WHO - Process to update the 'set of best buys and other recommended interventions for the prevention and control of NCDs' (also known as the Updated Appendix 3 of the WHO Global NCD Action Plan)

Comments from the New Zealand Ministry of Health

Appendix 3 with regard to its discussion of: Reducing the Harmful Effects of Alcohol, Best Buys and Other Recommended Interventions:

1. The references to 'young people' should enable an expansive focus – such as on 15 to 25/29-year-olds. Up until the age of 25, young people can experience impaired development from alcohol consumption. In addition, young people in the 18 to 24 bracket are the highest consumers of alcohol in New Zealand (and probably in many other States) – at 34.9 percent (*Annual Update of Key Results: 2020/21: New Zealand Health Survey*). However, the prevalence of hazardous drinking was also high in those aged 25–34 (23.9 percent) and, of those aged 15–17 years, 10.2 percent had engaged in hazardous drinking in the year before taking part in the survey. This suggests 'young people' should have a wide age-span in the revised Appendix.

2. The emphasis throughout Appendix 3 on 'reducing the harmful use of alcohol' carries the possible implication that there is a guaranteed, safe level of alcohol use. The evidence suggests there is no guaranteed, safe level or mode of consumption and for certain population groups, the safe course is to refrain from drinking any alcohol (eg, pregnant and breast feeding women). Instead the Appendix could refer to 'reducing the use of alcohol which will have the effect of reducing its harmful effects.'

3. Restrictions on physical availability of retailed alcohol: In addition to reducing the physical availability of alcohol by reduced hours of sale, there are other important ways to reduce availability – some of which should be put on an equivalent footing to reduced hours of sale. These include:

    (a) reducing early hours of the morning sales of alcohol – which has been associated with increased violence and consumption;
    (b) restricting the availability of high strength alcohol at particular events;
    (c) reducing on line sales and deliveries, which has been associated with over consumption and regarding which there may be no guarantee that young people under the adult drinking age will not be the consumers;
    (d) reducing the number of alcohol outlets which are licensed and also those types of outlet most associated with alcohol related harms. In New Zealand these outlets include: off-licence bottle stores, supermarkets, groceries; special licence large scale events or those which are child or young person oriented; licences in high risk areas /radii of harm.
    (e) reducing outlet density in districts;
    (f) reducing their location in neighbourhoods where the impacts of alcohol consumption are experienced inequitably (eg, in New Zealand, where a significant proportion of Māori, Pacific peoples live and people living in high deprivation areas generally);
    (g) reducing outlets in areas from which there emanates a radius of harm (eg, Wellington entertainment precint on Friday and Saturday nights);
    (h) reducing their proximity to, for example, schools, tertiary education institutions, addiction treatment services, probation and other offender management services (for example); and

(i) reducing exposure to alcohol and its normalising effect -such as through restrictions on displays at points of sale and reducing visibility /access to alcohol areas in outlets which sell other products as well as alcohol.

4. In addition to restricting or banning alcohol beverage promotions regarding sponsorships and activities targeting young people, reference should also be made to:
   (a) Avoiding marketing which targets other high need populations (eg, people living in high deprivation areas or people who are mentally ill and addicted);
   (b) restricting digital marketing and social influencing - ways of promoting alcohol which young consumers increasingly participate in
   (c) restricting alcohol marketing in gaming – which activity is becoming increasingly popular.

5. It may be beneficial to clarify the World Health Organization's approach to low or zero alcohol products and their promotion in Appendix 3. On the one hand, industry should be encouraged to produce a wider range of these products as a viable alternative to higher alcohol content products. On the other, care is needed to prevent association with alcohol branding, potentially indirectly encouraging alcohol use. For this reason equivalent marketing restrictions should apply to them. In 2021, approximately 47 percent of New Zealanders consumed low alcohol products. (Alcohol Beverages Industry, NZIER Report to the Alcohol Beverages Industry, 2022). It is unclear to what extent the products were a complete alternative to alcohol products or were consumed in addition to them.

6. Another initiative which may be effective is to encourage industry to focus on quality of product over quantity. This could be framed up a complementary to minimum pricing and higher alcohol taxes and duties.

