

**Effectively addressing alcohol-related harm in Australia -  
Our most taxing public health question:  
A submission to the Senate Community Affairs Committee  
Inquiry into Ready-To-Drink Alcohol Beverages**

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## INTRODUCTION

Alcohol consumption in Australia is associated with a range of social, economic and symbolic benefits. However, alcohol consumption in Australia is also associated with a range of adverse health and other consequences.

In 2004-05, there were 3,494 deaths caused by alcohol in Australia, and more than one million hospital bed days were committed to alcohol related causes (Collins and Lapsley 2008).

Research conducted as part of the National Alcohol Indicators Project by the National Drug Research Institute (NDRI) shows that:

- 44% of alcohol is consumed at levels that pose risk in the long-term, and 62% is drunk at levels that pose risk in the short-term;
- More than half (60%) of all police attendances and 90% of all late night calls involve alcohol;
- 24% of males and 17% of females are at risk of short-term harm at least once a month; and
- In 1998/99, it was estimated that 8,661 Australians were hospitalised as a result of injuries sustained in alcohol-related assaults (see <http://www.ndri.curtin.edu.au/publications/naip.html>).

Among young people, alcohol also plays a causal role in a range of physical, mental and social harms. In the short term, alcohol consumption has been found to increase the risk of adolescent mortality and morbidity from violence, depression, suicide, homicide, substance abuse, “date-rape” and reckless driving. In the long term, there is accumulating evidence that suggests that adolescents have a greater risk of physiological harm from alcohol abuse than mature adults. For example, adolescents have a greater risk of memory loss and decreased bone growth, neurological damage, and alcohol addiction developing later in life<sup>1</sup>.

Alcohol is a major contributing cause of death and hospitalisation for young Australians, with the majority of alcohol-related harms experienced by young people caused by episodes of drinking to intoxication. NDRI research has shown that:

- In the ten years between 1993–2002, an estimated 2,643 young Australians aged 15-24 died from alcohol-attributable injury and disease due to risky/high risk drinking – about 15% of all deaths in that age group.
- From 1993/94 to 2001/02 there were an estimated 101,165 alcohol-attributable hospitalisations for young people, accounting for one-in-five (about 22%) of all hospitalisations in that age group.
- Among under-aged drinkers, those in the 14-17 year age group, more than 80% of all the alcohol is consumed at risky/high risk levels for acute harm.
- Over the ten years from 1993–2002, an estimated 501 under-aged drinkers (aged 14–17) died from alcohol-attributable injury and disease caused by risky/high risk drinking in Australia, and another 3,300 were hospitalised for alcohol-attributable injury and disease in 1999/00 (see <http://www.ndri.curtin.edu.au/publications/naip.html>).

Despite these figures, there are a number of strategies that have been shown to be effective in ameliorating the harm alcohol causes in Australia.

The National Drug Research Institute recognises that international evidence consistently indicates that increases in excise on alcohol has a significant effect on overall levels of alcohol consumption. Lower levels of overall consumption in a population are closely related to lower levels of alcohol-related harm.

Furthermore, price changes have been demonstrated to influence consumption and harms among specific high-risk populations including young people, heavy drinkers and Indigenous populations. It can also be used as an effective means for 'directing' drinkers to beverages with lower alcohol content, which have a corresponding relationship with lower levels of alcohol-related harm (e.g. low or mid-strength beer).

The positive impact of any singular change in alcohol policy, such as an increase in alcohol excise, may be greater if it was introduced as part of a package of measures addressing alcohol-related harm, including: overall reductions in the physical availability of alcohol; targeted alcohol promotions and advertising; and, improved enforcement of relevant legislation such as drink-driving and sales to minors.

## **CONSUMPTION AND COSTS**

Alcohol consumption data, by age and sex breakdown, is available from a number of sources, including the National Drug Strategy Household Surveys

(<http://www.aihw.gov.au/publications/index.cfm/title/10579>) and the Australian

Secondary School Students

(<http://www.nationaldrugstrategy.gov.au/internet/drugstrategy/publishing.nsf/Content/mono58>) surveys.

Per capita alcohol consumption data indicate that there has been a substantial decline in alcohol consumption since the 1980s. However since about 1990 consumption has been essentially stable with small variations from year to year.

