New Zealand has a new government, elected on a commitment to refocus public policy on supporting and improving the lives of New Zealanders, with health, welfare and equity high in their priorities. Optimism is on the rise.

Services responding to health and welfare needs are often distinct, but the root causes of problems greatly overlap. One substantial contributor to poor physical and mental health, difficult family environments, ethnic and social disparities, and crime is New Zealand’s pathological relationship with alcohol. This is an area where great gains can be made at little cost to the country.

Hazardous drinking prevalence has been going up every year since the brief dip that accompanied the economic downturn, and is now sitting at about 20% of all New Zealanders over 14 years of age.1 This is no surprise given there has been no effective restraint on the commercial drivers of drinking for many years.

Alcohol has a substantial effect on the population because it is an extraordinary drug. It is intoxicating, toxic, carcinogenic,2 addictive and legal. Intoxication drives our desire to drink, whether we are light or heavy drinkers, addicted or not. Intoxication is also directly responsible for most of the injury deaths attributable to drinking—largely unintentional injuries and suicides—that make up over 40% of all alcohol-related deaths in New Zealand.3 Effects on the drinkers’ physical health, which also include serious chronic conditions, represent the most measurable of all of alcohol’s impacts at present, and result in at least 800 premature deaths a year.3 However, the large and obvious burden of alcohol’s harm to people other than the drinker encompasses physical, mental, social and intergenerational harm.4

The Social Aspects and Public Relations Organisations (SAPROs) of the alcohol industry,5 and politicians who take a highly individualistic approach to health-related behaviours, maintain that individuals should just choose to drink safely, and they pretend that the population can be taught to do this despite empirical evidence to the contrary.6 They also contend that alcohol-related harm is due to a minority of problem drinkers. However, it is not drinkers who are the problem, it is the product that is the problem.

Of more than 200 individual health conditions known to be caused by alcohol7 a couple deserve a special mention. Using the methods from the Global Burden of Disease Study it has been estimated that the leading cause of alcohol-related death for New Zealand women (Māori and non-Māori) is breast cancer, and that a substantial proportion of alcohol-attributable breast cancer arises in women who drink at a level that is socially acceptable and considered “safe”; up to two standard drinks per day.8 The second compelling illustration of no safe level, is fetal alcohol spectrum disorder (FASD). The neurotoxicity of alcohol for a fetus is well known, but the sensitivity of the fetus by gestation and by dose of alcohol is not well understood. Knowing that more than 40% of pregnancies are unplanned, how do we reduce the number of children, and families, affected by FASD when almost all women of reproductive age drink?

We all bear the cost of harm from alcohol; those of us who are affected personally or professionally, and every taxpayer. There are no recent costings of the externalities of alcohol in New Zealand, but surely when we know that they amounted to five billion dollars a year a decade ago8 we have enough information. Harm from alcohol is related to how much we drink and how
often we drink it, not just as individuals but as a community. Achieving any reductions in the average volume or frequency of drinking will have health and social benefits for the population and will also reduce the enormous drain that alcohol imposes on public resources, releasing funding for essential public services.

Alcohol consumption can be modified to reduce health and social harm. The pathological relationship we have with alcohol is actually between policy makers and alcohol companies, and it can be changed with political will.

The Law Commission’s review of alcohol legislation led by Sir Geoffrey Palmer that reported in 2010, provided a blueprint for a suite of synergistic evidence-based policy interventions to reduce harm. Its recommendations concurred with international alcohol policy experts but were spurned by the government of the time. What New Zealand got instead, in the Sale and Supply of Alcohol Act 2012, was evidence-free and industry-friendly. The only substantial policy change established voluntary Local Alcohol Policies, an untested devolvement of responsibility for determining availability of alcohol to Territorial Authorities, that was predicted to be complex and costly. It has turned out to involve protracted planning processes duplicated all over the country, each ending in a legal battle between public agencies and better-resourced supermarket lawyers.

The Law Commission (LC) recommended population-based approaches to reducing hazardous consumption, including changes to tax on alcohol, reduction in hours and days of sale, curbing displays in supermarkets, an incremental reduction in alcohol advertising and sponsorship, and returning the legal alcohol purchase age to 20. It also signalled that a minimum unit price for alcohol should be considered, and the BAC limit for driving needed to come down. Having failed to respond to this advice, in 2014 the National-led government convened a Ministerial Forum on Alcohol Advertising and Sponsorship to reconsider LC findings about curbing marketing, but their recommendations have also been ignored. Consistent with the LC, this forum clearly articulated the need to restrict marketing and ban the sponsorship of sport, to protect health, particularly of the young.

Policies that increase the price of alcohol are important because alcohol consumption is predictably sensitive to price even among people with plenty of disposable cash, and in hazardous drinkers, of which New Zealand now has 720,000.

Increasing excise tax is the most tested intervention to reduce harm from alcohol. The Law Commission recommended a 50% increase in excise tax, which would have increased the price of a drink by 10% and reduced consumption by 5%. In addition to excise tax, a minimum unit price for alcohol, which sets the lowest price a standard drink can be sold for, can be set to remove the cheapest products from the market, and offers the greatest health benefit to the most disadvantaged. Scotland has been successfully fighting legal challenges from the industry for the right to use minimum pricing since 2012, and is close to being able to implement it, along with Wales and Ireland, where it is incorporated in their new Public Health (Alcohol) Bill.

The focus of healthy alcohol policy on population-level interventions is not ideological but empirical. However, it is certainly consistent with our new government’s stated values. These policies are based on evidence of what is most capable of achieving change in population health status and reducing disparities. This is because they alter the environment in which our largely unthinking decisions about alcohol are made. Very importantly, these policies are not stigmatising and they are not victim-blaming. It’s the same deal for everyone, and all get benefits.

Our new policy makers have a lot of important commitments to attend to, but alcohol policy is time-sensitive. Provisions in the previous version of the Trans-Pacific Partnership Agreement would have made it impossible for the government of any partner country to introduce regulation of the alcohol marketplace without being subject to litigation from alcohol corporations. New Zealand is currently engaged in negotiating new “trade” treaties with similar provisions. In order to effectively protect and improve health and welfare in New Zealand, we need the freedom to adopt healthy alcohol policy.
REFERENCES:


