CHAPTER 2

Background to the inquiry

2.1 Risky and high risk drinking by young people and underage drinkers has become a major public health issue. A number of studies show an increase in regular risky drinking in these age groups in recent years, and in particular, for young women. The Minister for Health and Ageing told Parliament '20 000 young women under 15 every week are now drinking to risky levels'.[1]

2.2 The community is understandably concerned due to the greater vulnerability that adolescents and young people have to alcohol in terms of its effect on their development, lack of experience of drinking and the increased likelihood to engage in risky behaviour.

2.3 Data over recent years has also highlighted the rise in popularity and influence of pre-mixed alcohols, known as ready-to-drinks (RTDs) or 'alcopops' (see terminology below), on teenage alcohol use, particularly for females. Specific data on consumption patterns is introduced in this chapter. The Minister for Health and Ageing spoke about concerns regarding the consumption of 'alcopops' by young people:

> We believe that binge drinking is a community wide problem and deserves a community wide response. We think that young people are particularly at risk and we know that alcopops are used to hook them on drinking when they are young.[2]

2.4 The Australian Drug Foundation summarised the major concerns with RTDs:

> RTD beverages are of particular concern to our organisations because they are the most popular alcoholic beverage, and the most common first-used alcoholic beverage, among younger age groups. RTDs are the preferred drink for young people who drink at risky levels.[3]

2.5 Additional concerns regarding RTDs include that some disguise the taste of alcohol more than others, making them easy to drink and appeal to young people with sweet and fizzy drinks. The Minister for Health and Ageing told Parliament:

> …research shows that many young people cannot detect the taste of alcohol when it is combined with either sweet mixes or milk, which we know is

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1 The Hon Nicola Roxon MP, Minister for Health and Ageing, *House of Representatives Hansard*, 14 May 2008, p. 62.

2 The Hon Nicola Roxon MP, Minister for Health and Ageing, *House of Representatives Hansard*, 14 May 2008, p. 61.

3 Australian Drug Foundation, *Submission 28*, p. 2.

exactly how these products are used to get young people interested in drinking and hooked for a long time.[4]

2.6 Drug Awareness (NSW) agreed that 'alcopops' are designed to entice underage drinkers who do not like the taste of alcohol to start drinking as the alcohol taste is masked.[5] A consumer survey by *Choice* found participants had difficulty detecting alcohol in unmarked drinks. A survey of 18 and 19 year olds found that only 69 per cent thought the 'alcopops' contained alcohol, compared with 100 per cent correctly identifying the beer and wine as alcoholic drinks. *Choice* noted that this survey was of 18 and 19 year olds with some drinking experience and suggested that younger drinkers would find it more difficult to detect alcohol.[6]

2.7 Another concern with RTDs was noted by the Australian Drug Foundation that many premixed spirits now contain seven per cent alcohol by volume which makes them attractive to young people who are drinking to get drunk.[7]

2.8 Before embarking on an investigation of alcohol and RTD consumption patterns, the evidence provided to the inquiry and the issues raised, the report will firstly define a few key terms.

Terminology used in the report

Young people

2.9 For the purposes of this report, a young person is defined as being between 12 and 25 years of age. As this range spans several years, the report will break this range down where possible, particularly when referring to underage drinking.[8]

RTDs and alcopops

2.10 Diageo, the largest spirits and RTD producer in Australia, noted there is no clear definition of the term 'alcopop' and that the term RTD covers any pre-mixed beverage which includes: spirit-based RTDs; cider; fruit flavoured wines; and fruit flavoured beers.[9] There is also a distinction made between dark spirit-based RTDs

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4 The Hon Nicola Roxon MP, Minister for Health and Ageing, *House of Representatives Hansard*, 14 May 2008, p. 61.

5 Drug Awareness (NSW), *Submission 4*, p. 1.

6 Information available at: http://www.choice.com.au/viewArticle.aspx?id=106195&catId=100514&tid=100008&p=2&title=Alcopops accessed on 3 June 2008.

