7

Determining patterns of supply and demand

Introduction

7.1 The committee examined the supply of and demand for alcohol in Aboriginal and Torres Strait Islander communities with a particular focus on how the consumption of alcohol varies within and across different communities.

7.2 Patterns of alcohol consumption in Aboriginal and Torres Strait Islander communities are shown to vary significantly by age, gender and location, and differ from those of non-Indigenous people.

7.3 A recurring theme in the evidence presented to the committee was that the lack of accurate and systematic estimates of alcohol consumption in Aboriginal and Torres Strait Islander communities, and more broadly across Australian society, makes it difficult to monitor trends and target strategies to reduce harmful alcohol use.

7.4 This chapter examines a range of methods currently used for estimating alcohol consumption, including wholesale alcohol sales data and national, population-based surveys.

Alcohol consumption

7.5 While the majority of Australians who drink alcohol do so moderately and responsibly, many people consume alcohol at levels that can either cause

them harm over the course of their lifetime, or can increase their risk of harm from a single drinking occasion.[1]

7.6 Across the Australian population, on average one in five adults consumes more than two standard drinks per day on average. This level of consumption is associated with a lifetime risk of harm from alcohol-related disease or injury.[2] The harmful use of alcohol and other drugs is a significant public health problem for the Australian community as a whole and incurs significant economic costs.[3]

7.7 Aboriginal and Torres Strait Islander people are more likely to abstain from drinking alcohol than non-Indigenous people.[4] The *2008 National Aboriginal and Torres Strait Islander Social Survey* (Social Survey)[5] found that more than one third of Aboriginal and Torres Strait Islander adults abstained from drinking alcohol compared with around one eighth of non-Indigenous adults.[6]

7.8 However, Aboriginal and Torres Strait Islander people who do consume alcohol are more likely to drink it at high-risk levels than non-Indigenous people. The 2008 Social Survey found that one in six Aboriginal and Torres Strait Islander adults were drinking at high-risk levels for a long time, referred to as chronic drinking. One third of Aboriginal and Torres Strait Islander adults had reported drinking at high-risk levels over a short time, referred to as binge drinking, in the two weeks before they were interviewed.[7]

7.9 The *Aboriginal and Torres Strait Islander Health Performance Framework* (HPF) monitors progress in Aboriginal and Torres Strait Islander health outcomes, health system performance and the broader determinants of health. The Aboriginal and Torres Strait Islander health performance

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1 According to current guidelines for minimising the risk of harm from drinking alcohol, harmful alcohol use is classified in two ways: lifetime risk, or drinking more than two standard drinks each day on average; and single occasion risk, or drinking more than four standard drinks on a single occasion. See: National Health and Medical Research Council (NHMRC), *Australian guidelines to reduce health risks from drinking alcohol*, 2009, Canberra, pp. 2-3.

2 NHMRC, *Australian guidelines to reduce health risks from drinking alcohol*, 2009, Canberra, pp. 2-3.

3 Aboriginal Drug and Alcohol Council (SA) Inc. (ADAC), *Submission 40*, Attachment 3, p. 2.

4 Australian Institute of Health and Welfare (AIHW), *2013 National Drug Strategy Household Survey (Drug Survey) Detailed Report*, 2014, Drug statistics series no. 28, Cat. no. PHE 183, Canberra, AIHW, p. 94.

5 The 2008 survey is the most recent National Aboriginal and Torres Strait Islander Social Survey (NATSISS) dataset, with the survey being conducted every six years.

6 Australian Bureau of Statistics (ABS), NATSISS: summary booklet, 2008, Canberra

7 ABS, The health and welfare of Australia's Aboriginal and Torres Strait Islander peoples, October 2010, Canberra.

framework: 2012 report provides the most recent report against the HPF, finding that:

