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Alcohol Policies and Legislation Review
c/o Department of Health
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Dear Review Manager

SUBMISSION TO THE *ALCOHOL POLICIES AND LEGISLATION REVIEW:*

A system of government liquor stores as an effective measure for reducing drinking-related harm

This submission is concerned with the last question on the 3-page set of questions at the conclusion of the Issue paper for the Review: "Are there any other means of reducing supply in general?"

One of us (Room) is a Professor at La Trobe University and the Director of the Centre for Alcohol Policy Research. Room is a sociologist who has worked in alcohol research for over 50 years. Although he was born and grew up in Australia, much of his career has been overseas: he has worked in the United States, Canada, Norway and Sweden. Much of his attention in his career and in his research work has been on studies of alcohol policies and their effects, and on strategies to reduce rates of alcohol-related harms in a population.

The other of us (Brady) is currently an Honorary Associate Professor in the Centre for Aboriginal Economic Policy Research at the Australian National University, and has recently completed a five-year Australian Research Council QEII Fellowship. Brady is a social anthropologist with a long and multifaceted history of study in alcohol and Indigenous communities, including the responses of the 'mainstream' Australian treatment and legal systems to Indigenous drinking issues. Over the last few years, as part of the ARC-funded research, she has made a study of the 'Gothenburg system' in Australia of community-ownership and operation of alcohol sales premises: these are the closest in Australian history to the monopoly systems discussed in this submission.

Our answer to the question, "Are there any other means of reducing supply in general?", is "yes", and to offer a discussion of a particular strategy for the Territory government to control the supply of alcohol and limit alcohol-related harms. That strategy is for the government to monopolise the retail sale of alcohol for off-premises consumption in the Territory.

There is a long history, stretching back to 1850, of governments monopolising the sale of alcohol because of public health and order concerns. Canada has had provincial monopolies since the early 1920s, and Norway's monopoly dates from the same era. The current monopolies in 18 states of the US mostly date from the repeal of alcohol prohibition in the U.S. in 1933. Sweden has had alcohol monopolies at the community level since 1850; they were consolidated into a national monopoly over 50 years ago.

Australia also has had a history of public alcohol monopolies, but only at the community or municipal level. The history is recounted in a forthcoming book by one of us (Brady), entitled "Teaching 'civilised' drinking? Pubs and Clubs in Indigenous Australia", which is being published by ANU Press. The book covers not only the history of community-operated stores and clubs in Indigenous communities (also discussed in Brady, 2014), but also the history of municipal hotels in towns of the Riverina district of South Australia.

Other than this work by Brady and some essays in local history, there has been little study of the Australian experience. And, as discussed below, with respect to effects on public health and order, the history is mixed – there are lessons to be learned from it.

Particularly in North America and the Nordic countries, there have been substantial studies of the effectiveness of government retail alcohol monopolies. With some conditions discussed below, the general picture is that they are effective as a public health measure, and have a number of advantages over a licence system for off-premise sales (Room, 2000). Here are some of the potential advantages for the Northern Territory:

a. The Territory's management for the monopoly could then set the retail price of off-premise sales without a fuss, just as any retailer does. For instance, it could decide on a minimum price per unit of alcohol, and not sell any beverage for less than that price. Some Canadian provinces do this; this is why the small literature we have on the actual effects of minimum unit pricing is from Canada. In terms of setting a minimum price for alcohol, it is the off-sales which matter, since the lowest on-sale prices will almost always be considerably higher than the cheapest off-sale price.
b. Such a monopoly tends to be quite profitable, even if the retail prices are set no higher than in adjacent jurisdictions with private off-sales. (This is a major factor in the survival of the monopolies in the US, even through a neoliberal era – the state government realises it would lose too much revenue if the monopoly is privatised.) A monopoly system will have a smaller network of stores not competing with each other, and will usually have shorter opening hours. The retail-level profit margin (and potentially also the wholesale-level) will accrue to the Territory. The main aspect which is likely to be more expensive in a government monopoly store system than in private retail is that the employees will tend to be unionised and better-paid (though there will be fewer of them, because of the smaller network and shorter hours).
c. A monopoly system for off-sales would mean that only state employees would have to have access to the electronic records system of the Banned Drinkers Register (BDR), which would be better for privacy.
d. Well-paid government liquor store employees turn out to be much more observant of regulations about not selling to the under-aged, to someone who is already drunk, and presumably to someone on the BDR.