7 Australian Drug Foundation, *Submission 28*, p. 2. As a comparison, full-strength beer is any product above 4.65% alcohol by volume

8 The legal age permitting the consumption of alcohol in Australia is 18.

9 Diageo, *Submission 29*, p. 5.

(such as whisky, rum and bourbon) preferred by males and light spirit-based RTDs (such as vodka, gin and white rum) preferred by females.[10]

2.11 The Committee acknowledges that RTDs are commonly known as 'alcopops' and that the general understanding of the term is a premixed drink which is part spirit or wine and part non-alcoholic drink such as milk or soft drink. This report will use the term 'alcopop' to refer to the spirit-based RTDs, which are the subject of the tax increase, but reference to particular RTDs will be clarified as necessary. RTDs cannot exceed 10 per cent alcohol by volume.

Harmful consumption of alcohol

2.12 The Australian Institute of Health and Welfare (AIHW) does not support the term 'binge drinking' as there is no agreed definition and it can mean excessive consumption on a single drinking occasion or a prolonged period of drinking. Their preference is for the use of the language in the National Health and Medical Research Council (NHMRC) guidelines regarding risky and high risk drinking, as 'binge drinking' is typically thought to mean consumption which is risky or high risk for short-term harm.[11] The report will therefore use this terminology where relevant, acknowledging that while 'binge drinking' is a commonly used term it is avoided in official publications as ill-defined and unclear.

Guidelines for alcohol consumption

2.13 The 2001 guidelines for alcohol consumption by the NHMRC are currently under review. They define a 'standard drink' as containing 10 grams or 12.5 millilitres of alcohol.[12] NHMRC advised the Committee that the 2001 NHMRC *Australian alcohol guidelines: health risks and benefits* are being revised to reflect new evidence regarding health effects of alcohol. The draft guidelines (renamed the *Australian alcohol guidelines for low-risk drinking*) now contain a proposed guideline for 'low-risk' drinking that is lower than the levels recommended in 2001. The submission noted that the guidelines provide an overarching guideline:

> of two standard drinks or less for men and women in any one day for low-risk of both immediate and long term harm from drinking.[13]

2.14 NHMRC noted that the above guideline also covers young people from 18 to 25 years of age but there is also a specific guideline for young people under 18 years of age stating that 'not drinking is the safest option'. This guideline is based on

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10 DSICA, *Submission 27*, p. 9.

11 AIHW, *Submission 23*, p. 6.

12 National Health and Medical Research Council, Australian Alcohol Guidelines: Health Risks and Benefits, October 2001, p. 5. Information available at: http://www.alcoholguidelines.gov.au/internet/alcohol/publishing.nsf/Content/standard accessed on 28 May 2008.

13 NHMRC, *Submission 17*, p. 2.

evidence about developmental damage to the brain and long term harm to young people as a result of alcohol.[14] The guidelines note:

> …both young people under 18 years of age and young adults up to the age of 25 continue to be greater risk takers than older adults, but still have poorly developed decision-making skills, which are reflected in the high levels of injuries sustained in these groups. Alcohol affects brain development in young people thus drinking, particularly 'binge-drinking', at any time before brain development is complete (which is not until around 25 years of age) may adversely affect later brain function.[15]

2.15 In response to questions at the hearing on the draft guidelines, the NHMRC responded:

> The costs over and above that—the kinds of social costs, which are incredibly large—are beyond even the reach of this set of guidelines. While a number of people may say the guidelines seem very harsh, others from the social capital group would say, 'You are lenient.' We steer a course which is very much one of: here are the facts; we have looked at them; we have analysed them in as many ways as we can. I think it is interesting that what constantly comes up is the figure that above two drinks the risks escalate—not just for accident and injury but also for death. So there are biological mechanisms all coming together.[16]

2.16 The Australian Medical Association (AMA) noted that excess alcohol consumption is 'an issue of public health significance leading to an unacceptably high level of sickness and social disruption'. They added that the drinking behaviour of teenagers and adolescents was of particular concern as:

- young people were often involved in risk taking behaviours with little understanding of the potential effects of these choices;
- teenagers and adolescents were inexperienced with drinking and were at an earlier stage of brain and body development; and
- there was evidence that early onset of drinking was associated with long term alcohol consumption levels into adulthood.[17]

2.17 Based on the above findings, the AMA concluded that any level of risky drinking behaviour by teenagers and adolescents was problematic.[18]

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14 NHMRC, *Submission 17*, p. 2.

