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"Submission on the new National Drug Policy for New Zealand"

This submission is from
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Preamble

The Cancer Society of New Zealand is a non-profit organisation which aims to minimise the incidence and impact of cancer on all those living in New Zealand. We work across the Cancer Continuum (2003, New Zealand Cancer Control Strategy, MoH) with key work streams that include, provision of Supportive Care, Information, Funding of Research and Health Promotion (www.cancernz.org.nz).

In the context of the National Drug policy we are primarily concerned with and will focus our submission on, the reduction of harm and increased cancer risk caused by Tobacco and Alcohol. We thank you for the opportunity to respond to your discussion paper. We have not specifically answered each question but rather addressed the headings and discussion points in the body of the document. We would like to be part of the consultation process of the draft policy which results from this submission process.[1]

Tobacco

Tobacco is the only consumer product that kills its consumers when used as the manufacturer intended. Recognising that there are cancer risks linked with using too much of certain consumer products, the Cancer Society notes that smoking is unique because it is addictive, toxic, carcinogenic, and lethal to half of its long-term users.

Tobacco industry products are not regulated like other consumer products and historically they have been exempt from food and drug legislation, consumer product safety legislation and hazardous product legislation. **Note:** references for the evidence below can be supplied if required.

Effects on Health

- Tobacco use is responsible for the death of one in ten of all adults worldwide. Globally, 1.3 billion people smoke. Each year tobacco causes five million premature deaths. By 2020 this is projected to rise to 10 million deaths.
- Tobacco use is responsible for about 25% of cancer deaths in Aotearoa New Zealand.
- Smoking is responsible for the deaths of 5,000 New Zealanders each year (4,700 smokers and 300 from second-hand smoke).
- Tobacco-related costs to the health system are estimated to be about $1.7 billion per year (about 1.1% of GDP).
- On average, smokers lose 15 years of life.

Effects on Populations

- Half of the people who smoke today and continue smoking will eventually be killed by tobacco. Half of them will die in middle age.
- Lung cancer was the most common cancer death in 2010, accounting for 19.2% of all deaths from cancer.
- Tobacco plays a significant role in health inequalities within Aotearoa New Zealand with higher smoking prevalence seen among low-income groups, Māori and Pacific peoples.
- Smoking among young people in Aotearoa New Zealand is declining; however, one in ten young people currently smoke.

Second-hand Smoke

- Around 300 New Zealanders die each year because of exposure to other people's tobacco smoke. This makes second-hand smoke the leading environmental cause of death in this country.
- Children who breathe second-hand smoke are admitted to hospital more often compared with children who do not, and second-hand smoke causes a range of health problems in children, including asthma and infection.

[1] References for the evidence will be supplied if required.

We therefore recommend that throughout New Zealand's Drug Policy documentation any abbreviation of the list of drugs includes and prioritises tobacco explicitly, eg. '***tobacco, alcohol and other drugs'***.

Alcohol

We consider that the information provided aknowledges alcohol appropriately. However many people are unaware of the carconogenic properties of alcohol and the risk of drinking alcohol in relation to increasing their risk of cancer.

- Alcohol is responsible for 4% of global mortality each year. This equated to 2.3 million deaths in the year 2008.
- Over half of these deaths were from non-communicable diseases including cardiovascular disease (22%) and cancers (20%). Non-communicable disease is now the leading cause of death worldwide.
- Alcohol use is widespread in New Zealand. Over half the population aged 16-64 years consumes alcohol at least weekly and 15% percent of adults aged 15 years and over drink in a way that is hazardous to their health. This pattern of hazardous drinking is higher among men (22%) than among women (9%).
- The volume of alcohol consumed over one's lifetime, even if consumed in moderation, contributes to the risk of developing cancer.
- Public health researchers have stated that "reducing alcohol consumption is an important and under-emphasised cancer prevention strategy".
- In New Zealand in 2007, among those aged less than 80 years, 242 cancer deaths were attributable to alcohol consumption. This equated to 4% of all cancer deaths recorded in this age group for that year.

Evidence linking alcohol and cancer

Alcoholic beverages have been classified as a Group 1 carcinogen by the World Health Organisation's International Agency for Research on Cancer (IARC) since 1988.[4] This is the highest rating applied to substances that directly cause cancer, indicating that the link between alcohol and cancer in humans is underpinned by strong scientific evidence.

