Independent Review of the Alcohol Levy

Stage 2

12 March 2024

ALLEN + CLARKE

Contents

Allen + Clarke would like to thank all the participants who engaged with us over the course of this project. This review could not have happened without those who shared their thoughts, frustrations, and aspirations with the *Allen + Clarke* team.

The *Allen + Clarke* team were also well supported by Sarah, Tim, and Josiah as expert advisors; your knowledge and insights are deeply appreciated.

Overview of this report

Context

1. *Allen + Clarke* and the New Zealand Institute of Economic Research (NZIER) were commissioned by the Ministry of Health in February 2023 to undertake a review of the levy imposed, pursuant to the Pae Ora (Health Futures) Act 2022 (the Pae Ora Act), on alcohol products available for sale in New Zealand and to undertake a study to consider the cost of alcohol-related harm to New Zealand.[1]

2. All alcohol produced or imported for sale in New Zealand must pay the following:

    - Excise duties on alcohol that is manufactured in or imported into New Zealand (collectively excise tax). Excise tax is collected by the New Zealand Customs Service and becomes part of general Crown revenue (which means that it becomes part of the Government's income alongside other revenue streams). Usually, excise tax is adjusted for inflation on an annual basis, however this is not an automatic process and must be approved by Order in Council.
    - A levy on alcohol that is manufactured in or imported into New Zealand (the alcohol levy). The alcohol levy is hypothecated, which means that the revenue generated by the levy must be used for a specific purpose – in this case to enable the Ministry of Health | Manatū Hauora to recover costs it incurs in addressing alcohol-related harm and in its other alcohol-related activities. This levy is set annually by Cabinet via Order in Council.

3. While the excise tax is a revenue collection mechanism for the Government, the alcohol levy is a cost-recovery mechanism that allows the Ministry of Health (and formerly allowed the Health Promotion Agency | Te Hiringa Hauora) to collect revenue to cover the costs of activities undertaken to address alcohol-related harm. The aggregate expenditure figure that would be reasonable for the Ministry of Health to spend in a year is determined by the Minister of Health, with the concurrence of the Minister of Finance. The Minister of Health then must determine the aggregate alcohol levy, and then as amounts payable on each class of alcohol in order to yield an amount equivalent to the aggregate levy figure.

4. This report presents the findings from an independent review of the alcohol levy. The review was prompted by legislative changes to, and organisational changes within, the

[1] This review was commissioned and conducted prior to the introduction of the Pae Ora (Disestablishment of Māori Health Authority) Amendment Bill to Parliament. At the time this report was finalised, the Pae Ora (Disestablishment of Māori Health Authority) Amendment Bill had received Royal Assent. *Allen + Clarke* understands that, when the Pae Ora (Disestablishment of Māori Health Authority) Amendment Act enters into force, the functions and responsibilities of Te Aka Whai Ora will be transferred to the Ministry of Health and Health New Zealand. The discussion, findings, and recommendations in this report that relate to Te Aka Whai Ora should be read with this context in mind.

health system. These changes have created a new context for the alcohol levy and have changed its function within the health system.

The levy over time

5. In 1978, the alcohol levy was created to fund the Alcoholic Liquor Advisory Council (ALAC), which had a mandate to encourage and promote moderation in the use of alcohol. In 2012, the functions of ALAC were transferred to the Health Promotion Agency | Te Hiringa Hauora.

6. The Pae Ora Act came into force in July 2022 and reformed the health system in New Zealand. The Pae Ora Act established Health New Zealand | Te Whatu Ora and the Māori Health Authority | Te Aka Whai Ora. The Health Promotion Agency was disestablished, and its staff became part of the National Public Health Service within Health New Zealand. Prior to being disestablished, the Health Promotion Agency was a separate Crown entity with its own budget, and had specific, and limited, functions in relation to health promotion and prevention.

7. From 2012 until the Pae Ora Act came into force, the alcohol levy had been raised for the purpose of recovering only the costs incurred by the Health Promotion Agency in addressing alcohol-related harm and its other alcohol-related activities.

8. Under the new structure of the health system, the Ministry of Health can allocate levy funding via agreements to Health New Zealand and Te Aka Whai Ora for the commissioning of alcohol harm reduction services and programmes. This means, the cost-recovery mechanism can extend to activities undertaken by all three health entities.

9. The alcohol levy has not materially changed (in aggregate nominal dollars) in 11 years. It has not been adjusted for inflation or increased based on population growth (given higher population generally indicates more activities required). The total levy fund for 2023/24[2] is $11.5m (accounting for between 0.2 and 1.3 percent of the price of alcoholic beverages).

10. By comparison, the alcohol excise tax accounts for between 20.7 and 55.9 percent of the price of alcoholic beverages.

11. Between 2012 and 2022, the total levy amount was allocated to the Health Promotion Agency. Under the new system, for the 2022/23 financial year $980,000 was allocated to the Ministry of Health (Public Health Agency) and the balance $10.52m to Health New Zealand (Health Promotion Directorate). For the 2023/24 financial year, $980,000 is allocated to the Ministry of Health (Public Health Agency), $8.52m is allocated to

[2] This report refers to the "levy fund" for ease of comprehension. Technically, under the Pae Ora Act, there is relevant approved expenditure for the Ministry of Health for the year which can be allocated between the health entities for utilisation, and alcohol levies are collected throughout the year to recover the cost of that approved expenditure.

Health New Zealand (Health Promotion Directorate), and $2 million is allocated to Te Aka Whai Ora.

The purpose of the review

12. The Pae Ora Act changed the scope and context of the alcohol levy. Section 101 of the Pae Ora Act provides that a levy may be imposed for the purpose of enabling the Ministry of Health to recover costs it incurs in addressing alcohol-related harm and in its other alcohol-related activities. The Ministry of Health has a broader role in providing services that address alcohol related harm than the Health Promotion Agency did. This means that there are now potentially more services designed to address alcohol related harm that could be recovered via the alcohol levy.

13. The Pae Ora Act also places significant emphasis on the Crown's obligation to uphold Te Tiriti o Waitangi (Te Tiriti). Under section 6 of the Pae Ora Act, the Minister of Health and the health entities (the Ministry on Health, Health New Zealand, and Te Aka Whai Ora) must do certain things to give effect to the principles of Te Tiriti. Section 7 of the Act specifies the health sector principles, which the Minister of Health and the health entities must, so far as reasonably practicable, be guided by. This includes that Māori aspirations are included and that Māori are involved in decision-making about the alcohol levy. This is particularly important since Māori experience inequitable and disproportionate alcohol related harm.

14. The review was designed to enable assessment of the current state of alcohol harm and alcohol levy expenditure (levy funding applied to programmes and services designed to reduce alcohol-related harms), with a particular view to:

    - consider the history and current state of the alcohol levy in New Zealand
    - understand the costs associated with alcohol-related harm in New Zealand, including specifically the burden of these costs on the health sector, and
    - understand participants' views on the impact of levy expenditure and levy funded activities, particularly Māori and Pacific participants (given the disproportionate impact of alcohol related harm on these populations).

15. The review was also designed to enable consideration of the potential future state of the levy, including through:

    - understanding participants' views on the potential future state of the alcohol levy, and
    - considering how any proposed changes in relation to the alcohol levy may contribute to equitable health outcomes, especially for Māori, and align with wider health system priorities.

16. The scope of the review was limited to assessing and considering activities that are, or that could potentially be, funded by the levy rather than taking a system-level view of all activities funded to address alcohol harm. However, it is important to note that alcohol-related harm contributes significantly to the burden of health sector costs.

Alcohol-harm related Vote Health costs include for example, contracts with alcohol harm reduction advocacy and service providers; specialist mental health and addiction treatment services; and national services for fetal alcohol spectrum disorder (FASD) diagnosis and other support services provided through Health New Zealand.

17. The review was undertaken in two stages, which are described below.

Stage 1

18. Stage 1 was undertaken during February and March 2023 as a rapid review of current state, designed to inform the levy setting for the 2023/24 financial year.

19. The Stage 1 review found that the cost of alcohol-related harms was substantial and that the gulf between the costs of alcohol-related harm to the health sector and the quantum of the alcohol levy was significant. The Stage 1 review found that this gulf could suggest that the existing levy fund is insufficient, and/or the scale of activities and programmes being funded by the alcohol levy are having limited impact on the level of harm. However, the Stage 1 review did not find any evidence to suggest a relationship between the cost of harm and the cost of addressing harm. i.e., the cost of harm does not appear to indicate the level of investment required to address that harm.

20. The Stage 1 report recommended that existing funding levels, and existing recipients of that funding, be maintained for 2023/24 and that no commitments to continuing levy funding be made beyond June 2024. A full copy of the Stage 1 report is available here: **https://www.health.govt.nz/publication/independent-review-alcohol-levy-stage-1-rapid-review**.

Stage 2

21. Stage 2 of the review is made up of this report (the *Allen + Clarke* Report) and the NZIER Report.

NZIER Report

22. The NZIER report was completed as a separate workstream. The primary objective of the NZIER report was to support the Ministry of Health in its consideration of future investment opportunities, specifically:

    - to gain a better understanding of the nature and scale of harms that could be addressed through programmes and services funded by the alcohol levy, and
    - to contribute (along with other evidence, including cost-effectiveness evidence) to the prioritisation of interventions, both within the health sector and by other agencies and organisations.

23. A secondary objective was to offer information that could potentially be used to inform a wide range of policy decisions, including decisions about data collection and research.

24. Many previous and overseas reports on the costs of alcohol harms have sought to identify the net costs of alcohol-related harm, with the objective of informing the design of a corrective tax. A net costs approach takes into account all benefits and costs associated with alcohol. However, the alcohol levy is a cost-recovery instrument, not a corrective tax. Revenue raised by the levy funds services and programmes that address alcohol harms, irrespective of any apparent benefits. This called for a focus on harms and their costs only.

25. The NZIER report estimates that the current costs of harms associated with alcohol use in New Zealand amount to approximately $9.1 billion. The NZIER report notes that there is considerable uncertainty regarding this cost estimate with potential overestimation as well as significant gaps in the current evidence base, preventing all costs of alcohol-related harm in New Zealand from being estimated. It recommends consideration should be given to using some levy funding to fill those research gaps.

26. As the NZIER report highlights "….*while the level of certainty is not high for many of the estimates in this report, this is not an indication of low certainty of harm, but rather low certainty regarding the accuracy of cost estimates. In many cases, the true cost of alcohol harms may be considerably higher than existing evidence can show*".

27. The estimate of the cost of harms provides a starting point for discussion about the level of services that can be justified to address alcohol related harms in New Zealand. More information on the NZIER report and breakdown of the estimates of the costs can be found **here**.

The *Allen + Clarke* report (this report)

28. Alongside the NZIER report, this report completes the review of the settings of the levy and makes recommendations for its future administration and investment. Notably, the NZIER report focuses on the broader costs of alcohol harm to New Zealand, while the *Allen + Clarke* report focuses specifically on the services that are or could be provided by the Ministry of Health (and by extension, the other health entities) to address alcohol harm. Other organisations provide a wide range of other services designed to address harm in a range of other contexts that are not in scope of this review.

29. The approach to developing the *Allen + Clarke* report placed particular emphasis on the impact, and potential future impact, of levy funding on Māori in New Zealand, given the significant and constitutional role of Te Tiriti and in recognition of the disproportionate harm Māori experience from alcohol compared to non-Māori. This approach also aligns with the requirements of the Pae Ora Act to ensure that the aspirations of Māori are acknowledged, and that Māori are included in decision-making. The approach also sought to draw out the impacts and potential impact of levy funding on Pacific peoples.

30. A set of policy questions were developed to guide the work. These questions are set out in section 4.2.4. The policy questions were developed with the support of expert advisors and with input from representatives from the health entities supporting the project. These policy questions guided the engagement with participants, review of

evidence, and assessment against best practice management of cost-recovery mechanisms to ensure the findings were practicable and implementable. The methodology was designed with a focus on the future state to ensure that this report provides a proposed way forward for the administration and investment of the levy in its new legislative and organisational context.

31. Dr Sarah Herbert, Dr Tim Chambers, and Josiah Tualamali'i were engaged by *Allen + Clarke* as expert advisors to assist with Stage 2 of the review. The expert advisors were regularly involved with the review team to refine the project methodology, advise on technical elements of the project, support engagement, assist with research and insights, and provide technical review of deliverables.

Community and expert engagement

32. *Allen + Clarke* engaged with over 200 individuals (mostly in group settings) over the course of the review. Participants in the review included people who work to address alcohol-related harm in their communities, previous recipients of levy funding, alcohol researchers, healthcare workers, and staff from government departments who work in the area of alcohol harm minimisation.

33. Participants provided rich information about the nature, extent, and consequences of the avoidable alcohol-related harm experienced by individuals, whānau, and communities throughout New Zealand. Participants described how alcohol consumption significantly increases individuals' risk of developing cancers and many other diseases, contributes to whānau food and housing insecurity, and suppresses the overall potential of communities.

34. Māori participants highlighted the impacts of colonisation that continue to exacerbate alcohol-related harm for Māori and held expectations that the Crown should uphold and act on Te Tiriti obligations. Participants provided valuable insights into the current investments made with levy funds and the opportunities for future investment.

35. Participants generally expressed support for activities that are currently funded via the levy but unanimously agreed there is a significant unmet need for activities to address alcohol-related harm given the severity, frequency, and cost of the harms. However, there was some difference in opinion as to what activities should be funded via the levy.

36. Participants, excluding industry participants, generally felt that the Ministry of Health would be justified in expanding the current use of the levy to recover costs it incurs in undertaking evidence-based activities to:

    - address the normalisation of alcohol consumption (for example, by replacing alcohol sponsorship in sport and providing alcohol-free spaces and events)
    - address the availability, accessibility, affordability, and visibility of alcohol, where possible (for example, by supporting the district licensing process and organisations that can support policy change)
    - increase understanding of alcohol-related harm in New Zealand (for example, by supporting data collection in communities and continuing to fund research)

- support the communication of alcohol-related harm and approaches to minimise harm (for example, through public messaging and targeted health promotion campaigns)
- enable local solutions to address alcohol-related harm
- support the development of the alcohol-related harm reduction workforce
- provide support for individuals to reduce or eliminate their consumption of alcohol, and
- treatment for alcohol use disorders and alcohol-attributable diseases.

37. Industry participants considered that the alcohol levy should not be used to fund any activities that are outside the scope of what could be funded prior to the Pae Ora reforms.

38. Māori participants also emphasised the importance of full Māori participation and decision-making to determine solutions, and the need for kaupapa and mātauranga Māori based activities to address alcohol-related harm for whānau, hapū, iwi, and other Māori communities.

Targeted review of available evidence

39. Community and expert engagement were supplemented with an evidence review and engagement with academics. The function of the evidence review was to contextualise findings from the stakeholder engagement against available evidence. It was not designed to be a systemic review. A detailed, systemic assessment of available evidence on the effectiveness of potential investment of levy funds will be a crucial requirement for any future investment of levy funds. Previously, this has been undertaken by the Health Promotion Directorate. This review supports that assessment by identifying stakeholders' relevant aspirations and needs.

Cost-recovery analysis

40. Because the levy is a cost-recovery mechanism, the review included consideration of best practice approaches to setting fees and charges in the public sector published by the Treasury and the Office of the Auditor-General. This analysis ensured that that findings and recommendations were based on best practice approaches to cost-recovery.

Support from the health entities

41. The health entities established and appointed the members of an Alcohol Levy Working Group (the ALWG) and the Māori Alcohol Levy Working Group (the Māori ALWG). The ALWG oversaw the procurement and commissioning of *Allen + Clarke* and supported the ongoing provision of information for the review. The Māori ALWG was established during phase 2 of the review to provide guidance and support in relation to engaging with Māori stakeholders and Te Tiriti considerations.

42. Both groups had input into Stage 2 of the review at key stages including planning, stakeholder identification, and feedback during the development of the policy questions and engagement questions. *Allen + Clarke* engaged with the ALWG and Māori ALWG to ensure community engagement did not duplicate previous or planned community engagement and, where possible, built on existing relationships.

Key findings of the review

43. The three key findings of the review are set out below:

- Since at least financial year 2012/2013, the total levy quantum has been maintained at the same level year on year for pragmatic and potentially political reasons. The yearly decisions to maintain levy quantum do not appear to have been made based on a systematic assessment of the need for services, the cost of delivering those services, and an assessment of what would be 'reasonable' to expend and recover via the alcohol levy. Further, lack of inflationary adjustment to the levy since 2012/13 has led to a cumulative shortfall in the amount collected via the levy of approximately $10 million. If not addressed, the consequences of the cumulative shortfall caused by lack of inflationary adjustment are likely to cause difficulties for the Ministry of Health when it undertakes its assessment of the expenditure that would be reasonable to incur each year to address alcohol-related harm and to recover via the levy. There is a strong case to increase the levy quantum to enable the Ministry of Health and providers of levy funded activities to address the consequences of the cumulative shortfall resulting from a lack of inflationary adjustments and to prepare for changes to the levy system.
- There is an opportunity to co-design a new governance and investment approach to provide a long-term, community and evidence informed, transparent approach to investment and monitoring of levy expenditure to ensure value for money and alignment with community aspirations. A new governance and investment approach would also align with Māori stakeholders' aspirations to have 'by Māori, for Māori' approaches to alcohol harm with strong national leadership.
- The legal and operational context for the levy has changed to the extent that a full analysis of all services provided by the Ministry of Health to address alcohol-related harm (including through other health agencies and community providers) is recommended to provide long-term certainty for:
    - the types of services in scope for cost-recovery via the levy and policy decisions on which services should be funded by the levy, and
    - an agreed approach to costing services to inform setting the levy.

Recommendations

44. Based on those findings, *Allen + Clarke* recommends three tranches of work to align the levy with its new Pae Ora context:

- **Tranche 1** – Given the consequences of the cumulative shortfall in funds collected via the levy since 2012/13, *Allen + Clarke* recommends an immediate increase in

the levy quantum to enable current levy funded activities to be sustained, while also enabling providers to retain and train existing staff, enhance their administrative capacity (including monitoring and reporting functions), and conduct and communicate evaluations of their activities. This support for activity providers will in turn support the Ministry to increase the accountability and transparency of levy expenditure, which was one of the key concerns raised by participant stakeholders. *Allen + Clarke* also recommends that additional funding is made available to extend existing, effective levy-funded activities. Tranche 1 is an interim step that will enable more substantive changes to the administration of the levy.

- **Tranche 2** – Given the potential for relatively significant increases to the total levy quantum going forwards, *Allen* + Clarke recommends that the Ministry of Health develop a new governance and investment framework for the levy. This will support a long-term, transparent approach to investment and monitoring of levy expenditure, informed by community aspirations and evidence of the effectiveness of levy funded activities. This will provide stakeholders confidence in decisions relating both to what activities are funded, and the level of funding those activities receive. A new governance and investment approach would also support the Crown to ensure that Māori rights under Te Tiriti are given effect in the context of the alcohol levy.
- **Tranche 3** – Given the significant change to the legal and operational context of the levy, *Allen + Clarke* recommends that the Ministry of Health undertake a full cost-recovery analysis of all services provided by the Ministry of Health to address alcohol-related harm (including through agreements with other health agencies and community providers). This will provide long-term certainty for:
    - the types of services in scope for cost-recovery via the levy, and policy decisions on which services should be funded by the levy, and
    - an agreed approach to costing services to inform the annual setting of the levy.

45. The three tranches are designed to be translatable into workstreams to respond to the findings of the review. *Allen + Clarke* strongly recommends that all three tranches are undertaken concurrently under clear programme management to ensure that engagement, analysis, and lessons from each workstream strengthen the delivery of the other workstreams. An outcome of the proposed programme approach for delivering the three tranches would be that, in 2026, the three workstreams come together to provide a long-term approach to setting the levy to align with the Pae Ora context, meet community aspirations, and align with best practice approaches to setting and managing cost-recovery.

46. This review also includes a range of smaller recommendations that feed into the overarching tranches. These recommendations have been made throughout the report in the relevant context.

47. Overall, *Allen + Clarke*'s recommendations are designed to support the Ministry of Health to administer and invest the levy in a way that gives effect to community needs and aspirations to address alcohol-related harm. This can be achieved through the

Ministry of Health overseeing robust central processes at a national level, that, where appropriate, support local-level organisations to develop and implement effective activities to address alcohol-related harm in their communities.

48. Further detail on each of the proposed tranches of work has been set out in tables below.

Tranche 1: March 2024 – March 2025
1. In Tranche 1, *Allen + Clarke* recommends an immediate increase in the amount of funds recovered through the levy from the current $11.5 million to a new figure of between $21.5 million and $37.3 million for 2024/25 based on costs of services in the Core and Extend investment categories (see section 10.2 for a detailed explanation of the investment categories).
2. Increasing the levy to $21.5 million would create a new baseline for the alcohol levy, enabling the consequences of the cumulative shortfall in funds collected via the levy since 2012/13 to be addressed, while also restoring the purchasing power of the levy to its 2012/13 level. This would result in a very small increase to the levy on alcoholic beverages (for example, from currently approximately 0.5 cents to 1 cent on a standard can of beer).
3. *Allen + Clarke's* recommended option within Tranche 1 is to increase the levy to $37.3 million. This would include the new baseline and enable the expansion of existing levy funded activities that demonstrate sufficient alignment with the proposed investment criteria. This would result in an additional small increase to the levy on alcoholic beverages (for example, from currently approximately 0.5 cents to 1.6 cents on a standard can of beer).
4. Alongside the increase to the levy quantum, *Allen + Clarke* strongly recommends that the Ministry of Health implements short-term processes (leveraging existing processes) to increase the rigour of the administration and oversight of the alcohol levy. This reflects the need for greater assurance about how the increased amount of the levy funds are being spent to address alcohol-related harm and how the new Pae Ora-aligned approach to setting the levy is being administered from the 2024/25 financial year onwards.
5. The administration of the levy funds should include the implementation of separate accounting mechanisms to ensure that actual expenditure can be tracked, monitored, and reported to all stakeholders as well as supporting levy calculations in subsequent years. This will improve the transparency of how the levy is spent and will allow for reductions in levy rates to reflect underspend from previous years due to delays in contracting or other delivery delays during initial implementation.

Tranche 2: March 2024 – March 2026
1. The work in Tranche 2 builds on, and is enabled by, the increased investment that *Allen + Clarke* recommends in Tranche 1. In Tranche 2, *Allen + Clarke* recommends that the health entities develop an investment framework for the levy, which includes investment categories, investment criteria, and strategic priorities and outcomes, and establish new long-term governance structures. *Allen + Clarke* has developed and presented a draft investment framework that includes these components.

Tranche 2: March 2024 – March 2026
2. In Tranche 2, *Allen + Clarke* recommend that the health entities: • set up a strategic governance group, responsible for setting the strategic direction of the levy, setting the intended outcomes of the levy, and confirming investment criteria • set up a delivery governance group who will apply the investment criteria and strategic direction when determining how to allocate the levy funds for the following financial year • establish oversight and monitoring frameworks at a level proportionate to the new size and complexity of the alcohol levy system to support levy governance, determine investment criteria each year, provide assurance over the expenditure and its contribution to agreed outcomes, and • review the proposed investment criteria and strategic priorities to ensure both remain fit for purpose and adequately representative for the health entities.

Tranche 3: January 2024 – March 2026
1. In Tranche 3, *Allen + Clarke* recommends that the health entities undertake a first principles cost-recovery analysis of all the activities that the Ministry of Health undertakes to address alcohol-related harm (including through agreements with the other health entities) and their associated operational costs.
2. The first principles cost-recovery analysis would confirm the intent of the use of the levy in the Pae Ora context and provide decisions on the categorisation and scope of activities that should be cost recovered via the levy. This work would include policy decisions on whether the levy should be used to fund activities beyond the services that had been provided by the Health Promotion Agency. In particular, this review would finalise decisions about whether some types of treatment services may be in scope or whether the focus should continue to be on health promotion, prevention, education, policy, and research services.
3. The first principles cost-recovery review would require developing a system view of all services provided by the Ministry of Health that are designed to address alcohol-related harm, which would allow for a better understanding of the specific role and contribution of the levy funded services within that broader investment from Crown sources.

Conclusion

49. Alcohol consumption causes significant harms across all sectors of our population, from the wide range of health (including mental health) impacts to crime; accidents, and lost productivity - costing New Zealand taxpayers billions of dollars every year.

50. From speaking with more than 200 participants around the country, *Allen + Clarke* has concluded that using the levy to fund activities designed to address alcohol-related harm is widely supported and that there is strong support for funding more and different activities to meet the needs and aspirations of the communities.

51. The Pae Ora Act provides a legal mandate to explore the use of the levy to fund more and different activities to address alcohol-related harm, and to reduce the significant inequitable burden of harm experienced by Māori and Pacific, while recovering the costs of those investments from the alcohol-harm risk exacerbators; the producers and importers of alcohol.

52. In the short-term, expansion of existing alcohol related activities could help reduce harm and, if passed on to the consumer by the producers and importers of alcohol, will result in very small changes to the retail price of alcohol products. For example, if the levy was increased to $37.3 million for 2024/25 as per the recommendation in Tranche 1, this would, if passed on to the consumer by the producers and importers of alcohol, increase the cost of a price of a can of beer by approximately 1.1 cents.

53. In the medium- to long-term, there is a substantial opportunity to recover the costs of a broader scope of alcohol-related activities undertaken by the Ministry of Health, following a robust review of activities that are now potentially eligible for cost-recovery under the Pae Ora Act.

54. The Pae Ora context also creates an opportunity for the decisions and assurance functions related to levy spending to be more transparent and to be better aligned with the health sector principles and Te Tiriti. Strengthening decision-making and assurance functions would help to ensure that sound, reasonable investment decisions are made to effectively address the alcohol-related harm prevalent in New Zealand. Ensuring Te Tiriti-informed approaches to the governance and delivery of funds collected via the levy support the realisation of Māori aspirations for reducing the disproportionate harm Māori experience from alcohol.

1 Introduction

1. *Allen + Clarke* and the New Zealand Institute of Economic Research (NZIER) were commissioned by the Ministry of Health in February 2023 to undertake a review of the levy imposed, pursuant to the Pae Ora (Healthy Futures) Act 2022 (Pae Ora Act), on alcohol products available for sale in New Zealand ('the alcohol levy') and to undertake a study to consider the overall cost of alcohol-related harm to New Zealand.[3]

2. The review was designed to enable assessment of the current state of alcohol harm and alcohol levy expenditure (levy funding applied to programmes and services designed to reduce alcohol-related harms), with a particular view to:

    - consider the history and current state of the alcohol levy in New Zealand
    - understand the costs associated with alcohol-related harm in New Zealand, including specifically in the burden of these costs in the health sector, and
    - understand participants' views on the impact of levy expenditure and levy funded activities, particularly Māori and Pacific participants (given the disproportionate impact of alcohol related harm on these populations).

3. The review was also designed to enable consideration of the potential future state of the levy, including through:

    - understanding participants' views on the potential future state of the alcohol levy, and
    - considering how any proposed changes in relation to the alcohol levy may contribute to equitable health outcomes, especially for Māori, and align with wider health system priorities.

4. The scope of the review was limited to assessing and considering activities that are, or that could potentially be, funded by the levy. The review team could therefore only make recommendations in relation to activities and not legislative or regulatory changes.

5. The review was undertaken in two stages, which are described below.

Stage 1

6. Stage 1 was undertaken during February and March 2023 as a rapid review of current state, designed to inform the levy setting for the 2023/24 financial year.

[3] This review was commissioned and conducted prior to the introduction of the Pae Ora (Disestablishment of Māori Health Authority) Amendment Bill to Parliament. At the time this report was finalised, the Pae Ora (Disestablishment of Māori Health Authority) Amendment Bill had received Royal Assent. *Allen + Clarke* understands that, when the Pae Ora (Disestablishment of Māori Health Authority) Amendment Act enters into force, the functions and responsibilities of Te Aka Whai Ora will be transferred to the Ministry of Health and Health New Zealand. The discussion, findings, and recommendations in this report that relate to Te Aka Whai Ora should be read with this context in mind.

7. The Stage 1 review found that the cost of alcohol-related harms was substantial and that the gulf between the costs of alcohol-related harm to the health sector and the quantum of the alcohol levy was significant. The Stage 1 review found that this gulf could suggest that the existing levy fund is insufficient, and/or the scale of activities and programmes being funded by the alcohol levy are having limited impact on the level of harm. However, the Stage 1 review did not find any evidence to suggest a relationship between the cost of harm and the cost of addressing harm. The Stage 1 report recommended that existing funding levels, and existing recipients of that funding, be maintained for 2023/24 and no commitments to continuing levy funding be made beyond June 2024. A full copy of the Stage 1 report is available here: **https://www.health.govt.nz/publication/independent-review-alcohol-levy-stage-1-rapid-review**.

Stage 2

8. Stage 2 of the review was intended to be an in-depth analysis of the current state and potential future state of the alcohol levy. It was to have particular emphasis on the impact, and potential future impact, of levy funding on Māori in New Zealand, given the significant and constitutional role of Te Tiriti and in recognition of the disproportionate harm Māori experience from alcohol compared to non-Māori across a range of measures. It was also commissioned to draw out the harms and potential impact of levy funding on Pacific peoples, given the disproportionate impacts of alcohol-related harms also experienced by this group.

9. This report is the result of Stage 2 of the review. It presents the overall conclusions from the review and resulting recommendations.

2 Definitions

Table 1: Definitions

Term	Definition
Academic participants	Academics or researchers.
Activity	Used to refer to projects, programmes, or initiatives.
Agency participants	Government agency representatives or officials and other representatives of the Crown.
Alcohol	The term “alcohol” has been used generically to refer to alcoholic drinks (that meet the Ministry for Primary Industry requirements for labelling) which are drinks consumed with more than 0.5 percent alcohol by volume.
Alcohol levy	The “levy” or “alcohol levy” refers to the money raised in accordance with section 101 of the Pae Ora Act.
Brief intervention	Short counselling or screening sessions intended to raise a person’s awareness of their alcohol use and associated consequences, with a view to motivating them to reduce consumption or seek further treatment.
Community participants	People including representatives of hapori / community groups who understand the impacts of alcohol-related harm at a local level and have experience of implementing services or interventions designed to reduce alcohol related harm.
Competitive funding	This describes a process where potential funding recipients provide competing proposals to deliver an activity and the funder determines and funds the “best” proposal(s).
Hapori	Māori term for a section of a kinship group, society, or community.
Hazardous drinking	Refers to the definition from the New Zealand Health Survey, which means participants meet the AUDIT-C score to be deemed hazardous drinkers.[4]
Health entities	This refers to the Ministry of Health (Manatū Hauora), Health New Zealand (Te Whatu Ora), and the Te Aka Whai Ora (the Māori Health Authority).
Industry participants	Representatives of alcohol industry producer or retailer associations.
Pae Ora Act	Refers to the Pae Ora (Healthy Futures) Act 2022

[4] The AUDIT-C score is calculated using this tool: https://bpac.org.nz/BPJ/2010/June/docs/addiction_AUDIT-C.pdf

Term	Definition
Participant	This report refers to all those we engaged with as "participants" given the wide range of interests that those engaged represented. Many participants were stakeholders (with a vested interest in the levy decision-making process) but some were engaged to provide wider context about alcohol-related harm and/or opportunities for the future state. Where relevant, this report specifies whether a comment originated from Māori, Pacific, agency, academic, community, or industry participants.
Rangatahi	Māori term for the younger generation or youth.
Relational funding	This describes a process where the funder identifies and works with potential funding recipients to design and deliver activities. It is trust based and generally includes a high degree of collaboration and strong relationships between the parties.

3 Background and context

10. Alcohol is a psychoactive substance with dependence-producing properties that has been widely used in many cultures for centuries. Anyone aged 18 years or over and who shows approved identification can enter licensed premises and buy alcohol in New Zealand. The consumption of alcohol is associated with developing a range of physical and mental health problems. It is a cause, or a factor, in a range of intentional and unintentional injuries and is associated with various anti-social behaviours.

11. The Stage 1 report noted that alcohol causes significant harm across all communities in New Zealand. Among a wide range of harms, alcohol consumption contributes to an individual's risk of developing some types of cancers, heart disease, liver disease, type 2 diabetes, and dementia; suffering from strokes or personal injuries; contributes to mental health issues and suicide risk and is associated with a substantial amount of vehicle accidents, violence, and crime in New Zealand.

12. The Stage 1 report also noted that Māori were more likely to die of alcohol-related causes and that there has been very little, if any, shift in the disproportionate harm that Māori experience from alcohol. The causes of alcohol-related inequities for Māori are multiple and complex, and much work remains to be done to address them.

13. Alcohol-related harm costs the government and wider society a significant amount in New Zealand. The NZIER has estimated that the current costs of harms (that are of moderate to high certainty based on available data) associated with alcohol use in New Zealand may amount to as much as $9.1 billion. The NZIER report notes that there is considerable uncertainty regarding this cost estimate with potential overestimation as well as significant gaps in the current evidence base preventing all the costs of alcohol-related harm in New Zealand from being estimated.

3.1 The levy before the Pae Ora Act

14. The alcohol levy has historically been used to recover costs incurred, first by the Alcoholic Liquor Advisory Council (ALAC) and then by the Health Promotion Agency, in undertaking health promotion and policy work to minimise alcohol-related harm. These organisations' statutory mandates defined the nature of the activities that they could undertake to minimise alcohol-related harm, and thus the nature of activities that could be cost-recovered through the levy.

15. ALAC was established by the Alcoholic Liquor Advisory Council Act 1976, and a levy on alcohol begun to be collected in 1978. ALAC's primary objective was the encouragement and promotion of moderation in the use of liquor, the reduction and discouragement of the misuse of liquor, and the minimisation of the personal, social, and economic harm resulting from the misuse of liquor. The Alcohol Advisory Council Act 1976 was repealed on 1 July 2012 by section 13(1) of the New Zealand Public Health and Disability Amendment Act 2012, which established the Health Promotion Agency.

16. The Health Promotion Agency was established in 2012 by the repeal and substitution of section 57 of the New Zealand Public Health and Disability Act 2000 (the Public Health and Disability Act).[5] Section 59AA of the Public Health and Disability Act enabled levies to be imposed on alcohol for the purpose of enabling the Health Promotion Agency to recover costs it incurred in addressing alcohol-related harm and in its other alcohol related activities.[6] Section 58 of the Public Health and Disability Act set out the functions, duties, and powers of the Health Promotion Agency, including its alcohol-specific functions, which were:

    - giving advice and making recommendations to government, government agencies, industry, non-government bodies, communities, health professionals, and others on the sale, supply, consumption, misuse, and harm of alcohol so far as those matters relate to the Health Promotion Agency's general functions; and
    - undertaking or working with others to research the use of alcohol in New Zealand, public attitudes towards alcohol, and problems associated with, or consequent on, the misuse of alcohol.

