



Alcohol Action Plan

ISSUES PAPER

The Australian National Council on Drugs (ANCD) has developed this Alcohol Action Plan in response to the significant costs and harms of alcohol consumption in Australia. There are a number of existing key reports and strategies and the ANCD Plan draws from these. It is not intended to duplicate these reports or to present a comprehensive review or response to every issue. Nor does it replace the ongoing need to maintain a national alcohol strategy. Rather, the ANCD Plan seeks to identify issues of immediate or particular concern in the current environment. It provides recommendations on actions to address these issues, for the attention of governments and other key stakeholders. It is relevant to note that no single response to alcohol will be sufficient. For example, simply promoting public understanding of the range of responses will be insufficient if it is not coupled with investment in and support of evidence-based prevention and treatment responses. Therefore the Plan identifies eight comprehensive and overlapping areas for action. The actions aim to improve Australia's response to alcohol-related harms. Each action provides specific strategies for achieving these aims.

Actions

- 1 Increase informed public engagement with the harms associated with alcohol, by:**
 - 1.1 Promoting public understanding of the range of evidence-based options to prevent and respond to alcohol-related harm.
 - 1.2 Promoting better public understanding of the harms to others caused by alcohol consumption to ensure informed community debate about effective responses, especially harms to children and the costs of individual alcohol use borne by communities.
- 2 Obtain data on alcohol consumption and harms essential to informing effective responses that have currency and are sensitive to change, by:**
 - 2.1 Encouraging each State and Territory to collect and report alcohol sales data that allow local-level analysis.
 - 2.2 Implementing policies in each jurisdiction to increase the collection of information about alcohol's involvement with police incidents, and to standardise such reporting nationally.
 - 2.3 Initiating procedures to collate and analyse data on alcohol-related emergency department admissions across Australia.
 - 2.4 Including questions on the concurrent use of alcohol with other drugs in future National Drug Strategy Household Surveys.
- 3 Support local-level interventions in alcohol-related harms, by:**
 - 3.1 Encouraging States and Territories to ensure that liquor licensing legislation across all jurisdictions gives prominence to public health and safety considerations.

- 3.2 Ensuring that there is opportunity for local government and other local community stakeholders to be involved in decision-making processes without undue difficulty, and that communities are aware of their rights in these regards.
- 3.3 Ensuring access to local relevant data on alcohol consumption and related harm.
- 3.4 Building the capacity of local community stakeholders (e.g. local government) to respond effectively to prevent alcohol-related harm.
- 4 Recognise the critical role of regulating the availability of alcohol in reducing alcohol-related harms, by:**
 - 4.1 Give further consideration to implementing the recommendations regarding alcohol taxation made in the *Australia's Future Tax System* review.
 - 4.2 Developing liquor licensing procedures that consider outlet density, closing hours, and related risks and harms, drawing on local evidence and with the input of the local community.
 - 4.3 Monitor and enforce compliance with responsible service of alcohol laws with meaningful penalties.
- 5 Regulate alcohol advertising, promotions and sponsorship, by:**
 - 5.1 Initiating a parliamentary review of the impact of alcohol advertising, promotions and sponsorship on young people.
 - 5.2 Give further consideration to establishing an independent or government body to review, adjudicate and regulate alcohol advertising and promotions.
- 6 Enhance treatment responses for the whole population and for specific high-risk groups, by:**
 - 6.1 Basing funding decisions on a system that identifies local needs and resources, and identifies and responds to service gaps for high-risk populations, with a view to developing access to a range of evidence-based treatment options.
 - 6.2 Considering approaches for drinkers not currently engaged with the treatment system, such as opportunistic and brief interventions within the primary healthcare system or in other health and welfare services where higher rates of alcohol-related problems have been noted (such as homelessness, child protection and mental health).
 - 6.3 Developing and implementing online or other e-health promotions incorporating self-monitoring, provision of information on personal strategies for reducing consumption, and referral to treatment where appropriate; with particular attention to reaching those who would not normally access treatment.
 - 6.4 Promoting awareness of, and where indicated adoption of, pharmacotherapy treatments for alcohol dependence.
 - 6.5 Expanding the availability of police and court diversions into treatment for minor offences committed when intoxicated or in association with harmful alcohol use.
 - 6.6 Enhancing availability of and access to child- and youth-friendly services as well as services to support and assist parents seeking help in relation to their children's alcohol use.
- 7 Address alcohol-related problems among older Australians, by:**
 - 7.1 Undertaking further research into alcohol use among Australians aged over 65, including identifying patterns of use, age-specific risks and harms, and implications for prevention and treatment.
 - 7.2 Developing an evidence base that enables the development of alcohol consumption guidelines for older Australians.
 - 7.3 Introducing strategies to alert health professionals and older Australians themselves to the risks associated with alcohol among older people as well as appropriate interventions.
- 8 Address alcohol consumption and harms among young people, by:**
 - 8.1 Evaluating the impact of secondary supply legislation.
 - 8.2 Encouraging informed community debate on the minimum legal purchase age for alcohol.
 - 8.3 Encouraging broad prevention strategies such as increasing school engagement and awareness of the role families and parents can have in reducing alcohol-related harm, and investing in strategies consistent with this role.
 - 8.4 Developing and evaluating the impact of specific treatments for young people experiencing alcohol-related problems.

Introduction

Alcohol consumption is a regular part of social life for many Australians. However, levels and patterns of consumption are frequently risky or unhealthy. In 2010, per capita consumption of pure alcohol by Australians was estimated to be 10.25 litres, which is considered high by international standards (8, 15, 16).

Issues of concern include:

- 1 in 5 Australians consume alcohol at levels that put them at risk of lifetime harm from injury or disease (17).
- 2 in 5 Australians consume alcohol at levels that put them at risk of short-term harm at least once a year (17).
- Over one-third (36%) of drinkers say their primary purpose when drinking is 'to get drunk' (18).
- Alcohol has been causally linked to at least 60 different medical conditions (8).
- 3.2 per cent of the total burden of disease in Australia is related to alcohol use (19).
- Hazardous and harmful alcohol consumption results in costs of more than \$15.3 billion a year (20).

This Action Plan draws on research evidence to recommend strategies for addressing alcohol-related harms in Australia. It is not intended to be a comprehensive strategy for addressing alcohol-related harms, but aims to provide advice for action on issues of particular or immediate concern. The evidence suggests that comprehensive, multifaceted approaches are important. Therefore, the areas for action are overlapping, and are likely to have limited impact if implemented in isolation. For example, we cannot expect school drug education to reduce alcohol problems if heavy alcohol consumption continues unabated in the broader community.

