

**Policy options targeted consultation paper:**  
*Pregnancy warning labels on packaged alcoholic beverages*

### Overview

This submission template should be used to provide comments on the policy options targeted consultation paper: *Pregnancy warning labels on packaged alcoholic beverages*.

### Contact Details

<b>Name of Organisation:</b>	New Zealand College of Public Health Medicine
<b>Name of Author:</b>	New Zealand College of Public Health Medicine
<b>Phone Number:</b>	04 472 9183
<b>Email:</b>	pam@nzcphm.org.nz
<b>Website:</b>	<a href="https://www.nzcphm.org.nz/">https://www.nzcphm.org.nz/</a>
<b>Date of submission:</b>	14 June 2018

**If we require further information in relation to this submission, can we contact you?**  Yes  No

### Privacy

Personal information provided to the Food Regulation Standing Committee (FRSC) as part of the *Pregnancy warning labels on alcoholic beverages* public consultation will be dealt with in accordance with the Privacy Act 1988 (Cth) at [www.comlaw.gov.au](http://www.comlaw.gov.au) and the Australian Privacy Principles at [www.oaic.gov.au](http://www.oaic.gov.au). The Department of Health's Privacy Policy is available at <http://www.health.gov.au/internet/main/publishing.nsf/Content/privacy-policy>.

### Copyright and confidentiality

Copyright in an original submission resides with the copyright owner of that submission, but the act of making a submission will grant the Australian Government and the New Zealand Government a licence to use the submission for the purpose of making a summary of the submission for the website and for future policy or standard development work.

All submissions are subject to the *Freedom of Information Act 1982* in Australia and the *Official Information Act 1982* in New Zealand, along with relevant Freedom of Information legislation in each of the States and Territories.

If you consider that all or part of your submission should not be released, please make this clear when making your submission and indicate the grounds for withholding the information. Please provide two versions of the submission; one full version **with confidential information identified in red text**, and one with the confidential information removed.

A request made under the *Freedom of Information Act 1982* for access to a submission marked confidential will be determined in accordance with that Act.

**Do you want this submission to be treated as confidential?**  Yes  No

**If yes, please state why:**

## Submission Instructions

Submissions should be received by 5pm AEST on 14 June 2018. The Food Regulation Standing Committee reserves the right not to consider late submissions.

Please complete the attached template for your submission. Note that submissions may not be drawn upon in preparing the decision regulation impact statement (DRIS) to recommend a preferred policy option to the Australia and New Zealand Ministerial Forum on Food Regulation (the Forum) if they:

- are not supported by evidence;
- do not directly answer the questions in the Policy options targeted consultation paper; and/or
- do not use this template.

Please do not change the template.

Where possible, submissions should be lodged electronically. Please send your submission to: [FoodRegulationSecretariat@health.gov.au](mailto:FoodRegulationSecretariat@health.gov.au) with the title: *Submission in relation to pregnancy warning labels on packaged alcoholic beverages*.

OR mail to:

c/- MDP707  
GPO Box 9848  
Canberra ACT 2601

If you need to attach documents to support your submission, please make it clear which question/s they relate to.

1. The New Zealand College of Public Health Medicine thanks the Food Regulation Standing Committee for the opportunity to make a submission on the Policy options targeted consultation paper: Pregnancy warning labels on packaged alcoholic beverages.
2. The New Zealand College of Public Health Medicine (NZCPHM) is the professional body representing the medical specialty of public health medicine in New Zealand. We have 236 members, all of whom are medical doctors, including 183 fully qualified Public Health Medicine Specialists, with the majority of the remainder being registrars advanced training in the specialty of public health medicine.
3. Public Health Medicine is the branch of medicine concerned with the assessment of population health and health care needs, the development of policy and strategy, health promotion, the control and prevention of disease, and the organisation of services. The NZCPHM strives to achieve health gain and equity for our population, reducing inequalities across socioeconomic and cultural groups, and promoting environments in which everyone can be healthy.
4. All New Zealand Medical Officers of Health are members of the College, many of whom are directly involved the Local Alcohol Policies (LAP) and Liquor Licensing in the district.

## Consultation questions

**1:** Are these appropriate estimates of the proportion of pregnant women that drink alcoholic beverages? Do you have any additional data to show changes in drinking patterns during pregnancy over time? Please specify if your answers relate to Australia or New Zealand.

**Our response to this question and all subsequent questions are in relation to New Zealand.**

### Appropriateness of Estimates

The NZCPHM's position is that the estimates of the proportions of pregnant women who drink alcohol during pregnancy are likely an underestimation for the reasons outlined below. We acknowledge that estimations of the proportion of pregnant women who drink in pregnancy are difficult to produce due to the lack of regularly collected data. It is also worth noting that data collection relies on self-reported maternal alcohol consumption which may be biased toward underreporting due to reporting and recall biases<sup>1</sup>. We recognise the consultation statistic from the Growing Up in NZ Study (GUINZ) that 71% of pregnant women reported consuming alcohol prior to pregnancy recognition, but it is important to note that 29% were drinking at hazardous levels (4 or more units per week)<sup>2</sup>.