17. The Health Promotion Agency's general functions were to lead and support activities for the following purposes:

    - promoting health and wellbeing and encouraging healthy lifestyles
    - preventing disease, illness, and injury
    - enabling environments that support health and wellbeing and healthy lifestyles, and
    - reducing personal, social, and economic harm.

18. Under the Public Health and Disability Act, the Minister of Health, acting with the concurrence of the Minister of Finance, was required to assess the aggregate figure that, in the Minister of Health's opinion it would be reasonable for the Health Promotion Agency to expend during the following financial year in addressing alcohol-related harm and in its other alcohol-related activities[7]

19. The Public Health and Disability Act was repealed on 1 July 2022 by section 103(1) of the Pae Ora Act.

20. The legislated functions of ALAC, and particularly the Health Promotion Agency, are relevant when considering the current state of the alcohol levy because they acted as constraints on what activities could be undertaken and therefore cost-recovered

[5] New Zealand Public Health and Disability Act 2000. s 57.

[6] New Zealand Public Health and Disability Act 2000. s 59AA.

[7] The Minister of Health was then required to set the aggregate levy figure for the following year taking into account any amounts the Health Promotion Agency was likely to receive during that financial year by way of interest on money invested by the Health Promotion Agency or from third party or other revenue.

through the levy. These constraints are important to understand when considering why certain activities were undertaken by the Health Promotion Agency but others were not.

21. With the repeal of the Public Health and Disability Act, however, the constraints that applied to ALAC and the Health Promotion Agency no longer exist (although the functions of the Health Promotion Agency were transferred to Health New Zealand, National Public Health Service). As such, the activities that can be undertaken and cost-recovered through the levy by the Ministry of Health must be considered through a new lens.

3.2 The levy now

22. The Pae Ora Act came into force in July 2022 and provided the legislative basis for reform of the health system in New Zealand. The Pae Ora Act disestablished the Health Promotion Agency and changed the recipient of levies imposed for alcohol-related purposes. Section 101 of the Pae Ora Act now enables the Ministry of Health to recover costs it incurs in addressing alcohol-related harm and in its other alcohol-related activities.[8] Under the new structure of the health system, the Ministry of Health can allocate levy funding via agreements to Health New Zealand and Te Aka Whai Ora for the commissioning of alcohol harm reduction services and programmes. This means, the cost-recovery mechanism can extend to activities undertaken by all three health entities.

23. Under the Pae Ora Act, for each financial year, the Minister of Health, acting with the concurrence of the Minister of Finance, must assess the aggregate figure that, in the Minister of Health's opinion it would be reasonable for the Ministry to spend during the next financial year in addressing alcohol-related harm and its other alcohol-related activities. After assessing that aggregate figure for a financial year, the Minister must determine the aggregate levy figure for that year.

24. The Pae Ora Act has placed an obligation on the Minister of Health to be guided, so far as reasonably practicable, by the health sector principles set out in section 7 of the Pae Ora Act, when performing a function or exercising a power or duty under the Pae Ora Act. This includes when assessing the aggregate figure that it would be reasonable for the Ministry to spend, and when determining the aggregate levy figure for each financial year.

25. The alcohol levy is a small part of a broader system: the excise tax on alcohol generates significantly more revenue (approximately $1.29 billion in 2023) and is collected by the New Zealand Customs Service alongside taxes on fuel and tobacco. The excise tax collected is part of general Crown revenue and can be used for any Crown expenditure. Activities designed to address alcohol-related harm are not solely funded by the alcohol levy – there are a range of Crown funded activities in the health system and in the

[8] Pae Ora (Healthy Futures) Act 2022, s 101

broader public system (e.g., drink driving countermeasures are generally funded by the transport sector and the New Zealand Police).

26. The Ministry of Health, using Vote Health funding, already undertakes (including through allocations to Health New Zealand and Te Aka Whai Ora for commissioning) a more comprehensive suite of activities to address alcohol-related harm than was possible for ALAC or the Health Promotion Agency. For example, the Ministry of Health has always funded alcohol dependency treatment services as part of the alcohol and other drugs (AOD) functions. Under the Pae Ora Act, potentially any activity that addresses alcohol-related harm that is funded through Vote Health could be considered within the scope of the levy.

27. The health sector principles require that the Minister, and the health entities involved in the levy should be guided by engagement with actual and potential service users to develop and deliver services and programmes that reflect their needs and aspirations. Therefore, to support the Minister, and the health entities, this review sought to understand community and user needs and aspirations for services and programmes to be funded by the levy.

3.3 The cost of alcohol harm in New Zealand

28. To complement this report, NZIER has undertaken analysis to understand the current costs associated with alcohol-related harm in New Zealand. The NZIER report explores a range of costs of alcohol harms using the most recent available evidence and prioritising:

    - costs of harms that represent key areas for intervention through services and programmes delivered by public sector agencies and non-government organisations (NGOs), and
    - costs that can be estimated using new evidence of causal attribution, prevalence and impacts emerging from recent New Zealand research.

29. Costs that would be heavily reliant on assumption or overseas or outdated evidence were not estimated. However, the report notes that the most recently available data does not provide evidence for all the associated costs of alcohol harm that exist and that the evidence base in some areas is weak. There are categories of alcohol related harm where it is known significant additional costs exist at every level of impact on individuals, community and society, but data is not available to estimate them. The NZIER report provides recommendations for how these data gaps could be addressed in future.

30. While understanding the total costs of alcohol-related harm in New Zealand is not required to calculate the total levy quantum (given it is a cost-recovery mechanism, and the costs of harm are not the same as the costs of addressing or preventing the harm), it is crucial to understand the wider cost of harm to support appropriate investment decision-making and prioritisation of resources to address that harm.

3.4 The levy and Te Tiriti o Waitangi

31. Te Tiriti places a mandatory obligation on the Crown to protect and promote Māori health, including within the context of alcohol policy.

    - Kāwanatanga guarantees Māori the right to meaningful participation, decision-making and leadership in setting priorities, resourcing, and implementing and evaluating policy.
    - Tino Rangatiratanga recognises Māori rights to determine the factors that will address Māori health issues as well as enable pae ora (as the concept of achieving healthy futures), and to influence and hold authority in the policy process.
    - Ōritetanga guarantees Māori rights to citizenship equal to tauiwi (settlers, migrants, and their descendants) in policy setting and implementation.
    - Rītenga Māori recognises Māori rights to live and flourish as Māori, where Māori world views, values, and wairuatanga are respected.

32. In practice, this means that Māori have the right to meaningfully engage as equal partners and leaders alongside the Crown to determine policy development processes and outcomes. Public sector employees tasked with developing policy should actively seek meaningful input from Māori, including those with lived experience of alcohol-related harm, to ensure Māori voices inform the design and development of policies and their implementation.

33. The Pae Ora Act introduced iwi-Māori partnership boards to represent mana whenua across specific rohe (geographic boundary or territory) in New Zealand. These boards are tasked with providing Iwi-Māori perspectives about the needs and aspirations of Māori in relation to hauora Māori, monitoring health system performance and outcomes, and informing the design and delivery of services and public health interventions within localities (geographically defined areas for the purpose of arranging health services).[9] Under section 6 of the Pae Ora Act, Iwi-Māori partnership boards are to enable Māori to have a meaningful role in the planning and design of local services, which can include services funded via the levy to address alcohol-related harm.

34. Whakamaua: Māori Health Action Plan 2020-2025 (Whakamaua) draws on the principles identified by the Waitangi Tribunal in *Hauora: Report on Stage One of the Health Services and Outcomes Kaupapa Inquiry* which makes clear the significance of Te Tiriti as a foundational document of public health policy. These principles are applicable to the wider health sector and are applied in this report to show how Te Tiriti can be given effect with regards to future investment of the alcohol levy. The principles are as follows:[10]

[9] Pae Ora (Healthy Futures) Act 2022, s 30.

[10] Ministry of Health. (2020). *Whakamaua: Māori Health Action Plan 2020-2025*

- **Tino rangatiratanga:** Providing for Māori self-determination and mana motuhake in the design, delivery, and monitoring of health services.
- **Equity**: Being committed to achieving equitable health outcomes for Māori.
- **Active protection:** Acting to the fullest extent practicable to achieve equitable health outcomes for Māori. This includes ensuring that the Crown, its agents, and its Treaty partners are well informed on the extent and nature of both Māori health outcomes and efforts to achieve Māori health equity.
- **Options:** Providing for and properly resourcing kaupapa Māori health services. Furthermore, the Crown is obliged to ensure that all health services are provided in a culturally appropriate way that recognises and supports the expression of hauora Māori models of care.
- **Partnership:** Working in partnership with Māori in the governance, design, delivery, and monitoring of health services – Māori must be co-designers, with the Crown, of the health system for Māori.

35. As well as being the guiding document to progress Māori health aspirations, Whakamaua is a conduit to empowering the voices of whānau, lifting the visibility of Māori health needs, and positions the health and disability system to protect the health of iwi, hapū, whānau, and Māori communities.

36. The Pae Ora Act also requires the Minister of Health to determine a Hauora Māori Strategy. Pae Tū: Hauora Māori Strategy 2023 (Pae Tū)[11] provides the overall direction for hauora Māori, setting an interim pathway until 2025. It enhances the direction of Whakamaua to ensure both reflect the new health system and remain fit for purpose.

37. The Pae Ora Act explicitly references the role of Te Tiriti within the health system through section 6, which sets out requirements and actions to provide for the Crown's intention to give effect to the principles of Te Tiriti. This includes a requirement for the Minister of Health and the health entities to be guided by the health sector principles which include improving the health sector for Māori and improving hauora Māori outcomes.[12] Therefore, the alcohol levy should be administered in a way that improves hauora Māori outcomes in relation to alcohol-related harm.

38. This review was conducted through a Tiriti-informed approach by placing particular emphasis on hearing the voices of Māori in hapū, iwi, and community organisations about how best to address alcohol-related harms, and their aspirations for the future state of the levy (including administration, governance, and investment). Some of those voices have also directly informed the recommendations arising from this review.

[11] Minister of Health. (2023). *Pae Tū: Hauora Māori Strategy.* Wellington: Ministry of Health

[12] The health sector principles are set out at section 7 in the Pae Ora Act.

3.5 The levy and Pacific peoples

39. Pacific peoples make up approximately 9 percent of the New Zealand population.[13] New Zealand has close ties with many Pacific Islands given the close geographic proximity and the high level of migration. New Zealand's health policies and approaches to alcohol have an impact across the Pacific region through temporary migration programmes such as the Recognised Seasonal Employment (RSE) programme, permanent migration, and multi-country families. New Zealand's constitutional Pacific relationships are also a unique consideration in wellbeing policies.

40. The population of Pacific peoples is growing: Pacific peoples in New Zealand are diverse in their identities, geographical location, and languages. Pacific peoples have one of the fastest growing populations, with a median age of 23 years compared with 37 years for the total New Zealand population.[14]

41. Some Pacific Islands have a constitutionally significant connection with New Zealand. For instance, as members of the Realm of New Zealand, peoples of the Cook Islands, Niue, and Tokelau have New Zealand citizenship and can freely move between countries. The impact of alcohol-related harm on Pacific peoples was also a focus of this review.

3.6 The levy and the Sale and Supply of Alcohol Act 2012

42. The Sale and Supply of Alcohol Act 2012 (SSAA) is the primary piece of legislation that regulates alcohol accessibility in New Zealand. It is administered by the Ministry of Justice and devolves the function of alcohol licensing to local government. In 2023 Amendments were made to SSAA. Some amendments are due to come into effect by 30 May 2024, while others were implemented from 31 August 2023. Amendments include allowing any person or group to object to a licence application (except trade competitors), extending the timeframe for objecting to a licence, removing the ability to appeal provisional local alcohol policies, and removing the ability to cross-examine at alcohol licensing hearings.[15] Medical Officers of Health, who are employed by the Ministry of Health, have a responsibility to inquire into, and file reports on, applications for alcohol licences.

43. The Stage 1 report noted that participation in District Licensing Committee hearings was perceived to be one of the few opportunities available to communities to carry out a health protection activity, namely reducing the availability of alcohol in their

[13] Minister of Health. (2023). *Te Mana Ola: The Pacific Health Strategy*. Wellington: Ministry of Health.

[14] Ministry for Pacific Peoples. (2021). *Pacific Peoples In Aotearoa: A snapshot.* Wellington: Ministry For Pacific Peoples.

[15] Sale and Supply of Alcohol (Community Participation) Amendment Act 2023.

environment. However, for several reasons, it has been difficult for communities to meaningfully participate in those hearings.

44. Through the licence objection process, SSAA provides an opportunity for people to take action to address alcohol-related harm in their communities. This review has therefore considered whether the levy could be used to expand support for communities to meaningfully participate in district licensing hearings.

3.7 The levy and the Customs and Excise Act 2018

45. Separately from the levy raised on alcohol through the Pae Ora Act, the excise tax is also raised on alcohol under the Customs and Excise Act 2018. In 2022/23, the Government collected $1.29 billion in customs and excise duties on alcohol.[16] The excise duties are not hypothecated, and the funds go directly to core Crown revenue, which means it is used for Crown expenditure. The excise tax is adjusted for inflation annually, using a formula codified in the Customs and Excise Act 2018.

46. Relatedly, the Stage 1 report demonstrated that excise duties constitute a much greater share (between 20.7 and 55.9 percent) of the price of alcohol products than the alcohol levy (between 0.2 and 1.3 percent).

3.8 The levy and the WHO SAFER framework

47. The World Health Organization (WHO) SAFER Framework focuses on the most cost-effective, evidence-based, priority interventions to reduce alcohol related harm. These are to:

    - strengthen restrictions on alcohol availability
    - advance and enforce drink-driving counter measures
    - facilitate access to screening, brief interventions, and treatment
    - enforce bans or comprehensive restrictions on alcohol advertising, sponsorship, and promotion, and
    - raise prices on alcohol through excise taxes and pricing policies.

48. As the Stage 1 report noted, many of the SAFER interventions focus on measures that limit the physical, social, and psychological availability of alcohol. These measures are the most successful in reducing alcohol-related harm.

49. *Allen + Clarke* was commissioned, in part, to consider and evaluate how levy funding can be prioritised to support the WHO SAFER Framework. The WHO SAFER Framework provides a well-evidenced basis for an assessment of the likely cost-

[16] Customs New Zealand. (2023). *Annual Report 2023.*

effectiveness of some of the activities that could be funded through the levy. Furthermore, the extent to which current and potential levy funded activities might contribute, in part, to the implementation of SAFER interventions that cannot be implemented through funding alone (e.g., strengthening restrictions on alcohol availability), is a useful consideration for this review.

4 Review methods

4.1 Approach to Stage 1

50. *Allen + Clarke* undertook the Stage 1 rapid review between 3 February and 15 March 2023.

51. The Stage 1 review consisted of 16 stakeholder interviews and a desk-based review. The Stage 1 report was finalised on 27 April 2023.

52. The approach undertaken in Stage 1 is described in the Stage 1 report, as are the interim recommendations.

4.2 Approach to Stage 2

4.2.1 Overview

53. *Allen + Clarke* undertook the Stage 2 review between 16 March 2023 and 1 March 2024.

54. Stage 2 was intended to enable a future-focused assessment of what activities the Ministry of Health could and should undertake and recover the costs of doing so via the levy, to address alcohol-related harm.

55. Stage 2 took an approach informed by Te Tiriti, which meant placing particular emphasis on engaging with Māori to determine how best to address alcohol-related harm, the needs of Māori, and Māori aspirations for the future state of the alcohol levy (due to Māori being disproportionately impacted by alcohol related harm).

56. The primary focus of Stage 2 of this review was engagement with people who work to address alcohol-related harm in their communities (community participants) to understand their needs and aspirations in relation to services and programmes to address alcohol-related harm. In the Pae Ora context, the Minister, and the health entities, should be guided by these needs and aspirations, so far as reasonably practicable.

57. As discussed in the preceding section, the levy's new context means that the activities the Ministry of Health could undertake and cost recover through the levy are potentially wider than the activities previously undertaken by the Health Promotion Agency.

58. This Stage 2 community engagement was supplemented with an evidence review and engagement with academics, industry representatives, and people employed by government agencies (who work in alcohol-related harm reduction areas).

59. The function of the evidence review was to understand current levy expenditure, support the development of an overview of the nature of alcohol harm in New Zealand, and confirm whether services or programmes identified by community participants as meeting their needs or aspirations are supported by the evidence in terms of addressing

alcohol-related harm. It was not a systematic assessment of all available evidence on the effectiveness of the services or programmes identified by community participants, nor was it a systematic assessment of all available evidence on the nature of alcohol harm.

60. Similarly, the engagement with academics, industry representatives, and people employed by government agencies supported the assessment of whether the services or programmes identified by community participants would be effective at addressing alcohol-related harm.

61. *Allen + Clarke*'s review did not attempt to fully quantify the cost of developing and delivering the programmes and services required to fulfil the need and meet the aspirations identified in this report, nor assess the reasonableness of the Ministry incurring the cost of developing and delivering those programmes and services. These are necessary next steps for the health entities to undertake.

4.2.2 Support from expert advisors

62. Dr Sarah Herbert, Dr Tim Chambers, and Josiah Tualamali'i were engaged as expert advisors to assist with Stage 2 of the review. The expert advisors were regularly involved with the review team to refine the project methodology, advise on technical elements of the project, support engagement, assist with research and insights, and provide technical review of deliverables.

63. Dr Sarah Herbert has a strong and critical understanding of Māori health with a demonstrable commitment to honouring Te Tiriti, reducing inequities, and upholding Māori rights to health. Dr Herbert completed her PhD at Massey University in 2017, which explored Māori alcohol use in New Zealand. She is a Māori health leader and researcher focused on driving Te Tiriti led and system change to achieve pae ora for all.

64. Dr Tim Chambers is a public health expert with a focus on alcohol policy. He uses spatial and quantitative research methods to understand the connections between place, space, and health. His research also uses innovative technological solutions – such as wearable cameras, GPS devices, and Bluetooth tracking devices to understand complex human behaviour. Dr Chamber's research agenda also has a strong equity focus. His recent alcohol work includes a modelling study estimating the potential health gains that could be obtained from implementing stronger policies on the marketing, availability, and price of alcohol in New Zealand.

65. Josiah Tualamali'i supports the governance of a number of organisations and elevates Pacific people's voice in decision-making particularly around mental health and addictions policy. He was involved in the establishment of the Pacific Youth Leadership and Transformation Trust (PYLAT) to advocate for Pacific young people's voices in all worlds.

4.2.3 Guidance from the health entities

66. The health entities established and appointed the members of an Alcohol Levy Working Group (the ALWG) and the Māori Alcohol Levy Working Group (the Māori ALWG). The ALWG oversaw the procurement and commissioning of *Allen + Clarke* and supported the ongoing provision of information for the review. The Māori ALWG was established during Stage 2 of the review to provide guidance and support in relation to engaging with Māori stakeholders and Te Tiriti considerations.

67. Both groups had input into Stage 2 of the review at key stages including, planning, stakeholder identification, and provided feedback during the development of the policy questions and engagement questions. *Allen + Clarke* engaged with the ALWG and Māori ALWG to ensure community engagement did not duplicate previous or planned community engagement and, where possible, built on existing relationships.

4.2.4 Policy questions

68. To guide the review, *Allen + Clarke* developed a policy question and sub-questions in consultation with the expert advisors. A policy question asks how something should be done rather than asking what or why something has happened. The policy question and sub-questions are outlined in table 2 below. Table 3 provides the main documents that *Allen + Clarke* reviewed to inform the development of the policy questions.

Table 2 – Policy questions

How should a hypothecated levy on alcohol operate in the new Pae Ora context?
• What are participants' perceptions of how the alcohol levy could be most effectively administered?
• What are participants' perceptions of how the alcohol levy could be most effectively governed?
• What are participants' perceptions of how the alcohol levy could be most effectively be invested? Including participant perceptions of whether there should be a focus on health promotion, prevention, or treatment measures.
• How is the alcohol levy most effectively administered and governed in a way which centres the Crown's obligations under Te Tiriti o Waitangi (including consideration of how the levy functions in relation to the alcohol excise tax)?
• What is the extent, nature, and cost of alcohol-related harms in New Zealand?
• As pertains to the alcohol levy, what should cost-recovery for activities addressing alcohol-related harm look like in the Pae Ora context?
• What current investments from the levy fund should be retained, if any?
• As pertains to the alcohol levy, what are the options for the Ministry of Health to meet its obligations to Māori under Te Tiriti, including an obligation to protect and ensure Māori rights to health and equity, in relation to alcohol and related harms?

How should a hypothecated levy on alcohol operate in the new Pae Ora context?
• What are the options for the administration of the alcohol levy to support the investment as a cost-recovery mechanism?
• What are the options for governance of the alcohol levy regime to enable effective and efficient use of levy funds, and to provide appropriate oversight to measure success?
• What are the options for the investment of the alcohol levy, to ensure that the Crown upholds its obligations under Te Tiriti o Waitangi and protects people's health and wellbeing in relation to alcohol-related harm?

Table 3: Documents reviewed to inform development of policy questions

Document
World Health Organization (2019) SAFER initiative and technical package
World Health Organization (2010) Global strategy to reduce harmful use of alcohol
Babor, et al. (2022) Alcohol: No Ordinary Commodity: third edition
Te Hiringa Hauora (2020) National Harm Minimisation Framework
Connor, et al. (2013) Alcohol-attributable burden of disease and injury in New Zealand: 2004 and 2007
Law Commission (2010) Alcohol in our lives: curbing the harm. A report on the review of the regulatory framework for the sale and supply of liquor
Walker (2019) Issues of tobacco, alcohol, and other drug abuse for Māori. Report commissioned by the Waitangi Tribunal for the Health Services and Outcomes Kaupapa Inquiry (Wai 2575)
Nosa, et al. (2021) Pacific peoples and alcohol: a review of the literature
Ataera-Minster, et al. (2020) Taeao Malama: Alcohol use in Pacific peoples. Results from the New Zealand Health Survey & Attitudes and Behaviour towards Alcohol Survey. Commissioned by Te Hiringa Hauora
Government Inquiry into Mental Health and Addiction (2018) He Ara Oranga: Report of the Government Inquiry into Mental Health and Addiction

Document
Maynard (2022) Te Tiriti o Waitangi and Alcohol Law
Manatū Hauora (2022) The New Zealand Health Survey 2021/22 results
Canadian Centre of Substance Abuse (2022) Update of Canada's Low-Risk Alcohol Drinking Guidelines: Evidence Review Technical Report
New Zealand Auditor-General (2021) Setting and administering fees and levies for cost-recovery: Good practice guide

4.2.5 Engagement

69. In consultation with the ALWG, Māori ALWG, and expert advisors, *Allen + Clarke* identified individuals and organisations to invite to participate in this review. Participants were also invited to recommend others for *Allen + Clarke* to engage with. While, due to time and budget constraints, *Allen + Clarke* was unable to engage with all participants recommended, a wide range of groups and different demographics were engaged with across the country, providing sufficient basis to make recommendations for the future of the alcohol levy.

70. Engagement sessions were undertaken in-person or remotely, depending on participants' availability and preferences. With consent, *Allen + Clarke* staff took notes at each engagement session and recorded key insights.

71. During the engagement sessions *Allen + Clarke* heard from 206 participants, including:

    - 161 community organisation representatives
    - 32 agency participants
    - 8 academic participants
    - 5 alcohol industry participants.

72. A list of the organisations that were engaged with can be found at Appendix C.

4.2.5.1 Community engagement

73. *Allen + Clarke* undertook three streams of community-based engagement. Māori engagement was undertaken to reflect the Crown's obligations under Te Tiriti as well as in recognition of the disproportionate harms Māori experience as a result of alcohol. Pacific engagement was undertaken to reflect Pacific Peoples' disproportionate experience of alcohol-related harm. General engagement (not specifically focused on

Māori and Pacific people) was undertaken to inform the health entities of relevant community needs and aspirations when undertaking alcohol levy related functions and exercising alcohol levy related powers and duties. Participants were provided the opportunity to decide which stream of community-based engagement they wished to participate in.

74. Community engagements were semi-structured and participants were encouraged to share their experience and understanding of alcohol harm in their communities, expectations about minimising alcohol harm, and how the levy could support this.

75. Many community representatives had limited or no prior experience with the alcohol levy. Where this was the case, the review team provided a short introduction to the alcohol levy including its function and purpose. Given the significant change in the potential scope, governance, and administration of the alcohol levy, *Allen + Clarke* does not consider that participants' limited or lack of prior experience with the alcohol levy prevented their perspectives from being useful for this review.

76. All community participants had a deep understanding of alcohol-related harm in their communities, and well-informed views on what activities could address that harm, regardless of whether those activities were, or could have been, undertaken prior to the Pae Ora reforms.

77. The review team conducted a mix of group and individual interviews as part of each stream of community engagement:

    - 8 Māori community engagement interviews
    - 5 Pacific community engagement interviews
    - 23 general population community engagement interviews (many of which included Māori or Pacific participants)
    - An additional 2 general community organisations, who could not attend an engagement hui, provided written feedback.

78. *Allen + Clarke* did not require participants to share demographic information during engagements. However, based on communication leading up to community engagement, people voluntarily self-identifying, and/or information people shared during hui and interviews, *Allen + Clarke* estimate that at least 60 Māori and 20 Pacific individuals participated in community engagement (including participants in the general community engagement).

79. In this report, *Allen + Clarke* has presented community participants' views without critical analysis. *Allen + Clarke* considers that the health entities should undertake their own critical analysis of the needs and aspirations of communities to determine whether or to what extent it is reasonable to be guided by those needs and aspirations when developing and delivering services and programmes to address alcohol-related harm. Participants' views have been presented in this report to support that analysis by the health entities.

4.2.5.2 Academic and agency engagement

80. A mix of group and individual interviews were also undertaken as part of the agency and academic engagement stream. We heard from:

    - 32 agency representatives during 12 agency interviews (to understand relevant Crown processes and agencies' perspectives on the alcohol levy), and
    - 8 academics during two group interviews (to understand the actual and potential relationship between alcohol levy funds and alcohol-related research).

81. Some of the people who participated in the agency and academic engagement were Māori and Pacific.

82. As with community participants, in this report, *Allen + Clarke* has presented academic and agency participants' views without critical analysis.

4.2.5.3 Industry engagement

83. Industry engagement comprised one group interview with five alcohol industry association body representatives. Two of these representatives also provided written information, including a body of research on alcohol harm and on potential health benefits in relation to some conditions in some populations from some levels of alcohol consumption.

84. Alcohol industry association representatives were engaged to assist in understanding and communicating the perspectives of member organisations on alcohol policy matters.

85. Engaging with alcohol association representatives ensured that the broad perspective of alcohol industry organisations on the alcohol levy's administration, governance, and investment could be considered for this review, while maintaining the review's focus on engaging with participants involved in addressing alcohol-related harm.

86. As with all groups engaged with for this project, the number of industry representatives engaged with was limited by budget and project time constraints. All stakeholders wanted us to speak with more people across and within organisations. However, during the engagement with industry, the general views were well expressed by the industry representative organisations and provided the key relevant input required for the purposes of this review.

4.2.6 Corporate document review

87. *Allen + Clarke* reviewed documentation provided by the Health Promotion Directorate. These documents were reviewed to understand the current state of the alcohol levy, including current investments, funding approach, and the role of levy funding within the Health Promotion Directorate's wider alcohol work programme. The documents reviewed included:

- documents relating to the Community Social Movement programme, including project plans
- overviews of the Health Promotion Directorate's alcohol programme
- documents relating to the Health Promotion Directorate's sport related activities, including a project plan
- documents showing the broad level of levy investment across categories of activities
- documents that outline some of the wider alcohol work programme, and
- an alcohol research programme project plan.

88. These documents enabled *Allen + Clarke* to describe some of the current and previous activities undertaken with levy funds. Limited information was available given the timeframes and the current changes in the health system, so the analysis in this report is based on the documents provided.

4.2.7 Evidence review and analysis

89. *Allen + Clarke* also undertook a targeted review of published research on alcohol-related harm and the effectiveness of various services and programmes in addressing alcohol-related harm. This targeted review was not intended to provide a comprehensive justification of whether the services and programmes are reasonable for the Ministry to develop and deliver through the levy. It was conducted to confirm whether the health entities would be justified in undertaking an exercise to:

    - quantify the cost of developing and delivering the programmes and services required to fulfil the need and meet the aspirations identified in the report, and
    - assess the reasonableness of the Ministry incurring the cost of developing and delivering those programmes and services.

90. The team reviewed the engagement notes for accuracy and completeness. The engagement notes were grouped and analysed by theme and stakeholder type using a Miro (online collaborative workspace) board.

91. The review team then searched for and reviewed research that was relevant to the harms and activities to address harm identified during the engagement with participants.

92. *Allen + Clarke* synthesised and analysed the information from the engagement and evidence review to inform the final report and recommendations.

93. *Allen + Clarke* shared the analysis with the expert advisors to enable them to provide guidance and advice relating to alcohol-related harm, public health, Māori, Pacific, and Te Tiriti considerations.

4.2.8 Cost of alcohol-related harm

94. NZIER led the economic analysis and conducted a study into the cost of alcohol-related harm in New Zealand. NZIER provided a separate report, entitled, "Cost of alcohol harms in New Zealand: Updating the evidence with recent research", that should be read in conjunction with this report. NZIER state in their report *"this report does not present a comprehensive estimation of the costs of alcohol harms. But it presents new estimates where important evidence has emerged on critical issues of prevalence, impact and causal attribution."* The NZIER report seeks to:

    - improve the understanding of the nature and scale of harms that could be addressed through programmes and services funded by the alcohol levy, and
    - contribute (along with other evidence, including cost-effectiveness evidence) to the prioritisation of interventions by the health agencies (the Ministry of Health [Public Health Agency], the National Public Health Service in Health New Zealand, and the Te Aka Whai Ora), the broader health sector, and other agencies and organisations.

95. The NZIER report also provides information that could be used to inform a wide range of decisions, including decisions about data collection and research. It may also provide useful information for those working in the alcohol harm reduction field across government and in communities.

4.3 Limitations

96. While *Allen + Clarke* made a concerted effort to speak to a range of Māori participants around the country, the Māori perspectives in this report cannot be assumed to represent the views of all Māori. *Allen + Clarke* recognise the diversity of knowledges and perspectives held among various Iwi, hapū, and hapori around the motu. This review has therefore highlighted consistent themes across the insights provided by those Māori who participated and do not constitute a singular Māori perspective.

97. Pacific communities in New Zealand are multicultural and do not speak with a homogenous voice. The views of Pacific peoples in this report are based on consistent themes that were heard during engagement with Pacific peoples. They may not represent the views of all Pacific communities in New Zealand.

98. Asian peoples in New Zealand vary in culture, language, religion, politics, birthplace, and time lived in New Zealand. The Asian ethnic group population is the fastest growing in New Zealand.[17] The engagement within Asian communities for this review was limited due to budget constraints.

[17] Statistics New Zealand (2021, May 28). *Population projected to become more ethnically diverse.* **https://www.stats.govt.nz/news/population-projected-to-become-more-ethnically-diverse**

99. Budget and time constraints limited the number of people *Allen + Clarke* could engage with. In particular, *Allen + Clarke* did not engage with producers of alcohol, and we did not assess the potential impact of levy increases on producer businesses.

100. *Allen + Clarke* were not commissioned to undertake an exercise to assess whether beneficial health effects may occur in some populations at low levels of alcohol consumption, nor the extent of any such beneficial effects (for further discussion of this point, please see paragraphs 151 and 152).

101. Many participants spoke about the desire for broader policy and legislative changes in relation to alcohol, which were not in scope for this review. While some suggestions are included for context, the review does not make any recommendations regarding policy or legislative change.

4.4 Conflicts of interests

102. A range of community participants that were engaged with as part of this review received levy funding for the activities they undertake. In addition:

- Dr Chambers has received research funding from the alcohol levy for two projects; "Interventions to reduce alcohol's harms to health: a modelling study" (December 2021 to September 2022) and "Estimated alcohol-attributable health burden in Aotearoa New Zealand" (August 2023 – current). Dr Chambers' receipt of levy funding did not have a substantive impact on his role in this review, which was to provide *Allen + Clarke* with expert advice on alcohol-related harms and alcohol policy.
- Dr Sarah Herbert was a Principal Investigator on a University of Otago project entitled "Interventions to reduce alcohol's harms to health: A modelling study" from July 2021 to September 2022. The project was funded by the alcohol levy. From May 2022 to February 2023, Dr Herbert was a member of Te Hiringa Hauora Alcohol Research Advisory Group. tasked with advising on alcohol research funding priorities, guiding a 3-5 year alcohol research strategy, and overseeing implementation of the alcohol research strategy and plan. Dr Herbert's involvement in the levy funded research and activity listed above did not have a substantive impact on her role in this review, which was to provide *Allen + Clarke* support and guidance in relation to application of Te Tiriti and Māori perspectives throughout project planning, analysis, and reporting.
- Josiah Tualamali'i is on the boards of Le Va and Pacific Youth Leadership and Transformation Council (PYLAT). Both organisations were engaged as part of this review. Mr Tualamali'i's membership of the Le Va and PYLAT boards did not have a substantive impact on this role in this review, which was to provide *Allen + Clarke* support and guidance in relation to project planning and analysis and reporting of Pacific perspectives.

5 Alcohol-related harm in New Zealand

This section responds, in part, to the policy question

- What is the extent, nature, and cost of alcohol-related harms in New Zealand?
- This question is also responded to in NZIER's report.

> *"It impacts all of it – taha wairua, taha tinana, taha whānau, taha hinengaro."*
>
> *Māori participant*

103. Alcohol is a leading contributor to the global burden of disease; around 3 million deaths worldwide result from the harmful use of alcohol.[18] Alcohol consumption is associated with a range of non-communicable diseases, intentional and unintentional injury, and poor mental health outcomes. Alcohol is a carcinogen.[19] These harms are all explored in this section.

104. Alcohol is commonly consumed in New Zealand, with approximately 4 in 5 adults having consumed alcohol in the past year.[20] Alcohol purchase is legal for those over the age of 18 and is widely available in liquor stores and supermarkets around the country. Alcohol is consumed by people of all ages, genders, ethnicities, and socio-economic status.[21] There are currently over 11,000[22] premises licensed to sell alcohol in New Zealand, including on-licence (which allows for the sale of alcohol for consumption on the premises) and off-licence (which allows for the sale of alcohol for consumption elsewhere). Premises and events can also acquire a special licence, which allows the sale or supply of alcohol at specific events.

105. As covered in the Stage 1 report, understanding the scope of alcohol-related harms is important to consider the role of the alcohol levy in the broader context. The Stage 1 report provides an overview of some of the alcohol-related harms in New Zealand,

[18] World Health Organization. (2022, May 9). *Alcohol: key facts*. Retrieved from World Health Organization: **https://www.who.int/news-room/fact-sheets/detail/alcohol**

[19] National Toxicology Program. (2021). *Report on Carcinogens, Fifteenth Edition.* Research Triangle Park, NC: U.S. Department of Health and Human Services, Public Health Service. **https://doi.org/10.22427/NTP-OTHER-1003**

[20] Ministry of Health. (2023). *New Zealand Health Survey 2023/23*. Retrieved from **https://minhealthnz.shinyapps.io/nz-health-survey-2022-23-annual-data-explorer/**

[21] Ministry of Health. *New Zealand Health Survey 2023/23*.

