February 18, 2011

Committee Secretariat
Justice and Electoral Select Committee
Parliament Buildings
Wellington 6160

Alcohol Reform Bill

Dear Chair

Thank you for your invitation to make a submission to the Justice and Electoral Select Committee on this important matter.

Our submission is attached. We would like to appear before the Select Committee hearings.

Yours sincerely

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Who we are

The Public Health Association of New Zealand (PHA) is a voluntary association which provides a major forum for exchanging information and stimulating debate about public health in New Zealand. Membership of the PHA is open to individuals interested in public health. Our members belong to the public, private and voluntary sectors. As well as membership fees, donations and other earnings, the PHA has a contract with the Ministry of Health to encourage and facilitate informed debate on key public health issues, and to support public health workforce development. The PHA is a member of the World Federation of Public Health Associations.

Public health is defined as actions to improve, promote and protect the health of the whole population '*through the organised efforts of society*'[1].

The PHA operates in accordance with the Treaty of Waitangi. We partner with Māori in our decision-making, and recognise the rights Te Tiriti affords Māori as the indigenous people of Aotearoa New Zealand. Our organisational vision is "Good health for all - health equity in Aotearoa", or "Hauora mō te katoa – oranga mō te Ao".

Our overall view on the bill

As a long-term supporter of action to reduce alcohol-related harms, the Public Health Association welcomes the development of this Bill. From a public health perspective, we support measures to reduce the harms to the 80% of New Zealanders who use alcohol. We also believe that the freedom to drink alcohol should be balanced against the rights of New Zealanders to be free from the effects of others' alcohol use. We recognise that the Bill is the result of extensive research and policy development.

Given this effort, it is disappointing that Government has not taken the opportunity to adopt the comprehensive package of measures internationally recognised as cost-effective, set out in the Law Commission's report. The Government has accepted or partially accepted 126 of the Law Commission's 153 recommendations. Unfortunately, among those it has left out are some of the most effective policy levers to reduce alcohol-related harms, particularly around price and marketing. We urge the Government to adopt the recommendations as a package.

We are also concerned about the Bill's focus on young people. There is no doubt that young New Zealanders are suffering significant damage from alcohol, both their own use and their peers'. However, it is ineffective to focus exclusively on young people, and it supports a false stereotype that young people are the alcohol problem. It allows older people, who drink the majority of alcohol, to treat New Zealand's alcohol problem as just as a 'youth problem'. In fact, 70% of heavy drinkers are aged 25 and over, and a third of men in their 40s and 50s are drinking hazardously[2].

We start this submission by summarising alcohol use and harms; then discuss the proposals in the existing Bill; before recommending additional measures that we believe are essential to create a safe drinking environment in Aotearoa New Zealand.

Alcohol use and harms in Aotearoa New Zealand

Alcohol availability, use and promotion in Aotearoa New Zealand

In the last two decades, liberalisation of alcohol legislation, and intensive marketing by the alcohol industry, has contributed to a rise in total alcohol consumption by 9% between 1998 and 2008. Alcohol has become very easy to access. The number of outlets licensed to sell alcohol more than doubled from 6,296 in 1990 to 14,424 in 2010. Alcohol has also become significantly more affordable.[need a figure here].

Alcohol advertising has been extended in the media, and is becoming increasingly focused on social media which target young people. Existing laws are failing to control alcohol advertising, which continues to blatantly associate alcohol with social, sporting and sexual success.

Among the results are that 700,000 New Zealanders have been categorised as binge drinkers (consuming seven or more standard drinks per session). Of particular concern is the massive increase in binge drinking among younger teenagers.[1]

Alcohol harms health

Each year, about 1,000 New Zealanders die due to alcohol[3]. Half of these deaths are from chronic alcohol-related diseases such as cancers, while the other half are from injuries. Alcohol is responsible for a net loss of 12,000 years of life each year. The long-term effects of alcohol contribute to over sixty different health conditions, including cancers, gastrointestinal conditions, mental health problems and fetal disorders.[4] [5] Alcohol is now recognised as a significant contributor to cancers - of which New Zealand was recently shown to have high rates[6] - and has been classified by the World Health Organization as a Class 1 carcinogen[7].