Our belief that the numbers presented are an underestimation is based on the increasing levels of hazardous alcohol consumption among women of childbearing age since the consultation data was collected in 2013, combined with high numbers of unplanned pregnancies in NZ.

The burden of alcohol harm is likely increased for those with unplanned pregnancies, such as younger women who have higher rates of pre-pregnancy alcohol consumption and in the 2012/13 New Zealand Health Survey (NZHS) cohort, higher rates of drinking in pregnancy<sup>3</sup>. Evidence from the GUINZ study supports this, reporting up to 40% of pregnancies in NZ as being unplanned and more common in younger women (average age 28 vs 32), with less educational attainment<sup>3,4</sup>. Younger women with unplanned pregnancies may also continue to drink hazardously for longer, as confirmation of pregnancy appears to occur later in pregnancy for those whose pregnancies are unplanned<sup>3,5</sup>. The evidence from the GUINZ Study highlights that in the first three months of pregnancy more mothers in the 'unplanned pregnancy' group were still drinking alcohol compared to the 'planned pregnancy' group (31% vs 17%) and were drinking more hazardously (12.4% vs 2.9%)<sup>4</sup>.

### Increasing Hazardous Drinking in the General Population of Women of Child Bearing Age

Multivariate analysis reveals that the status of alcohol drinking prior to awareness of pregnancy is a strong predictor of whether a woman drinks any alcohol during pregnancy<sup>2</sup>. An established pattern of risky drinking increases the risk of fetal harm and may be difficult to change leading up to or during pregnancy<sup>3</sup>. Most women in the NZHS 2012/13 who drank alcohol during pregnancy also reported past-year risky drinking<sup>3</sup>. Since the consultation data was collected, hazardous drinking in NZ women has increased. The 2016/17 New Zealand Health Survey reports hazardous drinking by women has increased by approximately 30% over five years (12.4% of all women compared to 8.6% in 2011/12)<sup>6</sup>. Approximately 20% of women age 15-24 drink in a hazardous way, and 16% of women age 25-44<sup>6</sup>. While fewer adolescents are choosing to drink, young adolescent females have been increasing the volume of alcohol they consume when drinking<sup>7</sup>. A study released in 2017 found young females in NZ (mean age 24) have the heaviest drinking patterns, consuming 23 litres of absolute alcohol a year compared to 9 litres for the general population<sup>8</sup>.

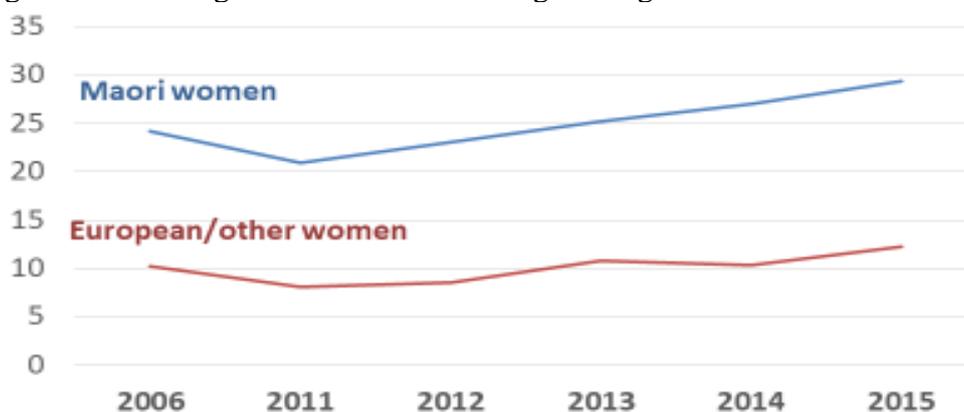
### Disparities in Alcohol Harm in Pregnancy

Māori appear to be disproportionately affected by alcohol harm in pregnancy and this needs to be recognised and addressed in any regulatory changes, as part of the Crown's commitment to Te Tiriti o Waitangi.

Although not confirmed in the GUINZ cohort, the NZHS 2012/13 reported the highest rates for drinking during pregnancy were for Māori women<sup>3</sup>. Māori women were twice as likely as non-Māori women to have drunk during their most recent pregnancy, after adjusting for age differences. It is also important to note that Māori women are 2.3 times more likely than non-Māori women to drink hazardously (27.6%) (see **Figure 1**)<sup>6</sup>. Those most deprived in the population are also over represented in harmful alcohol consumption statistics

with a gradient of increasing hazardous drinking seen with increasing deprivation, with the most deprived 1.35 times more likely to be hazardous drinkers than the least deprived<sup>6</sup>. However, for a given amount of consumption, poorer populations may experience disproportionately higher levels of alcohol-attributable harm<sup>9</sup>.

