FARE's Submission to the *Competition Policy Review Draft Report*

November 2014

The Foundation for Alcohol Research and Education (FARE) is an independent, not-for-profit organisation working to stop the harm caused by alcohol.

Alcohol harm in Australia is significant. More than 5,500 lives are lost every year and more than 157,000 people are hospitalised making alcohol one of our nation's greatest preventative health challenges.

For over a decade, FARE has been working with communities, governments, health professionals and police across the country to stop alcohol harms by supporting world-leading research, raising public awareness and advocating for changes to alcohol policy.

In that time FARE has helped more than 750 communities and organisations, and backed over 1,400 projects around Australia.

FARE is guided by the World Health Organization's *Global Strategy to Reduce the Harmful Use of Alcohol*[*] for stopping alcohol harms through population-based strategies, problem directed policies, and direct interventions.

If you would like to contribute to FARE's important work, call us on (02) 6122 8600 or email fare@fare.org.au.

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

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Introduction

The Foundation for Alcohol Research and Education (FARE) welcomes the opportunity to make a submission on the 'Competition Policy Review Draft Report' (Draft Report). This submission addresses the application of Competition Policy to alcohol policy in Australia.

In principle National Competition Policy and this review of Competition Policy acknowledge that the nature of alcohol necessitates regulatory controls that are counter to the objectives of Competition Policy. However, in practice the previous rounds of Competition Policy resulted in several jurisdictions liberalising their liquor licensing regulations. This liberalisation has resulted in considerable increases in licensed premises, which has substantially increased the availability of alcohol and contributed to alcohol becoming more affordable than it has been in over three decades.[1]

Increases in the availability, affordability and promotion of alcohol are consistently demonstrated to increase alcohol consumption and increase social and health harms.[2] In Australia 15 people die and 430 are hospitalised due to alcohol each day, making the reduction of alcohol harms one of Australia's greatest preventive health challenges.[3] The Australian public is concerned about alcohol and want action taken to reduce harms. FARE's '2014 Annual Alcohol Poll' showed that the majority of Australians think that alcohol is a problem (78 per cent) and 79 per cent believe more needs to be done to reduce alcohol harms.[4]

As the Draft Report of Competition Policy stands, its recommendations will potentially result further liberalisation of the sale of alcohol in Australia. The review has significant implications for the sale and supply of alcohol in Australia as it impacts on the ability for state, territory and local governments to respond appropriately to alcohol-related harms in their communities.

In this submission FARE has referred directly to the recommendations in the Draft Report that will impact on alcohol policy in Australia. These recommendations have the potential to:

1. Remove restrictions related to planning and zoning for alcohol outlets;
2. Deregulate retail trading hours for alcohol outlets; and
3. Reduce constraints on supermarkets being able to sell alcohol.

In this submission FARE has also considered the outcomes of Queensland regulation and whether this has produced better health and social outcomes and the potential impacts of Competition Policy on the alcohol and other drug treatment sector, especially as competitive tendering processes have already created division within the sector rather than promote multi-agency collaboration and wrap around services. It has also led to increases in the administrative burden and been found to compromise service quality.

Recommendations

FARE makes the following recommendations to the Review Panel about alcohol and Competition Policy.

1. FARE urges the Competition Policy Review Panel to further consider the social and health harms that could result from recommendations that arise from this review, and ensure that this process does not result in the increased availability of alcohol and subsequent alcohol-related harms.

2. FARE urges the Competition Policy Review Panel to more concertedly acknowledge the harms that alcohol causes and assert that the balancing test for the regulation of alcohol be the effectiveness of regulations to minimise the harms caused by alcohol, not competition in access and sale.

3. FARE urges the Competition Policy Review Panel to ensure that Competition Policy does not interfere with the legitimate rights of communities and sovereign entities to exercise their democratic rights to regulate alcohol through planning and zoning controls and Liquor Licensing.

4. FARE urges the Competition Policy Review Panel to ensure that Competition Policy does not interfere with the rights of state and territory governments to impose controls on the sale of alcohol to limit the trading hours of outlets, the type of outlets (including supermarkets) and the number of outlets in the interest of community safety and wellbeing.

5. FARE urges the Competition Policy Review Panel to carefully consider the application of Competition Policy to alcohol and other drug treatment in Australia, acknowledging that:
    a. Competitive tendering processes may further exacerbate division within the sector, place a high administrative burden on providers and favour larger services with resources to respond, thereby reducing competition.
    b. Outcome based funding models such as payment by results are inappropriate for alcohol and other drug (AOD) treatment; as these would negatively impact on individuals receiving treatment and further affect the financial viability of many services.

Alcohol is no ordinary commodity

Alcohol, because of its potential to cause harms, is not like other products. It is not the same as cornflakes, nor is it similar to washing powder or orange juice. However it is increasingly being sold and promoted in a similar way to these products without due consideration to the harms that it causes.[5] Alcohol is a drug that has a depressive effect on the central nervous system; it is an addictive substance; it is a known carcinogen, it is a known cause of birth defects and is second only to tobacco as a preventable cause of death and hopsitalisations in Australia.[6] [7] Alongside harms to the individual drinker, alcohol also results in harms to others including acts of violence, road traffic accidents, child maltreatment and neglect. As a result of these harm to others, over 360 people die, 14,000 are hospitalised and over 70,000 are victims of alcohol-related assault due to others drinking per year.[8]

Alcohol and its consumption is entrenched in Australian culture, beginning with colonisation and continuing today. Much of how and why we consume alcohol is influenced and shaped by the alcohol industry. Over the last two centuries the alcohol industry has increased their range of products, increased the amount of alcohol being produced and increased and diversified their advertising strategies (including sponsorship of individuals, teams and events).[9] The alcohol industry has also promoted alcohol as a normal, everyday product by linking it to sporting events and sporting personalities, through sponsorship of cultural events and festivals, promoting alcohol as part of national celebrations such as ANZAC Day and Australia Day, and promoting the idea that alcohol should be consumed every day as a reward, as relaxation and for no reason in particular.[10] [11]

However, society does not consider alcohol to be an ordinary product. Society determines that alcohol requires special laws and regulations that govern how and when it can be sold as well as who can consume it (i.e. legal drinking age). We deem these restrictions to be appropriate due to the harms that alcohol causes.[12] The view that alcohol requires regulation is not new. 'Stemming the Tide of Alcohol: Liquor Licensing and the public interest' (Stemming the Tide) describes the approach to regulation in Australia, highlighting that *"although much of the detailed knowledge of alcohol's adverse health and social effects is recent, the recognition that alcohol carries special dangers as a commodity is not new. Restrictions on alcohol as a special commodity are ancient… The requirement of a licence to sell alcoholic beverages was first established in England in 1552; later, in response to the 'gin epidemic' of the 18th century, as distilled spirits became cheaply available, British parliaments passed a series of laws intended to mitigate the harms, culminating in 1753 in a Licensing Act…"* Therefore *"…British licensing approaches and laws were carried over into the Australian colonies, becoming the forerunners of the licensing systems in effect today."*[13]

Across Australia, legislation limits the times when alcohol can be sold, where alcohol can be sold and the types of premise that can sell alcohol (i.e. off-licence or on-licence including restaurants, pubs, bars, club and nightclubs). This regulation is not static; 'Stemming the Tide' notes that there have been two waves of liquor licensing in Australia since the 1930s. The first wave was as a reaction to the temperance movement which *"…provided a rationale for putting alcohol in much the same class as any other commodity in the push for unfettered markets and competition, which culminated in the National Competition Policy era after 1995."*[14]

The second wave was the *"…adoption of the public health-oriented objective of harm minimisation in today's liquor licensing laws. This turnaround at the symbolic level can be seen in part as a delayed response to rises in rates of alcohol consumption and problems, and in part as reflecting a turnaround in public opinion on public health-oriented alcohol control policies."*[15]

Impacts of previous rounds of Competition Policy

Competition Policy commenced in 1995 following the release of the 'National Competition Policy' report in 1993. In the years that followed more than 1,800 pieces of legislation were identified as potentially being anti-competitive and 85 per cent of these were reformed.[16]

The reformation of liquor licensing legislation was included as part of this agenda and this has contributed to poor health and social outcomes. This section explores the impact of Competition Policy on liquor licensing and alcohol harms in Australia.

