



Alcohol

This document provides an overview of alcohol and the harm it causes to our communities.

[Get more information if you are worried about your own or someone else's drinking.](#)

What is this?

Alcohol is the most commonly used recreational drug in New Zealand, with the potential to harm both the drinker and others.¹

Why is it important?

Alcohol is a major public health issue because of the harm it causes to individuals and communities.

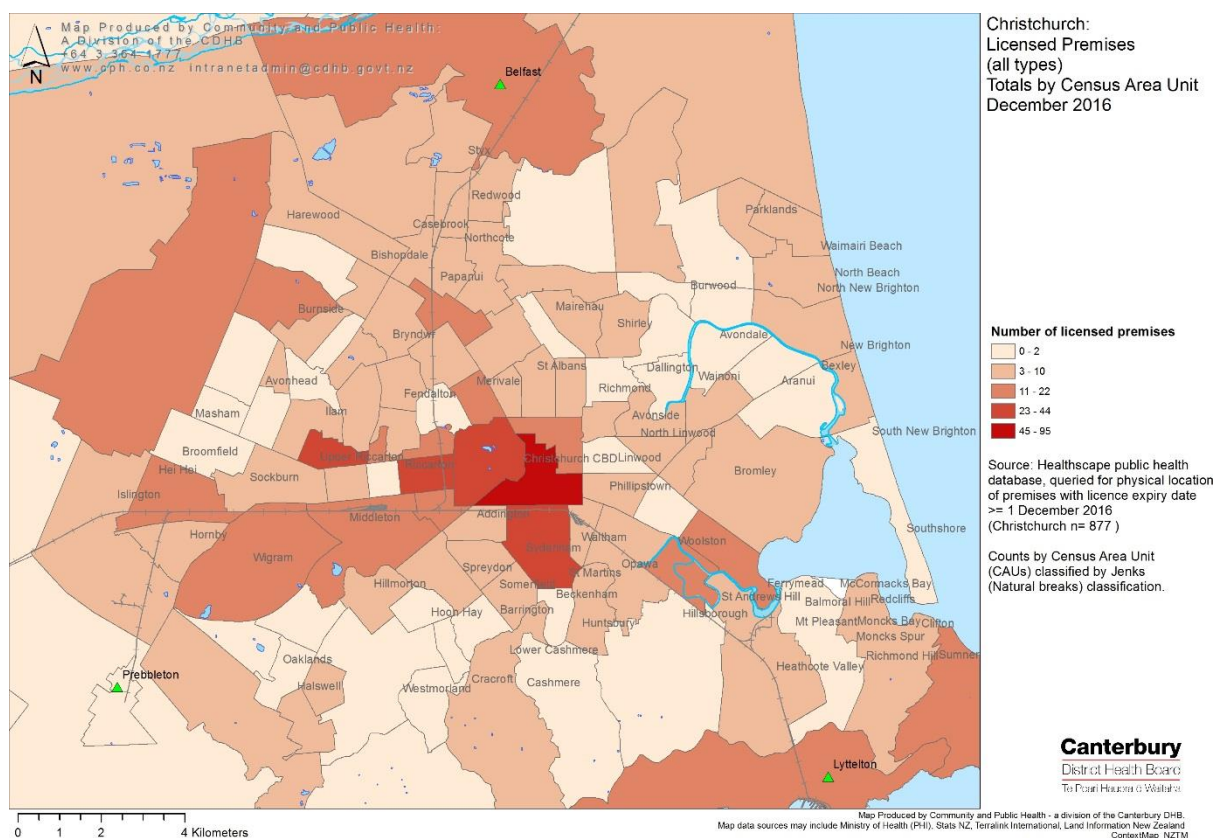
Individuals who drink alcohol may be harmed in three main ways: through its toxic effects on organs and tissues; intoxication, leading to impaired physical and mental functioning; and dependence.² Individuals may experience both chronic harm, associated with the cumulative toxic effects of alcohol consumed over many years; and acute harms, such as alcohol poisoning, injury or assaults, which occur at the time of consumption and are typically the result of intoxication.³ How much harm people experience is determined through the volume of alcohol consumed, the pattern of drinking and occasionally, the quality of alcohol consumed.⁴ Harm due to alcohol may be experienced by those who are not drinking such as children who witness family violence that is exacerbated by alcohol; or people involved in car crashes caused by others' drinking. Additionally, alcohol abuse is implicated in approximately one third of all crimes in New Zealand and half of all serious violent crimes.^{5 6} It is linked to more than 200 disease and injury conditions, including cancers; diabetes; cardiovascular, digestive and neuro-psychiatric disorders; infectious diseases; fetal alcohol syndrome; suicide and violence; and road traffic accidents, falls and drownings.⁷

In general, the more alcohol consumed, the higher the risk of diseases and injuries causally impacted by alcohol; this is particularly the case for cancers.⁸ As well as contributing causally to at least 200 health conditions, alcohol is the sole cause of some conditions, including alcoholic liver disease, alcoholic cardiomyopathy, alcohol poisoning, alcohol-related injuries and other chronic mental, behavioural and medical conditions.⁹ It is estimated that 600 to 3,000 babies are born in New Zealand each year who suffer from fetal alcohol spectrum disorder caused by women drinking alcohol during pregnancy.¹⁰

Data

Alcohol is now much more widely accessible than in the past, with the number of licensed premises by more than doubling (from 6,295 in 1990 to 14,424 in 2010), following the 1989 Sale of Liquor Act.¹¹ It has been available in supermarkets for almost 30 years. One way of monitoring the availability of alcohol is through the proportion of liquor licences per capita. In 2014 in New Zealand, there were 24 liquor licences per 10,000 population. In the South Island, the proportion was higher, with 32 liquor licences per 10,000 population.¹² As shown in Figure One below, in Christchurch most alcohol outlets are heavily concentrated in the central city, with some also concentrated around the university area and to the south of the city centre. Overall, the number of alcohol outlets in the city has dropped since the 2010/11 earthquakes, but numbers are rising again.¹³

Figure One: Location of alcohol outlets in Christchurch 2017



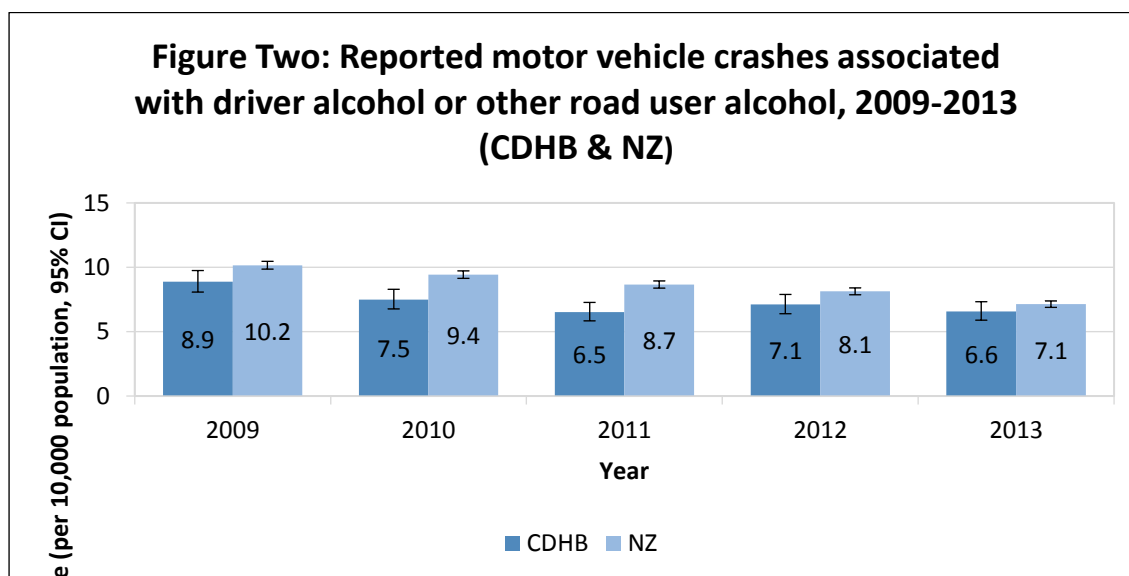
Source: Community and Public Health

Most (80%) New Zealanders (aged 15 years and over) drink at least some alcohol.¹⁴ In 2015/16, 21% of adults reported drinking alcohol at a level that was hazardous to their health, with over twice as many men (29%) as women (13%) reporting hazardous drinking.¹⁵



Alcohol is estimated to contribute to 800 deaths a year in New Zealand, of which nearly half are injuries, almost one third are from cancer and over a quarter are from other diseases.¹⁶ In 2012 in New Zealand, alcohol was a factor in motor vehicle crashes that resulted in 93 deaths, 454 serious injuries and 1,331 minor injuries.¹⁷