- Aboriginal and Torres Strait Islander males and females were hospitalised at four and five times the rate, respectively, of their non-Indigenous counterparts for diagnoses related to alcohol use
- 86 per cent of all hospital episodes for Aboriginal and Torres Strait Islander people relating to alcohol use had a principle diagnosis of mental and behavioural disorders due to alcohol use (including acute intoxication, dependence syndrome and withdrawal)
- Aboriginal and Torres Strait Islander people were hospitalised at six times the rate of non-Indigenous people for alcoholic liver disease, and
- Aboriginal and Torres Strait Islander males and females died at five and eight times the rate, respectively, of their non-Indigenous counterparts from causes related to alcohol use. The greatest causes of death for Aboriginal and Torres Strait Islander people related to alcohol use were:
  - ⇒ mental and behavioural disorders (seven times the rate of non-Indigenous people)
  - ⇒ alcoholic liver disease (six times the rate of non-Indigenous people), and the greatest overall cause of death, and
  - ⇒ alcohol poisoning (five times the rate of non-Indigenous people).[8]

7.10 There is continuing concern in Aboriginal and Torres Strait Islander communities and in the wider community of the serious effect that alcohol is having on many Aboriginal and Torres Strait Islander individuals and communities.

7.11 In considering the evidence on alcohol consumption in Aboriginal and Torres Strait Islander communities, the committee was mindful that there is significant variation both within and between those communities. The committee was careful to ensure that it avoided assumptions about the uniformity of Aboriginal and Torres Strait Islander peoples.

Gender and alcohol consumption

7.12 The Royal Australian College of General Practitioners (RACGP) reports that, in 2012-13, Aboriginal and Torres Strait Islander men were more

8 Australian Health Ministers' Advisory Council (2012) Aboriginal and Torres Strait Islander health performance framework: 2012 report. Canberra: Office for Aboriginal and Torres Strait Islander Health, Department of Health and Ageing, p.105.

likely than women to drink alcohol at levels that increased their risk of harm on a single occasion (64 per cent and 44 per cent respectively).[9]

7.13 While national statistics suggest that in certain communities, the situation is particularly dire, Dr Patricia Miller from the Central Australian Aboriginal Legal Aid Service (CAALAS) comments that, as a consequence of harmful alcohol use:

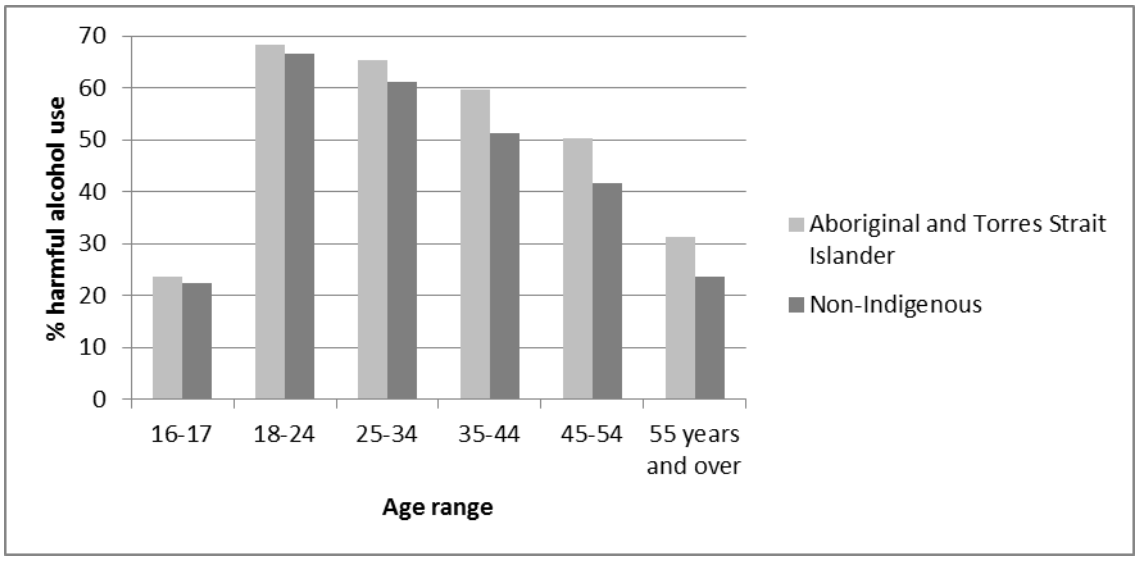
> … we have communities that are actually lacking that middle age group of young men because they are all incarcerated or in hospital, or they have been buried.[10]

Age

7.14 Figure 7.1 shows that across all age groups, Aboriginal and Torres Strait Islander people are more likely to consume alcohol at harmful levels than non-Indigenous people.