Impact of National Competition Policy on liquor licensing in Australia

In 2003 five Australian jurisdictions, New South Wales (NSW), Queensland, Western Australia (WA), South Australia (SA) and the Northern Territory (NT) had competition payments of $27.2 million withheld for failing to reform their liquor licensing regulations.[17] These states were further penalised in 2005 with the National Competition Council (NCC) recommending that these states lose five per cent of their annual payment, equating to $7.8 million for Queensland, $3.9 million for WA, $3 million for SA and $400,000 for the NT.[18] The threat of further and ongoing loss of competition payments pressured state and territory governments to reform their liquor licensing legislation leading to greater liberalisation of alcohol licensing.

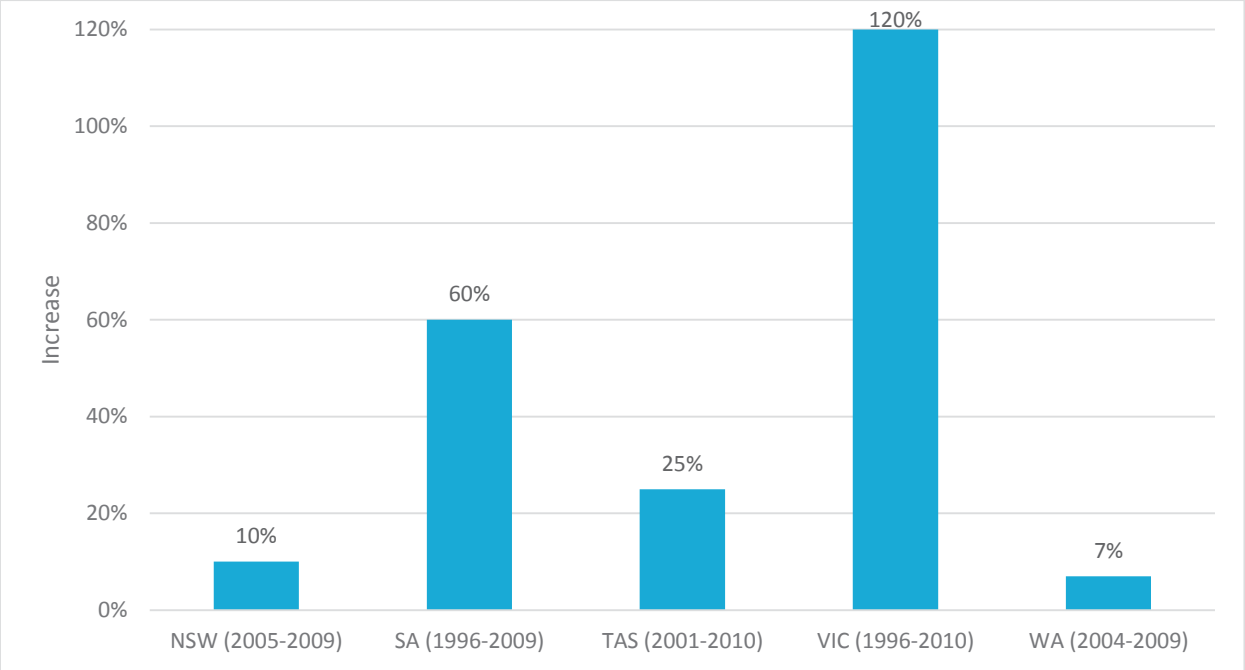
These changes, however, were made under duress as evidenced by the statement given by the then NSW Premier, the Hon Mr Bob Carr during the second reading of the 'National Competition Policy Amendments (Commonwealth Financial Penalties) Bill 2004' who said *"Given the substantial harm associated with alcohol abuse and the clear support for tight regulation that came out of the Alcohol Summit, we strongly support the maintenance of a robust liquor regulatory regime. However, the National Competition Council continues to hold that the current needs test in the Liquor Act restricting the number and location of liquor outlets is being used by existing liquor licensees to restrict competition.*

Therefore, this bill will make changes to the Liquor Act's licensing provisions that we think will be sufficient to satisfy the Commonwealth while hopefully maintaining the integrity of our liquor licensing system…. We will not allow the Commonwealth's demands to result in a proliferation of liquor outlets across NSW."[19]

The past 10 to 15 years has seen unprecedented growth in the availability of alcohol in Australia, which is a result of the application of Competition Policy principles to alcohol and in alcohol being treated like an ordinary product. There has been consistent growth in numbers of liquor licenses in Australia and in the increase of liquor licenses per head of population over 18 years of age. As at June 2010, there were approximately 53,533 liquor licenses in Australia. The increase in outlets and concentration of outlets has resulted in alcohol becoming more readily available, and more affordable than it has been in the past three decades.[20]

Figure 1, reproduced from 'Liquor Licensing legislation in Australia: A jurisdictional breakdown' demonstrates the increase in licensed premise numbers in Australia.

Figure 1: Percentage growth in liquor licenses in NSW, SA and Tasmania and licensed premises in Victoria (VIC) and WA.



Reproduction of: Trifonoff, A., Andrew, R., Steenson, T., Nicholas, R. and Roche, A.M. (2011). Liquor Licensing legislation in Australia: An Overview. National Centre for Education and Training on Addiction (NCETA). Flinders University, Adelaide, SA.

The impacts of Competition Policy and the increase in licensed premises have been most starkly seen in Victoria where between 2003 and 2012 licensed premises increased by 21 per cent. Over the same period, treatment episodes for alcohol rose by 28 per cent and ambulance attendances for alcohol doubled. This situation is explained in more detail in the Victorian case study on page 5.

In looking at the outcomes of applying Competition Policy to alcohol the economists Marsden Jacob Associates found that:

- *"Greater competition has promoted strategies that increase the availability and consumption of alcohol. For example, the increasing market share of major corporate groups in liquor retailing appears to have extended opening hours, increased accessibility and buying power and lowered prices.*
- *In practice implementation of some policies has also not had regard to the medical harm concerns. For example, the removal of discriminatory licensing regimes has been achieved by the granting of additional licenses to new applicants rather than allowing the redistribution of existing licenses to new entrants.*
- *Moreover, as might be expected of new entrants, the new licence holders are likely to be more cost efficient than many of the pre-existing licensees. This is most evident in the case of the major corporate chains which have superior scale, buying power and advertising power than 'traditional' single outlet businesses."*[21]

The effective regulation of alcohol can minimise the harms that result from its consumption, both on the individuals who consume alcohol and those harmed by others drinking. It is critical that any further review and application of Competition Policy to liquor licensing regulation take full account of the need to minimise the harms from alcohol.

Case study: Victoria

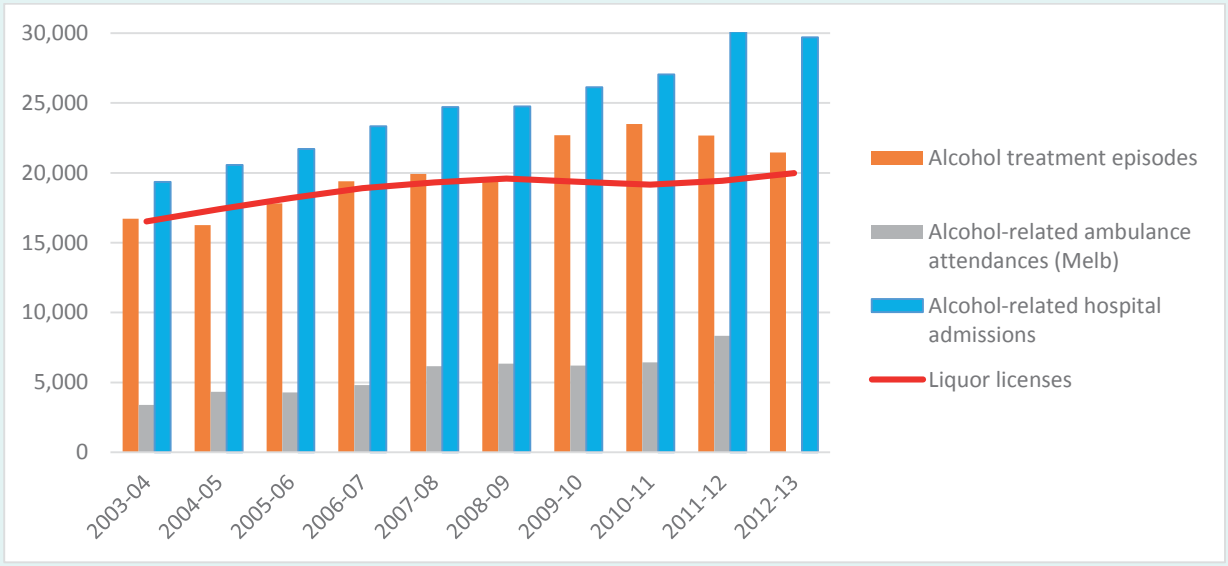
Since the introduction of Competition Policy the number of licensed premises in Victoria has more than doubled from 8,965 licensed premises in 1998 to 19,978 licensed premises in 2013.[22] In addition to the increase in premises there has been an expansion in late night trading premises in Victoria with 952 premises currently allowed to trade late at night, after 1am. Of these 495 can trade to 3.00am, 270 trade between 4.00am and 7.00am and 136 are able to trade 24 hours a day.[b]

Two substantial reviews of liquor licensing legislation have been undertaken in Victoria since 1988, resulting in the broadening of licence types and relaxation of trading hours. The extension in numbers of licensed premises and the hours the premises are able to trade has resulted in increases in alcohol harms. Over a ten year period (from 2003 to 2012):

- there was a 28 per cent increase (10 per cent per 100,000 population) in alcohol treatment episodes;
- ambulance attendances more than doubled from 3,395 to 8,349 (112 per cent increase per 100,000 population); and
- alcohol-related hospital admissions increased by 44 per cent (33 per cent 100,000 population).[23]

These harms are shown in Figure 2 below, data taken from 'The state of play: alcohol in Victoria'.