The first three actions address general requirements for developing and implementing successful strategies to address alcohol-related harm in Australia, acting as 'pillars' to support implementation of further strategies:

- 1 Engaging Australians in issues related to alcohol-related problems and harms in the community.
- 2 Obtaining timely, quality data on alcohol consumption and harms, nationally and locally, to inform and assess the impact of policy and responses.
- 3 Developing support for local-level interventions to reduce alcohol-related harms.

Next, we identify two areas for action to reduce alcohol-related harms, by

- 4 Regulating economic availability (price) and physical availability.
- 5 Establishing better controls on advertising, promotions and sponsorship (regulating sociocultural acceptance).¹

We then identify actions to effectively address alcohol-related problems that arise for the general community and for specific groups², by

- 6 Enhancing access to treatment, including meeting the particular needs of specific groups and individuals, and engaging the significant number of at-risk drinkers who do not access the current range of treatment options.
- 7 Introducing strategies to address and improve Australia's response to alcohol consumption by people aged over 65.
- 8 Introducing strategies to address and improve Australia's response to alcohol consumption by young people.

1 Increase informed public engagement with the harms associated with alcohol, by:

- 1.1 Promoting public understanding of the range of evidence-based options to prevent and respond to alcohol-related harm.
- 1.2 Promoting better public understanding of the harms to others caused by alcohol consumption to ensure informed community debate about effective responses, especially harms to children and the costs of community alcohol use borne by communities.

It is important to encourage public engagement with and dialogue on alcohol-related harms. Some strategies are contentious and difficult to introduce, even when they are the strategies most likely to have a significant impact on alcohol-related harms. Increasing public understanding of alcohol-related harms, and of the interventions that are available and likely to succeed, can increase the likelihood of their adoption — and also increase their effectiveness once adopted (21, 22).

Promoting better understanding of alcohol's harm to others, particularly children, provides one opportunity in this regard.³ Harms caused to others by alcohol consumption — such as deaths and injuries from road crashes, assaults, domestic violence, workplace accidents, and financial and emotional harms — are substantial, with an annual economic cost of \$20 billion. Harms to children, including fetal alcohol spectrum disorders (FASD), child abuse or neglect, child deaths and abandonments, and psychological harms, are of particular concern. The 2010 National Drug Strategy Household Survey (NDSHS) (17) reports that:

- 25 per cent of respondents had been a victim of alcohol-related verbal abuse
- 8 per cent of respondents had been a victim of alcohol-related physical abuse, and
- 21.4 per cent of respondents under the age of 18 had been harmed by another's drinking.⁴

Educating the public on the costs of alcohol use in the community, which are borne by the whole community, could also facilitate community engagement. For instance:

- Up to 60 per cent of all police attendances, including 90 per cent of late-night calls, involve alcohol (26).
- Local governments are increasingly concerned about the impact of alcohol on public safety and cleaning. While there is limited research in this domain, the Australian Bureau of Statistics estimated that local governments spent nearly \$800 million on public order and safety in 2010–11, and one West Australian report noted that alcohol consumption and other drug use are among the highest priority issues they deal with in this domain (27, 28).
- In 2004–05, insurance administration costs related to alcohol were at least \$185 million (20).

Various communication and social marketing strategies could be used to promote understanding of the nature of alcohol-related harms; the range of evidence-based strategies available to address them; understanding of specific information relating to response, such as laws surrounding random breath testing (see example 1), the risks of consuming alcohol while pregnant, Australia's low-risk drinking guidelines (18, 29), and knowing where to obtain help.

EXAMPLE 1: RANDOM BREATH TESTING AND EDUCATION IN AUSTRALIA

Random breath testing (RBT) is a means to deter drink driving and enforce the relevant laws. It has been demonstrated to be highly effective in the reduction of road crashes, injuries and fatalities. This effectiveness depends on a public perception that one has a high chance of being caught.

Australia's RBT program has been evaluated as a success internationally. This success has been attributed to a high level of implementation, testing all stopped drivers, and high community perception of the chance of being caught. The latter has been enabled by the use of high-visibility policing, and regular public advertising campaigns (7, 8).

2 Obtain data on alcohol consumption and harms essential to informing effective responses that have currency and are sensitive to change, by:

- 2.1 Encouraging each State and Territory to collect and report alcohol sales data that allow local-level analysis.
- 2.2 Implementing policies in each jurisdiction to increase the collection of information about alcohol's involvement with police incidents, and to standardise such reporting nationally.
- 2.3 Initiating procedures to collate and analyse data on alcohol-related emergency department admissions across Australia.
- 2.4 Including questions on the concurrent use of alcohol with other drugs in future National Drug Strategy Household Surveys.

Data are needed on levels of alcohol consumption on national and local levels to inform any attempt to understand and respond to alcohol-related harms. Despite collection of a number of important alcohol-related datasets,⁵ Australia lacks quality, timely data on consumption levels. Before 1997, consumption could be calculated using sales data, but these data are no longer collected by most jurisdictions.⁶ Other measures such as the NDSHS are known to under-report consumption (34) and are gathered only every three years. Recommencing sales data collection across all jurisdictions is a critical step to inform and evaluate the impact of policy and interventions.

Similarly, data on alcohol-related harms that can be broken down geographically (such as by local government area) are needed.⁷ Ideally, indicators of harms should be sensitive to change (so that trends can be readily tracked without long delays), and capable of being routinely gathered (so that data collection is not overly difficult or expensive). Two indicators that could meet these criteria are emergency department admissions where alcohol is involved, and alcohol-related police incidents (see example 2). These data could be triangulated (locally and nationally) with sales data to inform decisions about interventions, broader public health measures and priorities, liquor licensing decisions, and intelligence-led policing.