15 NHMRC, *Submission 17*, p. 2.

16 Professor John Currie, *Proof Committee Hansard*, 12 June 2008, p. CA95.

17 AMA, *Submission 33*, pp 2–3.

18 AMA, *Submission 33*, p. 3.

2.18 The vulnerability of young people was supported by Professor Ian Webster, Alcohol Education and Rehabilitation (AER) Foundation, who told the Committee there were a range of vulnerabilities:

> They are vulnerable in the sense that they can be persuaded or affected in their behaviour by a range of pressures from advertising and peers. They are vulnerable in the sense that their psychological processes are still developing, their social development is still taking place and their educational development is still taking place. We have increasing evidence, and I have no doubt you have had some of that before you, about the neurobiology of the brain and the degree to which that can be affected by alcohol and for that matter other drugs. So that is an important area for our society and governments in particular to be responding to, because the young are the future and, as I have said, they are highly vulnerable.[19]

The changes to the alcohol excise regime

2.19 On 27 April 2008 the tax rate applying to alcohol known as 'other excisable beverages not exceeding 10 per cent by volume of alcohol' ie. RTDs, was increased from $39.36 to $66.67 per litre of alcohol. Prior to 27 April 2008, RTDs were taxed at the same rate as full strength beer, although in comparison to beer, RTD products did not receive an exemption on the first 1.15 points of alcohol by volume.[20]

2.20 The government says that this measure closes a loophole created in 2000 with the introduction of the GST which made RTDs cheaper than if consumers bought the spirits and mixed them themselves. The excise increase means that RTDs are now taxed at the same volumetric rate as bottled spirits, so that now consumers buying spirits and a cool drink and mixing them themselves can do so more cheaply than if they buy pre-mixed RTDs.

2.21 The Minister for Health and Ageing noted that the Government had:

> moved to close the previous tax loophole on ready-to-drink products. This was a loophole that was opened up in 2000 by the previous government. It is a loophole that makes no sense because it treats alcopops differently to other spirits and it has led to an explosion in young women in particular drinking these products.[21]

2.22 On 13 May 2008, the Minister for Health and Ageing tabled Excise Tariff Proposal (No.1) 2008 and Customs Tariff Proposal (No.1) 2008 which contained alterations to the *Excise Tariff Act 1921* and *Customs Tariff Act 1995*. The proposals

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19 Professor Ian Webster, *Proof Committee Hansard*, 11 June 2008, p. CA27.

20 Treasury Executive Minute dated 14 May 2008 'Information paper on the costing of the impact of the increase in excise on 'other excisable beverages', tabled by the Minister for Health and Ageing in the House of Representatives on 15 May 2008.

21 The Hon Nicola Roxon MP, Minister for Health and Ageing, *House of Representatives Hansard*, 14 May 2008, pp 61–62.

formally placed before Parliament changes to both acts to increase the rate of excise and customs duty applying to 'other excisable beverages not exceeding 10 per cent by volume of alcohol' on and from 27 April 2008.[22]

2.23 Under the new tax regime, RTD drinkers will, by 2011–12, pay roughly the same total amount of excise as beer drinkers. The Government advised that this measure will result in an estimated gain to revenue of approximately $3.1 billion over the forward estimates period.[23]

2.24 This measure has raised the question of whether a price rise can be expected to improve the public health outcomes related to harmful alcohol consumption. This question is addressed below and in chapter three.