7.15 In particular, while young people are most likely to binge drink, more Aboriginal and Torres Strait Islander people continue to drink at harmful levels later in life than non-Indigenous people.

Figure 7.1 The prevalence of harmful alcohol use by age: Aboriginal and Torres Strait Islander and non-Indigenous people.



Source *ABS, National Aboriginal and Torres Strait Islander Health Survey: First Results, 2012-13, 2014, cat. no. 4727.0.55.001.*[11]

9 Royal Australian College of General Practitioners (RACGP), *Submission 82*, p. 2.

10 Dr Patricia Miller, Chief Executive Officer, Central Australian Aboriginal Legal Aid Service (CAALAS), *Committee Hansard*, Alice Springs, 31 March 2014, p. 20.

11 Figures show the proportion of people who consumed alcohol at levels that placed them at risk of harm from a single drinking occasion.

7.16 High rates of binge drinking amongst young Aboriginal and Torres Strait Islander people was raised as a particular issue of concern in a variety of locations. In Sydney, the Aboriginal Medical Service reports that alcohol use among young people is increasing,[12] while at Halls Creek, concerns were raised that binge drinking amongst young Aboriginal and Torres Strait Islander people was being facilitated by alcohol trafficking.[13]

7.17 A Perth study found that while some young participants were able to buy alcohol directly from bottle shops while they were underage, the majority of alcohol the young people consumed was supplied by older relatives and friends, as well as asking strangers outside bottle shops to purchase alcohol on their behalf.[14]

Location

7.18 The most recent *National Aboriginal and Torres Strait Islander Social Survey* (Social Survey) reports that, in 2008, over two-thirds of Aboriginal and Torres Strait Islander people lived outside of major cities. It found that 44 per cent lived in regional areas and 24 per cent lived in remote or very remote areas.[15]

7.19 The Royal Australasian College of Physicians (RACP) notes the relationship between differences in rates of alcohol consumption in Aboriginal and Torres Strait Islander communities and remoteness. It states that while Aboriginal and Torres Strait Islander people in remote areas were more likely to have abstained from alcohol than those in non-remote areas, 38 per cent and 19 per cent respectively, more people in remote areas were likely to drink at levels that increased their risk of harm at least once a week, 23 per cent and 18 per cent respectively.[16]

7.20 The available data indicates that patterns of harmful alcohol use vary greatly both within and between Aboriginal and Torres Strait Islander communities. However, the RACP stressed that caution should be exercised in interpreting survey results because of concerns about the quality of statistical data they contain.[17] The RACP suggests that this

12 Aboriginal Medical Service Redfern, *Submission 119*, p. 1.

13 Ms Alice Wason, *Committee Hansard*, Halls Creek, 2 July 2014, p. 25.

14 Dr Mandy Wilson and Ms Jocelyn Jones, National Drug Research Institute (NDRI), *Submission 118*, pp. 5–6.

15 ABS, *National Aboriginal and Torres Strait Islander Social Survey (Social Survey) 2008*, 2009, cat. no. 4714.0.

16 Royal Australasian College of Physicians (RACP), *Submission 28*, p. 9.

17 RACP, *Submission 28*, p. 8.

'reinforces the need for higher quality, relevant and timely information to be made available to support informed policy decisions'.[18]

Measuring consumption

7.21 The committee heard that estimates of alcohol consumption are currently derived from:

- data collected for the purposes of levying alcohol excise
- information collected from the wholesale sale of alcohol, and
- national surveys.

7.22 Data on alcohol consumption can be an effective method of monitoring changes in drinking behaviour before and after interventions to minimise harmful alcohol use. For example, wholesale alcohol sales data from the Northern Territory demonstrates changes in alcohol consumption following the introduction of a Liquor Supply Plan in Alice Springs in 2006.[19]