Another significant gap is lack of information on the use of alcohol in conjunction with other drugs. Though the NDSHS asks about polydrug use, questions are limited to illicit drugs. However, there are some recent indications that rates of people using alcohol with amphetamine-type stimulants, and consuming alcoholic energy drinks specifically to mask the effects of alcohol, are increasing. That is, some people appear to be using stimulants to enable them to drink more for longer periods with the attendant risks. More information on these patterns of use is needed to effectively respond.⁸

EXAMPLE 2: THE ALCOHOL LINKING PROJECT AND INTELLIGENCE-LED POLICING

The Alcohol Linking Project in New South Wales focused on enhancing the enforcement of liquor licensing laws by police as they relate to licensed premises. Noting evidence that providing information on resulting harms to licensees can be an effective, low-cost way to change behaviour, the project involved the collection by police of more information at incidents concerning the intoxication levels of people involved, and which licensed premises they had last attended. This provided local intelligence data on premises most associated with acute harms. Police provided reports to licensees on numbers of incidents connected with their premises, and conducted 'audits' with a non-punitive focus on premises judged to be high-risk.

This 'intelligence-led policing' approach progressed through several studies which all showed reductions (of 15–22 per cent) in the number of assault incidents associated with the practice. The strategy was implemented into routine practice in New South Wales during 2003–05 (11, 12).

3 Support local-level interventions in alcohol-related harms, by:

- 3.1 Encouraging States and Territories to ensure that liquor licensing legislation across all jurisdictions gives prominence to public health and safety considerations.
- 3.2 Ensuring that there is opportunity for local government and other local community stakeholders to be involved in decision-making processes without undue difficulty, and that communities are aware of their rights in these regards.
- 3.3 Ensuring access to local relevant data on alcohol consumption and related harm.
- 3.4 Building the capacity of local community stakeholders (e.g. local government) to respond effectively to prevent alcohol-related harm.

Although national-level interventions and uniform strategies are crucial, interventions introduced on a local level are also important because they can respond to the issues most relevant to that area, and more successfully integrate complementary interventions. Interventions effective in one location may fail in others, due to factors such as local geographical and cultural differences, and access to services and resources. As the harms related to alcohol result from many different interacting factors, a multifaceted approach that recognises the context surrounding alcohol consumption is needed. In practice this implies that strategies implemented to address alcohol-related harm should complement each other, and utilise the cooperation of different sectors and stakeholders. Support for local-level strategies may be more easily harnessed, as people are more likely to be motivated by more immediate, personal concerns (such as feeling threatened by someone who is intoxicated) than by longer-term or distant concerns (such as risks of some more remote individuals developing liver disease after many years of heavy drinking).

A number of studies demonstrate that community-level interventions can be effective (21, 41, 42). In practice, even successful community-level interventions are hard to sustain beyond the study funding period, and are often frustrated by lack of local-area data on consumption and harms (21, 42). Cooperative practice between police, the health sector, community organisations, local business and government has also been identified as important for successful local-level interventions (21). International literature on community mobilisation to address alcohol-related problems identifies other key characteristics of successful community action programs which could be sustained: cultural relevance; consistency with community values; cultivating key leader support; utilising Indigenous staff where appropriate; developing local resources; and maintaining flexibility (42).

The role of federal and State/Territory governments in this regard lies in ensuring availability of local-area data and enabling local stakeholders' input to be given weight in relevant decision making. As well as the strategies specified in Action 2, another opportunity is the reform of liquor licensing regulations, one of the chief means through which alcohol availability can be regulated locally. At present there is some concern that licensing decisions do not give sufficient prominence to local social impact and public health and safety objectives. In addition, processes that aim to allow for local community input can be quite difficult or onerous for local stakeholders to engage with. Reform of procedures could, for example, seek to ensure the input of local government through the integration of licensing with development applications, land use regulations, and entertainment precinct guidelines (43).⁹ It is important that processes to enable input from the local community to be considered in licensing decisions are known to the community and their engagement encouraged. Such reform would need to occur at the State/Territory level, but federal leadership could play an important role in promoting this process.

4 Recognise the critical role of regulating the availability of alcohol in reducing alcohol-related harms, by:

- 4.1 Give further consideration to implementing the recommendations regarding alcohol taxation made in the *Australia's Future Tax System* review.
- 4.2 Developing liquor licensing procedures that consider outlet density, closing hours, and related risks and harms, drawing on local evidence and with the input of the local community.
- 4.3 Monitor and enforce compliance with responsible service of alcohol laws with meaningful penalties.

Two critical evidence-based approaches to reduce alcohol-related harms are regulating economic availability (increasing price), and regulating physical availability (44–51). Evidence consistently shows that higher prices reduce consumption and alcohol-related harms.¹⁰ Meta-analyses indicate that, in general, a 10 per cent increase in price results in a 5 per cent drop in overall consumption (56, 57). Reductions in consumption are associated with reductions in harm. Even small changes in price can have an impact on consumption and harm (see example 3).

Price levers available to government include the alcohol taxation system, minimum pricing, or some combination of the two. There are many complex issues to consider in implementing price levers. These include the price elasticity of different beverages (which has implications for beverage choices being redirected), and which levers will have the most impact on groups of particular concern (such as risky drinkers) (47).¹¹ Some have argued for a tiered volumetric model that incorporates incentives to manufacture and consume lower-alcohol products (22, 62). Others propose minimum pricing per standard drink as a means of increasing the price of the cheapest beverages while (potentially) imposing less of a burden on industry, avoiding some issues of beverage choice redirection, and preventing below-cost selling.¹²

Currently, Australia's alcohol taxation system is complex, with different beverages treated differently; most notably, wine is taxed on a value-added basis, while spirits and beer are taxed volumetrically.¹³ The taxation system does not serve Australia's public health well. The *Australia's Future Tax System* review described the current taxation system as 'incoherent' and ill-suited to the aim of addressing alcohol-related harms and improving community wellbeing (66), and recommended the reform of alcohol taxation to implement a volumetric model. This recommendation has been echoed by numerous other reviews, reports and statements by key bodies in the alcohol and other drug (AOD) sector (51, 62, 67–70). Reforming this system as a first step is warranted. If the recommendations from the taxation review were implemented and monitored, further alterations to price via the introduction of taxation 'tiers' for low- or high-volume products or a minimum price, in addition to volumetric taxation, could be introduced in the future.¹⁴

EXAMPLE 3: THE LIVING WITH ALCOHOL PROGRAM, NT

Between 1992 and 1997, the Northern Territory placed a levy of 5 cents per standard drink on all beverages of 3% alcohol content or higher. The levy was introduced in response to concern over high levels of alcohol-related harms. Per capita consumption was estimated to be 70 per cent higher than in other areas of Australia, the number of alcohol-related road deaths 50% higher, and rates of alcohol-related deaths three times higher.

