Minister of Justice
Hon Kris Faafoi
Parliament Buildings
Wellington

Via e-mail

Tēnā koe Minister Faafoi

My name is Dr Nick Eichler and I am the alcohol Medical Officer of Health for Auckland Regional Public Health Service (ARPHS). I hold a statutory role under the Sale and Supply of Alcohol Act 2012 (**'the Act'**). ARPHS is the largest public health unit in Aotearoa New Zealand and the geographic area of responsibility covers nearly one third of the general population and the largest Māori population. ARPHS' alcohol licensing unit for which I am the lead receives the largest volume of alcohol licence applications in the country (alongside Auckland Council and Auckland Police).

I am writing to you in support of your recent comments in the media on the 8th March 2021, where you stated "*I consider it would be beneficial to review the Sale and Supply of Alcohol Act ... I want to ensure alcohol regulation in New Zealand is fit for purpose and operates effectively.*" I fully support these comments as in my opinion the Act is currently not fit-for-purpose and is not effective at minimising alcohol-related harm, as per the Object of the Act (s4). This is particularly pertinent for our populations most unfairly impacted by alcohol harm, in particular Māori, youth and Pacific people.

Despite being met with early optimism when implemented in 2012/13, the expected outcomes from the Act have not materialised. As such, I now view the Act as largely an administrative processing exercise that has a low return on investment and very little impact on minimising alcohol-related harm, particularly for Māori and other population groups. My opinion that the Act is not fit-for-purpose has been formed by our experience in Auckland, which I will briefly discuss below:

- We conducted an analysis of alcohol licencing across Auckland over a four year period. Out of 16,478 alcohol licence applications received in that time, 180 or 1% were heard at a District Licensing Committee hearing. Out of the 180 hearings, 155 or 86% of licences were granted, despite oppositions and objections from agencies and the community. Our analysis shows that the success rate for the community, if objecting without agency support, was only 2%.[1]
- Auckland's Local Alcohol Policy (LAP) was developed in 2013 but is still tied up in legal challenges brought by the alcohol industry, with the next stage being heard at the Court of Appeal in June 2021. LAPs were intended to give territorial authorities, in consultation with public interest groups and the community, powers to prevent and minimise alcohol harm in their local geographical areas. Despite considerable investments in the development of Auckland's LAP, I do not have confidence that we will ever see implementation due to the influence of the alcohol industry.
- The community voice has not been prioritised in licensing decisions as intended, with community access to the process being poor. Furthermore, the hearings process is overly

[1] https://www.arphs.health.nz/assets/Uploads/Resources/Alcohol/Is-the-communitys-voice-being-heard_alcohol-licensing-applications_FINAL.pdf

litigious, with alcohol licence applicants frequently employing specialist lawyers, creating an uneven playing field for community objectors lacking these resources. At ARPHS, we at times use in-house legal services to level the playing field somewhat, but this option is often not available to the community. Furthermore, the community are often denied standing to appear at a hearing if they do not live within a 1-2km radius of a premise, despite evidence suggesting the harm from a premise goes much further than this.[2] Anecdotally, the most successful community objections appear to be by communities from affluent neighbourhoods who either have a legal background or can obtain legal support.

- Access to the process and District Licensing Committee hearings for Māori is particularly poor. Improving access for Māori including inserting a te Tiriti clause in the Act would enable improved outcomes for Māori and other New Zealanders in general.
- Alcohol outlet density is particularly high in south Auckland, with evidence linking higher density with higher consumption and thus higher harm. Higher density also results in premises competing on price, further accelerating accessibility of cheap alcohol.[3] The Act does not have a mechanism to purposefully lower outlet density in priority areas, as might be the case with pokies or other hazardous exposures. In my view, the DLC structure is likely incapable of reducing outlet density as renewal applications are usually granted (despite opposition in some cases) by the DLC as there is no mandate to reduce existing harm.
- ARPHS recently audited 66 bottle shops in south Auckland and found a 100% non-compliance rate with at least one criterion of Auckland Council and Auckland Transport's signage bylaw. This raises widespread suitability issues (i.e. shops are not complying with the law) that cannot easily be addressed through the current provisions in the Act. We know that Māori and Pacific children have five and three times more exposure to alcohol advertising respectively than other population groups[4] - this is highly inequitable. Reducing exposure to alcohol advertising, particularly for children, is a World Health Organisation 'Best Buy'[5] to prevent alcohol-related harm and contributes to the Government's Child Wellbeing Budget Priorities.[6]
- S237 of the Act and the Advertising Standards Agency (ASA) voluntary code is not fit-for-purpose regarding protecting children and people in general from the harm caused from exposure to alcohol marketing.[7] We know that for children, exposure to alcohol advertising leads to early initiation of drinking and more harmful patterns of alcohol consumption.[8] The evidence is abundantly clear that voluntary codes do not work and require a response similar to that of tobacco, given that alcohol is New Zealand's most used recreational drug

