Southern District Health Board April 2012

POSITION STATEMENT ON ALCOHOL

This position statement is consistent with the position statements of Nelson Marlborough, West Coast, Canterbury, and South Canterbury District Health Boards and should be read in conjunction with the evidence-based background paper on alcohol.[1] Both documents have been developed collaboratively by the South Island Public Health Units and represent the South Island DHBs working together to address alcohol-related harm.

The Southern District Health Board acknowledges the wide range of alcohol-related harm that is experienced by people within the Southern district and that the burden of this harm is carried disproportionately by some population groups. It recognises that alcohol use is a major risk factor for numerous health conditions, injuries and social problems. Additionally, alcohol-related harm costs the health sector significant money, time and resources.

Southern DHB POSITION:

The Southern District Health Board will reduce the alcohol-related harm experienced by people within the Southern district by developing an Alcohol Harm Reduction Strategy. This strategy will set out the actions Southern District Health Board will undertake to reduce alcohol-related harm, including a communication plan.

The Southern District Health Board will identify and record alcohol-related presentations within the Southern district in a consistent manner.

The Southern District Health Board will support and assist Territorial Authorities to develop local alcohol plans that seek to reduce alcohol-related harm by providing information on alcohol-related presentations to emergency departments, and other information pertaining to the burden of alcohol. It will provide further evidence-based advice to assist with these plans.

EVIDENCE BASED SOLUTIONS:

The Southern District Health Board will advocate for the following evidence-based solutions to reduce the alcohol-related harm experienced by New Zealanders[2]:

Raise alcohol prices

- Increase levels of excise tax on alcohol by at least 50%

[1] A summary of evidence from the paper is attached as an appendix. Full references are in the background paper.
[2] These recommendations align with the CDHB's Submission to The Law Commission's Issues Paper on the Reform of New Zealand's Liquor Laws (2009), and with those contained in a recent Commentary from the Injury Prevention Research Unit: Kypri, K., Maclennan, B., Langley, J.D., and Connor, J.L. 2011. 'The *Alcohol Reform Bill*: More tinkering than reform in response to the New Zealand public's demand for better laws'. *Drug and Alcohol Review* 30, 428-433.

- Adjust excise tax so that alcohol products taxed directly on level of ethanol
- Use revenue from increase in excise tax to reduce harm amongst high-risk consumers
- Set minimum retail price for alcohol (per alcohol unit)

Raise the alcohol purchase age

- Restore alcohol purchase age to 20 years for both on-licences and off-licences
- Ensure enforcement of minimum purchase age
- Additionally, make it an offence for an adult other than a parent/guardian to supply alcohol to a child; and require parents/guardians who supply alcohol to their child to supervise the consumption of that alcohol

Reduce alcohol accessibility

- Restrict on-licences from selling alcohol after 2am
- Restrict off-licences to selling alcohol between 8am and 10pm
- Restrict convenience stores / dairies from selling alcohol
- Tighten law on granting of liquor licences – provide further grounds to refuse licences (e.g. detrimental social impact to community)
- Tighten restrictions on numbers of outlets in a given area

Reduce marketing and advertising of alcohol

- Ban alcohol sponsorship of sporting and cultural events
- Ban advertising of alcohol from television and cinema
- Advertising of alcohol to convey only basic information about the product
- Put health warning labels on alcohol products
- Ensure alcoholic beverages are labelled with ingredient and nutritional information
- Prohibit marketing of alcohol to youth

Reduce legal blood-alcohol limits for drivers

- Lower the legal blood alcohol (BAC) limit from 80mg/100ml blood to 50mg/100ml blood

APPENDIX: Summary of Evidence

Alcohol Related Harm:

Alcohol use is a major risk factor for numerous health conditions, injuries and social problems, causing approximately 4% of deaths worldwide and (in 2000) 3.9% of all deaths in New Zealand. Much acute harm results from intoxication and includes: road traffic injuries and fatalities, burns, falls, drowning, poisoning, foetal alcohol spectrum disorder, assault, self-inflicted injury, suicide and homicide.

Biological effects of alcohol
Alcohol affects the brain. It 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, leading to motor vehicle accidents and other injuries. Alcohol use is linked to a wide range of major diseases, including: heart disease, cancer, psychiatric and neurological conditions, gastrointestinal disease, and birth defects including foetal alcohol syndrome. It also contributes to diabetes, sleep disorders, and infectious diseases such as pneumonia and tuberculosis.

Unborn children and adolescents are particularly vulnerable to the effects of alcohol. Unborn children exposed to alcohol are at high risk of problems with memory, language, attention, learning, visuo-spatial ability, fine and gross motor skills, and social and adaptive functioning. Adolescent brains are still developing and therefore vulnerable to alcohol toxicity, addictive problems and psychiatric disorders.

Alcohol-related harm
Alcohol contributes to crime in New Zealand. Nearly half of all homicides in New Zealand between 1999 and 2008 involved alcohol. A third of all offenders in the year 2007/08 had consumed alcohol. Drink driving causes substantial harm - 27% of drivers in all fatal crashes between 2007 and 2009 were reported as having consumed alcohol.

Social harm results from alcohol: reportedly 12.2% of adults experienced harmful effects on friendships, social life, home life, work/study/employment opportunities, financial position, and legal problems or difficulty learning from their own drinking in the past year.

The economic cost of alcohol-related harm in New Zealand is significant. Harmful alcohol use in 2005/06 alone cost New Zealand an estimated $4,794 million of diverted resources and lost welfare.

