe, T., et al. (2010). The relation between different dimensions of alcohol consumption and burden of disease: An overview. *Addiction,* 105(5), 817–843

[5] Room, R., Babor, T., & Rehm, J. (2005). Alcohol and public health. The Lancet, 365(9458), 519–530.

[6] Ministry of Health. (2009) *Alcohol Use in New Zealand: Key results of the 2007/08 New Zealand Alcohol and Drug Use Survey*. Wellington

[7] Babor, T., Caetano, R., Casswell, S., Edwards, G, Giesbrecht, N., Graham, K., Grube, J. et al. 2010. Alcohol: no ordinary commodity. Research and public policy. 2nd ed. New York: Oxford University Press

The economic cost of alcohol-related harm in New Zealand is significant. Harmful alcohol use costs New Zealand an estimated $5 billion each year[8] (expressed in 2005/6 currency) of diverted resources such as insurance, lost wages, healthcare costs, road crashes, and police and justice costs. A recent update suggests that the current cost could now be as high as $7.85 billion per year.[9]

Alcohol is a key driver of crime in New Zealand, particularly family violence. NZ Police estimate that;[10]

- approximately one third of all Police apprehensions involve alcohol
- half of serious crimes are related to alcohol
- At least one third of all criminal offenders had consumed alcohol prior to committing an offence.

Harm from drink driving is also substantial– 29% of drivers in all fatal crashes between 2014 and 2016 were reported as having consumed alcohol/drugs.[11]

Inequities in alcohol-related harm

Alcohol-related harm is experienced variably throughout the population. Men have a higher rate of alcohol-related mortality than women and Māori have a higher rate than non-Māori. Evidence clearly demonstrates that Māori suffer disproportionately from a wide range of alcohol-related harms compared to non-Māori. New Zealanders with lower socioeconomic status also bear a disproportionate burden of alcohol-related harm. Children are particularly vulnerable to alcohol-related harm caused by the drinking of others.

Cost of alcohol-related harm to the health sector

Alcohol-related harm costs the health sector significant money, time and resources. Intoxicated patients impact negatively on staff and other patients. An estimated 35% of injury-based emergency department presentations are alcohol-related[12].

During the 2016/17 Financial Year 1,280 patients presented to NMH Emergency Departments (ED) with signs of intoxication peaking over the summer period. Over the 2017/18 summer period (Dec-Feb), 4.5% of patients presenting to ED showed signs of intoxication. Intoxicated presentations peaked during weekend nights and in the early hours of the morning. Presentations to ED and St John Ambulance Services are highest

[8] Slack A, Nana G, Webster M, et al. Costs of harmful alcohol and other drug use. BERL Economics 2009:40

[9] Nana, G. (2018). Alcohol costs, but who pays? Alcohol Action Conference, August 15, Wellington.

[10] NZ Police (2014) Framework for preventing and reducing alcohol-related offending and vicitimisation 2010-2014 Retrieved from http://www.police.govt.nz/about-us/publication/online-version/framework-preventing-and-reducing-alcohol-related-offending-and#impact

[11] Ministry of Transport (2016) Alcohol and drugs 2016 retrieved from https://www.transport.govt.nz/assets/Uploads/Research/Documents/Alcohol-drugs-2017.pdf

[12] Humphrey, G., Casswell, S. Han, D.Y. 2003. Alcohol and injury among attendees at a New Zealand emergency department. New Zealand Medical Journal 116(1168)

among females aged under 25 years, or between 40-44 years old and males between 20-29 years and 50-54 years.[13] The estimated annual cost burden of intoxicated patients attending ED was $435,840 (based on the national average cost of $350.75).[14]

NZ DRINKING PATTERNS

Alcohol is widely available in NZ

Alcohol is easily accessible from a wide variety of outlets and to anyone aged 18 years and over. It can be purchased seven days a week, on most days of the year, and consumed at on-licence premises, club licence premises, special licence events, or purchased from an off-licence and consumed elsewhere. Seventy eight percent of New Zealanders live within 1.5km of any on-licence or off-licence premises.[15]

Alcohol is more widely available now than in the past: In 2018[16], the number of premises nationally which held an alcohol licence was 12,099; this has increased from 6,295 in 1990.