Alcohol use is now so normal in New Zealand that it is often forgotten that it is a dependence-causing drug[8]. People with alcohol use disorders have a high prevalence of other mental health disorders, substance use disorders and physical health problems, and have much higher use of health services than the general population.[9]

Research at Wellington Hospital found that 40% of those who turn up at emergency rooms suffering from alcohol-related illness or injury are under 20[10]. Similarly, Auckland City Hospital has been concerned by a 30% increase in the past five years in the number of young people going to its emergency department because of drink-related problems

[1] Between 1995 and 2004, the proportion of young people binge drinking on a typical occasion increased from 14% to 25% in 14 –15 year olds, and 25% to 36% in 16 –17 year olds.

It's also 'how we're drinking'. Both the volume of lifetime alcohol use and a combination of frequency of drinking and amount drunk per occasion increase the risk of a wide range of health and social harm, largely in a dose-dependent manner[11]. (WHO 2009, p10). In addition, a pattern of heavy episodic drinking increases risk for some disease and all injury outcomes[12].

Other harms from alcohol

We support the broad definition of 'harms' in clauses 3 and 4. We are particularly pleased that this definition recognises that the costs of alcohol use are borne not only by users, but by other people, families/whānau, and neighbourhoods and communities. Alcohol is a factor in one in three of all recorded crimes. New Zealanders have suffered too much from 'passive consumption'[13] of alcohol, and until recently this damage has been tolerated and treated as normal.

New Zealand taxpayers also bear the costs of alcohol use. Alcohol-related harm in New Zealand has been recently estimated to cost $5.3 billion per year, or $14.5 million every day[14]. Much of this cost is divided between Health and Justice.

Alcohol-related harms to Māori

Unknown to pre-European Māori society, alcohol (waipiro) had a profoundly negative effect on Māori society as a tool of colonisation. Today, Māori are disproportionately affected by alcohol. Alcohol-attributable deaths are responsible for around 8% of all deaths among Māori, including 3.9% of deaths among Māori women and 11.3 % of deaths among Māori men.[15] As a high proportion of the Māori population is young, alcohol problems that effect young people have an even greater effect on Māori [ref to Bramley][16]

Alcohol-related harms to other population groups

While Pacific people in Aotearoa New Zealand are still more likely to be non-drinkers than the population as a whole, those who do drink are relatively heavy drinkers, preferring to drink in groups and until they are intoxicated[17]. Alcohol use is also increasing among young Pacific people, especially those born in Aotearoa New Zealand[18].

The Alcohol Reform Bill

Object of the Bill

We are pleased that the Bill's objects are framed more broadly than those in section 4 of the Sale of Liquor Act 1989 ("establish a reasonable system of control over the sale and supply of liquor to the public with the aim of contributing to the reduction of liquor abuse, so far as that can be achieved by legislative means"). However, this Bill still focuses on minimising "excessive" and "inappropriate" consumption of alcohol,

rather than on reducing the harms of alcohol more generally. The terms “excessive” and “inappropriate” are not defined in clause 5 of the Bill. In the absence of a definition, they could well be contended by the alcohol industry.

We recommend that the objects of the Bill be revised in line with the Gambling Act (2003). The purpose of that Act (set out in Section 3) is to “control the growth of gambling”, and to “prevent and minimise the harm caused by gambling, including problem gambling”.

We strongly support the broad definition of ‘harms’ in clauses 3 and 4, which recognises that, as noted earlier, much alcohol-related harm is the result of passive consumption[19].

Licensing provisions

Community control and Local Alcohol Policies

We commend the bill’s provisions giving communities having more control over licences issued, including location. This is likely to be the provision in the Bill as it currently stands that will have the greatest impact to reduce alcohol-related harms. We also appreciate the broadening of the criteria being considered.