Since 2009, in New Zealand, the rate of reported motor vehicle crashes associated with alcohol (either the driver or other road users) has reduced significantly within Canterbury – shown in Figure Two below.¹⁸



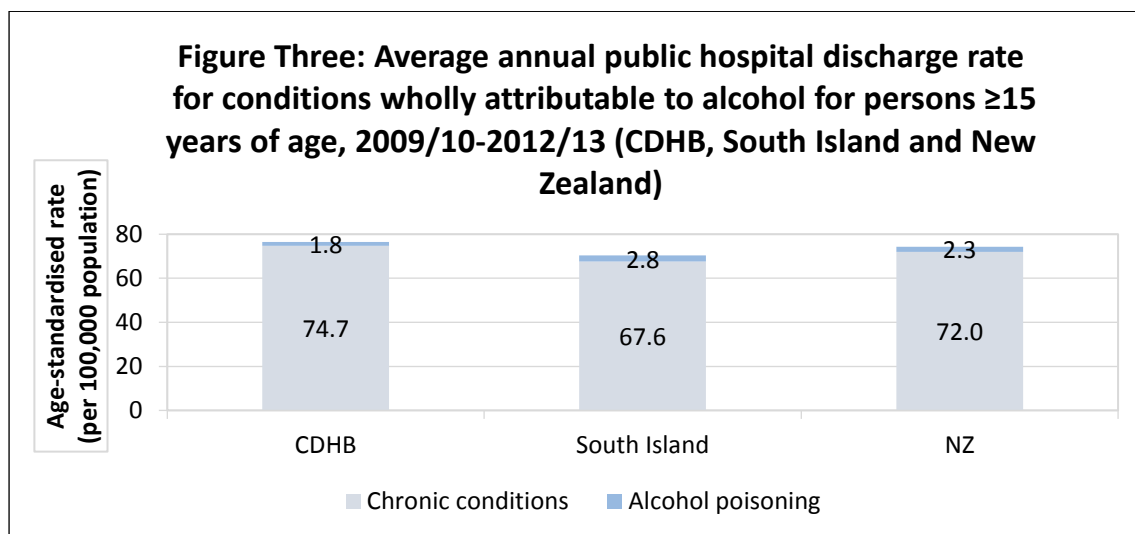
Source: Alcohol Harm Reduction Indicators, Canterbury District Health Board 2014

Alcohol-related injuries and illness are a large burden on hospitals around the country. Nationally, one in four (25%) patients who present to Emergency Departments (ED) do so as a result of the harmful use of alcohol.¹⁹ In Christchurch, the rate is even higher, with more than one in three (37%) patients presenting to ED as a result of the harmful use of alcohol.²⁰ Christchurch Hospital ED continues to collect data on alcohol-related ED presentations. From July 2017 the Ministry of Health will require all DHBs to report on the number of alcohol-associated presentations to hospital. This will help improve the accuracy of local and national data.²¹

Another way of monitoring the harm from alcohol is through the rate of public hospital discharges for conditions wholly attributable to alcohol. Such conditions include alcoholic liver disease, alcoholic cardiomyopathy, mental and behavioural disorders due to alcohol, chronic pancreatitis and degeneration of the nervous system caused by alcohol.²² Between 2009 and 2013, the rate of discharges for wholly attributable conditions, both nationally and locally, did not significantly change.²³ The CDHB rate of public hospital discharges for chronic conditions



wholly attributable to alcohol is similar to the national rate, but significantly higher than the South Island rate (Figure Three).²⁴



Source: Alcohol Harm Reduction Indicators, Canterbury District Health Board 2014

Many people do not know that alcohol causes cancer – see Figure Four. Internationally, approximately 6% of all cancers can be attributed to alcohol.²⁵ In New Zealand, cancer deaths make up almost one third of all deaths from alcohol-related causes.²⁶ In particular, breast cancer is the leading cause of alcohol-related death for women.²⁷

Figure Four: Common cancers linked to drinking alcohol



Source: Cancer Society NZ



In 2011, within the Canterbury DHB, it was estimated that the direct costs of alcohol attributable cases cost the hospital system \$27.4 million.²⁸ This is likely to be an underestimate as the number of alcohol-related admissions is now much higher than what the original estimate was based upon.²⁹ Across all sectors, alcohol abuse has been estimated to cost the country \$4.9 billion.³⁰

Data limitations

Where possible the most recent data on alcohol has been obtained. While the New Zealand Health Survey is a robust source of information and is carried out annually, only two indicators relating to alcohol were reported on for the 2015/16 year. These are past-year drinkers and hazardous drinkers.

