West Coast District Health Board

Te Poari Hauora a Rohe o Tai Poutini

Corporate Office
High Street, Greymouth 7840

Telephone 03 769-7400
Fax 03 769-7791

1 December 2021

9(2)(a) [redacted]

RE Official Information Act request WCDHB 9635

I refer to your email dated 5 November 2021 requesting the following information under the Official Information Act from West Coast DHB. Specifically:

Copies of the items on smoke free and alcohol policies - taken out of the West Coast DHB Board Meeting Public Excluded agenda for 5 November 2021 by the Chair

Please find attached as **Appendix 1** – National DHB Position Statement on the Smokefree Aotearoa 2025 Goal and as **Appendix 2** – National DHB Position Statement on the Sale and Supply of Alcohol Act 2012. Both papers were endorsed by the Board at that meeting.

Note: we have redacted information pursuant to section 9(2)(a) of the Official Information Act to protect individual privacy.

I trust that this satisfies your interest in this matter.

You may, under section 28(3) of the Official Information Act, seek a review of our decision to withhold information by the Ombudsman. Information about how to make a complaint is available at www.ombudsman.parliament.nz; or Freephone 0800 802 602.

Please note that this response, or an edited version of this response, may be published on the West Coast DHB website after your receipt of this response.

Yours sincerely

Tracey Maisey
Executive Director
Planning, Funding & Decision Support

APPENDIX 1

DHBS AND THE SMOKEFREE AOTEAROA 2025 GOAL

West Coast – District Health Board – Te Poari Hauora a Rohe o Tai Poutini

TO: **Chair and Members**
West Coast District Health Board

PREPARED BY: **Jenni Stephenson, Team Leader, West Coast Team, Community & Public Health**

APPROVED BY: **Tanya McCall, Interim Executive Director, Community & Public Health**

DATE: **4 November 2021**

Report Status – For:	Decision ☑	Noting ☐	Information ☐

1. ORIGIN OF THE REPORT

At the October DHB Chairs and Chief Executives meeting, the group reviewed the National DHB Position Statement on the Smokefree Aotearoa 2025 Goal (the *Position Statement*) prepared by 9(2)(a) [redacted]. It was recommended the Position Statement be updated to reflect discussions at that meeting (e.g., including statements about vaping) and then accepted as a shared position.
This report presents the updated Smokefree 2025 paper and seeks endorsement by the Board.

2. RECOMMENDATION

That the Board:

i. endorses the National DHB Position Statement on the Smokefree Aotearoa 2025 Goal.

3. SUMMARY

In 2011, the Government adopted the Smokefree 2025 goal (the *Goal*). While there has been some progress, New Zealand is not on track to achieve the Goal and inequities remain, particularly for Māori, Pacific, and people on low incomes.

In 2021, the Government released a draft discussion document on a national plan for achieving the Goal. Critical to this is a fourfold increase in the number of smoking quitters and a proportionate increase in smoking cessation services and funding.

The Position Statement's recommended areas for action are that DHBs review stop smoking pathways and services locally and support development of local plans to deliver the fourfold increase in the number of smoking quitters.

4. DISCUSSION

Tobacco use is an extensive source of harm experienced by the West Coast population and the burden of harm is distributed inequitably. Tobacco use is a major risk factor for numerous health conditions and is a significant cost to the health system.

Key Recommendations and Implications
The Position Statement makes recommendations for actions across seven key areas. WCDHB is already undertaking action in many of these areas to varying degrees. These areas and the implications for WCDHB are identified below.

Recommended Areas for Actions	Implications for WCDHB
1. Increase the quality and quantity of referrals to stop smoking services – systematic identification of people who smoke and referral to stop smoking services.	• Already an aim of the current services. • Primary health work in this area. • Recent work in this area with Lead Maternity Carer (LMC) midwives. • Secondary health work in this area focuses on *quality* of referrals. Early efforts in this area generated high *quantity* of referrals but few motivated clients.
2. Proactively engage with smokers to reduce drop off in engagement from referrals including developing dedicated pathways and providers for Māori and Pasifika smokers.	• Already delivering pathways for Māori through Poutini Waiora and other services working with Māori whānau. • Already exploring further development in this area (e.g., growing existing incentives programme beyond pregnancy).
3. Scale up stop smoking services to deliver the 4-fold increase in smoking quitters required assuming that additional funding is available to deliver this and being careful to ensure a genuine expansion in the trained workforce.	• Under way; unable to progress further until additional funding available. • Oranga Hā – Tai Poutini service to engage with Ministry of Health via Allen + Clarke over the coming months.
4. Support the adoption of best practice and supporting local innovation and flexibility.	• Already applying best practice and local innovation. Utilise variety of clinics, assessment, and programmes. Stop Smoking Practitioners as well as DHB and primary care nurses tailor to need through individual quit plans. Team work holistically and use different methods/resources to support people.
5. Limit the public promotion of vaping products only to smokers who want to quit	• Practitioners already aware of alternative nicotine devices to support smokers who want to quit. • Smokefree Enforcement Officer already working with tobacco and vaping products retailers about legislation changes.
6. Accelerate public health promotion to young people, non-smokers and non-vapers, to dissuade them from taking up vaping or smoking in the first instance.	• Supported through health promotion initiatives, e.g. Smokefree and Vapefree public spaces, Smokefree Cars. • Work already underway with Greymouth and Westland High Schools
7. Rigorously measure progress to support improvement.	• Currently achieved through Ministry of Health reporting.

Smokefree / Auahi Kore Position Statement (November 2012)

The position paper is compatible with the DHB's Smokefree/Auahi Kore Position Statement (November 2012).

Risks

A risk to WCDHB in supporting the position statement is whether WCDHB will have the capacity to fully act on the recommendations. For instance, Community & Public Health has suspended nearly all business as usual (*BAU*) while the unit supports the COVID response, including:

- Controlled Purchase Operations (*CPOs*) for tobacco and vaping (suspended).
- Smokefree and vapefree health promotion (suspended).

There is also a series of risks associated with assumptions about scaling up stop smoking services to deliver the fourfold increase in smoking quitters. There is an assumption that services will receive additional funding to scale up services and that the WCDHB can ensure a genuine expansion in the trained workforce.

5. CONCLUSION

This National DHB Position Statement on the Smokefree Aotearoa 2025 Goal is consistent with the established position of the South Island DHBs in supporting achievement of the Smokefree 2025 Goal and with the WCDHB's associated actions to date. There are some risks to the WCDHB in delivering on the recommended actions if additional funding is not provided and if Public Health Unit (*PHU*) capacity to support the actions continues to be diminished as a result of COVID-related demands.

6. APPENDICES

Appendix 1: DHBs and the Smokefree Aotearoa 2025 Goal

All District Health Boards

DHBs and the Smokefree Aotearoa 2025 Goal

To:	DHB Chief Executives and Chairs
From:	Nick Chamberlain, CE NDHB and Lead CE for Public Health
Subject:	District Health Board action to support the Smokefree Aotearoa 2025 Goal
Date:	12 August 2021

Decision ☒	**Discussion** ☐		**Information** ☐	
Seeking Funding	**Yes**	☐	**No**	☐
Funding Implications	**Yes**	☐	**No**	☐

1. Recommendations

It is recommended that DHB Chief Executives and Chairs:

- **Note** that cigarette smoking is the most readily preventable cause of health inequities in New Zealand and is responsible for at least two years of the life expectancy disadvantage experienced by Māori.
- **Note** that NZ is not on track to achieve the Smokefree Aotearoa 2025 Goal and that Māori are currently not forecast to reach the target until 2060.
- **Note** that the Government has recently consulted on a Smokefree Aotearoa 2025 Action Plan which is likely to greatly accelerate progress towards the Smokefree 2025 Goal and significantly reduce smoking related harm and health inequities.
- **Note** that Dr Nick Chamberlain, as agreed at the combined DHB CE/Chairs meeting on 13 May 2021, submitted a submission on behalf of the DHB CEs on the Government's proposed Action Plan.
- **Note** that achieving the Smokefree 2025 Goal will require a fourfold increase in the number of successful quitters and a proportionate increase in stop smoking services and funding.
- **Note** that additional government funding has been allocated for stop smoking services in budget 2021, but this is not available until 2022/23 and that significant further increases or reprioritisation of resources are needed to achieve the Smokefree 2025 Goal.
- **Note** that stop smoking services are highly cost effective, every dollar spent on smoking cessation saves $10 in future healthcare costs and health gain, and the long term quit rate of smokers who access face to face group based stop smoking services is 4 times higher than those who do not participate in a programme.
- **Note** that only one DHB is currently achieving the Better help for smokers to quit – Primary Care health target**.**

- **Note** that there is considerable variation (up to 10 fold variation) across DHBs in the referral rate to stop smoking services, quit rates, and costs per quitter by stop smoking provider.
- **Agree** to advocate for full implementation of the Smokefree Aotearoa 2025 Action Plan.
- **Agree** to the National Public Health Advocacy team and DHB leads working collaboratively with the MOH to support the development of an investment plan for stop smoking services.
- **Agree** to fully support the MOH in future funding bids for stop smoking services.
- **Agree** to review DHB tobacco control expenditure and ensure that this is being optimally used to support Smokefree 2025 where possible within budgetary constraints.
- **Agree** to review stop smoking pathways and services locally and support development of local plans to deliver a fourfold increase in the number of smoking quitters. This should include consideration of opportunities to:
    - Increase the quality and quantity of referrals to stop smoking services, for example, by following up primary care attendees, hospital discharges, and opportunistic clinical interventions with appropriate support
    - Proactively engage with smokers to reduce drop off from referrals including developing dedicated pathways and providers for Māori and Pasifika smokers
    - Scale up the capacity and capability of smoking cessation services
    - Support the adoption of best practice and local innovation and flexibility
    - Limit the public promotion of vaping products and less harmful nicotine delivery devices to only smokers who want to quit
    - Accelerate public health promotion to young people, non-smokers, and non-vapers to dissuade them from taking up vaping or smoking in the first instance.
    - Rigorously measure progress to support improvement.
- **Agree** to advocate to Pharmac to reduce the cost of nicotine replacement therapies (NRT), e.g. gums, patches, and mists.
- **Agree** to mental health and addiction service users being added to priority populations for stop smoking services due to the very high rates of smoking and within this population.
- **Note** the Ministry of Health vaping statements:
    - The best thing you can do for your health is to be smokefree and vape free
    - Vaping is not for children and young people
    - Vaping can help some people quit smoking
    - Vaping is not harmless, but it is much less harmful than smoking
    - Vaping is not for non-smokers.