There are lessons from experience overseas (and also from Australian experience with community-level monopolies) concerning how to organise an alcohol monopoly system in the interests of public health and order. A crucial issue is where the system is placed in the government's organisation. The best experience has been to organise it as a freestanding government corporation, with a clear mandate that, while it should provide good service to customers, its priority is to be on maximising the interests of public health and public order. In terms of cabinet responsibility, the corporation should report to a ministry concerned with public health or order – a ministry responsible for health or justice or family welfare. It would be a mistake to place it under the treasury or a ministry of finance. The Australian experience with community-run monopoly stores has been that the effects on health and public order can be adverse if the store is run with a primary goal of raising revenue (see case studies in Brady's book, and more general discussion in Brady, 2014). Even at the state level overseas, there are some problematic monopolies from this perspective. For instance, the New Hampshire state government is recurrently starved for revenue, since it does not collect state income tax or sales tax. As a result, the New Hampshire monopoly is organised to maximise revenues, for instance locating state stores at the boundary with Massachusetts, a much more populous state, to attract purchasers from there.

The issues of which ministry is responsible for the monopoly, and whether and for what purposes its profits are earmarked, are crucial choices in setting up such a monopoly. Another critical question is whether off-sales of all alcoholic beverages are monopolised, or only of some. None of the US state monopolies include beer, since it was argued at the time they were set up that beer was not intoxicating. The Swedish monopoly includes all alcoholic beverages other than beer below 3.5% in strength, which is sold in grocery stores. The Swedish monopoly shops, however, also sell alcohol-free beer, to encourage its choice. The basic public health position now is that for most adverse consequences what matters is the amount of pure alcohol consumed, no matter in what form it comes, so any exclusions from the monopoly system should be carefully considered.

There is substantial historical experience to draw on, particularly from the Canadian and Nordic monopolies, with the operation of individualised controls on purchasing, relevant to the NT's Banned Drinkers Register. Until 1955, for instance, the Swedish system assigned a monthly ration as the maximum that could be purchased by a family, and denied any ration at all to about 10% of the families which applied, on the basis of previous misuse. This required individual-level decisions about and surveillance of particular customers. That the system was effective in holding down consumption by heavy drinkers is shown by the fact that the cirrhosis mortality rose substantially after the rationing system was abolished (Norström, 1987). Individualised controls were mostly abandoned in the monopoly systems on civil-liberties grounds in the later 20th century.

A side-benefit of government alcohol monopoly systems is that they have tended to be much more open than private enterprises to policy impact research, so that there are substantial traditions to draw on of the effects of policy measure taken in monopoly systems (see, for example, the compilation in Room, 2002).

Related to this, but more generally, an important benefit of a government monopoly in this field is that it serves the interests of public health and order by occupying a market position that would otherwise be occupied by interests pushing recurrently towards deregulation. The private interests holding licenses in a licensing system have a permanent interest in gradually reducing the controls, allowing the market to grow (Room, 2001).

The effectiveness of a government monopoly as a prevention strategy. There have been a number of studies of effects relevant to public health of a monopoly versus a licence system for alcohol retailing, and on the basis of them modelling what would happen if a national or state/provincial monopoly system shifted to a licensing system. The results of such modelling are substantial increases in alcohol consumption and rates of alcohol-related problems (e.g., Her at al., 1999; Stockwell et al., 2017). In 2012 the US Centers for Disease Control published a systematic review (Hahn et al., 2012), finding "strong evidence that privatization of retail alcohol sales [replacing a government monopoly] leads to increases in excessive alcohol consumption". There is also evidence from changes in the opposite direction -- of decreases in consumption and alcohol-related health and social problems from monopolisation (e.g., Ramstedt, 2002).

Further information. The U.S. monopolies have an umbrella organization, the National Alcoholic Beverage Control Association (NABCA), http://www.nabca.org/States/States.aspx The Nordic monopolies in the current era are described in Cisneros Örnberg & Olafsdottir (2008).

Both of us would be pleased to provide further information or otherwise assist the Review if that is desired. Brady could arrange for a copy of the typescript of her forthcoming book to be made available to the Review Committee if that was thought desirable.

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