Alcohol has also become more affordable over time, mainly due to incomes increasing at a faster rate than alcohol prices. Since 2012, beer, spirits and liqueurs have become 10% more affordable, whilst wine has increased in affordability by 20%.[17]

Drinking patterns in NZ

Most New Zealanders drink at least some alcohol. The 2017/18 New Zealand Health Survey[18] found that 78.7% of adults 15+ years had consumed alcohol in the past 12 months. Twenty percent of people drank alcohol hazardously in a way that could harm themselves or others.

Hazardous drinking is defined by the Ministry of Health as an established pattern of alcohol consumption that carries a risk of harming the drinker's physical or mental health, or having harmful social effects to the drinker or others.

Hazardous drinking rates for men (27.3%) were more than double that of women (12.7%), however, for women, this has increased from 8.6% in 2011/12.[18]

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[13] Nelson Marlborough Health Data 2018

[14] Ministry of Health figure

[15] NZ Health Survey Retrieved from https://www.health.govt.nz/publication/alcohol-use-2012-13-new-zealand-health-survey

[16] Data retrieved the Alcohol Regulatory and Licensing Authority from https://www.justice.govt.nz/assets/Documents-Other/May-2018-Licences.xlsx

[17] Health Promotion Agency. (2018). *Trends in affordability of alcohol in New Zealand.* Wellington: Health Promotion Agency Retrieved from https://www.hpa.org.nz/sites/default/files/Final%20Report%20-%20Trends%20in%20affordibility%20of%20alcohol%20in%20New%20Zealand%20April%202018_0.pdf

[18] Ministry of Health (2018) NZ Health Survey 2017 -2018 https://minhealthnz.shinyapps.io/nz-health-survey-2017-18-annual-data-explorer/_w_1776bce5/#!/explore-indicators

Among population groups, the highest levels of hazardous drinking are found among 18-24 year old males (38%), 25-34 year old males (35%), and Maori men (39%).[18]

Adults aged 45 years and over are one of the fastest growing populations of hazardous drinkers. Between 2011/12 and 2015/16, hazardous drinking significantly increased for those aged 45-54 years old, 55-64 years old, 65-74 years old.

Hazardous drinking increases as deprivation increases, 16% of those living in the least deprived areas are hazardous drinkers compared with 21% of those in the most deprived areas.[19]

Harmful drinking (alcohol consumption that results in physical or psychological harm) is more common amongst Māori and young people.

Early initiation into drinking alcohol is a risk factor for alcohol-related harm in young people.[19] However more 15 to 17 year olds are choosing not to drink alcohol and, if they do drink, fewer are drinking at harmful levels. 43% had not drunk alcohol in the past year.[19] 7% are classified as hazardous drinkers.

How the current law impacts upon these drinking patterns

New legislation to control the sale and supply of alcohol was enacted in December 2012. The Sale of Liquor Act (1989) was replaced by the Sale and Supply of Alcohol Act 2012, with an objective to minimise the direct and indirect harms to an individual, society or the community caused by the excessive or inappropriate consumption of alcohol. The Act increased the role of the Medical Officer of Health (MOH) in the licensing process, requiring them to enquire into all types of licence applications. The new Act also provides for local councils to adopt Local Alcohol Policies (LAP) that specify controls on the local availability of alcohol. LAPs are drafted in consultation with the police, alcohol licensing inspectors, and Medical Officers of Health and include community input. As of August 2017[20], 33 LAPs had been notified, 32 of which had been appealed by the alcohol retail industry. As a result of the appeal process, 71% of LAPs have become less restrictive than the policy originally notified.

The Resource Management Act (1991) legislates how local communities manage the use of land, and requires that a District Plan be developed and adopted. The plan can contain rules concerning location and density of alcohol outlets as well as trading hours.

The Local Government Amendment Act 2001 allows local authorities to impose liquor bans, banning alcohol in public places at certain times. Councils can also implement bylaws and policies to reduce the harm from alcohol advertising (e.g. alcohol signage restrictions, advertising on public transport, etc).

In 2011, the Land Transport Amendment Act lowered the blood alcohol concentration (BAC) limit for drivers under 20 years to zero. In 2014, the Limit for drivers over 20 years was reduced to 50mg per 100ml blood.