Treasury modelling

2.25 On 15 May 2008, Treasury modelling was tabled by the Minister for Health and Ageing which assumed a four per cent slowdown in RTD sales resulting in a reduction of growth by 42.7 million 375ml bottles in 2008–09. The financial implications provided by Treasury show the corresponding revenue would be $640.1 million in 2008–09.[24]

2.26 At Senate Budget Estimates, Treasury officials noted that their task was to estimate the impact of the policy on the budget. Officials noted the key assumption they made was the price elasticity of demand for RTDs and they used a known price elasticity of demand at minus 0.4 which was derived from a number of academic studies in Australia and overseas on the price elasticity demand for alcohol.[25]

2.27 Submissions from industry questioned the assumptions used by Treasury in the modelling and suggested the estimates of the revenue may be overstated by as much as 40 per cent.[26] Submissions also noted that the Treasury modelling assumed zero substitution of other alcohol products.[27]

2.28 In response to questions on the assumed zero substitution at Senate Estimates, Treasury officials argued that with different alcoholic beverages some are substitutes

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22 The Hon Nicola Roxon MP, Minister for Health and Ageing, *House of Representatives Hansard*, 13 May 2008, p. 45.

23 The Hon Nicola Roxon MP, Minister for Health and Ageing, *House of Representatives Hansard*, 13 May 2008, p. 45.

24 Treasury Executive Minute dated 14 May 2008 'Information paper on the costing of the impact of the increase in excise on 'other excisable beverages', tabled by the Minister for Health and Ageing in the House of Representatives on 15 May 2008.

25 Mr Nigel Ray, Acting Executive Director, *Estimates Hansard*, 3 June 2008, p. E50.

26 Independent Distillers Australia, *Submission 22*, p. 2.

27 DSICA, *Submission 27*, p. 42.

and some are complements and there was no evidence that substitution effects would dominate.

> When you look at relevant studies in this area you will find that some of them have positive cross-price elasticities and some of them find negative cross-price elasticities and that is because of the pattern of the relationship between different alcoholic beverages – some are substitutes and in some circumstances they are complements – and on balance we did not have a reasonable reason to move away from zero.[28]

Conclusion

2.29 The Committee notes that Treasury declined to provide a submission to the inquiry, so further discussion on the modelling and assumptions is not possible. However, the Committee also notes that the Treasury modelling was done to estimate the effect of the measure on the budget and the question of revenue is not central to the inquiry. The measure had already been announced in response to health evidence from researchers, health and medical professionals. The health evidence is addressed in chapter three and the issue of substitution is addressed in chapter four.

Responsiveness to price

2.30 In a speech to the National Press Club, The Treasurer, Mr Wayne Swan said the measure had been introduced to target teenage consumption of the drinks. 'And all of the medical evidence and all of the behavioural evidence indicates that they are responsive to price'.[29]

2.31 The link between increasing price and lowering consumption was supported by a number of organisations. Overseas experiences are outlined in chapter three. Drug Awareness (NSW) noted there is substantial research to show that the sale of alcohol is price responsive.[30] The Chief Executive Officer of the Alcohol Education and Rehabilitation Foundation (AER), Mr Daryl Smeaton has stated:

> International evidence demonstrates that taxing alcopops at the same rate as bottled spirits will change the consumption patterns amongst young people and lead to less alcohol-related harm. AER has economic modelling data which demonstrates that young binge-drinkers prefer to drink Ready-to-Drink (RTD) spirits because they offer the most alcohol for the cheapest price. As the National Household Drug Survey shows, teenagers and teen girls, especially are exploiting this loophole to binge drink with alarming regularity.[31]

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28 Mr Nigel Ray, *Estimates Hansard*, 3 June 2008, p. E52.