[22] Ministry of Justice. (2024, February 27). *Licenses Register.* Retrieved from Register of Licenses & Certificates: **https://www.justice.govt.nz/tribunals/arla/register-of-licences-and-certificates/**

including personal health harms, violence, and other indicators of alcohol-related harm. The costs of these harms have been assessed in further depth in the NZIER report.

106. The following section outlines what participants said about the harms within the communities that they work in. Participants' views about alcohol-related harm are generally consistent with the evidence about alcohol's role in specific adverse personal health harms, violence and community harm.

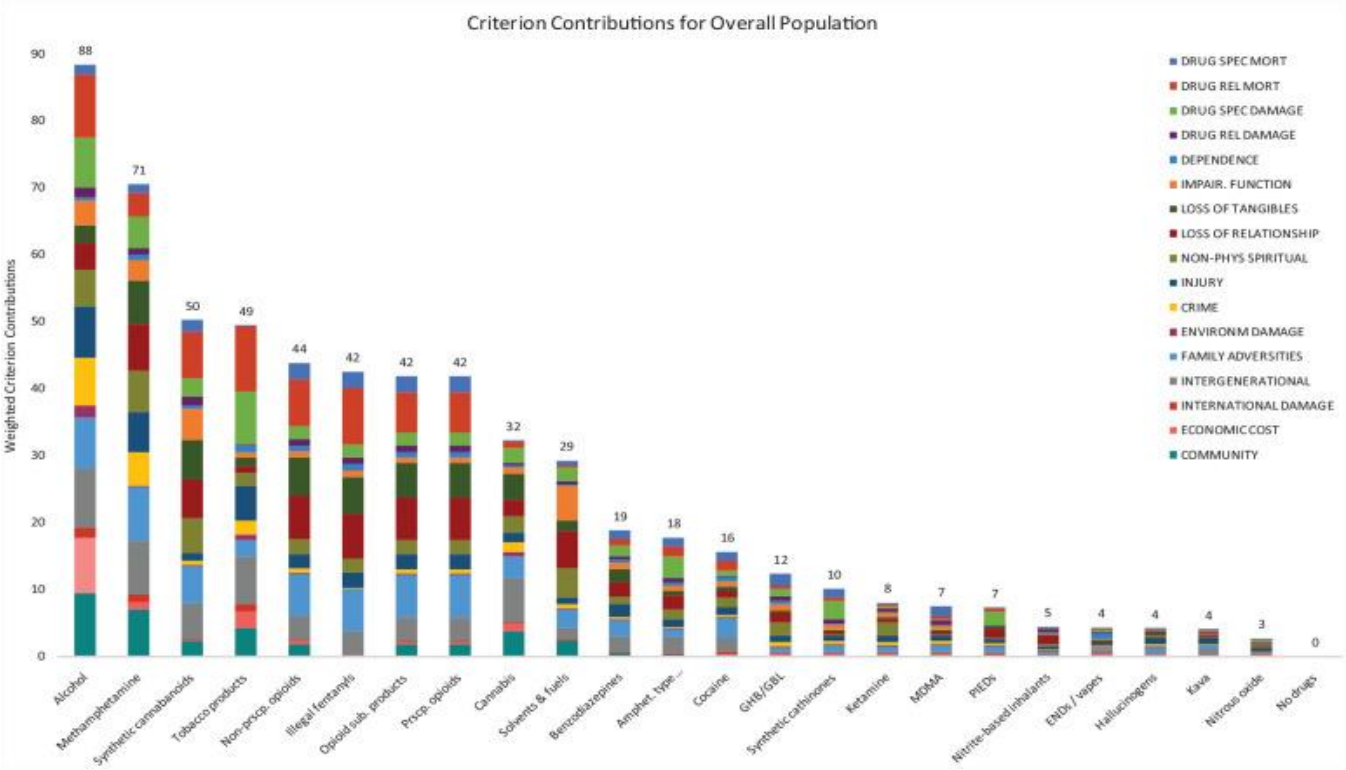
107. This section of the report is intended to demonstrate the need for activities to address alcohol-related harm and to contextualise the activities that participants identified as meeting their needs and aspirations. The harms presented are not an exhaustive list of the harms discussed by participants or the harms established by scientific evidence. To be clear, these are all harms participants believe the levy should have a role in addressing.

108. Participants consistently communicated that the breadth and depth of alcohol-related harm experienced by individuals, whānau, and communities in New Zealand is enormous; a full description of which would require its own report. NZIER's report illustrates the vast economic impact of that harm.

109. The high impact of alcohol harm on individuals and communities is demonstrated by the 2023 New Zealand drug harms ranking study. The drug ranking study used a multi-criteria decision analysis framework to assess and calculate harm by specific types of harm to self and others as assessed by 23 experts. In 2023, alcohol was the most harmful substance across all categories of substances.[23]

[23] Crossin, R., et al. Cleland. (2023). The New Zealand drug harms ranking study: A multi-criteria decision analysis. *Journal of psychopharmacology (Oxford, England)*, *37*(9), 891–903. **https://doi.org/10.1177/02698811231182012**

Figure 1: Drugs in order of their overall harm scores for the Aotearoa New Zealand population, showing individual criterion contributions after weighting. The cumulative preference values (sum of weighted contribution for each criterion) for each drug are shown.[24]



[24] Crossin, R., et al. Cleland. The New Zealand drug harms ranking study.

5.1 Physical harms

111. Alcohol is inherently toxic irrespective of the amount consumed and consumption can adversely affect nearly every organ and system in the body (alcohol toxicity).[25] Further, the evidence shows that cumulative experience of alcohol toxicity increases the significance of the detrimental effects on physical systems.[26] Some of the specific physical harms associated with alcohol consumption are discussed in further in this section.

Cancer

112. Many participants noted that alcohol consumption is linked to an increased risk of a range of cancers. There is sufficient epidemiological evidence that alcohol is a carcinogen and evidence from cohort and case-control studies show that alcohol consumption plays a causal role in cancers of the mouth, throat, voice box, oesophagus, colon, rectum, liver, and female breasts.[27,28,29,30] The International Agency of Cancer Research (IARC) continues to assess the relationship between alcohol consumption and other cancers including prostate, pancreatic and melanoma. Alcohol consumption is responsible for 4.2 percent of all cancer deaths in New Zealand. Alcohol-related cancer deaths are 2.5 times higher in Māori than non-Māori. It is estimated that an average of 12.7 years of life was lost per Māori person and 10.1 years for non-Māori from alcohol-attributable cancers. Almost two-thirds of all alcohol-attributable cancer deaths for women are from breast cancer.[31] [32] Over 100 bowel cancer cases per year in New Zealand are attributable to alcohol consumption, twice

[25] Babor, T., et al. (2022). *Alcohol: No Ordinary Commodity 3rd Edition.* Oxford: Oxford University Press.

[26] Babor, T., et al. *Alcohol: No Ordinary Commodity.*

[27] New Zealand Cancer Society (2020). *Position Statement: Alcohol and Cancer.*

[28] Bagnardi, V., et al. (2015). Alcohol consumption and site-specific cancer risk: a comprehensive dose-response meta-analysis. *British journal of cancer*, *112*(3), 580–593. **https://doi.org/10.1038/bjc.2014.579**

[29] International Agency for Research on Cancer. (2021). *Alcohol Consumption.* **https://www.iarc.who.int/wp-content/uploads/2018/07/WCR_2014_Chapter_2-3.pdf**

[30] National Toxicology Program. 2021. *Report on Carcinogens.*

[31] Wild. C., Wiederpass, E., Stewart, B. World Cancer Report: Cancer Research for Cancer Prevention. *International Agency for Cancer Research*. (2020). **https://www.iccp-portal.org/sites/default/files/resources/IARC World Cancer Report 2020.pdf**

[32] Connor J, et al (2017). *Alcohol-attributable cancer deaths under 80 years of age in New Zealand*. Drug Alcohol Rev. 2017;36(3):415-423. https://pubmed.ncbi.nlm.nih. gov/27306121/

as high as bowel cases attributable to smoking or processed meat consumption.[33] Participants were often concerned that the public seems largely unaware of alcohol's contribution to the development of specific types of cancers, including its positive dose-response relationship.

Neurological effects

113. Some participants commented on the impact of alcohol consumption on the brain. Alcohol has a range of impacts on the brain. Intoxication can impair balance and result in lengthened reaction time, chronic consumption contributes to neurotoxicity and the acceleration of neurodegeneration, and heavy drinking sees significant shrinkage of the frontal lobe.[34] [35] Participants also commented on the well-established after-effects of alcohol consumption (the hangover) and the impact that being hungover can have on productivity and the 'Mondays off sick' that can lead to job loss and financial insecurity.

Fetal alcohol spectrum disorder (FASD)

114. For many Māori participants, fetal alcohol spectrum disorder (FASD) was the most concerning physical harm caused by alcohol consumption. Participants said that FASD results in significant harm to affected individuals, their whānau, hapori, and society. Many participants who discussed FASD considered that the Crown's failure to provide adequate support to individuals with FASD and their whānau was the primary and avoidable cause of the ongoing harm.

115. Alcohol crosses the placenta, has a dose-response relationship with irreversible fetal harm and is a known teratogen.[36] FASD is a generic term covering a range of birth defects, developmental disabilities and neurocognitive or behavioural difficulties that are preventable if alcohol is not consumed in pregnancy.[37] Prevalence rates of FASD have been estimated for New Zealand, based on the WHO's comparative risk

[33] Richardson, A., et al. (2016). Modifiable lifestyle factors that could reduce the incidence of colorectal cancer in New Zealand. *The New Zealand medical journal*, *129*(1447), 13–20.

[34] Babor, T., et al. (2022). *Alcohol: No Ordinary Commodity 3rd Edition.* Oxford: Oxford University Press**;** Nutt, D., Hayes, A., Fonville, L., Zafar, R., Palmer, E. O. C., Paterson, L., & Lingford-Hughes, A. (2021). Alcohol and the Brain. *Nutrients*, *13*(11), 3938. **https://doi.org/10.3390/nu13113938**

[35] Kubota, M., et al. (2001). Alcohol consumption and frontal lobe shrinkage: study of 1432 non-alcoholic subjects. *Journal of neurology, neurosurgery, and psychiatry*, *71*(1), 104–106. **https://doi.org/10.1136/jnnp.71.1.104**

[36] Kaufman M. H. (1997). The teratogenic effects of alcohol following exposure during pregnancy, and its influence on the chromosome constitution of the pre-ovulatory egg. *Alcohol and alcoholism (Oxford, Oxfordshire)*, *32*(2), 113–128. **https://doi.org/10.1093/oxfordjournals.alcalc.a008245**

[37] Janet F. Williams, Vincent C. Smith, the Committee on Substance Abuse; Fetal Alcohol Spectrum Disorders. *Pediatrics* November 2015; 136 (5): **10.1542/peds.2015-3113**

assessment methodology.[38] In 2018/19, the general population prevalence data was 1.3 percent (95% CI: 0.9, 1.9) or 780 cases per annum, but some population groups experience more FASD harm than others. Wahine Māori had the highest rates of alcohol consumption in pregnancy (24.4 percent compared with 15.3 percent for the general population) and the highest estimated rates of FASD (2.1 percent). Asian and Pacific babies had the lowest rates of alcohol consumption in pregnancy and the lowest rates of FASD (2.4 percent and 0.2 percent; 6.8 percent and 0.6 percent FASD respectively).

Intentional and unintentional injuries

116. Injury as a result of alcohol consumption manifests in a range of ways. Unintentional injury, often occurring during acute alcohol intoxication, is a common occurrence in New Zealand. Injury from motor vehicle accidents where alcohol consumption was a factor is also a common occurrence in New Zealand. No comprehensive up-to-date data on alcohol's role in injury is available for New Zealand, with the latest data being from 2012.[39] Unpublished data from ACC suggests that, in the calendar years 2018 and 2019, 3,562 claims for alcohol related injuries received payment from ACC.[40] Estimates of emergency department presentations suggest that 9.5 percent (95% CI: 8.9, 10.1) presentations are alcohol-positive.[41]

117. Many participants spoke about the link between alcohol use and self-harm and suicide, calling alcohol a "*suicide enabler.*" The link between alcohol and suicidal behaviour is well-established.[42] Alcohol consumption is also linked to poor mental health and is associated with intentional injury.[43] Alcohol misuse can be a factor in self-harm and

[38] Romeo, J. S., Huckle, T., Casswell, S., Connor, J., Rehm, J., & McGinn, V. (2023). Foetal alcohol spectrum disorder in Aotearoa, New Zealand: Estimates of prevalence and indications of inequity. *Drug and alcohol review*, *42*(4), 859–867. **https://doi.org/10.1111/dar.13619**.

[39] Connor, J., & Casswell, S. (2012). Alcohol-related harm to others in New Zealand: evidence of the burden and gaps in knowledge. *The New Zealand medical journal*, *125*(1360), 11–27.

[40]Response to Official Information Act Request **https://www.acc.co.nz/assets/oia-responses/claims-and-claims-cost-for-alcohol-related-injuries-oia-response-gov-024671.pdf** Accessed 21/2/24.

[41] Egerton-Warburton, D., Gosbell, A., Moore, K., Wadsworth, A., Richardson, D., & Fatovich, D. M. (2018). Alcohol-related harm in emergency departments: a prospective, multi-centre study. *Addiction (Abingdon, England)*, *113*(4), 623–632. **https://doi.org/10.1111/add.14109**

[42] Boden, J., et al. (2022). Empowering community control over alcohol availability as a suicide and self-harm prevention measure: Policy opportunity in Aotearoa New Zealand. *The Lancet Regional Health Western Pacific*, 29: 100631.

[43] Connor, J., & Casswell, S. (2012). Alcohol-related harm to others in New Zealand: evidence of the burden and gaps in knowledge. *The New Zealand medical journal*, *125*(1360), 11–27.

suicide in adolescents.[44] In New Zealand, data from the National Coronial Information System showed that 26.6 percent of all suicide deaths involved acute alcohol use, with stronger associations in those of Māori and Pasifika ethnicity, at 32.3 percent, and 35.3 percent respectively.[45]

> *"Acute psychological harm is very understated. Especially for young women, Māori, and Pacific peoples."*
>
> *Academic participant*

118. Participants were concerned that alcohol consumption caused unintentional injuries. There is a dose response relationship between alcohol and injury, with the risk of injury beginning at low levels of consumption.[46] Participants spoke about the accidents they had seen in their communities while people were drinking (for example, someone having a concussion after losing their balance and hitting their head). As discussed in the Stage 1 report, in 2019, 3,247 new alcohol related injury claims were lodged with ACC at a cost of approximately $3.7 million per week. This is likely a major underestimate due to reporting challenges and bulk funded service agreements (for example, emergency treatment at public hospitals). NZIER has estimated the cost to ACC to be approximately $327 million annually.

119. Many participants mentioned drink driving as a key harm associated with alcohol. It is a significant risk factor for motor vehicle death and injury: between 2019 – 2021, alcohol (or drugs) was identified as a factor in 43 percent of fatal crashes, 11 percent of serious injury crashes, and 14 percent of minor injury crashes in New Zealand.[47] The flow-on effects of drink driving were also seen as a significant harm. One participant said, "*for young people, DUI is a big concern. Friends who are in near fatal crashes and in the courts as a result*".

[44] Hawton, K., Saunders, K. E., & O'Connor, R. C. (2012). Self-harm and suicide in adolescents. *Lancet (London, England)*, *379*(9834), 2373–2382. https://doi.org/10.1016/S0140-6736(12)60322-5

[45] Crossin, R., Cleland, L., Beautrais, A., Witt, K., & Boden, J. M. (2022). Acute alcohol use and suicide deaths: an analysis of New Zealand coronial data from 2007-2020. *The New Zealand medical journal*, *135*(1558), 65–78.

[46] GBD 2016 Alcohol Collaborators (2018). Alcohol use and burden for 195 countries and territories, 1990-2016: a systematic analysis for the Global Burden of Disease Study 2016. *Lancet (London, England)*, *392*(10152), 1015–1035. https://doi.org/10.1016/S0140-6736(18)31310-2

[47] Ministry of Transport. (2022). *Safety - annual statistics: Alcohol and drugs.* https://www.transport.govt.nz/statistics-and-insights/safety-annual-statistics/sheet/alcohol-and-drugs

Directly attributable personal health risks

120. Beyond cancers, neurological affects, disability and injury, there are a range of other serious health conditions that are directly attributable to alcohol consumption.

121. The relationship between regular, heavy alcohol consumption and hypertension is well-established.[48] Heavy alcohol use is the most common cause of chronic pancreatitis and the extent of liver disease is related to the amount of alcohol consumed.[49] There is also a significant relationship between alcohol consumption and the increased risk of other harmful health conditions such as stroke, type 2 diabetes, and dementia.[50] This not only affects individual health but places considerable financial burden on the New Zealand health system each year.

Psychological harms

Addiction, depression, and anxiety

122. Alcohol has a powerful effect on the brain and continued regular alcohol consumption can lead to the development of dependence.[51] Alcohol dependence and 'addiction' directly link to a range of significant adverse health outcomes (such as overdose and liver cirrhosis). Between 2017 – 2019, 129 people died by overdose from alcohol in New Zealand, making it the drug with the second highest overdose rate (behind opioids).[52] Alcohol dependence can occur in a range of circumstances; some participants told us that they see alcohol dependence as a symptom of broader issues, and people use alcohol as an attempt to cope with trauma, grief, social isolation, or anxiety and depression. A 2011 literature review reported on a range of epidemiological and clinical studies, which suggested that having an alcohol use disorder doubled the risk of developing a major depressive illness (and vice versa), suggesting also that this relationship was causative rather than associative.[53] Additionally, individuals diagnosed

[48] Klatsky A. L. (1996). Alcohol and hypertension. *Clinica chimica acta; international journal of clinical chemistry*, *246*(1-2), 91–105. https://doi.org/10.1016/0009-8981(96)06230-4

[49] Babor, T., et al. (2022). *Alcohol: No Ordinary Commodity 3rd Edition.* Oxford: Oxford University Press

[50] Allen + Clarke, NZIER. (2023). *Interim Report of Independent Review of the Alcohol Levy.* Wellington: Ministry of Health.

[51] Becker H. C. (2008). Alcohol dependence, withdrawal, and relapse. *Alcohol research & health : the journal of the National Institute on Alcohol Abuse and Alcoholism*, *31*(4), 348–361.

[52] New Zealand Drug Foundation. (2022). *Report: Fatal overdoses in Aotearoa 2017-2021.* https://www.drugfoundation.org.nz/news-media-and-events/overdose-report-2017-2022/.

[53] Boden, J. M., & Fergusson, D. M. (2011). Alcohol and depression. *Addiction (Abingdon, England)*, *106*(5), 906–914. https://doi.org/10.1111/j.1360-0443.2010.03351.x

with anxiety-related illnesses have an elevated risk of developing alcoholism.[54] The 2018 Government Inquiry into Mental Health and Addiction identified alcohol use as a major contributor to New Zealand's substantial mental health burden, and highlighted major concerns around high suicide rates, growing substance abuse, and poorer mental health outcomes for Māori.[55]

Indirect harms

123. Participants stated that an individual's alcohol consumption and/or dependence can be a significant contributor to a range of indirect harms. The indirect harms include financial insecurity, food insecurity, and housing insecurity. Indirect harms can also impact other people around the individual drinking, including through violence, children affected, and victims of motor vehicle accidents. Research conducted in the United Kingdom concluded that alcohol expenditure appears to exacerbate poverty in low-income households.[56] Participants believed that while the likelihood of these harms is greater for individuals with low socioeconomic status, alcohol addiction or alcohol attributable injury or illness can also lead to job loss, impacting individuals regardless of their socio-economic status. Where job loss occurs, individuals who otherwise were not at risk of financial, food, and housing insecurity may experience these challenges.

124. Some participants also considered that alcohol consumption is likely to increase an individual's propensity to commit crime, either as a result of lowered inhibitions, or to procure resources to purchase more alcohol. As discussed in the Stage 1 report, in 2009 the New Zealand Police National Alcohol Assessment showed that alcohol is involved in a third of all Police-recorded violence offences, half of sexual assaults, and half of all homicides.[57] Many participants viewed the legal penalties for crimes committed due to alcohol consumption or to sustain alcohol consumption as a form of alcohol-related harm.

125. Participants highlighted the interconnectedness of indirect and direct alcohol-related harms, which was described by one participant as *"the vicious cycle of drinking".*

[54] Butler, T. R., et al. (2016). Adolescent Social Isolation as a Model of Heightened Vulnerability to Comorbid Alcoholism and Anxiety Disorders. *Alcoholism, clinical and experimental research*, *40*(6), 1202–1214. https://doi.org/10.1111/acer.13075

[55] Government Inquiry into Mental Health and Addiction. (2018). *He Ara Oranga: Report of the Government Inquiry into Mental Health and Addiciton.*

[56] Nyakutsikwa, B., Britton, J., & Langley, T. (2021). The effect of tobacco and alcohol consumption on poverty in the United Kingdom. *Addiction (Abingdon, England)*, *116*(1), 150–158. https://doi.org/10.1111/add.15096

[57] New Zealand Police. (2009). *National Alcohol Assessment*

5.2 Harm to whānau and families

126. Participants shared a range of harms to whānau arising from alcohol consumption. They highlighted that alcohol consumption can create or contribute to an unsafe family environment, even impacting family members who do not consume alcohol, particularly children.

127. Participants talked about the cycles of alcohol use and the ingrained role that alcohol consumption has in New Zealand culture. They talked about seeing children in their communities witness, and replicate, the drinking habits of older family members. The role of environmental factors that encourage alcohol consumption (such as alcohol availability and consumption at many social occasions, alcohol advertising and sponsorship being commonplace, and a lack of public awareness of the health risks associated with alcohol consumption) were often discussed by participants. Many participants felt that alcohol being 'everywhere' contributes to poor health outcomes for their communities.

128. Participants also discussed more serious impacts on whānau where alcohol plays a role. Participants said that family members, including children, are exposed to violence perpetrated by family members who are intoxicated by alcohol. This exposure can normalise violence and can lead to children becoming violent themselves, and, in the words of one participant "*becom[ing] a disadvantage to their community.*" Further, regular use of violence within a family increases the likelihood that Oranga Tamariki will intervene and place children in state-care, fracturing families.

129. Estimating the prevalence of family harm, and the role that alcohol plays in family harm, is challenging as harm can be underreported by victims and alcohol use can be underreported by perpetrators. NZIER conservatively estimated, based on available evidence, that the alcohol-attributable cost of intimate partner violence is $256 million (of low to moderate certainty, due to the evidence available). A 2022 New Zealand cohort study of 58,359 children aged 0–17 years and their parents found a 65 percent increased risk of substantiated child maltreatment for those exposed to parents with a hospitalisation or service-use event related to alcohol.[58]

130. Some participants commented that the alcohol consumption by family members can normalise alcohol consumption and/or binge drinking amongst children. We also heard that caregivers' alcohol consumption can lead to family deprivation, as caregivers may forgo purchasing necessities such as food or transport to purchase alcohol. Participants were concerned that this leads to children experiencing food insecurity or truancy.

[58] Huckle, T., & Romeo, J. S. (2023). Estimating child maltreatment cases that could be alcohol-attributable in New Zealand. *Addiction (Abingdon, England)*, *118*(4), 669–677. https://doi.org/10.1111/add.16111

131. NZIER also estimates that the cost of child maltreatment (with similar methodology and certainty to the intimate partner violence cost estimate) attributable to alcohol to be approximately $74 million annually.

5.3 Environmental harm

> *"Just walk down Courtenay Place, you can see the harm. It's everywhere."*
>
> *General participant*

132. Participants considered that alcohol consumption can make communities unsafe or undesirable places to live or be in. They mentioned that people consuming alcohol in public often leave empty alcohol containers in public spaces, creating a negative environment. Glass bottles are often found smashed in playgrounds and outside schools, posing an obvious risk to children's physical health. A 2022 survey conducted for the Health Promotion Directorate (n=155 participants) found that, among other harms, alcohol-related rubbish and glass were widespread in many locations, requiring regular effort to clean up.[59] Participants were concerned about the unquantified cost of alcohol consumption, specifically the effort invested by individuals and councils to clean up alcohol-related rubbish and glass. Participants also viewed alcohol advertising as both a driver of harm and a harm in and of itself, acting as a 'visual pollution', diminishing the desirability of an area.

5.4 Community harm

133. Participants highlighted the substantial time, resource, and effort invested by individuals, communities, and the state in addressing the repercussions of alcohol-related harm which comes at an enormous opportunity cost, as those resources cannot be invested elsewhere. Many participants noted that a key driver for many alcohol-related harms is the availability of alcohol within their community, with the level of harm experienced within a community being directly related to the level of alcohol availability within the community.

134. There is strong evidence to demonstrate that consumption and associated problems increase when alcohol is readily available and decrease when availability is limited.[60]

135. Participants considered that alcohol availability and consumption significantly increases the level of violence experienced in communities. In particular, they expressed concern about the violence experienced by individuals who do not consume

[59] Randerson, S., et al. (2022) *"I feel it's unsafe to walk": Impacts of alcohol supply on public space in eight neighbourhoods, and residents' input to alcohol licensing decisions.*

[60] Babor, T., et al. (2022). *Alcohol: No Ordinary Commodity 3rd Edition.* Oxford: Oxford University Press.

alcohol themselves. In New Zealand, close geographic access to alcohol outlets is associated with increased levels of serious violent offending: a cross-sectional ecological analysis with Geographic Information System analysis reported a strong association between geographic access to alcohol outlets and various crime outcomes, including violent crime. It also demonstrated a dose-response relationship, showing that areas with the greatest access to alcohol outlets also had the highest incidence of crime.[61]

> *"Alcohol continues to be a tool of colonisation."*
>
> *Māori participant*

136. Many Māori participants were deeply concerned that alcohol, which was not consumed or produced by Māori prior to the arrival of Europeans, has caused, and continues to cause, immense damage to Māori individuals, whānau, hapū, iwi, communities, and society more broadly. Many Māori participants considered that alcohol was, and continues to be, used by the Crown as a tool of colonisation. Some Māori participants believed the Crown's failure to address present-day alcohol-related harm was a deliberate strategy of continued colonisation.

> *"Asian communities and people struggle to fit in here, alcohol is one way to fit in."*
>
> *General participant (from Asian communities)*

137. Some participants also noted alcohol consumption in New Zealand has disproportionate effects on Asian communities and migrants. Participants described how culture forms different understandings and relationships with alcohol which they argued were not reflected in the levy funded activities or overall health system.

138. We heard that alcohol consumption acts as a barrier to the flourishing of modern-day Māori whānau, hapū, iwi, communities, and broader society. We also heard that many iwi and Māori organisations have to invest significant resources to address alcohol-related harm within their communities, sometimes at the expense of addressing other important priorities. Many Māori participants considered that the Crown has failed to appropriately address the sale, supply, and advertising of alcohol through policy and regulation.

139. Many Pacific participants considered that alcohol-related harm prevents many Pacific peoples from contributing fully to society. It acts as a barrier to them strengthening their

[61] Day, P., et al. (2012). Close proximity to alcohol outlets is associated with increased serious violent crime in New Zealand. *Australian and New Zealand journal of public health*, *36*(1), 48–54. https://doi.org/10.1111/j.1753-6405.2012.00827.x

families, identities, and cultures, addressing intergenerational trauma resulting from migration experiences, the dawn raids, and racism. Participants said that alcohol-related harm includes people being excluded from their churches and other communities because of their consumption.

140. Pacific participants also conveyed that Recognised Seasonal Employer (RSE) workers and their families and communities experience significant harm from alcohol. Participants said that, in New Zealand, compared to the home countries of many RSE workers, alcohol is consumption is normalised and affordable. In the absence of their usual community and family support networks, RSE workers can begin regularly consuming alcohol at relatively high rates. This can lead to RSE workers returning home with alcohol addictions, or poor health outcomes from consumption while in New Zealand. As well as the obvious detriment this represents for the RSE worker themselves, *Allen + Clarke* heard that negative consequences of RSE workers alcohol consumption also accrue to their families and home countries.

> *"There is no room for healing or finding a place where you fit."*
>
> *Pacific participant*

5.5 Summary

141. A consistent theme throughout the engagement was that New Zealand's alcohol legislation, and the drinking guidelines do not currently reflect the extent of the health, social, and financial costs of alcohol consumption.

142. As the Stage 1 report also concluded, the level of harm caused by alcohol remains high. This is particularly concerning for Māori, who are disproportionately affected by alcohol-related harm, and gives rise to concerns that the Crown may be failing to uphold its obligations under Te Tiriti in relation to alcohol.

143. NZIER have estimated the cost of a range of alcohol-related harms. Some pertinent examples are:

- inpatient hospitalisation attributable to alcohol (including alcohol-attributed cancers) - $337 million
- absenteeism and presenteeism attributable to alcohol in New Zealand results in productivity loss worth over $3 billion in 2023, and
- the productivity loss attributable to FASD in New Zealand is over $134 million.

144. In its new Pae Ora context, the levy can be a powerful tool to address both the drivers and consequences of alcohol-related harm in New Zealand.

6 No safe level of alcohol consumption

145. Many participants clearly communicated that any level of alcohol consumption causes harm to the individual consuming alcohol and can cause harm to others or society. The understanding of alcohol-related harm has shifted in recent years, with some comparable jurisdictions (for example, Canada and Australia) amending their alcohol intake guidelines to lower amounts.

146. Globally, there is increasing recognition of the extent and nature of alcohol-related harm. During the 63rd session of the World Health Assembly, the 193 member states of the WHO (including New Zealand) unanimously endorsed the global strategy to reduce the harmful use of alcohol.[62] That strategy defines the harmful use of alcohol as "*drinking that causes detrimental health and social consequences for the drinker, the people around the drinker, and society at large, as well as the patterns of drinking that are associated with increased risk of adverse health outcomes*".[63]

147. New Zealand has endorsed a definition of harmful use of alcohol that includes any consumption that causes detrimental health and social consequences for the drinker.

148. In 2023, the WHO, referencing an article published in The Lancet Public Health, stated: "*When it comes to alcohol consumption, there is no safe amount that does not impact health*".[64] The article referenced by the WHO states that there is currently no evidence of a threshold at which the carcinogenic effects of alcohol "switch on",[65] which means there is a risk of developing alcohol-related cancers or other diseases at any level of alcohol consumption.

149. In the New Zealand context, the Ministry of Health considers that "there is no amount of alcohol that is considered safe and drinking any alcohol can be potentially harmful"[66]

150. In the most recent New Zealand Health Survey (2022/23), approximately 80 percent of New Zealand adults reported consuming alcohol in the past year and approximately 16 percent of those people reported they had consumed alcohol in a manner that was

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[62] World Health Organization. (2010). *Global strategy to reduce the harmful use of alcohol.*

[63] World Health Organization. *Global strategy to reduce the harmful use of alcohol.*

[64] World Health Organization. (2023, January 4). *No level of alcohol consumption is safe for our health.* ***https://www.who.int/europe/news/item/04-01-2023-no-level-of-alcohol-consumption-is-safe-for-our-health***

[65] Anderson, B., et al. (2023*).* Health and cancer risks associated with low levels of alcohol consumption. *The Lancet Public Health*, *8*(1), E6-E7. **https://doi.org/10.1016/S2468-2667(22)00317-6**

[66] Ministry of Health (2022, July 4). *Alcohol*. https://www.health.govt.nz/your-health/healthy-living/addictions/alcohol-and-drug-abuse/alcohol

deemed to be hazardous (particularly harmful).[67] Māori adults reported the highest rate of hazardous drinking (33%) compared to other ethnic groups. The high prevalence of current drinkers means that the majority of New Zealanders are exposed to some degree of harm due to their own alcohol use, in particular from their increased risk of 23 disease conditions established as part of the Global Burden of Disease Study.[68]

151. *Allen + Clarke* acknowledges that some research may indicate that, for some conditions, in some populations, there may be some beneficial health effects from low levels of alcohol consumption. However, the WHO has stated that *"…there are no studies that would demonstrate that the potential beneficial effects of light and moderate drinking on cardiovascular diseases and type 2 diabetes outweigh the cancer risk associated with these same levels of alcohol consumption for individual consumers*". In the same press-release, Dr Jürgen Rehm, member of the WHO Regional Director for Europe's Advisory Council for Noncommunicable Diseases, was quoted as saying "*Potential protective effects of alcohol consumption, suggested by some studies, are tightly connected with the comparison groups chosen and the statistical methods used, and may not consider other relevant factors*".[69]

152. *Allen + Clarke* was not commissioned to undertake an exercise to assess whether the potential for some beneficial health effects in some populations outweighs the clear evidence that, as the Ministry of Health and WHO state, there is no amount of alcohol that does not cause some harm, either to the individual consuming alcohol, to those around the individual, or to society at large.[7071] This position is supported by *Allen + Clarke's* engagement with individuals with clinical and research expertise during this review.

6.1 Relevance to this report

153. The Global Alcohol Action Plan (GAAP) was developed by the Director-General of the WHO to effectively implement the global strategy to reduce the harmful use of alcohol as a public health priority.[72] The GAAP provides specific actions and measures to be implemented by member states, presented in six action areas. Action Area 1:

[67] Ministry of Health. (2023). New Zealand Health Survey 2022/2023

[68] GBD 2016 Alcohol Collaborators (2018). Alcohol use and burden for 195 countries and territories, 1990-2016: a systematic analysis for the Global Burden of Disease Study 2016. *Lancet (London, England)*, *392*(10152), 1015–1035. **https://doi.org/10.1016/S0140-6736(18)31310-2**

[69] World Health Organization. *No level of alcohol consumption is safe for our health.*

[70] World Health Organization. *No level of alcohol consumption is safe for our health.*

[71] Ministry of Health (2022, July 4). *Alcohol*. **https://www.health.govt.nz/your-health/healthy-living/addictions/alcohol-and-drug-abuse/alcohol**

[72] World Health Organization. (2023). *Alcohol action plan 2022-2030.* Geneva: World Health Organization.

Implementation of High Impact Strategies and Interventions recognises that there has been limited progress achieved to date in reducing the harmful use of alcohol. The first proposed action for member states in this action area is to "to promote the prioritization, according to national needs and contexts, of the sustainable implementation, continued enforcement, monitoring and evaluation of high-impact cost-effective policy options included in the WHO SAFER technical package".[73]

154. Because (as discussed above) evidence shows no safe level of alcohol consumption, any reduction in per capita consumption of alcohol in New Zealand is likely to lead to a reduction in alcohol-related harm.