The Living With Alcohol (LWA) program used proceeds of the levy to fund treatment and prevention programs. Concurrently the legal blood alcohol limit for drivers was lowered and restrictions on hotel trading hours were introduced in some areas. While the LWA program was in operation, there were reductions in harmful drinking, reductions in per capita consumption, reductions in fatal and non-fatal traffic accidents with alcohol involved, and reductions in alcohol-related mortality.

The 5 cent levy continued until 1997 and other LWA measures until 2002. LWA is an example of integrating small changes in alcohol pricing with other interventions to successfully reduce alcohol-related harms (13, 14).

Regulating physical availability can be implemented via various strategies, including controls on days or hours of sale, other local-area restrictions on sale or consumption, enforcement of responsible service of alcohol (RSA), and regulating outlet density (49, 51, 71–74). A number of Australian studies have confirmed that these measures can reduce acute alcohol-related harms including assaults, domestic violence, blood alcohol levels in drivers, and hospital admissions (6, 49, 73–78), reducing harm for the whole community, not just for individual drinkers. Over the last decade or more, there has been a move towards liberalisation in the regulation of the physical availability of alcohol. Increased concern expressed by communities, police and health services about alcohol-related harms, and increases in hospital admissions, have accompanied this trend. While regulating the physical availability of alcohol is the subject of contentious debate, recently some areas, such as Newcastle and remote areas in Western Australia, have introduced restrictions on pub trading hours or on ‘take-away’ sales, in response to community alarm at the level of alcohol-related harm, with significant positive effects (see examples 4 and 5) (1, 6, 79).

EXAMPLE 4: HOTEL CLOSING TIMES AND ASSAULTS IN NEWCASTLE

In 2008, closing hours in pubs in central Newcastle were restricted to 3am, with a lockout at 1am. Previously pubs had been permitted to open until 5am. This measure was introduced in response to public complaints about violence, damage to property and public disorder. The restriction was relaxed several months later to 3.30am closing, with a 1.30am lockout, in response to a legal challenge from the affected hotels.

A study investigating the effects of this restriction found a relative reduction in assaults of 37 per cent, in comparison to a control area in nearby Hamilton (a city with similar conditions to Newcastle, but without the restrictions). Assaults after 3am decreased most dramatically, by two-thirds. This is equivalent to 132 assaults prevented per year (6).

EXAMPLE 5: FITZROY CROSSING AND HALLS CREEK, WESTERN AUSTRALIA

In 2007, a restriction on the sale of packaged (‘take-away’) liquor was introduced in Fitzroy Crossing. In 2009 a similar restriction was introduced in Halls Creek, along with a restriction on the sale of alcohol for on-premise consumption before noon. Fitzroy Crossing and Halls Creek are small towns acting as regional hubs in the Fitzroy Valley in northwest Western Australia; both have a history of alcohol-related problems.

In the three months prior to the restrictions being introduced in Fitzroy Crossing, 9360 litres of pure alcohol were sold at the town’s main alcohol outlet. In a comparable period two years later, 2512 litres of pure alcohol were sold. In Halls Creek, police activities reduced from 2058 tasks in the year prior to the restrictions, to 1027 in the second year after their introduction. The number of alcohol-related assaults more than halved, drink-driving charges fell by 70 per cent, and alcohol-related emergency admissions fell by 65 per cent. Presentations at the sobering-up centre fell dramatically from 1084 in the 12 months pre-restriction to 189 in the second year post-restriction. In addition, there have been reports of decreases in notifications of sexually transmitted diseases, such as chlamydia and gonorrhoea, and more recently reports of upturns in tourism. (1–5)

There is scope to improve RSA in Australia (see example 6). Evidence indicates that RSA needs to be backed up by police enforcement of penalties on servers and premises, in order to be effective. Currently police enforcement may not occur effectively for several reasons: it can be a low priority for police with limited resources (11); efforts at enforcement can be frustrated by lack of a centralised strategy and data on locations and times of highest risk; or enforcement demands significant resourcing (80). To have the most impact, there is a need for penalties imposed to have meaningful ramifications which can be readily and speedily enforced by the legal system (7). Since a large proportion of acute alcohol-related harms are typically associated with a small proportion of venues, the availability of data on which venues carry this risk in all jurisdictions (Actions 2 and 3) would enhance intelligence-led policing.

EXAMPLE 6: RESPONSIBLE SERVICE OF ALCOHOL (RSA) IN NEW SOUTH WALES

New South Wales introduced measures to improve enforcement of RSA. A scheme introduced in 2008 classifies venues as levels 1, 2 or 3 according to the number of violent incidents associated with them. Each level carries with it certain licensing restrictions, and higher-risk venues need to lodge a 'venue safety plan' with the Office of Liquor, Gaming and Racing, detailing plans for improvement.

Although the effectiveness of this scheme is not yet clearly established, a report by the Bureau of Crime Statistics and Research (BOCSAR) indicates some recent improvements in RSA. There have been decreases in the number of people in licensed premises showing signs of intoxication, and increases in the provision of RSA measures to people who showed signs of intoxication. However, respondents to this survey also reported that the most common reaction by staff at licensed premises to people who were intoxicated was to continue to serve them. Continuing to increase efforts to enforce RSA in Australia thus has the potential to further reduce harms (9, 10).

5 Regulate alcohol advertising, promotions and sponsorship, by:

- 5.1 Initiating a parliamentary review of the impact of alcohol advertising, promotions and sponsorship on young people.
- 5.2 Give further consideration to establishing an independent or government body to review, adjudicate and regulate alcohol advertising and promotions.

Some evidence suggests that alcohol advertising has a limited impact on consumption and harm. On the other hand, research indicates that naive or not yet fully exploited markets, such as young people, may respond differently to saturated markets. Some of the research focusing on young people suggests that alcohol advertising and promotional materials are associated with increases in positive attitudes/expectations about alcohol, intentions to drink, risky consumption and acute alcohol-related harms (81–87). In addition, research has lagged behind some new developments in alcohol promotion; for example, using new media.

