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VIEWPOINT

The dissolution of the Alcohol Advisory Council: a blow for public health

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Abstract

In June 2012 the Alcohol Advisory Council (ALAC) ceased to be after more than three decades of providing advice on alcohol policy, undertaking health promotion activities, and funding research on the prevalence and causes of unhealthy alcohol use and strategies to address alcohol-related harm. Perversely, its dissolution followed soon after the Law Commission's "once in a generation" review recommending law reform to address New Zealand's substantial alcohol-related health burden.

ALAC's functions were ostensibly taken over by the Health Promotion Agency (HPA) but this new entity was given less autonomy than ALAC and a remit including areas as disparate as rheumatic fever and sun safety. In addition, HPA was compromised from the start by the appointment of a food, alcohol and tobacco industry representative to its Board. ALAC sometimes fell short of community and scientists' expectations that it provide independent and fearless advice on politically contested matters, such as controls on alcohol marketing. However, it seems that the way the HPA has been set up makes effective action to address health and social problems caused by alcohol consumption in New Zealand unlikely.

The latest burden of disease estimates show alcohol consumption is responsible for 5.4% of deaths and 6.5% of disability-adjusted life years lost in New Zealanders <80 years of age. Of the 802 premature deaths in 2007, 43% were due to injuries, 30% to cancer and 27% to other chronic conditions combined.[1] These direct harms are suffered disproportionately by men and Māori, largely determined by underlying alcohol consumption patterns and contributing to health disparities.[2] There are also harms arising from others' drinking (e.g., domestic violence) that are less well documented and are more often suffered by women and children.[3]

This article examines the dissolution of the lead government agency on alcohol-related harm and the implications of this decision for New Zealand's alcohol policy.

As a consequence of a Royal Commission of Inquiry into the sale of alcohol, the Alcohol Liquor Advisory Council was established by Act of Parliament in 1976. "Liquor" was dropped from the name in 2000 but the acronym ALAC remained part of the New Zealand vernacular. ALAC was an Autonomous Crown Entity funded by a levy on alcoholic beverages, with its primary role being: "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 legislation specified 12 functions, including: encouraging and funding policy-relevant research, health promotion, funding treatment and rehabilitation, making recommendations to government about the advertising and sale of alcohol, and the dissemination of relevant research findings from New Zealand and abroad. The development of ALAC is put in historical context in Table 1 which presents a history of New Zealand alcohol legislation over the last 40 years.

On 30 June 2012, ALAC was disestablished and its functions were ostensibly transferred to a new body, the Health Promotion Agency (HPA), which came into being on 1 July 2012 with a broad health promotion remit. The Government gave assurances that ALAC's functions would be preserved in the new body, however, the HPA is a Crown Agent "which must give effect to government policy when directed by the responsible Minister" (the Crown Entities Act 2004). This arrangement provides for an organisation oriented toward assisting in the implementation of Government policy, in contrast with the more independent role of an Autonomous Crown Entity.

Table 1. A brief history of New Zealand alcohol legislation 1974-2014

1974 Royal Commission on the Sale of Liquor	Recommended changes to unfreeze and change distribution of licencing, which influenced the 1976 Sale of Liquor Amendment Act and resulted in major increases in outlet numbers, licenced sports clubs, and BYO licences.
1976 Alcohol Liquor Advisory Council Act	Establishes the Alcohol Liquor Advisory Council which began operation in 1978
1976 Sale of Liquor Amendment Act	Established caterer's licences and ancillary licences, greatly expanding number of licenced venues, and BYO restaurants. Hotels and taverns permitted to close at 11pm on Friday and Saturday nights where previously limited to 10pm.
1978 Transport Amendment Act (No 3)	Introduction of evidential breath testing; lowering of permitted blood alcohol from 0.10 g/dL to 0.08 g/dL [20]
1989 Sale of Liquor Act	Laking Review explicitly rejects the notion that greater availability of alcohol contributes to increased consumption. The new act removed the need to show the 'need' for an outlet, substantially reduced the cost of obtaining a liquor licence, and permitted supermarkets to sell wine [12].
1992 Transport Amendment Act (No. 3)	Blood alcohol limit for drivers under 20 years of age reduced from 0.08 g/dL to 0.03 g/dL [20] (commenced Apr 1993)
1992 Transport Amendment Act (No. 3)	Compulsory breath testing introduced [20] (commenced Apr 1993)
1999 Sale of Liquor Amendment Act	Parliament passed legislation lowering the alcohol minimum purchasing age from 20 to 18 years. Beer sales were permitted in supermarkets and alcohol was allowed to be sold on Sundays [12].
2008	Law Commission asked by government to conduct a 'root and branch' review of laws concerning the sale and supply of alcohol.
2009	Law Commission Issues paper published [12].
2010	Law Commission Advice to Government published [21].
2011 Land Transport (Road Safety and Other Matters) Amendment Act	Blood alcohol limit for drivers under 20 years of age and repeat drink drivers reduced to zero
2012	ALAC disbanded and Health Promotion Agency created.
2012 Sale and Supply of Alcohol Act (coming into effect in 2012-2013)	Territorial Authorities (local governments) are empowered (but not required) to develop Local Alcohol Policies with potential to affect where and how alcohol is sold locally (for discussion see [22]). Introduction of maximum default trading hours of 4am for on-licence outlets and 11pm for off-licences (for discussion see [22]). It became illegal to supply alcohol to anyone under 18 years of age without the express consent of the child's parent(s) from 18 December 2013.
2014 Land Transport Amendment Act (No 2)	Drink-driving limits for drivers aged 20 years and over reduced from 0.08 to 0.05g/dL, from 1 December 2014