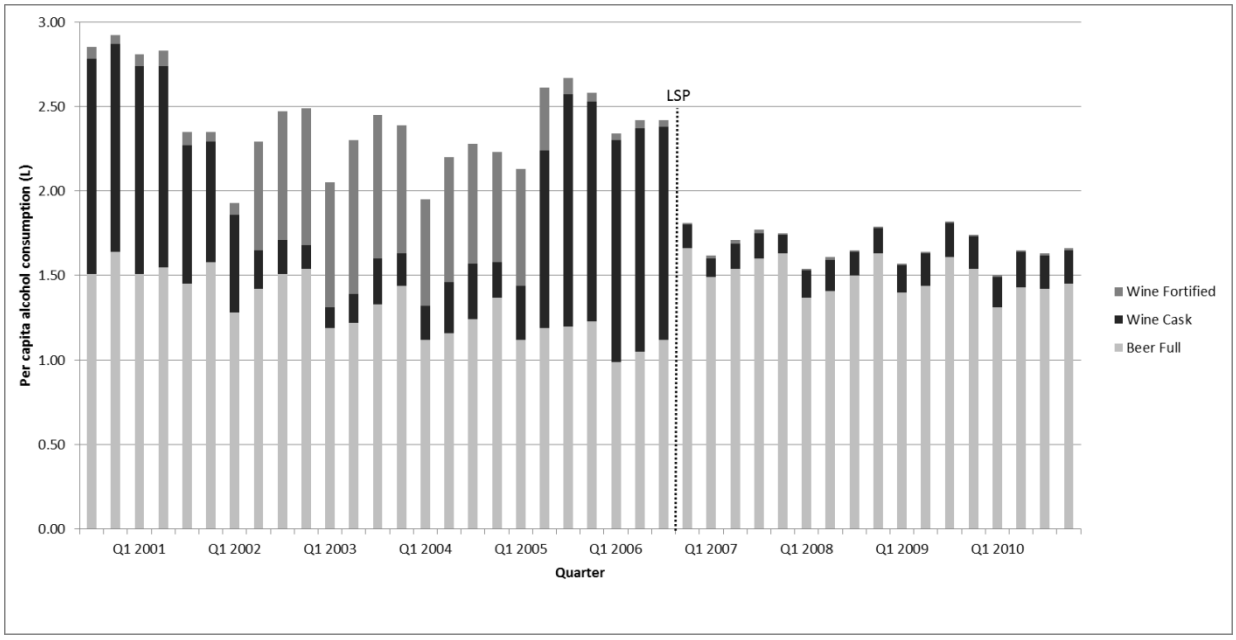
7.23 The Alice Springs Liquor Supply Plan prohibited the sale of table wine in containers larger than two litres and fortified wine in containers larger than one litre. Wholesale sales data indicates that while the Liquor Supply Plan was in operation, there was a reduction in overall alcohol consumption and a significant reduction in consumption of cask table and fortified wine. There was a moderate increase in the consumption of beer.[20] Figure 7.2 illustrates these trends.

18 RACP, *Submission 28*, p. 8.

19 NDRI, *Submission 47*, p. 19. For original study, see: M Symons, D Gray, T Chikritzhs et al, *A longitudinal study of influences on alcohol consumption and related harm in Central Australia: with a particular emphasis on the role of price*, 2012, Perth, NDRI.

20 NDRI, *Submission 47*, p. 19. For original study, see: M Symons, D Gray, T Chikritzhs et al, *A longitudinal study of influences on alcohol consumption and related harm in Central Australia: with a particular emphasis on the role of price*, 2012, Perth, NDRI.

Figure 7.2 The impact of changes to supply on alcohol consumption: the Alice Springs Liquor Supply Plan (LSP)



Source *National Drug Research Institute, Submission 47, p. 19; M Symons, D Gray, T Chikritzhs et al, A Longitudinal Study of Influences on Alcohol Consumption and Related Harm in Central Australia: With a Particular Emphasis on the Role of Price, 2012, National Drug Research Institute, Perth, p. 35.*

7.24 Hospital admissions and police statistics also help to provide a more comprehensive picture of alcohol consumption, however such data is frequently not available.

Current methods

Estimates based on alcohol sales

7.25 In Australia, the total volume of alcohol available for sale to consumers is recorded nationally through the collection of alcohol excise. Excise is a commodity–based tax on alcohol, tobacco and petroleum products that is levied by the Commonwealth.[21] Information collected as part of levying the alcohol excise form the basis of the national Apparent Consumption of Alcohol dataset, which is published by the Australian Bureau of Statistics (ABS).[22]

7.26 The volume of alcohol available for sale by alcohol retailers is recorded in some states and territories in the form of wholesale alcohol sales data.