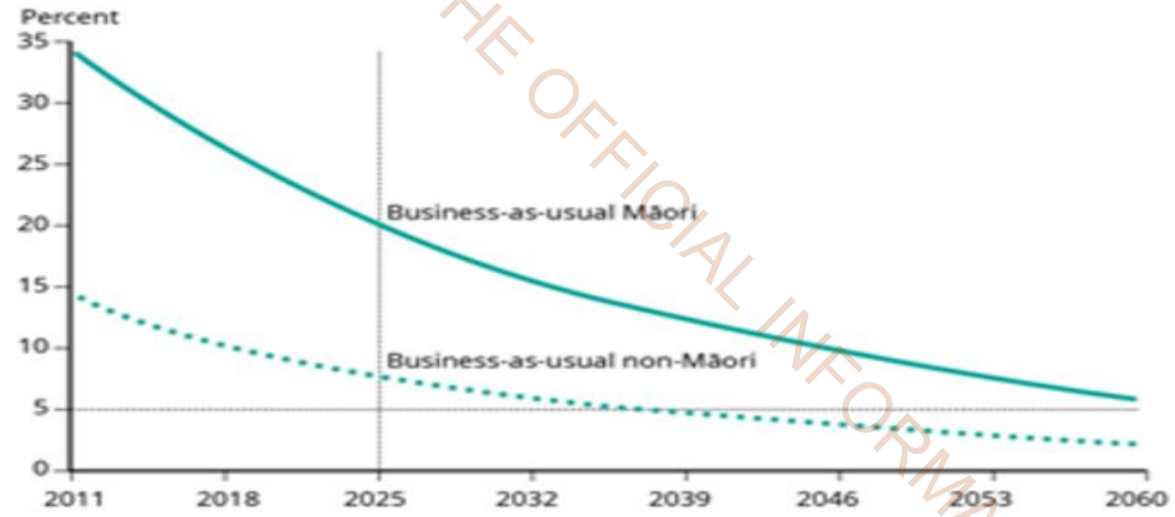
2. Background

In 2011 the Government adopted the Smokefree 2025 Goal of a minimal adult cigarette smoking rate which is widely interpreted as being less than 5% for all New Zealanders.

Cigarette smoking is uniquely harmful and kills 14 New Zealanders every day; 2 in 3 cigarette smokers will die as a result of smoking, each losing about ten years of life expectancy. Cigarette smoking is the most readily preventable cause of health inequity in New Zealand and is responsible for at least two years of the life expectancy disadvantage experience by Māori. People smoke for the nicotine, but die from the toxic ingredients in burnt tobacco.

It is possible to readily reduce the health and economic burdens from smoked tobacco. Over the last decade many important cigarette smoking control policies have been introduced including annual tax increases, point of sale ad bans, plain packaging. Adult daily smoking rates have declined since 2011 from 20% to 11.6% in 2019/20 but we have enormous remaining inequities with adult Māori and Pasifika smoking rates of 30% and 20% respectively. There have been noteworthy successes in reducing smoking rates in young people. In the 2019 ASH Year Ten Survey 2% of 14 and 15 year olds were daily cigarette smokers, with higher rates in Māori and Pasifika youth.

Projections of adult smoking prevalence (for daily smoking) for Māori and non-Māori to 2060



Source: Blakely et al 2018

Critically, we are not currently on track to achieve the Smokefree 2025 goal, especially for Māori, Pasifika and people on low incomes – cigarette smoking is essentially a marker of social and economic disadvantage. Mental health and addiction service users have particularly high rates of smoking with a rate of smoking of about 43% total population, rising to 70% for Māori and 59% for Pacific (WDHB data, March 2021). At the current rate of progress Māori are not forecast to achieve the target until 2060, as shown in the graph below.

3. The National Plan to Achieve the Smokefree Aotearoa 2025 Goal

In April 2021 the Government released a draft discussion document on a national plan for achieving the Smokefree Aotearoa 2025 Goal. The plan recognises the importance of ongoing evidence based interventions to encourage more cigarette smokers to make more quit attempts more often through mass and targeted media campaigns supported by the wider availability of cessation support including the use of reduced harm products. The plan proposes 5 key action areas including:

- Strengthening the tobacco control system
- Making smoked tobacco products less available
- Making smoked tobacco products less addictive and less appealing
- Making tobacco products less affordable
- Enhancing existing initiatives

If the action plan and the actions proposed in it can be successfully implemented it will greatly accelerate progress towards the Smokefree 2025 Goal and significantly reduce smoking related harm and health inequities. Achieving the Smokefree 2025 Goal will however require a fourfold increase in the number of smoking quitters and a proportionate increase in smoking cessation services and funding as outlined below.

Additional funding has been provided in the recent budget as shown in the table below. However, this is insufficient to achieve the scale of the increase in smoking quitters required. A $4.625m investment per year, at median cost per quitter of $4473 would yield 2635 additional quitters per year compared to the additional 40,000 quitters per annum that are required to meet the target as outlined below.

	2021/22	2022/23	23/24	24/25	**Total**
Scale up stop smoking services	n/a	4.625	4.625	4.625	**13.875**

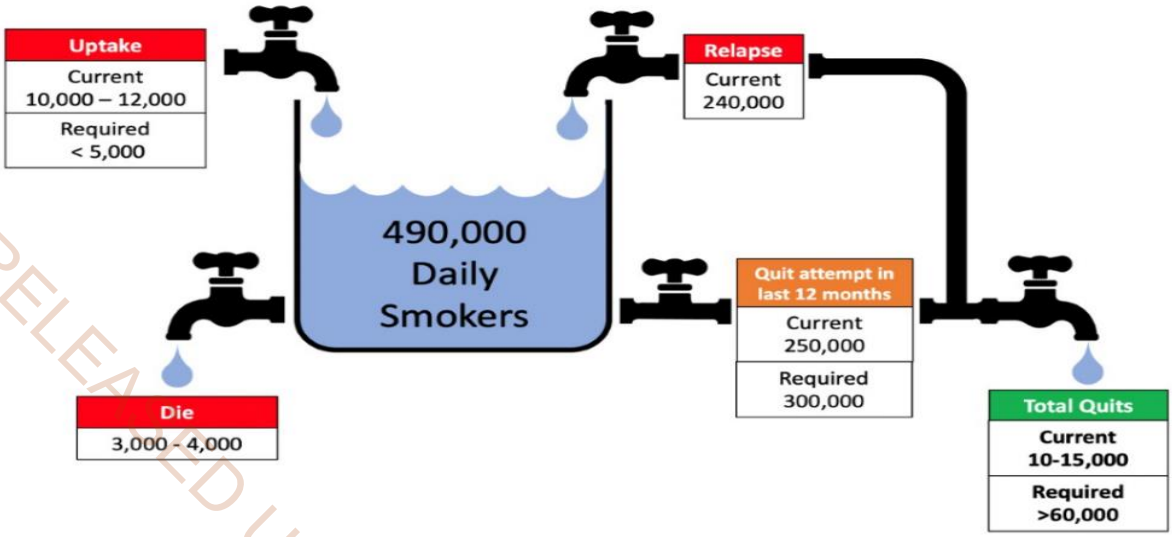
4. Increasing quit rates: the key to achieving Smokefree 2025

There are approximately 500,000 daily cigarette smokers in New Zealand. Reaching the 5% goal requires approximately 300,000 cigarette smokers to quit permanently by the end of 2025, i.e., in 4.5 years. This equates to roughly 60,000 successful quitters each year. At present we are achieving approximately 15,000 quitters each year. Thus, we need to dramatically increase successful quitting numbers by at least 40,000 a year; half the quitters must be Māori and one third Pasifika to achieve equitable cigarette smoking rates.

The Ministry of Health funds stop smoking providers to deliver multi-sessional behaviour support and NRT to people who want to quit smoking. The Ministry of Health priority audiences for service are young Māori wāhine (18 to 30), pregnant women, Māori, and Pasifika. Ready Steady Quit (WDHB and ADHB) are only able to see priority groups and plan to refer all other smokers to Quitline.

The Ministry of Health also provides tobacco control funding to all 20 DHBs to provide Tobacco Control Leadership and Coordination and support the Governments Health Targets. Funding for Smokefree Enforcement Officers is also provided to Public Health Units to enforce the Smokefree Environments Act.

Smoking quitters required to achieve the Smokefree Aotearoa 2025 Goal (Source: ASH)



Stop Smoking Services have been shown to be cost effective both internationally and in New Zealand. The cost of providing Stop Smoking Services is significantly less than the health costs of tobacco related diseases. According to the National Institute for Clinical Excellence (NICE) in the UK, every £1 spent on smoking cessation saves £10 in future health care costs and health gains.[1] A New Zealand modelling study has estimated that a targeted stop smoking support intervention that costs $100,000 a year would only need to support three to four people who smoke to quit to break even ($25 - $33,000/quitter). The MOH contracted face-to-face Stop Smoking Services currently cost significantly less than this, ranging from $653 - $3857 per quitter (median cost $1755) for the period July to December 2020.

Group based smoking cessation programmes provide the most effective smoking cessation support. The long term quit rate of smokers who access face to face group based smoking cessation services is 4 times higher than those who do not receive support to quit.[2]

DHBs, with their 'captive' smoking populations (information on admission and in primary health care), are in a unique position to encourage and support cigarette smokers to transition towards less harmful alternatives and smokefree status. Over 500,000 people who smoke are seen in primary care every quarter. There are also approximately 150,000 middle-aged patients discharged from public hospitals each year with smoking induced conditions such as cardiovascular and many cancers, and patients with mental illnesses who have very high smoking rates. These patients are a priority for becoming smokefree but will need DHB and community-based support and encouragement. Consideration should be given to funding DHB/hospital services to provide cessation support, so that there is continuity in care as there is a large drop-off upon referral from hospital to an external stop smoking service.

[1] Health Economics Research Group, Estimating Return on Investment of Tobacco Control: Tobacco Control Return on Investment tool, NICE 2014

[2] Bauld et al, English Stop-Smoking Services: One-Year Outcomes. International Journal of Environmental Research and Public Health, 2016 Dec; 13(12): 1175.

5. Tobacco harm minimisation

People smoke for the nicotine, but die from the tar. Nicotine is not a cause of disease. In terms of tobacco harm minimisation less harmful alternatives to cigarettes such as patches, gum, lozenges, nicotine sprays and now newer vaping products need to be made available to smokers who want to quit tobacco.

The Ministry of Health has produced a national position statement on vaping in the context of Smokefree 2025 (see Appendix 1). This is currently being reviewed and revised. Key messages in the position statement include:

- The best thing smokers can do is to quit smoking for good
- Vaping products are intended for smokers only
- Vaping products carry much less risk than smoking cigarettes but are not risk free
- Stop smoking services must support smokers who choose to use vaping products to quit
- There is not international evidence that vaping products are undermining the long term decline in cigarette smoking, and may in fact be contributing to it.

Current evidence states that vaping is 95% less harmful than cigarettes[3]. Nick Wilson and colleagues have recently reviewed the health risks associated with vaping and suggested that the overall harm to health from vaping was estimated to be 33% that of smoking.[4] They state that this should be considered to be the likely upper level of vaping risk.

The Smokefree Environments and Regulated Products (Vaping) Amendment Act 2020 came into force in November 2020, amending the Smoke-free Environments Act 1990. The new Act strikes a balance between ensuring vaping products are available for smokers who want to quit smoking, and making sure these products aren't marketed or sold to non-smokers, especially young people under the age of 18 years. Minister Verrall has requested that public health units initiate controlled purchase orders (CPOs) of vaping outlets to ensure that vaping products are being sold in accordance with the Act.

DHBs and Smoking Cessation Services are ideally placed to help distribute vaping products to those that have been unable to quit smoking and to those identified in primary or secondary care services. A number of DHBs are currently utilising vaping products as part of their armamentarium in helping smokers quit tobacco.