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We are reminded of the dissolution of the Public Health Commission in 1995. The Commission was established as part of the health service reforms of 1992 to conduct health monitoring, purchase health services and provide *arm's length* policy advice. In its short life the Commission produced comprehensive advice on a range of issues, including alcohol policy, with recommendations for increased alcohol taxes, restricting the physical availability of alcohol, and substantial limitations on broadcast advertising of alcohol.[4]

The reports were explicitly informed by public health science [5] and by systematic reviews of the empirical literature. It has been suggested that pressure brought to bear on the Shipley government by the tobacco, alcohol, dairy and processed food industries was instrumental in its demise in 1995 when the Commissioner, Professor Sir David Skegg, and all of the Commission's members, resigned *en masse* in protest against government interference in its activities [6].

Because of the change in statutory designation only some of ALAC's functions persist in the new HPA. The critical permission to publicly express views that might offend government and to undertake or fund research examining the direction and effects of alcohol policy appears diminished. As health researchers and advocates we were not always happy with ALAC's approach, finding it too closely aligned with industry at times, muddled on some issues,[7] and apparently unwilling to offer frank and fearless criticism on occasion.

It did, however, highlight alcohol harm and made a substantial contribution to the development of community alcohol and other drug services and brief intervention in primary healthcare. Its single issue focus, policy expertise, and ring-fenced financial resources made it a welcome ingredient in the public health response to alcohol-related harm in a small country where commercial interests can dominate in public affairs.

The move away from an alcohol-focused agency to a multifunction one with responsibilities including immunisation, mental health, gambling, heart and diabetes checks, rheumatic fever, nutrition, physical activity, tobacco control and sun safety is a concern given the potential for dilution of the expertise necessary to provide advice on often technical aspects of alcohol policy, fund high quality research, and implement effective interventions.

Of additional concern is the appointment of a leading alcohol industry figure, Katherine Rich, to the Board of the HPA.[8] A former National Party MP, Rich is Chief Executive of the New Zealand Food and Grocery Council, a lobby group representing the food, tobacco and alcohol industries. Prime Minister Key's assurance that Rich would be able to manage the conflict of interest in the performance of her role guiding the HPA[8] was unconvincing given the well-documented tactics of the tobacco and alcohol industries to influence government policy, which include industry membership on the boards of public agencies.[9,10] Key's assurances have now been undermined by allegations that Rich paid for a smear campaign against health experts;[11] allegations that have not been denied by Rich.

New Zealand alcohol policy is in crisis. The alcohol burden is reflected in unprecedented public and official concern but little action from government. In the latest major review of New Zealand's liquor laws, the Law Commission Issues Paper attracted 3000 public submissions,[12] and the review finally yielded a comprehensive set of recommendations, many of them the same as proposed by the Public Health Commission 20 years ago.

The most crucial recommendations, including increasing the price of alcohol, were excluded from the Government's Alcohol Reform Bill.[13] In the passage to legislation, the Bill was watered down further such that Local Alcohol Policies, which will supposedly underpin community approaches to preventing and ameliorating alcohol problems, offer the only hope of change,[14] yet there is substantial uncertainty about whether they will empower communities or be subverted by commercial interests.

Early signs are that policies seeking to restrict the density or opening hours of alcohol outlets are being fiercely contested by the alcohol industry.[15] The alcohol industry has paid a University economist to provide expert testimony seeking to undermine the research evidence tendered in

opposition to industry demands for longer trading hours than were permitted in new Local Alcohol Plans (e.g.,[16]). Such legal proceedings are costly for local councils and will deter some from defending policies developed through public consultation.

Funding for independent evaluation is critical to ensure that something is learned about whether the new legislation achieves its stated objectives which include facilitating greater public participation in decision making about alcohol. The hypothecated tax levied on alcohol products that financed ALAC ($12M in 2012[17]) has been retained and now pays for the alcohol work of the HPA. The alcohol industry sometimes portrays this as a tax on its activities but it is of course a tax on consumers and therefore public money for which the HPA should be accountable.

We are concerned that the dissolution of ALAC reflects a move by the Government away from funding independent public good research on alcohol-related harm and strategies to address it. We call on the HPA to adopt a transparent strategy for funding policy-relevant research including independent assessment of proposals. This could be undertaken via a subcontract with the Health Research Council (HRC), or the proceeds of the hypothecated tax could go directly to the HRC to be distributed through its competitive grant review processes.

We have previously expressed concern at ALAC's involvement in social marketing campaigns which are continuing as a major focus of the HPA. These are of dubious effectiveness, may increase health disparities,[18] and therefore represent poor use of public money. The activities of the HPA must build on existing research that has been systematically appraised, and should be guided by an evaluation plan. Anything else risks wasting resources and opportunities, or causing inadvertent harm. When there is no evidence to guide intervention programmes, innovation should be guided by public health theory and research should be undertaken to directly inform policy and practice so that learning occurs and mistakes are not repeated.[19]

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