7. Providing consumer information about the harm related to alcohol: Health literacy initiatives should be given more prominence, avoiding deficit speak or stigmatizing language in identifying particularly high need populations who experience disproportionate alcohol harms. Many New Zealanders are unaware that alcohol consumption (even within the low risk drinking advice) contribute to at least seven forms of cancer (eg, two of the most common cancers in New Zealand are bowel cancer and breast cancer.) Alcohol was the cause of an estimated 950 new cancer cases in 2020 and over 640 cancer deaths in 2021 in New Zealand. (Te Aho O Te Kahu/ Cancer Control Agency, *Pūrongo Ārai Mate Pukupuku: Cancer Prevention Report*).

   In New Zealand, other health conditions alcohol causes or contributes to include cardiovascular disease, fetal alcohol spectrum disorder, miscarriage or still birth, mental illness, self-harm and suicide. Therefore, greater community awareness is needed, through the provision of information. This includes information about the contribution alcohol makes to other health and social problems - eg, acute hospital admissions, domestic violence, homicide and other crime, motor-vehicle accidents and drowning. Because of its high energy content alcohol can contribute to weight gain and obesity – but this is not widely understood.

8. Strengthening the knowledge base and improved monitoring and surveillance systems: Specific examples could include: monitoring the extent and modes of alcohol sales and marketing and of growing alcohol markets and outlets; assessing the extent of likely harms; and further exploring the linkages between alcohol and overweight, and the links between alcohol marketing targeting particular population groups and alcohol harms experienced in those populations.

9. Appropriate minimum age for consumption: New Zealand does not have a legislated minimum drinking age and reform initiatives tend to focus on the age and context in which young people can purchase alcohol (currently 18-year-of-age) and age-based drink-driving prohibitions. Much exposure to alcohol comes to many New Zealanders in a family or peer group context, well before the authorised age of purchase. Although the legal age for purchasing alcohol in New Zealand is 18 years old, 59.3% of those aged 15–17 years drank alcohol in the past year (*NZ Health Survey, Annual Update 2020/21*). Concerningly, this rate has not changed significantly since 2011/12. More information is needed on jurisdictions which have imposed a minimum drinking age and to what extent their particular cultural and religious mores may impede or reinforce such restrictions.

10. In many jurisdictions, indigenous peoples and some cultural minorities experience disproportionate alcohol harms. In 2020, Māori were 1.7 times as likely to be hazardous drinkers and Pacific people were 1.3 times as likely to be hazardous drinkers than their non-Māori and non-Pacific counterparts, after adjusting for age and gender (*NZ Health Survey, Annual Update 2020/21*). Appendix 3 should recognise this trend and suggest measures which seek to address this inequity and its intergenerational effects (eg, special support to ensure indigenous communities voices are heard in alcohol licensing processes and decision-making; supporting and investing in harm minimisation initiatives developed by indigenous populations). This latter example is one of the initiatives identified by Te Hiringa Hauora/the Health Promotion Agency in its *National Alcohol Harm Minimisation Framework*. A link to the Framework is attached for information purposes:
    National Alcohol Harm Minimisation Framework | Te Hiringa Hauora/Health Promotion Agency (hpa.org.nz)

11. Appendix 3 (or a separate document) could include and counteract instances of misinformation about alcohol consumption and alcohol harms (eg, that a per capita reduction in alcohol consumption by people 15 and over means that there is little need for tighter alcohol regulation; or if a product is made in a carbon neutral/climate friendly way or is low in preservatives or calories or provides jobs this negates the very real harm individuals, whanau and communities experience from it).

12. Finally, prominence should be given to alternatives to alcohol related sport and cultural event sponsorship. In New Zealand tobacco sponsorship was prohibited by legislation in 1990 and replaced with Health Sponsorship Council funding. However, there are no equivalent restrictions for alcohol sponsorship. Sports and culture attract large segments of the population, including the young. Constant visibility of alcohol branding on uniforms, hoardings, score boards and promotions has the effect of further normalising alcohol and convincing populations that is an integral to sporting and social success. Therefore, a revised Appendix 3 which explores experiences with implementing bans and restrictions in various jurisdictions and contexts would be very useful.

Nutrition and Physical Activity Content:

Objectives 1 and 2: supported, including the enabling actions noting New Zealand's current position on taxation

Objective 3: strongly supported, including the enabling actions on unhealthy diet and physical activity. It is positive to see reformulation policies for healthy food and beverage products identified as a specific intervention through WHO-CHOICE analysis. New Zealand has introduced (with Australia) Front of Pack Labelling and the Ministry for Primary Industries is leading work

on menu labelling, but we have some way to go to implement the other identified interventions. It is also positive to see brief interventions in primary care for physical activity identified.

Objective 4: strongly supported. There is no content in this area that we disagree with or would like to see alternative wording for.