The cost of NRT is a barrier for whānau, with a course of NRT costing more than a packet of cigarettes. Pharmac currently subsidises some but not all NRT products. Mists and inhalers for instance are not currently subsidised and some interventions are known to work better for some groups than others.

In summary, the health and economic benefits to middle aged and older patients of successful quitting are immense. The economic benefits to the DHBs from reduced readmissions after quitting are also immense and occur in the short-term, i.e., in the months after quitting.

[3] PH England report

[4] Wilson N., et al. Improving on estimates of the potential relative harm to health from using modern ENDS (vaping) compared to tobacco smoking. MedRxiv preprint 27 June 2021. https://www.medrxiv.org/content/10.1101/2020.12.22.20248737v2

6. Accelerating progress towards the Smokefree 2025 Goal is possible

Several potential drivers of success are now available:

1. The Government is explicitly committed to the goal as evidenced by comments by Associate Health Minister Hon Ayesha Verrall, the Minister responsible for Smokefree 2025.
2. The options available to cigarette smokers who want to quit are increasing rapidly including vaping devices. These alternative nicotine delivery devices are effective in helping some smokers quit, are cheaper and much less harmful than conventional cigarettes.
3. Legislation was passed in 2020 to ensure that these alternative nicotine products will be widely available, safe and fully regulated. In addition, the legislation and associated regulations will do much to prevent young people from becoming dependent on these alternative nicotine products.
4. Most cigarette smokers express a desire to quit and have already made multiple attempts. The increased range of options now available will increase successful quit rates.

7. DHB Smokefree 2025 priorities

DHBs can and should do much more to accelerate progress towards the Smokefree 2025 Goal. Better help for smokers to quit – Primary Care continues to be a DHB health target. Only one DHB is currently achieving the 90% target and performance varies across DHBs from 56.1% to 91.4% (see appendix 2. for the full data). 395,000 were given brief advice to quit in Q2 2020/21, meeting the 90% target would have resulted in an additional 65,000 smokers receiving brief advice to quit. There is also considerable variation in the performance of stop smoking services as shown in Appendix 3, including an 8 fold variation in referral rates, a 10 fold variation in quit rates and a 6 fold variation in cost per quitter by DHB.

The Ministry of Health funds stop smoking services directly and also provides tobacco control funding to DHBs. The Ministry currently funds 16 stop smoking providers, with a number covering more than one DHB. Five of the 16 are DHB services, the others are a mix of PHOs, Whānau Ora providers or Māori Health Providers. Consideration could be given to amending existing contracts for high performing services with no ceiling on number of quitters per year, and conditional funding per patient for services that achieve beyond their annual targets to cover the additional costs that would be efficiently incurred to achieve more, provided there is evidence of growing their own workforce.

DHBs also have a responsibility for the health of their local population and commission and provide broader health services that refer to stop smoking services. There are challenges linking up these different services at a local level. There is also a lack of visibility and information sharing about how funding is utilised and services are provided. There is therefore a need to work collaboratively at a local level to optimise delivery of stop smoking services.

Counties Manukau Health Living Smokefree Service (LSS) is an example of best practice nationally and is described in Appendix 4. Given inequitable access to health services including primary care it is important that efforts to scale up stop smoking services are complemented by broader efforts to improve access to health services such as whānau ora.

Recommended areas for action

It is recommended that DHBs review stop smoking pathways and services locally and support development of local plans to deliver a fourfold increase in the number of smoking quitters. This should include consideration of opportunities to:

1. *Increase the quality and quantity of referrals to stop smoking services – systematic identification of people who smoke and referral to stop smoking services.*
    - Increasing referrals from primary and community services eg GPs, pharmacies, mental health providers, NGOs with a particular focus on achieving the Better help for smokers to quit health target.
    - Increasing referrals from secondary care by ensuring that all patients who are admitted as cigarette smokers should be encouraged and supported within hospital to be smokefree at all times and referred to smoking cessation.
    - Utilising other opportunistic clinical interventions to provide brief advice and referral to smoking cessation services.
2. *Proactively engage with smokers to reduce drop off in engagement from referrals including developing dedicated pathways and providers for Māori and Pasifika smokers.*
    - Developing dedicated pathways and providers for Maori and Pacific smokers.
    - Reaching into Māori and Pacific communities to provide stop smoking support groups in their communities e.g. Kava groups, Pacific churches and marae.
    - Rigorously following up all smokers referred and supporting them to access stop smoking services that meet their needs at a convenient time, place and setting.
3. *Scale up stop smoking services to deliver the 4 fold increase in smoking quitters required assuming that additional funding is available to deliver this and being careful to ensure a genuine expansion in the trained workforce.*
    - Planning for and establishing smoking cessation services on a sufficient size and scale to deliver the Smokefree 2025 Goal.
    - Recruiting, training, and developing an expanded workforce.
4. *Support the adoption of best practice and supporting local innovation and flexibility.*
    - Developing and training a culturally representative and responsive workforce who are flexible to the needs of clients and their whānau.
    - Ensuring that smoking cessation services are offered in a variety of settings (for example, phone assessments followed up with face to face support, drop-in-clinics in local communities, group-based programmes in workplaces, churches, sports club etc) and in a flexible way (for example, client contact after hours) to reduce barriers to accessing services.
    - Services also need to be tailored to meet the specific needs of the people they are supporting e.g. mental health and addiction service users often need a longer period of support, including support to reduce the amount they smoke before making a quit attempt.

- A variety of cessation methods and tools should be available for all patients, including modern alternative nicotine delivery devices.
- The use of incentives should be encouraged, including vouchers, nicotine replacement therapies, and free vaping starter kits.

5. *Limit the public promotion of vaping products only to smokers who want to quit*
   - Educate staff on the benefits of vaping products as a tool to help smokers quit.
   - Adopt vaping as a specific tool in the armamentarium of the Stop Smoking Services.
   - Provide free vaping products to key priority groups, with a particular focus on pregnant Māori woman and middle-aged people most at risk of disease and early death.
6. *Accelerate public health promotion to young people, non-smokers and non-vapers, to dissuade them from taking up vaping or smoking in the first instance.*
   - Educate the population on the importance of non-smokers not using vapes, particularly youth.
7. *Rigorously measure progress to support improvement.*
   - Ensure the availability of comprehensive and up-to-date cigarette smoking data including by age, sex, ethnicity, and deprivation. NZ Health Survey data will be useful but may require supplementation from other sources.
   - Regularly assess progress towards the Smokefree 2025 Goal.
   - Review DHB Smokefree activities and resources to ensure that the are operating at optimal efficiency and effectiveness.
   - Ministry of Health information should guide all DHB activities, including on lower risk alternatives to cigarettes.

Appendix 1:
The Ministry of Health's national position statement on vaping in the context of Smokefree 2025.

MINISTRY OF HEALTH
MANATŪ HAUORA

133 Molesworth Street
PO Box 5013
Wellington 6140
New Zealand
T+64 4 496 2000

9 July 2021

To: DHB Chief Executives

Kia ora koutou katoa

I am writing in support of the Associate Minister of Health, Hon Dr Ayesha Verrall's, Smokefree 2025 priority.

The Government is committed to achieving an equitable Smokefree 2025. This requires us to reduce the burden of preventable death and disease caused by smoking, and to eliminate the health inequities associated with smoking.

Consultation on *Proposals for a Smokefree Aotearoa 2025 Action Plan* closed on 31 March and my officials are analysing these to inform the final action plan. Over 5,000 submissions were received. Thank you for your own well considered submission and for the joint work district health boards have underway to support Smokefree 2025.

It is my expectation that, as part of this work, district health boards will actively support the Government's position that vaping has a role to play in reducing the harm caused by smoking.

Health sector position statements

The following statements, agreed to by all district health boards as part of the development of the Vaping Facts website, remain a sound basis for your approach to vaping:

- the best thing you can do for your health is to be smokefree and vape free
- vaping is not for children or young people
- vaping can help some people quit smoking
- vaping is not harmless but it is much less harmful than smoking
- vaping is not for non-smokers.

The Ministry of Health's position statement (available on its website), which expands on these core statements, is under review and will be updated to take account of legislative developments and any changes in evidence.

Compliance and enforcement of the Smokefree Environments and Regulated Products Act 1990

The Smokefree Environments and Regulated Products Act 1990 (the Act) now regulates vaping products and smokeless tobacco devices, in addition to tobacco products and herbal smoking products.

The Act aims to balance the needs of adult smokers who want to quit using vaping or switch to a less harmful alternative with discouraging non-smokers, especially children and young people, from taking up vaping.

I expect public health units and the Ministry of Health to actively enforce the Act's smoking and vaping provisions, such as the prohibitions on sales to minors and the advertising and promotion restrictions (including online).

I understand that the Ministry is working with public health units to clarify expectations on enforcement activities related to the Act, including the new regulatory controls on vaping and vaping products.

Detailed information about the regulatory regime for vaping products can be found on the Ministry of Health's website: Vaping Regulatory Authority

Monitoring of vaping-related incidents

Please remind health workers to report any adverse vaping events to the Centre for Adverse Reactions Monitoring. This system is used to monitor vaping-related incidents. A specific form for reporting adverse reactions to vaping products is available on CARM's home page: New Zealand Pharmacovigilance Centre. To date, no reports of adverse events in minors from vaping products have been made.

Supporting schools

The Ministry is looking at how the health sector can better support schools to keep students vapefree. I am advised that public health units have been invited to participate in this work and look forward to seeing a coordinated approach develop, together with the education sector.

New regulations

Finally, proposals for regulations under the Act have been consulted on, and the final regulations are due to be approved by Cabinet shortly. I expect the regulations to be publicly notified on 13 July, before taking effect from 11 August 2021.

From that date, manufacturers and importers of vaping products may begin notifying their products and, to continue to be sold in New Zealand, all products must be notified before 11 February 2022. Products are required meet new safety standards before they can be notified.

If you have any questions or require further information about this letter, please contact Sally Stewart, Manager, Tobacco Control (sally.stewart@health.govt.nz).

Nāku noa, nā

Deborah Woodley
Deputy Director-General
Population Health and Prevention

Appendix 2:
Health Target Performance, Better help for smokers to quit - Primary care (Quarter 2 2020/21)

DHB Name	Target %	Achievement %
Auckland	90%	82.3%
Bay of Plenty	90%	87.3%
Canterbury	90%	71.2%
Capital & Coast	90%	80.2%
Counties Manukau	90%	84.3%
Hawke's Bay	90%	56.1%
Hutt Valley	90%	88.3%
Lakes	90%	69.3%
MidCentral	90%	82.9%
Nelson Marlborough	90%	72.9%
Northland	90%	68.5%
South Canterbury	90%	78.8%
Southern	90%	75.5%
Tairawhiti	90%	71.1%
Taranaki	90%	79.7%
Waikato	90%	80.0%
Wairarapa	90%	87.3%
Waitemata	90%	78.9%
West Coast	90%	91.4%
Whanganui	90%	76.9%
National	90%	78.0%

Appendix 3:
Smoking Cessation Performance by Provider, July to December 2020.