155. Consequently, population-level interventions (such as those proposed by the WHO and the New Zealand Law Commission) are appropriate alcohol harm reduction activities for the Ministry of Health to undertake and to recover the costs of doing so via the alcohol levy. Importantly, population-based interventions are also substantially cheaper than individual-based interventions. The WHO identified restrictions on alcohol marketing, availability, and price as the most cost-effective interventions to reduce alcohol-related harm.[74] Further, participants in this review often identified that activities that reduce per capita alcohol consumption (and by extension per capita alcohol harm) will also reduce hazardous alcohol consumption, while the reverse is not necessarily true.

[74] World Health Organization. (2013). *Global Action Plan for the Prevention and Control of Non-communicable diseases 2013-2020.*

7 Current levy expenditure

156. This section provides a short overview of what is currently funded by the alcohol levy. It outlines levy expenditure for the 2023/24 financial year (as of July 2023) and a description of how the expenditure process works.

7.1 Overview of the current programmes funded by the alcohol levy

157. Until June 2022, the whole levy fund was allocated to the Health Promotion Agency. The levy allocation for 2022/23 can be found in the Stage 1 report.

158. The levy fund for 2023/24 ($11.5m) is allocated between Health New Zealand, Health Promotion Directorate ($8.52m, 74.1%), Te Aka Whai Ora ($2.00m, 17.4%) and the Ministry of Health – Public Health Agency ($0.98m, 8.5%), see Table 4.

Table 4: Alcohol levy funding per health entity

Organisation	$m	Percentage of the total levy fund
Ministry of Health (Public Health Agency)	$0.98	8.5%
Health New Zealand (Health Promotion Directorate)	$8.52	74.1%
Te Aka Whai Ora	$2	17.4%

159. For the 2023/24 financial year, the majority of the levy fund was allocated to the Health Promotion Directorate within the National Public Health Service at Health New Zealand (this organisation has since been restructured). Health New Zealand is using its allocation to fund community and other organisations to continue previously committed activities related to alcohol-related harm reduction, and activities undertaken by the Health Promotion Directorate (with the 2022/23 activities outlined in Table 5). The table reflects the broad mix of projects, but the value of the investments may be subject to change.

160. Through the levy funding, Health New Zealand is conducting work on: reducing alcohol-related harm through providing advice to the Ministry of Justice to strengthen implementation of the SSAA; reducing inequities for Māori, Pacific people, and others through community-centred initiatives and key national leadership; changing the alcohol environment by piloting approaches like alcohol sponsorship replacement in community sports; leading the coordination of the National Public Health Service input into alcohol policy, while also playing a role in activating and informing wider action on policy priorities within and outside the health system; and producing evidence that addresses key policy-related evidence gaps and facilitating the use of this research in decision- and policy-making processes.

Table 5: Alcohol levy funding distributed by Health Promotion Directorate in FY2022/23

Description	Amount	Percentage of allocation
Kaupapa Māori Research Needs Analysis	$500,000	5.9%
Alcohol specific New Zealand research projects	$850,000	10%
Reducing alcohol advertising impacts – sports sponsorship demonstration projects	$500,000	5.9%
Pacific Alcohol Harm Minimisation programme	$350,000	4.1%
Community Social Movement project	$500,000	5.9%
Strategic messaging – Amohia Te Waiora we're stronger without alcohol	$500,000	5.9%
Focus on pregnancy and early years – a range of community grants	$500,000	5.9%
Digital and non-digital alcohol related resources for the public and industry	$500,000	5.9%
Policy change activities – support of Community Law pilot, professional development of DLCs, coordination of the Regulatory Agencies Steering Group, reactive response to other govt agency consultation in relation to alcohol harms	$400,000	4.7%
Regional activities – community grants	$700,000	8.2%
Internal Health New Zealand 24 equivalent FTE and other operational costs	$3,200,000	37.6%

161. At the time of writing, Te Aka Whai Ora has received its first allocation of levy funding and so is still in the planning stage but has indicated that the majority of the funding will be earmarked for activity in prevention and community-led programmes in relation to FASD ($1.8 million) and FTE to support the commissioning of those programmes ($200,000), see Table 6.

Table 6: Te Aka Whai Ora levy expenditure

Description	Amount	Percentage of allocation
Support for FASD Initiatives: A dedicated investment to strengthen FASD work, focusing on activities in prevention, and community-led initiatives that address Fetal Alcohol Spectrum Disorders.	$1,800,000	90%
Te Aka Whai Ora Alcohol Support Resource: To fund an additional senior advisor and activation resource to support the alcohol harm work.	$200,000	10%

162. In the current financial year, the Ministry of Health is using its $980,000 to both engage 4 FTE to support the policy, engagement functions, and overall alcohol-related harm reduction work programme of the Public Health Agency within the Ministry, and to fund this review (including NZIER's quantification of the costs of alcohol-related harm in New Zealand).

7.2 Process for allocating levy funding to contracts and grants

Ministry of Health

163. The Ministry of Health's levy portion will be used as set out above, and not allocated to external services. The Ministry does not commission external services, but works with its health partner agencies who commission external services. Hence, why the majority of the levy funds are allocated to Health New Zealand and Te Aka Whai Ora.

Te Aka Whai Ora

164. The 2023/24 financial year is the first year that Te Aka Whai Ora has received levy funding. *Allen + Clarke* understands that Te Aka Whai Ora are developing their levy allocation processes.

Health New Zealand - The Health Promotion Directorate

165. The Health Promotion Directorate within the National Public Health Service business unit of Health New Zealand includes a number of levy funded staff who transitioned from the Health Promotion Agency. *Allen + Clarke* understands that the Health Promotion Directorate is in the middle of a change process to integrate and align with the wider Health New Zealand organisation. While this transition occurs, some processes are reflective of the previous Health Promotion Agency structures.

166. There are four key mechanisms used by the Health Promotion Directorate, and previously the Health Promotion Agency, to allocate levy funds. There is no set amount allocated to each mechanism – it is allocated as part of the annual programme planning and budgeting. All mechanisms operate according to the All-of-Government procurement rules.

- **Activity Programme** - the Regional Managers have the flexibility to decide where the effort should be focused in their regions (within the principles of the Alcohol Harm Minimisation Framework).[75] They invest time and energy to understand their communities, to help identify where the greatest need is, and where the greatest impact can be made. Sometimes the funding is open/contestable and sometimes it is direct sourced based on identified need.
- **Contestable funds** - Health New Zealand has a number of contestable funds for certain things (for example, youth and First 1000 days contestable fund) and levy funding is sometimes distributed via these funds for certain, alcohol-related initiatives. Research is sometimes funded in this way.
- **Open tender Requests for Proposals (RfPs)** - Standard procurement processes are also used. The Community Social Movement (CSM) provides an example of innovative procurement: community partners are chosen by a panel and funding is devolved to rōpū who determine how best to spend the funding on activities within their communities.
- **Internal FTE** – 24 equivalent FTE work on alcohol-related activities within the Health Promotion Directorate, and overheads related to their work. These staff members have extensive experience, and knowledge, in relation to alcohol policy and alcohol-related harm reduction in New Zealand. The FTE deliver work programmes and work with communities.

Internal full-time equivalent (FTE)

167. The internal FTE is split between two programmes of work:

- 8.4 FTE on a health promotion policy and advice work programme
- 15.6 FTE on a de-normalisation and culture change work programme.

168. *Allen + Clarke* understands that since this review commenced, these programmes have been slightly restructured in the 2023/24 FY as part of the continuing change in the health system occurring as a result of the Pae Ora reforms, with an overall reduction of 6 FTE, to a total of currently 18 FTE, but the activities are still undertaken.

Health promotion policy and advice

169. The policy and advice work programme includes the following activities. This information was provided by the Health Promotion Directorate.

- Providing leadership and advice on national policy and legislation. This includes setting an example for how government should work with Māori communities in a way that prioritises devolving power and resources, mana motuhake, and decolonised models of funding.

[75] https://www.hpa.org.nz/national-alcohol-harm-minimisation-framework

- Building knowledge and capacity by resourcing and upskilling organisations and communities to ensure they can meaningfully interact with the SSAA (for example, community law centres, district licensing committees and regulatory agencies and community based groups).
- Building awareness and capability in the regions to ensure meaningful input into legislation and policy consultations.
- Providing advice on all alcohol-related matters to other national organisations, the regions, and communities.
- Connecting organisations together and resourcing collaborative alcohol-related mahi.
- Influencing and providing alcohol-related expertise to inform other agencies and decision makers.
- Building relationships with key stakeholders to ensure a consistent approach to the expertise provided by the Health Promotion Directorate on alcohol-related matters.
- Undertaking work and working with others to develop the alcohol evidence base in New Zealand.
- Leading the way in providing the strategy and resourcing for alternative alcohol-free sports sponsorship. This includes the identification and development of relationships with whānau, iwi, hapū, and Māori organisations who are wanting to reduce alcohol related harm.

170. *Allen + Clarke* understands that the health promotion policy and advice FTE engages with regulatory agency networks, local government, wider health agencies, and Police, and has expertise in alcohol research and the intersection between local government and health.

171. *Allen + Clarke* also understands that the health promotion policy and advice FTE engages with iwi and Māori organisations as part of efforts to support Māori communities to lead action nationally, and the promotion of coordinated action led by Māori and grounded in mātauranga Māori, to address alcohol harm.

De-normalisation and culture change

172. *Allen + Clarke* understands that this work programme includes the following activities:

- Leading the development of an alcohol-related harm minimisation strategy for Pacific peoples.
- Supporting and resourcing community participation/activation and engagement with alcohol-related harm minimisation projects in the regions.
- Connecting different groups together within and between the regions.
- Building relationships with key stakeholders to increase knowledge and capacity (for example, the Te Aka Whai Ora and the Public Health Agency).

- Building sustainable relationships with Māori and Pacific peoples and resourcing community and whānau-led activities that reduce alcohol-related harm (for example, the Community Social Movement project).
- Planning, designing, developing, and hosting alcohol-related resources for agencies and communities including social marketing activities and digital and non-digital health education resources and activities. This requires extensive engagement to ensure that the design and development is appropriate (for example, Amohia Te Waiora).
- Gathering information and responses to support early intervention, screening, and access to treatment services.

173. The de-normalisation and culture change FTE includes Pacific and Māori health expertise, programme management resource, and the regional managers (whose role is to be embedded within their community).

Other operational costs

174. The Heath Promotion Directorate estimates that, in 2022/23, 26 percent ($832,000) of its internal operating costs funded by the levy are overheads (including the ongoing maintenance of websites and health education resources) required to run an organisation (for example, payroll, human resources, infrastructure, and travel).

175. The operating model of the health system has significantly changed with the development of Health New Zealand, and the integration of the Health Promotion Agency into the Health Promotion Directorate of the National Public Health Service. At the time of writing the report, the Health Promotion Directorate has not fully integrated and is still managing its overheads and other activities until the integration is complete. The Health Promotion Directorate expects the levy expenditure on these costs will decrease when the transition to Health New Zealand is complete and overhead costs become part of Health New Zealand's operating budget. At this time, the Health Promotion Directorate does not yet know how much levy expenditure on these costs will decrease, nor exactly when this would occur.

Health New Zealand - Other

176. At present no part of the alcohol levy is allocated to other parts of Health New Zealand that are directly involved in alcohol-harm related matters. For example, Alcohol and Other Drug divisions and regional medical officers of health are funded via general Vote Health appropriations and not from alcohol levy funding.

8 What do participants want the levy to fund in the future?

This section responds to the policy questions
• What are participants' perceptions of how the alcohol levy could be most effectively invested? Including stakeholder perceptions of whether there should be a focus on health promotion, prevention, or treatment measures.
• What current investments from the levy fund should be retained, if any?
• As pertains to the alcohol levy, what are the options for the Ministry of Health to meet its obligations to Māori under Te Tiriti, including an obligation to protect and ensure Māori rights to health and equity, in relation to alcohol and related harms?
• What are the options for the investment of the alcohol levy, to ensure that the Crown upholds its obligations under Te Tiriti o Waitangi and protects people's health and wellbeing in relation to alcohol-related harm?

177. This section provides an overview of the participants' views on their aspirations for the future use of the levy. Where possible, it provides an overview of what is funded by the alcohol levy for the 2023/24 financial year. It also provides a summary of evidence relating to the activities and opportunities that participants identified during *Allen + Clarke's* community and expert engagement.

178. This section reflects the health sector principles in the Pae Ora Act (particularly that the health sector should engage with Māori, Pacific, other population groups, and other people to develop and deliver services and programmes that reflect their needs), and the principle that the health sector should provide a choice of quality services to Māori, Pacific, and other population groups.

179. This section sets out the types of activities that participants believe the levy should fund and the reasons behind their choices.

8.1 What is the purpose of the levy?

180. The investment of the alcohol levy is currently focused on health promotion and prevention activities, that are supported by an evidence base regarding effective interventions, based on the mandate of what was the Health Promotion Agency.[76]

181. The Pae Ora context has changed the scope for the expenditure of the alcohol levy. This provides the opportunity for the Ministry of Health to consider setting up systems

[76] See section 3.2 of this report.

to use the levy to cost-recover a wider range of activities that address alcohol-related harm.

182. The Pae Ora context also means that explicit consideration needs to be given to Te Tiriti in order to give effect to the principles set out in section 6 of the Pae Ora Act, and to other priority population groups, such as Pacific peoples, as set out in the health sector principles in section 7 of the Pae Ora Act. While the scope for levy expenditure is now greater than it was previously, the levy may still only be expended on costs incurred by the Ministry of Health, despite the substantial costs of alcohol-related harms incurred by other sectors, such as justice.

> *"Whatever is currently happening is not working - $11 million might sound like a lot but when you compare the billions of dollars that the alcohol industry are making off the back of others' pain and suffering it is not good enough."*
>
> *Māori participant*

183. Participants described the inadequate funding of harm prevention, harm minimisation, addiction treatment services, community interventions, and other activities that are key tools to address alcohol-related harm.

> *"The levy should be increased to the level that reflects something about the reality of what's going on."*
>
> *Academic participant*

184. A range of activities undertaken by the health entities to address alcohol-related harm are funded from other Crown revenue sources, such as workforce development, addiction services, and costs incurred in the treating alcohol attributable fractions of disease and injuries. However, participants were often concerned that funding for addressing alcohol related harm external to the levy (e.g., from other Crown revenue) could be reallocated or lost at any point. As such, many participants expressed a desire for the levy to be increased, as funds collected through the levy must be spent on activities addressing alcohol-related harm and cannot be redirected to other things.

> *"If the intention is to address the costs of harm, then there is a need to challenge why the levy is so small. How much do [the alcohol industry] make off our communities and how much do we need to fight that?"*
>
> *Māori participant*

185. As noted in the Stage 1 report, the alcohol levy is disproportionately small relative to the cost of alcohol-related harm in New Zealand, which NZIER have estimated to be up to $9.1 billion.

186. Staff members of the health entities involved with alcohol-related harm policy and activities have stated that the scope of activities funded by the levy are restricted by the available levy fund rather than the available levy fund reflecting the cost of activities needed to address alcohol-related harm in the health system.

187. Many participants expressed disappointment at the low quantum of the alcohol levy and felt that it significantly limited the resources available for addressing alcohol-related harm, despite other Crown funding mechanisms.

188. Many of the programmes and services identified by participants as desirable investments of the alcohol levy would require an increase in the levy to fund and implement.

189. Overall, the current investments made by the levy generally align with participants' views on the activities that should be funded by the levy in the future. There was a clear view from participants, however, that the levy quantum is currently too small to effect substantive change in addressing alcohol-related harm. Many participants were not aware of the levy, or that levy funding was available.

190. Participants generally supported activities that focused on alcohol-related harm prevention, such as addressing the normalisation of alcohol in communities, creating alcohol-free community spaces, and reducing the availability, accessibility, affordability, and visibility of alcohol where possible. Devolving the funding to community providers, while providing national level support and guidance, was popular with many participants, particularly Māori participants.

191. Te Ao Māori / kaupapa Māori solutions are important and there is a need to strengthen resourcing of Māori specific initiatives. Māori leadership and participation in determining alcohol harm reduction activity is also necessary.

192. There was also strong support for alcohol-related harm awareness and education campaigns, despite some concerns regarding the evidence of success of these measures.

193. Community aspirations throughout this section provide a strong basis for determining future levy funding. This information should be given significant weight, given the role of the health sector principles in the Pae Ora context, when assessing activities that should be cost recovered through the levy mechanism.

194. The views of agency, academic, and community participants were generally consistent. As such, we only refer to specific categories of participants where the views of different groups were specific to that category.

8.2 The levy should be used to fund alcohol-free alternatives

195. Participants considered that the normalisation of alcohol consumption acts as a barrier to individuals and communities recognising alcohol-related harm, which undermines the efforts of individuals, communities, and society to address these harms. Participants

were concerned that binge drinking is,[77] in many contexts, a normalised form of celebration and commiseration, causing significant harm to individuals and their communities.

196. Participants considered that the levy could address the normalisation of alcohol consumption by reducing sports sponsorship and funding the creation of alcohol-free events, activities, and spaces. These activities are discussed below.

197. Participants also considered the levy should fund public health messaging and education campaigns to address the normalisation of alcohol consumption, these are discussed separately in section 8.5.

8.2.1 Current activities to reduce alcohol sponsorship are supported by participants and based on evidence

What is currently funded?

198. In FY2022/23, $500,000 of levy funds is allocated to sporting bodies and sports clubs to remove alcohol sponsorship and advertising, and to support health and wellbeing promotion in sports clubs. These demonstration projects are intended to inform the evidence base for, and understanding of, how to replace alcohol sponsorship with health promotion messages, and alternative forms of funding. This project was supported by 0.825 FTE from the Health Promotion Directorate, made up of a project manager, project members, and support and advice from the Te Tiriti, communications, marketing, and insights and evaluation teams.

Alignment to evidence

199. Sponsorship replacement aligns closely with one of the WHO's five key recommended policy interventions: "enforce bans or comprehensive restrictions on alcohol advertising, sponsorship and promotion".[78] In New Zealand, the Law Commission and the 2014 Ministerial Forum on Alcohol Advertising and Sponsorship recommended phasing alcohol sponsorship out of sport.[79] A 2023 New Zealand multi-stage life-table intervention modelling study estimated that 123,000 years of healthy life (95% UI:

[77] Binge drinking, for the purposes of this report, is used interchangeably with "hazardous drinking".

[78] World Health Organization. (2019). *The technical package. SAFER: A World Free from Alcohol Related Harms.*

[79] New Zealand Law Commission. (2010). *Alcohol in Our Lives: Curbing the Harm.* (Law Commission report; no 114).; Ministerial Forum on Alcohol Advertising & Sponsorship. (2014). *Recommendations on Alcohol Advertising and Sponsorship.*

21,000, 219,000) could be gained over the life of the 2018 population by phasing out alcohol sponsorship.[80]

200. Exposure to alcohol marketing is associated with early onset of drinking and increases the amount of alcohol consumed by those already drinking.[81] Among New Zealand children, alcohol sponsorship is a major source of alcohol marketing exposure. A 2018 study used cameras to assess the level of exposure to alcohol.[82] On average, children aged 11 to 13 years were exposed to alcohol marketing 4.5 times per day (95% CI: 3.3, 6.0). Sports sponsorship was the source of marketing in 31.4 percent of total exposures. Children living in more deprived areas, Māori and Pacific children were exposed on average to alcohol marketing at a rate five and three times higher respectively than other New Zealand children.

201. The replacement of alcohol sponsorship in sport aligns closely with the recommendations from the WHO (which recommends phasing out alcohol sponsorship of sport)[83], the Law Commission[84], and the Ministerial Forum[85] (both of which consider that alcohol-related sponsorship should be phased out and sponsorship funds replaced via other means) and is supported by evidence that minimising exposure to sponsorship (as a form of marketing) is an effective way to reduce alcohol-related harm.[86]

[80] Chambers, T., et al. (2023). *The estimated health impact of alcohol interventions in New Zealand: A modelling study*. Addiction (Abingdon, England), 10.1111/add.16331. Advance online publication. **https://doi.org/10.1111/add.16331**.

[81] Babor, T., et al. (2022). *Alcohol: No Ordinary Commodity 3rd Edition.* Oxford: Oxford University Press

[82] Chambers, T., et al. (2018). 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 (Oxford, Oxfordshire), 53(5), 626–633. **https://doi.org/10.1093/alcalc/agy053**.

[83] World Health Organization. (2019). *The technical package. SAFER: A World Free from Alcohol Related Harms.*

[84] New Zealand Law Commission. (2010). *Alcohol in Our Lives: Curbing the Harm.* (Law Commission report; no 114).

[85] Ministerial Forum on Alcohol Advertising & Sponsorship. (2014). *Recommendations on Alcohol Advertising and Sponsorship.*

[86] Chambers, T., Jackson, N., & Hoek, J. (2021). New Zealand's proposed ban on alcohol sponsorship of sport: a cost-effective, pro-equity and feasible move towards reducing alcohol-related harm. *The Lancet regional health. Western Pacific*, *13*, 100218. https://doi.org/10.1016/j.lanwpc.2021.100218.

What do participants think?

> *"We were already on the pathway but the financial oomph from the [levy] funding really supercharged it. There has to be a financial tally up, so it enabled us to break away from the brewery and bar funding."*
>
> *Participant (recipient of levy funding from sports sponsorship programme)*

202. Many participants considered the relationship between alcohol and sport in New Zealand to contribute to the "drinking culture".

203. Many participants supported scaling up existing funding to remove alcohol sponsorship from community sports. They believed that completely replacing alcohol sponsorship in all sports would be a highly effective way of reducing alcohol-related harm. However, they recognised that achieving this would require a substantial increase to the levy, along with a variety of other activities aimed at de-linking alcohol and sport while also addressing alcohol-related harm.

What do Māori participants think?

204. Many Māori participants considered that buying out alcohol sponsorship would enable sports clubs to continue operating while reducing the exposure of tamariki and rangatahi Māori to alcohol advertising and consumption. Rugby union, rugby league, and netball were often used as examples.

What do Pacific communities think?

> *"It needs to be about strengths-based stuff. How to have healthy relationships, identity within Aotearoa as a minority population, and other wellbeing discussions. Kapa haka does this really well, so does Polyfest, and church groups [who] do activities on a weekly basis which bring people in off the street."*
>
> *Pacific participant*

205. Pacific participants considered that, to be effective, sports sponsorship buy-outs must be accompanied by the strength-based provision of broader, culturally responsive, and age-tailored wellbeing support for club members.

206. Sport was raised as a positive and significant part of many Pacific families' lives. Participants felt that weakening the correlation between sport and alcohol would be beneficial for wellbeing and support sport continuing to play a positive role for Pacific families.

8.2.2 What do the participants see as opportunities for the future?

207. There is an opportunity to extend the current funding to replace the revenue that all sports organisations receive from the alcohol industry with revenue from the alcohol levy. Participants felt that this should be a temporary arrangement to enable sports organisations to secure new revenue streams, and support the transition away from alcohol sponsorship.

Giving effect to Te Tiriti

208. The principles of **active protection** and **equity** would apply to opportunities leveraged to denormalise alcohol in sport, including minimising tamariki and rangatahi exposure to alcohol sponsorship, coupled with the provision of wellbeing support and supporting environments where alcohol is not visible or present. Importantly, there is opportunity to provide **options** and build **partnerships** with Māori to meaningfully and specifically determine funding decisions and actions relating to the de-normalisation of alcohol in sports and/or exposure to alcohol sponsorship. Moreover, in working closely with Māori to determine how the de-normalisation of alcohol in sports may occur **tino rangatiratanga** would also be upheld as Māori aspirations would be acknowledged and reflected in decision-making outcomes.

> **Recommendation**: Continue to fund the alcohol sponsorship replacement pilot and increase the alcohol levy to extend the programme to fully replace alcohol sponsorship for sport in New Zealand - see **Extend** in the proposed investment framework at section 10.2).

8.2.3 There is strong support for funding the creation of alcohol-free events, activities, and spaces

What is currently funded?

209. An allocation of levy funding is used to provide community grants that support community-level aspirations to minimise alcohol-related harms.

Alignment to evidence

210. *Allen + Clarke* understands that when making decisions about community grant funding, the Health Promotion Directorate considers whether sufficient evidence of effectiveness of the proposed activity is available to warrant levy investment on a case-by-case basis.

What do participants think?

> "*Friday night stuff [social sport] lets us run soft interventions and have soft conversations. People have their whole family come because it is free, and we give them food. By aligning with them it gives us authenticity."*
>
> *General participant*

211. There was wide support from participants for the levy being used to fund organisations to create alcohol free events, activities, and spaces. Many participants highlighted that such initiatives are most effective at reducing alcohol-related harm when delivered during times when alcohol consumption is especially prevalent, such as Friday and Saturday nights, and paired with broader wellbeing work. *Allen + Clarke* understand that these types of events are strong contributors to alcohol denormalisation. Participants often referenced the success of New Zealand's efforts to denormalise tobacco consumption through supporting smokefree events, and believed that a similar approach to denormalising alcohol would be successful over time. Participants also recognised that this aligns with the understanding that addressing alcohol-related harm requires a holistic approach – many participants felt that better overall wellbeing outcomes are intrinsically linked with lowering alcohol-related harm, for example by reducing the prevalence of drivers of alcohol consumption in an individual's life.

What do Māori participants think?

> "*We know that when we change the kaupapa of our events from alcohol-focused to children-focused, 99.99% of whānau will buy into it."*
>
> *Māori participant*

212. Many Māori participants strongly supported the levy funding organisations to create alcohol-free events, activities, and spaces at a local level. They considered that alcohol-free events, activities, and spaces are often both inherently wellbeing-enhancing, and an opportunity to deliver holistic wellbeing support to individuals and whānau who may not otherwise access such support. They felt a wide range of free or low-cost alcohol-free events and activities were needed to bring individuals and whānau in, including marae and/or taiao or natural environment-based initiatives.

What do Pacific participants think?

213. Pacific participants generally supported the levy funding alcohol-free events for young people and their families as they act as an alternative to the normalisation of alcohol

consumption at events and provide an opportunity to deliver information about alcohol-related harm and harm reduction strategies to attendees.

214. Several Pacific participants said that Polyfest performing arts festivals around the country were used as examples of local "by Pacific, for Pacific" community spaces which act as an alternative to events with alcohol and provide the opportunity for alcohol-free messaging (for example, utilising the Amohia Te Waiora brand which is part of a campaign facilitated by the Health Promotion Directorate similar to the Smokefree New Zealand campaign. Participants also noted that it is important to ensure that Pacific community leaders are involved, including youth, spiritual, and rainbow leaders, to ensure that the spaces are culturally safe and approachable and relate to the relevant community.

215. Seasonal workers are an example of a Pacific community requiring nuanced pastoral care and cross-agency planning to create and offer alcohol-free spaces that still provide for social connection and relaxation, as seasonal workers are often in New Zealand for fixed periods of time, sometimes without family or community networks. A few participants said that low cost or free events without alcohol need to be in all education spaces. At the same time, they see the benefit of weaving Pacific ancestral stories and insights about how Pacific communities did not use alcohol and how addiction challenges are worked through culturally into education curriculums.

What do the participants see as opportunities for funding the creation of alcohol-free events, activities, and spaces?

216. There is an opportunity to provide funding for more alcohol-free activities to provide cheap (or free) community spaces.

217. Many participants felt that, to be effective at denormalising alcohol consumption, alcohol-free activities should be paired with strategic messaging campaigns (like Amohia Te Waiora). A proportion of alcohol free activities could be targeted to Māori and Pacific populations, either by providing further support to existing alcohol free activities such as Te Matatini and Polyfests, or by supporting Māori and Pacific communities to create new alcohol free activities.

Giving effect to Te Tiriti

218. The principle of **options** can be given effect to by resourcing targeted alcohol-free activities that are provided in a culturally appropriate way and recognise hauora Māori models. In resourcing and providing these targeted alcohol-free activities, the principles of **equity** and **active protection** are also supported. Likely outcomes are a reduction in alcohol harms observed among Māori and, in the very least, a reduction in the consumption of alcohol among Māori which, on the basis that there is no safe level of alcohol use, may in turn lead to improved health outcomes (**active protection** of Hauora). Further, ***tino rangatiratanga*** may also be upheld if the alcohol free activities that are funded are chosen by Māori, hapū, and iwi. Clearly the way in which these kinds of levy funding decisions are made also provides opportunities to uphold **partnership** if Māori are to have meaningful and equal decision-making authority in determining the resourcing and provision of alcohol-free activities.

Recommendations:

- Continue to fund community grants that allow for alcohol-free places and spaces - see **Core** in the proposed investment framework (at section 10.2).
- Increase the available fund for innovative programmes and services to trial new things - see **Trial** in the proposed investment framework (at section 10.2).

8.3 The levy should address the availability, accessibility, affordability, and visibility of alcohol, where possible

8.3.1 Participants think this would occur best through supporting policy change

What is currently funded?

219. The levy currently funds a range of programmes of work. These include the Health Promotion Directorate's coordination of the Regulatory Agencies Steering Group, the District Licensing Committee (DLC) network and the DLC advisory group, Pacific Advisory Group, Research Governance Group, and proactive and reactive responses to other local and central government agency consultation in relation to alcohol and alcohol-related harms.

220. Additionally, the levy previously funded FTE within the Health Promotion Agency and now funds FTE within the Health Promotion Directorate. These FTE include expertise in alcohol policy and research, local government, and the coordination function of the regulatory agency network.

221. Further, some levy funded projects, such as Community Social Movement are intended to mobilise communities to support and advocate for harm-reduction focused alcohol policy and legislation.

222. While this funding cannot directly impact policy related to availability, accessibility, affordability, or visibility of alcohol, it can support agencies and communities to more fully participate in policy processes that regulate these factors.

Alignment to evidence

223. The WHO's SAFER Framework and 'Best buys' include examples of policies intended to reduce alcohol harm that are well supported by evidence of their cost-effectiveness.

As policy change recommendations are outside the scope of this report, *Allen + Clarke* did not undertake detailed investigation of other effective policy interventions to address alcohol harm.

224. Participants considered that community mobilisation is effective for achieving policy and legislation change. For instance, we heard that community mobilisation was a significant contributor to the replacement of the Sale of Liquor Act 1989 with SSAA. We also heard anecdotal evidence about the role of researchers, health professionals, and others supporting community mobilisation to achieve policy and legislative change.

What do participants think?

225. Many participants considered that a cross-agency, cross-sector, national strategy and plan for reducing alcohol-related harm would positively contribute to addressing issues related to the availability, accessibility, affordability, and visibility of alcohol.

226. Some participants considered that while effective legislative and policy measures are well researched, clearly defined, and widely understood, they are rarely adopted. Participants were concerned that the failure to adopt public health focused law and policy is sustaining and increasing alcohol-related harm.

227. Community participants representing Asian communities wanted to see a framework for addressing alcohol harm and the delivery of initiatives that reflects their communities.

228. Participants often commented on the price of alcohol relative to other goods and services in New Zealand, with one participant saying, "*it's the cheapest form of entertainment once you reach a certain age.*" Some participants want to see the price of alcohol raised through policy mechanisms.

229. *Allen + Clarke* notes that the alcohol levy is a cost-recovery mechanism, rather than a demand modifying mechanism. A significant increase in the price of alcohol via the levy could only occur as a consequence of significant investment in activities to address alcohol-related harm (and recovering the costs of doing so via the levy).

What do Māori participants think?

> *"Communities should be the ones saying what is needed, not being told what it is we need."*
>
> *Māori participant*

230. Māori participants felt that they are not adequately involved in the development of the overall alcohol policy direction. Māori participants strongly recommended that the development of any national strategy and plan to reduce alcohol-related harm must be

led by communities. They considered that communities should be funded to participate in the development, implementation, and monitoring of the strategy and plan.

What do Pacific participants think?

> *"The causes, the impacts, and the pathways to change can't happen in isolation."*
>
> *Pacific participant*

231. Pacific participants highlighted that alcohol-related harm can only be addressed through a whole-of-system approach that enables community organisations and the Crown to work together to address the drivers of alcohol-related harm. They viewed this as essential, given the wide variation of circumstance and context between and within Pacific communities.

232. Many Pacific participants considered faith to be an essential part of their holistic wellbeing. Accordingly, they said that faith should be considered in policy design led by Pacific communities.

233. Some participants felt that kava policy and support should also be considered alongside alcohol.

234. One Pacific organisation stated that the Realm of New Zealand and Treaty of Friendship with Samoa should be considered when shaping alcohol-related harm minimisation policy.

8.3.2 What do participants see as opportunities for the future?

235. Many participants considered that there is an opportunity for the levy to fund the development, implementation, and monitoring of a cross-agency, cross sector national strategy and plan to reduce alcohol-related harm. A national strategy and plan should unite government and non-government harm reduction activities, enhancing the effectiveness of both. This could work to address alcohol availability, affordability, and access through policy change.

Giving effect to Te Tiriti

236. The principle of **partnership** can be given effect to by the Crown working alongside Māori in the governance, design, delivery, and monitoring of a cross-sector national alcohol harm reduction strategy and plan. Resultingly, **options, equity,** and **active protection** may also be upheld as Kaupapa Māori and Te Ao Māori solutions become designed and developed including in the implementation of the alcohol harm reduction strategy and plan. This would also improve access to alcohol reduction activities for Māori and therefore, ideally, improved health or alcohol related outcomes among Māori

(**active protection** and **equity)** and other groups in the population. Further, Māori rights to **tino rangatiratanga** will also be given effect when there is space for Māori to determine what alcohol reduction strategies include and how they are implemented.

> **Recommendation:** Consider using the alcohol levy to fund the development of a cross-sector, cross-agency, national plan for alcohol to provide strategic direction for alcohol policy in New Zealand.

8.3.3 Participants want the levy to support harm reduction through the District Licensing Committee process

What is currently funded?

237. The levy currently funds a range of projects, including the Community Law Alcohol Harm Reduction Project (in some Community Law centres) and the coordination and professional development for territorial authorities' District Licensing Committees (DLCs) as required.[87] The levy has also been used to fund the Health Promotion Directorate to support regulatory agencies' professional development, development and maintenance of resources to support the licensing process, guidance for territorial authorities on selecting and appointing DLCs, and expert advice and support to agencies, territorial authorities, DLCs and community objectors.

What do participants think?

238. Participants often identified the central role of the DLC in addressing alcohol-related harm in geographic communities.

239. The DLC process can feed into the regulation of alcohol availability, such as using licence conditions to restrict hours of sale (for both on and off licence premises) and restricting outlet density (acting in accordance with local alcohol policies, where they are in effect). *Allen + Clarke* notes that policies that restrict hours of sale or alcohol outlet density have been shown to have a moderate effect on reducing consumption or alcohol-related problems.[88]

[87] District licensing committees are independent decision-making bodies that, within their local areas, decide applications for new on-licences, off-licences, clubs and special licences, renewals, new and renewed managers' certificates, variations of licence conditions, and enforcement action for special licences.

[88] Babor, T., et al. (2022). *Alcohol: No Ordinary Commodity 3rd Edition.* Oxford: Oxford University Press.