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21 Australian Taxation Office (ATO), *Excise and excise equivalent goods*, 2014, < https://www.ato.gov.au/ Business/Excise-and-excise-equivalent-goods/> viewed 3 November 2014.

22 ABS, Apparent Consumption of Alcohol, Australia 2012-13, *Explanatory Notes*, cat. no. 4307.0.55.001.

Both the National Drug Research Institute (NDRI) and the Foundation for Alcohol Research and Education (FARE) observe that alcohol wholesale sales data is an important source of information for monitoring alcohol consumption and the impact of public health measures to limit alcohol supply and associated harm.[23] The NDRI further highlights that wholesale sales data enables the identification of regional and local patterns of consumption.[24]

7.27 Unfortunately, across Australia wholesale alcohol sales data is not uniformly collected.[25] The NDRI highlights that, prior to 1997, all state and territory jurisdictions recorded information on the wholesale sales of alcohol products as a basis for imposing liquor franchise (license) fees.[26] After a High Court of Australia ruling in 1997 several jurisdictions, including New South Wales, South Australia and Victoria, stopped collecting wholesale alcohol sales data.[27]

Limitations of consumption data

7.28 A range of limitations were identified in the ways that alcohol consumption is currently estimated through the collection of information through excise and wholesale sales.

7.29 While the Apparent Consumption of Alcohol dataset may be a useful estimate of alcohol consumption on a national level, it is of limited use as a public health planning tool.[28] The People's Alcohol Action Coalition (PAAC) stresses the need for a combination of comprehensive wholesale alcohol sales data and data on alcohol-related harms to 'allow for targeting of effort at areas of most need as well as ongoing, routine monitoring of the effect of programs and policies aimed at reducing alcohol-related harm'.[29]

7.30 Wholesale sales data is currently not collected in all jurisdictions. FARE asserts that the collection and publication of wholesale alcohol sales data should include postcode data and this information should be collected at

23 NDRI, *Submission 47*, p. 4; Foundation for Alcohol Research and Education (FARE), *Submission 83*, p. 8.

24 NDRI, *Submission 47*, p. 4.

25 Wholesale alcohol sales data is currently collected in Western Australia, Queensland, the Northern Territory and the Australian Capital Territory; it is not collected in New South Wales, Victoria, South Australia and Tasmania. NDRI, *Submission 47*, p. 4.

26 NDRI, *Submission 47*, p. 4.

27 NDRI, *Submission 47*, p. 4.

28 RACP, *Submission 28*, p. 31. The NDRI notes this is because the dataset cannot be broken down by location or by population characteristics. See: NDRI, *Submission 47*, p. 4.

29 People's Alcohol Action Coalition (PAAC), *Submission 7.1*, p. 3.

least annually, be publically available, and mandatory for all states and territories.[30]

7.31 FARE calls for the alcohol industry to play a more proactive role in the provision of data about alcohol supply volumes and practices, particularly in relation to supply to 'Aboriginal and Torres Strait Islander communities and nearby regions given the disproportionate levels of harm evidenced'.[31]

7.32 The PAAC observes that other sources of data, such as alcohol-related hospitalisations and mortality rates, shows there is significant regional variation in alcohol consumption in Aboriginal and Torres Strait Islander communities that are not adequately captured using currently–available estimates.[32]

National surveys

7.33 Currently, three national surveys collect information about alcohol consumption in Aboriginal and Torres Strait Islander communities:

- the *National Drug Strategy Household Survey* (Drug Survey)[33]
- the *National Aboriginal and Torres Strait Islander Social Survey* (Social Survey),[34] and
- the *National Aboriginal and Torres Strait Islander Health Survey* (Health Survey).[35]

7.34 While the Drug Survey, Social Survey and Health Survey complements sales data, these surveys have limitations.[36] The PAAC states that such surveys are infrequent, tend to underestimate consumption, and do not obtain adequate information from Aboriginal and Torres Strait Islander people about their drinking.[37]

7.35 The Australian Institute of Health and Welfare (AIHW) reports that while the Drug Survey was designed to estimate drug and alcohol use nationally, it was not specifically designed to obtain reliable estimates for Aboriginal and Torres Strait Islander people's drug and alcohol use.[38] The AIHW therefore stresses the need for caution in interpreting estimates of