	Popn	Referrals	Referral rate per 100,000	Enrolments	CO Validated Quitters	Quit Rate per 100,000 popn	% Quitters	Cost per Quitter
Northland	181,640	764	421	438	108	59	25%	$1,667
ADHB WDHB	1233000	2571	209	1315	277	22	21%	$1,353
CMDHB	586930	3379	576	1046	434	74	41%	$653
Waikato - Tairawhiti	481145	1633	339	834	176	37	21%	$1,651
Bay of Plenty	245290	728	297	375	62	25	17%	$2,139
Lakes	117990	590	500	289	78	66	27%	$1,029
Taranaki	121065	275	227	126	31	26	25%	$2,208
Hawkes Bay	167020	168	101	122	74	44	61%	
Midcentral	181070	669	369	424	55	30	13%	$1,755
Whanaganui	64510	537	832	130	39	60	30%	$2,179
Capital and Coast - Hutt - Wairarapa	521120	1156	222	341	58	11	17%	$3,857
Nelson Marlborough	152920	341	223	216	44	29	20%	$1,931
Canterbury	589060	2061	350	721	180	31	25%	$2,584
South Canterbury	60,940	281	461	174	20	33	11%	$1,776
West Coast	32365	159	491	159	33	102	21%	$1,484
Southern	325770	1105	339	386	183	56	47%	$968

Appendix 4: Case Study: Counties Manukau Health

CM Health is currently funded by the Ministry of Health to provide both core tobacco control activities and the provision of Stop Smoking Services. CM Health employs a team of 8.5 FTE who provide tobacco control leadership, planning and strategy, analysis, support to achieve health targets, delivery of a triage service, health promotion, and national service development work. The Living Smokefree Service (LSS) employs a team of 10 FTE and delivers stop smoking services in individual, whānau or group settings with face to face, phone or digital support. The service currently receives over 7000 referrals per annum.

The LSS has one of the highest quit rates in New Zealand, with a 76.4% CO-validated quit rate at four weeks in 2019/20205. The cost per quitter for the period 2017/18 to 2019/20 was $1275.73, significantly less than the national average. The LSS is successful at equitably enrolling and supporting priority populations who smoke (Māori, Pacific peoples, pregnant women, people with mental illness and/or addictions, youth.

The collaboration between core tobacco control activities and the LSS service is a key enabler of the services success. This ensures that a whole-of-systems approach is used to implement the Smokefree Ask, Brief advice and Cessation support (ABC) in primary, secondary, maternity, mental health, community health and non-health settings. The core tobacco control advisors have strong relationships with staff in these different settings, support workforce development and training, and provide clinical supervision.

Achieving equity is a key focus area for the LSS, and this is achieved through a focus on the priority populations previously outlined, and training a culturally representative and responsive workforce who are flexible to the needs of clients and their whānau. This includes employing a holistic approach to addressing the broader health, social, and cultural needs of whānau.

Services are offered in a variety of settings (for example, phone assessments followed up with face to face support, drop-in-clinics in local communities, group-based programmes in workplaces) and in a flexible way (for example, client contact after hours) to reduce barriers to accessing services. The LSS also champions innovative approaches for smoking cessation, including unique contracting (for example outcome based contracting with incentives for community providers), incentive based programmes, and the use of e-cigarettes in smoking cessation.

[5] Quit rate denominator - people who smoke who set a quit date

APPENDIX 2

NATIONAL DHB POSITION STATEMENT ON THE SALE AND SUPPLY OF ALCOHOL ACT

West Coast – District Health Board – Te Poari Hauora a Rohe o Tai Poutini

TO: Chair & Members, West Coast District Health Board

PREPARED BY: Chantal Lauzon, Health in All Policies Advisor/Facilitator Canterbury Health System Alcohol-related Harm Reduction Strategy Working Group

APPROVED BY: Tanya McCall, Interim Executive Director, Community & Public Health

DATE: 5 November 2021

Report Status – For: Decision ☑ Noting ☐ Information ☐

1. ORIGIN OF THE REPORT

The National DHB Position Statement on the Sale and Supply of Alcohol Act 2012 (the *Position Statement*) was prepared by 9(2)(a) and the Public Health Advocacy Group for the national DHB Chief Executives and Chairs group. The Position Statement was discussed at the October 2021 DHB Chief Executives and Chairs meeting where it was recommended that all DHBs accept the Position Statement as a shared position. The Position Statement was presented and agreed to at the 22 September EMT meeting.

2. RECOMMENDATION

The Committee recommends that the Board:

i. endorses the National DHB Position Statement on the Sale and Supply of Alcohol Act 2021.

3. SUMMARY

The DHB Chief Executives have identified alcohol and the reduction of alcohol-related harm as a priority issue they would like the new National Public Health Advocacy Team to address.

The Position Statement calls for a review of the Sale and Supply of Alcohol Act 2012 (the *Act*), outlines several specific changes to the Act, and also calls for a number of broader changes to address alcohol related harm. Recommended priorities for revision to the Act are giving effect to Te Tiriti O Waitangi in such a way that the health system is held accountable for reducing inequities in alcohol related harm, reducing the harm from high alcohol availability, and reducing the harm from alcohol advertising and sponsorship.

4. DISCUSSION

Alcohol is one of the leading causes of mortality and health loss in New Zealand. International evidence confirms that the key driver to reducing alcohol-related harm in our population is reduced availability and accessibility of alcohol.

Background

The DHB Chief Executives have identified alcohol and alcohol related harm as a priority issue they would like the new National Public Health Advocacy Team to address. In November 2020, DHB Chief Executives and Chairs were presented with a paper on alcohol harm which names Canterbury as one of the models for producing a joint National DHB Harm Reduction Action Plan. This Action Plan is now in development and will be handed to Health New Zealand next year.

The Position Statement was subsequently developed and includes a paper summarising the Act, the problems with it and recommended improvements. The Position Statement (Appendix 1) calls for a review of the Act, outlines a number of specific changes to the Act and also calls for a number of broader changes to address alcohol related harm.

Following discussions at the October DHB Chief Executives and Chairs meeting, the Position Statement was updated to have a stronger emphasis on the role of the health system to reduce inequities in alcohol harms for Māori.

Key Recommendations in the Position Statement

The Position Statement calls for:

- Giving effect to Te Tiriti O Waitangi in such a way that the health system is held accountable for reducing inequities in alcohol related harm by:
  - Embedding Te Tiriti O Waitangi principles in the object of the Act
  - Ensuring the health system supports, invests in and enables:
    - Māori leadership and decision-making
    - Whanau-centred service provision and kaupapa Māori models of care
    - Workforce development, provider development and equitable funding

- The reduction of alcohol related harm and alcohol availability by:
  - Reducing the default national maximum trading hours by requiring the closing hours of 9 pm for off licences and 2 am for on licences and club licences
  - Abolishing the appeals process for Local Alcohol Policies (*LAPs*) and make LAPs mandatory
  - Increasing the legal purchase age for alcohol from 18 years to 20 years
  - Enabling community participation in licensing decisions by amending the District Licensing Committee structure and hearing process
  - Restricting the online sale of alcohol and aligning the restrictions across all types of online alcohol retailers

- Reduce the harm from alcohol advertising and sponsorship by:
  - Strengthening section 237 of the Act by prohibiting alcohol marketing across all media

CDHB and WCDHB Input into the Position Statement

Community and Public Health (*CPH*) received a request for feedback on a draft of the Position Statement via the Public Health Clinical Network in June 2021. CPH staff involved in the alcohol programme, including those on the West Coast, and members of the Canterbury Health Sector Alcohol-related Harm Reduction Strategy Working Group contributed to the consultation and following review by a Medical Officer of Health, feedback was submitted in early July 2021.

Implications for CDHB and West Coast DHB

Several activities to reduce alcohol-related harm occur within the Canterbury and West Coast Health Systems, including health promotion, treatment services, and alcohol licensing and compliance.

Under the Act, Medical Officers of Health report on all applications for on, off, club and special licences. The primary focus of these inquiries is the suitability of the applicant, including preventing alcohol-related harm and host responsibility. Alcohol Licensing Officers at CPH (which includes the West Coast) in monitor premises with alcohol licences and assist the local Medical Officers of Health to inquire into and report on proposed licence applications or renewals.

In 2012, both CDHB and WCDHB adopted Position Statements on Alcohol. Both positions statements suppot the evidence-based solutions to reducing alcohol-related harm by: raising alcohol prices; raising the alcohol purchase age; reducing alcohol accessibility; reducing marketing and advertising of alcohol; and, reducing legal boll-alcohol limits for drivers. Collectively these are

known as the 5+ solution and are in line with the World Health Organization SAFER framework, an initiative that can help governments reduce the harmful use of alcohol and related health, social and economic consequences.

Subsequently the Canterbury Health System Alcohol-related Harm Reduction Strategy 2018-2023 (the *Strategy*) was developed. A working group under the CCN Population Health and Access SLA oversees the implementation of the Strategy which covers multiple activities and organisations in the health system. Implementation focuses on four key areas:

- Influence social norms and behavioural change;
- Promote healthy environments;
- Coordinate prevention, identifications, treatment and support; and
- Measure harm and monitor performance.

Wider Context

Minister of Justice Chris Faafoi has signalled that a review of the Act is planned during the current political term.

The Code for the Advertising and Promotion of Alcohol which currently covers the advertising and sponsorship of alcohol was updated in 2020. The Code is voluntary industry code of practice and has been criticised for focusing on the content of advertising and not adequately addressing the inequitable exposure to alcohol in our environment. The World Health Organisation recommends restrictions to the marketing of alcohol (including advertising and sponsorship) as one of the three most effective strategies to reduce alcohol harm.

5. CONCLUSION

This National DHB Position Statement on the Sale and Supply of Alcohol Act 2012 is consistent with the established position of CDHB and WCDHB as strong advocates for national alcohol law reform in line with the 5+ solution to reduce availability and accessibility. The recommendations in the Position Statement align with the Strategy, in particular the focus area of promoting healthy environments and would strengthen the ability of alcohol licensing officers to reduce alcohol-related harm.

6. APPENDICES

Appendix 1: DHB Position Statement on the Sale and Supply of Alcohol Act

All District Health Boards

DHB Position Statement on the Sale and Supply of Alcohol Act

To:	DHB Chief Executives and Chairs
From:	Nick Chamberlain, CE NDHB and Lead CE for Public Health
Subject:	DHB Position Statement on the Sale and Supply of Alcohol Act
Date:	12 August 2021

Decision ☒ **Discussion** ☐ **Information** ☐

Seeking Funding **Yes** ☐ **No** ☐

Funding Implications **Yes** ☐ **No** ☐

Recommendation

It is recommended that DHB Chief Executives and Chairs:

- **Note** that a paper summarising alcohol related harm and considering gaps and opportunities to reduce this was presented to DHB CEs and Chairs in November 2020.
- **Note** that at that meeting DHB CEs and Chairs agreed to advocate for a review of the Sale and Supply of Alcohol Act 2012 (the Act) as one of 3 priority areas of action in relation to alcohol.
- **Note** that the Minister of Justice and the Minister of Health have expressed a willingness to review the Act and that this is likely to be a mid-range review focusing on amending the current Act rather than undertaking a full review.
- **Note** that unless we can create a sense of urgency, the review is likely to occur late in this electoral cycle.
- **Agree** to the Position Statement on the Sale and Supply of Alcohol Act 2012 (Appendix 1) asking for a review of the Act
- **Agree** that the top priorities for changes to the Act should be:

1. ***Give effect to Te Tiriti O Waitangi in such a way that the health system is held accountable for reducing inequities in alcohol related harm by:***

- Embedding Te Tiriti O Waitangi principles in the object of the Act
- Ensuring the health system supports, invests in and enables:
    - Māori leadership and decision-making
    - Whanau-centred service provision and kaupapa Māori models of care
    - Workforce development, provider development and equitable funding
- Including Māori as Te Tiriti o Waitangi partners who must be represented on all decision making panels and heard as public objectors at any hearings

- Criteria for oppositional matters should include Te Tiriti o Waitangi under s 105, 131, and 142 of the Act.