Figure 1: Percentage of Hazardous Drinking Among NZ Women 2006-2015



2: Are these appropriate estimates of the prevalence and burden (including financial burden) of FASD in Australia and New Zealand? Please provide evidence to support your response.

The NZCPHM's position is in agreement with the consultation document that the estimates of the proportions of Fetal Alcohol Spectrum Disorder (FASD) are likely an underestimation of the actual frequency for the reasons outlined below. FASD is completely preventable. The consultation document does not adequately portray the likely burden of FASD in New Zealand to the affected individual, to their family and the primary caregivers and to the wider community.

### Prevalence

As noted in the consultation document, there are no current NZ estimates of the incidence of FASD due to issues around accurate diagnosis. Using overseas estimates will underestimate the incidence of FASD in NZ due to differences in the population harmful drinking patterns between NZ and commonly used comparison countries such as the United States (US) and Canada (estimated drinking during pregnancy 10%). It is important to note that recent research suggests that estimates in the US may also be as high as 3-5% and 2-3% in Canada, and that NZ estimates could be above this<sup>10-13</sup>.

### Burden

There is a huge burden to NZ from FASD in terms of economic costs as well as costs to society. FASD is likely to be New Zealand's leading preventable cause of non-genetic intellectual disability<sup>12</sup>. The consultation document outlines the lifelong and wide reaching affects that FASD has on individuals and families; resulting in increased anatomical defects and mortality rate; and affecting intellectual development, neural development (attention, memory, motor and sensory), communication skills, and executive and adaptive functioning<sup>14</sup>. There is also the burden psychologically and/or risk of morbidity/mortality to the mother as a consequence of increased risk of miscarriage, stillbirth or premature birth and raising a child with FASD<sup>15,16</sup>.

### Societal Costs

The above consequences of FASD can result in secondary disabilities which are a tremendous cost to society such as mental health problems, trouble with the law, dropping out of school, becoming unemployed, homelessness and/or developing alcohol and drug problems<sup>17</sup>. FASD affects about 50 percent of children and young people in Child, Youth and Family (CYF) care<sup>12</sup>. The most recent survey of Prisoner Health in NZ that we are aware of took place in 2005, and while FASD was not specifically addressed in that survey the symptoms described by many of those surveyed may be attributable in some cases to FASD<sup>18</sup>. With no accurate or current assessments, the societal costs cannot be fully measured.

## Economic Costs

The costs associated with FASD change across age groups<sup>14</sup>. The costs for adolescents and adults are incurred primarily through the health care system, mental health and substance abuse treatment services, the criminal justice system, the long-term care of individuals with intellectual and physical disabilities, and lost productivity and decreased participation in the workforce<sup>14</sup>. Costs that need to be included in modelling include ongoing medical services for physical anomalies, special education, substance abuse, mental health and vocational services, services for mild physical and learning disabilities and lost productivity of caregivers and FASD-affected persons<sup>17</sup>. We have no additional economic modelling data other than that presented in the consultation document by Easton et al., but economic costs need to include costs associated with all the societal costs listed above to be an accurate representation. It is important to also note that Easton et al. reported that there is justification to spend \$49 million per year on effective prevention programmes just based on productivity losses alone<sup>14,17</sup>.

### 3: Do you have evidence that the voluntary initiative to place pregnancy warning labels on packaged alcoholic beverages has resulted in changes to the prevalence of FASD, or pregnant women drinking alcohol, in Australia or New Zealand? Please provide evidence to justify your position

As there has been no independent formal evaluation included in the implementation of the voluntary initiative and there is currently no regular monitoring or reporting of drinking alcohol in pregnancy or FASD rates in NZ, we are unable to determine that the voluntary initiative has influenced either. Warning labels are just one method of reducing drinking in pregnancy and FASD rates, and need to be evaluated with regards to the effectiveness of combined measures to reduce alcohol harm. We do know that harmful drinking in young women has continued to increase and this increases the risk of drinking in pregnancy<sup>6</sup>. Evaluating implementation, as was done by Tinewai et al. is an acceptable surrogate with the information currently available. Findings from this study report voluntary recommendations in NZ appear to have been inadequate for producing health warnings on alcoholic beverage containers that are consistent with evidence informed recommendations for effective labels<sup>19</sup>.

### 4. Variation in labelling coverage and consistency, and some consumer misunderstanding associated with the current voluntary pregnancy warning labels in Australia and New Zealand were identified as reasons for possible regulatory or non-regulatory actions in relation to pregnancy warning labels on alcoholic beverages. Are there any other issues with the current voluntary labelling scheme that justify regulatory or non-regulatory actions? Please provide evidence with your response.