A comprehensive review of the scientific literature examining cancer and its association with food, nutrition and physical activity was jointly published in 2007 by the World Cancer Research Fund (WCRF) and American Institute for Cancer Research (AICR). The review panel consisted of 21 international experts in the fields of nutrition, cancer research, physical activity, biochemistry, epidemiology, statistics, public health and public policy. They concluded that there was *convincing* scientific evidence that alcohol consumption increased the risk of cancers of the breast (female), colorectum (in males), oral cavity, pharynx, larynx and oesophagus. The panel also stated that alcohol *probably* increases the risk of liver and bowel (in females) cancer. *Convincing* and *probable* are the two highest categories applied by the WCRF and AICR when describing the empirical basis for causal relationships in cancer.

The IARC conducted a subsequent review in 2009. This was undertaken by 30 global experts in the fields of cancer research, epidemiology and public health. The group's findings were congruent with those in the WCRF report with the exception that there was *sufficient* evidence to conclude alcohol consumption increases the risk of liver cancer.

Feedback on your discussion document

A new policy, a new direction

Tobacco, Alcohol & other drugs is our suggested new title.
We also consider that the full phrase: tobacco, alcohol, and other drugs is used throughout any documentation as otherwise the harm caused by tobacco is diminished.

We were concerned to see the brevity of the section in the discussion paper on Tobacco in both the purpose section and the *Alcohol and drug* use section.

A revised view of 'harm'

We support clause 15 which expresses the desire to expand the definition of harm to put a greater emphasis on the impact of tobacco, alcohol and other drugs for people beyond consumer/user themselves. The Cancer Society has a priority focus on preventing children's exposure to tobacco, in the interests of protecting them not only from harm caused by second-hand tobacco smoke, but also from uptake of tobacco in the future. We strongly urge you to place protection of children at the centre of an expanded definition of harm inside New Zealand's Drug Policy.

Keeping what works and making it better

We consider it important that all three sections of the current 'three pillars' are worked on at the same time. Our experience and contribution to the National Smoke Free Working Group's (NSFWG) Action plan suggests that to make a significant difference, ***Cessation*** (in your model **problem limitation**), ***Regulation and Legislation*** (in your model **supply control**) and ***Public support, including preventing initiation*** (in your model **demand reduction**) are required. The key is in the planning, the commitment to a goal then action by all persons and organisations that work in that specific sector. We invite other sectors to use the model the Tobacco Control sector has developed to address their specific areas of focus.

Outcomes and action plans

The Smokefree National Action Plan (attached with this submission as a separate document) is an example of how to put the three pillars into action. The Action Plan document started with the development of the logic model and was developed after comprehensive consultation with the tobacco control sector in New Zealand. It outlines the roles and priorities for action within the first phase of a strategic plan with the goal of Smokefree Aotearoa New Zealand 2025.

We consider there is an urgent need for a plan of action to address alcohol. We have the evidence of the harm and what it will take to effectively address alcohol over consumption. A focus on the addicted individual by itself is not useful and we strongly recommend any planning must include effective regualtion and legislation such as that outlined in our submissions to the Law commission in 2011 in which we supported many of the recommendations made by the Law Commission and the solutions proposed by Alcohol Action NZ. (See Appendix A)

Measuring results

We support clause 22 which states "we think we'll need performance measures and targets so we can know if our new approach is working". There are three tobacco control measures: prevalence, consumption and uptake. These measurements are outcomes-focused and their monitoring is already regular. We suggest this approach is followed for alcohol.

Looking to the future

We are aware that many off shore companies including the tobacco industry are investing in the growth industry of e-cigarettes. We are also aware that without clear evidence that shows these products are safe to use and significantly effective as a cessation device we cannot promote their use among New Zealanders who smoke.

Until policy is developed that regulates the sale and use of e-cigarettes the Cancer Society does not support their use. We are also concerned that e-cigarettes will encourage young people to use them as a precursor to tobacco and therefore continue to normalise smoking.

Also, if and when in the future there is clear evidence showing e-cigarettes' efficacy for cessation, and policy that permits their use as a cessation tool in New Zealand, it is critical that tobacco industry owned e-cigarette products containing nicotine be blocked from registration as a Medicine, in compliance with the World Health Organisation's Framework Convention guidelines

We are also aware that new methods of selling alcohol, especially to young people are and will continue to provide challenges in terms of supporting safe drinking and harm minimalisation. These ongoing challenges can be controlled by a comprehensive plan of action for alcohol that includes regulation and legislaiton as well as reducing initiation and effective treatments for those affected.