2. ***Reduce the harm from high alcohol availability by:***
   - Reducing the default maximum national trading hours, especially the closing hour (e.g. to 9pm for off licences and 2am for on licences and club licences).
   - Abolish the Local Alcohol Policy (LAP) appeals process and mandate LAP development by Territorial Authorities
   - Enabling licence numbers to be lowered in vulnerable or high deprivation locations
   - Enabling community participation in licensing decisions by amending the District Licensing Committee structure and hearing process; and
     - Restricting online sale of alcohol and aligning the restrictions across all types of online alcohol retailers

3. ***Reduce the harm from alcohol advertising and sponsorship by:***
   - Strengthening section 237 of the Act (irresponsible promotion of alcohol) to implement comprehensive restrictions to alcohol advertising including sponsorship of sports and events.

- **Agree** to advocate for a full review of the Act by an independent external agency such as the Law Commission as a subsequent stage following finalisation of the immediate changes to the act.
- **Agree** to also advocate to implement the Law Commission Recommendations on alcohol pricing at the earliest opportunity, including minimum unit pricing (MUP) and increasing alcohol excise tax, as part of broader changes to address alcohol related harm.
- **Request** that the Director General of Health provides advice to the Minister of Health and Minister of Justice to support a review of the Act.
- **Engage** in an advocacy process where all DHBs collaborate for collective action on alcohol harm reduction.

Summary

The Sale and Supply of Alcohol Act 2012 is widely acknowledged to have failed in its objective to minimise alcohol related harm. In a recent media statement Minister of Justice Kris Faafoi has expressed a willingness to review the Act. It is understood that this is likely to be a mid-range review focusing on amending the current Act rather than a full review of the Act.

This paper follows an earlier paper to DHB Chairs and CEs summarising the gaps and opportunities for DHBs to address alcohol related harm. The paper briefly summarises the Act, outlines some of the problems and deficiencies in the current Act, and proposes recommended changes to the Act in order to better address alcohol related harm. A position statement is proposed for DHB Chairs and CEs that calls for an urgent review to the Act, outlines a number of specific changes and also calls for a number of broader changes to address alcohol related harm and its inequities.

A wide range of people have contributed to the development of this paper including the prioritisation of recommended changes to the act. The paper has been widely circulated for input including to: the National Public Health Advocacy Steering Group, Te Hiringa Hauora (Health Promotion Agency), Public Health Clinical Network, Te Tumu Whakarae, Alcohol Healthwatch, Health Coalition Aotearoa and the Ministry of Health.

Background

Alcohol Related Harm

Alcohol is the most widely used drug in New Zealand and is a group 1 carcinogen. Every year more than 800 deaths are caused and more than 60,000 disability adjusted life years are estimated to be lost due to alcohol consumption. The consequences of hazardous alcohol consumption are borne by whānau, families and friends of those involved and exacerbates family harm, sexual assault, and is a major risk factor for suicide.

One in five New Zealanders aged 15 years and over are hazardous drinkers. Among the drinking population, one-quarter (25%) were found to drink hazardously. In 2019/20, this equated to 838,000 adults aged 15 years and over. Significant inequities exist and persist in drinking patterns. In 2019/20, Māori men and women were 1.6 times and 2.2 times more likely to drink hazardously when compared to non-Māori men and women, respectively.

Harmful alcohol use is a significant burden to society – its misuse is estimated to cost the government $7.8 billion per year.[1] By comparison, alcohol excise revenue was $1.064 billion in 2020, Alcohol also puts considerable pressure on the health sector, particularly emergency services, as well as on our police and justice systems.

Law Commission Report: Alcohol in our Lives: Curbing the Harm

In 2008, the Law Commission undertook a broad and comprehensive review of the role of alcohol in New Zealand led by Sir Geoffrey Palmer. This review was undertaken after nearly twenty years of liquor law liberalisation that occurred as a result of a review of liquor laws in the mid-1980s. The report to Parliament, 'Alcohol in our Lives: Curbing the Harm'[2], recommended significant changes to the sale and supply of liquor including reducing alcohol affordability and availability and restricting advertising and sponsorship.

Key policy recommendations included:

1. the introduction of a new Alcohol Harm Reduction Act;
2. raising the price of alcohol by an average of 10% through excise tax increases;
3. regulating irresponsible promotions that encourage the excessive consumption, or purchase, of alcohol;
4. returning the minimum purchase age for alcohol to 20 years;
5. strengthening the rights and responsibilities of parents for the supply of alcohol to minors;
6. introducing national maximum closing hours for both on and off-licences; (4am and 10pm respectively)
7. increasing the ability of local people to influence how and where alcohol is sold in their communities;
8. increasing personal responsibility for unacceptable or harmful behaviours induced by alcohol, including a civil cost-recovery regime for those picked up by the police when grossly intoxicated;
9. moving over time (5 years) to implement comprehensive restrictions to alcohol advertising and sponsorship.

Three Acts were agreed by parliament in response to the Law Commission's recommendations including:

[1] Nana, G. (2018). Alcohol costs - but, who pays? Presented at the Alcohol Action NZ Conference, Wellington, New Zealand.
[2] New Zealand Law Commission. Alcohol In Our Lives: Curbing the Harm, 2010.

1. Sale and Supply of Alcohol Act
2. Local Government (Alcohol Reform) Amendment Act
3. Summary Offences (Alcohol Reform) Amendment Act.

While the Act incorporates many of the recommendations from the Law Commission report, fundamental harm reduction recommendations were not implemented. These included the raising of the purchase age to 20 and limiting advertising to objective product information only. In 2014, the Ministerial Forum on Advertising and Sponsorship made comprehensive recommendations on banning alcohol advertising and sponsorship, which have not been responded to.

World Health Organisation SAFER Framework

The World Health Organization (WHO) SAFER Framework released in 2018 outlines five high-impact strategies to help governments reduce the harmful use of alcohol and related health, social and economic consequences.[3] The 5 high impact strategies are:

1. **S**trengthen restrictions on alcohol availability
2. **A**dvance and enforce drink driving counter measures
3. **F**acilitate access to screening, brief interventions and treatment
4. **E**nforce bans or comprehensive restrictions on alcohol advertising, sponsorship, and promotion
5. **R**aise prices on alcohol through excise taxes and pricing policies.

New Zealand has made some progress in implementing aspects of WHO recommended best practice but there needs to be a comprehensive, evidence-based review of how the country protects it citizens against these harms – including a review of the provisions of the Act.

Public Support for reducing Alcohol related harm

There is strong public support for policies and approaches that reduce alcohol related harm as summarised in the table below.

Policy/strategy	**Law Commission submissions**	**Public Opinion Surveys**
Restricting/reducing hours of trading	78% for all off-licences 52% for on-licences	65.6% (support or strongly support) – HPA public opinion survey
Reducing number of outlets	69% for off-licences particularly small grocery stores/diaries	64.6% (thought there were too many) – HSC public opinion survey
Alcohol sponsorship		68% of New Zealanders support banning alcohol-related sponsorship at events that people under 18 may attend.
Increasing the price of alcohol		61% of persons polled supported increasing the price of alcohol if the revenue was earmarked for the funding of mental health and addiction services - UMR public opinion polling (February 2019)

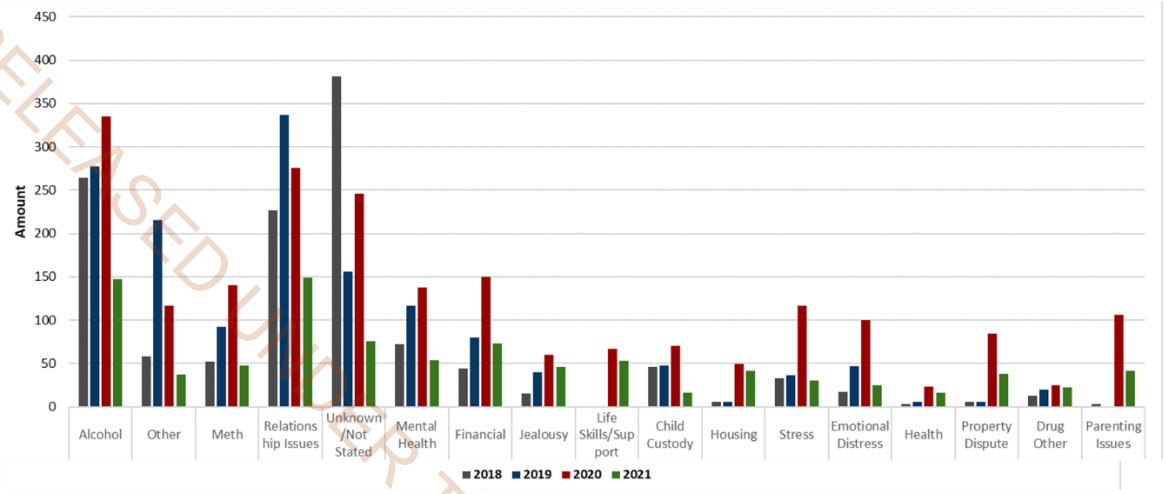
[3] World Health Organization. The SAFER initiative Geneva: WHO; 2018. http://www.who.int/substance_abuse/safer/en/

Inter-agency support for reducing Alcohol related harm

The following is a report on Whiria Te Muka which is an interagency programme in the Far North (Te Hiku) region which demonstrates that Alcohol is by far the highest reason for family violence incidents.

He Muka

Figure 2: Pressure points of incidents entered into Whiria Te Muka



- Alcohol remains the top pressure point for reported family violence in Te Hiku
- Relationship issues as a pressure point spiked in 2019 but has been steadily declining since
- Meth harm spiked as a pressure point to reported whānau harm in May 2020

Sale and Supply of Alcohol Act 2012

The Sale and Supply of Alcohol Act 2012 is administered by the Minister of Justice and replaced the Sale of Liquor Act 1989. The objectives of the Act are that:

a) The sale, supply, and consumption of alcohol should be undertaken safely and responsibly; and
b) The harm caused by the excessive or inappropriate consumption of alcohol should be minimised.

Key features of the Sale and Supply of Alcohol Act 2012 include:

1. increasing the ability of communities to have a say about alcohol licensing in their local area
2. allowing local-level decision-making for all licence applications
3. requiring the consent of a parent or guardian before supplying alcohol to a minor
4. requiring anyone who supplies alcohol to under 18-year-olds to do so responsibly
5. strengthening the rules around the types of stores allowed to sell alcohol
6. introducing maximum default trading hours for licensed premises (8am-4am for on licences and club licences and 7am -11pm for off licences)
7. restricting supermarket and grocery store alcohol displays to a single area.