Alcohol advertising is subject to the Alcohol Beverages Advertising Code (ABAC) and the Commercial Television Industry Code of Practice.¹⁵ Although ABAC aims to avoid exposing young people to alcohol advertising, a number of researchers and public health bodies have suggested that current rules do not achieve this aim. A 2003 review of ABAC by the Ministerial Council on Drug Strategy (MCDS) found that it was inadequate, and thereafter measures were taken to strengthen the code and its enforcement. Nonetheless, several studies in the last five years have found that children and young people are regularly exposed to alcohol promotions (88–91).¹⁶ The potential for the measures in place to control some methods of promotion (such as competitions and point-of-sale promotions) and newer methods of advertising (such as viral or social marketing) are also concerns (e.g. 93).¹⁷

A parliamentary inquiry to investigate and assess the evidence surrounding the impact of advertising, promotions and sponsorship on young people could provide further clarity on the current evidence and situation and identify effective action. It is also worth considering further reform of the current system of advertising regulation, including the establishment of an independent or government body to review, adjudicate and regulate alcohol advertising.

6 Enhance treatment responses for the whole population and for specific high-risk groups, by:

- 6.1** Basing funding decisions on a system that identifies local needs and resources, and identifies and responds to service gaps for high-risk populations, with a view to developing access to a range of evidence-based treatment options.
- 6.2** Considering approaches for drinkers not currently engaged with the treatment system, such as opportunistic and brief interventions within the primary healthcare system or in other health and welfare services where higher rates of alcohol-related problems have been noted (such as homelessness, child protection and mental health).
- 6.3** Developing and implementing online or other e-health promotions incorporating self-monitoring, provision of information on personal strategies for reducing consumption, and referral to treatment where appropriate; with particular attention to reaching those who would not normally access treatment.
- 6.4** Promoting awareness of, and where indicated adoption of, pharmacotherapy treatments for alcohol dependence.
- 6.5** Expanding the availability of police and court diversions into treatment for minor offences committed when intoxicated or in association with harmful alcohol use.
- 6.6** Enhancing availability of and access to child- and youth-friendly services as well as services to support and assist parents seeking help in relation to their children's alcohol use.

In 2009–10, there were 67 450 treatment episodes where alcohol was the primary drug of concern. The proportion of alcohol and other drug (AOD) treatment service episodes where the primary drug of concern was alcohol has risen from 38 per cent in 2002–03 to 48 per cent in 2009–10. While it is difficult to estimate unmet demand (94), treatment penetration is thought to be low.

The treatment system also needs to include more options for people with problems of different kinds or levels of severity. Many of those with alcohol-related problems will never seek treatment for them, and specialist alcohol-directed treatments in the AOD treatment sector are often accessed by those experiencing chronic alcohol dependence, an important but not isolated group in terms of need. Enhancing access to interventions for those drinkers who may benefit from a reduction in risky use would enable our treatment system to more fully respond to the broad range of risk and health problems. Such interventions might be integrated into primary healthcare systems, and general health and welfare services, to improve treatment penetration. Options for alcohol-related interventions also include opportunities for early detection of problems, such as through screening and/or brief interventions. Evidence for the efficacy and cost-effectiveness of screening and brief intervention is continuing to mount, and studies suggest that they can be successfully integrated into primary care, emergency departments, and other settings such as ante-natal care and domestic violence counselling programs.¹⁸ Notwithstanding this evidence, there has not been widespread adoption, such as through the setting of resources and targets for Medicare Locals.

Australia's treatment system also needs to enhance treatment access for more severe problem drinkers, and those who are severely dependent, who do not currently have ready access. One area of opportunity lies in improving the integration of and communication between different services within the AOD sector, and between sectors which may also service people in AOD treatment (for instance, other health and welfare services addressing homelessness, mental health and child protection). This is a complex issue, but a first step towards improving this situation would be to develop systems that identify local service needs and gaps, for use for example in funding decisions. This should include identifying needs and resources available for high-risk populations and the local availability of different types of service. For those who are alcohol-dependent, pharmacotherapies such as naltrexone and acamprosate, which can enhance relapse prevention strategies (102), are available and are probably under-utilised in Australia (103). Promoting knowledge of these options, and identifying and responding to barriers to their use, would be necessary to increase their adoption.

The development of e-health interventions could potentially provide opportunities for new treatment pathways for alcohol-related problems at different levels of severity. In addition, such interventions could encourage self-monitoring of alcohol consumption and greater awareness of when consumption is problematic. Some recent research projects have investigated alcohol interventions using online strategies (104, 105); and 'Smartphone' applications, which have been developed for smoking cessation, could be usefully adapted to promote self-monitoring of alcohol consumption patterns (106).

There is also an identified need for AOD treatment services to address issues surrounding AOD clients with children (107, 108). Although seeking help for an issue with alcohol use can improve parenting, treatment services may struggle to be 'family-sensitive' given the complexity of issues to be managed and funding levels that generally do not take this into account. Parents cannot always continue to care for their children, especially when undergoing residential treatment. It is important to identify and resource family support and interventions that enhance rather than limit access to treatment (e.g. residential family services; child care facilities). As these issues can have an impact on treatment retention, negative consequences can result for both children and parents.

Lastly, expansion of police and court diversion programs for people arrested for minor offences while intoxicated, or in association with harmful alcohol use, could also help to improve treatment penetration.¹⁹ While some such programs are available, current diversion programs largely grew out of a decade of the federally funded Illicit Drug Diversion Initiative to 2009, where most resources have targeted those detected with illicit drugs. Expansion of programs relating to alcohol, or changes to eligibility criteria of existing programs so as to include alcohol-related offences, could be beneficial.

7 Address alcohol-related problems among older Australians, by:

- 7.1** Undertaking further research into alcohol use among Australians aged over 65, including identifying patterns of use, age-specific risks and harms, and implications for prevention and treatment.
- 7.2** Developing an evidence base that enables the development of alcohol consumption guidelines for older Australians.
- 7.3** Introducing strategies to alert health professionals and older Australians themselves to the risks associated with alcohol among older people as well as appropriate interventions.

Alcohol consumption, and related risk, by older Australians is currently poorly understood (109), but of much importance given our ageing population. High-risk drinking occurs at lower rates among older people (using levels determined for those under the age of 65). However, long-term alcohol-related health issues are higher, and it is probable, given the ageing population and the likelihood that people will take their drinking trajectories with them, that there will not only be more older people, there will be more older people drinking more. This raises concerns about the associated acute and long-term harms. Among over-65s,

- 10 592 alcohol-attributable deaths occurred between 1994 and 2003
- 110 800 alcohol-attributable hospitalisations occurred between 1993–94 and 2001–02;
- the most common causes of alcohol-related hospitalisations and death include liver cirrhosis, haemorrhagic stroke, heart problems and falls (110–112).