Figure 2: Liquor licenses and alcohol harms in Victoria from 2002-03 to 2012-13



Adapted from: Foundation for Alcohol FARE (2014). The state of play: alcohol in Victoria. FARE

In addition there were 24 cases of death due to one punch[c] or 'coward punch' deaths between 2000 and 2012. A third of these occurred between midnight and 6.00am, 10 involved only alcohol and 14 involved alcohol and other drugs.

Victorians' experience of alcohol-related harms has resulted in Victorian residents perceiving their central business districts as unsafe. More than half (57 per cent) of Victorians consider the city or centre of town

[b] It should be noted that the number of licensed premises would be higher had the Government not introduced a freeze on new late night premises as a result of high numbers of alcohol-related violent incidences in the Melbourne CBD in 2008.[b] The is explored in more detail later in the submission.

[c] A single blow to the head, incapacitating a victim causing them to fall to the ground becoming unconscious.

to be unsafe on a Saturday night, and two thirds (68 per cent) have had at least one negative experience (e.g. property damage, having something stolen) attributable to someone else's drinking.[24]

Victorians are concerned about alcohol-related harms and want governments to do more to address these harms. More than three quarters (77 per cent) of Victorians believe that the government should be doing more to reduce alcohol-related street violence (77 per cent), alcohol-related family and domestic violence (76 per cent), risky alcohol consumption among young people under 18 (73 per cent) and Emergency Department hospital presentations from alcohol (67 per cent).[25]

Despite reservations being expressed by members of Parliament in 2006 about the increasing liberalisation of liquor licensing in Victoria[26], it is now the state that has the most deregulated alcohol market as evidenced by the vast growth in licensed premises over time.

Impact of alcohol harms in Australia

The consumption of alcohol is one of the main risk factors for poor health globally. The World Health Organization (WHO) states that alcohol can *"ruin the lives of individuals, devastate families and damage the fabric of communities."*[27]

Alcohol is a cause or a component factor in more than 200 diseases including strokes, ischaemic heart disease, cancers, liver cirrhosis, respiratory diseases and sexually transmitted infections. Alcohol is also associated with neuropsychiatric diseases and deaths, including epilepsy, dementia, mental health and behavioural disorders.[28] The comorbidity and co-occurrence of mental health disorders and alcohol use disorders is also high, although likely to be underestimated.[29] One third of respondents to the National Survey of Mental Health and Wellbeing study who identified as having an alcohol use disorders also had at least one mental health disorder.[30] Alcohol use during pregnancy can lead to Fetal Alcohol Spectrum Disorders (FASD), a lifelong condition characterised by brain damage, cognitive, social, emotional and behavioural deficits. Alcohol harms also occur in the short term with immediate harms for the drinker and those around them including road traffic accidents, suicide, homicide, alcohol poisoning, injury and violence in and around licensed venues and in our homes.[31] The NSW Police estimate that 41 per cent of all reported domestic assault incidents in NSW are alcohol-related.[32]

Earlier this year FARE published a study titled 'Alcohol's Burden of Disease' that demonstrates that in 2010 alcohol caused 15 deaths and hospitalises 430 Australians every day. Deaths due to alcohol have increased by 62 per cent since the study was last undertaken a decade ago.

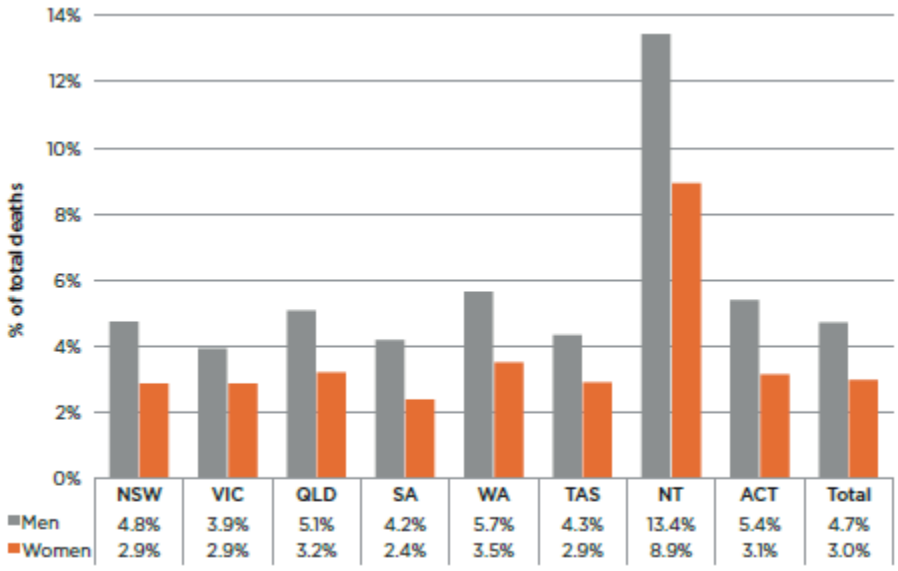
For men, injuries accounted for more than one in three (36 per cent) alcohol-related deaths, while cancer and digestive diseases caused 25 and 16 per cent, respectively. For women, one in three alcohol-related deaths were due to heart disease (34 per cent), followed by cancers (31 per cent) and injuries (12 per cent). Residents from the NT are also three times more likely to die from alcohol use than other Australians.

Also worrying is the doubling in alcohol-related hospitalisations that have occurred in the past ten years, rising from 76,467 in 2000 to 157,132 in 2010. This rise in hospital admissions reflects increasing levels of chronic harms due to alcohol being experienced by the population.

It is clear that both the short and long term harms from alcohol in Australia are increasing. These harms include death, disability, hospitalisation as well as the increasing social impacts from alcohol in Australia.

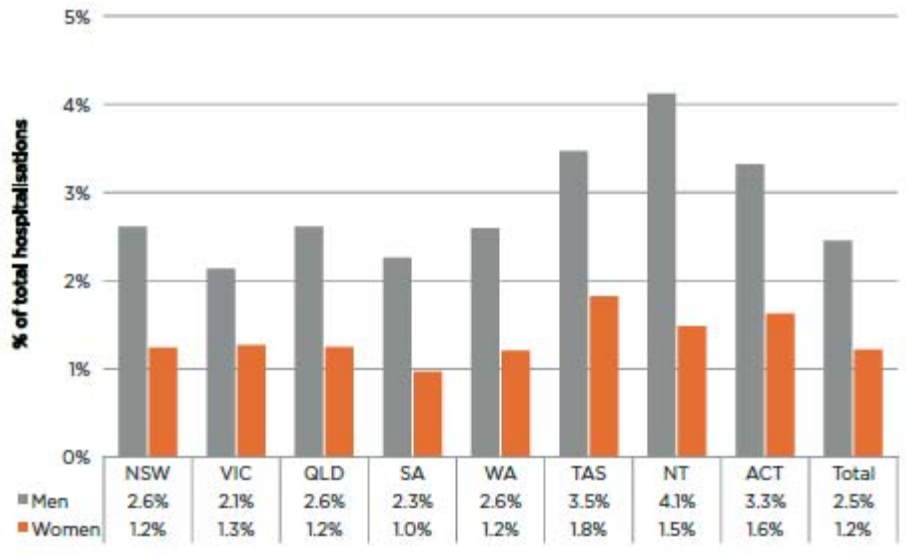
Figures 3 and 4 taken from 'Alcohol's Burden of Disease' demonstrates the proportion of deaths and hospitalisations attributed to alcohol in Australia.