However, the Act made little or no change to the most cost-effective policy areas for reducing harm, including alcohol taxation, the minimum purchase age and control of alcohol marketing.

Problems with the Sale and Supply of Alcohol Act

The Sale and Supply of Alcohol Act has failed to deliver on its intended objective. Between 2011/12 and 2015/16, hazardous drinking prevalence increased every year and by 2014/15 and 2015/16 was significantly higher in the total population than in 2011/12. Marked increases in this period were found among wahine Māori and middle aged and older adults. Since 2015/16, hazardous drinking prevalence has remained stable.

Various reports have recommended changes to strengthen the Act[4,5,6]. That the Act is not performing as it was intended is widely acknowledged by numerous groups including health, non-government, community advocates, Medical Officers of Health, alcohol treatment services and politicians alike. In a recent media statement Minister of Justice Kris Faafoi said: [7]

"I consider it would be beneficial to review the Sale and Supply of Alcohol Act and I'm assessing the ability to do that within what is already a fairly full work programme in the Justice portfolio… I want to ensure alcohol regulation in New Zealand is fit for purpose and operates effectively."

As a demonstration of how poorly the Act regulates industry, products and social harms it was also used as an example of 'what not to do' during the development of the proposed cannabis legislation, developed for last year's referendum.

Te Tiriti o Waitangi

Colonisation and breaches of Te Tiriti o Waitangi have contributed to the disproportionate impact of alcohol-related harm on Māori. In response to this, Te Tiriti o Waitangi Healthcare claim Wai 2624 (Wai 2575)[8] has called for the government to work in partnership with iwi, hapū, whānau and communities, to reduce alcohol-related inequities for Māori.

The Act does not address the disproportionate impact that alcohol has on Māori, nor does it uphold and honour the Crown's obligations under Te Tiriti o Waitangi. There is no role for Māori leadership or consultation processes to ensure Māori voices are heard and involved in decision making. The object of the Act should incorporate the importance of the Crown and Māori relationship in considering sale and supply of alcohol and this commitment needs to be operationalised within the Act with urgency.

Lack of community input into local alcohol licensing decisions

A priority objective of Aotearoa New Zealand's liquor law reforms in 2012 was to "improve community input into local alcohol licensing decisions". Eight years later, this objective has been far from realised. Alcohol licences have not become "harder to get and easier to lose". In 2020, there were more than 11,000 businesses that sold alcohol in Aotearoa New Zealand. There are more places to buy alcohol in our most socio-economically deprived communities. Community members continue to take time out of their busy lives to object to alcohol licence applications in their neighbourhood, rarely achieving success.

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4 *He Ara Oranga - the* Government *Inquiry into Mental Health and Addiction* (2018).
5 *Reducing* Alcohol-*Related Harm* (New Zealand Medical Association, 2015).
6 Alcohol Healthwatch. *Evidence-based alcohol policies: Building a fairer and healthier future for Aotearoa New Zealand* (Alcohol Healthwatch, 2021).
7 https://www.newsroom.co.nz/targeting-irresponsible-alcohol-promos
8 https://forms.justice.govt.nz/search/Documents/WT/wt_DOC_148205985/Wai%202624%2C%202.5.003.pdf

The 2019 Alcohol Regulatory and Licensing Authority annual report[9] noted the following:

"The Authority notes that the number of applications refused for new licences is very low compared to the number of applications being granted. The same can be said for applications for licence renewals and new manager's certificates. The reasons why there are so few refusals may be worthy of some investigation by policy officials to see if this is consistent with what was envisaged at the date of commencement of the Act"

Legalistic and ineffective Local Alcohol Policy Process

Provisions under the Act allow a Territorial Authority to adopt a Local Alcohol Policy (LAP) in consultation with their local community to control the number and location of premises in a district, the clustering of premises and trading hours. These legislative provisions offered Councils much hope to implement best practice measures to reduce alcohol harm. Development of a LAP is not mandatory.

However, experience suggests that the development of Local Alcohol Policies (LAPs) has been time consuming, expensive, overly legalistic and largely ineffective. The two big supermarket chains and the alcohol industry have blocked local government from minimising alcohol related harm through Local Alcohol Policies (LAPs) by funding expensive appeals.

As of May 2021, 41 (61%) of the 67 Councils in New Zealand have LAPs in place. The majority of policies have been watered down as they proceeded through the legal appeals process. Fifteen Councils have chosen not to proceed to developing a LAP. Our four largest population centres – Wellington, Hamilton City, Christchurch and Auckland – have no LAP in place. Christchurch City Council abandoned their policy after spending more than $1 million fighting it, Hamilton City have aborted too, as has the Far North District Council.

The legal fight has been lengthy and costly for ratepayers. In Auckland, a four-week public hearing before the Alcohol Regulatory and Licensing Authority in February 2017 has since proceeded to judicial review before the High Court. It has been heard at the Court of Appeal in June 2021. It is therefore unsurprising that in 2018 and 2019, two Local Government NZ remits were passed calling for urgent change to the appeal provision and review of the Act.

There are also problems with the level of evidence that is required to support Provisional LAPs, with the apparent insistence and weight being placed on available local data by both Industry and ARLA. For example, local 'proof' is required that particular off licence restrictions will result in the minimisation of harm, or that purchase of alcohol between 7am-9am results in direct harm.

Proposed changes to the Sale and Supply of Alcohol Act

It is clear that the Act has had little impact on the alcohol environment since being introduced other than a small reduction in on-licence and off-licence trading hours in urban centres (resulting from the end of 24-hour trading hours) and alcohol no longer being sold from premises that resemble dairies. By taking action to amend and strengthen sections of the Act, health outcomes across the population, particularly in vulnerable communities, can be improved.

Four key areas could potentially be addressed by amendments to the Act. These are:

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9 Alcohol Healthwatch. *Evidence-based alcohol policies: Building a fairer and healthier future for Aotearoa New Zealand* (Alcohol Healthwatch, 2021).

1. Give effect to Te Tiriti O Waitangi in alcohol legislation
2. Reduce the harm from high alcohol availability
3. Reduce the harm from alcohol advertising and sponsorship
4. Reduce the harm from cheap alcohol.

Consideration of these areas and potential changes to the Act is provided in the remainder of this section. This has been informed by key documents including the Law Commission's 2010 review *Alcohol in our Lives: Curbing the harm*, the World Health Organisation's global alcohol strategy and their *SAFER* guidelines, the New Zealand Medical Association report *Reducing Alcohol-Related Harm* and by Alcohol Healthwatch's recent report entitled *Evidence-based alcohol polices: building a fairer and healthier future for Aotearoa New Zealand.*[10].

The relative impact and cost effectiveness of various changes has also been considered. The graph below presents selected interventions from the University of Otago BODE[3] Cost Effectiveness Study comparing the benefits, potential savings and costs from a range of interventions in relation to alcohol. Most of the studies used have been developed in the Australian context.

This illustrates that taxation increases would deliver the greatest health benefits (220,000 quality adjusted life years) and potentially save the health system $3.58 billion dollars. Taxation increases however are likely to exceed the scope of a mid-range review and may need to be considered as part of a broader review of the Act.

Summary of the health impacts and cost effectiveness of alcohol interventions from the University of Otago BODE[3] Cost Effectiveness Study.

Intervention	Health Gain (QALYs)	Health system savings / costs	Intervention Costs	ICER
Tax increase	220,000	-3,580,000,000		Cost-saving
Comprehensive advertising ban	7,800	-16,400,000	20,000,000	Cost-saving
Licensing controls to restrict operating hours	2,700	11,900,000	20,000,000	4,504
Random breath testing	2,300		71,000,000	35,490
Mass media 'drink driving' campaigns	1,500	38,200,000	39,000,000	19,110
Residential treatment	460	75,100,000	59,000,000	163,804
Brief intervention by a GP	340	4,780,000	6,100,000	13,650
Increase in minimum legal drinking age	150	-218,000	640,000	Cost-saving

The tax increase is modelled on; 'applying an equal tax rate to all beverages equivalent to a 10% increase in the current excise applicable to spirits and ready-to-drink products'. This is calculated to result in a 50% increase in taxation (which is similar to the amount recommended by the Law Commission) and a 10.6% reduction in consumption.

Comprehensive advertising bans and licensing controls to restrict operating hours are the next most important interventions in terms of health gain. The evidence consistently shows that interventions to address alcohol related harm are highly cost effective and that taxation and regulatory changes at the national level show greatest health gain and cost effectiveness compared to health promotion or clinical interventions. By addressing the alcohol environment, they produce sustainable changes to population norms of drinking for this generation and the next to benefit.

[10] Alcohol Healthwatch. *Evidence-based alcohol policies: Building a fairer and healthier future for Aotearoa New Zealand* (Alcohol Healthwatch, 2021).

1. Give effect to Te Tiriti O Waitangi in alcohol legislation

The Crown is currently failing in its duty to actively protect Māori from alcohol related harm. Māori are one of the groups most adversely affected by alcohol and yet the Act makes no special consideration or recognition of their place as tangata whenua. Emerging research has demonstrated links between Māori who face racism and alienation, and heavy drinking.

It would also be important to give effect to Te Tiriti principles in the act in a number of ways. This could include for example the following:

1. Māori have effective agency to self-determine the place of alcohol sale and supply (Tino Rangatiratanga)
2. Reduce levels of excessive consumption and alcohol related harm for Māori, reduce to at least the level of non-Māori, and differentials in the density of alcohol sale and promotion outlets to these communities are eliminated (Equity)
3. Regulators act to the fullest extent and err on the side of preventing harm with a precautionary principle where there is uncertainty (Active Protection)
4. Attention and mitigation is given to the specific pathways of harm for Māori not simply general pathways of harm for all communities (Options)
5. Māori – and all local communities – communities have equal power and agency on decisions, relative to commercial interests seeking to promote alcohol sale and use. Regulators must have a duty to hear and heed the quieter voices of those who have a legacy of feeling powerless (Partnership).

Te Hiringa Hauora (Health Promotion Agency) have work underway to identify what would be required to give effect to Te Tiriti O Waitangi. The recommendation below will be updated to align with the position advocated for by Te Hiringa Hauora. The National Māori Authority have also signalled that they are calling for a review of the Act and will begin consultation soon.[11] A partnership approach is needed for example having members of DLCs who are Māori .

Recommendation: Give effect to Te Tiriti O Waitangi in such a way that the health system is held accountable for reducing inequities in alcohol related harm by:

- Embedding Te Tiriti O Waitangi principles in the object of the Act
- Ensuring the health system supports, invests in and enables:
    - Māori leadership and decision-making
    - Whanau-centred service provision and kaupapa Māori models of care
    - Workforce development, provider development and equitable funding
- Including Māori as Te Tiriti o Waitangi partners who must be represented on all decision making panels and heard as public objectors at any hearings
- Criteria for oppositional matters should include Te Tiriti o Waitangi under s 105, 131, and 142 of the Act.

2. Reduce the harm from high alcohol availability

The next four recommendations in this section focus on reducing the availability of alcohol by reducing the default national maximum trading hours, removing the LAPs (local alcohol policies) appeals process and making LAPs mandatory, changing the District Licensing Committee structure and hearings process, and lifting the legal purchase age. Each of these initiatives will minimise alcohol harm by reducing its accessibility and enabling greater community participation in decision-making processes regarding alcohol availability.