Alcohol-related harm and population groups
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 other people and can suffer from increased susceptibility to

child abuse, neglect and witnessing family violence if caregivers have an alcohol problem.

Cost of alcohol-related harm to the health sector
Alcohol-related harm in New Zealand costs the health sector significant money, time and resources. Intoxicated patients also impact negatively on staff and other patients. An estimated 35% of injury-based emergency department presentations are alcohol-related. From 1 November 2010 to 29 October 2011 892 patients were seen in Dunedin Hospital Emergency Department for alcohol-related presentations. The average length of stay for these patients was 4.5 hours, with an average cost to Southern District Health Board of $1,000 per person.

NZ Drinking Pattern:

Alcohol is widely available in NZ
Alcohol is easily accessible from a wide variety of outlets and to anyone over the age of 18. It can be purchased 24 hours a day, 7 days a week and on most days of the year. Alcohol can be consumed either on the premises (on-licences) in bars, restaurants, cafes, hotels, pubs and individual clubs or at special functions; or off the premises (off-licences) when purchased from liquor stores, supermarkets, grocery stores or dairies. Alcohol is more widely available now than in the past: in 2010 the number of places which held liquor licences was 14,424; this has increased from 6,295 in 1990. It is inexpensive: reportedly, in 2010, 3 litres of cask wine could be purchased (on special) for as little as $16.99.

Drinking patterns in NZ
According to recent surveys, most New Zealanders (85%) drink at least some alcohol. At least two-thirds of those surveyed in 2007/08 drank once a week. Of people surveyed, nearly two-thirds of all people drank to excess at least once a year and one in ten did so at least once a week. Harmful drinking is more common amongst Māori, Pacific and young people. New Zealanders tolerate excess drinking – less than half surveyed agreed that “It is never O.K. to get drunk” and over one quarter agreed that it is “O.K. to get drunk as long as it’s not everyday”. A third of those surveyed started drinking at around the age of 14.

How the current law impacts upon these drinking patterns
The Sale of Liquor Act (1989) has liberalised the sale of alcohol, allowing it to be sold widely, including from supermarkets and over a 24 hour period. Since 1999 (with an amendment to the Act), the purchase age has dropped to 18 (from 20 years), beer has become available in supermarkets and alcohol can be purchased on Sundays. District Licensing Authorities (DLAs) in each local area grant and renew licenses and stipulate opening times. Licensing Inspectors check that premises within their area comply with regulations (e.g. not selling to those who are already intoxicated). The Resource Management Act (1991) legislates how local communities manage the use of land, which requires that a District Plan be put into place and complied with. The Local Government Amendment Act 2001 allows local authorities to impose liquor bans, banning alcohol in public places at certain times. The Land Transport Amendment Act (2011) has lowered the blood alcohol

concentration (BAC) limit for drivers under 20 years to zero. The limit for drivers over 20 years is 80mg per 100ml blood.

Evidence Based Strategies to Reduce Harm:

Raise prices

Evidence shows that when alcohol prices go up, consumption goes down. One of the best ways to influence the consumption of alcohol is through pricing. Alcohol prices are subject to excise tax, which in New Zealand is set at a particular rate depending on which band of alcohol strength the product falls into (e.g. alcoholic beverages between 9-14% alcohol are taxed at 10%). Currently excise tax rates are lower than that of other countries; they are also not adjusted for inflation. In New Zealand there is often a price differential between on and off-licences, which encourages 'pre-loading' (loading up on cheap alcohol before frequenting on-licences).

Raise the purchase age

Research shows that the legal purchase age affects how much youth drink. A lower purchase age has been associated with increased harm (including traffic crashes). In order for a higher purchase age to be effective, it needs to be combined with adequate enforcement. A higher purchase age acknowledges that the effect of alcohol and its harms is much greater on the adolescent brain as it is still developing.

Reduce alcohol accessibility

It is scientifically and economically effective to restrict the physical availability of alcohol in order to reduce harm. Limiting the physical availability of alcohol can be achieved through limiting the hours and days of sale, and controlling outlet density. Currently alcohol is too easily purchased and facilitates pre-loading. There are often too many alcohol outlets within an area – high densities of alcohol outlets have been shown to be associated with increased harm, including traffic crashes.

Reduce marketing and advertising

Advertising of alcohol has increased in many countries over recent decades, including New Zealand. Prior to the 1980s alcohol advertising in New Zealand was mostly non-existent, due to legislation controlling the advertising of alcohol – now alcohol advertising is left to the self-regulation of the industry. Since 1992, advertising of alcohol has been allowed on both television and radio – albeit at restricted times (9pm-6am) for television. Since 1987 alcohol companies have been allowed to sponsor sports and advertise corporately. Alcohol advertisements often sell the image that drinking is attractive, glamorous and fun; and these messages are particularly appealing to young people. Alcohol advertising not only leads to greater consumption of alcohol, but also colours people's perceptions of the drinking habits of others.

Reduce legal blood alcohol limits for drivers

With increasing levels of alcohol in the blood, driving performance declines. Currently (as of 2011), there is zero tolerance for drivers under 20 years with any alcohol at all in their blood. Drivers over 20 are legally entitled to drive after drinking with no more than 80mg per 100ml of alcohol in the blood. In 2009 in New Zealand, 138 deaths resulted from traffic accidents where alcohol (and/or drug use) was a

contributing factor. Research has shown that the risk of traffic crashes goes up proportionate to the level of alcohol in the blood: the risk doubles for those with 0.05% BAC compared to those with none; there is ten times the risk for those with 0.08% BAC; and one hundred times the risk for those with 0.15% BAC or higher.