240. Participants also noted that the ability of the DLC to place conditions on licences, such as restricting the sale of single cans of relatively cheap, high strength beers, can act as a control on the price of alcohol within a community.

241. The funding of professional development for DLC members was considered a good use of the levy by a range of participants with different interests, including government agencies and regional public health representatives. Given the recent changes to the SSAA,[89] the district licensing processes will be changing, and it is likely that additional support will be needed to ensure a smooth transition.

242. Participants, including Māori and Pacific participants, also expressed their support for Community Law Centres of Aotearoa's involvement in DLC processes, suggesting, "*fund Community Law Centres to conduct DLC advocacy*" and "*beef up Community Law.*" Some participants felt that nationwide funding for the Community Law Alcohol Harm Reduction Project would offer significant benefits for networking and proper support for community objectors. Industry representatives were not supportive of the alcohol levy being invested to support objectors to licence applications without equivalent investment in supporting licence applicants. No community, agency, or academic participants raised any potential for alcohol-related harm reduction from providing financial support to licence applicants.

243. Participants' view that support for objectors in the DLC process would lead to a reduction in alcohol-related harm is supported by *Allen + Clarke's* independent evaluation of the Community Law Alcohol Harm Reduction Project in 2020. *Allen + Clarke* found that the quality and effectiveness of community objectors' participation in the DLC process was improved through support from Community Law Centres. *Allen + Clarke* also found that strengthening and expanding the service would further improve outcomes, helping to reduce alcohol-related harms. *Allen + Clarke's* discussion noted that the regulatory agencies and those who work in the alcohol harm prevention sector considered that allowing Community Law to represent communities would make a real difference, as the DLC process "is so asymmetric and out of balance".[90]

244. Many participants felt that, for various reasons, the existing (i.e., prior to amendments coming into force in May 2024) DLC system fails to operate effectively to address alcohol-related harm. Participants were concerned that the combination of the highly legalised DLC process, a resource disparity between objectors and applicants, and underfunding of responsible agencies creates a power imbalance. This often results in licenses being approved or renewed despite their potential to cause undue harm (for example, in areas where there is already a high density of alcohol outlets or near schools or kura). Further, *Allen + Clarke* heard that DLCs are either unwilling or unable to adopt a definition of harm that aligns with communities' definitions. We also heard

[89] The Sale and Supply of Alcohol (Community Participation) Amendment Act 2023 received Royal assent on 30 August 2023 and (with the exception of sections 15 and 18) is now in force and effect.

[90] Allen + Clarke. (2021). *Community Law Alcohol Harm Reduction Project: A formative evaluation.* Wellington: Te Hiringa Hauora

that the DLC members often lack the cultural competency required to serve populations disproportionately affected by alcohol-related harm, including Māori and Pacific.

245. *Allen + Clarke* notes that, when discussing DLC-related levy funding, some participants noted that the most that could be achieved was short-term 'fixes' for a fundamentally inadequate system of alcohol control.

What do Māori participants think?

246. Several Māori participants considered that Māori wardens have a unique relationship with alcohol licensing law.[91] Māori wardens were recognised as having close ties with their communities and a strong understanding of the impact of alcohol harm on those communities from witnessing it first hand in their roles. Māori participants often supported providing levy funding for Māori wardens to engage more extensively in the DLC process to oppose alcohol licenses and as a way to reduce alcohol-related harm. Participants highlighted that Māori wardens had been particularly effective in Auckland DLC processes. The levy has previously been used to support up-skilling of Māori warden participation in for the process.

What do Pacific participants think?

247. Pacific participants highlighted the importance of assisting families and communities to object to alcohol licences. One Pacific participant also felt that DLCs often lacked the cultural competency to understand Pacific communities and how certain licences, or licence conditions (or lack thereof) would impact Pacific communities.

8.3.4 What do participants see as opportunities for the future?

> *"Through the DLC process, [communities] can achieve gradual change from opposing licences…"*
>
> *General participant*

248. Participants generally considered the DLC process, despite its flaws, to be a lever available to communities to directly address the accessibility, availability, price, and visibility of alcohol in their communities. We heard that there is a significant opportunity to support communities to participate in the DLC process, including funding for legally trained advocates to support communities before and during DLC hearings.

[91] Via the Māori Community Development Act 1962

249. There is an opportunity to expand the current pilot programme and fund a national roll-out of the Community Law Alcohol Harm Reduction Project to provide advocacy support for communities during DLC hearings. Alternatively, we heard that the levy could be used to fund a "friend of the objector" system, modelled on the "friend of the submitter" system used in Resource Management Act 1991 submissions processes. We heard that this approach may engender less opposition from the alcohol industry than funding advocates for objectors.

250. There is also an opportunity to fund Māori wardens, through the alcohol levy, to participate in the DLC process, given their mana and role in Māori communities. Similarly, while lacking a statutory mandate, Pacific wardens could also be funded to participate in the DLC process. Resource could also be provided to evaluate the effectiveness and co-benefits of Māori Warden contributions to DLC processes.

251. Given the changes to the SSAA that now allow community participation from anyone in the country, some participants suggested that Alcohol Healthwatch should receive additional funding (they are primarily funded through Vote Health), to provide research and data support to communities participating in the DLC process.

Giving effect to Te Tiriti

252. The principle of **equity** could be given effect through enhanced resourcing and support of Māori and communities to adequately engage in the DLC process. Further, through enhanced resourcing and support of Māori to engage in the DLC process **options** would be supported by Māori communities having increased agency in determining the nature of their engagement with the DLC and ultimately the outcomes of DLC decisions. Similarly, the principles of **active protection** being upheld if Māori are supported to be successful in influencing alcohol licensing outcomes that restrict access to alcohol in communities. Importantly, and as mentioned already in relation to strategy development, by resourcing and supporting Māori communities to engage more fully in the DLC process the principle of ***Tino Rangatiratanga*** will be supported as Māori will have increased agency in determining the availability of alcohol within communities.

Recommendations:

- Continue funding the support of the DLC process, in a permanent fashion - see **Core** in the proposed investment framework (at section 10.2)
- Consider the expansion of the Community Law Alcohol Harm Reduction Project nationwide - see **Extend** in the proposed investment framework at section 10.2).
- Consider re-instating levy funding for Māori warden participation in the DLC process.

8.4 The levy should be used to increase the understanding of alcohol-related harm in New Zealand and understanding of effective measures to reduce alcohol-related harm

What is currently funded?

253. A range of research projects are funded by the alcohol levy to inform policy advice. This includes research conducted in partnership with communities across New Zealand to amplify the voice of communities and inform policy across national, regional, and local levels. Research has also been funded to inform future levy investment to address alcohol-related harm, specifically for Māori.

254. *Allen + Clarke* understands that internal Health Promotion Directorate FTE funded by the levy include individuals with alcohol research expertise who manage the alcohol research programme. The alcohol research programme consists of numerous projects.

255. The strategic direction, priorities, and implementation approach to the Health Promotion Directorate's alcohol research activities are guided by the Alcohol Research Advisory Group, which has oversight of the programme. Research and data sources relating to alcohol are also available through a wide range of other sources, given that alcohol-related harm impacts many sectors in New Zealand.

What do participants think?

> *"[Due to the lack of data collection] we don't have any comprehensive ongoing clarity around harms."*
>
> *Academic participant*

256. Many participants perceived a lack of local and national data on the level of alcohol consumption, full range of harms and their costs, and the broader alcohol environment as a major barrier to addressing alcohol-related harm in their communities.

257. Many participants also suggested that more research is needed on how to address alcohol-related harm given New Zealand's unique demographics and constitutional make up compared to overseas jurisdictions.

258. Participants considered that improved data collection and research will facilitate the development and delivery of more effective and efficient services and interventions. We consistently heard, particularly from academic participants, that data is most useful when it is collected systematically and continually in a range of relevant environments.

259. Community participants who were involved in objecting to alcohol licences through DLCs felt that they lacked access to sufficient data to demonstrate the harm that

granting a specific alcohol licence would cause in their community. Community participants who were involved in policy or legislation development reported that data limitations are a major barrier to evidence-based policy and law reform. We heard that the lack of adequate data is a barrier to communities effectively advocating for, or implementing, actions to address alcohol-related harm.

260. Participants representing Asian communities perceived that there is a need for research to understand the gaps in knowledge about alcohol-related harms in different Asian communities. They described existing research and data as "*not diving into our communities"* or allowing for disaggregation. They noted research needs to be designed to reflect changing demographics within Asian and migrant populations.

> *"Problem with data collection, no breakdown of Asian populations in health data. This needs to be looked at, we are very diverse. I don't think they collect it currently, if they do – it's not good enough."*
>
> *General participant (from Asian communities)*

261. Some academic participants considered that there is unmet need for long-term programmatic research on alcohol-related harm and harm reduction.

What did Māori participants think?

> *"Ultimately we want to be building research capacity at a community level."*
>
> *Māori participant*

262. Many Māori participants emphasised the importance of having access to data that enables them to advocate for the needs of their people while also exercising rangatiratanga over all data that concerns Māori. They considered this especially important when dealing with people who are data focused, such as territorial authorities, who are making decisions regarding local alcohol policies in their area, or government agencies who are providing funding to address alcohol-related harms.

263. In general, Māori participants highlighted that research funding should be carried out at a local level and enhance the research capacity and capability within Māori communities, particularly amongst rangatahi. Many Māori participants considered it essential that rangatahi Māori are provided opportunities to gain research skills, both to provide immediate employment opportunities and to support the long-term development of the Māori research workforce. Māori participants considered that providing employment opportunities and developing the Māori research workforce would lead directly to some reduction in alcohol-related harm, and the findings from research would support further reduction in alcohol-related harm.

What do Pacific participants think?

> *"Health New Zealand has some work to do to understand the issue. Is it young people, is it our general population, is it our traditional communities, is it our Samoan communities, is it our Tongan communities, is it our 'born here' population?"*
>
> *Pacific participant*

264. Pacific participants often emphasised the value of granular data for supporting effective decision-making. Participants told us that terms such as "Pasifika" mask wide variations between and within ethnic groups. They said that data should be collected, and research conducted, into specific ethnic groups and communities. Pacific participants consistently noted that specific data about Pacific communities in rural and small centres will help ensure they are reached by alcohol-related harm reduction activities. Pacific student leaders would like the levy to fund decision makers, providers of support, and all other related decision makers to come to student events, have relationships with them, and hear from them what will work.

8.4.1 What do participants see as opportunities for the future?

265. There is an opportunity to use levy funding to support mapping, collation, and integration of routinely collected and available data related to alcohol consumption, associated harm, and the wider alcohol landscape. In particular, the collation of data could enable communities to document harm within their communities and support objections to licensing applications decisions.

266. There is an opportunity to fund training in research and data collection to support communities, including Māori, to collect their own data and potentially have their own research teams.

267. There is an opportunity to fund long-term programmatic data collection and research.

Giving effect to Te Tiriti

268. Resourcing the development and strengthening of the Māori research workforce as well as research specifically interrogating alcohol use and related harms among Māori gives effect to the principle of **active protection**. This would enable the provision of accurate, comprehensive, and responsive information and data to Māori and communities in order to strengthen alcohol harm reduction activities at a local level and in response to Māori health rights. Further, through resourcing Māori research and data collection, the principles of **equity** and **options** will be given effect, as Māori communities will be afforded greater options to develop their own mechanisms for monitoring the impact of alcohol use and related harms in their communities, and to respond accordingly with alcohol harm reduction activities. Broadly, these actions will

also support **tino rangatiratanga** as Māori will have greater agency to comprehensively understand alcohol harm as well as the management of alcohol harm reduction efforts among whānau, hapū, iwi, and communities.

Recommendations:

- Continue funding the alcohol research programme and make funds available for the development of an alcohol research strategy and plan - see **Core** in the proposed investment framework (at section 10.2).
- Provide levy funding to support communities to conduct local level research and monitoring of alcohol harm and harm prevention activities.
- As recommended by the NZIER:
    - focus decisions regarding the alcohol levy and the funding of services and programmes on evidence of impact, cost-effectiveness, and scale of unmet need
    - consider using a portion of the alcohol levy revenue or other funds to fund:
    - a research programme to fill important evidence gaps regarding alcohol harms in New Zealand, potentially prioritising areas where insufficient relevant evidence allows the problem to be quantified or valued, such as:
        - health-related victim impacts of alcohol-attributable crime, such as injuries and mental health impacts
        - alcohol-attributable use of outpatient services, mental health services, and aged residential care
    - collaborate with justice sector agencies, social sector agencies and the Ministry of Education to improve the evidence base regarding the non-health costs of alcohol harms, and
    - consider using a portion of the alcohol levy revenue or other funds to address problems with a demonstrated strong causal attribution to alcohol, such as FASD where investment in diagnostic and therapeutic services is much needed (to improve outcomes, reduce the private burden of FASD, and help fill significant evidence gaps such as the prevalence of FASD in New Zealand), including in the youth justice system and the prison population.

This would require an increase in the levy to adequately fund these recommendations alongside other recommendations in this report.

8.5 The levy should support the communication of alcohol-related harm and approaches to minimise harm

What is currently funded?

269. *Amohia Te Waiora: We're strong without alcohol* is a strategic messaging platform that includes various community action initiatives using multiple media. Each community determines the "best" communications medium to use based on their community and participants. *Amohia Te Waiora* is a comprehensive health promotion approach to addressing harm associated with alcohol - it includes community action coupled with social marketing. It was developed through 14 hui across the country to understand how alcohol affects midlife Māori, and to seek a mandate to assist Māori communities to tackle alcohol-related harm in their own way. The approach was endorsed by communities bringing solutions and narratives to the table alongside the Health Promotion Agency resources. From hui, the key message "*alcohol, we're stronger without it*" was developed to be used in supporting communities to reduce alcohol-related harm.

270. *Digital and non-digital resources* includes the maintenance of a range of alcohol-related resources for both the public and the industry to provide information, education, and guidance on how to meet legislative requirements. It also includes website development, which now prioritises responsiveness to whānau Māori through the use of Māori health models. For example, there are three 2-3-minute documentary style videos capturing different perspectives on wairua informed by previous research. This work also delivers an alcohol consumer website with a focus on Te Ao Māori, and specifically aimed at whānau Māori. It also includes a series of resources to help parents understand the effects of alcohol on teens and helpful strategies and advice to keep their teens safe.

271. The Health Promotion Agency has also previously funded a wide range of behaviour change campaigns such as "Ease up on the drink", "Say Yeah, Nah", the "Dept of Lost Nights" and "Not beersies". These marketing campaigns used relatable language with the aim to shift social norms around drinking for different population age groups.

What do participants think?

> *"Public health messaging needs to be led by people like us, NGOs who understand their communities."*
>
> *General participant*

272. In general, participants believed that information and education campaigns are useful when deployed in conjunction with other interventions, such as access to screening,

brief intervention, treatment, assistance in objecting to alcohol licences, or the provision of alcohol-free events and spaces. Participants highlighted that, to achieve harm reduction, national-level information and education campaigns must be designed to be adapted at a local level to support local activities.

273. Participants felt that potential alcohol-related harms, and ways to minimise those harms, are not sufficiently communicated. They said that there was. a lack of education regarding harms caused by alcohol. Participants were concerned that much of the population does not understand the risks of harm from alcohol, the extent of the costs incurred by society in responding to that harm, and how to address the harm. Many participants highlighted that this is not the result of individual failings, and that levy funding could be used to disseminate information about alcohol-related harm in ways that can be easily understood. The information campaigns used to reduce tobacco-related harm were often referenced.

274. Participants representing Asian communities considered that messaging was not "*aimed at [their communities]*" and that a "*one-size fits all*" approach does not work. As with many other communities in New Zealand, alcohol use is often reflective of individual context and participants emphasised that cultural competency is crucial when trying to address alcohol-related harm.

What did Māori participants think?

> *"For as long as the alcohol companies are benefiting from our communities then our babies need to have an opportunity to prepare themselves well for life and combat this harm. We need to educate and make people aware of the impacts of alcohol harm"*
>
> *Māori participant*

275. Many Māori participants considered that Māori, particularly tamariki and rangatahi, should be equipped with necessary tools to break the cycle of intergenerational alcohol consumption and harm, in conjunction with other measures to address the environmental/societal causes of alcohol-related harm. Māori participants identified three main focuses for education:

- Educating people (including rangatahi) who already consume alcohol about lowering their risk.
- Educating alcohol retailers about the harm that alcohol causes amongst vulnerable communities.
- Educating tamariki and rangatahi about alcohol-related harm with a view to increasing the likelihood of a gradual denormalisation of alcohol consumption.

What do Pacific participants think?

> *"We don't have the funding to go in there and meet with church leaders and convince them of the need to address alcohol harm."*
>
> *Pacific participant*

276. Pacific participants emphasised that churches play a huge role in many Pacific people's lives. We heard that funding Pacific NGOs to design and deliver education programmes for church and community leaders would enable alcohol-related harm reduction in populations that are often not reached by mainstream services, particularly RSE workers. Pacific participants said that this approach was highly successful when used to deliver messaging around the COVID-19 vaccine.

8.5.1 What do participants see as opportunities for the future?

277. Participants saw value in extending the devolution of funding to empower and resource community organisations to provide education and public health messaging in a way that relates to that community. The COVID-19 vaccination campaign was used by participants as an example of how this can be successful. In that campaign money was provided to community organisations to support public health messaging about vaccination, which resulted in uptake of the vaccine in Māori and Pacific communities. Tailored public messaging does, however, require more resource and expense to undertake.

Giving effect to Te Tiriti

278. Resourcing and enabling Māori and community organisations to design, deliver, and monitor communications, including the public health messaging about alcohol-related harm reduction, with a kaupapa Māori lens would support the principles of **partnership, active protection** and **options** as there would be greater focus and responsiveness to the needs and rights of whānau Māori and communities The principle of **partnership** would also be given effect through robust relationships between the Crown and Māori organisations tasked with providing kaupapa Māori and Te Ao Māori communications, public health messaging and education. Moreover, through bolstering kaupapa Māori and Te Ao Māori communications, **tino rangatiratanga** would be upheld as a by Māori, for Māori approach may be employed and subsequent communications and education would reflect Māori aspirations and ideals.

Recommendations:

- Continue funding public messaging campaigns - see **Core** in the proposed investment framework (at section 10.2).
- Consider the expansion of the public messaging campaign to support the development of tailored messaging for other communities - see **Extend** in the proposed investment framework at section 10.2).

8.6 The levy should fund local solutions to alcohol-related harm

What is currently funded?

279. Many of the activities funded by the alcohol levy are delivered by organisations embedded in their communities, such as the activities delivered via grants the Health Promotion Directorate provides to a number of to community organisations. This sub-section focuses on two activities that exemplify the mechanisms and benefits associated with funding local solutions to alcohol-related harm.

280. The Community Social Movement project (CSM) is a movement led, and driven, by Māori to minimise alcohol-related harm in communities across New Zealand. The movement is currently made up of a collective of five rōpū: He Waka Tapu, Hapai Te Hauora/Community Action against Alcohol Harm/Turehou Māori wardens, Te Rūnanga o Toa Rangatira, E Tipu E Rea Whānau Services, and Ngāti Hine Health Trust.

281. These five rōpū design locally grounded, community-led, and strengths-based initiatives that contribute to reducing alcohol-related harm in Māori communities. The movement harnesses the power of collective action by honouring each community's unique approach and solution to alcohol-related harm reduction. The movement is underpinned by a set of guiding principles, including prioritising whānau voices, trust and commitment, grounding in te āo Māori, and health is wealth. It is designed to prioritise tino rangatiratanga.

282. The CSM was well received by participants who receive levy funding as part of the CSM project. Other participants who were not aware of the CSM, essentially described the same model when explaining their ideal future state for the levy. Key features include the devolved nature of funding, the high level of trust for community providers, and the flexible nature of the funding that can be used to best serve the relevant community.

283. In FY2022/23, $500,000 was allocated to the CSM. Providers were selected based on a tender process designed to assess readiness to receive funding. This is supported by 2 FTE (across a range of staff, including a Project Lead, Programme Manager, Te Tiriti culture and partnership advisor, and Regional Managers).

284. The Pacific Alcohol Harm Minimisation programme involves establishing a dedicated work stream for Pacific alcohol-related harm minimisation building on the wider work programme priorities of the Health Promotion Directorate. Key deliverables are to develop a strategy and action plan to guide and mobilise the sector and Pacific communities to begin to reduce and minimise the inequitable harms of alcohol for Pacific communities.

285. This includes funding the Pacific Alcohol Advisory Group, which is made up of Pacific alcohol-related harm reduction and addiction experts and leaders from across the country. It is a new group that is currently establishing their roles and responsibilities.

286. In FY2022/23, $350,000 was allocated to the Pacific Alcohol Harm Minimisation programme.

What did participants think?

287. A strong theme throughout the engagement was that, where possible, funding local solutions to alcohol-related harm should be prioritised. Given the limited resources available through the alcohol levy, participants saw a role for a 'seed funding' function for locally-led activities; where grant funding could be used to trial innovative solutions on a small scale with a view to national roll-out if successful and appropriate.

288. Participants considered that organisations with an understanding of, and connections with, the communities they serve can identify the most effective harm reduction activities, delivery models, and community champions. Further, we heard that funding local organisations provides employment opportunities and enables capacity building for community members, which also lead to reductions in alcohol-related harm by addressing some of the drivers of alcohol consumption (for example, poverty).

289. Participants considered that the drivers and nature of alcohol-related harm vary between communities. We heard that locally led solutions are able to account for, and address, this variation in a way that nationally determined solutions cannot.

290. Community participants also commented that appropriate support would lead to successful outcomes, such as having planning support when setting up a project or programme, and monitoring and evaluation support to understand what works.

What did Māori participants think?

291. Many Māori participants considered that, given that Te Tiriti guarantees partnership, the levy must fund hapori Māori to design and deliver their own solutions to alcohol-related harm. We heard that hapori Māori best understand how to address alcohol-related harm in their rohe. Māori participants emphasised that organisations embedded in their hapori know the realities of that hapori and hold valuable insights which makes them best placed to do work that will improve people's wellbeing.

292. Māori participants described how hapori Māori designed and led programmes would allow for innovative, culturally appropriate, and empowering solutions to address alcohol related harm. Māori participants discussed previous and ongoing kaupapa

Māori initiatives which were supporting rangatahi and others in their rohe. Māori participants noted instances of rangatahi helping to design and deliver projects for rangatahi and discussed how designing and delivering projects can be empowering.

293. Māori participants often used the word 'trust' and felt that it is important for the levy to be used in a way that demonstrates trust in the intention and ability of communities to successfully deliver activities to address alcohol-related harm.

What do Pacific participants think?

> *"Provide autonomy to community providers."*
>
> *Pacific participant*

294. Pacific participants noted that New Zealand's Pacific population is extraordinarily diverse. We heard that solutions that work for one Pacific population may be inappropriate for another population. Pacific community participants considered that Pacific health and community providers have strong relationships throughout the Pacific population and can be trusted to use these relationships to support a range of populations to design and implement their own effective solutions to alcohol-related harm. Pacific participants highlighted that the need to acknowledge diversity should not stop the development of pan-Pacific alcohol programmes and services.

8.6.1 What opportunities does the community see for the future?

295. There is an opportunity to broaden the scope of, and increase the funding for, the Community Social Movement programme. This would enable it to include more Māori communities and expand to include Pacific and other communities (such as churches and sports organisations). There is opportunity to provide participating communities with the option to access additional programme management/planning and monitoring and evaluation resource or training.

Giving effect to Te Tiriti

296. Increasing the funding and resourcing of the Community Social Movement programme and similar initiatives to provide for kaupapa Māori and community-based services to support alcohol harm reduction will uphold the principles of **options, equity** and **active protection**. As Māori participants highlighted, the principle of **partnership** would also be given effect by enabling hapori Māori to design and delivery of those alcohol harm reduction initiatives and programmes. As detailed in previous examples, the principle of **tino rangatiratanga** would also be upheld as hapori Māori, who are best placed to respond to the needs of local people, would have the authority and agency to determine what the solutions look like for their whānau and communities.

Recommendations:

- Continue funding the Community Social Movement project - see **Core** in the proposed investment framework (at section 10.2).
- Consider the expansion of the Community Social Movement project - see **Extend** in the proposed investment framework at section 10.2).
- Create a **Trial** fund to allow for seed funding for innovative, locally-led solutions (e.g., build on the Regional Manager model being used by the Health Promotion Directorate).
    - Consider establishing a framework for this funding to provide clarity to potential applicants.

8.7 Participants think there is an opportunity for the levy to fund alcohol screening, brief intervention, peer support and treatment services

What is currently funded?

297. There is levy investment in pregnancy and early years through a range of community grants that are available to projects that support intergenerational change for pēpi, māmā, and whānau to create an environment during hapūtanga that supports wellbeing.

298. Te Aka Whai Ora are still in the planning stage for the use of its allocation of levy funding but indicated that the majority of their allocation will be invested in their FASD work programme.

299. Under the Health Promotion Directorate's uses the levy to fund an online one-stop shop for rangatahi mental health and wellbeing. It is intended to bring together the knowledge of a network of youth mental health and AOD support networks. This activity includes the development of digital resource in consultation with communities and the actual development of the resource.

300. Currently, the levy does not fund treatment services, as they do not fall into the health promotion remit and are funded through Vote Health. However, the levy does fund small peer support programmes. For example, the New Zealand Drug Foundation has received funding which has supported Living Sober, a peer support website for people struggling with alcohol dependence. The New Zealand Drug Foundation is predominantly funded by Vote Health, with a small portion of alcohol-related activity being funded by the levy.

301. The potential role of the levy in fully recovering the costs incurred by the Ministry of Health in the treatment of alcohol-related disease and injuries is discussed separately, in section 10 of this report.

What do participants think?

> *"Access to alcohol is easy – but if you want help [to reduce consumption or address alcohol-related harms] you have to wait in line."*
>
> *General participant*

302. Participants felt that there is an opportunity to better meet the need for services to support individuals to reduce or eliminate their consumption of alcohol. These services

include screening and brief intervention, individual and group peer-support, detoxification facilities, and long-term residential care. These services are currently funded through other Crown revenue streams. A few participants also saw a need for sobering up facilities to be provided in order to relieve pressure on Police custody facilities and hospital Emergency Departments, which we heard often are required to temporarily house intoxicated individuals. There is currently no funded sobering up facilities in New Zealand.

303. Participants also felt there is an opportunity to fund alcohol-related services that are grounded in kaupapa Māori principles/tikanga, and which value mātauranga ands whānau centric models of care.

304. *Allen + Clarke* heard that there is significant unmet need for alcohol-related harm reduction workforce development at all levels, from the people developing law and policy through to those delivering alcohol addiction treatment. This is not unique to work in the alcohol-harm reduction space; participants spoke about the workforce in the health system generally and the importance of building capability and retaining required skills and capability. Community participants also commented the workforce should be representative of all populations in New Zealand.

305. Participants believed that investing in capacity development within existing services can provide good value for money and is a sound investment decision. Some agency participants noted that health professionals, particularly in hospital settings, currently lack the training and time required to provide screening and brief intervention. To remedy this, participants suggested that that the levy could be used to develop and provide comprehensive screening and brief intervention training for the health workforce and could be used to fund specific alcohol screening and brief intervention roles within hospitals.

306. The guidelines for screening and brief intervention are currently being rewritten and are likely to be published in 2024.

307. Participants considered that a significant increase in the levy quantum to enable ongoing funding for a range of screening and brief intervention services would lead to significant reductions in both alcohol-related harm and the downstream costs incurred by individuals, communities, and society in responding to harm.

What did Māori participants think?

> *"Co-located services are magic."*
>
> *Māori participant*

308. Māori participants considered that, as alcohol-related harm often results from many factors, the levy should fund the establishment and operation of service hubs to address

the drivers of alcohol consumption. These hubs should operate *as "one stop shop[s] that provides full wraparound service[s] for people."*

309. We also heard that, for various reasons, some Māori do not wish to access kaupapa Māori or iwi-provided services. Therefore, some Māori participants highlighted that it is important to ensure that 'mainstream' services receive sufficient funding to provide culturally appropriate services to Māori.

What did Pacific participants think?

> *"The services are alien, they don't understand your world. There's not enough services, they aren't the right services, and then you've got our cultural barriers. There are a lot of things to look at."*
>
> *Pacific participant*

310. Pacific participants considered that the levy should fund organisations to provide support services that are responsive to the full range of Pacific cultures, languages, and circumstances. Pacific student leaders would specifically like to see the levy consider projects for harm minimisation on education campuses, at halls of residence and digital projects led with Pacific students.

8.7.1 What opportunities do participants see for the future?

311. Given the change in the Pae Ora context and the corresponding change in scope of activities that the levy can fund, there is an opportunity to investigate providing additional funding for screening and brief intervention, sobering up, individual and group peer-support, detoxification facilities, and long-term residential care. In particular, we heard that funding FTE within hospital emergency departments and on hospital wards specifically to deliver screening and brief intervention would be a highly effective harm reduction intervention. Many participants also highlighted that programmes to support people to reduce or eliminate their consumption of alcohol should not necessarily be abstinence based, as programmes that focus on harm reduction work better for many individuals and populations.

312. There is strong support for levy funding to be used to support the professional development of the alcohol-harm treatment workforce. Many participants expressed this view in a general manner, rather than using specific examples of programmes for workforce capability uplift. However, some agency and academic participants specifically noted that funding could be provided to mental health and addiction workforce development organisations to invest as they see appropriate to build the alcohol-related harm reduction workforce. Some academic participants suggested that, to build the research workforce, the levy should fund scholarships for Māori and Pacific researchers.

Giving effect to Te Tiriti

313. The principles of **equity, active protection.** and **options** would be upheld through strengthening the provision of responsive services, including co-located hubs, that provide another avenue of support for individuals and whānau to reduce or eliminate their consumption of alcohol and thereby ultimately improve Māori health outcomes. Importantly, the provision of these services would require Māori leadership to ensure they are responsive to Māori individuals and whānau, giving effect to the principle of **partnership**. With the establishment of culturally responsive services and support which are determined by and reflect Māori aspirations or ideals, there will be a strengthening of individual and whānau ability to experience and live in accordance with **tino rangatiratanga.**

Recommendations:

- Consider funding a broader range of screening, brief intervention, and peer support services through the alcohol levy.
- Consider funding treatment services through the alcohol levy, after undertaking a full cost-recovery analysis (see Tranche 3 in Section 10.2).

9 What do participants think the future of the levy administration and governance should look like?

This section responds, in part, to the policy questions

- What are participants' perceptions of how the alcohol levy could be most effectively administered?
- What are participants' perceptions of how the alcohol levy could most effectively be invested? Including stakeholder perceptions of whether there should be a focus on health promotion, prevention, or treatment measures.

314. This section briefly outlines participant's perceptions of how the alcohol levy is administered and views on the use of the alcohol levy beyond programmes and services.

315. In general, participants, including those who received levy funding, had little knowledge about how the levy is administered. To be clear, this is not a criticism of the participants in this review. Rather, it potentially indicates a need for more active communication with communities regarding how the levy is administered, including how funding decisions are made and the activities that are funded. Participants provided general feedback regarding their aspirations for the levy governance and administration based on their experiences of good practice.

316. This section also briefly outlines participant views on general considerations relating to levy funding and opportunities for the future to invest levy funding most effectively.

9.1 Participants want transparency regarding how the levy is invested and how decisions are made

317. **Note:** this section refers to accountability and transparency over the levy fund specifically, rather than any organisation.

318. Transparency and accountability over the spending of public funds is a key aspect of New Zealand's public service,[92] and a crucial element of cost-recovery.[93] Transparency allows the Government to build and maintain the public's trust and confidence. Being transparent about the investment of the levy fund provides the public with the

[92] For example, the Official Information Act 1982 is underpinned by the principle of availability and the Public Service Act 2020 principles include to foster a culture of open government.

[93] See the Treasury Guidelines for Setting Charges in the Public Sector (2017).

information about how those funds are used to invest in activities addressing alcohol-related harm. This also provides those who are levied (in this case, alcohol importers and manufacturers) with information about the investment of the levy fund.

319. The Office of the Auditor-General's Setting and administering fees and levies for cost-recovery: Good practice guide states that a public organisation should:

- have clear documentation of decisions, charging system, and revenue and costs
- monitor and record revenue from fees and levies (and memorandum accounts are one way of doing this)
- monitor and review fees and levies, and
- engage with fee and levy payers at regular intervals.

320. Adhering to this guidance enables agencies to have a stronger understanding of how the levy is being used, how decisions are made, and to continue to justify the total levy fund collected based on cost-recovery principles.

321. Before Stage 1 of this review, the breakdown of investment from the levy fund was not publicly available. When the levy was allocated fully to the Health Promotion Agency, as part of its annual reporting processes, the Health Promotion Agency published the activities it had undertaken to address alcohol-related harm and the total revenue it received from the alcohol levy, but it did not break down the levy fund expenditure separately from its other revenue streams. There is limited information available publicly about how the levy fund is expended (separate to the total revenue of the Health Promotion Agency, acting in accordance with obligations under the Crown Entities Act 2004), who determines the expenditure, and how the amount of funding for each recipient is determined.

322. Agency, academic, community, and industry participants felt there is an opportunity in the new context to provide transparency about who receives levy funding, how they are selected, and how the amount of funding is determined. Some participants, who had not received levy funding but engaged in alcohol-related harm reduction activities, had not heard of the alcohol levy. Others were aware of the levy but did not know how to access or apply for levy funds. Some participants felt that, particularly if the levy fund is significantly increased, there would be a stronger public interest in transparency.

323. Māori participants also emphasised this point, with participants commenting that the levy would be more viable and sustainable if it was fair, clear, and transparent in scope to 'allow people to get on with it'. Some participants felt that it would be beneficial to have a fair and transparent process about how investment decisions were made. One participant said, "*create a system where you are [a] preferred supplier and you have a spread of outcomes and collectively you can see what has been done and value for dollars spent.*"

324. Participants noted that wider knowledge of the levy's existence and purpose might have resulted in more community initiatives being brought to the [formerly] Health Promotion Agency's attention for levy funding.

9.1.1 What are the opportunities for the future?

325. The health entities could regularly publish information about how the levy fund is expended, who determines the expenditure, how the amount of funding for each recipient is determined, and the total amount of funding used for internal FTE and provided to external recipients. The health entities could also advertise the availability of the levy fund and its purpose, to ensure that all individuals and organisations that undertake activities that could be funded are aware of the levy's potential to act as a funding source. This is likely to be pertinent if the levy is increased. The health entities could also undertake an ongoing exercise to record expressions of interest in receiving levy funds (and the likely dollar value of those investments), which may assist in advising Ministers as to the level of reasonable expenditure the health entities could incur to address alcohol-related harm.