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[19] Ministry of Health (2016) *Annual Update of Key Results, NZ Health Survey* https://www.health.govt.nz/system/files/documents/publications/annual-update-key-results-2015-16-nzhs-dec16-v2.docx

[20] Jackson, N. and Robertson, H. (2017). A review of Territorial Authority progress towards Local Alcohol Policy development (2nd edition). Auckland: Alcohol Healthwatch. http://www.ahw.org.nz/Portals/5/Resources/Documents-other/2017/LAPReport_2017_WEB_amended%2020_3_18.pdf

The Ministry of Health National Drug Policy[21] frames alcohol and other drug (AOD) problems as, first and foremost, health issues. The Policy aims to minimise AOD-related harm and protect health and wellbeing by delaying the uptake of AOD by young people, reducing illness and injury from AOD, reducing hazardous drinking of alcohol, and shifting attitudes towards AOD.

EVIDENCE-BASED STRATEGIES TO REDUCE HARM

There are a number of interventions available to reduce alcohol harm, from individually focused to population-based approaches. Whilst screening and brief interventions for hazardous drinking are effective and can achieve significant health gain, the implementation costs are high. The most effective polices[22] that can achieve the greatest impact on health at minimal cost are:

- Alcohol excise tax increases
- Restrictions on alcohol advertising
- Reductions to off-licence trading hours

Increasing the price of alcohol

Evidence shows that when alcohol prices go up, consumption goes down[23,24]. One of the most effective strategies to reduce the consumption of alcohol in a population is increasing the price of alcohol.

Alcoholic products sold in New Zealand are subject to excise tax, with tax rates varying by type of beverage and alcohol strength. Alcohol excise taxes can be increased to cover the cost of the externalities associated with consumption, to alter behaviour and reduce associated harms, to prevent drinking initiation and to generate revenue to fund public services. Those who drink the most, pay the most in excise tax.

A Minimum Unit Pricing policy can also be used alongside excise tax increases. This policy regulates the floor price or minimum price of a standard drink of alcohol, and so is a targeted measure to reduce the harm from very cheap alcohol in New Zealand.[25]

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[21] https://www.health.govt.nz/publication/national-drug-policy-2015-2020

[22] Chisholm, D.; Moro, D., Bertram, M., Pretorius, C. et. Al (2018) *Are the "Best Buys" for Alcohol Control Still Valid? An Update on the Comparative Cost-Effectiveness of Alcohol Control Strategies at the Global Level* Journal of Studies on Alcohol and Drugs 79(4),514-522 Retrieved from https://www.jsad.com/doi/10.15288/jsad.2018.79.514

[23] Babor, T., Caetano, R., Casswell, S., Edwards, G, Giesbrecht, N., Graham, K., Grube, J. et al. 2010. Alcohol: no ordinary commodity. Research and public policy. 2nd ed. New York: Oxford University Press.

[24] Ministry of Justice. 2007. The sale and supply of alcohol to under 18 year olds in New Zealand: a systematic overview of international and New Zealand literature. Final Report. Wellington: Ministry of Justice. Available: http://www.justice.govt.nz/publications/global-publications/t/thesale-and-supply-of-alcohol-to-under-18-year-olds-in-new-zealand-a-systematic-overview-ofinternational-and-new-zealand-literature-final-report/11-international-policy-and-legislativeinterventions

[25] https://www.justice.govt.nz/justice-sector-policy/key-initiatives/sale-and-supply-of-alcohol/alcohol-minimum-pricing-report/

Research shows that as prices rise, alcohol consumption tends to fall, and with it, the harms that stem from drinking. The cost savings that can be reallocated to public services are considerable.

Increasing the legal purchase age

Research shows that the legal age to drink or purchase alcohol affects how much, and how early, youth drink[26,27]. A lower purchase age has been shown to be associated with increased harm, increased adolescent access to alcohol, and the lowering of the overall age at which young people start drinking. A higher purchase age acknowledges that the effects of alcohol and its harms are much greater on the developing brain that is continuing to mature well into the twenties. In order for a higher purchase age to be effective, it needs to be combined with adequate enforcement.

Reduce alcohol availability

Restricting the availability of alcohol is effective in reducing a range of alcohol-related harms[28]. Availability can be restricted by limiting the hours and days of sale and controlling the location and number of licensed premises.

In New Zealand, alcohol outlets are inequitably distributed with more alcohol outlets situated in socioeconomically deprived areas[29]. Competition arising from high off-licence density is associated with longer trading hours and lower alcohol prices, stimulating demand and facilitating heavier consumption.[30] Local Alcohol Policies or District Plan rules can include restrictions on the density and location of alcohol outlets as well as maximum trading hours.