Physically, older people may have lower tolerance for alcohol. Alcohol use can also exacerbate other health conditions or interact with prescription medications, both of which are likely to affect the older population disproportionately. It is also important to recognise the social functions of alcohol use. Older people are at higher risk of isolation and more likely to experience loss or bereavement, due to life changes such as the loss of partners, friends and previous jobs or other roles. This may have relevance for their alcohol use (113). There are indications that health services do not respond optimally to alcohol-related problems among older people. Studies have found that medical practitioners are less likely to ask older patients about alcohol consumption patterns, less likely to recognise alcohol use problems in older patients, and less likely to refer older patients to treatment (109). Despite these issues, there is little knowledge of what constitutes low-risk alcohol consumption for older people, no targeted low-risk drinking guidelines have been developed, and little research has been undertaken into tailoring treatment to the needs of older people (109).

8 Address alcohol consumption and harms among young people, by:

8.1 Evaluating the impact of secondary supply legislation.

8.2 Encouraging informed community debate on the minimum legal purchase age for alcohol.

8.3 Encouraging broad prevention strategies such as increasing school engagement and awareness of the role families and parents can have in reducing alcohol-related harm, and investing in strategies consistent with this role.

8.4 Developing and evaluating the impact of specific treatments for young people experiencing alcohol-related problems.

Alcohol consumption among young people is a significant concern. Young people typically engage in fewer episodes of drinking overall, but are more likely to consume to risky levels in each episode. They are more likely to drink specifically to become intoxicated; and more likely to experience acute alcohol-related harms:

- 60 per cent of students aged 12–17 reported consuming alcohol in the past year, and 23 per cent in the past week, in the 2008 Australian School Students Alcohol and Drug (ASSAD) survey (114)
- 61 per cent of 18–29 year olds in the 2012 FARE Alcohol Poll reported they drank specifically to get drunk (18)
- up to 22 per cent of hospitalisations and 13 per cent of deaths of young people are alcohol-attributable (115, 116)
- 52 per cent of alcohol-related road injuries and 32 per cent of alcohol-related hospital admissions for injuries from violence involve 15–24 year olds (117).

There is also potential for longer-term risks: alcohol may interfere with normal brain development (118); and earlier age of initiation into alcohol use is a predictor of later alcohol-related problems (119, 120).

While young people will benefit from broader interventions, targeted strategies might be indicated, including controlling exposure to advertising and promotions (Action 5). It is also important to ensure that children and young people are provided with adequate and evidence-based education programs on these issues. The School Health and Alcohol Harm Reduction Project (SHAHRP), for example, has developed an evidence-based school education intervention that has attained significant results in reducing consumption and harms.²⁰ One area of research focus for targeted youth treatments has been school-based interventions. There is some international evidence for the effectiveness of brief interventions, counselling-based interventions and family therapy (121). Systematic reviews indicate that brief interventions for those with identified problems may be as effective as long-term counselling, although their effect tends to wane over 6–12 months (122). It would be necessary, however, to develop the evidence base on how targeted treatments for youth could best be implemented in an Australian context.

It is also important to address supply. For instance, strengthening secondary supply legislation and increasing its enforcement nationally may be a positive move given that adults and older siblings are a common source of supply of alcohol to under-age drinkers.²¹ The ASSAD Survey found that 60 per cent of respondents who had consumed alcohol in the week prior to the survey did so under adult supervision (114). It is also relevant to note that licensed premises are another source of supply of alcohol for under-age drinkers. Strategies to reduce supply should also target this domain, supporting those in the industry who ‘do the right thing’ while holding to account those who do not. Changing the legal drinking age is another potential intervention which evidence clearly links to reductions in acute harms.²² This is likely to be a contentious proposition,²³ but informed public discussion on age of access to alcohol should be a priority.

Measures to engage the wider community with issues surrounding alcohol and youth more broadly are also important. Engagement with schools, parental drinking habits and attitudes, monitoring their children’s behaviour, providing a supportive and caring environment, are known to provide protective factors against high-risk drinking by young people, for example (126). Exactly how parents’ attitudes, habits and parenting strategies surrounding alcohol — as well as other family dynamics — impact on their children can be complex, but does suggest a range of possible interventions (127–129). Enhancing access to advice and support on these issues for parents is one important strategy. Engaging schools and community organisations more generally through increasing awareness of these issues has the potential to contribute to broader social changes over time.

NOTES

- 1 Other important strategies include broad-based prevention strategies such as addressing the social determinants of health (e.g. access to and engagement with school; addressing poverty and social isolation), addressing the manner in which alcohol is advertised and promoted, addressing the needs of specific groups such as young and older Australians, and reducing risks in specific contexts (e.g. the workplace). We focus on these two kinds of strategy as they represent areas in which Australia can clearly improve its alcohol policies to address current concerns.
- 2 This Action Plan does not make any recommendations regarding the needs of Aboriginal and Torres Strait Islander peoples and communities, although we recognise the critical importance of addressing such needs. A range of resources has been developed by the National Indigenous Drug and Alcohol Committee (NIDAC), including a paper on *Addressing Harmful Alcohol Use amongst Indigenous Australians*. This paper and other resources are available on the NIDAC website <<http://www.nidac.org.au/>>.
- 3 Public health measures can sometimes be viewed as government paternalism; but emphasising the ways in which alcohol consumption in the community impacts on everyone, and the harms caused to people other than those directly engaged in a practice — particularly children — provides a rationale that diminishes this criticism. Some evidence indicates that knowledge about tobacco's harm to others through second-hand smoke has similarly played an important role in the adoption and support of tobacco control policies (23, 24).
- 4 Figures are for the 12 months prior to the survey. In addition, a recent report on alcohol's harm to others (25) found that 30 per cent of survey respondents had been harmed by the drinking of someone they knew; 54 per cent had been negatively affected by others' drinking when strangers were included; and 70 per cent had been negatively affected by others' drinking when less serious harms such as noise or annoyance were included. The report also analysed child protection cases in Victoria and concluded that 33 per cent of substantiated cases involved alcohol.
- 5 For overviews of available datasets, as well as data limitations and gaps, see (30, 31).
- 6 These data were previously collected by State and Territory licensing bodies. However, when State- or Territory-imposed licensing fees and levies were judged unconstitutional by the High Court, the incentive for States and Territories to collect this information was removed. Only Western Australia and the Northern Territory continued to collect this information; Queensland has more recently recommenced collection (8, 32, 33). Other jurisdictions are now considering or taking action to reinstate collection.
- 7 Alcohol-related harms include disease, injuries, violent incidents, and traffic accidents. For some of these harms data are not collected in all jurisdictions; for others, information is collected as part of routine administration but not collated or analysed.
- 8 See (35). Knowledge of patterns of use and associated risks in this regard is limited, though research thus far suggests greater medical risks and increased risky behaviour; see (36–40).
- 9 More information on the role of local governments in managing alcohol-related harms is available on the website of the National Local Government Drug and Alcohol Advisory Committee at <<http://www.lgadin.gov.au/home/default.asp>>.
- 10 See, for example, (52–55).
- 11 Some argue that there are issues of justice here; see (58–61).
- 12 A minimum price has recently been adopted in Scotland, and is under consideration in England and other nations. Economic modelling conducted in the United Kingdom indicated that profits from a minimum price would primarily go to large supermarket chains, and there are reasons to think this would also occur in Australia (63). A detailed report on the public interest case for minimum pricing of alcohol has been released by the Australian National Preventative Health Agency (64) and a public submissions process is currently underway.
- 13 Volumetric taxation is also currently applied at different levels for different beverages, and there are a number of exemptions and adjustments made within this system, for instance with low-alcohol beer and ready-to-drink beverages ('alcopops'). The 'alcopops' tax, which increased the price of ready-to-drink beverages popular among young people, succeeded in reducing overall consumption (65).