Once again we thank you for this opportunity and look forward to seeing a comprehensive National drug policy that is inclusive of all harmful substances that have an impact on the health of New Zealanders

Yours Sincerely

Dr Jan Pearson
Deputy Chief Executive and Health promotion Manager
28 February 2014

Appendix A- Except from the Cancer Society Submission to the Law Commission 2011

We consider the most important legislation that it required is the restriction of marketing and advertising.

As with the measures that were required to tackle Tobacco use in New Zealand it is essential that the aggressive marketing of alcohol, including sponsorship of sporting and cultural events is diminished. Other measures we consider are needed are:

- Marketing of alcohol at youth must be explicitly prohibited in all forms including sponsorship, the internet, all other electronic forms of communication and by clubs and pubs in games and deals that incentivise alcohol drinking.
- No alcohol promotion permitted through television, radio, cinema, billboard or internet advertising
- Limited advertising in printed media permitted only for messages that provide information directly related to the product rather than 'selling' values or lifestyle

We also consider it essential that the price of alcohol is addressed to reduce accessibility, especially to youth. Towards this end the bill needs to include:

- The Introduction of a minimum price per unit of alcohol. The aim is to ensure alcohol can no longer be used as a 'loss leader' to attract customers and provide low cost products. This action would also bring the Ready to Drink (RTD) products aimed to introduce youth to alcohol though a vehicle that tastes like a non-alcoholic beverage into a higher and less accessible price bracket for the target market.
- Increase the current level of excise tax on alcohol. Primarily to compensate for the harm and cost to New Zealand tax payer.

We support the attempt to alter the growing acceptability of a culture of youth initiation to heavy alcohol use by supporting improved parental supervision and to restore the minimum age for purchasing alcohol from any licensed premises to 20 years. While this will probably mean those younger than 20 will access alcohol current legislation supports very young and therefore more vulnerable, teenagers to be able to purchase and consume alcohol with little restriction.

We further consider that currently alcohol is accessible at too many retail outlets which supports a culture of impulse drinking leading to heavy alcohol use. We therefore consider the bill needs to return supermarkets as well as convenience stores to being alcohol free.

We further consider all local bodies should be required to develop local liquor plans in consultation with local communities, without the undue influence of liquor licence holders, with the aim of restricting the number and location of retail outlets and limiting licensed premises.

We consider the only way to effectively monitor restrictions on sales of alcohol is to limit the availability of the product. Reducing the number of premises that are able to sell alcohol will also reduce the advertising of branded product.

We also consider that the hours of alcohol sales outlets need to be restricted as follows:

o Restrict the opening hours of all off-licenses on a nationwide basis from 10am to 10pm
o Restrict on-license premises from selling alcohol after 1am on a nationwide basis
o Provide for a standing extension to serve alcohol until 3am if the premises operates a one-way door policy whereby patrons can remain on the premises, but new patrons cannot enter the premises after 1am

Other restrictions that we consider essential to reduction of harm and work to change the drinking culture are to increase drink-driving counter-measures by lowering the Blood Alcohol Level limit from 0.08 to 0.05 for those 20 years and over and lowering the Blood Alcohol Level limit to zero for those under 20 years.

It is acknowledged that there is currently a culture of drinking that will be difficult to change and will require:

- education to ensure awareness is raised of the widespread risk of heavy alcohol use and how it is portrayed as a desirable part of youth culture.
- general awareness raising about the toxicity of alcohol, for example warning labels on products.
- media action to reduce the number of stories of youth drinking that advertise excessive alcohol and result in glorifying resulting injuries and death. A change to positive non-alcohol smoke free life styles that includes sport and other activity is one image that the media should be encouraged to portray.
- Tertiary Education institutional action to change the culture of attracting students to an environment of drinking rather than learning.
- parental support to think and take action on what they are doing as role models, suppliers and supporters of a culture that leads to harm rather than being safe for their children.

  The responsibility of changing New Zealand Society will need to be led by a strong government willing to change legislation that will impact on business in the interests of public health.

  Alcohol needs to be treated in the same way as Tobacco Control with a focus on youth initiation initiatives to reduce the numbers of young people starting the habit. Support for those that want to quit harmful alcohol abuse will need to include appropriate health services to ensure those that have alcohol addictions are able to change behaviours that are harmful and costly to themselves and New Zealand Society.

Yours Sincerely

Jan Pearson, 28 February 2014