Impact on inequalities

Alcohol has been identified as a driver of inequalities.³¹ An example of this is alcohol outlets, which are more heavily concentrated in socially deprived areas.^{32 33}
³⁴ People living in these areas are more likely to have harmful drinking patterns and to suffer alcohol-related harms.^{35 36}

Globally, it is recognised that alcohol is a major contributor to health inequalities and one that can be influenced by public policy.³⁷ For example, according to a recent international meta-analysis, those with a lower socioeconomic status may be up to twice as likely to die from alcohol-attributable causes compared with all causes.³⁸

Within New Zealand, alcohol contributes to maintaining inequalities in disadvantaged populations. Alcohol-related deaths are two and a half times as high among Māori as non-Māori.³⁹ There is some disparity between Māori and non-Māori in drinking patterns, with Māori also reported to have disproportionate rates of hazardous drinking.⁴⁰ It is interesting to note that alcohol was introduced to Māori via European colonisation. For decades following its introduction, many Māori resisted its spread amongst their communities.⁴¹

In New Zealand, there are different patterns of drinking according to social deprivation. For example, those who live in less deprived areas tend to drink more frequently.⁴² However, they are less likely to drink enough to feel drunk.⁴³ By comparison, people who live in more deprived areas drink less frequently, but are nearly twice as likely to get drunk when they drink.⁴⁴ That is, “people living in the most deprived areas drink alcohol less frequently but become intoxicated more often”.⁴⁵



Similarly, more alcohol-related harm is reported in the most deprived areas of New Zealand.⁴⁶ In particular, in 2012/13, the prevalence of alcohol-related injuries was higher amongst those living in the most deprived areas (6.2%) compared with those living in the least deprived areas (2.4%).⁴⁷

Solutions

In 2012, the Sale and Supply of Alcohol Act replaced the Sale of Liquor Act 1989, with a greater emphasis on the “safe and responsible sale, supply, and consumption of alcohol and the minimisation of harm caused by its excessive or inappropriate use.”⁴⁸ This includes the provision for local councils to adopt Local Alcohol Policies (LAP), giving local communities more input into the location and density of alcohol outlets and conditions around trading. In 2013, the Christchurch City Council (CCC) developed a provisional LAP.⁴⁹

Following submissions, the LAP was amended and publicly notified in mid-2015. Appeals to the LAP were subsequently lodged to the Alcohol Regulatory and Licensing Authority (ARLA); following the resolution of these appeals, the CCC will be able to adopt the LAP for Christchurch City. Whilst the aim of the Act and of the LAPs was to increase community input into decision-making around alcohol, a recent review of LAPs suggests this is yet to be achieved.⁵⁰

Partnerships between various relevant authorities, including local government, police, health authorities, educational institutions, community leaders and those who supply alcohol can help to reduce alcohol-related harm. One local initiative arising from such partnerships is the “Good One” party register, a campaign that encourages university students to register their party with the police.⁵¹ Where partnerships include an agreement between parties to work together to solve alcohol-related problems, they are known as Alcohol Accords.⁵² These aim “to promote safe alcohol use and minimise alcohol-related harm.”⁵³

In 2012, the Canterbury District Health Board agreed to advocate for the following evidence-based solutions to reduce alcohol-related harm:

1. Raise alcohol prices
2. Raise the alcohol purchase age (from 18 years to 20 years)
3. Reduce alcohol accessibility (restricting the hours of sale, the range of alcohol outlets and the number of alcohol outlets within a given area)
4. Reduce marketing and advertising of alcohol
5. Reduce legal blood-alcohol limits for drivers⁵⁴

Since then, the government has passed legislation reducing blood-alcohol limits for drivers (aged 20 years and over) from 80mg/100ml to 50mg/100ml. For drivers under 20 years of age, the limit remains at zero.⁵⁵ In 2012, the Sale and Supply of Alcohol Act restricted the promotion and display of alcohol in supermarkets and introduced maximum trading hours.^{56 57}



The CDHB is developing an alcohol-related harm reduction strategy. This will identify goals and actions to prevent and address the impact of alcohol-related harm on the health system. This strategy will align with the Christchurch City Alcohol Action Plan, which is a collaborative initiative led by the CCC, Police and the CDHB. Both the Christchurch City Alcohol Action Plan and the CDHB alcohol-related harm reduction strategy are expected to be complete by the end of 2017.

Connections with other issues

Cancer, Mental Health, Smoking, Gambling, Antisocial Behaviour.

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