However, Local Alcohol Policies (LAPS) must not be voluntary. Not making them mandatory means that local authorities could be pressured or influenced not to adopt policies. We recommend that Clause 75 be strengthened to require local authorities to develop Local Alcohol Policies, and are appropriately resourced to do so. We recommend the cost is recovered through licensing fees.

Increased outlet density generally reduces the ‘price’ of acquiring alcohol (time and transport), and is linked to discounting and other retailer competition. Outlet density is also shown to be associated with violence, both at off-licence outlets in the suburbs, and on-licence (bars etc) in the inner-city[20]. The measures proposed to prevent density-related problems worsening are welcome, but as these problems already exist[21], this legislation should take the opportunity to reduce outlet numbers in areas where problems are already occurring.

The special consultative procedure proposed is the same process by which class 4 venue policies are developed under the Gambling Act (Section 102). The requirement to develop local gambling policies, and the consultation requirement under the special consultative procedure in that context, has arguably assisted community groups to influence the development of favourable ‘sinking lid’ gaming venue policies. We look forward to a similar outcome for alcohol sales outlets.

We also recommend strengthening clause 78 to require local authorities preparing Local Alcohol Policies to engage their community in designing the policy. They should also be required to consult with local iwi (as well as with Police, Medical Officers of Health, etc). A Health Impact Assessment should be carried out to inform the policy and to help identify harm reduction performance measures.

Clause 79 requires councils developing a local alcohol policy to first “assess” a number of factors (including demographic and health-related factors). This should be strengthened from “assess” to require councils to “take these factors into account”.

Licence holders
We support the changes in the Bill regarding who can hold a licence (clauses 29 – 34), as well as the new restrictions on issuing licences, in particular clause 38 which excludes petrol stations, dairies, conveyances or some shops within shops from being able to hold a liquor license.

We recommend the Select Committee also consider strengthening the Bill to restrict off-licence sales to specialist alcohol retailers, and to remove alcohol licences from grocery outlets and supermarkets. While this measure would be controversial, it is line with the aims of the Bill and will reduce alcohol-related harm.

Default national maximum trading hours

The Bill proposes default national maximum trading hours (clause 44). It should provide explicitly for national maximum trading hours, as recommended by the Law Commission.

The Bill appears to exempt casinos from needing to comply with the trading hours permitted in the relevant district. Clause 47(3) makes compliance with the permitted trading hours subject to section 173 of the Gambling Act 2003, which provides that an on-licence granted for a licensed casino “must be treated as authorising the sale of liquor for consumption in the casino while the casino is lawfully operated”. The Bill also exempts casinos from the prohibition on operating on Easter Sunday: clause 48(4). The purpose of maximum trading hours is to reduce alcohol related harms. There is no reason that casinos should be exempted - drinking alcohol in a casino is no less harmful than in other venues.

Enforcement of licensing provisions

We urge the Select Committee to strengthen sanctions against non-compliant alcohol retailers, whether off-license or on-licence. The intent of this legislation will be undermined if it is not accompanied by an effective enforcement regime.

As the World Health Organisation says “The most effective means of enforcement is on the sellers, who have a vested interest in retaining the right to sell alcohol.”[22] Ministers supporting earlier, softer, legislation promised that licences would be hard to get and easy to lose. In fact, few licences have been lost. At most, bars are closed for a few days (mid-week rather than on peak drinking days). Licensees who have sold alcohol to under-age young people have been granted new licences.

We recommend those caught criminally selling alcohol to under-age people have their licences suspended for long periods of time – weeks or months – and that liquor licences and manager certificates be automatically cancelled (as the Law Commission

recommended) after two convictions during a five-year period. You do the crime (illegal selling) then you do the time (loose the privilege to sell).
The purpose of the legislation is to reduce alcohol-related harm. Business operators must consistently demonstrate that they are sufficiently responsible to have a licence to gain profit from the sale of dangerous substances or lose the privilege.