There are a number of issues with the current voluntary labelling scheme that justify regulatory mandatory labelling to improve coverage, consistency and consumer understanding. Voluntary pregnancy-related warning labels in NZ lack the essential design elements of salience, visibility, and readability and are currently only present on 80% of all alcohol containers, being inconsistently applied<sup>19</sup>. Tinewai et al's study showed only 73–80% of RTDs (commonly consumed by young women), imported beers and wines had a pregnancy-related warning label and few were on the front of the bottle<sup>19</sup>. When women receive mixed messages about the risks of drinking during pregnancy, they are likely to listen to advice that conforms to their own drinking preferences<sup>12</sup>. Overall warnings are very small compared to promotional elements such as the brand logo, poorly designed for effectiveness, readability (tiny fonts and often being a similar colour as the background or blended with other elements such as the barcode), position and wording<sup>19</sup>. Picture pregnancy warnings occupy less than 1% of the available surface area of the containers, averaging between 45 and 36 mm<sup>2</sup>, the size of a pea. Some warnings were also the same colour as all other text information or the background<sup>19</sup>. New Zealand beers, wines and RTDs had less pictograms compared to imported products<sup>19</sup>.

Another significant issue is the industry's response to the initiative. The WHO: Global strategy to reduce the harmful use of alcohol outlines that all involved parties have the responsibility to act in ways that do not undermine the implementation of public policies and interventions to prevent and reduce harmful use of alcohol<sup>9</sup>. The NZ alcohol industry publicly persists with disputing the evidence for warning labelling, and in May released a press release saying, "There is no credible research anywhere that shows that warning labels

reduce harmful consumption of alcohol<sup>20</sup>." The NZCPHM notes that, aside from the counter that absence of evidence is not evidence of absence<sup>21</sup>. The alcohol industry has attempted to 'legitimise a role for itself as a partner in developing policy responses' to alcohol-related harms<sup>19</sup>. It has tried to be a 'potential collaborator in reducing alcohol harm', thus potentially delaying government interventions, despite obvious 'vested interests'<sup>19</sup>. These are similar to lobbying tactics employed by other industries e.g. tobacco and big oil<sup>22,23</sup>. A striking incompatibility exists between the profit goals that commercial companies, including alcohol manufacturers, must prioritise and their desired role as partners in efforts to reduce alcohol-related harm<sup>19</sup>. Consequently, their involvement in developing warning labeling policy remains 'ethically questionable'<sup>19</sup>. Any involvement is likely to see the continuation of suboptimal warning labels that do not meet best practice standards, such as those observed in this New Zealand sample<sup>19</sup>.

**5: Has industry undertaken any evaluation on the voluntary pregnancy warning labels? If so, please provide information on the results from these evaluations.**

We have no evidence that the industry has evaluated voluntary pregnancy warning labels. The industry continues to undermine the initiative and directly contradicted the most recent published research of NZ labeling that found that voluntary recommendations in NZ appear to have been inadequate for producing health warnings on alcoholic beverage containers that are consistent with evidence informed recommendations for effective labels. They responded by saying, "the vast majority of New Zealand alcohol products now contain pregnancy warnings after a successful voluntary roll-out of labels by industry<sup>19,20</sup>." It is disappointing to see this lack of understanding, support or evaluation for a voluntary scheme the industry proposes to support.

The NZCPHM supports the successful implementation of mandatory labeling to include independent evaluation of implementation, impact and compliance. Labels should be evaluated to ensure they capture attention, are understood, are able to be recalled, and increase awareness of risk<sup>24</sup>.

**6: Considering the potential policy options to progress pregnancy labelling on alcoholic beverages and address the implementation issues:**

- a) Are there additional pros, cons, and risks associated with these options presented that have not been identified? Please provide evidence to support your response

### **Mandatory Labeling**

According to the World Health Organization, 'policy interventions are the most effective strategies available to governments to reduce the burden of disease and injury associated with alcohol use'<sup>9</sup>. As of 2017, 13 of the 53 Member States of the WHO European Region alone reported that health warning labels are legally required on the containers/bottles of alcoholic beverages at the national level, and ten have national legal requirements stipulating the size of the health warning labels<sup>13</sup>. Mandatory evidence based labeling, if designed in consultation with consumers and adequately enforced, **would** overcome the issues outlined by Tinewai et al, improving the adoption, consistency and effectiveness of pregnancy warning labels<sup>19</sup>. No negative effects have been demonstrated from alcohol warning labels<sup>13</sup>.