30 FARE, *Submission 83*, p. 8.
31 FARE, *Submission 83*, p. 19.
32 PAAC, *Submission 7.1*, p. 6.
33 AIHW, *2013 Drug Survey Detailed Report*, 2014, Drug statistics series no. 28, Canberra, AIHW.
34 ABS, *NATSISS 2008*, 2009, cat. no. 4714.0.
35 ABS, *NATSIHS 2012–13*, 2014, cat. no. 4727.0.55.001.
36 PAAC, *Submission 7.1*, p. 7; RACP, *Submission 28*, p. 31; NDRI, *Submission 47*, p. 7.
37 PAAC, *Submission 7.1*, p. 7.
38 AIHW, *Submission 19*, p. 3.

alcohol consumption based on the Aboriginal and Torres Strait Islander population group in the Drug Survey.[39]

7.36 The NDRI notes that neither the Social Survey nor the Health Survey conforms to recommendations made by the World Health Organisation (WHO) for eliciting responses about alcohol consumption.[40] The PAAC asserts that both the Social Survey and the Health Survey need to be upgraded to follow the methodology established by the WHO.[41]

7.37 The Department of the Prime Minister and Cabinet (PM&C) states:

> … the main source of alcohol use prevalence estimates are from national surveys. It is well understood that these surveys tend to under report the prevalence of alcohol usage and they do not capture variations in consumption for specific communities.[42]

7.38 A supplement to the 1994 Drug Survey was identified as an example of best practice in the conduct of surveys relating to alcohol consumption in Aboriginal and Torres Strait Islander communities.[43] The PAAC refers to the survey as the most comprehensive of its type conducted on Aboriginal and Torres Strait Islander alcohol and drug consumption.[44]

7.39 Professor Dennis Gray from the NDRI observes that the 1994 survey was both unique and important because it distinguished between people who have never consumed alcohol and people who previously drank and no longer do. Professor Gray also notes that the 1994 survey had a large Aboriginal and Torres Strait Islander sample, in contrast to more recent Drug Survey.[45]

7.40 The NDRI asserts that in order for alcohol trends to be better tracked and interventions targeted more effectively, similarly comprehensive data that was elicited by the 1994 survey needs to be collected on a regular basis.[46]

7.41 Similarly, the PAAC recommends that either:

- the 1994 survey be replicated and conducted on a regular basis, or

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39 AIHW, *Submission 19*, p. 3.

40 NDRI, *Submission 47*, p. 7; See: World Health Organization (WHO), *International Guide for Monitoring Alcohol Consumption and Related Harms*, 2000, pp. 56–8.

41 PAAC, *Submission 7.1*, p. 7.

42 Department of Prime Minister and Cabinet (PM&C), *Submission 102*, p. 11.

43 NDRI, *Submission 47*, p. 7; PAAC, *Submission 7.1*, p. 7; Professor Dennis Gray, Deputy Director, NDRI, *Committee Hansard*, Perth, 30 June 2014, p. 15; See: Department of Human Services and Health, *National Drug Strategy Household Survey: Urban Aboriginal and Torres Strait Islander Supplement 1994*, 1996, Canberra, Australian Government Publishing Service.

44 PAAC, *Submission 7.1*, p. 7.

45 Professor Gray, NDRI, *Committee Hansard*, Perth, 30 June 2014, p. 15.

46 NDRI, *Submission 47*, p. 7.

- the relevant sections on alcohol consumption in the regular surveys be upgraded.[47]

Conclusion

7.42 The committee observes that patterns of alcohol consumption in Aboriginal and Torres Strait Islander communities vary significantly according to location. The committee is aware that people living in very remote communities may be less likely to consume alcohol at harmful levels compared to those in regional and remote areas.[48] However, the committee also notes concerns about the quality of available data, and remains cautious about drawing conclusions about regional differences.

7.43 The committee sees benefit in further research being conducted to identify these regional differences and the reasons why patterns of alcohol consumption in Aboriginal and Torres Strait Islander communities vary considerably according to degrees of remoteness.

7.44 Issues of data quality and the need for caution in interpreting statistics about alcohol consumption in Aboriginal and Torres Strait Islander communities were reiterated throughout the inquiry.[49]

7.45 With better data, Aboriginal and Torres Strait Islander communities can develop strategies that may be better targeted, monitored and evaluated.