Restrict alcohol marketing and advertising

The marketing and advertising of alcohol influences the age of the first alcoholic drink and levels of consumption among current drinkers[31]. Alcohol and marketing companies in New Zealand have developed their own Code for Advertising and Promotion of Alcohol. This Code contains a set of guidelines for all alcohol advertisements in NZ, ensuring that advertising is socially-responsible and does not appeal to minors. The current code

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[26] O'Malley P.M. and Wagenaar A.C. 1991. Effects of minimum drinking age laws on alcohol use, related behaviors and traffic crash involvement among American youth: 1976-1987. Journal of Studies on Alcohol 52(5), 478-91.

[27] Wagenaar, A.C., Wolfson, M. 1994. Enforcement of the legal minimum drinking age in the United States. Journal of Public Health Policy 15(1), 37-53

[28] Babor, T., Caetano, R., Casswell, S., Edwards, G, Giesbrecht, N., Graham, K., Grube, J. et al. 2010. Alcohol: no ordinary commodity. Research and public policy. 2nd ed. New York: Oxford University Press

[29] Morrison, C., Gruenewald, P. J., & Ponicki, W. R. (2015). Socioeconomic determinants of exposure to alcohol outlets. *Journal of studies on alcohol and drugs*, *76*(3), 439-46.

[30] ALAC (2012) The Impacts of Liquor Outlets in Manukau City Report No. 3 The spatial and other characteristics of liquor outlets in Manukau City.

[31] Ministerial Forum on Alcohol Advertising & Sponsorship (October 2014) Recommendations on Alcohol Advertising & Sponsorship. Retrieved from https://www.health.govt.nz/system/files/documents/publications/ministerial-forum-on-alcohol-advertising-and-sponsorship-recommendations-on-alcohol-advertising-and-sponsorship-dec14.pdf

includes restrictions on traditional television broadcasting but does not include rules regarding television subscriptions, on-demand television or user-generated content on social media that is external to alcohol company websites.

Alcohol advertising and sponsorship of sports has been linked to increased problem drinking[32]. In order to reduce the association between sport and alcohol, many independent reviews (New Zealand Law Commission, Ministerial Forum on alcohol advertising and sponsorship) have recommended strong restrictions on alcohol sponsorship and advertising[33].

Increase drink-driving countermeasures

Driving performance declines with increasing levels of alcohol in the blood[34]. The legal drink drive limit for drivers;

- under 20 years of age is a blood alcohol concentration (BAC) of zero.
- 20 years and over is a breath alcohol limit of 250 micrograms (mcg) of alcohol per litre of breath and a blood alcohol limit of 50mg of alcohol per 100ml of blood.

Between 2003-2007 in New Zealand, over 25% of road traffic injuries across all road users involved alcohol and 43% of injuries were to someone other than the drinking person responsible.[35] Between 2014-16, 261 deaths resulted from traffic crashes where alcohol (and/or drug use) was a contributing factor.[36] One third of drink driving convictions are for repeat offenders. In 2018, alcohol interlock devices (a breath testing device wired into a vehicle's starting system) became mandatory for serious and repeat drink-driving offenders.

Summary

Alcohol contributes to many health, social and economic burdens in New Zealand. To improve population health and reduce health inequities, NMH is committed to reducing alcohol-related harm through a range of evidence-based interventions in our Nelson Marlborough communities.

This position statement should be read in conjunction with the evidence-based background paper on alcohol, further references are in the background paper.

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[32] 38 Gee, S., Jackson, S. J. & Sam, M. (2013). The culture of alcohol consumption and promotion at major sports events in New Zealand. Wellington: Health Promotion Agency

[33] https://www.health.govt.nz/system/files/documents/publications/ministerial-forum-on-alcohol-advertising-and-sponsorship-recommendations-on-alcohol-advertising-and-sponsorship-dec14.pdf

[34] Babor, T., Caetano, R., Casswell, S., Edwards, G, Giesbrecht, N., Graham, K., Grube, J. et al. 2010. Alcohol: no ordinary commodity. Research and public policy. 2nd ed. New York: Oxford University Press

[35] Connor J, Casswell S. 2012. Alcohol-related harm to others in New Zealand: evidence of the burden and gaps in knowledge. The New Zealand Medical Journal. 125(1360), 11-27.

[36] Ministry of Transport (2017) Alcohol and Drugs 2015 Retrieved from https://www.transport.govt.nz/assets/Uploads/Research/Documents/Alcohol-drugs-2017.pdf