



## **Maori/non-Maori alcohol consumption profiles: implications for reducing health inequalities**

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The paper 'Differences in patterns of alcohol consumption between Maori and non-Maori in Aotearoa (New Zealand)' by Bramley et al appears in this issue of the NZMJ.<sup>1</sup> It is an important study that includes data from five surveys – encompassing nearly 45 000 people – and a comparison of consumption patterns for Maori and non-Maori, by age and sex.

The principal finding is that while the total volume of alcohol consumed was similar in the two populations, the drinking patterns differed markedly. Relative to Maori, non-Maori drank more frequently but, on average, 40% less alcohol per drinking occasion. The findings are consistent with previous New Zealand research,<sup>2</sup> and with differences between indigenous and non-indigenous people documented in other countries.<sup>3</sup>

The study contributes to an emerging body of research examining patterns of alcohol consumption and their effects on health. Recent international studies of this type found that at the country level, aggregate consumption (estimated from sales or tax data) and drinking patterns (estimated from survey data) were independently related to the incidence of alcohol-related harm.<sup>4,5</sup> Heavy episodic drinking was found to be particularly problematic. Rehm and colleagues argue that attention to both total volume and the incidence of heavy episodic drinking is important in understanding and preventing harm at the population level.

In general, the detrimental health effects of alcohol are characterised as either chronic or acute. The former, including liver cirrhosis, a range of cancers, depressive disorders, alcohol dependence, hypertensive disease, and haemorrhagic stroke, can result from repeated exposure to alcohol over many years.<sup>6</sup>

In contrast, acute consequences can result from relatively brief exposures to the toxic or intoxicating effects of alcohol. They include road-traffic-crash injuries, falls, drowning, poisoning, assault, self-inflicted injury, and foetal alcohol syndrome, all of which have high attributable fractions for alcohol, particularly among the young.<sup>6</sup> In contrast to chronic consequences, they do not require the victim to be a regular heavy drinker,<sup>7</sup> and can be the result of another person's drinking.<sup>8</sup>

Net alcohol-related mortality is primarily attributable to the acute consequences listed above, and a disproportionate burden is borne by young people.<sup>4</sup> This has particular implications for Maori health, considering the age distribution of the Maori population (69% aged under 35 years) relative to the non-Maori population (47% aged under 35 years).<sup>9</sup> Furthermore, the cardio-protective benefits of moderate consumption for older individuals are enjoyed by a smaller proportion of Maori relative to non-Maori. Accordingly, if alcohol policies remain unchanged, the disparity in Maori/non-Maori life expectancy<sup>10</sup> attributable to alcohol will likely increase in years to come.

Changes to the Sale of Liquor Act in 1989 and the 1999 amendments effected a substantial liberalisation of the availability of alcohol in New Zealand,<sup>11</sup> with the introduction of supermarket sales, longer opening hours, and a near doubling in the number of liquor outlets in the period 1990 to 1995.<sup>12</sup> Alcohol sponsorship, and brand advertising in the broadcast media, permitted for the first time in the early 1990s, continue to proliferate. Despite substantial evidence of a likely increase in youth alcohol-related harm,<sup>13</sup> and opposition from numerous public health agencies and advocates, the minimum purchase age was reduced in 1999. It is too early to evaluate the effects of that change in terms of alcohol-related morbidity and mortality, but studies indicate that youth drinking levels have increased<sup>14</sup> and that significant numbers of 15- to 17-year-olds can purchase alcohol from licensed premises or from friends who are of age.<sup>14</sup> Given the relative youth of the Maori population, the effects of this particular change are also likely to increase health disparities.

The burden of injury and disease attributable to alcohol may be lessened by reducing aggregate consumption levels and/or by adopting less harmful patterns of drinking. Experts agree that a mix of preventive strategies is required, including measures to reduce aggregate consumption, and strategies aimed at high-risk situations and individuals.<sup>15</sup> There is now a substantial literature on methods to reduce overall consumption, for example via increases in price and restrictions on availability.<sup>15</sup> These approaches are, however, vigorously lobbied against by the alcohol industry<sup>16</sup> and have, for some time, been out of favour politically in New Zealand. Evidence is comparatively sparse on the efficacy of methods reputed to selectively reduce high-risk consumption.<sup>15</sup>

Rehm et al observe that 'the impact of average volume of consumption on mortality or morbidity is partly moderated by the way alcohol is consumed by the individual, which in turn is influenced by the cultural context'.<sup>5</sup> There is relatively little research on the way policies, economic conditions, and interventions are mediated and moderated by cultural contexts in New Zealand.

We know little about the likely reasons for the differences in drinking patterns described by Bramley et al.<sup>1</sup> We know less still about what policies and interventions benefit Maori. Addressing alcohol-related health inequalities is not simply a matter of 'doing something special for Maori'; we need to learn to be comfortable in talking about disparities, to understand their origins, and to conduct policy-relevant research on their reduction. The research described by Bramley et al is an excellent start.<sup>1</sup>

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