Figure 3: Proportion of deaths in men and women attributable to alcohol by state in Australia in 2010.



Source: Gao, C., Ogeil, R., and Lloyd, B. (2014). Alcohol's burden of disease in Australia. Canberra: FARE and VicHealth in collaboration with Turning Point.

Figure 4: Proportion of hospitalisations in men and women attributable to alcohol by state in Australia in 2010.



Source: Gao, C., Ogeil, R., and Lloyd, B. (2014). Alcohol's burden of disease in Australia. Canberra: FARE and VicHealth in collaboration with Turning

Principles of Competition Policy and its application to alcohol

The Draft Report states that "*Competition Policy, like other arms of government policy, is aimed at securing the welfare of Australians"* and that the Competition Policy Review Panel (Review Panel) has been *"tasked with examining whether Australia's competition policies, laws and institutions remain 'fit for purpose', especially in light of the changing circumstances of the Australian economy that are expected to unfold over the next decade or so."* The Draft Report goes on to state that the "*benefits of these economic opportunities should reflect in the living standards of everyday Australians."*

When examining alcohol (and gambling) the Review Panel's view is that "…*there is* ***no case to exempt regulations*** *in these areas from ongoing review to ensure that they are meeting their stated objectives at least costs to consumers*[33] (emphasis added). All recommendations in the Draft Report will consequently apply to the regulation of alcohol in Australia, with the likelihood that this will lead to further liberalisation of liquor licensing. This will result in increased access, availability and affordability of alcohol, all of which increases deaths, injuries and hospitalisations.

When examining policy options that impact on the regulation of alcohol, the welfare of Australians should be at the centre of all policy decisions and legislation. For many years, public health advocates, politicians and economists have presented well-reasoned arguments for alcohol, being a unique product, not being subject to Competition Policy. For example in 2003 the former Premier of NSW, the Hon Mr Bob Carr said in a radio interview that he was being forced to *"adopt policies that encourage alcoholism, all in the name of competition"* and that Competition Policy *"… just increases pretty dramatically the number of outlets, and there would've been a consensus at our liquor summit some months ago, where we had all the stakeholders gathered in Parliament House, that you don't increase the number of outlets if you want to control teenage access to liquor, which is a major component of the problem we've got with liquor abuse."*[34]

Queensland Treasurer, Mr Terry Mackenroth said in a media interview in 2003 that *"I'm standing firm, and I'll take my argument to the Commonwealth that they shouldn't penalise us when in fact what we're doing is providing for a very good and regulated system of providing alcohol."*[35]

A Victorian Inquiry in 2006 into 'Strategies to reduce harmful alcohol consumption' recommended that "*the Victorian Government request the Commonwealth Government to review the application of National Competition Policy and the Trade Practices Act [previous name of the 'Competition and Consumer Act'] with regard to alcohol sale and regulation to ensure that Competition Policy does not impede efforts to develop strategies to reduce the cost to the economy of harmful alcohol consumption."*[36]

The peak body for the alcohol and other drugs sector, the Alcohol and other Drugs Council of Australia (ADCA)[d] stressed in its submission to the National Productivity Commission Inquiry into National Competition Policy in 2004 that it was: *"… inappropriate to assess liquor licensing legislation according to its capacity to generate competition and it is therefore fundamentally opposed to National Competition Policy (NCP) reforms being applied to jurisdictions' legislation in this area. ADCA calls for the removal of liquor licensing legislation from the reform agenda and the reversal of payment deductions to the affected jurisdictions."*[37] ADCA also warned that applying Competition Policy to alcohol would lead to increases in the number and type of outlets that sell alcohol and the resultant harms.[38]

[d] The Alcohol and other Drugs Council of Australia (ADCA) was the peak body for the alcohol and other drugs sector in Australia from 1967 to 2013 when its funding was abruptly ended by the incoming Federal Government. Currently there is no national peak body for the sector.

Economists Marsden Jacob Associates have also challenged the premise that applying Competition Policy to the sale of alcohol is in the public interest. FARE agrees with this premise. Their research 'Identifying a framework for regulation in packaged liquor retailing' undertaken for the NCC in 2005 demonstrates that the principal aim for those that produce and sell alcohol is to return a profit to shareholders and maintain profitability to stay in business. They found there was no requirement for alcohol producers and sellers to consider the impact of the distribution or consumption of their products on the individual or whole of society and that to do so "*…would contradict the commercial imperative, ignore the shareholder's interest and offend the operation of the free market*."[39]

Marsden Jacob Associates conclude that "*…the major problem in adopting a pure economic approach in relation to alcohol is that alcohol is an addictive substance associated with significant harm in the community. This undermines the 'consumer-sovereignty' argument against intervening because the conditions for making rational choice are not met."*

They found that '*increased competition is likely to exacerbate problems…"* and *"…consumers are entitled to the many benefits of competition. They are also entitled to the protection offered by appropriate regulation of alcohol."*[40]

Recommendations

1. FARE urges the Competition Policy Review Panel to further consider the social and health harms that could result from recommendations that arise from this review, and ensure that this process does not result in the increased availability of alcohol and subsequent alcohol-related harms.
2. FARE urges the Competition Policy Review Panel to more concertedly acknowledge the harms that alcohol causes and assert that the balancing test for the regulation of alcohol should be the effectiveness of regulations to minimise the harms caused by alcohol and not competition in access and sale.

Implications of the Draft Report's Recommendations for alcohol policy in Australia

The recommendations made within the Draft Report have significant implications for the sale and supply of alcohol in Australia and may also affect state and territory governments' ability to respond appropriately to issues in their communities. The recommendations that would significantly increase the availability of alcohol are:

1. Removing restrictions related to planning and zoning for alcohol outlets (Draft Recommendation 10);
2. Deregulating retail trading hours (Draft Recommendation 11); and
3. Reducing constraints on supermarkets being able to sell alcohol (Draft Recommendations 11 and 51).

These areas are investigated in the sections that follow.

Removing planning and zoning restrictions

The Draft Report outlines that land use planning and zoning regulations by state and local governments restrict competition by being overly-localised in priority, favouring incumbent operators or creating barriers to new entrants to the markets.

Draft Recommendation 10 of the report states:

"All governments should include competition principles in the objectives of planning and zoning legislation so that they are given due weight in decision-making.

The principles should include:

- *a focus on the long-term interests of consumers generally (beyond purely local concerns);*
- *ensuring arrangements do not explicitly or implicitly favour incumbent operators;*
- *internal review processes that can be triggered by new entrants to a local market; and*
- *reducing the cost, complexity and time taken to challenge existing regulations."*

This recommendation has implications for alcohol policy as it may require local, state and territory governments to give equal or greater weight to Competition Policy above addressing the social harms caused by alcohol. This recommendation could also result in Competition Policy having greater weight than other planning considerations such as environment aspects and amenity of local areas.

Across Australia, liquor licensing applications are first considered by local governments with reference to local and state government planning laws that include land use planning as well as specific requirements on density and impacts on amenity.[41] Licensing applications are then assessed by state licensing authorities such as the Office of Liquor Gaming and Racing in NSW. This recommendation would result in planning and zoning laws needing to consider the interests of Competition Policy above those addressing or limiting the social harms caused by alcohol.

The recommendation may also limit the ability of governments to introduce policies that restrict or freeze liquor licence applications or late night liquor licenses, such as those that have been introduced in the Central Business Districts (CBD) of Sydney and Melbourne in recent years. These measures have been introduced by state governments in response to community concern about the rising levels of anti-social behaviour and alcohol-related violence that resulted from the increased availability of alcohol.[42] The case studies below outline policies that may be deemed as anti-competitive under a revised competition policy agenda.