We disagree that there have been strong industry efforts in NZ to support reduction of alcohol harm in pregnancy and this is highlighted by the lack of successful implementation and the industry's ongoing denial of the effectiveness of pregnancy warning labels<sup>19,20</sup>. Specifying standardised messages and designs could help minimise manipulation attempts by manufacturers to obscure health warnings and other consumer-relevant information<sup>19</sup>.

### **Voluntary Labeling**

It is clear from the latest research and the response from the alcohol industry that voluntary labeling is ineffective, even after an extended amount of time given to be implemented<sup>19</sup>. Governments should not be making such decisions based on costs to industry, trade negotiations or improving reputational benefit to the industry. As a general principle of good governance, citizens should feel confident that the food regulatory system, which is designed to protect their health and safety, operates effectively without the influence of

vested interests<sup>13</sup>.

**b)** Are there other potential policy options that could be implemented, and if so, what are the pros, cons and risks associated with these alternate approaches? Please provide evidence to support your response.

Strategies to change New Zealand's hazardous drinking culture require a range of actions addressing supply, demand, and risk minimisation. Mandatory labelling should be accompanied by decreasing availability, an increase in excise tax and minimum pricing options. A comprehensive set of strategies (such as those in both the Law Commission and WHO publications) will be required to change New Zealand's drinking culture<sup>13,25</sup>.

**7:** Which option offers the best opportunity to ensure that coverage of the pregnancy warning labelling is high across all types of packaged alcoholic beverages, the pregnancy warning labels are consistent with government recommendations and are seen and understood by the target audiences? Please justify your response.

Mandatory Labelling is the only option that will ensure coverage of pregnancy warning labelling and that labels will be consistent with evidence. Please see previous responses for justification.

**8:** Do you support the use of a pictogram? If so, do you have views on what pictogram should be used (e.g. pregnant woman holding beer glass or wine glass), and also, what colour/s should be used, and why? Do you have any views on size, contrast, and position on the package? Please provide research or evidence to support your views.

**9:** Do you support the use of warning text on a label? Why or why not? Do you have views on what text should be used, and if so, what is it? Do you support the use of warning messages already used in other markets? Please provide research or evidence to support your views.

**10:** Do you have views on what colour should be used for text, and whether green should be permitted? Do you have any views on size, contrast, and position on the package? Please provide research or evidence to support your views.

**11:** Should both the text and the pictogram be required on the label, or just one of the two options? Please justify your response.

**We have combined our response for questions 8, 9, 10, and 11 to avoid duplication.**

The NZCPHM recommends having a range of suitable labels that are periodically updated to maximise impact as familiarity decreases recall of a warning<sup>24</sup>. Warnings are most effective when displayed as a standardised pictogram and text<sup>13,19</sup>. We also ask for consideration of messages written in both English and Te Reo Māori (for the New Zealand setting).

Decreased positive perceptions of alcohol occur when warning labels<sup>13,19,24</sup>:

- are easily identifiable on the container occupying half the available space of the container front with little surrounding clutter separated from branding and product information;
- are red, or black on a yellow background, as this is most effective in gaining consumer attention and communicating danger;
- are separate from the main body of label information;
- are written in a minimum font size for each of the text components (e.g. 9 point and above), in capital letters and bold font;
- space information into easily encoded units, and information is presented vertically rather than horizontally;
- are enclosed by a distinct border, which increases noticeability.

In terms of colour, we prefer the red pregnancy warning pictogram that is commonly used on packaged alcohol internationally and is mandatory in France. We understand that there has been confusion in New Zealand with the use of green colour by the DrinkWise pictogram, where some people consider green means it is acceptable to drink when pregnant. Most people associate red with a warning.

Labels should be clear, non-ambiguous and include<sup>13,19,26,27</sup>:

1. a signal word to attract attention e.g. danger;
2. a picture or symbol which elicits a memorable emotional response. This induces greater recall than text warnings alone. Pictures should be specific and communicate a specific message which increases perception of health risks and influence intentions to change behavior;
3. factual descriptions of possible harm/risks, dispelling common myths and giving a related instruction. This is because women are unsure or confused on the effects of moderate or low levels of drinking in pregnancy;
4. the use of a personal pronouns;
5. tapping into a positive motivator e.g. to give babies the best start in life;
6. guidance regarding maximum alcohol intake;
7. a call to action and directions to a source of reliable further information about alcohol and health, such as a government website and not include industry initiatives that could be seen to encourage excessive or hazardous drinking, for example, [cheers.org.nz](http://cheers.org.nz).

Examples could include<sup>19</sup>:



However, the wording of such labels does need to be simple, including short words, which the above warnings do not necessarily employ. Wording could be “Don’t drink pregnant”, or “When pregnant, any alcohol can seriously damage your baby”

The wording needs feedback from the target audience (young women e.g. teenage-20s) to find wording that is clear, catchy and evokes an emotional response. Likewise, font size, colour and positioning should also be validated on the results from testing.