326. The Ministry of Health could set up separate accounting measures for the total alcohol levy expenditure across the health entities with documentation about the allocation and spending decisions, charging system, and revenue from the alcohol levy, which will provide stronger information to monitor and review the levy for the future. The Ministry of Health should ensure there are adequate systems in place to monitor the levy. Given the alcohol levy is raised from the alcohol industry, there is an opportunity to engage with the industry at regular intervals. Having greater transparency over the levy fund is likely to support constructive engagement with the industry, as the industry will have a better understanding of the activities that the levy is funding and how funding decisions are made.

Recommendations:

- Consider periodic publication of the broad programmes and services funded by the alcohol levy (such as a service plan).
- Consider setting up separate accounting measures for the alcohol levy to more easily track the allocations of the alcohol levy.

9.2 Participants would like more transparency over the funding of internal FTE

327. A significant proportion of the levy fund is spent on FTE and other internal operational costs.

328. Funding of FTE is critical to the effective administration and governance of the alcohol levy, as well as to provide in-house alcohol expertise, policy development capability, cultural capability, and a range of other required services.

329. Participants noted that there is a need for the Crown to hold specialist alcohol-related expertise across a range of sectors (for example justice, transport, education, and welfare). Further, participants generally recognised that the relational and collaborative funding approach favoured by many participants requires sufficient FTE to be employed to manage relationships with communities and to provide specialist support where communities may initially lack sufficient expertise or knowledge.

330. Transparency regarding the work that the levy-funded FTE conduct may support stronger relationships with the alcohol-harm reduction sector and alcohol industry and would create a better understanding of the internal activities funded to address alcohol-related harm.

9.2.1 What are the opportunities for the future?

331. In the new Pae Ora context, there is an opportunity to be transparent about the value of the FTE funded by the levy who deliver activities in the health promotion and policy advice and de-normalisation and culture change workstreams; particularly to support increased relational funding and collaboration capacity across the three health entities.

332. With the continuing transition from the HPA to Health New Zealand, the operational costs currently funded by the levy (i.e., information technology services and administrative support services) could be moved from levy funding to Health New Zealand operational funding.

9.3 Participants would like to see an increase in activity funding periods

333. Since the health system reforms (i.e., for the 2022/23 and 2023/24 financial years), the contract periods for levy-funded investments have been one year. This has been due to this review occurring. Prior to that, investments made by the levy were of variable lengths, based on the programme or service being funded.

334. The process of setting the levy can be found at Appendix B. The instrument made under the Pae Ora Act to amend the amount collected by the levy must be determined annually by the Minister of Health, acting in concurrence with the Minister of Finance, before going to Cabinet and being approved by the Executive Council. It is also subject to the 28-day rule, meaning that the instrument must be made 28 days before it comes into force.

335. This process generally takes approximately 2-3 months to undertake. While the Pae Ora Act requires the aggregate expenditure for the levy to be assessed on an annual basis, this could be reconsidered to provide greater certainty for funding providers and recipients.

336. Raising the length of time for expenditure assessments would allow for greater certainty for the organisers of programmes receiving funding, however the current approach enables greater flexibility in funding decisions and commitments.

337. Since the Pae Ora Act, the advice that goes to joint Ministers regarding setting the annual levy quantum[94] is provided by the policy team at the Ministry of Health (Public Health Agency) working collaboratively with the Health Promotion Directorate within the National Public Health Service of Health New Zealand and Te Aka Whai Ora. There is an opportunity for the previous year's investment decisions to be better utilised to input into the decision for the following year.

338. Many participants felt that longer funding periods provide more certainty and support the sustainability of organisations. A Māori participant told us *"[We] need sustainable funding to enable organisations to develop and grow systems and retain staff."*

339. Participants generally opposed one-year funding periods as they considered them to be highly undesirable and unlikely to support organisations to deliver outcomes. A Pacific participant told us, *"One year contracts mean you can only plan for one year, who is going to sign up for a job with no guarantee beyond the year."* We also heard that under single year funding arrangements/contracts organisations do not have the ability to build strong relationships with communities.

340. Many participants considered that, at a minimum, three-year funding periods should be standard where appropriate. Participants said that funding periods shorter than three years often meant that their organisations were unable to recruit and train the required staff and evaluate outcomes.

341. Some participants considered five-year funding periods to be ideal. Community participants considered that five-year contractual periods enabled organisations to recruit, develop, and retain staff; evaluate outcomes, provide a degree of insulation from the political cycle; and enable organisations to build administrative systems to support ongoing work. Academic participants considered a five-year funding period as essential for programmatic research to be undertaken.

342. Some participants considered that ten-year funding periods should be considered for programmes that have demonstrated their effectiveness. One participant told us *"Funding should initially be 5 years because you need to review and tweak and change. Then consider 10 years for well evidenced programmes with proof of concept and have been running for a few years.*"

343. The nature of the activity will be relevant to determine appropriate funding periods.

9.3.1 What are the opportunities for the future?

344. Māori participant perspectives around funding periods were consistent with other participants who felt there is an opportunity for the funding period to be co-determined between the provider and funder on a case-by-case basis, to ensure that the funding period enables, rather than inhibits, providers' ability to achieve outcomes.

[94] See Schedule 6(2)(1) of the Pae Ora Act

345. There is also an opportunity to undertake both long-term investments and fund innovative pilots through the levy.

Recommendations:

- Consider co-determined activity funding period between the provider and funder on a case-by-case basis.

9.4 Participants want to see evaluation funding ring-fenced, where appropriate

346. Participants emphasised that monitoring and evaluation is critically important for measuring success, where appropriate. We heard that evaluation enables service providers, decision-makers, and stakeholders to understand the impacts of investments, develop improvements, and contribute to the development of an evidence base to support future investment decisions. However, we also heard that many alcohol-related harm reduction initiatives (both levy and non-levy funded) are not evaluated. A Māori participant told us *"It's almost like they [the Crown] fund things and then there is no follow up."*

347. Community participants commented that, as the funding provided for service delivery is often insufficient, providers are hesitant to allocate a portion to evaluation. One participant told us *"[If you're] giving people money, they would never spend on evaluation, because that's taking money away from service delivery."*

348. We also heard that the style of evaluation required for a programme should be co-determined between the provider and funder. Many participants told us that quantitative evaluation of outcomes (for example, the percentage decrease in alcohol-related crime in an area) is often inappropriate for alcohol-related harm reduction activities, particularly in the short to medium term for small-scale initiatives. Rather, participants considered that qualitative evaluation (for example, reporting what those experiencing alcohol-related harm have said about the effectiveness of the activity) is a more useful measure of success. However, participants said that as initiatives are scaled up and run over long time periods, it may be appropriate to evaluate outcomes quantitatively.

9.4.1 What are the opportunities for the future?

> *"The trouble is we don't have the expertise to get the evidence-based data to say that it is working well."*
>
> *Māori participant*

349. There is an opportunity for all levy investments to explicitly require and ringfence adequate funds for outcomes evaluation. This may include supporting providers to sub-

contract evaluators, as we heard that small providers may not have in-house evaluation capacity. Ring-fencing funds for evaluation would ensure that providers do not feel that they must choose between service delivery and evaluation.

350. There is an opportunity for levy investments to be cognisant of the need to resource and support evaluations of kaupapa Māori initiatives with Te Ao Māori-based evaluation models. This is critical to strengthening the monitoring and evaluation of the levy overall.

351. There is an opportunity for evaluation to be used to measure success, and feed into an investment framework in order to determine whether funding for that programme/project should continue, and to assist with assessment of what the total levy quantum should be.

Recommendations:

- Consider including evaluation funding for levy-funded programmes and services, where appropriate, in addition to the programme or service funding.
- Consider funding Te Ao Māori-based evaluation models for kaupapa Māori initiatives.

9.5 Participants think there is an opportunity to utilise flexible funding approaches and reporting requirements

9.5.1 Reporting requirements

352. Many participants discussed the reporting requirements in various government contracts. We heard that contracts with agencies generally require quantitative reporting (for example the number of individuals who engaged with a service) that does not allow providers to communicate outcomes from their activities.

353. Several Māori participants considered that funders should allow funding recipients to provide video testimonials from service users or whānau as a form of reporting, noting that this would be appropriate for small contracts. Some participants felt that reporting requirements should be proportionate to the level of funding being received (i.e., more onerous reporting requirements for more funding).

354. A Māori community participant told us "reporting is important, because we need to get funded what we need, but we need to be able to communicate the full picture of what we're doing and the outcomes. For example, someone not drinking on Mondays, drinking less, considering not drinking."

9.5.2 What are the opportunities for the future?

355. The nature of reporting required could be co-determined between the funder and recipient to ensure that reporting is not unreasonably onerous and enhances, rather than inhibits, recipients' ability to achieve outcomes.

356. As illustrated above, there is an opportunity for Māori to be involved in determining the type of reporting required and for consideration to be given to Te Ao Māori based models and methods of reporting and monitoring.

9.5.3 Funding approaches

357. Participants had some general feedback about the funding approach for the alcohol levy, and 'what good looks like' for funding activities relating to alcohol-harm generally. *Allen + Clarke* uses the term 'funding' deliberately, as we heard that a grant model may suit some circumstances, whereas a contract model may suit others.

358. For context, *Allen + Clarke* understands that both the Health Promotion Directorate and the Te Aka Whai Ora have been utilising (where appropriate and in accordance with Government procurement rules) a relational funding approach, investing in FTE whose role is to establish and maintain close connections in the community, and make investment decisions based on the aspirations of the community.

359. Participants receiving small contracts felt that competitive funding should be avoided. We heard that it is extremely onerous to prepare proposals for competitive funding, particularly for small organisations. One Māori participant told us "*It can cost thousands of dollars just for the resource to respond to the RFP.*" A Pacific participant told us *"Funding is often made too difficult to receive and too many boxes to tick to achieve."*

360. Participants generally supported a relational funding approach. *Allen + Clarke* understands that the Health Promotion Agency commonly engaged in relational funding through its Regional Managers. Participants who had received funding through engagement with the Health Promotion Agency's Regional Managers were very positive about their experience. They noted that the Regional Managers removed many of the barriers commonly associated with applying for and receiving government funding.

361. One participant whose organisation had received levy funding said, "[the Health Promotion Agency] were great, easy to get money. They sat on steering group and were instrumental on guiding us when we set up governance group. They weren't too dominant and had practical good reporting processes. [the Health Promotion Agency] have been great to deal with, and they have some amazing employees, I can only speak really highly."

362. However, some participants who had not engaged with Regional Managers were concerned that the Health Promotion Agency's relational funding approach may have excluded organisations that Regional Managers were not aware of or did not have relationships with.

363. Participants expressed a desire to see funding at local, regional, and national levels to see real change in the level of alcohol-related harm.

364. Some academic participants considered that competitive funding is appropriate for significant, long-term programmatic research.

9.5.4 What are the opportunities for the future?

365. There is an opportunity to develop, communicate, and utilise a tiered approach to funding that enables relational and competitive funding in conjunction with governance structures to ensure the levy is used consistently to work toward clear and agreed outcomes. The strategic direction of the levy fund should still incorporate community voice, and ensure that Māori both, a) determine or contribute to funding decisions and b) Māori communities have equitable access to the funding.

Recommendations:

- Consider engaging with levy-funded organisations to co-determine the nature of reporting.
- Continue increasing the use of relational funding, where appropriate.

9.6 Participants felt that a 'system approach' should be taken to address alcohol-related harm

366. Participants felt that there is a lack of strategic vision generally with alcohol-related activities and policy.

367. Given there are a range of stakeholders in relation to alcohol-related harm, from small community organisations to the New Zealand Police and the Ministry of Justice, there is an opportunity, as described in the Stage 1 report, to design a national strategy and action plan to ensure that all stakeholders are working in alignment.

368. Some agency participants felt that a small portion of the levy could be invested in the development of a strategy and plan. Some government agency participants felt that alcohol policies across different sectors (for example, health, justice, Police, transport, etc) were currently only aligned when individuals within these sectors leveraged their existing relationships. They considered that a cross-government strategy would help with consistent alignment and progress across government work programmes. Some agency participants did note, however, that different agencies had different mandates and priorities that would need to be finely balanced.

369. Participants were concerned with this lack of cross-sector alignment and felt that this review provided an opportunity to support greater alignment between the various agencies that work in the alcohol-harm minimisation space. Most notable is the

regulatory separation between the Ministry of Health, the Ministry of Justice, the Ministry of Transport, and the New Zealand Police, that implement health-related activities, regulate alcohol licensing, sale and supply, regulate drink driving, and enforce drink driving measures, respectively.

370. Some participants felt that the Ministry of Justice's administration of the SSAA did not give adequate attention to health considerations in the licensing process, which is a key policy lever to manage access and availability of alcohol.

9.6.1 Māori voice from the beginning

371. Participants were clear on the importance of Māori should be involved from the beginning of any levy decision-making processes, including determining the amount of funding that is needed for the given year and how that funding is allocated. Participants also emphasised that a single Māori person cannot represent all Māori in New Zealand – there needs to be a diversity of voices at the table, or structures in place, to represent the range of whānau, hapū, iwi, and Māori communities that are impacted by alcohol-related harm.

372. This is crucial, given the Crown's obligations under Te Tiriti, the role of the health sector principles in the new Pae Ora context, and the disproportionate alcohol-related harm experienced by Māori. Te Tiriti affirms Māori rights to tino rangatiratanga, equity, active protection, options, and partnership, which should be given effect to through the alcohol levy.

9.6.2 Other voices that should be amplified

373. There are other groups that are disproportionately impacted by alcohol-related harm in New Zealand. Pacific peoples should have representation at the governance level by people who can connect with Pacific community leaders around the country. We heard that successful 'by Pacific, for Pacific' alcohol-harm reduction activities occur when Pacific leaders in communities are engaged. Some participants raised Pacific involvement at the governance level also honours the Realm of New Zealand relationships.

Recommendation:

- Consider using the alcohol levy to fund the development of a cross-sector, cross-agency, national plan for alcohol to provide strategic direction for alcohol policy in New Zealand. This should include Māori and Pacific representation and co-design in all stages of development. Also see Section 8.3.

10 What should the levy look like in the future?

This section responds to, in part, the following policy questions
• What are participants' perceptions of how the alcohol levy could be most effectively governed?
• How is the alcohol levy most effectively administered and governed in a way which centres the Crown's obligations under Te Tiriti o Waitangi (including consideration of how the levy functions in relation to the alcohol excise tax)?
• As pertains to the alcohol levy, what are the options for the Ministry of Health to meet its obligations to Māori under Te Tiriti, including an obligation to protect and ensure Māori rights to health and equitable health outcomes, in relation to alcohol and related harms?
• What are the options for governance of the alcohol levy regime to enable effective and efficient use of levy funds, and to provide appropriate oversight to measure success?

10.1 What should the purpose of the levy be, in the new Pae Ora context?

374. Given the history and the previous mandate of the Health Promotion Agency, funds collected via the alcohol levy have, until now, been invested in health promotion, research, and health protection activities. There is strong support from participants for the levy to continue to be invested in health promotion, research, and prevention activities to address alcohol-related harm.

375. The prior constraints on what the levy could fund means that the levy currently only funds a small portion of the activities that could be funded to address alcohol-related harm. Given the new Pae Ora context, many participants were eager to see the levy increased to fund more and different service to address the alcohol-related harms.

376. Participants generally felt that health promotion and prevention activities provide "*better bang for buck*" and have a strong evidence base. When considering the current quantum of the levy, many participants considered that these activities were the most cost-effective when they can be applied on a population level. However, participants also considered that, given the scale of alcohol-related harm in New Zealand, and the scale of the costs incurred across the health system in responding to that harm (for example in treating alcohol attributable diseases), there is clearly scope for the levy to be significantly increased to replace Vote Health expenditure on addressing alcohol-related harm.

377. Generally, participants perceived a huge unmet need for substantial investment in health promotion and harm prevention measures, as well as treatment measures.

378. Many participants also emphasised that alcohol-related harm can only properly be addressed when New Zealand's societal relationship with alcohol has changed. Many

participants considered that health promotion, protection, and prevention activities contribute to changing the 'drinking culture' and breaking down some of the societal and environmental factors that lead to alcohol-related harm. One participant said, "*Link the use of the alcohol levy with wellbeing and [we] don't want to always be at the bottom of the cliff trying to lift them back up the hill.*"

379. Ultimately, the health entities will need to determine whether or to what extent the levy should be used to undertake activities outside the scope of what was possible prior to the Pae Ora reforms. This determination, and the reasoning underlying it, should be clearly communicated to all relevant stakeholders, and ideally be undertaken in partnership with communities throughout New Zealand.

10.2 Determining the purpose, governance, and delivery of the levy in the Pae Ora context

380. *Allen* + Clarke has developed three proposed tranches of work that can guide policy work to inform final decisions on the governance and delivery of the levy, as well as on how the levy will be used for the 2023/24 financial year and beyond.

381. These tranches relate to potential system and process changes that would respond to the findings of this review. The tranches provide a mechanism to categorise the recommendations based on the level of transformation required, with Tranche 1 providing short-term, quick changes that would enable the fuller transformation outlined in Tranches 2 and 3.

382. The three tranches are designed to be translatable into workstreams to implement the findings of the review. *Allen + Clarke* recommends that all three tranches are undertaken concurrently under clear programme management to ensure that engagement, analysis, and lessons from each workstream strengthen the delivery of the other workstreams. An outcome of the proposed programme approach for delivering the three tranches would be that, in 2026, the three workstreams come together to provide a long-term approach to setting the levy to align with the Pae Ora context, meet community aspirations, and align with best practice approaches to setting and managing cost-recovery.

383. If a staged approach to the work is preferred, each tranche could be completed on different timelines.

Recommendations

Tranche 1 –immediate increase in the levy within current governance and policy settings (March 2024 – March 2025)

384. This section sets out the proposed components for Tranche 1 that allow for immediate to short-term changes that could be made to the levy within the current governance and policy settings. Tranche 1 could take effect from March 2024.

385. While Tranche 1 could be implemented independently of Tranche 2, some of the approaches to categorising services in this section refer to concepts introduced more fully in Tranche 2.

386. To be clear, *Allen + Clarke* does not consider that the changes to the levy quantum and governance included in Tranche 1 would adequately reflect or enable the aspirations of communities and other stakeholders communicated during this review. Rather, Tranche 1 represents an interim step that should be undertaken immediately to somewhat align the levy system with its new Pae Ora context. The recommendations in Tranche 1 presume that the health entities will also undertake work to progress the recommendations in Tranches 2 and 3. There is a significant risk that merely implementing the recommendations in Tranche 1 would effectively mean that the levy system stagnates, as it appears to have done for at least a decade.

Tranche 1 - Setting a new baseline

387. *Allen + Clarke* recommends an immediate increase to the levy for the 2024/25 financial year and beyond.

388. *Allen + Clarke*'s engagement with stakeholders, the review of evidence, and the total cost of alcohol-related harm estimated by NZIER strongly indicate that current level of services provided to address alcohol related harm that are funded by the levy could be reasonably increased, resulting in an increase in the levy rates (and levy quantum).

389. It is important to note that the cost of alcohol-related harm itself does not indicate the level of funding required to address that harm and is not a justification alone for increasing the levy. However, the level of harm does provide an indication of the significant need for activities to address alcohol-related harm across all alcohol-related harm categories, and that the risk of collecting more funds via the levy than would be reasonable to expend on activities that address alcohol-related harm is very low.

390. It is important to acknowledge that the levy quantum has been, and continues to be, required to be set based on the reasonable expenditure required to deliver activities to address alcohol-related harm.

391. During this review, *Allen + Clarke* found that the evidence indicated the total levy quantum has been maintained at the same level year on year (for the last decade or

more) for pragmatic and potentially political reasons. The yearly decisions to maintain levy quantum do not appear to have been made based on a systematic assessment of the need for services, the cost of delivering those services, and an assessment of what would be 'reasonable' to expend and recover via the alcohol levy.

392. The Stage 1 report outlined a cumulative shortfall in the funds collected via the levy (due to a lack of inflationary adjustment) since 2012/13 of approximately $10 million. For context, the excise tax placed on alcohol (administered by the New Zealand Customs Service in accordance with the Customs and Excise Act 2018) is generally adjusted annually for inflation, but the alcohol levy has not been.

393. In the absence of a systemic assessment of the level of services needed, the cost of delivering those services, and an assessment of what would be reasonable to expend and recover via the alcohol levy, *Allen + Clarke* considers that an increase to the levy, calculated by reference to the cumulative shortfall in funds collected via the levy since 2012/13, is a reasonable and pragmatic interim step to maintain the integrity of the levy system (described below as a CPI-based increase). This will enable the Ministry of Health and providers of levy funded activities to address the consequences of the cumulative shortfall resulting from a lack of inflationary adjustments and to prepare for further changes to the levy system that are recommended in Tranches 2 and 3.

394. A CPI-based increase will also have the effect of restoring the purchasing power of the levy to at least its 2012/13 level.

395. A CPI-based increase recognises that, given the levy quantum has not increased materially for at least a decade, the purchasing power of the levy has decreased, reducing the number of activities that can be undertaken with levy funding and the service level able to be provided by the activities that are undertaken. Further, if not addressed, the cumulative shortfall caused by lack of inflationary adjustment is likely to cause difficulties for the Ministry of Health when it undertakes its assessment of the expenditure that would be reasonable to incur each year to address alcohol-related harm and to recover via the levy.

396. Recipients of levy funding spoken to during this review often highlighted that, on a system level, expenditure on the wages, overheads, and goods and services required to deliver activities to address alcohol-related harm is continually increasing, yet available funding remains effectively static. Participants identified that, in the context of limited funding, providers are hesitant to invest a portion of the funds available to them into evaluating activities, as doing so reduces the proportion of the funds available to deliver their activities. Similarly, inability to adequately invest in provider staff development and to offer permanent contracts with competitive renumeration are impacting on retention of staff for providers across financial years.

397. An interim CPI-based increase to address the cumulative shortfall will therefore support the Ministry of Health and levy-funded providers to produce the information required to support the application of the proposed investment framework (see Tranche 2) in subsequent years, while not compromising the service levels of existing activities.

398. The decrease in the purchasing power of the levy since 2012/13 is also likely to have contributed to the relatively large proportion of the total levy fund being expended by the Health Promotion Directorate on internal costs. This is because the Health Promotion Directorate was required to carry out baseline enabling functions and the cost of doing so was, and is, also increasing year on year.

399. For these reasons, in Tranche 1, *Allen + Clarke* recommends an immediate increase in the amount of funds recovered through the levy from the current $11.5 million to a new figure of between $21.5 million (minimum baseline uplift) and $37.3 million (recommended baseline uplift) for 2024/25. This is recommended as an interim measure prior to the quantification of reasonable expenditure to address alcohol-related harm that can be achieved through the implementation of a new approach to investment and governance of the levy (see Tranche 2) and the full first principles review of the actual costs of delivering services to address alcohol-related harm can be completed (see Tranche 3). Further detail on the Tranche 1 minimum and recommended baseline uplifts are provided below.

400. To be clear, while these recommendations are interim measures for the 2024/25 financial year, *Allen + Clarke* considers that it is highly unlikely that, when applying the investment framework in Tranche 2 in subsequent years, the Ministry of Health would then determine that it is reasonable to expend (and recover via the levy) less than $37.3 million per annum on addressing alcohol-related harm. If the levy were to be reduced from the new baseline set in 2024/25 (which is provided for in the Pae Ora Act), it would need to be reduced only on the basis that the Ministry of Health considers it reasonable to expend less on addressing alcohol-related harm. This would result from the need for services to address alcohol-related harm (or the cost of delivering those services) reducing, likely due to reduced incidence of alcohol-related harm.

Minimum baseline uplift option – increase to $21.5 million

401. This CPI-based baseline up lift option would retain the existing process for setting the levy rates to recover a set pool of funds to be used on activities to address alcohol related harm but would increase the levy quantum to enable the Ministry of Health and levy-funded providers to address the consequence of the cumulative shortfall caused by lack of inflationary adjustment and return to the 2012/13 purchasing power of the levy. The minimum uplift would therefore increase the levy quantum from the current $11.5 million to a new figure of $21.5 million - an increase of $10 million per year (which, as identified above, is equivalent to the cumulative shortfall caused by lack of inflationary adjustment).

402. This minimum baseline uplift acknowledges that, after over a decade of static funding, the levy funding available for harm reduction services has reduced significantly, with compounding effect. This has resulted in reduced services to communities, very constrained service budgets, and limited to no certainty of funding for activity providers year on year. The CPI-based uplift will ensure that current levy funded activities can be sustained, while also enabling providers to retain and train existing staff, enhance their administrative capacity (including monitoring and reporting functions), and conduct and communicate evaluations of their activities. This support for activity providers will in turn

support the Ministry to increase the accountability and transparency of levy expenditure, which was one of the key concerns raised by participant stakeholders. The additional $10 million will also enable providers to make preparations for any extension to effective activities, should that be considered appropriate in subsequent years.

403. The minimum baseline approach would also respond to challenges current levy-funded activities face associated with the rising costs of goods and services.

404. *Allen + Clarke* does not consider that this increase would be sufficient to significantly expand the activities delivered with levy funding. Rather, this will improve the effectiveness and sustainability of existing activities in the short-term. It will also support providers to demonstrate whether or to what extent their activities are suitable for further investment in the medium-term, and, where suitable, to prepare for (capacity build) future expansion of services. As such, this increase will, in the short term, protect the integrity of the levy system, ensuring that activities can continue to deliver results for communities despite ongoing challenges associated with the rising cost of delivering those activities.

405. Enabling service providers to improve their administrative capacity, including monitoring and reporting functions, and to conduct and communicate evaluations of the outcomes of their activities will also enhance the ability of the Crown to communicate to industry and stakeholders what levy funds are expended on, and the outcomes achieved through that expenditure. This will help address the concerns we heard from stakeholders that there has been a lack of accountability and transparency in relation to levy expenditure.

406. This $10m increase would likely also reduce the proportion of levy funds expended by Crown agencies on carrying out enabling functions and return a greater proportion to front line services provided in communities.

Recommended baseline uplift – increase to $37.3 million

407. The recommended baseline uplift (this option) would increase the levy quantum from $11.5 to approximately $37.3 million in 2024/25, which includes the $10 million CPI-based uplift. This recommended baseline uplift option recognises that the scale of alcohol-related harm, and community aspirations to address that harm, necessitates immediate government action. On the basis of its review, *Allen + Clarke* considers that there are existing levy funded activities that, with further funding, could scale up to increase their capacity to address alcohol-related harm, or that are proven pilots that are ready to be rolled out to more regions. Further, *Allen + Clarke* considers that there are likely to be organisations that do not currently receive levy funding that, with the investment of levy funds, could begin delivering new and innovative pilot activities.

408. To assist with communicating the nature of the increase that *Allen + Clarke* recommends, the description of this recommended baseline uplift refers to the investment categories described in detail in Tranche 2. In brief, the investment categories are:

- **Core -** "Must do" investment required to sustain the availability, quality, and transparency of existing effective activities, which are facing challenges associated with upward cost pressures (including enabling functions carried out by Crown agencies).
- **Extend** - "Should do" opportunities to extend the availability or quality of core activities (including enabling functions carried out by Crown agencies) to further address alcohol-related harm.
- **Trial** - "Could do" investments to enable providers to test and trial new activities, or to innovate in relation to existing activities.
- **Reserve** - An additional amount that is not immediately allocated but that could be used for emergent challenges or opportunities, can also be earmarked as part of this framework. This is a future opportunity that could be added to the investment framework if desired, so no funding has been allocated as **Reserve** in any recommendations in this report.

409. This recommended baseline uplift option should therefore be read in conjunction with the description of Tranche 2 in the subsequent section of this report.

410. Using the investment categories set out in Tranche 2, this recommended increase would be made up of:

- a CPI-based $10 million increase to the current levy amount to enable the Ministry and levy-funded providers to, in the short term, address the consequences of the cumulative shortfall created by a lack of inflationary adjustment and return the purchasing power of the levy to its 2012/13 level, ensuring the sustainability and transparency of existing activities, enabling their evaluation (without compromising service levels) and, if appropriate, their preparation for future extension (this is referred to as **Core** in Tranche 2)
- a minimum of an additional $13.8 million to fund the extension of programmes that have been piloted (at relatively low funding levels) through the levy fund, have proven effective, are supported by communities, and are aligned with the Pae Ora context (this is referred to as **Extend** in Tranche 2).[95]
- an additional $2 million to fund new and innovative programmes through 'seed funding' style arrangements (this is referred to as **Trial** in Tranche 2).

411. Lifting the levy quantum to $37.3 million in total would add approximately 1.1 cents to the price of a standard can of beer, and up to 7 cents to the price of a standard bottle of wine.

[95] *Allen + Clarke* notes that this additional $13.8 million of funding relates only to the sports sponsorship demonstration, Community Social Movement, and Community Law Centres of Aotearoa activities used as examples. It is highly likely that many of the other existing levy funded activities would align sufficiently with the investment criteria to warrant receiving funding in the 2024/2025 financial year and beyond.

412. The increased level of funds recommended in this baseline uplift option may necessitate a significant shift in the governance and management of the levy, as the increase in funds would be expected to bring increased interest in decisions about the levy and higher expectations for both transparency over the outcomes of the activities funded and the decisions to fund particular activities.

413. There is a risk that the system will take time to 'gear up' to be able to respond to that increased interest. The proportion of the increased funds recommended in this option that is allocated to **Core** responds to this risk, as it will enable organisations delivering services funded by the levy to improve their administration and reporting functions. This will enable greater monitoring of the levy spend and its impact, without compromising service levels.

414. *Allen + Clarke* also notes that there is a risk that the increased levy funds may not be able to be spent in a single year, as some providers may not be able to immediately scale up their activities. However, the levy powers in the Act enable any underspend from the 2024/25 year to be factored into decisions on the levy for the 2025/26 year.

Considerations for the recommended baseline uplift to $37.3 million

415. The Ministry of Health will need to justify whether and to what extent the activities are addressing alcohol-related harm, the appropriate service level for those activities, and the level of operational costs needed to support those activities (in accordance with public sector best practice).

416. The administration and commissioning requirements will likely increase to manage the increased quantum, including more complex arrangements with existing service providers.

417. The Health Promotion Directorate does not appear to have routinely collected information on the expenditure required to fully fund all activities that could be cost-recovered through the levy. Further, complete and specific financial information regarding the current costs of services carried out by all three health entities is not available given the way the levy is currently used as a contributing revenue stream by the Health Promotion Directorate. Therefore, the portion of this recommended baseline uplift in the **Extend** and **Trial** investment categories represents *Allen + Clarke*'s low-end estimate of the expenditure that would be reasonable to incur to undertake activities within these categories.

418. The recommendations in Tranches 2 and 3 are designed, in part, to ensure that a full and accurate cost-recovery assessment can be undertaken in the medium- to long-term. In the short term, measures can be implemented to support such an assessment. This includes, for example, the use of separate accounting measures that allow for alcohol levy funds to be tracked and reported on as a separate, rather than contributing, revenue stream for the Health Promotion Directorate. *Allen + Clarke* understands that the Ministry of Health and Te Aka Whai Ora do track their portion of the levy funds separately.

419. Further barriers to undertaking an accurate cost-recovery assessment in the context of the recommended baseline uplift include:

- Certain expenditure covers alcohol *and* drug harm with no current mechanism to apportion part of the expenditure to the alcohol component (for example, Community Action on Youth and Drugs (CAYAD) services that have a strong alcohol-related component).
- The existing expenditure is based on the existing fiscal envelope and is not set at the level of service that would likely be considered reasonable in the Pae Ora cost-recovery context.

420. In addition, there may be no existing mechanism to pro rata some of the levy funded activities that are currently, or will be, delivered.

Interim Governance in the context of tranche 1 baseline uplift

421. *Allen + Clarke* 's view is that the governance of the levy fund could be strengthened through the creation of an independent strategic governance group that aligns with the Pae Ora context and has the capabilities to scale with increased complexity and size of the activities funded via the levy, including the potential to oversee a relatively significant increase to the levy quantum.

422. It is expected that transition to alternative governance arrangements would take some time, and interim governance arrangements will need to be in place to guide the transition and provide assurance and transparency over all decisions around the levy.

423. Currently, the governance of the alcohol levy sits with the Shared Public Health Leadership Group (SPHLG), who make the allocation and investment decisions across the health entities. The SPHLG includes members from all three health entities and the membership has strong expertise in alcohol policy and regulation. Individual investment programmes and projects have delivery governance in place and there is governance over general organisational revenue spend through established management structures at Health New Zealand, Te Aka Whai Ora, and the Ministry of Health.

424. Any decision to fund additional services via the levy will increase the quantum of the levy and increase the complexity of the system being governed. Over the longer term, this report recommends implementing a new approach to the strategic and delivery approach of the levy system (see Tranches 2 and 3 for a fuller description of this). In the short-term, however, it is expected that the existing governance mechanism (consisting of the ALWG and the SPHLG) will provide sufficient interim strategic governance for the system and the implementation of the short-term recommendations in this report.

425. As part of the interim governance process, *Allen + Clarke* strongly recommends that an ongoing review process is implemented that provides structured review points of the governance arrangements. Each review point would provide an opportunity to confirm that the interim governance arrangements have access to the right capability to

successfully implement any change programme responding to this report. In particular, the review points will help to ensure the financial and strategic risks are reviewed and the right level of assurance and transparency around decisions on the levy are in place.

426. *Allen + Clarke* recommends that the first review point considers the concerns expressed by participants in this review regarding the lack of transparency; lack of strategic direction; lack of sufficient Māori involvement from the beginning of decision-making processes; and lack of sufficient systems to adequately incorporate local voices in national decision-making.

Tranche 2 – January 2024 – March 2026

427. Tranche 2 builds on, and is enabled by, the increased investment set out in Tranche 1 and recommends a collaborative approach to the design and establishment of new long-term governance and investment frameworks to increase transparency and stakeholder confidence in decisions about the levy. *Allen + Clarke* recommends that in the short- to medium term, the health entities develop an investment framework for the levy, which includes investment categories, investment criteria, and strategic priorities and outcomes. Based on its review, *Allen + Clarke* has developed a draft investment framework, which is provided in this section.

428. In Tranche 2, *Allen + Clarke* also recommends that the health entities:

- set up a strategic governance group, responsible for setting the strategic direction of the levy, setting the intended outcomes of the levy, and confirming the investment framework
- set up a delivery governance group who will apply the investment criteria and strategic direction when determining how to allocate the levy funds for the following financial year
- establish oversight and monitoring frameworks at a level proportionate to the new size and complexity of the alcohol levy system to support levy governance, determine investment categorisation each year, provide assurance over the expenditure and its contribution to agreed outcomes, and
- conduct ongoing review of the investment framework to ensure that it remains fit for purpose.

429. *Allen + Clarke* has provided a detailed description of its Tranche 2 recommendations below, beginning with governance, followed by the draft investment framework.