[11] http://www.voxy.co.nz/national/5/387572

Hours of sale

Aotearoa New Zealand's legislated default national trading hours (in the absence of a Local Alcohol Policy) are 8am to 4am for on-licences and club licences and 7am to 11pm for off -licences. Reducing the national trading hours can reduce harm and save lives. Many/all of the LAP appeals sought to establish longer trading hours than communities wanted. This could be circumvented by reducing the hours of sale at a national level via a legislative change.

Recommendation: Advocate for a reduction in the minimum default closing hours to 9pm for off licences and 2am for on licences and club licences

Number of licences

In New Zealand, the number of outlets licensed to sell alcohol more than doubled from 6,296 in 1990 to 14,424 in 2010.[12] 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.[13] [14]

New Zealand research has demonstrated that higher outlet density is more common in lower socio-economic neighbourhoods than in higher socio-economic neighbourhoods. 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. Introducing a cap or a sinking lid on the number of off-licences available in a given area would limit the proliferation of new stores. We could for example argue a future trajectory for total number of off-licences which includes reducing density of the highest deprivation areas to those of the lowest – and that would mean every time a licence was given up it would not be replaced if an area was above its target level.

Recommendation: Advocate to enable the number of licences to be lowered particularly in vulnerable or high deprivation areas.

For example, by requiring the existing levels of density to be considered in licensing applications, beyond its effects on amenity and good order; and explicitly requiring the level of deprivation in the locality to be considered in licensing decisions.

LAP appeals process

As previously discussed the current LAP process is highly legalistic and not working as intended. Removing the appeals process would bring the LAP development and implementation process in line with other locality-specific social harm policies such as that which governs gambling, prostitution and psychoactive substances. Importantly these local government policies do not have an appeals process.

Removing the LAP appeals process and making them mandatory would enable Councils to use stronger controls to limit or reduce alcohol availability, especially in areas that have outlet high

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

13 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.

14 Donnelly N, et al. Liquor Outlet Concentrations and Alcohol-related Neighbourhood Problems. Alcohol studies bulletin 2006, no. 8.

proliferation. A greater number of Territorial Authorities could look to set caps on the number of alcohol outlets in their districts, or even introduce sinking lid policies to reduce the existing density of outlets. Proximity controls (i.e. required distances between premises) and location controls (i.e. proximity to sensitive sites such as schools), may also be used to a greater extent following the removal of the LAP appeals process.

Recommendation: Advocate for the abolition of the Local Alcohol Policy appeals process and require LAPs to be mandatory

Community input into local alcohol licensing decisions

Despite the priority objective of the Alcohol Reform Bill being to "improve community input into local alcohol licensing decisions", communities still face many challenges in their participation in these processes.

Firstly, it is difficult for communities to become aware of licence applications in their neighbourhood. Once they do become aware, they have 15 working days to submit their objection. Once the application proceeds to a public hearing before a District Licensing Committee (DLC), they face a highly-legalistic process with cross-examination by well-resourced lawyers acting for the licence applicant.

Changes are required to the Act to enable greater community participation in matters of local alcohol availability. Cross-examination should be prohibited in the Act and District Licensing Committees should be replaced with a national panel of Commissioners, to ensure consistency in evaluation and decision-making and put an end to local government elected officials sitting on DLCs.

Recommendation: Amend the structure of District Licensing Committees and remove cross-examination from public hearings.

Age

The minimum purchase age in NZ is currently 18 years. The Law Commission Review recommended that this should be increased to 20. Given the inequities in consumption and harm experienced by rangatahi Māori, increasing the legal purchase age should be considered as pro-equity.

Evidence suggests that the longer a young person delays drinking, the more they are protected from alcohol harm and that each year a young person delays drinking, they are estimated to reduce their risk of becoming dependent on alcohol by 9–21%[15]. Studies have shown that the 1999 law change in Aotearoa New Zealand that lowered the purchase age from 20 to 18 years was associated with an increase in a number of alcohol-related harms for young people, including alcohol-related hospitalisations[16], prosecutions for driving with excess alcohol and disorder[17], and traffic crashes[18]. New Zealand research shows that almost 50% of all cases of alcohol abuse and dependence develop by the age of 20 years and 70% by the age of 25. As such, this is a critical and vulnerable period for the development of alcohol use disorders in New Zealand.

Recommendation: Advocate for an increase in the minimum purchase age to 20 as recommended by the Law Commission Report.

15 Donaldson, L. Guidance on the consumption of alcohol by children and young people. London, UK: Department of Health, 2009.

16 Everitt, R., & Jones, P. (2002). Changing the minimum legal drinking age - its effect on a central city emergency department. New Zealand Medical Journal, 115(1146), 9-11.

17 Huckle, T, Pledger, M, & Casswell, S. (2006). Trends in alcohol-related harms and offences in a liberalized alcohol environment. Addiction, 101(2), 232-240.

18 Kypri, K, Davie, G, McElduff , P, Langley, J, & Connor, J. (2017). Long-term effects of lowering the alcohol minimum purchasing age on traffic crash injury rates in New Zealand. Drug and alcohol review, 36(2):178185.

Remote sales (also called online sales)

The writers of the Act, which received Royal Assent in 2012, began development of the Act in 2010 and were guided by the Law Commission's recommendations, could not have conceived of the role the internet would play in facilitating alcohol purchasing and consumption in Aotearoa New Zealand. This has been further exacerbated as a result of COVID 19 with alcohol sellers diversifying their business models. The rate of growth in the number of online alcohol sellers has been exponential. Currently, only retailers with a Section 40 endorsed liquor licence (i.e. online only sellers) are required to state their intention to sell online. All other physical off-licences (e.g. supermarkets, grocery stores, bottle stores), are permitted to sell online but are not required to register that they are selling online. As such, there is a substantial lack of information as to which premises are selling online and to which regions in New Zealand. Determining compliance with the Act is therefore challenging.

The Act needs to be modernised to take into account the various delivery services that deliver alcohol to residential addresses. As alcohol can be currently purchased online and delivered without any face-to-face interaction, there is a risk that underage or intoxicated persons may purchase and consume alcohol. Also, it is currently possible to have alcohol delivered in less than 30 minutes from time of purchase.

Recommendation: Restrict online alcohol sales and align the requirements for online alcohol sales with in-person sales including:

1. Require all online alcohol sellers to obtain a section 40 (remote sellers) liquor licence
2. Require the buyer and receiver to verify their age (i.e. make this mandatory in legislation)
3. Prohibit alcohol products to be left unattended at delivery
4. Require an intoxication assessment of the person who receives alcohol
5. Prohibit same day delivery
6. Require that the delivery should only occur within permitted trading hours of the physical premises or for online only sellers the more restrictive of the default national maximum trading hours or local alcohol policy.

3. Reduce the harm from alcohol advertising and sponsorship

Exposure to alcohol advertising is causally associated with earlier drinking initiation among adolescents and heavier drinking among adolescents who drink.[19] [20] Alcohol advertising also serves to normalise drinking and maintain our heavy drinking culture. Controls over the marketing of alcohol are important for delaying drinking initiation for young people and those who want to cut down or stop drinking. Around 80% of New Zealanders support increasing restrictions on alcohol advertising or promotion seen or heard by people under 18.[21]

Replacing alcohol sports sponsorship could be achieved through increasing the existing Health Promotion Agency levy that is placed on all alcohol products sold in Aotearoa New Zealand (for the purposes of undertaking activities to reduce alcohol harm). Funding the replacement of alcohol sports sponsorship would add as little as 6 cents to a bottle of wine, 2 cents to a can of beer, 2 cents to an RTD, and 7 cents to a bottle of spirits.

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19 Stautz K, Brown KG, King SE, Shemilt I, Marteau TM. Immediate effects of alcohol marketing communications and media portrayals on consumption and cognition: a systematic review and meta analysis of experimental studies. BMC Public Health 2016; 16: 465.

20 Sargent JD, Babor TF. The Relationship Between Exposure to Alcohol Marketing and Underage Drinking Is Causal. J Stud Alcohol Drugs Suppl 2020; 113–24.

21 Health and Lifestyles survey Alcohol-related attitudes over time. See https://www.hpa.org.nz/sites/default/files/Alcohol-related%20attitudes%20over%20time%20October%202018.pdf

The Law Commission Report recommended that a phased programme should be in place with 5 years to limit exposure to alcohol promotion and restrict the content of alcohol promotion messages including alcohol related sponsorship. The Commission recommended a 3 stage programme be implemented. Only stage 1 of this programme has been implemented to date. Stage 2 measures are primarily aimed at reducing exposure to advertising particularly for young people. Stage 3 measures prohibits any alcohol advertising in any media other than advertising that communicates objective product information, including the characteristics of the beverage, the manner of its production and its price.

Alcohol advertising is currently addressed in section 237 of the Act. This section should be extended to prohibit all alcohol marketing across all media, as per requirements for tobacco and vaping products in New Zealand.

Recommendation: Advocate to strengthen section 237 of the Act by prohibiting alcohol marketing across all media, as per requirements for tobacco and vaping products.

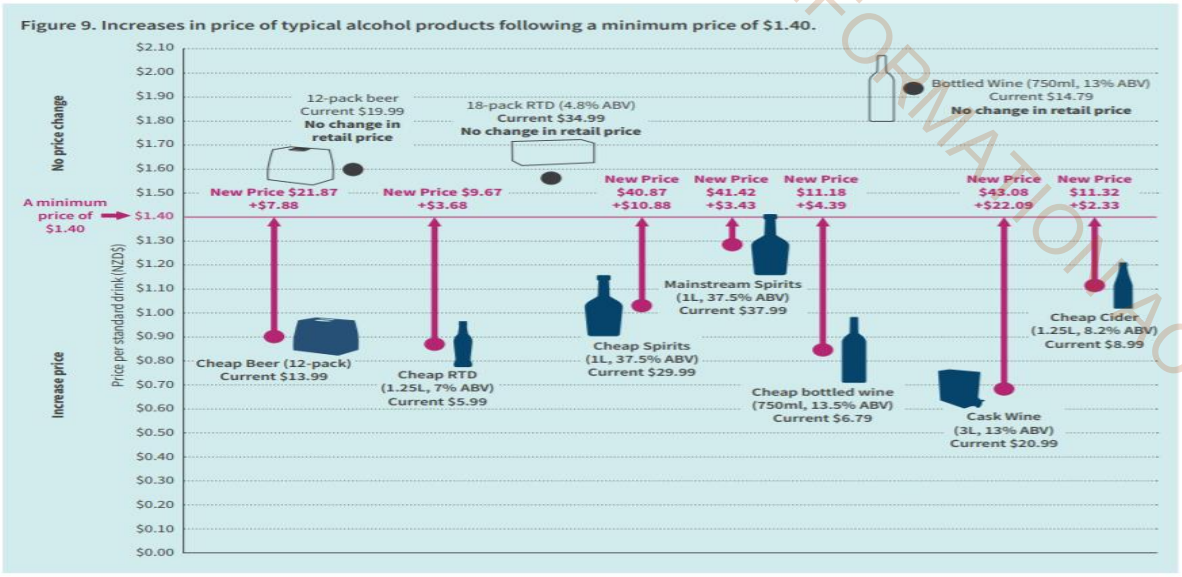
4. Reduce the harm from cheap alcohol

Pricing is one of the most influential drivers of alcohol consumption in the population. There are two complementary ways to tackle this issue –introducing a minimum unit price to address the harms from the cheapest alcohol for sale alongside increasing excise tax to shift population level patterns of consumption. Pricing changes could be introduced through the Sale and Supply of Alcohol Act but they are unlikely to be addressed as part of the mid-range review signalled by the government and therefore they should pursued by other means such as specific legislative initiatives.