[2] Connor, J. L., Kypri, K., Bell, M. L. & Cousins, K. Alcohol outlet density, levels of drinking and alcohol-related harm in New Zealand: a national study. *J. Epidemiol. Community Health. 2011;* 65, 841–846.
[3] Cameron MP, Cochrane W, Livingston M. The relationship between alcohol outlets and harm. 2016. https://www.hpa.org.nz/sites/default/files/The%20relationship%20between%20alcohol%20outlets%20and%20harm.pdf (accessed: 23 March 2021)
[4] Chambers T, Stanley J, Signal L, et al. Quantifying the nature and extent of children's real-time exposure to alcohol marketing in their everyday lives using wearable cameras: Children's exposure via a range of media in a range of key places. *Alcohol and Alcoholism*. 2018; 53:626–633.
[5] World Health Organization. Tackling NCDs: 'best buys' and other recommended interventions for the prevention and control of non-communicable diseases. Geneva: World Health Organization, 2017.
[6] The Treasury (2020) https://www.budget.govt.nz/budget/2020/bps/wellbeing-priorities.htm
[7] Jackson N, Cowie N, Robinson A. Ineffective, meaningless, inequitable: analysis of complaints to a voluntary alcohol advertising code. *New Zealand Medical Journal*. 2021; 117-122.
[8] Sargent JD, Babor TF. The Relationship Between Exposure to Alcohol Marketing and Underage Drinking Is Causal. *J Stud Alcohol Drugs Suppl.* 2020;113–24. doi:10.15288/ jsads.2020.s19.113

and the most harmful.[9] Clear recommendations have been made regarding alcohol advertising in the past with the Law Commission in 2010[10], Ministerial Forum on Alcohol Advertising and Sponsorship in 2014[11] and the Government Inquiry into Mental Health and Addictions in 2018.[12]

As alcohol-related harms are major contributors to inequities in health and wellbeing outcomes, particularly for Māori, strengthening the Act is urgently needed as it is not meeting the object as was originally intended, nor meeting our obligation to te Tiriti o Waitangi. In my view, a full review of the Act is required.

In the interim and recognising your comments in the media that you already have a "*…fairly full work programme*", 'tweaks' to the Act that would be most beneficial in our view would include:

- Inserting a te Tiriti clause and giving it mandated effect to decision makers (DLCs and ARLA). Meaningful partnership with Māori needs to be a core element of alcohol harm reduction given the general obligations of te Tiriti and the disproportionate harm experienced by Māori
- Implementing Stage three of the Law Commission 2010's recommendations of alcohol advertising and sponsorship, in particular the sponsorship of sport and cultural events

Thank you for your time and I am happy to discuss any of these points in further detail with you if you wish.

Mauri Ora

Dr Nick Eichler FNZCPHM, Medical Officer of Health for the Auckland Region

[9] Auckland District Health Board Alcohol Position Statement: https://www.adhb.health.nz/assets/Uploads/ADHB-Alcohol-Position-Statement-FINAL2.pdf
[10] New Zealand Law Commission. Alcohol in our lives: curbing the harm. Wellington; NZ. 2010.
[11] Ministerial Forum on Alcohol Advertising and Sponsorship. Ministerial Forum on Alcohol Advertising and Sponsorship: Recommendations on alcohol advertising and sponsorship. 2014.
[12] Mental Health and Addiction Inquiry. He ara oranga: Report of the Government Inquiry into mental health and addiction. Wellington, New Zealand. 2018. https://mentalhealth.inquiry.govt.nz/assets/Summary-reports/He-Ara-Oranga.pdf (accessed 21 March 2021).