Tranche 2 - Governance of the levy fund allocation

430. *Allen + Clarke*'s view is that the governance of the levy fund could be strengthened through the creation of a strategic governance group that aligns with the Pae Ora context and has the capabilities to scale with increased complexity and size of the services funded via the levy, including the potential to oversee a (relatively) significant increase the levy quantum. The proposed enhanced governance structure would provide oversight at a national level and set strategic direction, decision-making

processes, and could be held to account if levy investments are not achieving intended outcomes. Governance provides transparency and accountability regarding who is making investment decisions, how those decisions are made, and how those decisions should be assessed when determining their effect.

Strategic governance

431. Establishing strategic governance of the alcohol levy would set the levy fund apart from other revenue streams, reflecting the hypothecated nature of the fund. It would create a group with responsibility for setting the overall strategic direction of the fund and investment framework.

432. The Iwi-Māori partnership boards which were established in the Pae Ora Act could be utilised in the strategic governance structure of the levy. They are established to represent local Māori perspectives regarding the needs and aspirations of Māori in relation to hauora Māori outcomes, how the health sector is performing in relation to those needs and aspirations, and the design and delivery of services and public health interventions within localities.[96] We have heard that they should be used as needed, rather than as a primary source of strategic governance, as it is expected that the IMPBs will already have significant demands on their limited time and resources in the reformed health system.

433. The levy currently funds the Pacific Alcohol Advisory Group (PAAG) and the Regulatory Steering Group which could also be utilised to incorporate Pacific community perspectives and cross-agency perspectives into the strategic governance. We have heard that the PAAG should be utilised in an advisory capacity, not to provide permanent strategic governance.

434. The strategic governance group would also have oversight of the delivery governance group and their decisions, ensuring that the investments align with the investment criteria and strategic priorities and are achieving the intended outcomes.

435. *Allen + Clarke* recommends that the Ministry of Health investigate whether the costs associated with establishing the Tranche 2 governance structures are best funded from the alcohol levy or via general Crown revenue. Using the Cabinet fees framework for a new governance approach, an indicative estimate for the establishment and operation of a co-designed governance and investment framework would be between $1.2 and $2 million per year. This amount includes amounts for internal health entity staff to plan, design, and facilitate the process, as well as fees for individuals that are appointed to the governance group.

[96] Pae Ora Act 2022, s 29

Delivery governance

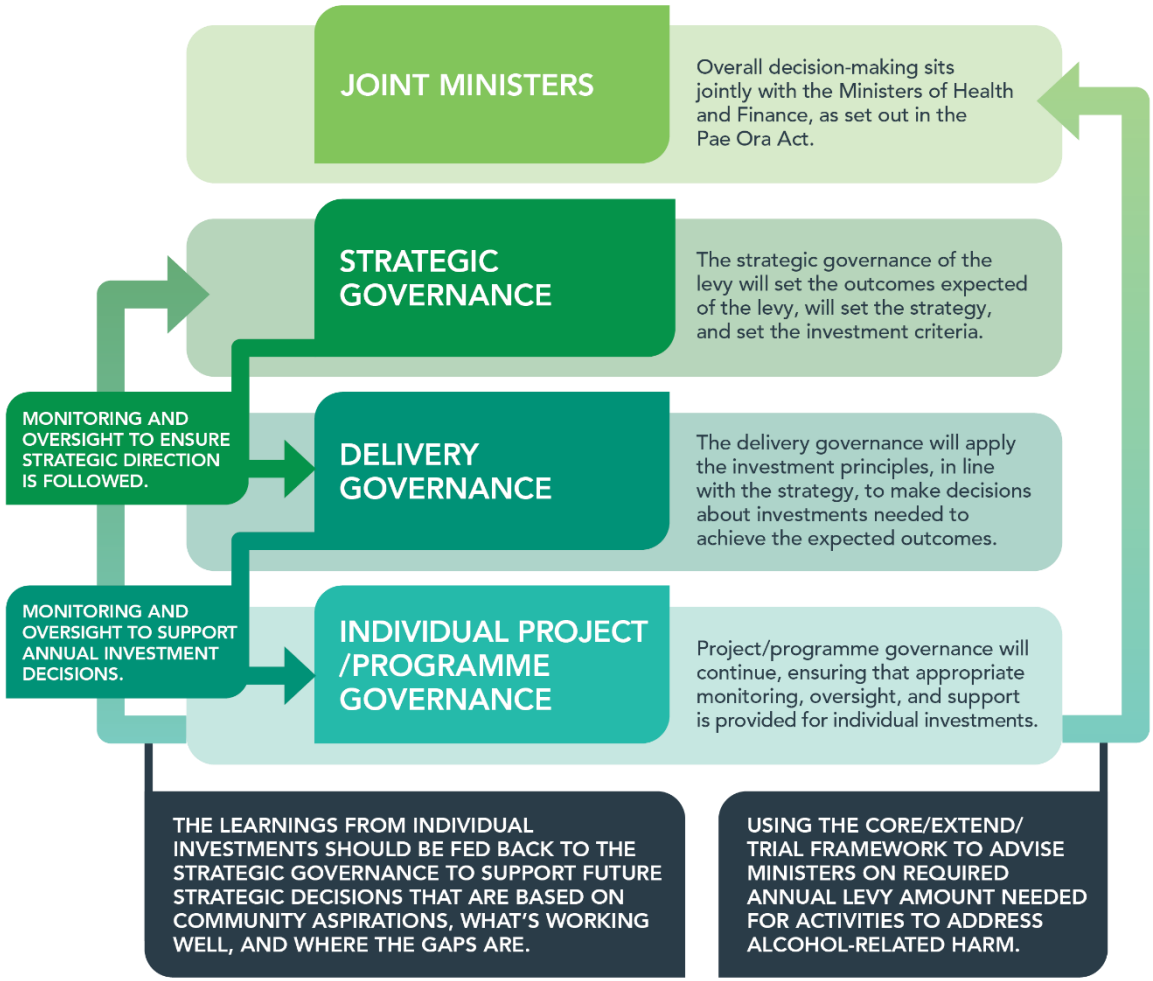
436. A gap in the current administration of the alcohol levy is strong oversight of the alcohol levy as a distinct funding source. It has previously been utilised as a contributing revenue stream for the Health Promotion Agency (and now Health Promotion Directorate) to support their wider health promotion activities in relation to addressing alcohol-related harm.

437. The new Pae Ora context provides an opportunity for the levy to be used to make significant progress in addressing alcohol-related harm in New Zealand. This will require a clear strategic direction and strong delivery governance to ensure that the funds are being used effectively and to support the annual legislative process of setting the total levy amount.

438. A permanent group should be established to provide delivery governance of the levy; making decisions to invest and providing oversight and monitoring of investment to measure success against intended outcomes. The delivery governance group can use the investment framework set out below to calculate the reasonable expenditure required for a given financial year, and therefore the levy quantum. The delivery governance group's calculation of reasonable expenditure could then be considered by Ministers during the levy setting process.

439. The diagram on the following page proposes a new structure that could be used to support the investment of the levy fund in the new Pae Ora context and suggests who could form each level of governance. While the Ministers of Health and Finance have the legislative discretion to determine the total expenditure to be recovered via the levy for the following financial year, there is a role for both strategic and delivery governance to make appropriate recommendations to those Ministers about the reasonable expenditure required for activities to address alcohol-related harm (and associated operating costs).

Figure 2: Proposed levy governance structure



Tranche 2 - Investment framework

This section responds, in part, to the policy question
• What are the options for the administration of the alcohol levy to support the investment as a cost-recovery mechanism?

440. Establishing, the full range of activities that should be funded via the levy and then quantifying the reasonable expenditure required to undertake those activities were outside the scope of this review. *Allen* + Clarke recommends that the Ministry of Health undertakes such an assessment as part of Tranche 3.

441. However, this section provides a draft investment framework that the health entities could use in the interim to assess existing and potential activities and to inform advice to Ministers regarding reasonable expenditure for a given financial year.

442. The investment framework, alongside the investment criteria described in the next section of this report, provides a starting point for structuring investment decisions. It can be adapted to best suit the strategic and delivery governance of the levy. The suitability of the investment framework should continue to be assessed with the changing scale of the levy quantum and the nature of the activities being recovered for.

443. The investment framework provides a mechanism for the Ministry of Health to ensure that:

- the mix of services and programmes supports harm reduction based on international evidence of best practice and effectiveness
- funding can be prioritised to align with the WHO SAFER framework and to meet obligations under Te Tiriti
- funding can contribute to equitable health outcomes, and
- funding aligns with wider system priorities (both the health system, and other sectors impacted by alcohol harm).

444. The investment framework also provides a mechanism to determine whether treatment services, and other services not currently funded by the levy, should be funded by the levy in future. The investment framework consists of investment categories, investment criteria, and strategic priorities and outcomes. These components are described in detail below.

Investment categories

445. Investment opportunities fall within four investment categories, described below. *Allen + Clarke* recommends that all investments in each category include a ring-fenced portion of funding to enable monitoring and evaluation.

Core

446. These are 'must do' investments required to secure and sustain the core base of existing activities. **Core** activities are activities that are already funded by the levy and that continue to meet the investment criteria.

447. Activities funded in the **Extend** or **Trial** categories that are successful (as demonstrated by achieving outcomes that should be established at the beginning of the investment), should transition into the **Core** category at the end of their investment and evaluation cycle.

448. The proportion of levy funding required for the **Core** category will increase when either:

- an activity (or an aspect of an activity) funded in the **Extend** or **Trial** categories demonstrates sufficient alignment with the investment criteria to become part of the **Core**; or
- an activity currently funded in the **Core** category requires additional expenditure (e.g., due to inflation or to enable preparation for expansion, or new or increased monitoring requirements) to maintain existing service levels.

What should be secured?

449. Although participants felt that the funding levels are currently too low to affect consistent, widespread change, the services that are currently funded by the alcohol levy are generally viewed by participants as effective and worthwhile investments. Based on *Allen + Clarke*'s targeted evidence review, the current activities appear to be aligned with a strong international evidence base for effectiveness and/or are activities that are themselves contributing to that evidence base. The exception to this is the funding for strategic messaging and digital and non-digital resources. Both programmes have strong community support but are not so strongly supported by the existing evidence base.

450. Some spending on FTE is required to support investment of the levy. This includes policy and research expertise, Māori and Pacific health expertise, relationship managers and programme managers with strong connections to their communities, and management and operational support staff.

451. In future years, rather than using a CPI-based proxy (as we have, in the absence of an assessment of actual costs), the **Core** should be calculated based on the actual costs of the full range of alcohol-related activities undertaken by the Ministry of Health and adjusted for annual inflation.

Extend

452. These are 'should do' opportunities and fall into two categories.

453. The first category is existing levy funded **Core** activities that, through additional funding, can be extended for greater impact.

454. **Extend** funding for a **Core** activity presumes that the **Core** activity is adequately funded to deliver the **Core** activity's current service level. **Extend** funding is entirely additional to **Core** funding and should be provided where a **Core** activity has demonstrated its sufficient alignment with the investment criteria and where the activity provider has developed plans to extend the activity.

455. Examples of **Core** services that could receive **Extend** funding include (but are not limited to):

- the sports sponsorship demonstration projects in order to enable a total replacement of sports sponsorship in New Zealand for a transitional period. This has been costed in 2023 at approximately $12 million per annum. The current investment of $500,000 would be subtracted from this amount as it is currently in the Core category of investment.
- the Community Social Movement project to expand to further Māori community sites (and expand programme reach) and expand to Pacific community sites. This has been costed at $600,000 per annum for five additional sites. Therefore, five new Māori sites and five Pacific community sites would cost approximately $1.2 million per annum. This would be in addition to the current Community Social Movement investment.
- The Community Law Alcohol Harm Reduction Project to expand coverage and improve services, as recommended by *Allen + Clarke's* independent evaluation of the project. This has been costed at approximately $1.2 million per annum. The current investment would be subtracted from this amount as it is currently in the Core category of investment. The current investment cost has not been provided but $290,000 has been used as an estimate, based on the proposed budget for this project for 2023/24.

456. The second category of activities eligible for **Extend** funding are activities that have previously been funded by other mechanisms (e.g., by charities or Vote Health) and that have demonstrated sufficient alignment to the investment criteria to warrant levy funding.

457. Any activities provided with **Extend** funding should be evaluated and assessed against the investment criteria at the end of the funding period. If they demonstrate sufficient alignment to the criteria, they should be funded under **Core** to enable their ongoing provision.

458. The estimated cost of **Extend** funding to enable increased availability and quality of existing **Core** activities would be, conservatively, $13.8 million for the 2025/26 financial year.

Trial

459. These are "could do" investments to enable providers to test and trial new ways of working and allow for innovative investments. These are likely to be activities that are not yet proven but are strongly expected (based on international evidence and best practice models) to reduce alcohol-related harms.

460. By providing clear expectations, process guidance, support, and building innovation reporting into regular reporting, contracts can remain non-prescriptive as to how this funding allocation is used.

461. If an activity undertaken in this category is proved to be successful at addressing alcohol-related harm, it can then be moved into the **Core** category for ongoing funding.

462. This category could include a range of programmes and services that were suggested by participants during the engagement for this review that are not currently funded by the levy. For example, a range of alcohol-free activities and events that provide an alternative space from traditional, alcohol saturated, environments, and begin to shift the normalisation of having alcohol at social and community events.

463. This category is proposed to act as a fund that can be applied for in a similar manner to current grant funding and funding of regional activities. It is proposed that this **Trial** funding begins at $2 million for the 2025/26 financial year.

Reserve

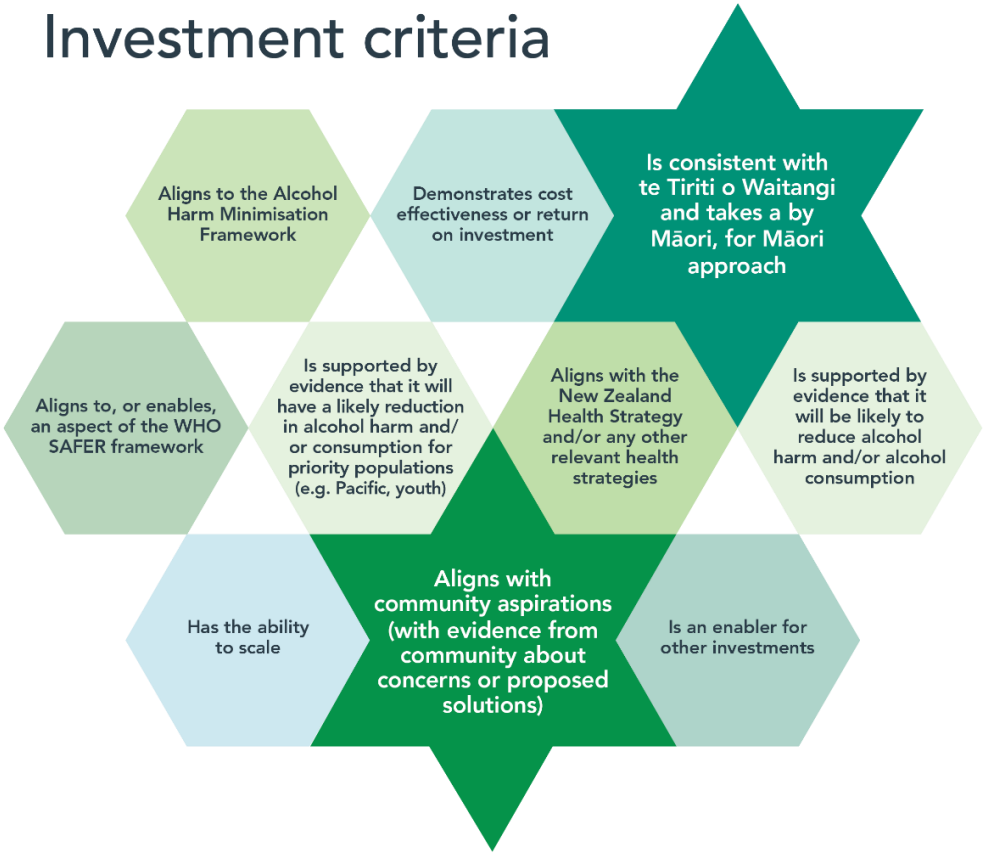
464. Having a **Reserve** amount available for emergent challenges and opportunities provides a “safety net” for programmes. This could be used for covering programmes or services that justifiably go over budget (for example, unexpected overutilisation of existing services). It would act as a cash reserve and would not need to be a large amount. This should be established by the Ministry of Health.

Investment criteria

465. When setting the levy each year, after the cost-recovery analysis has been undertaken to determine a reasonable amount of expenditure on activities addressing alcohol-related harm and the operational costs associated, the total levy amount should then be categorised into the four investment categories. Each investment category should be measured against the same investment criteria, but with different standards for each category. For example, when assessing the evidence of effectiveness of addressing alcohol-related harms, activities in the **Trial** category will have a lower standard of evidence to meet, given the innovative function it performs. Whereas activities in the **Core** category should be required to be supported by strong, ongoing evidence that they continue to meet the investment criteria.

466. Based on the engagement undertaken in this project, the following draft criteria have been developed. It is essential that the final criteria are adequately co-developed between the three health entities and relevant community stakeholders.

Figure 3: Investment criteria



Note: Those criteria that are represented as a star have double the weighting as those without. The strategic governance group will need to determine how the criteria should be weighted when using them to assess individual investments. Not all investment criteria must be met.

467. A significant amount of work by the Health Promotion Agency went into developing the National Alcohol Harm Minimisation Framework.[97] This framework provides a base for future investment decisions. Using the Alcohol Harm Minimisation Framework principles, the Ministry of Health can seek alignment from providers when assessing and making decisions on future investment.

468. The key message from engagement was that communities felt local alcohol-related activities should be organised by local organisations; "*local faces in local spaces*."

Giving effect to Te Tiriti

469. To receive and continue to receive levy funding, all investments should explicity demonstrate how they consistently give effect to Te Tiriti. That means they must demonstrate how their proposed services have and will continue to:

- Support **equity** of access and outcomes
- Provide **options** which are responsive to Māori and reflective of what Māori want
- Demonstrate how the activity or funding has or will continue to seek **active protection** of Māori and enhance Māori health and wellbeing,
- Show how Māori will be involved as equal **partners** with detail around the nature and extent of those partnerships
- How Māori rights to **tino rangatiratanga** will be supported or enabled through the provision of services

470. To determine whether an investment is consistent with Te Tiriti, the following questions could be considered. For example:

- **Tino rangatiratanga**: How does this investment provide for Māori self-determination and mana motuhake in the design, delivery, and monitoring of the service? How will resources and power be restored to Māori?
- **Equity**: How does this investment demonstrate a commitment to achieving equitable health outcomes for Māori? How will this investment ensure equity of outcomes as Māori define them?
- **Active protection**: How does this investment act to the fullest extent practicable to achieve equitable health outcomes for Māori? How will this investment enable Māori to protect their communities from exposure or reduce exposure to alcohol harms? How will this investment achieve a different outcome from historical efforts?

[97] Te Whatu Ora. 2022. *National Alcohol Harm Minimisation Framework*

- **Options**: Does this investment provide or, properly resource, kaupapa Māori health services? How will this investment support people to live as Māori and according to Māori values and customs?
- **Partnership**: Does this investment demonstrate working in partnership with Māori in the governance, design, delivery and monitoring of the programme/project? How will decision-making processes ensure that Māori have the final word on how this investment benefits Māori people?

Strategic priorities and outcomes

471. The following is an example of how agreed strategic priorities could be set out. This is based on the Alcohol Harm Minimisation Framework designed by the Health Promotion Agency and includes draft outcomes. These would need to be consulted on and agreed by the strategic governance group for the alcohol levy.

Figure 4: Strategic priorities

Summary of Tranches 1 and 2 – Short- to medium-term approach to administration and investment of levy funds

472. Tranche 1 recommends an increase to the levy baseline of at least $21.5 million, and preferably $37.3 million for the 2024/25 financial year, which will enable levy-funded providers to undertake work necessary to support the Ministry to complete Tranche 2 work, while not compromising service levels.

473. For the 2025/26 financial year, the levy amount should be calculated based on a detailed assessment, using an investment framework, of the activities funded in 2024/25 in the **Core** investment.

474. As set out in the description of Tranche 1, based on the information made available to *Allen + Clarke*, applying the investment criteria would bring the total levy fund for the 2024/25 financial year to approximately $37.3 million. This would be made up of:

- **Core**: a $10 million increase to the current levy amount to ensure the sustainability of existing activities and to enable their evaluation and, if appropriate, extension.
- **Extend**: a minimum of an additional $13.8 million to fund the extension of programmes that have been piloted (at relatively low funding levels) through the levy fund, have proven effective, are supported by communities, and are aligned to the Pae Ora context.[98]
- **Trial**: an additional $2 million to fund new and innovative programmes through 'seed funding' style arrangements.
- **Reserve** would not be allocated for the 2024/25 financial year, but the investment structures set in place will help to enable an assessment of the **Reserve** funding required to respond to emergent challenges within a given financial year.

475. Lifting the levy total to $37.3 million in total would likely have little impact on the price paid by consumers of alcohol, adding approximately 1.1 cents to the price of a standard can of beer, and up to 7 cents to the price of a standard bottle of wine.

476. For the 2025/26 financial year, there is scope to significantly increase the levy to recover the expenditure required to deliver the full range of activities identified by participants as meeting community needs and aspirations to address alcohol-related harm. Some activities and services funded under **Trial** in 2024/25 could be moved to

[98] *Allen + Clarke* notes that this additional $13.8 million of funding relates only to the sports sponsorship demonstration, Community Social Movement, and Community Law Centres of Aotearoa activities used as examples. It is highly likely that many of the other existing levy funded activities would align sufficiently with the investment criteria to warrant receiving **Extend** funding in the 2025/2026 financial year and beyond.

Core if, following their pilot phase, they demonstrate sufficient alignment with the investment criteria. Similarly, some activities funded under **Core** in 2024/25 could demonstrate sufficient alignment with the investment criteria to warrant receiving **Extend** funding in 2025/26.

477. For the 2025/26 financial year, if Tranches 1 and 2 are implemented, there will be more detailed information available to help determine the funding levels required for **Extend, Trial,** and the **Reserve**. There should also be sufficient information available to adjust the **Core** based on actual expenditure requirements, as opposed to the CPI-based increase that this report has recommended as a proxy.

478. As discussed above, the cost-recovery provisions in the Pae Ora Act enable the amount recovered via the levy (and therefore the levy quantum) to be reduced. Based on its review, *Allen + Clarke* considers it highly unlikely that, after applying the investment framework, the Ministry of Health would consider it reasonable to expend less than $37.3 million per annum on activities to address alcohol-related harm. However, it is important to state that this could occur, should the Ministry of Health conclude that the need for (and cost of) services to address alcohol-related harm has reduced (likely only due to a reduction in the incidence of alcohol-related harm across New Zealand).

Tranche 3: A full cost-recovery analysis should be undertaken to ensure long-term sustainability for the levy

This section responds to, in part, the following policy questions
• As pertains to the alcohol levy, what should cost-recovery for activities addressing alcohol-related harm look like in the Pae Ora context?
• What are the options for the administration of the alcohol levy to support the investment as a cost-recovery mechanism?
• What current investments from the levy fund should be retained, if any?
• What are participants' perceptions of how the alcohol levy could most effectively be invested? Including stakeholder perceptions of whether there should be a focus on health promotion, prevention, or treatment measures.

479. In Tranche 3, *Allen + Clarke* recommends that the Ministry of Health undertake a full cost-recovery analysis to determine the actual expenditure it incurs (including through arrangements with Health New Zealand and Te Aka Whai Ora) on activities to address alcohol-related harm, and the proportion of that expenditure that should be recovered through the levy.

480. To support this recommendation, this section provides an overview of the cost-recovery settings under the Pae Ora Act and provides insights and analysis into what costs may be appropriate to recover in the new Pae Ora context.

481. This section also provides insights into, and analysis of, the factors that should be considered for inclusion (or exclusion) in the levy setting process in the future.

482. See Appendix A for an introduction to cost-recovery and an outline of the change in scope that the Pae Ora Act allows for, and the breadth of activities that could be funded.

Why are the cost-recovery settings under the Pae Ora Act important?

483. While the cost-recovery provisions for the alcohol levy are effectively carried over from the New Zealand Public Health and Disability Act, the cost-recovery system takes on a completely new context in the Pae Ora Act. Under the Pae Ora Act, the alcohol levy can be used to recover the costs of any activities the Ministry of Health undertakes to address alcohol-related harm as well as the operational costs to support these activities. As *Allen + Clarke* has noted in this report, the activities that the Ministry of Health (including through its partner agencies) does currently, and can in future, undertake to address alcohol-related harm are broader than those that could be undertaken by the Health Promotion Agency. This interpretation of the relevant provisions in the Pae Ora Act has been confirmed with the Ministry of Health's legal team.

484. This provides an opportunity for the Ministry of Health to undertake a full cost-recovery analysis to support the determination of the future quantum of the levy, which will involve considering what activities currently funded via Vote Health should instead be funded via the levy or could be expanded using levy funds.

Legal authority to cost recover

485. Section 101 of the Pae Ora Act provides an explicit power to impose levies for the purposes of enabling the Ministry of Health to recover costs it incurs:

- in addressing alcohol related harm, and
- in its other alcohol-related activities (which include its operating costs that are attributable to alcohol-related activities).

486. Schedule 6 provides further information on the power to recover costs. It provides a mandatory process for setting the levy that requires the Minister to:

- assess the level of spending that would be 'reasonable' for the Ministry of Health to spend that year in addressing alcohol-related harm and in meeting the operating costs that are attributable to alcohol-related activities, and
- determine the total amount to be collected by the levy.

487. Schedule 6, clause 2(3) provides that the Ministry of Health does not need to spend the entire levy amount collected and can accumulate levy in one financial year to be spent in a future year. This differs from other common cost-recovery provisions that can require levy income to be spent in a specific period, and to trend down to zero in that time. In practice, accumulated surplus expenditure could be considered by the Minister when identifying a reasonable levy quantum for a particular year.

The services to be recovered

488. The legislation does not define the services that are covered by the levy. It provides broad, enabling powers to allow for levies to recover all costs that the Minister of Health considers reasonable to incur to address alcohol-related harm.

489. For the purposes of this report and analysing the suitability of cost-recovery, the potential health services that could be funded by the levy have been grouped into six categories:

- **Promotion:** health promotion activities aimed at the general population to inform their own decisions about their use of alcohol.
- **Prevention:** targeted campaigns or interventions based on risk, such as at targeted population groups, self-selected individuals, or otherwise.
- **Treatment:** secondary or tertiary specialist services within the health system for people requiring treatment for alcohol use disorders or alcohol-related disease and injury conditions.
- **Research:** research and evaluation to understand the nature and extent of alcohol-related harm and the effectiveness of activities to address it.
- **Data collection:** comprehensive national and regional collection of data to track alcohol-related harms and costs, as well as data from activities funded by the levy, including reporting by service providers.
- **Policy services:** machinery of government services to support Ministerial decision-making, policy development, policy implementation and operationalisation, public finance requirements, public reporting, and relationship with other stakeholders.

490. The economic characteristics of these services and the appropriate options for who should pay, according to standard cost-recovery considerations, are set out in Table 10 in Appendix A. Terms used in Table 10 in Appendix A follow the specific cost-recovery definitions outlined in Table 9 in Appendix A.

Setting the levy

491. As above, the alcohol levy is designed to recover the costs the Ministry of Health incurs to *address* alcohol-related harm, and in carrying out other alcohol-related activities. The alcohol levy is *not* intended to recover the costs of alcohol-related harm. This distinction is essential to setting the levy within the Pae Ora context.

492. NZIER's report quantifies the current costs of alcohol-related harms within New Zealand using recent local evidence, including several health services currently funded by Health New Zealand, insofar as recent local data and evidence permit. While the levy is based on actual costs of providing activities to address alcohol related harm, the scale of the harm indicated in the NZIER report provides context for consideration of whether the amount of proposed expenditure in a year to address alcohol-related harm is 'reasonable'.

493. In the Pae Ora context, the Ministry of Health will need a mechanism to do the following:

- identify the activities it is providing, or intends to provide, that address alcohol-related harm, including setting out how they will do so, for example:
    - whether they are promotion, prevention, treatment, research, data collection, policy services, or other activities, and
    - explaining the intervention logic for how those activities will address alcohol-related harm.
- justify the service level for those activities based on factors such as:
    - the level of need in communities and strength of evidence of effectiveness
    - evidence of cost effectiveness (including reducing negative externalities of alcohol-harm)
    - ensuring that Māori and other population groups have access to services in proportion to their needs, receive equitable levels of service to achieve equitable health outcomes, and
    - the level of agreement with Māori, other population groups, and other people that the proposed services and programmes reflect their needs and aspirations.
- justify the level of operational costs required to support those activities.

494. Within the Pae Ora context, the Ministry of Health may consider whether to use the alcohol levy to recover costs for alcohol-related treatment services and other alcohol-related health services (delivered or commissioned through Health New Zealand). These are not currently recovered through the levy and are funded by Vote Health. *Allen + Clarke* understands current demand outstrips supply of these services. Consideration for funding these services would include a final assessment of the legal mandate to recover costs associated with different types of services, especially treatments, as well as an assessment of the economic characteristics of the in-scope services.

495. For services delivered or commissioned by Health New Zealand that are considered in-scope for the levy, and for which an assessment of the economic characteristics has determined that cost-recovery would be allocatively efficient and equitable, Health New Zealand would then have to quantify the attributable costs. NZIER's report quantifies the costs of the alcohol attributable proportion of several of these services, illustrated below in Table 7 (Note: Health New Zealand services to address FASD are excluded from this table and are discussed separately below).

Table 7: Health New Zealand services to address alcohol-related harm

Health New Zealand service for consideration	Cost estimate (2023 $ values)
Inpatient hospitalisations attributable to alcohol	$337 million.
Alcohol-attributable Emergency Department visits	$102 million.
Outpatient services attributable to alcohol	Not available. Current state of evidence is discussed in NZIER report.
Medical services resulting from alcohol-attributable road crashes	Total medical services: $19 million (includes hospital services $9 million, emergency services $6.3 million, and follow on services $3.8 million.

496. NZIER's report also quantifies the prevalence and productivity losses associated with FASD in New Zealand. Within the Pae Ora context, the Ministry of Health must consider whether to use the alcohol levy to fund activities to both prevent and address FASD, both new and those currently funded through other Crown funding streams.

497. As above, this consideration would include a final assessment of the legal mandate to recover costs associated with different types of services to prevent and address FASD, as well as an assessment of the economic characteristics of the in-scope services. For services which are deemed in-scope and are assessed as being allocatively efficient and equitable, the Ministry of Health would then have to quantify the attributable costs.

498. At the end of that process, there will be an aggregated expenditure amount, which feeds into the levy calculation. To calculate the levy, the Ministry of Health could consider the level of funds already collected by the levy and the amount needed in future years to fund agreed services.

499. *Allen + Clarke* considers that bringing together the different threads of inquiry for the levy would require the adoption of an investment framework to support justifiable decisions about what services, programmes, and activities will be funded by the levy, and the level of service that will be funded.

Tranches 1, 2, and 3 - summary of recommendations

Tranche 1: January 2024 – March 2025

500. Tranche 1 would support a short to medium term immediate increase in the amount of funds recovered through the levy from the current $11.5 million to a new figure of between $21.5 million and $37.3 million for 2024/25 based on the expenditure required to undertake activities in the **Core** and **Extend** investment categories.

501. This CPI-based increase of $10 million is a pragmatic proxy for the quantification of the reasonable expenditure to address alcohol-related harm and is based on the cumulative shortfall caused by lack of inflationary adjustment to the levy since 2012/13. It will enable the Ministry of Health and levy-funded providers to address the consequences of the cumulative shortfall since 2012/13, which will support the Ministry of Health to undertake the work recommended in Tranche 2. It will also restore the purchasing power of the levy to the 2012/2013 level. The $21.5 million should be allocated to the **Core** investment category. It would enable existing levy funded activities to be sustained and evaluated, support providers to enhance their monitoring and reporting, and prepare to extend existing activities if appropriate. This would result in a very small increase to the price of alcoholic beverages (for example, from the current approximately 0.5 cents, to 1 cent on a standard can of beer).

502. There is an option, within Tranche 1, to increase the levy to $37.3 million (our recommended option). This would result in $21.5 million available in the **Core** investment category and $13.8 million in the **Extend** investment category. This would result in an additional small increase to the levy on alcoholic beverages (for example, from the current approximately 0.5 cents to 1.6 cents on a standard can of beer).

503. Alongside the increases to the levy quantum, *Allen + Clarke* strongly recommends that the Ministry of Health implements short-term processes (leveraging existing processes) to increase the rigour of the administration and oversight of levy, given the increased quantum. This reflects the need for greater assurance about how an increased amount of the levy funds would be spent to address alcohol-related harm and how the new Pae Ora-aligned approach to setting the levy is administered from the 2024/25 financial year onwards. *Allen + Clarke* notes that the $10 million increase to the funds available for **Core** activities will enhance the ability of providers to support the Ministry of Health to provide transparent administration and oversight of the alcohol levy.

504. The management of the levy funds should include the implementation of separate accounting mechanisms to ensure that actual expenditure can be tracked, monitored, and reported to all stakeholders. This will also support levy calculations in subsequent years to allow for reductions in levy rates to reflect underspend from previous years due to delays in contracting or other delivery delays.

Tranche 2: January 2024 – March 2026

505. The work in Tranche 2 builds on, and is enabled by, the increased investment that *Allen + Clarke* recommends in Tranche 1. In Tranche 2, *Allen + Clarke* recommends

that the health entities develop an investment framework for the levy, which includes investment categories, investment criteria, and strategic priorities and outcomes, and establish new long-term governance structures. *Allen + Clarke* has developed and presented a draft investment framework that includes these components.

506. In Tranche 2, *Allen + Clarke* recommends that the health entities:

- set up a strategic governance group, responsible for setting the strategic direction of the levy, setting the intended outcomes of the levy, and confirming investment criteria
- set up a delivery governance group who will apply the investment criteria and strategic direction when determining how to allocate the levy funds for the following financial year
- establish oversight and monitoring frameworks at a level proportionate to the new size and complexity of the alcohol levy system to support levy governance, determine investment categorisation each year, provide assurance over the expenditure and its contribution to agreed outcomes, and
- review the proposed investment criteria and strategic priorities to ensure both remain fit-for-purpose and adequately representative for the health entities.

Tranche 3: January 2024 – March 2026

507. Tranche 3 focuses on developing a stronger basis for future decision-making on the alcohol levy and its role in the broader health system by undertaking a first principles cost-recovery analysis of all the Ministry of Health activities that address alcohol-related harm and their associated operational costs.

508. The first principles cost-recovery analysis would confirm the intent of the use of the levy in the Pae Ora context and provide decisions on the categorisation and scope of activities that should be cost recovered via the levy. This work would include policy decisions on whether the levy should be used to fund activities beyond the services that could have been provided by the Health Promotion Agency, given its legislative mandate. This review would finalise decisions about whether some types of treatment services may be in-scope or whether the focus should continue to be on health promotion, prevention, education, policy, and research services.