7.46 The committee is concerned that despite there being three national surveys that collect information about alcohol use, the only example of a comprehensive survey of alcohol consumption amongst Aboriginal and Torres Strait Islander people was a one-off survey conducted in 1994, 21 years ago.

7.47 The Drug Survey was not designed to provide a reliable estimate of Aboriginal and Torres Strait Islander people's drug and alcohol use. The committee regards this as a serious oversight that should be corrected prior to the conduct of the 2017 Drug Survey.

47 PAAC, *Submission 7.1*, p. 7.

48 ABS, *Health Survey 2012–13*, 2014, cat. no. 4727.0.55.001.

49 AIHW, *Submission 19*, p. 3; PAAC, *Submission 7.1*, p. 7; RACP, *Submission 28*, p. 31; NDRI, *Submission 47*, p. 7.

Recommendation 22

7.48 **That the Australian Institute of Health and Welfare review and update the methodology and instrument of the National Drug Household Survey to obtain reliable estimates on Aboriginal and Torres Strait Islander and non-Indigenous illicit drug and alcohol use. These changes should be implemented for the conduct of the 2017 survey.**

7.49 Both the Social Survey and Health Survey should be comprehensively reviewed so there is improved data collection relating to alcohol consumption. This should be done in cooperation with Aboriginal and Torres Strait Islander stakeholders.

Recommendation 23

7.50 **That the Australian Bureau of Statistics conducts a review of the relevant sections of the National Aboriginal and Torres Strait Islander Social Survey and the National Aboriginal and Torres Strait Islander Health Survey to ensure international best practice is adopted in the instrument and conduct of surveys on alcohol consumption.**

7.51 The committee believes the scope of the work being done in the Aboriginal and Torres Strait Islander controlled health organisations needs to be recorded and be available to inform future decisions.

7.52 These organisations are often the organisations that can facilitate treatment for those who consume alcohol at harmful levels and their insight and information on the trends and harms of alcohol use are highly valuable and should be captured.

7.53 The committee is of the view that all medical services that provide treatment for Aboriginal and Torres Strait Islander people should collect data on trends and harms of alcohol use as a routine element of their work.

Demand – why do people drink to harmful levels?

7.54 As with other products that people consume, the demand for alcohol is related to a range of factors, including the price, desirability and access or

availability of alcohol products. However, alcohol is unlike many other commodities because of its capacity to cause addiction and harm.[50]

7.55 Evidence to this inquiry has shown that some individuals will continue to drink to excess regardless of changes to alcohol supply. For example, where alcohol restrictions are introduced, people who misuse alcohol may simply relocate to another location to continue drinking.[51] Reducing the demand for alcohol therefore means addressing the reasons why some individuals consume alcohol at harmful levels.

7.56 The committee heard that for Aboriginal and Torres Strait Islander people who drink to excess, their demand for alcohol is a response to a range of social and economic determinants, including poor physical and mental health, a lack of educational and employment opportunities, boredom, experiences of racism and trauma, cultural acceptance of heavy drinking as a norm, a lack of connection to family, and a loss of community, culture and country.[52] These determinants are examined in detail in Chapter 1.

7.57 The National Drug Strategy 2010 – 2015 has three pillars of the Australian Harm Minimisation approach: demand reduction, supply reduction and harm reduction. The National Drug Strategy considers four key elements for demand reduction are:

- 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, and
- support efforts to promote social inclusion and resilient individuals, families and communities.[53]

50 Mr Michael Thorn, Chief Executive, FARE, *Committee Hansard*, Canberra, 28 August 2014, p. 3. See also: T. F. Babor, R. Caetano, S. Casswell, G. Edwards et. al., *Alcohol: No Ordinary Commodity. Research and Public Policy*, 2010, Oxford University Press, New York.

51 NIDAC, *Submission 94*, Attachment 6, p. 14; Professor Marcia Langton, Dr Richard Chenhall and Ms Kristen Smith, University of Melbourne, *Submission 44*, p. 7.

52 Nepean Community & Neighbourhood Services (NCNS), *Submission 122*, p. 1. See also: AIHW, *What works? A review of actions addressing the social and economic determinants of Indigenous Health*, 2013, pp. 4-9.

53 Ministerial Council on Drug Strategy, *National Drug Strategy 2010–2015*, February 2011, p. ii.