**12:** Are you aware of any consumer research on understanding and interpretation of the current DrinkWise pictogram and/or text? What about other examples of pictogram and/or text?

We are not aware of any additional DrinkWise research beyond what is presented in the consultation document.

**13:** Describe the value of pregnancy warning labels. Please provide evidence to support your views.

Adding effective health labels to alcohol containers is an important first step in raising awareness, and has a longer-term utility in helping to establish a social understanding of the harmful use of alcohol<sup>13</sup>. We need to increase community awareness and ensure that the same messages are being given key influencers: friends,

partners, whānau (family), work colleagues and the general public<sup>26</sup>. Labelling, in combination with a comprehensive package of interventions that address alcohol use in pregnancy, will have huge value to the mothers, their children, whānau, and wider society through the prevention of FASD and the social and economic costs associated with it.

**14:** Which is the option that is likely to achieve the highest coverage, comprehension and consistency? Please provide evidence with your response.

Any mandatory labelling that adheres to the specifications outlined above will result in the highest coverage, comprehension and consistency. This will need to be further developed with design experts and consumer consultation.

**15:** Which option is likely to achieve the objective of the greatest level of awareness amongst the target audiences about the need for pregnant women to not drink alcohol? What evidence supports your position?

Mandatory Labelling that adheres to the above specifications. Changing the drinking culture and influencing relatives and friends of pregnant women is important as it influences a pregnant woman's views on drinking in pregnancy. Of those who were advised not to drink in the NZHS 2012/13 cohort, in addition to health professional advice, advice was also received from a spouse or partner, relative or friend<sup>3</sup>.

**16:** More information is required on the benefits of each of the regulatory options. Do you have any information on the benefits associated with each option in relation to social, economic or health impacts for individuals and the community? Please provide evidence with your response.

Please see our responses to other questions.

**17:** To better predict cost to industry associated with each option, can you provide further information that could inform the cost to industry associated with each of these approaches, particularly costings from a New Zealand industry perspective? Please provide evidence to support your response.

The NZCPHM advocates for this decision to be made based on public health importance, not cost saving to industry.

**18:** For Australia, is the estimated cost of \$340 AUD per SKU appropriate for the cost of the label changes? To what extent do these cost estimates capture the likely impacts on smaller producers? Should the cost estimates be adjusted upwards to capture disproportionate impacts on smaller producers?

This is outside of our scope as an organisation.

**19:** Is the number of active SKUs used in the cost estimation appropriate? What proportion of SKUs on the market is from smaller producers?

This is outside of our scope as an organisation.

**20:** Should there be exemptions or other accommodations (such as longer transition periods) made for boutique or bespoke producers, to minimise the regulatory burden? If so, what exemptions or other accommodations do you suggest?

There is no reason to delay the mandatory process as the industry should have been aware of the likelihood of these changes coming into practice with the launch and extension of the voluntary scheme and made provisions for this. Public policies and interventions to prevent and reduce alcohol-related harm should encompass all alcoholic beverages and surrogate alcohol<sup>9</sup>.

**21:** To better predict the proportion of products that would need to change their label to comply with any proposed change, information on the type of pictogram and text currently used is required. Do you have evidence of the proportion of alcohol products that are currently using the red pictogram, and what proportion of products are using an alternate pictogram (e.g. green)? Do you have evidence on the proportion of alcohol products that are currently using the beer glass pictogram, or the wine glass pictogram? Please specify which country (Australia or New Zealand) your evidence is based on.

The latest NZ evidence for this comes from the recently published research by Tinawi et al<sup>19</sup>.

**22:** What would be the cost per year for the industry to self-regulate? Please justify your response with hours of time, and number of staff required. Please specify which country (Australia or New Zealand) your evidence is based on.

This is outside of our scope as an organisation.

**23:** For each of the options proposed, would the industry pass the costs associated with labelling changes on to the consumer? Please specify which country (Australia or New Zealand) your evidence is based on.

This is outside of our scope as an organisation.

**24:** If you identified an alternate policy option in question 5, please provide estimates of the cost to industry associated with this approach.

Not applicable.

**25:** Based on the information presented in this paper, which regulatory/non-regulatory policy option do you consider offers the highest net benefit? Please justify your response.