509. The first principles cost-recovery review would require developing a system view of all services provided by the Ministry of Health that are designed to address alcohol-related harm and allow for a better understand of the role and contribution of the levy funded services within the broader investment from Crown sources.

11 Conclusion

510. Alcohol consumption causes significant harms across all sectors of our population, from the wide range of health and mental health impacts to crime, accidents, and lost productivity. The harms associated with alcohol consumption costs New Zealand taxpayers billions of dollars every year and addressing these harms diverts significant resources from other areas.

511. From speaking to more than 200 hundred participants around the country, *Allen + Clarke* has concluded that using the levy to fund services designed to address alcohol-related harm is strongly supported. However, *Allen + Clarke* has also concluded that there is significant potential to fund more and different services to meet the needs and aspirations of communities.

512. The Pae Ora Act provides a legal mandate to explore the funding of more and different investment in activities to address alcohol-related harm and to reduce the significant inequitable burden of harm experienced by Māori and Pacific, while recovering the costs of those investments from the alcohol-harm risk exacerbators; the producers and importers of alcohol.

513. In the short-term, expansion of existing alcohol related activities could help address the harm and will result in only small changes to the cost of alcohol.

514. In the medium- to long-term, there is a substantial opportunity to recover the costs associated with undertaking a broader scope of activities than those that could be undertaken by the Health Promotion Agency prior to the Pae Ora reforms. This should only be done following a robust review of activities that are now eligible for cost-recovery under the Pae Ora Act.

515. The Pae Ora context also creates an opportunity for the levy to be transparent, have strong governance, and be better aligned with health sector and Te Tiriti principles. This will allow for sound investment decisions to be made to effectively address alcohol-related harm in New Zealand. Establishing new Te Tiriti-informed approaches to the governance and delivery of funds collected via the levy will also help to ensure that the new systems will support the realisation of Māori aspirations for reducing the disproportionate harm Māori experience from alcohol.

Bibliography

Alcohol Healthwatch. (n.d.). *Harm to Māori*. Retrieved from Alcohol Healthwatch: https://www.ahw.org.nz/Issues-Resources/Harm-to-M%C4%81ori

Allen + Clarke. (2021). *Community Law Alchol Harm Reduction Project: A formative evaluation.* Wellington : Te Hiringa Hauora.

Allen + Clarke, NZIER. (2023). *Interim Report of Independent Review of the Alcohol Levy.* Wellington: Ministry of Health.

Alliston, L. (2012). *Alcohol-related inquiry: An evidence-based literature review.* Wellington.

Anderson, B. O., Berdzuli, N., Ilbawi, A., Kestel, D., Kluge, H. P., Krech, R., . . . Ferreira-Borges, C. (2023). Health and cancer risks associated with low levels of alcohol consumption. *The Lancet. Public Health, 8*(1), e6-e7. doi:10.1016/S2468-2667(22)00317-6

Ataera-Minster, J., & Trowland, H. (2018). *Te Kaveinga - Mental health and wellbeing of Pacific Peoples.* Wellington: Health Promotion Agency.

Ataera-Minster, J., Guiney, H., & Cook, S. (2020). *Taeao Malama: Alcohol use in Pacific peoples. Results from the New Zealand Health Survey & Attitudes and Behaviour toward Alcohol Survey.* Wellington: Te Hiringa Hauora Health Promotion Agency.

Babor, T., Casswell, S., Graham, K., Huckle, T., Livingston, M., Osterberg, E., . . . Sornpaisarn, B. (2022). *Alcohol: No Ordinary Commodity 3rd Edition.* Oxford: Oxford University Press.

Becker, H. (2008). Alcohol Dependence, Withdrawal, and Relapse. *Alcohol Research and Health: the journal of the National Institute on Alcohol Abuse and Alcoholism, 31*(4), 348–361.

Bell, C., Williman, J., Every-Palmer, S., Beaglehole, B., Stanley, J., Jenkins, M., . . . Rapsey, C. (2021). Psychological distress, loneliness, alcohol use and suicidality in New Zealanders with mental illness during a strict COVID-19 lockdown. *Australian & New Zealand Journal of Psychiatry, 56*(7), 800-810. doi:10.1177/00048674211034317

Boden, J., & Fergusson, D. (2011). Alcohol and depression. *Addiction, 106*(5), 906-914. doi:10.1111/j.1360-0443.2010.03351.x

Boden, J., Hetrick, S., Bowden, N., Fortune, S., Marek, L., Theodore, R., . . . Hobbs, M. (2022). Empowering community control over alcohol availability as a suicide and self-harm prevention measure: Policy opportunity in Aotearoa New Zealand. *The Lancet Regional Health - Western Pacific, 29*. doi:10.1016/j.lanwpc.2022.100631

Butler, T., Karkhanis, A., Jones, S., & Weiner, J. (2016). Adolescent Social Isolation as a Model of Heightened Vulnerability to Comorbid Alcoholism and Anxiety Disorders.

Alcoholism, clinical and experimental research, 40(6), 1202–1214. doi:10.1111/acer.13075

Canadian Centre on Substance Use and Addiction. (2023). *Canada's Guidance on Alcohol and Health: Final Report.* Ottawa.

Chairs and Chief Executives of District Health Boards. (2021). DHB Position Statement on the Sale and Supply of Alcohol Act 2012.

Chambers, T., Jackson, N., & Hoek, J. (2021, August). New Zealand's proposed ban on alcohol sponsorship of sport: a cost-effective, pro-equity and feasible move towards reducing alcohol-related harm. *The Lancet regional health - Western Pacific*. doi:10.1016/j.lanwpc.2021.100218

Chambers, T., Mizdrak, A., Herbert, S., Davies, A., & Jones, A. (2023). The estimated health impact of alcohol interventions in New Zealand: A modelling study. *Addiction*. doi:10.1111/add.16331

Chambers, T., Stanley, J., Signal, L., Pearson, A., Smith, L., Barr, M., & Ni Mhurchu, C. (2018). 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, 53*(5), 626–633. doi:https://doi.org/10.1093/alcalc/agy053

Commerce Commission New Zealand. (2022). *Annual Report 2021/22.* Wellington.

Connor, J., Kydd, R., Maclenna, B., & Shield, K. (2017). Alcohol-attributable cancer deaths under 80 years of age in New Zealand. *Drug and Alcohol Review, 36*(3), 415-423. doi:10.1111/dar.12443

Crossin, R., Cleland, L., Beautrais, A., Witt, K., & Boden, J. (2022). Acute alcohol use and suicide deaths: an analysis of New Zealand coronial data from 2007-2020. *New Zealand Medical Journal, 135*(1558), 65–78.

Crossin, R., Cleland, L., Wilkins, C., Rychert, M., Adamson, S., Potiki, T., . . . Boden, J. (2023). The New Zealand drug harms ranking study: A multi-criteria decision analysis. *Journal of Pyschopharmacology, 37*(9), 891-903. doi:10.1177/02698811231182012

Customs New Zealand. (2023). *Annual Report 2023.* Wellington.

Day, P., Breetzke, G., Kingham, S., & Campbell, G. (2012). Close proximity to alcohol outlets is associated with increased serious violent crime in New Zealand. *Australian and New Zealand Journal of Public Health, 36*(1), 48-54. doi:10.1111/j.1753-6405.2012.00827.x

GBD 2016 Alcohol Collaborators. (2018). Alcohol use and burden for 195 countries and territories, 1990-2016: a systematic analysis for the Global Burden of Disease Study 2016. *Lancet*, 1015-1035. doi:https://doi.org/10.1016/S0140-6736(18)31310-2

Government Inquiry into Mental Health and Addiction. (2018). *He Ara Oranga translates as Pathways to Wellness.* Wellington.

Halsall, T., Lachance, L., & Kristjansson, A. L. (2020). Examining the implementation of the Icelandic model for primary prevention of substance use in a rural Canadian community: a study protocol. *BMC Public Health, 20*(1), 1235. doi:10.1186/s12889-020-09288-y

Hawton, K., Saunders, K., & O'Connor, R. (2012). Self-harm and suicide in adolescents. *Lancet, 379*(9834), 2373–2382. doi:10.1016/S0140-6736(12)60322-5

Huckle, T., & Romeo, J. (2023). Estimating child maltreatment cases that could be alcohol attributable in New Zealand. *Addiction, 118*(4), 669-677. doi:10.1111/add.16111

Jackson, N., & Dixon, R. (2020). The practice of the alcohol industry as health educator: a critique. *The New Zealand medical journal, 133*(1515), 89-96.

Klatsky, A. (1996). Alcohol and hypertension. *Clinica chimica acta; international journal of clinical chemistry, 246*(1-2), 91-105. doi:10.1016/0009-8981(96)06230-4

Kubota, M., Nakazaki, S., Hirai, S., Saeki, N., Yamaura, A., & Kusaka, T. (2001). Alcohol consumption and frontal lobe shrinkage: study of 1432 non-alcohol subjects. *Journal of neurology, neurosurgery, and psychiatry, 71*(1), 104-106. doi:10.1136/jnnp.71.1.104

Legislation Design and Advisory Committee. (2021). *Legislation Guidelines*.

Manatū Hauora. (2022, July 4). *Alcohol*. Retrieved from Ministry of Health: https://www.health.govt.nz/your-health/healthy-living/addictions/alcohol-and-drug-abuse/alcohol

Māori Community Development Act. (1962).

Meyers, C., Mann, M., Thorisdottir, I. E., Garcia, P. R., Sigfusson, J., Sigfusdottir, I. D., & Kristjansson, A. (2023). Preliminary impact of the adoption of the Icelandic Prevention Model in Tarragona City, 2015–2019: A repeated cross-sectional study. *Frontiers in Public Health, 11:1117857*. doi:10.3389/fpubh.2023.1117857

Ministry for Pacific Peoples. (2021). *Pacific Aotearoa Status Report: A snapshot 2020.* Wellington: Ministry for Pacific Peoples.

Ministry for Pacific Peoples. (2021). *Pacific Peoples In Aotearoa: A snapshot.* Wellington: Ministry For Pacific Peoples.

Ministry of Health. (2014). *Ministerial forum on alcohol advertising and sponsorship: recommendations on alcohol advertising and sponsorship.* Wellington.

Ministry of Health. (2020). *Whakamaua: Māori Health Action Plan 2020–2025.* Wellington: Ministry of Health.

Ministry of Health. (2022). *New Zealand Health Survey 2021/22*. Retrieved from https://minhealthnz.shinyapps.io/nz-health-survey-2021-22-annual-data-explorer/

Ministry of Health. (2023). *Independent Review of the Alcohol Levy Stage 1: Rapid Review.* Wellington: Ministry of Health.

Ministry of Health. (2023). *New Zealand Health Survey 2022/23*. Retrieved from https://minhealthnz.shinyapps.io/nz-health-survey-2022-23-annual-data-explorer/

Ministry of Justice. (2024, February 27). *Licenses Register.* Retrieved from Register of Licenses & Certificates: https://www.justice.govt.nz/tribunals/arla/register-of-licences-and-certificates/

Ministry of Transport. (2022). *Safety - annual statistics: Alcohol and drugs*. Retrieved from https://www.transport.govt.nz/statistics-and-insights/safety-annual-statistics/sheet/alcohol-and-drugs

National Health and Medical Research Council. (2020). *Australian Guidelines to Reduce Health Risks from Drinking Alcohol.* Canberra: National Health and Medical Research Council.

New Zealand Cancer Society. (2020). *Position Statement: Alcohol and Cancer.* Wellington.

New Zealand Drug Foundation. (2022). *Fatal Overdoses in Aotearoa 2017-2021.* Wellington.

New Zealand Law Commission. (2010). *Alcohol in our lives curbing the harm: a report on the review of the regulatory framework for the sale and supply of liquor.* Wellington.

New Zealand Police. (2009). *National Alcohol Assessment.*

New Zealand Public Health and Disability Act. (2000).

Nutt, D., Hayes, A., Fonville, L., Zafarm, R., Palmer, E., Paterson, L., & Lingford-Hughes, A. (2021). Alcohol and the Brain. *Nutrients, 13*(11), 3938. doi:10.3390/nu13113938

Nyakutsikwa, B., Britton, J., & Langley, T. (2021). The effect of tobacco and alcohol consumption on poverty in the UK. *Addiction, 116*(1), 150-158. doi:10.1111/add.15096

Pae Ora (Healthy Futures) Act. (2022).

Randerson, S., Gordon, L., Casswell, S., Lin, J., Borell, B., Rychert, M., & Huckle, T. (2022). *"I feel it's unsafe to walk": Impacts of alcohol supply on public space in eight neighbourhoods, and residents' input into alcohol licensing decisions.* Wellington: Te Whatu Ora.

Richardson, A., Hayes, J., Frampton, C., & Potter, J. (2016). Modifiable lifestyle factors that could reduce the incidence of colorectal cancer in New Zealand. *New Zealand Medical Journal, 129*(1447), 13-20.

Romeo, J., Huckle, T., Casswell, S., Connor, J., Rehm, J., & McGinn, V. (2023). Foetal alcohol spectrum disorder in Aotearoa, New Zealand: Estimates of prevalence and indications of inequity. *Drug and Alcohol Review, 42*(4), 859-867. doi:10.1111/dar.13619

Rovira, P., & Jurgen, R. (2021). Estimation of cancers caused by light to moderate alcohol consumption in the European Union. *European journal of public health, 31*(3), 591-596. doi:10.1093/eurpub/ckaa236

Sale and Supply of Alcohol (Community Participation) Amendment Act. (2023).

Stats New Zealand. (2021, May 28). *Population project to become more ethinically diverse*. Retrieved from Stats NZ: https://www.stats.govt.nz/news/population-projected-to-become-more-ethnically-diverse

Te Hiringa Hauora. (2022). *Annual Report 2021/2022.* Wellington.

Te Whatu Ora. (2022, February). *National Alcohol Harm Minimisation Framework*. Retrieved from Health Promotion Agency New Zealand: https://www.hpa.org.nz/national-alcohol-harm-minimisation-framework

The Treasury. (2017). *Guidelines for Setting Charges in the Public Sector.* New Zealand Treasury.

Tian, W. (2023). *Understanding alcohol and drug use among New Zealand Asian communities.* Synergia.

Wong, S. (2021). *Asian Public Health in Aotearoa New Zealand.* Auckland: The Asian Network Inc.

World Health Organisation. (2013). *Global Action Plan for the Prevention and Control of Non-communicable Diseases.* Geneva, Switzerland: WHO Press.

World Health Organization. (2010). *Global strategy to reduce the harmful use of alcohol.* Italy: World Health Organization.

World Health Organization. (2010). Sixty-Third World Health Assembly, Resolutions and Decisions., (p. 43). Geneva.

World Health Organization. (2019). *The SAFER technical package: five areas of intervention at national and subnational levels.* Geneva.

World Health Organization. (2022, May 9). *Alcohol: key facts*. Retrieved from World Health Organization: https://www.who.int/news-room/fact-sheets/detail/alcohol

World Health Organization. (2023). *Alcohol action plan 2022-2030.* Geneva: World Health Organization.

World Health Organization. (2023, January 4). *No level of alcohol consumption is safe for our health*. Retrieved from World Health Organization: https://www.who.int/europe/news/item/04-01-2023-no-level-of-alcohol-consumption-is-safe-for-our-health#:~:text=The%20World%20Health%20Organization%20has,that%20does%20not%20affect%20health

Appendix A: Cost-recovery

Introduction to cost-recovery

Table 8: Summary of economic characteristic (Treasury, 2017)

Summary
Goods and services can be grouped based on two key economic characteristics: • Is it excludable – can people be prevented from using it? • Is it rivalrous – if one person uses the good or service, does it reduce other's enjoyment of it? Categorising goods under public, private, merit, or club goods is often used to characterise the economic characteristics of goods and services provided by government.

Table 9: Cost-recovery definitions (Treasury, 2017)

Term	Definition
Cost-recovery	The charging of a party for the costs of producing a good, service or activity.
Costs (of services)	The full cost of producing outputs, including all overhead and non-cash costs (such as the capital charge). It is measured in accrual accounting terms.
Goods, club	A club good has the property that people can be excluded from its benefits at low cost, but its use by one person does not detract from its use by another.
Goods, merit	A merit good has the property that the community as a whole desires the higher use of the output than would be likely if it were charged for at full cost.
Goods, private	A private good has the property that people can be excluded from its benefits at low cost, and it's use by one person detracts from its use by another.
Goods, public	A public good has the property that excluding people from it's benefits is either difficult or costly, and its use by one person does not detract from its use by another.
Outputs	The goods and services produced by a government agency.

1. Within a cost-recovery context, outputs (see above) are defined narrowly and relate specifically to the service provided by the government. The economic characteristics and broader analysis of cost-recovery settings relate specifically to the output rather than the broader outcomes or regulatory settings that exist around the service. The analysis in this section is more narrowly focused than the rest of the report to follow

best practice methodologies for settings fees and charges in the public sector. The benefits resulting from outputs are only those which are directly provided as a result of the outputs. While outcomes and broader societal benefits are important to cost-recovery discussions, these secondary benefits, such as the increased wellbeing of others and the community from one person's addiction treatment, are not attributable as cost-recovery benefits.

2. Cost-recovery is the recuperation of the costs of government-provided or funded products or services that, at least in part, provide private benefits to individuals, entities, or groups. Cost-recovery has the potential to advance efficiency and equity objectives. In particular, cost-recovery can allow for those that create risks that the services are designed to manage, to pay for the costs of the service.

3. This section provides a high-level analysis of the basis for cost-recovery in the new context, including:

- understanding best practice approaches to cost-recovery
- the legislative context of cost-recovery in the Pae Ora Act
- the services that could be recovered under the Pae Ora Act
- options for charging for these services
- alignment of those options to cost-recovery principles, and
- setting the levy.

Setting fees and levies

4. Cost-recovery requires explicit legislative authority to be implemented. The Pae Ora Act allows for a specific type of cost-recovery called a levy. Accepted best practice for settings fees and charges in the public sector comes from the Treasury's *Guidelines for Setting Charges in the Public Sector* and the Office of the Auditor-General's *Setting and Administering Fees and Levies for Cost-recovery: Good Practice Guide.*

5. These guides provide a framework for assessing:

    - the legal authority for cost-recovery (set by legislation)
    - the outputs and costs of the services
    - the economic characteristics of the outputs of the services provided and their suitability for cost-recovery
    - who benefits from the outputs of the service or creates the risks that the service is designed to manage
    - the options for charging
    - the alignment of the potential options against the cost-recovery principles, and
    - determining the appropriate level of the levy.

- Following these steps provides a basis for analysing the potential uses of cost-recovery.

6. The Legislation Design and Advisory Committee (LDAC) has published its Legislation Guidelines (Legislation Design and Advisory Committee, 2021) that provide further context around the distinction between levies and other types of fees that are relevant to this discussion.

7. LDAC provides a definition of a levy that is relevant to this discussion.

> *"A levy does not relate to a specific good or service. It is usually charged to a particular group (often referred to informally as a "club") to help fund a particular government objective or function. Accident Compensation Corporation levies, for example, are factored into the costs of petrol and vehicle licensing to help cover the cost involved in treating people who are injured in motor vehicle accidents. The person paying might never benefit personally from the government service, but it is desirable that they contribute to the cost.*
>
> *Another example is where the members of a particular industry pay a levy to cover the costs of a regulator or promoter of that industry. A particular member may have little direct contact with the regulator or may not directly benefit from the promotion, but it is appropriate that the member contribute towards the costs."*

8. This list of services is based on current services and is not exhaustive but illustrates economic characteristics of different types of services to support further discussion about the design of fees and charges.

Table 10: economic characteristics of activities to address alcohol-related harm

Services	Activities	Description	Output	Administrative efficiency considerations				Equity and allocative efficiency considerations		Where and how should charges be directed?
				Excludability from output benefits	Rivalry for output benefits	Economic character	Likely efficient options for charging	Who benefits from the output?	Who creates risks?	
Prevention	Community based services	Services targeted at those seeking help to reduce or stop their harmful drinking	Support for a specific individual's alcohol intake	High - only the person or people receiving the support directly benefit	High* - only the person that receives the support or the ability to sell alcohol products for financial gain	Private good	Direct charging of person receiving support Existing levy on alcohol	The person who receives the support benefits most directly	The individual consuming alcohol Alcohol suppliers	Levy based on volume of alcohol sold as charging people receiving support would reduce uptake and may result in higher costs to taxpayers if that individual's use of alcohol creates negative externalities such as requiring ED admission, drunk driving, or being involved in a domestic violence incident.
Promotion	Campaigns	Health promotion campaigns educating people about the harms of alcohol	Increase in knowledge of those that receive public health messages	Moderate – messages can be targeted at specific groups but some will receive more benefit from messages tailored to them than the general population	Low – one person receiving a health promotion message does not prevent someone else from receiving one	Merit good – public health and education campaigns help to prevent harmful drinking that causes higher costs elsewhere in society	Levy on alcohol	The person receiving the message benefits most directly Downstream public health benefits – society benefits when population as a whole consume less alcohol – health, social and justice outcomes all improve	Alcohol suppliers	Levy based on volume of alcohol sold
Treatment	Specialist services	Secondary or tertiary health services (including mental health services)	Targeted medical support to an individual	High – only the person/people receiving the treatment directly benefits	High – only the person/people receiving treatment received the benefit	Private good	Direct charging of person receiving treatment Existing levy on alcohol	The person/people receiving the treatment directly benefit	The individual consuming alcohol Alcohol suppliers	Levy based on volume of alcohol sold as charging people receiving treatment would reduce uptake and may result in higher costs to taxpayers if that individual's use of alcohol creates negative externalities such as requiring ED admission, drunk driving, or being involved in a domestic violence incident/criminal act etc

Services	Activities	Description	Output	Administrative efficiency considerations				Equity and allocative efficiency considerations		Where and how should charges be directed?
				Excludability from output benefits	Rivalry for output benefits	Economic character	Likely efficient options for charging	Who benefits from the output?	Who creates risks?	
Research	Research projects or evaluations	Research on effectiveness of addressing alcohol-related harm	Improved evidence of effectiveness of interventions	Low – everyone benefits from increased knowledge	Low – one person receiving the knowledge does not prevent another from receiving it	Public good	Tax Existing levy on alcohol	All New Zealanders Specific providers (that have their services evaluated)	People consuming alcohol Alcohol suppliers	Levy based on volume of alcohol sold as research is crucial to the process of assessing the effectiveness of services funded by the levy and to reflect that suppliers benefit privately from the sale of alcohol that creates the harm that gives rise to the need for research
Data collection	Data collection systems	Data collection from providers and other services funded by the levy Population wide data collection re: harms (health, social and justice) (to inform services and track progress)	Specific data about the outputs of services	Low – improved data on services and harms informs a range of interventions and public reporting	Low – data becomes available to inform improved interventions and public reporting	Public good	Tax Existing levy on alcohol	All New Zealanders Specific providers (that have improved data about their services) the Ministry of Health (to inform performance management of providers and investment decisions) Other government depts who currently manage the fall-out from alcohol harm (Ministry of Social Development, Police, Ministry of Transport, Ministry of Justice etc).	The service providers (compared to the Ministry of Health providing the services directly itself) Alcohol suppliers	Levy based on volume of alcohol sold as data collection is crucial to the process of establishing reasonable levels of services (and therefor funds) to address alcohol-related harm
Policy services	Machinery of government activities	Machinery of government activities and operational activities to support the design and delivery of activities to address alcohol-harm	Ministerial decisions and compliance with public finance requirements	Low – decisions affect all	Low – the decision affects all New Zealanders	Public good	Tax Existing levy on alcohol	All New Zealanders	The service providers (compared to the Ministry of Health providing the services directly itself) Alcohol suppliers	Levy based on volume of alcohol sold as these services comprise “operating costs that are attributable to alcohol-related activities” and are therefore leviable.

Options for charging

9. Within a cost-recovery framework, the three options for who should pay for the Ministry of Health's activities to address alcohol-related harm and the operational costs that are attributable to alcohol-related activities are as follows.

a. Direct charging of individuals receiving services, where the person receiving the service pays for it. In this context, that would mean people receiving interventions would pay directly for them.

b. General taxation, where services are funded by all taxpayers.

c. Levy on alcohol suppliers (schedule 6 of the Pae Ora Act currently imposes the charge on importers and manufacturers of alcohol).

10. **Direct charging** is normally appropriate where the output of the service is a private good. Direct charging of people that receive services to reduce alcohol-related harm is not considered a viable option because the outputs of the services are merit goods in that they provide benefits to others as well as to the individual consumer. As set out in this report, a community and population-based response is required to address alcohol related harms. Additionally, requiring individuals to pay for services would reduce uptake, which is less efficient at a system level as it would likely result in higher costs at other more acute parts of the system (such as hospitals, police etc).

11. Funding services via **general taxation** is normally appropriate where the output of the service has low excludability and low rivalry, or where the output is a merit good that provides benefits to others as well as to the individual consumer and charging would result in a lower than optimal use of that service. The externalities from alcohol-related harm are currently for the most part being paid for by taxpayers. Cost-recovery via additional **general taxation** (for example, via an increase in the excise tax) is inequitable and unjustifiable from a cost-recovery perspective. General taxation is particularly unjustifiable when there is a readily identifiable club of risk exacerbators with a suitable cost-recovery mechanism that would allow for administratively efficient recovery of costs. Risk exacerbators are those whose actions create costs that spill over to third parties (create negative externalities) or put at risk benefits that spill over to third parties (put positive externalities at risk).

12. **A levy** is generally appropriate where there is a club of individuals or organisations that benefit from a service, or that create the risks that give rise to the service, and there is an equitable method of allocating the cost of that service to members of that club (for example, so organisations that create more risk would pay more than another that created less risk). A **levy on alcohol suppliers** (based on the amount of alcohol of each type they manufacture or import) is considered the most equitable and efficient option. Charging risk exacerbators a levy based on the volume of each type of alcohol sold is equitable, as a reasonable proxy for the risk caused.

Appendix B: Calculating the total levy amount for a financial year

How is the total levy amount currently determined?

How the levy is calculated

1. The amount of revenue collected by any tax is the product of the tax's base and the tax rate.

2. In most cases, however, the tax base and the tax rate are what is specified in the appropriate legislation, with the amount of revenue raised varying as the volume of the taxed activity, good or service changes, or when rates are adjusted. Thus, the normal relationship is described in this formula:

$$Revenue = Base\ x\ Rate$$

3. In the case of the Levy, however, the amount to be collected is set by the Minister, with the legislation containing a procedure for determining the rate of Levy needed to raise that amount.

$$Rate = \frac{Revenue}{Base}$$

The base

4. The tax base for the levy is alcoholic beverages that contain more than 1.15 percent[99] alcohol by volume imported or produced locally. As we will see below, for the purposes of calculating the rate of the Levy, the amount of alcoholic beverages imported or produced in the previous financial year is used.

The rate

5. As with the general excise, the amount of the Levy increases with the concentration of alcohol. In the legislation, this concentration is confusingly referred to the "Rate".[100] The six bands of concentration, called "Classes" in the legislation, are set out in Table 11, together with examples of the type of product included in each Class and

[99] The precise figure of 1.15 percent comes from the threshold for imposing the main excise on alcohol. See the *Excise and Excise-equivalent Duties Table* at https://www.customs.govt.nz/globalassets/documents/tariff-documents/working-tariff-document-2018/excise-and-excise-equivalent-duties-table-1-july-2021.pdf.

[100] In the Excise and Excise-equivalent Duties Table, the concentration of alcohol is simply described, without being assigned a name. The term "rate of duty", as is traditional in tax policy, is the name applied to the amount of duty imposed, which is measured in either litres of alcohol or litres of beverage. For example, the rate of duty applied on spirits containing more than 23 percent of alcohol is $56.625 per litre of alcohol. If the occasion arises, it would be preferable to use "concentration" or "proportion of alcohol" rather than Rate in the Act. This is, however, a minor point.

approximate[101] amounts of different alcohol available for consumption in the year ended December 2022.

6. This differential is that the concentration of alcohol means that those who drink strong beverages contribute more per standard drink than those who consume low alcohol products. The World Health Organization suggest that it is the amount of alcohol consumed, not the beverage type that causes harm.[102] [103] [104]

7. We are not aware of any studies that link beverage type, or concentration levels, to any specific harms. What the relationship is between concentration and harm is something that could be usefully reviewed in future.

[101] The data that StatsNZ releases is grouped in a slightly different way than the Classes in the Act.

[102] World Health Organization. 2023. 'No Level of Alcohol Consumption is Safe for Our Health' **https://www.who.int/europe/news/item/04-01-2023-no-level-of-alcohol-consumtpion-is-safe-for-our-health**.

[103] Anderson, Benjamin, Nino Berdzuli, Andre Ilbawi, Devora Kestel, Hans Kluge, Rudiger Krech Bente Mikkelsen et al. 2023. 'Health and Cancer Risks Associated with Low Levels of Alcohol Consumption' *The Lancet Public Health* 8(1): e6-7

[104] These latest statements draw attention to the risks of cancer associated with alcohol consumption, rather than the more traditional harms relating to liver damage and heart conditions. They also address the issue of whether moderate amounts of red wine can have beneficial effects.

Table 11: Classes of alcohol

Class of Alcohol	Description	Examples	Approximate volumes (Litres of alcohol, 2022)
Class A	1.15% -- 2.5%	"Low alcohol" beer, cider, fruit wine	Beer between 1.15% and 2.5%: 8,700
Class B	2.5% – 6.0%	Other beer, fruit wine	Beer above 2.5%: 1,307,200[105]
Class C	6.0% -- 9.0%	Wine, other fermented beverages	No data available
Class D	9.0% -- 14%	Table wine, champagne	Grape wine containing less than 14%: 921,800
Class E	14% -- 23%	Vermouth, fortified wine, liqueurs	Grape wine containing more than 14%: 6,600 Spirits containing less than 23%: 561,400
Class F	More than 23%	Spirits, liqueurs	Spirits containing more than 23%: 671,700

Source: Pae Ora (Healthy Futures) Act 2022, Little (2002), StatsNZ.

Beverages in Classes A, C and D are, for the purposes of the levy, deemed to have a set Rate of alcohol by volume, as set out in Table 12.

Table 12: Deemed concentration of alcohol

Class of Alcohol	Range	Deemed Rate
Class A	1.15% -- 2.5%	1.5%
Class C	6.0% -- 9.0%	8%
Class D	9.0% -- 14.0%	10%

Source: Pae Ora (Healthy Futures) Act 2022

8. For the other classes, the concentration of alcohol used is set by the Minister, using a method prescribed in Schedule 7 of the Act. This method sets the Rate based on the average alcohol content by volume of all the alcohol of that Class that was imported into or manufactured in New Zealand in the preceding year. The Rates for these Classes are set each year by Regulations made by Order-in-Council. The current rates are set out in Table 13.

[105] StatsNZ reports that 172,900 litres of alcohol was made available in beer that contained more than 5%, but there is no publicly available data on how much had a concentration of more than 6%.

Table 13: Amount of the Levy in 2023

Class	Range	Calculated Rate
Class B	2.5% – 6.0%	4.56%
Class E	14% -- 23%	16.68%
Class F	More than 23%	37.78%

Source: Pae Ora (Healthy Futures) Alcohol Levy Order 2023.

9. Calculating the Levy requires the Minister to undertake a six-step process, as set out in Table 14.

Table 14: The process for calculating the Levy

Step	Description	Result
Step 1	Determine, with the concurrence of the Minister of Finance, the amount the Minister considers it would be reasonable for the Ministry of Health to spend during the year in addressing alcohol-related harm and in meeting its operating costs that are attributable to alcohol-related activities.	The total amount of the Levy to be imposed in a year.
Step 2	Determine the total amount of alcohol imported or manufactured in in the previous year	The tax base to be used for calculating the Levy, measured in litres of product
Step 3	For each Class, multiply the amount from Step 1 by the relevant Rate	The deemed amount of alcohol in each Class, measured in litres of alcohol
Step 4	For each Class, divide the deemed amount of alcohol by the total number of litres of alcohol for all classes	The proportion of the Levy to be imposed on each Class in the year.
Step 5	For each Class, multiply the result in Step 1 by the result in Step 4.	The amount of the Levy to be imposed on each Class.
Step 6	For each Class, divide the result of Step 5 by the result of Step 1.	The amount of levy to be paid on each litre of alcohol of that Class.

Source: Schedule 6, Pae Ora (Healthy Futures) Act 2022.

Appendix C: Participants in the review

Table 15: Organisations/groups of participants

Organisation name
Salvation Army
Māori Wardens
Emerge Aotearoa
Alcohol Healthwatch
Taituarā
Community Law Centres of Aotearoa
Wellington City Mission
New Zealand Drug Foundation
Students for Sensible Drug Policy
E Tipu e Rea
CAYAD representatives from various locations
Te Waka Whaiora
Takiri Mai te Ata Whanau Ora
Living Sober
Koru Ngakau Consultancy
Te Waka Tapu
Tāmaki Youth Council
Ngā Kete Mātauranga Pounamu
Te Waka Whaiora
Local Government New Zealand
Te Paepae Arahi Trust
Ora Toa

Organisation name
Whanganui Regional Health Network
Le Va
Communities Against Alcohol Harm
Pacific Student Leaders
PYLAT
Pegasus Health
New Zealand Police
Te Puni Kōkiri
New Zealand Cancer Society
Ministry of Justice
New Zealand Customs Service
Horowhenua Kapiti Rugby Union
Health New Zealand (Health Promotion Directorate, Addictions (Commissioning, representatives from regional offices/services in Auckland, Northland, Nelson-Marlborough and Wellington)
Students for Sensible Drug Policy Dunedin
Organisation engaged under Chatham House rules
Organisation engaged under Chatham House rules
Organisation engaged under Chatham House rules
Organisation engaged under Chatham House rules
Organisation engaged under Chatham House rules
Organisation engaged under Chatham House rules
Organisation engaged under Chatham House rules
Organisation engaged under Chatham House rules
Organisation engaged under Chatham House rules

Organisation name
Organisation engaged under Chatham House rules
Campus Watch Dunedin
Organisation engaged under Chatham House rules
Te Piki Oranga
Te Rūnanga o Ngāti Kuia
Te Kotahi o Te Tauihu Charitable Trust
Spirits New Zealand
Hospitality New Zealand
Brewers Association
Brewers Guild
New Zealand Winegrowers
Auckland Council
Accident Compensation Corporation
Asian Family Services
Touch New Zealand
Planet Youth Papakura
Pacific Alcohol Advisory Group
Te Aka Whai Ora
Te Whatu Ora

Note: a number of individuals participated in a forum where Chatham House rules was sought and agreed to. To protect the identity of those individuals and their organisations, the names of the organisations that those individuals represented have not been provided in the table above. For the avoidance of doubt, where a representative of an organisation participating in the forum engaged separately with *Allen + Clarke*, the name of the organisation has been provided above.

Table 16: Individuals engaged (anonymised)

Description
Emergency Department doctor
District Licensing Committee member
Academics and researchers
Individual with lived experience of alcohol dependence

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