Case study: Sydney CBD

In 2008 the NSW Government introduced the Liquor Legislation Amendment Act 2008 to prevent the application of new 24 hour licensed premises in Sydney and introduced a mandatory six hour closure period to all liquor licenses (new and those applying for extended trading from 30 October 2008 onwards). This was introduced as a *'package of measures to crack down on anti-social behaviour and alcohol-related violence.'*[43] The policy was adapted in 2009 to place a freeze on all new licence applications within Kings Cross, Oxford Street/Darlinghurst[44] and the southern part of the CBD. This freeze was extended numerous times but despite the freeze between 2011 and 2012, 63 new liquor licenses were granted in the City of Sydney.[45]

In 2014 following the deaths of several young men from alcohol-related assaults and rising levels of community concern about alcohol-related violence, a new Sydney CBD Entertainment Precinct was established in January 2014.[46] [47] The precinct laws restrict access to and sale of alcohol in licensed premises after certain times, with last drinks at 3.00am and a lockout from 1.30am. Takeaway alcohol sales across NSW were also restricted to before 10.00pm.[48] To date it is too early to make quantifiable conclusions about the success of these interventions but anecdotal reports suggest that there have been noticeable reductions in alcohol-related hospital admissions, and no 'coward punch' victims.[49] Police and ambulance officers have also reported significant drops in violent incidents in the city since the

introduction of the laws, with the police further stating that there has been no discernible displacement of alcohol-related violence to areas surrounding the precinct.[50]

Case study: Melbourne CBD

In Melbourne a freeze on new late night licensed premises (trading after 1.00am) was introduced by the Victorian Government in 2008 as part of its 'Alcohol Action Plan: Restoring the Balance.' This policy was also in response to growing community concerns about incidents of violence and anti-social behaviour in and around licensed premises.[51] [52] This freeze has been extended several times and is now extended until 30 June 2015.

However, similar to the Sydney experience, despite the freeze being in place, new liquor licenses have been granted. This has included one premise in South Melbourne which is allowed to trade until 5.00am. This is despite the fact that the application received objections from police, the local council and liquor licensing authorities. This process highlights the difficultly that council and state governments have in objecting to license application as they can only intervene on the grounds that the amenity of the neighbourhood has been compromised and not on health and social harms.[53]

FARE strongly supports the ability of local and state/territory governments to regulate and control alcohol sales within their jurisdiction in the interests of the health, wellbeing and community safety of the community. This includes restrictions on types of outlets, numbers of outlets, density of outlets, freezes on license types, trading hours or size of premises through Liquor Licensing and planning laws. State and territory governments are best placed to regulate alcohol unfettered by Competition Policy.

Recommendation

3. FARE urges the Competition Policy Review Panel to not allow Competition Policy to interfere with the legitimate rights of communities and sovereign entities to exercise their democratic rights to regulate alcohol through planning and zoning controls and Liquor Licensing.

Deregulating retail trading hours

The Draft Report contends that the full deregulation of retail trading hours is overdue, and that remaining restrictions should be removed as soon as possible.

Draft Recommendation 51 of the report states:

"The Panel notes the generally beneficial effect for consumers of deregulation of retail trading hours to date and the growth of online competition in some retail markets. The Panel recommends that remaining restrictions on retail trading hours be removed. To the extent that jurisdictions choose to retain restrictions, these should be strictly limited to Christmas Day, Good Friday and the morning of ANZAC Day."

This recommendation has implications for alcohol policy as it may limit the ability for state, territory and local governments to introduce policies that restrict the hours and days when alcohol can be sold, which is currently covered by state and territory government liquor licensing legislation. In addition to this legislation, additional restrictions are also implemented by governments to prevent alcohol harms or address particular issues being experienced, as per the Sydney example outlined previously.

Draft Recommendation 51 is likely to result in trading hours for both on-licence premises (pubs, clubs and bars) and off-licence premises (takeaway or packaged liquor outlets) being extended. This raises significant concerns because increases in trading hours are associated with increased alcohol harms.[54] A West Australian study found that a one hour extension of trading hours (from midnight to 1am) resulted

in an increase in violent assault in or near licensed venues. The study also examined trends in assaults between 1991 and 1997 finding a 70 per cent increase in assaults per hotel per month for venues after extended trading hours were introduced.[55]

This recommendation could also significantly increase the availability of alcohol in the country. In Sweden when alcohol was able to be sold on Saturdays this resulted in a 3.7 per cent increase in total alcohol consumption. A US study also found a 29 per cent increase in the daily rate of alcohol-related motor vehicle crashes after the removals of a state-wide ban on Sunday sales of alcohol.[56]

Across Australia there are examples of communities and local governments that have introduced alcohol restrictions to address issues with alcohol in their area. Two of these communities are examined in the case studies below. These restrictions on type of alcohol and hours of sale are often critical features of Alcohol Management Plans (AMPs) and alcohol restrictions in Aboriginal and Torres Strait Islander communities.[57] [58]

Case study: Fitzroy Crossing, Western Australia

Alcohol restrictions were introduced to the Fitzroy Valley in Western Australia in 2007 limiting the types of alcohol that can be sold and the times when alcohol can be sold.[59] Community leaders in Fitzroy lobbied for the introduction of the measures as a response to 13 suicides in one year and increasing rates of community dysfunction.[60] An evaluation in 2010 found reductions in rates and severity of domestic violence; reduced street violence; reduced street drinking; less litter; less anti-social behaviour; generally better care of children and a reduction in the amount of alcohol being consumed by residents.[61]

This case study demonstrate the importance of local-led, locally driven solutions to address alcohol-related problems in Indigenous communities. There is potential for Draft Recommendation 51 to lead to AMPs or other locally driven solutions being limited or legally challenged on the basis that they are anti-competitive.

Case study: Newcastle, New South Wales

Positive outcomes have been found following restrictions being imposed in 2008 by NSW Liquor Administration Board and the City of Newcastle on 14 licensed premises, including a 3.00am close time and 1.00am lockout (later amended to 3.30am and 1.30am). An evaluation found that the restrictions resulted in a 37 per cent reduction in night-time alcohol-related assaults [62] and no geographic displacement to the nearest late night district of Hamilton.[63] These positive effects were sustained over time with an evaluation undertaken five years later finding sustained reduction in alcohol-related assaults, with an average of a 21 per cent decrease in assaults per hour.[64]

These restrictions have not impaired the local economy, with a review finding a 9.6 per cent decline in 'drink' sales revenue but a 10.3 per cent increase in 'food' sales revenue;[65] this indicates a diversification of the night-time economy.

These findings have also been seen in Norway which experienced decreases in violence when alcohol outlets were closed on Saturdays. This research found that the people most affected by these closures were those who were more likely to be involved in domestic violence and disruptive intoxication.[66]

Reducing constraints on supermarkets being able to sell alcohol

The Draft Report noted that a large number of submissions to the *Competition Policy Review Issues Paper* related to supermarkets, and stated that "*trading hours restrictions and restrictions preventing supermarkets from selling liquor impede competition. The Panel recommends that restrictions preventing supermarkets from selling liquor be prioritised as part of the renewed round of regulatory review proposed at Draft Recommendation 11 and that retail trading hours be full deregulated (Draft Recommendation 51).*"

Draft Recommendation 11 of the report is focused on the principles of Competition Policy and public benefits tests, it has implications for alcohol policy in terms of how public benefit tests are applied as well as the reduction of constraints on supermarkets selling alcohol.

Draft Recommendation 11 of the report states:

"All Australian governments, including local government, should review regulations in their jurisdictions to ensure that unnecessary restrictions on competition are removed.

Regulations should be subject to a public benefit test, so that any policies or rules restricting competition must demonstrate that:

- *they are in the public interest; and*
- *the objectives of the legislation or government policy can only be achieved by restricting competition.*

Factors to consider in assessing the public interest should be determined on a case-by-case basis and not narrowed to a specific set of indicators.

Jurisdictional exemptions for conduct that would normally contravene the competition laws (by virtue of subsection 51(1) of the Competition and Consumer Act (CCA)) should also be examined as part of this review, to ensure they remain necessary and appropriate in their scope. Any further exemptions should be drafted as narrowly as possible to give effect to their policy intent.

The review process should be transparent, with highest priority areas for review identified in each jurisdiction, and results published along with timetables for reform."

This recommendation contends that all regulation should be subject to the public benefits test, but to date public benefit and public interest tests have largely failed to serve public health interests. 'Stemming the Tide' included an examination of liquor licensing case law, and found that public interest arguments have been ineffective when *"considering complaints against existing licensees or applications for new, or amended, liquor licenses… The [review] tribunals are extremely unlikely to actually extinguish a licence, and are even reluctant to suspend a licence for two days. This general finding means that liquor licensing in its current form is ineffective as a tool to alter the behaviour of licensees. A state licence is supposed to be granted on condition that the holder obeys certain rules, but this function of discipline and control has almost been overlooked in the day-to-day operation of the systems… For an application for a liquor licence to be denied, the best chance of success is for multiple objectors, including police, local government and health departments, to make well-argued evidence-based submissions in an environment where the necessary evidence is hard to obtain; in these cases the burden of proof of (lack of) public interest lies with the objectors. Only in Western Australia, where the burden of proof of public interest has been reversed, have new applications for liquor licenses been refused with any frequency. To achieve the public interest objective of harm minimisation, other states and territories should consider adopting Western Australia's*

reversal of the burden of proof. Unless such a reversal is made, the liquor licensing system as it currently operates (on the basis of the case studies), despite purporting to act in the public interest to reduce harm, is largely ineffective."[67]

The issue of public benefit has also been considered by the Ministerial Council on Drug Strategy which in 2006 requested the Intergovernmental Committee on Drugs (IGCD) to develop a framework for alcohol and Competition Policy. IGCD formed a working group, commissioned research and undertook key informant interviews on the subject. A framework for action was developed and presented to IGCD but the report was not made public so it is unclear if the Government perused or implemented any of the recommendations within the report.[68] The Competition Policy Review Panel should review this work in determining how Competition Policy is applied to alcohol.