### **Need for an Integrated Approach**

The NZCPHM strongly support mandatory pregnancy warning labels on all packaged alcoholic beverages, as part of implementing the wider FASD Action Plan. Alcohol is widely accepted in society and the harms it can do are poorly known or understood by the general public. We agree with the consultation document and the WHO that labels stand out as an underutilised way of empowering consumers to make healthy decisions about alcohol intake, providing a unique opportunity for governments to disseminate health messages at the point of sale and point of consumption<sup>13</sup>. We have previously called for a legal framework and statutory body to regulate and control all forms of liquor marketing and recommend this include packaging, advertising, promotions, point of sale displays, retail positioning and sponsorship and makes provision to regulate newer forms of marketing through electronic media and other media as these come along. We advocate for an integrated health promotion approach to alcohol harm which includes: building healthy public policy through activities such as mandatory labelling; creating supportive environments; strengthening community action; developing personal skills; and reorienting the health and social sectors. Measures should be assisted by monitoring impact and compliance and establishing and imposing sanctions for non-compliance with adopted laws and regulations<sup>9</sup>. We also support bringing alcohol packaging requirements into line with those that apply to non-alcoholic beverage packaging including listing ingredients and seven nutritional values per 100 ml<sup>13</sup>.

### **Industry Participation as a Barrier to Improving Public Health**

The ability to use policy to improve public health should not be restricted by considerations to trade agreements and economic concerns of the alcohol industry. We would like to highlight the alcohol industry's past attempts to protect profits and undermine public health measures by endorsing ineffective voluntary regulation and interventions, extensive lobbying activity and minimising the health impact of consumption behaviours<sup>28</sup>. Research into past submissions shows the industry seeking to undermine community concern, debate the evidence, promote ineffective measure which are no threat to the profit margins and attack independent health professionals and researchers, consistent with tactics employed by the

tobacco industry, who previously offered to take part in voluntary labeling schemes<sup>28</sup>.

The industry gives a passing acknowledgment that its product can do harm by sponsoring some selected 'harm prevention' activities. However, Tinewai et al. report that from a public health perspective the wording and intention of the industry-led initiatives have been ambiguous, as has been found in Australia, e.g. 'please drink responsibly' includes the words 'please drink', while 'cheers!' brings to mind a group of people celebrating<sup>19</sup>. We note that the industry-sponsored cheers.org.nz has no reported evaluation findings. It has only been in the last month, while this consultation was commenced, that the Cheers.org.nz website was changed to reflect evidence-based information on the harms of drinking during pregnancy. This strongly suggests to us that their commitment to reducing alcohol harm in pregnancy is only in line with the possibility of changes to regulation, and not actually in minimising alcohol harm in line with best practice evidence, and that mandatory regulation is necessary to change the industry's behavior. The website previously contained advice for women/girls if they still wanted to drink during pregnancy.

### References:

1. O'Keeffe LM, Kearney PM, McCarthy FP, et al. Prevalence and predictors of alcohol use during pregnancy: Findings from international multicentre cohort studies. *BMJ Open*. 2015;5(7):e006323. <http://www.ncbi.nlm.nih.gov/pubmed/26152324>. doi: 10.1136/bmjopen-2014-006323.
2. Cheung J, Timmins J, Wright C. Patterns and dynamics of alcohol consumption during pregnancy in a recent New Zealand cohort of expectant mothers. 2015. <http://www.superu.govt.nz/sites/default/files/Alcohol%20and%20Pregnancy%20Research%20Report.pdf>
3. Ministry of Health. Alcohol use 2012/13:New Zealand Health Survey. 2015. <https://www.health.govt.nz/publication/alcohol-use-2012-13-new-zealand-health-survey>
4. Morton S, Carr P, Bandara D, et al. Growing up in New Zealand: A longitudinal study of New Zealand children and their families. report 1: Before we are born. *Growing Up in New Zealand*. 2010.
5. Mallard SR, Connor JL, Houghton LA. Maternal factors associated with heavy periconceptional alcohol intake and drinking following pregnancy recognition: A post-partum survey of new zealand women. *Drug Alcohol Rev*. 2013;32(4):389-397. <https://onlinelibrary.wiley.com/doi/abs/10.1111/dar.12024>. doi: 10.1111/dar.12024.
6. Ministry of Health. Tier 1 statistics 2016/17: New Zealand Health Survey. 2017. <https://www.health.govt.nz/publication/tier-1-statistics-2016-17-new-zealand-health-survey>
7. Jackson N, Denny S, Sheridan J, et al. Uneven reductions in high school students' alcohol use from 2007 to 2012 by age, sex, and socioeconomic strata. *Subst Abus*. 2017;38(1):69-76. <http://www.tandfonline.com/doi/abs/10.1080/08897077.2016.1252827>. doi: 10.1080/08897077.2016.1252827.
8. Wall M, Casswell S. Drinker types, harm, and policy-related variables: Results from the 2011 international alcohol control study in new zealand. *Alcohol Clin Exp Res*. 2017;41(5):1044-1053. <https://onlinelibrary.wiley.com/doi/abs/10.1111/acer.13372>. doi: 10.1111/acer.13372.
9. World Health Organization. WHO: Global strategy to reduce the harmful use of alcohol [internet]. 2010. [http://www.who.int/substance\\_abuse/activities/gsrhua/en/](http://www.who.int/substance_abuse/activities/gsrhua/en/)