- 14 One concern to governments in introducing price increases is resistance from the general public. However, the NDSHS reveals that increasing the price of alcohol was supported by 28 per cent of respondents in 2010 and support has been increasing over time. This support is much higher (43%) where the proceeds are used for addressing alcohol-related harms. It is also important to note that price increases need only be minimal in order to have an impact; better public awareness of the size of proposed increases may result in further increases of support. In addition, the reason government has thus far not acted on the *Australia's Future Tax System* review recommendations is that reforming alcohol taxation should not be attempted in the middle of a wine glut and industry restructure (8), but there are reports that the wine glut will cease in the coming 1–2 years (63).
- 15 Alcohol advertising is permitted between 8.30pm and 5am, and between 12 noon and 3pm on school days, and during live sports broadcasts on weekends and public holidays. Other exemptions also apply which permit alcohol advertising during live sporting events, depending on where the event is being held and where it is being broadcast.
- 16 In addition, self-regulation through codes of practice is known to be limited by its reliance on public knowledge of the code for reporting breaches and sufficient sanctioning powers being available to those administering the code (92).
- 17 In March 2012 an independent body, the Alcohol Advertising Review Board, was founded by a coalition of public health bodies and aims to provide an independent review of alcohol advertising complaints. The Board provides reports on complaints received and advertisers' responses to upheld complaints, although it is an advocacy and research body with no power to enforce recommendations. However, the Board's founding is suggestive of the demand for an independent body to evaluate, adjudicate and enforce alcohol advertising standards. Action has recently been taken on alcohol sponsorship of sports, with the introduction of the Community Sponsorship Fund to provide alternative funding for community sporting organisations.
- 18 Screening and brief interventions may be carried out differently in different studies and some reviews indicate differing efficacy for certain sub-populations. However, there is evidence that they can be effective for a range of outcomes including reducing consumption, alcohol-related deaths, and driving while intoxicated (95–101).
- 19 This could also play an important role in reducing the numbers of people in the justice and correctional systems, and potentially, recidivism.
- 20 Further information is available at <<http://ndri.curtin.edu.au/research/shahrp/>>.
- 21 In the Australian Capital Territory, Western Australia and South Australia there are no restrictions on supplying under-18s with alcohol (except via sale) if alcohol is consumed on private premises; in other jurisdictions, conditions of parental consent and/or supervision apply. An inquiry on this issue is currently underway in New South Wales.
- 22 There is reliable evidence that road crashes involving young people increase when drinking ages are lower, and decrease when drinking ages are higher (123, 124). Some evidence also suggests that increasing the legal drinking age lowers consumption by young people and reduces other alcohol-related harms (125).
- 23 Public support for this measure was most recently reported at just over 50 per cent (17).

Appendix: Summary of key government documents

National Drug Strategy 2010–2015

The National Drug Strategy is guided by a harm minimisation approach, incorporating three pillars:

Demand reduction: Specific objectives relevant to alcohol are to:

- prevent uptake and delay onset of drug use
- reduce use of drugs in the community
- support people to recover from dependence and reconnect with the community
- support efforts to promote social inclusion and resilient individuals, families and communities.

Supply reduction: to control, manage and/or regulate the availability of legal drugs. Specific objectives relevant to alcohol are to:

- control and manage the supply of alcohol.

Harm reduction: to reduce the adverse health, social and economic consequences of the use of alcohol. Specific objectives relevant to alcohol are to:

- reduce harms to community safety and amenity
- reduce harms to families
- reduce harms to individuals.

The approaches in the three pillars will be applied with sensitivity to age and stage of life, disadvantaged populations, and settings of use and intervention. The pillars are underpinned by commitments to:

- building workforce capacity
- evidence-based and evidence-informed practice, innovation and evaluation
- performance measurement
- building partnerships across sectors. (130)

National Alcohol Strategy 2006–2011

This strategy is current pending the development of a new National Alcohol Strategy (NAS). The goal of the NAS is to prevent and minimise alcohol-related harm to individuals, families and communities in the context of developing safer and healthier drinking cultures in Australia. The NAS identifies priority areas for coordinated action:

1 Reduce the incidence of intoxication among drinkers

- Increase community awareness and understanding of the extent and impacts of intoxication.
- Improve enforcement of liquor licensing regulations.
- Ensure the inclusion of Aboriginal and Torres Strait Islander groups to identify specific responses for Aboriginal and Torres Strait Islander communities.
- Implement strategies to reduce the outcomes of intoxication and associated harm in and around late night (extended hours) licensed premises and outlets.

2 Enhance public safety and amenity at times and in places where alcohol is consumed

- Prevent and reduce alcohol-related injuries.
- Revise, develop where necessary, and disseminate best practice guidelines.
- Increase the capacity of local communities, including government, to address public health and safety issues associated with alcohol.

3 Improve health outcomes among all individuals and communities affected by alcohol consumption

- Initiate a national effort to enhance the capacity and legitimacy of the nursing profession in addressing alcohol-related health problems.
- Promote primary care settings as an accessible and non-stigmatising opportunity for health promotion, prevention and treatment of alcohol use problems.
- Improve capacity and encourage a system-wide health response to people at risk of short-term and longer-term alcohol-related health problems.
- Support whole-of-community initiatives to reduce alcohol-related health problems.