Minimum Unit Pricing

Many countries and jurisdictions throughout the world have adopted legislation to set a floor price (minimum price) that alcohol can be sold. These policies are important in relation to cheap sales of alcohol from off-licences; where 84% of all alcohol is now purchased from in New Zealand. Research from Scotland demonstrates the positive impacts of Minimum Unit Pricing (MUP), especially on equity.[22]

Alcohol Health Watch, Roadmap for Alcohol Pricing Policies.=



[22] O'Donnell A, Anderson P, Jané-Llopis E, Manthey J, Kaner E, Rehm J. Immediate impact of minimum unit pricing on alcohol purchases in Scotland: Controlled interrupted time series analysis for 2015-18. BMJ 2019; l5274.

In the first year of MUP in Scotland, purchases of alcohol reduced the most among low income, heavy drinking households. Because the policy has the greatest impact on the purchases of very cheap alcohol (i.e. especially by low-income heavy drinkers), the positive impacts on health inequities from MUP are considerable, given the disproportionate harm that these drinkers experience. In particular, MUP is shown to be the most pro-equity alcohol pricing policy – having the potential to narrow socio-economic, alcohol-related health inequities the most. In a United Kingdom modelling study, it was estimated that 90% of the lives saved from MUP would be from lower socio-economic groups.

MUP should be introduced to lift the low cost of alcohol sold at off-licences, and predominantly purchased by heavy drinkers who buy the cheapest alcohol available - cask wine. This can be bought for 68c per standard drink. Very low priced bottled wine (beginning at $6.79), some RTDs (ready to drink ie. Spirit and soft drink pre-mixers) and some cheap beer would also be strongly affected by this increase. It will have a marginal affect or no effect on most other beverages, and will not generally affect the hospitality sector as their drinks are sold at prices well above these levels.

Recommendation: Advocate for the introduction of Minimum Unit Pricing

Increase Alcohol Excise taxes

Raising the price of alcohol is the most cost-effective measure to reduce alcohol consumption (in terms of cost per health life-years gained).[23] Increasing the price of alcohol has been shown to be associated with reductions in alcohol-related disease and injury outcomes, alcohol-impaired driving, motor vehicle crashes and injuries, death from cirrhosis, alcohol dependence, sexually transmitted infections, suicide, and violence (including rape, robbery, and violence towards children).[24] [25]

In 2017, all alcohol was more affordable than ever before. Currently, around 15-25% of the price of mainstream beers, wines and Ready to Drinks (RTDs) is excise tax. Due to the higher tax rate on high-strength spirits, around half of the price of a bottle of spirits is excise tax.

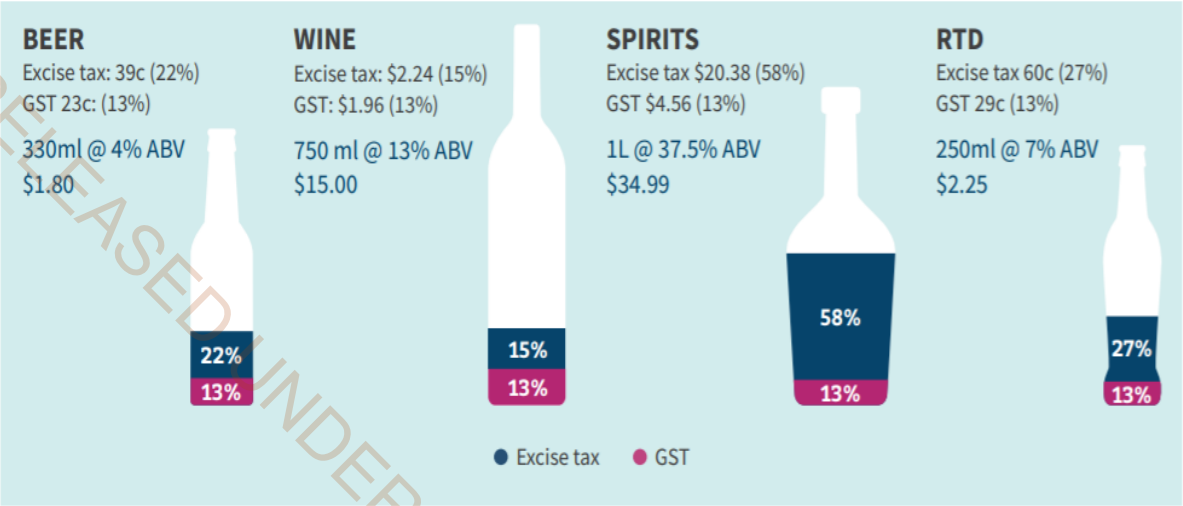
The Law Commission recommended that the alcohol excise tax rates increase by 50% – this would, on average, increase alcohol prices by around 10% and reduce overall consumption by 5%.22 A 50% tax increase would raise the price of a 12-pack of beer by <$3, a bottle of wine by $1.30, a bottle of spirits by $12 and a 12-pack of RTD by $4 (as at July 2020).

[23] Chisholm D, Moro D, Bertram M, et al. Are the "Best Buys" for Alcohol Control Still Valid? An Update on the Comparative Cost-Effectiveness of Alcohol Control Strategies at the Global Level. J Stud Alcohol Drugs 2018; 79: 514–22.

[24] Elder RW, Lawrence B, Ferguson A, et al. The effectiveness of tax policy interventions for reducing excessive alcohol consumption and related harms. Am J Prev Med 2010; 38: 217–29.

[25] Wagenaar AC, Salois MJ, Komro KA. Effects of beverage alcohol price and tax levels on drinking: a meta analysis of 1003 estimates from 112 studies. Addiction 2009; 104: 179–90.

Alcohol excise rates in Aotearoa New Zealand, Alcohol Health Watch, Roadmap for Alcohol Pricing Policies



The Ministry of Justice examined the effects of an 82% excise tax increase[26] and estimated that:

1. Harmful drinkers would reduce their annual consumption the most, by around 13.1%;
2. Low-risk drinkers would pay an additional $1.77 per week, increased risk drinkers $5.87 per week, and harmful drinkers $13.65 extra per week; and
3. Net cost savings to society from reduced harm were estimated to be $339 million in the first year, and $2.45 billion over ten years. The majority of these savings were from reduced costs to ACC, the justice sector and health system.

Tax prices are currently set through Customs and Excise but the Act could be amended to include a requirement that alcohol taxes are imposed to ensure that the price of alcohol remains at a level that is consistent with the Object of the Act.

Recommendation: Advocate for a substantive increase to alcohol excise in line with that recommended by the Law Commission.

Proposed DHB Position Statement

Appendix 1. sets out a proposed DHB position statement re the Sale and Supply of Alcohol Act. The intention is that DHBs collectively adopt the position statement in order to begin advocating for a modification and strengthening of the Act and eventually a full review of the Act. It is crucial to use this opportunity to position alcohol law reform as a key public health issue that offers significant potential to improve Māori health gain and reduce alcohol harm inequities. It is also intended that this position statement is circulated with health leaders and others to build consensus on the scope of the review.

[26] White J, Lynn R, Ong S-W, Whittington P, Clare C, Joy S. The Effectiveness of Alcohol Pricing Policies. 2014.https://www.justice.govt.nz/assets/Documents/Publications/effectiveness-of-alcohol-pricing policies.pdf (accessed April 30, 2018).

Currently 18 of the 20 DHBs have alcohol position statements. In November 2020, Hauora Tairawhiti conducted a stocktake that showed that all the current position statements noted the significance of alcohol related harm and advocated for national population-based policy changes including changes to tax, minimum age, and marketing. However, many of the statements did not specifically list the changes needed.

This position statement provides a brief, evidence-based, high level statement about the changes needed to the Act. This statement has been reviewed by alcohol-related harm experts. It provides a strong base for the Public Health Advocacy Team, DHBs and health leaders to advocate for alcohol harm minimisation work by clearly stating the policies and actions that the DHBs, and later Health NZ, should take.

These changes are informed by key documents including the Law Commission's 2010 review *Alcohol in our Lives: curbing the harm*, the World Health Organisation's global alcohol strategy and their *SAFER* guidelines, and by Alcohol Healthwatch's recent report entitled *Evidence-based alcohol polices: building a fairer and healthier future for Aotearoa New Zealand.*

Further work on reducing alcohol-related harm, such as reducing social harms, improvements to health services, alcohol and addiction treatments, and legislation beyond the Act are outside the scope of this paper.

Health sector leaders should have a collective view on what the review should entail, and one that is publicly available. This position statement will provide direction for the amendments to the Act.

Given that we are already eight months into this 36-month term it is likely that work to scope the terms of the review could begin by the end of this calendar year. It's therefore essential that DHB health leaders have a clear and collective view on what we want from this review.

Appendix 1. Proposed DHB Sale and Supply of Alcohol Act 2012 Position Statement

We, the Chairs and Chief Executives of the 20 District Health Boards, believe that the Sale and Supply of Alcohol Act 2012 must be amended and strengthened in order to prevent and minimise alcohol-related harm and inequities in Aotearoa New Zealand and uphold our obligations to Te Tiriti o Waitangi.

We are guided by the science, data and research:

1. Alcohol is a toxin and an intoxicant
2. Alcohol is a carcinogen
3. Alcohol causes premature death, disability, and injuries
4. Alcohol regulation must be understood as a (mental) health (and addictions) issue
5. Alcohol is New Zealand's most harmful drug.

Specific changes we want to see are:

Give effect to Te Tiriti O Waitangi in such a way that the health system is held accountable for reducing inequities in alcohol related harm by:

- Embedding Te Tiriti O Waitangi principles in the object of the Act
- Ensuring the health system supports, invests in and enables:
    - Māori leadership and decision-making
    - Whanau-centred service provision and kaupapa Māori models of care
    - Workforce development, provider development and equitable funding

Reduce the harm from high alcohol availability by

1. Reducing the default national maximum trading hours, by requiring the closing hours of 9pm for off licences and 2am for on licences and club licences.
2. Abolishing the appeals process for Local Alcohol Policies (LAPs) and make LAPs mandatory
3. Increasing the legal purchase age for alcohol from 18 years to 20 years.
4. Enabling community participation in licensing decisions by amending the District Licensing Committee structure and hearing process;
5. Restricting the online sale of alcohol and align the restrictions across all types of online alcohol retailers.

Reduce the harm from alcohol advertising and sponsorship by:

6. Strengthening section 237 of the Act by prohibiting alcohol marketing across all media.

A full review of the Act by an independent external agency such as the Law Commission is also called for. This should be undertaken as a subsequent stage following finalisation of the immediate changes to the act.

We also want to see the Law Commission Recommendations on alcohol pricing implemented at the earliest opportunity, including minimum unit pricing and increasing alcohol excise tax, as part of broader changes to address alcohol related harm.

END