10. Philip A May, Christina D Chambers, Wendy O Kalberg, et al. Prevalence of fetal alcohol spectrum disorders in 4 US communities. *JAMA*. 2018;319(5):474. <https://search.proquest.com/docview/2032386145>.
11. Centers for Disease Control and Prevention. CDC Vital Signs, February 2016. <https://www.cdc.gov/vitalsigns/pdf/2016-02-vitalsigns.pdf>. Updated 2016.
12. FASD Working Group. Taking action on fetal alcohol spectrum disorder: 2016–2019 an action plan. Wellington: Ministry of Health, 2016. <https://www.health.govt.nz/publication/taking-action-fetal-alcohol-spectrum-disorder-2016-2019-action-plan>
13. World Health Organization. Alcohol labelling. A discussion document on policy options. 2017. <http://www.euro.who.int/en/health-topics/disease-prevention/alcohol-use/publications/2017/alcohol-labelling-a-discussion-document-on-policy-options-2017>
14. Easton B, Burd L, Rehm J, Popova S. Productivity losses associated with fetal alcohol spectrum disorder in new zealand. *N Z Med J*. 2016;129(1440):72. <http://www.ncbi.nlm.nih.gov/pubmed/27538041>.
15. Avalos LA, Roberts SC, Kaskutas LA, Block G, Li D. Volume and type of alcohol during early pregnancy and the risk of miscarriage. *Subst Use Misuse*. 2014;49(11):1437-1445. <http://www.ncbi.nlm.nih.gov/pubmed/24810392>. doi: 10.3109/10826084.2014.912228.
16. Bailey BA, Sokol RJ. Prenatal alcohol exposure and miscarriage, stillbirth, preterm delivery, and sudden infant death syndrome. *Alcohol Res Health*. 2011;34(1):86. <http://www.ncbi.nlm.nih.gov/pubmed/23580045>.
17. Popova S, Stade B, Bekmuradov D, Lange S, Rehm J. What do we know about the economic impact of fetal alcohol spectrum disorder? A systematic literature review. *Alcohol Alcohol*. 2011;46(4):490-497. <http://www.ncbi.nlm.nih.gov/pubmed/21515625>. doi: 10.1093/alcalc/agr029.
18. Ministry of Health. Results from the prisoner health survey 2005. 2006. <https://www.health.govt.nz/system/files/documents/publications/prisoner-health-survey-2005.pdf>
19. Tinawai G, Gray T, Knight T, et al. Highly deficient alcohol health warning labels in a high-income country with a voluntary system. *Drug Alcohol Rev*. 2018. <https://onlinelibrary.wiley.com/doi/abs/10.1111/dar.12814>.
20. Alcohol Beverages Council. Press release: Labels won't reduce alcohol harm. 2018. <http://www.scoop.co.nz/stories/PO1805/S00324/labels-wont-reduce-alcohol-harm.htm>.
21. Altman DG, Bland JM. Statistics notes: Absence of evidence is not evidence of absence. *BMJ*. 1995;311(7003):485. <http://dx.doi.org/10.1136/bmj.311.7003.485>. doi: 10.1136/bmj.311.7003.485.
22. Diethelm P, McKee M. Denialism: What is it and how should scientists respond? *Eur J Public Health*. 2009;19(1):2-4. <http://www.ncbi.nlm.nih.gov/pubmed/19158101>. doi: 10.1093/eurpub/ckn139.
23. Daube M. Tobacco targets—doomed to fail? *N Z Med J*. 2018;131(1473):11-13. <https://www.nzma.org.nz/journal/read-the-journal/all-issues/2010-2019/2018/vol-131-no-1473-13-april-2018/7538>
24. Argo JJ, Main KJ. Meta-analyses of the effectiveness of warning labels. *J Public Policy Marketing*. 2004;23(2):193-208. <https://www.jstor.org/stable/30000760>. doi: 10.1509/jppm.23.2.193.51400.
25. Law Commission. Alcohol in our lives: Curbing the harm. 2010. <http://www.lawcom.govt.nz/sites/default/files/projectAvailableFormats/NZLC%20R114.pdf>

26. Research New Zealand. Insights from women about drinking alcohol during pregnancy: A qualitative research report. Wellington: Health Promotion Agency. 2014.
27. Hankin JR, Firestone IJ, Sloan JD, et al. The impact of the alcohol warning label on drinking during pregnancy. *J Public Policy Marketing*. 1993;12(1):10-18. <https://www.jstor.org/stable/30000107>.
28. Avery MR, Droste N, Giorgi C, et al. Mechanisms of influence: Alcohol industry submissions to the inquiry into fetal alcohol spectrum disorders. *Drug Alcohol Rev*. 2016;35(6):665-672. doi: 10.1111/dar.12399.