29 Michelle Gratton and Tim Colebatch, 'Opposition threatens to block alcopop tax rise', *The Age*, 15 May 2008, p. 1.

30 Drug Awareness (NSW), *Submission 4*, p. 1.

31 Media Release, The Alcohol Education and Rehabilitation Foundation, 'AER welcomes Alcopop tax as first step towards a fairer alcohol taxation system', 27 April 2008.

2.32 The Royal Australasian College of Physicians (RACP) also noted that tax and price controls were among the most effective and cost-effective strategies to reduce rates of alcohol consumption and harm and could have a profound and rapid effect. They pointed to the conclusions from a number of studies which found that, while the effect varied for different countries and beverages, no other single policy had the same potential to reduce the social, health and economic costs of excess alcohol use as much as alcohol taxation.[32]

2.33 The Australian Drug Foundation (ADF) agreed there was strong evidence that the use of pricing and taxation to increase the real price of alcohol was one of the most effective strategies to influence alcohol consumption, particularly among young and heavy drinkers.[33]

2.34 The National Drug Research Institute (NDRI) asserted that even small price changes had an effect on reducing alcohol consumption. Furthermore, that evidence indicated high risk populations such as young people were sensitive to price changes.[34]

2.35 The AER noted that studies in Australia and overseas showed that consumers with a greater propensity to drink at risky levels were more price sensitive than moderate drinkers.[35] However, they pointed out the potential for consumers to swap to other alcohol products and this is addressed in chapter four.

2.36 The Australian General Practice Network (AGPN) also supported the measure and indicated that higher priced alcohol was associated with per capita decline in consumption and 'in particular, younger people and those who drink at risk levels were sensitive to price changes'.[36] Ms Kate Carnell, AGPN Chief Executive Officer, stated:

> There is starting to be some evidence—I accept comments that were made earlier that there is no definitive evidence yet—that we are seeing a change in the sorts of drinking that young people are engaging in based upon the price of the particular beverage.[37]

2.37 The AGPN cautioned that the tax should be carefully regulated to ensure it kept ahead of increases in disposable income.[38]

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32 Royal Australasian College of Physicians, *Submission 25*, p. 2.

33 Australian Drug Foundation, *Submission 28*, p. 3.

34 National Drug Research Institute, *Submission 15*, p. 5.

35 AER, *Submission 14*, p. 1.

36 AGPN, *Submission 11*, p. 5.

37 Ms Kate Carnell, *Proof Committee Hansard*, 12 June 2008, p. CA23.

38 AGPN, *Submission 11*, p. 5.

2.38 The AMA supported the measure and also noted long term research conducted in many countries indicating that alcohol behaved like other commodities and was responsive to changes in price. In particular the AMA quoted the British Medical Association which concluded that 'the relationship between the affordability of alcohol and the level of consumption provides an effective tool for controlling levels of consumption and reducing levels of alcohol-related harm'.[39]

2.39 The National Drug and Alcohol Research Centre believed that the excise increase was likely to arrest the increase in RTD sales. While they questioned whether this would reduce overall rates of risky consumption, they noted:

> This does not indicate, however, that the Government's decision was wrong: going part of the way is not the same as going the wrong way.[40]

2.40 Professor Robin Room, Alcohol and other Drugs Council of Australia, told the Committee that:

> …we find in the literature that there is some responsiveness to price. It is not a perfect responsiveness across the whole drinking spectrum. Obviously someone who has less money in their pocket will be more affected by price than someone who has a lot of money in their pocket. In particular, teenagers and the marginalised heavy drinkers are both quite responsive to price against a lot of assumptions, simply because they lack the resources.[41]

2.41 Professor Steve Allsop from the NDRI told the Committee:

> Alcohol availability of course can be influenced particularly by price and, by inference, tax… It is probable, based on other evidence, that the recent increase in tax for RTDs will place downward pressure on consumption...[42]

2.42 In their submission the Department of Health and Ageing noted that there was clear domestic and international evidence that price levels could be employed to reduce alcohol consumption.[43] The Department referred to evidence and reported that even with substitution, overall alcohol consumption was still lowered and high risk groups such as heavy drinkers and young people appeared to be price sensitive. The Department concluded:

> Alcohol taxes are capable of being designed explicitly to target the types of alcohol known to be the subject of abuse and to discriminate in favour of types associated with lower levels of abuse. Given that young people are more influenced by the price of alcohol, increasing the tax rate on alcoholic

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39 AMA, *Submission 33*, p. 4.