Draft Recommendation 11 alongside Draft Recommendation 51 has implications for alcohol policy, in terms of the sale of alcohol in supermarkets which is likely to increase access to alcohol as well as the physical ease of access and economic availability of alcohol. In turn this will increase alcohol harms.

Research evidence both internationally and in Australia demonstrates that increases in the number of outlets that sell packaged liquor either through supermarkets or other off-licenses is associated with increased rates of chronic disease, risky drinking by young people and domestic violence.[69] Research in Victoria in 2011 found that a 10 per cent increase in off-licence liquor outlets is associated with a 3.3 per cent increase in domestic violence.[70] Internationally, increases in outlet density have been linked to higher rates of road traffic accidents, drink driving or being a passenger of a drink driver, robbery, homicide, suicide (both attempted and completed), child maltreatment, deviant adolescent behaviours, sexual offences and sexually transmitted infections.[71]

The ability to sell alcohol through supermarkets is also likely to increase the market domination of larger supermarkets such as Woolworths and Coles and lead to reduced competition in Australia. Woolworths and Coles already have a 59 per cent share of liquor retailing market in Australia and stock over 100 private label brands of wines making it difficult for consumers to distinguish between actual and real competitors.[72] IBISWorld highlight that Coles and Woolworths already use their market domination to *"strike favourable agreements with alcohol producers, discounting some liquor products to levels that independent retailers have struggled to compete with. The supermarkets have also exploited their market position to reduce shelf space dedicated to branded products and push their own, higher margin private and control-label beer and wine."*[73] This situation is likely to worsen through changes to Competition Policy.

In addition, if all supermarkets are able to sell alcohol then it will lead to alcohol being used further as a 'loss leading' product. This is a practice whereby retailers sell alcohol for less than wholesale or cost price to raise sales on other products that are full price. This practice is already occurring with IBISWorld noting in 2011 that supermarkets are increasingly using their market power to push their own label wines. They do this by cutting the prices of own brand labels to undercut other products and undermine producers' profitability.[74] This practice is of concern because international evidence clearly shows that lower alcohol prices result in higher consumption, including heavier drinking, occasional drinking and underage drinking.[75]

The sale of alcohol at supermarkets also leads to changes in how alcohol is consumed by the population. For example data from Roy Morgan demonstrates that 45.2 per cent of New Zealanders bought alcohol from a supermarket in the past four weeks, compared to 9.3 per cent of Australians. One third of

Australians (37.6 per cent) bought alcohol from individual retailers, and one in ten bought alcohol from a hotel bottle shop, compared to one per cent of New Zealanders.[76] Additionally, in England supermarket alcohol sales account for 50 per cent of all alcohol sold in the country. This increase in supermarket sales has led to increases in home drinking which is associated with increased levels of consumption, as most drinkers are unaware how many standard drinks they are consuming and are unlikely to stick to national safe drinking guidelines.[77] Alcohol Concern in the UK has noted that unlike tobacco, alcohol products are located in numerous positions within supermarkets (beyond an aisle specifically for alcohol) including *"doorways, checkout areas, end-of-aisle displays, and free standing displays. They also frequently undertake 'cross-merchandising', whereby drinks are displayed next to matched food items to encourage purchases. Very often such drinks are available at discount prices. Such practices fuel the acceptability of alcohol in society, reinforcing the notion that alcohol is a normal and desirable part of our culture, rather than an intoxicating and potentially harmful drug."*[78]

The situation in the United Kingdom (UK) has forced countries like Scotland to seek to introduce legislation to limit these promotional and 'loss leading' practices by supermarkets after having recognised the harms it causes.[79]

Recommendation

4. FARE urges the Competition Policy Review Panel to ensure that Competition Policy does not interfere with the rights of state and territory governments to impose controls on the sale of alcohol to limit the trading hours of outlets, the type of outlets (including supermarkets) and the number of outlets in the interest of community safety and wellbeing.

Outcomes of Queensland's controls on packaged liquor

The Competition Policy Review Panel is seeking views on whether within *"…more heavily regulated markets…"* that *"…burdensome or intrusive regulatory frameworks remain fit for purpose."* In particular, the Draft Report outlines that *"state and local liquor licensing regimes could be reviewed to test for any evidence that the more burdensome regimes are producing superior outcomes."*

Different liquor licensing regulations exist across Australia. This legislation is controlled by state and territory governments including licensing, planning and enforcement. The legislation is amended or reviewed in response to particular issues or emerging concerns within jurisdictions.[80] Alcohol harms and alcohol regulation are not uniform across Australia. They reflect historical, cultural and social changes to alcohol consumption and therefore place state and territory governments in the best position to regulate the liquor industry. This regulation should be unfettered by Competition Policy.

It should also be noted that all licensed premises carry some risk. A monograph by the National Drug Law Enforcement Research Fund in 2003 highlighted that restaurants, hotels and off-licenses are correlated with malicious damage to property, whereas off-licenses, clubs and hotels are correlated with assaults and offensive behaviour.[81]

In Australia it is impossible to ascertain if legislation that is more stringent has resulted in fewer alcohol harms because of two factors. Firstly that the totality of alcohol available has increased across Australia and secondly that insufficient data is collected to either establish correlation or causation in these factors. In Australia the overall number of venues and premises that sell alcohol has vastly increased over the last ten to 15 years. At the same time, data on alcohol harms and alcohol sales have not kept pace and are inconsistently collected across Australia. Some data is available on alcohol consumption and harm through population level surveys (reliant on self-reporting on alcohol consumption) and through hospitals,

police and emergency services. However this data is not collated at regional or national levels and there are differences in the definitions of harms. In addition some states collect alcohol sales data but this is not consistently collected across Australia. Collecting alcohol sales data allows governments to assess the proportion of alcohol sold at off-licence locations compared to on-licence and map alcohol sales according to suburb, and potentially by licensed premise. This would be an invaluable data collection tool in evaluating the impact of various policies on reducing alcohol harm.

That said it is likely that as alcohol is increasingly allowed to be sold for longer hours and in more venues than before, any benefits from more restrictive regulations would be ameliorated. These issues are explored in the case study of Queensland below, in which it is clear that if the limitations around the sale of packaged liquor (off-licence/takeaway liquor can only be sold from a premise connected to an on-licence) were to be removed there will be an increase in alcohol harms as a result.

Case study: Queensland

Liquor Licensing in Queensland is regulated by two legislative instruments, the 'Liquor Act 1992' and 'Wine Industry Act 1994.' The regulation of licensed premises is undertaken by the Office of Liquor and Gaming Regulation (OLGR) and the Queensland Police Service.

The 'Liquor Act 1992' is currently undergoing amendment by the Queensland Government under the guise of 'Red tape reduction' and the government has also recently introduced a 'Safe Night Out Strategy.' This strategy had a strong focus on personal responsibility rather than looking at drivers of alcohol consumption. This strategy has also led to the removal on the moratorium on late night trading hours (from 31 August 2014).