4 Facilitate safer and healthier drinking cultures by developing community understanding about the special properties of alcohol and through regulation of its availability

- Strengthen the regulation of alcohol availability including liquor licensing controls.
- Investigate price-related levers to reduce consumption of alcohol at harmful levels.
- Monitor and review alcohol promotions.
- Develop and implement social marketing campaigns to reduce alcohol-related harms.
- Develop a shared vision for long-term culture change with the aim of reducing alcohol-related harm and developing safer and healthy drinking cultures in Australia.
- Examine the legal aspects of alcohol availability.

The above will include both universal approaches to reduce overall consumption and strategies targeted to reduce harm. The NAS also identifies supportive actions required:

- coordinated and integrated approaches
- building the research agenda
- data collection
- monitoring and evaluation
- developing the workforce
- developing partnerships and links
- shaping the future — providing strong leadership. (130)

Australian National Preventative Health Taskforce: Alcohol Recommendations

The Australian National Preventative Health Taskforce's alcohol recommendations identified the following eight key action areas related to alcohol:

1 Improve the safety of people who drink and those around them

- 1.1** States and Territories to harmonise liquor control regulations, by developing and implementing best practice nationally consistent approaches to the policing and enforcement of liquor control laws.
- 1.2** Increase available resources to develop and implement best practice for policing and enforcement of liquor control laws and regulations.
- 1.3** Develop a business case for a new Council of Australian Governments' national partnership agreement on policing and enforcement of liquor control laws and regulations.
- 1.4** Provide police, other law enforcement agencies and private security staff with information and training about approaches to complying with and enforcing liquor licensing laws and managing public safety.
- 1.5** Change current system to ensure local communities and their local governments can manage existing and proposed alcohol outlets through land use planning controls.
- 1.6** Establish the public interest case to exempt liquor control legislation from the requirements of National Competition Policy.
- 1.7** Support the above through partnerships with health and law enforcement groups and the alcohol beverage and related industries, such as alcohol retailers, hoteliers, licensed clubs, local communities and major event organisers; and data collection and monitoring of alcohol sales, policing, and health and social impacts.

2 Increase public awareness and reshape attitudes to promote a safer drinking culture in Australia

- 2.1** Develop and implement a comprehensive and sustained social marketing and public education strategy at levels likely to have significant impact, building on the National Binge Drinking Campaign and state campaigns.
- 2.2** Embed the main themes and key messages within a broad range of complementary preventative health policies and programs.
- 2.3** Introduce basic strategies in the workplace to prevent and reduce alcohol-related harm in a range of key industries.

3 Regulate alcohol promotions

- 3.1** In a staged approach phase out alcohol promotions from times and placements which have high exposure to young people aged up to 25 years.
- 3.2** Introduce enforceable codes of conduct requiring national sporting codes to take greater responsibility for individuals' alcohol-related player behaviour.
- 3.3** Require health advisory information labelling on containers and packaging of all alcohol products to communicate key information that promotes safer consumption of alcohol.
- 3.4** Require counter-advertising (health advisory information) that is prescribed content by an independent body within all alcohol advertising at a minimum level of 25 per cent of the advertisement broadcast time or physical space.

4 Reform alcohol taxation and pricing arrangements to discourage harmful drinking

- 4.1** Commission independent modelling under the auspices of Health, Treasury and an Industry panel for a rationalised tax and excise regime for alcohol that discourages harmful consumption and promotes safer consumption.
- 4.2** Develop the public interest case for minimum (floor) price of alcohol to discourage harmful consumption and promote safer consumption.
- 4.3** Direct a proportion of revenue from alcohol taxation towards initiatives that prevent alcohol-related societal harm.

5 Improve the health of Indigenous Australians

- 5.1** Increase access to health services for Indigenous people who are drinking at harmful levels.
- 5.2** Support local initiatives in Indigenous communities.
- 5.3** Establish a reliable, regular and sustained system for the collection and analysis of population statistics on alcohol and drug use among Indigenous people.
- 5.4** Establish and fund a multi-site trial of alcohol diversion programs.
- 5.5** In communities that desire them and which are large enough to support them, the availability of night patrols and sobering-up shelters should be expanded.

6 Strengthen, skill and support primary healthcare to help people in making healthy choices

- 6.1** Enhance the role of primary healthcare organisations in preventing and responding to alcohol-related health problems.
- 6.2** Develop a more comprehensive network of alcohol-related referral services and programs to support behaviour change in primary healthcare.
- 6.3** Increase access to primary healthcare services and improve health outcomes for hard-to-reach disadvantaged individuals who are at risk of alcohol-related health problems.

7 Build healthy families and children

- 7.1** Protect the health and safety of children and adolescent brain development.
- 7.2** Support parents in managing alcohol issues at all stages of their children's development through community-level approaches.
- 7.3** Measure the impact of harmful consumption of alcohol on families and children by ensuring all population surveys that collect data to monitor drug use and drug trends across Australia collect information on parental status or childcare responsibilities of drinkers.

8 Strengthen the evidence base

- 8.1** Develop a system for nationally consistent collection and management of alcohol wholesale sales data to inform key alcohol policy developments and evaluations.
- 8.2** NPA to define a set of essential national indicators on alcohol consumption and health and social impacts by reviewing what is currently available and what is also required.
- 8.3** Expand the collection of patterns of drinking data to include place of drinking, duration of drinking occasion, and reasons for drinking.
- 8.4** Improve utilisation of key datasets on the harm to drinkers and harm to others. (8)

National Health Reforms

Federal and State and Territory governments have committed to implementing reforms to health and aged care under the National Healthcare Agreement released in 2011. The reforms cover the organisation, funding and delivery of care and aim to improve healthcare for all Australians with specific recognition of Australia's ageing population, trends in rates of chronic and preventable disease, and costs. Specific measures include:

- a new framework for funding public hospitals and an investment of an additional \$19.8 billion in public hospital services over this decade
- a focus on reducing emergency department and elective surgery waiting times
- increased transparency and accountability across the health and aged care system
- a stronger primary care system supported by joint planning with States and Territories and the establishment of Medicare Locals, and
- the Australian Government taking full policy and funding responsibility for aged care services. (131)

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