40 Christopher Doran and Anthony Shakeshaft, 'What price for public health: using taxes to curb drinking in Australia, National Drug and Alcohol Research Centre, University of NSW, *The Lancet*, June 2008, p. 4. Tabled by NDARC at the 11 June 2008 hearing.

41 Professor Robin Room, *Proof Committee Hansard*, 11 June 2008, pp CA7–8.

42 Professor Steve Allsop, *Proof Committee Hansard*, 12 June 2008, p. CA59.

43 Department of Health and Ageing, *Submission 35*, p. 3.

> drinks which are specifically targeted at the youth market (for example, ready to drink alcohol products) is likely to be effective.[44]

2.43 At the hearing the Department of Health and Ageing told the Committee there was a good body of evidence which looked at the effect of price increases on consumption and which generally found that:

> Particularly for price-sensitive groups like young people…that an increase in the price of an alcoholic product will lead to a decrease in consumption. The studies also acknowledge that there is a degree of substitution–that, once the price of a preferred product goes up, some groups will switch to a different brand or type of product that is cheaper. But the general conclusion from the evidence seems to indicate that overall, taking into account substitution, consumption levels are lower than the sort of baseline data.[45]

Conclusion

2.44 The Committee notes that although there is some discussion about the precise degree of the responsiveness of alcohol consumption to price there is substantial evidence to indicate that alcohol behaves like other commodities and consumption is responsive to price, particularly among young and heavy drinkers. The Committee accepts that the price of alcohol affects consumption. The data supporting the measure and a summary of findings from overseas are addressed in chapter three.

Consumption patterns since excise increase

2.45 Data released by the Distilled Spirits Industry Council of Australia (DSICA) on 29 May 2008, drawn from the latest Nielson ScanTrak survey of liquor retailers and independent bottle shops, reported that sales of 'alcopops' fell by almost 40 per cent in the fortnight after the tax increase. However, they noted that these figures had been offset by a 20 per cent increase in spirit sales. The data reported that sales of dark-spirit alcopops (mixing scotch, rum and bourbon with cola), favoured by males over the age of 25 dropped by 39 per cent, indicating that older male drinkers were being affected by the policy aimed at teenagers. The light-spirit drinks (containing vodka, gin and white rum) preferred by females dropped by 37 per cent.[46]

2.46 The media noted that DSICA reported:

> Not only have consumers simply substituted full-strength spirits for RTDs, the real problem is that self-mixing drinks makes it near impossible to know how much alcohol is being served and consumed.[47]

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44 Department of Health and Ageing, *Submission 35*, p. 6.

45 Ms Virginia Hart, Assistant Secretary, Drug Strategy Branch, *Proof Committee Hansard*, 12 June 2008, p. CA87.

46 DSICA, *Submission 27*, p. 9.

47 Ben Packham, 'Pre-mixed down, but spirits up', *Herald Sun*, 29 May 2008, p. 19.

2.47 Regarding these and similar short-term findings, the Public Health Association of Australia (PHAA) cautioned that there was a risk in taking short-term findings and using them to make long-term decisions. However, they noted that the very early indications were that this approach was effective in reducing introduction to alcohol among young women and arresting growth in RTD sales, but urged follow-up research.[48]

Conclusion

2.48 The Committee notes the figures released by the DSICA on the sales of RTDs cover a very short period only and believes this period is not sufficient to draw long term conclusions. In the next chapter the Committee will turn to a description and discussion of the data supporting the measure. The issue of substitution is addressed in chapter four.

48 Public Health Association of Australia, *Submission 24*, p. 7.