Queensland does not publish trend data on numbers of licensed premises. However information published by the Queensland Ombudsman in December 2013 shows that in 2009 there were 6,700 liquor licenses. By 2011 this had increased to 6,776 and as at the end of 2013 there are approximately 6,800 licensed premises.[82]

The Ombudsman report also shows that in addition to the 6,800 licensed premises there were 966 satellite premises (e.g. detached bottle shops). This is because Queensland's 'Liquor Act 1992' places restrictions on the sale of packaged liquor (off-licence/takeaway liquor) to being sold only if the premise is connected to a hotel or other licensed venue. This has resulted in Queensland having a smaller share of the Australian package liquor market compared to other states and relative to its population size. It has also prompted Coles and Woolworths to undertake, as IBISWorld describes it "*…a pub buying frenzy during the last decade in an effort to circumvent this legislation."*[83] These companies now own 14.8 per cent of hotels and 49 per cent of detached bottle shops.[84]

Outcomes of the Queensland Government's recent 'Safe Night Out' strategy and removal of the moratorium on late night premises remain to be seen but between 31 August (when the policy was announced) and 21 September more than 40 venues applied for extended trading hours.[85] The statistics outlined here demonstrate the constant push by the alcohol industry (including Coles and Woolworths) to expand their businesses and increase their sales of alcohol. This substantiates the view that Marsden Jacob Associates made in 2005 that there is no requirement for alcohol producers and sellers to consider the impact of the distribution or consumption of their products on the individual or whole of society and that to do so "*…would contradict the commercial imperative, ignore the shareholder's interest and offend the operation of the free market*."[86]

Against this backdrop of increasing numbers of licensed premises, there has also been inadequate enforcement of the regulations under the Act. The Queensland Ombudsman found that enforcement by OLGR has been piecemeal at best and that the office is failing to achieve the harm minimisation objectives of the Act. [87] This substantiates the assertion made in 'Stemming the Tide' that the Liquor Licensing legislation in Australia is currently failing to mitigate harms from alcohol or protect the public interest.

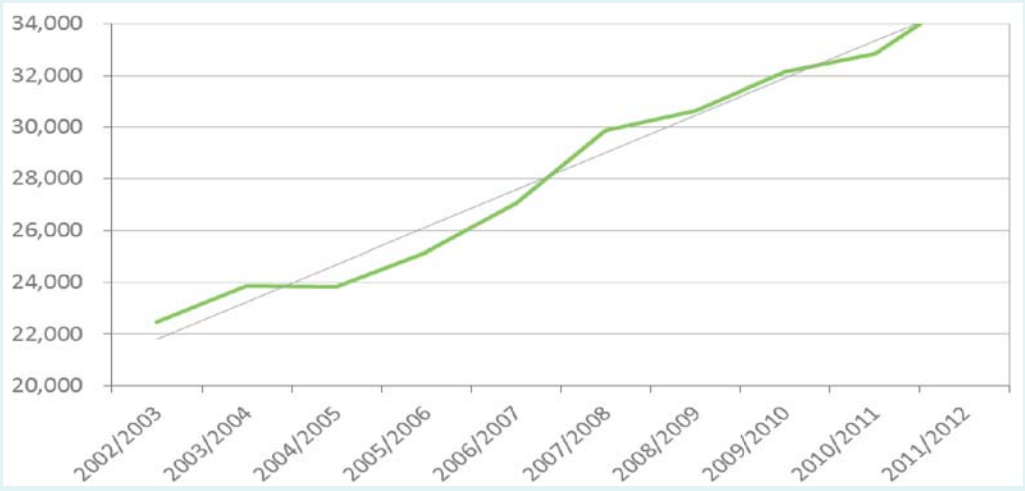
Queenslanders would agree with 65 per cent of residents considering the city or centre of town unsafe on a Saturday night. Two thirds (66 per cent) have also had at least one negative experience (e.g. property damage, having something stolen) due to someone else's drinking. [88]

It is little wonder then that restrictions on packaged liquor and government interventions over time have had little weight against the increasing availability of alcohol in Queensland. Nor is it surprising that alcohol harms are increasing. For example, there has been a:

- 57 per cent increase in alcohol-related hospitalisations from 2002 to 2011;
- 31 per cent increase in alcohol-related emergency department presentations from 2007 to 2012;
- 45 per cent increase in treatment episodes where alcohol was the principal drug of concern from 2005 to 2010; and [89]
- 35 per cent of Queenslanders have been affected by alcohol-related violence, whether directly or through a family member or friend.[90]

Figure 5 below demonstrates the change in the number of alcohol-related hospitalisations between 2002-03 and 2011-12 in Queensland.

Figure 5: Alcohol-related hospitalisations in Queensland from 2002-03 to 2011-12.



Source: FARE (2013). Alcohol-related harms in Queensland.

It is impossible to say whether the restrictions or more 'burdensome' legislation in Queensland have produced more positive outcomes compared to other states because of the overall increase in availability of alcohol over time. It is likely, as evidenced above that should the restrictions around packaged liquor be removed there will be an explosion of licensed premises selling alcohol in Queensland and we will see further increases in harms. The legislation, regulation and management of liquor licensing should, however, remain within the jurisdiction of the state unfettered by Competition Policy.

Potential impacts of Competition Policy on alcohol and other drug treatment

The Draft Report notes that "*the lives of Australians are immeasurably richer from access to high-quality human services. The human services sector covers a diverse range of services including health, education, disability care, aged care, job services, public housing and correctional services.*"

The Panel's view is that for Human Services *"a separation of regulation, funding and provision of human services can improve outcomes for users, including through enhancing choice, diversity and innovation."* They also recognise that the "*separation of these functions must be carefully implemented to address any concerns relating to access, costs to consumers, and fairness."*

The application of Competition Policy in Human Services is relatively new in Australia but within the alcohol and other drug treatment (AOD) service sector there is already considerable competition due to limited and shrinking funding available to provide services.

It is important that when the Competitive Review Panel is considering the application of Competition Policy, that principles of resource allocation of health services are kept in mind. These principles are: equity (in access to services and service capacity), and evidence of effective interventions and fairness in decision making.[91] Issues relating to these principles are captured in the information on the AOD treatment system that follows.

Alcohol and drug treatment in Australia

In Australia there are 714 AOD treatment agencies. In 2012-13 these agencies provided 162,400 episodes of treatment.[e] Alcohol is consistently identified as the principal drug of concern, increasing from 38 per cent of treatment episodes relating to alcohol in 2003-04 to 41 per cent of treatment episodes in 2012-13.[92]

Nearly all treatment (96 per cent) is for the individual themselves and most of these (68 per cent) were provided to men. There has also been a six per cent increase in the number of treatment episodes across Australia from 2011-12 to 2012-13.

Services are funded by state and territory health departments and the Commonwealth Government, as well as philanthropic funding, client payment for services, Attorney General Departments, Social Services Departments and Aboriginal and Torres Strait Islander services.[93]

AOD treatment services provide assistance to individuals seeking support for their own alcohol and drug use, for those diverted from the criminal justice system, and for those seeking assistance for someone else's AOD use. Just over half (56 per cent) of all treatment agencies are in the non-government sector but in NSW, Queensland and SA government agencies are more likely to deliver these treatment services.[94] Figure 6 reproduced from the Australian Institute of Health and Welfare's (AIHW) report on 'Alcohol and other Drug Treatment services in Australia 2012-13' shows the number of treatment agencies and closed episodes by service sector in 2012-13.

[e] Only closed treatment episodes are presented. The Australian Institute of Health and Welfare considers a treatment episode to be closed when: the treatment is completed or has ceased; there has been no contact between the client and treatment provider for 3 months and there is a change in the main treatment type, principal drug of concern or delivery setting.

Figure 6: Publicly funded alcohol and drug treatment agencies and closed episodes, by service sector, states and territories, 2012-13

Service sector	NSW	VIC	QLD	WA	SA	Tas	ACT	NT	Aust
Treatment agencies									
Government	186	0	56	14	48	7	1	5	317
Non-government	59	129	77	54	45	10	9	14	397
Total	**245**	**129**	**133**	**68**	**93**	**17**	**10**	**19**	**714**
Closed episodes									
Government	26,197	0	18,923	2,475	6,566	1,570	2,383	1,177	59,291
Non-government	9,105	54,184	11,641	18,139	4,757	786	2,033	2,44	103,071
Total	**35,302**	**54,184**	**30,564**	**20,614**	**11,323**	**2,338**	**4,416**	**3,621**	**162,362**

Reproduced from: Australian Institute of Health and Welfare (2014). Alcohol and other drug treatment services in Australia 2012–13. Drug treatment series 24. Cat. no. HSE 150. AIHW, Canberra. Page 26.

There are few agencies that provide AOD treatment in rural or remote areas with 53 per cent of treatment agencies and 69 per cent of treatment episodes being provided in major cities. Less than 10 per cent of agencies deliver services in remote or very remote areas. This has implications for an individual's choice of service being provided as alcohol remains the principal drug of concern in major cities, regional centres (both inner and outer), remote and very remote areas.