Age limits

Age for alcohol sale

We support legislation changes that reduce the access to and use of alcohol by younger people. This is because of the evidence that greater consumption of alcohol at a younger age is more harmful, and that laws setting a minimum age at which alcohol can be sold show clear reductions in drink–driving casualties and other alcohol-related harms[23].

We believe that the evidence - especially the increasing body of research on the effects of alcohol on brain development - supports the need to increase the selling age overall.

We are therefore prepared to support the ‘split age’ proposal as it will reduce some harm, and as a first step towards re-establishing a safer drinking age. We understand the rationale (identifying when people are most vulnerable, as with driving and young people) but are not sure that the rationale is well supported by evidence.

We are also concerned that the “split age” legislation sends confusing signals to young people – that drinking to excess is all right as long as you are drinking in a bar. This appears to be based on the view that bars are a safe place to drink, whereas there is evidence that the culture of bars can encourage excessive drinking[24]. Therefore, if Parliament proceeds with the “split age” proposal rather than increasing age overall, there should be an explicit requirement in the legislation for a review of its effectiveness in reducing alcohol harm, monitoring if bars are safe places for young people to drink safely.

Alternatively, if a “split age” proposal is desired, one that raises the selling age to 25 should be considered: that is the upper “split age” for full driving licence.

Supply to minors

We support clause 224, which provides that only parents or guardians can supply alcohol to minors, and requires that supply is supervised. Parents need to be supported to keep young people safe from alcohol-related harms.

However, we recommend the clause be strengthened by removing the ‘consent’ clause, so that only parents and guardians can legally supply alcohol to people under 18 years.

Alcohol in public places

We support reinstating the offence of being drunk in a public place, as way to increase other people's ability to feel safe in public areas.

However, we are concerned about the potential for Police to abuse these new powers, especially to harass young Māori, Pacific peoples and young people generally. We ask the Select Committee to consider ways to make sure that while this provision is implemented, citizens' rights are respected.

We suggest this being an infringement offence (an on the spot fine) to minimise the cost to its enforcement.

Regulating alcohol content

We agree with the proposal to limit the alcohol content of certain drinks (clause 383), and the increased powers to ban certain alcohol products. We would like to see the alcohol content of RTDs restricted to 5%, and container sizes limited to no more than 1.5 standard drinks. However, the same provisions should also be considered for other alcohol products, rather than placing restrictions solely on alcohol products aimed at young people.

We also believe that the Bill should provide the regulatory powers to require licensed premises to offer standard measures of wine, beer and spirits.

We recommend that the Select Committee require the Government to report back to the Committee on the progress of regulation. Regulations will need to be introduced quickly. The regulations to implement and enforce this legislation will need to be carefully drafted, flexible, and capable of being acted on or changed fast, as the alcohol industry has shown itself to be very fast in modifying or introducing products to exploit regulatory loopholes.

Information on alcohol harms

We support Clause 384 (requiring licensees to provide information on alcohol content and harmful effects at the point of sale).

In our view, it should be accompanied by provisions to require health warning labels, nutritional information and an ingredient list on alcohol products. Ingredient lists are required on food and other substances that people consume – there is no reason for alcohol to be exempt.

Alcohol, marketing and promotion, restrictions on alcohol advertising and sponsorship

We support Clause 220 of the Bill which creates a new offence to restrict irresponsible promotions. Current alcohol promotions in licensed premises (such as

‘two for one’ drinks, happy hours, and free drinks for women on certain nights, are clearly not aimed at moderate drinking but at encouraging excess. If the split age provision - which privileges licensed premises - become law, it will be important to make sure that on-licence holders do not abuse their special position.

However, the bill’s proposals do not go far enough to address the current alcohol marketing situation. According to the World Health Organisation “… various forms of alcohol marketing, including exposure to alcohol advertising in the traditional media as well as promotion through the content of films and alcohol-branded merchandise, have an impact on when young people start to drink and on riskier patterns of drinking among young people.”