A presentation at the Australian Winter School Conference by Professor Alison Ritter from the National Drug and Alcohol Research Centre (NDARC) on AOD prevention and treatment services revealed that there is $1.26 billion available to fund AOD treatment services in Australia. Of this, 31 per cent is funded by the Commonwealth, 49 per by state and territory governments and 20 per cent privately funded. Her research also found that AOD treatment funding accounts for 0.9 per cent of all health care spending and that closer to $2.4 billion in funding is required to adequately support those needing help.[95]

Issues identified in providing alcohol and other drug treatment in Australia

In 2002 the Australian National Council on Drugs undertook a mapping exercise to ascertain the number, nature and capacity of AOD treatment services in Australia.

This report noted that the existence and location of AOD treatment services changes constantly, with services moving, opening and closing. This was due to changes in:

- Grant funding, with funding coming to an end or changing focus;
- Services being offered, with changes in staff and staff capacity, local demand, or new alliances among agencies; and
- Government policy and direction.[96]

There was also a lack of an agreed Specific Needs Index or a resource allocation formula for AOD treatment services in Australia. The report concluded that no one was able ascertain if the extent or nature of resource allocation in the sector was appropriate at the time.

This report recommended that:

- Resource allocation formulas be developed nationally and for state jurisdictions.
- Models of Care with evidence-based commissioning guidelines be developed, alongside the development of valid indicators of need for AOD treatment planning.
- Data collection instruments that gather consistent information on treatment models, proportion of services catering for specific sub-populations, the source and longevity of funding, treatment capacity and waiting times be developed.[97]

Further research undertaken by the Australian National Council on Drugs in 2008 found little change, with key issues identified by the sector as being:

- Unreliable and unsustained government funding;
- Difficulties in recruiting and retaining staff as a result of the uncertainty in funding; and
- Governments having influence on the independence of non-government-organisations to be able to advocate for their community, and to contribute to government policy development.

In addition there were significant financial problems being experienced by most in the sector with funders refusing to pay for the full cost of services/projects, increasingly complex clients, increased organisational costs, infrastructure and compliance issues, increased competition for funds, and a tendency for funding to be short term and project-specific. Smaller organisations in remote areas were particularly struggling in the current environment. Overall the combination of *"financial difficulties and a competitive funding model was reportedly exacerbating fragmentation within the sector."* [98]

In terms of responding to competition, the report found that *"Under the competitive funding model, NGOs have been treated as though they were businesses. They have been exposed to increased expectations for accountability and performance, while at the same time they have been dealing with increasingly complex clients and increased back-office costs. Limitations in governance, management and workforce capacity, and barriers to cooperation within the sector, have made improving these conditions a challenge."*[99]

In 2013 the Australian Government announced that it was undertaking two reviews on the AOD sector, one on prevention and treatment services and one on AOD research organisations.[100] The final reports of these reviews have been submitted to the Commonwealth Department of Health and are not publicly available but Working Papers from the prevention and treatment review were open for public comment.

The research by NDARC investigated the funding models currently available for AOD treatment in Australia as well as what treatment is currently available. This found that Australian health care and AOD treatment is funded through a variety of mechanisms including activity-based funding, competitive tendering, block grants, and fee-for-service. The research noted that "*for alcohol and other drug (AOD) treatment, there are also specific considerations. These include:*

- *The nature of alcohol and other drug problems, as chronic, relapsing disorders, occurring over the life-course. Some funding approaches are preferentially suited towards chronic disease management; others appear better for funding treatment for acute, time-limited conditions;*
- *A holistic approach to AOD treatment, where multiple agencies are engaged and wrap around health and welfare services are important. Again some funding approaches appear to better support multi-agency collaborative interventions;*
- *The desired planning processes: centralised planning may be preferentially associated with certain funding approaches (eg block grants), whereas localised planning may be better matched with others (eg third party consortium or outsourcing to a local, knowledgeable purchaser);*

- *The infrastructure requirements (on both purchaser and provider). Some funding models require a greater intensity of infrastructure. For example whether the purchaser has the infrastructure to manage hundreds of contracts; whether the provider has data collection systems for collecting outcomes and so on. Contract management approaches largely flow from the choice of funding approaches, so keeping contract management issues in mind when considering the options is important; and*
- *The timelines available for implementation of the funding approaches. Some funding approaches can be implemented rapidly; others can take a lengthy amount of time to see through the processes."*[101]

In particular the research undertaken highlighted that:

- While competitive tendering can allow for transparency and clarity of funding purposes, this is only possible if there are enough providers available to apply and it has the potential to reduce service quality if the main emphasis is on cost reduction.
- Open competitive processes place a high administrative burden on providers and this can be a barrier to small- to medium-sized services to respond to the tender; it can also impact on collaboration and promote division within the sector.
- There is a lack of national strategic planning and technical planning for AOD service delivery at both Commonwealth and state and territory levels. [102]

The Competition Review Panel does not make recommendations on overall levels of funding for Human Services but does note that "*… funding levels and methods can have important implications for choice, diversity and innovation in human services markets."* How services are funded has important implications in AOD treatment and the research undertaken by NDARC investigated the impact of funding arrangements on the financial viability of AOD treatment services.

This research confirmed that outcome based funding (payment by results; pay for performance, payment by outcome) was inappropriate for AOD treatment in Australia. An outcome based funding model provides payment after a person successfully leaves a service or program, and does not recognise the chronic, relapsing nature of alcohol and other drug issues as well as the other AOD specific treatment issues above. When views on this funding model were sought, key informants said there was a *"challenge of agreeing to and then measuring an 'outcome'. For example, they asked; "what would be a 'success' in our business" (purchaser) and, "how do you accommodate what the patient wants from treatment" (purchaser), noting that, "success in AOD treatment is difficult to achieve and assess" (purchaser) and "at what point do we say we have an outcome?" (provider). What is the relationship between all the activity undertaken in an AOD service and the client outcomes (do you have to pay for every piece of work regardless of outcome?). Some key informants questioned whether funding should only be provided when treatment is successful; despite the best efforts of workers the desired outcomes may not be met. Do these efforts get paid for? The measurement of outcomes (including 3, 6 or 12 month follow-up interviews with clients) would be costly for services, and require a funding program of its own."*[103]

The report concluded that "*these are fundamental problems with any outcome based funding approach, and it is worth noting that no area of healthcare in Australia uses outcome based funding."* Therefore, outcome based funding is an inappropriate funding model for AOD services in Australia and should not be introduced.

Recommendation

5. FARE urges the Competition Policy Review Panel to carefully consider the application of Competition Policy to alcohol and other drug treatment in Australia, acknowledging that:
    a. Competitive tendering processes may further exacerbate division within the sector, place a high administrative burden on providers and favour larger services with resources to respond, thereby reducing competition.
    b. Outcome based funding models such as payment by results are inappropriate for alcohol and other drug (AOD) treatment; as these would negatively impact on individuals receiving treatment and further affect the financial viability of many services.

Conclusion

Alcohol is not an ordinary commodity. It is a product that contributes to substantial health and social harms and subsequently the regulations that govern its sale and access should reflect the harm that it causes.

Previous rounds of Competition Policy have contributed to alcohol becoming more available and more affordable than it has been in over three decades.[104] As a result alcohol harms such as deaths and hospitalisations have increased markedly over this time, reflecting the ease with which alcohol can be obtained and the promotion of alcohol as being an everyday product by the alcohol industry. Until this situation changes alcohol will remain as one of Australia's greatest preventative health challenges and a leading cause of preventable death and disability in the country.

FARE urges the Competition Policy Review Panel to further consider the social and health harms that could result from the recommendations within this review and the damage done. Historically, legislation that governs the sale and supply of alcohol has been overseen by state and territory governments. These governments are best placed to regulate alcohol unfettered by Competition Policy. The regulation of alcohol should promote minimising the harm caused by alcohol, not competition. Alcohol should be exempt from any changes to planning and zoning controls, retail trading hours and sale through supermarkets.

The Competition Policy Review Panel should also carefully consider the application of Competition Policy to alcohol and other drug treatment, taking note of the issues that have already occurred through competitive funding processes and the limited funding that is currently available for AOD treatment.

While FARE is supportive of the stated aim of Competition Policy is "*improve the welfare of Australians"* we maintain that this will not be achieved by the application of the draft recommendations to alcohol. FARE urges the Competition Policy Review Panel to further acknowledge that alcohol is a commodity that causes significant harm in the community and that effective legislation is needed to regulate its sale and access. This regulation is both in the public's interest and for the public's benefit.

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Foundation for Alcohol Research & Education
PO Box 19, Deakin West ACT 2600
Level 1, 40 Thesiger Court Deakin ACT 2600
Ph 02 6122 8600
info@fare.org.au
www.fare.org.au

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