WHO also points out that “The effects of exposure seem cumulative and, in markets where alcohol advertising is more widespread, young people are more likely to continue to increase their drinking as they move into their mid-twenties, while drinking declines at an earlier age in those who are less exposed.”[25]

We recommend that the Government includes provisions in the Bill to enact *all* of the Law Commission’s recommendations to restrict alcohol advertising and sponsorship.

We support the introduction of a framework similar to the French Loi Evin, which among other things specifically prohibits promoting alcohol to young people.

Legislation which eliminated tobacco advertising has been a key factor in the significant reduction in the numbers of tobacco users in Aotearoa New Zealand. There is no evidence that similar moves would be any less effective in reducing alcohol use among young people.

Further action needed to reduce alcohol-related harm

We urge the Select Committee to recommend that the Bill include the Law Commission’s most significant recommendations, including:

- Increasing the excise tax on alcohol and imposing a minimum price for alcohol
- Reducing allowable BAC to 0.5
- Improving intervention and treatment for people with inappropriate or excessive alcohol use

Increase alcohol prices through tax and minimum prices

There is indisputable evidence that the price of alcohol matters. If the price of alcohol goes up, alcohol-related harm goes down. Younger drinkers are affected by price, and heavy drinkers are more affected than light drinkers; in fact, if a minimum price were established per gram of alcohol, light drinkers would hardly be affected at all[26].

The cost of a standard drink of alcohol has steadily decreased in recent years, and it is time to stop this trend.

The Select Committee has the opportunity to recommend that Government act to increase alcohol prices. This could be done through increasing tax, changing the excise system and/or introducing a minimum price regime. Given that submissions to the Law Commission showed high public support, the Government's decision not to act on recommendations to change pricing are surprising.

We support a change from the current alcohol excise system to one based on the actual alcohol content in beverages (often referred to as a volumetric tax). We would like to see taxes substantially increased, in order to increase alcohol prices (and to support alcohol health promotion, enforcement of the legislation, and increased treatment services).

Reduce the allowable BAC to 0.05

We believe that the evidence, both in New Zealand and internationally, is more than strong enough to support introducing a 0.05 limit for people over the age of 20 years immediately.

Since the present blood alcohol concentration of 80mg alcohol/100ml blood (0.08) was established in New Zealand in 1978, research has shown that important driving skills including vision, steering, and braking are adversely affected by even small amounts of alcohol. At the current blood alcohol limit, New Zealand drivers are still at least five times more likely to have a crash than before drinking[27]. The relative risk of having a crash is even higher for those aged 16-19 years old[28].

It is irresponsible for government to continue to allow people who are impaired by alcohol to drive and put others at risk.

Improve intervention and treatment for people with inappropriate or excessive alcohol use

While the PHA's focus is more often on prevention rather than treatment services, treatment for alcohol use problems is a significant preventive measure. Treatment reduces alcohol-related harm for the individual, prevents those people from developing other health problems resulting from alcohol use, and reduces harm to others in the family or community who are injured by the alcohol-impaired person.

But the most significant long term impact of effective, early detection and treatments services is to increase the proportion of people in the community who understand the risks and damage of alcohol and who, by their own changes, become effective role models to change the overall drinking culture. Every risky drinker who moves to say "I stop at two" or "This is one of my alcohol-free days" influences their friends and family towards healthy alcohol use.

For this reason, we ask the Select Committee to recommend that Government support the expansion of brief interventions throughout the health sector. Identifying alcohol problems and preventing further should be part of quality healthcare services. Primary

care providers should be funded and trained to deliver screening, brief and early interventions and refer people to specialist treatment as needed.

Treatment also needs to be extended urgently, so that people convicted of drink-driving offenses are automatically referred for assessment and treatment. Recent evidence shows that a high number of people convicted of drink-driving are recidivists, yet it seems that few of them have ever been assessed or offered treatment.

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