However, the more pertinent question is whether the current levels of consumption and attributable harms are acceptable. For example, according to the National Drug Strategy Household Survey, in 2007, 37.4% of males and 41.2% of females aged 14-19 consumed alcohol at a level that placed them at risk of short term harm (for example being involved in fight, a car crash or engaging in risky sexual behaviour) in the past year. Just under one in ten in this age group did so every week (8.8% males, 9.4% females). Current levels of morbidity and mortality place an unacceptable burden on the community. Not only does alcohol related harm have relevance for individual drinkers, but alcohol problems also affect innocent bystanders and the broader community. A large proportion of our policing and health services are involved in responding to alcohol related problems.

Data presented by Collins and Lapsley<sup>2,3</sup> indicated that the costs of alcohol to society more than doubled in the six years between 1998-99 and 2004-05. Of particular note, the costs associated with health increased seven-fold between the 1998-99 and 2004/05 estimates – although methodological differences may in part be responsible for some of the increase in estimated health costs.

*Total social costs of drug abuse 1998-99 and 2004-05 (from Collins and Lapsley 2002 and 2008)*

	1998-99		2004-05		% increase in total costs
	Total in \$m	Proportion	Total in \$m	Proportion	
<b>Alcohol</b>	7,560.3	22%	15,318.2	27.3%	102.6%
<b>Tobacco</b>	21,063	61.2%	31,485.9	56.2%	49.5%
<b>Illicit Drugs</b>	6,075.8	17.6%	8,189.8	14.6%	34.8%

*Note: The sum of the individual costs of all drugs differs from the "All Drugs" total as a result of adjustment for the effects of interaction on the aggregation of the individual aetiological fractions, and because the "All Drugs" total includes some crime costs attributed jointly to alcohol and illicit drugs.*

*Selected tangible costs of alcohol abuse 1998-99 and 2004-05 (from Collins and Lapsley 2002 and 2008)*

	1998-99 (\$m)	2004-05 (\$m)
<b>Crime</b>	1,235.3	1,611.5
<b>Health (net costs taking into account benefits)</b>	225	1,976.7
<b>Production in the workplace</b>	1,949.9	3,578.6
<b>Production in the home</b>	402.6	1,571.3
<b>Road crashes</b>	1,875.5	2,202

This trend is evident in alcohol consumption by under-aged drinkers. The Australian Secondary Students' Alcohol and Drug Survey indicates that the proportion of 12 to 15 year olds who drank in the recent past (last week/last month) declined significantly from 1999 to 2005. Among 16 and 17 year olds, however, the proportion who drank in the week or month before the survey did not change significantly. While the overall number of 12 to 15 year olds who drink declined from 1999 to 2005, among the group who drank in the recent past, more were drinking at levels which would put an adult at risk or high risk of short-term harm (e.g. violent assault, falls, pedestrian road injury). Longer term trends which go back to 1984 suggest that the current overall proportion of youngsters (12-17 years) who drink at such levels has not been higher. It is important to bear in mind that these estimates are based on levels of drinking which would place an adult at risk of harm and do not take into account the psychological and physiological impact that alcohol consumption may have on developing brains and bodies.

## EFFECTIVE MEASURES

### *Price and tax*

Alcohol taxation is an important source of government revenue and influences the price of alcohol over and above market forces. Changes in taxation and prices (even small changes) have an effect on alcohol consumption. The evidence consistently indicates that higher priced alcohol is associated with lower per capita consumption. The evidence also indicates that particular subgroups, such as young people and heavy drinkers, are sensitive to price changes.

The Northern Territory's Living With Alcohol (LWA) program is a highly relevant Australian example of the effect of a price/excise increase. Introduced in 1992, LWA was a comprehensive program to reduce alcohol consumption and alcohol-related harms in the Northern Territory. It was initially funded by the imposition of a small levy on all alcoholic beverages sold in the Territory containing 3% alcohol by volume or greater. The LWA Levy effectively raised the retail cost of these beverages by about 5 cents per standard drink. As a direct result of a High Court ruling, the LWA Levy was removed in 1997 which in turn resulted in a fall in the real price of alcoholic beverages with more than 3% alcohol by volume. Nevertheless, LWA programs and services continued to operate to 2002 and were funded from redirected taxes collected by the Commonwealth.

NDRI evaluations of the program showed that the public health, safety and economic impact of the LWA program resulted in significantly reduced alcohol-attributable deaths and financial cost savings to the Territory<sup>4,5,6,7</sup>.

The combined impact of the LWA program and Levy resulted in an immediate reduction in acute alcohol-attributable deaths among both Indigenous and non-Indigenous Territorians. In the absence of the Levy, the LWA program alone did not show a significant impact on acute alcohol-attributable deaths.

The results of these evaluations present strong evidence about the impact of even small increases in taxation, alone and when combined with comprehensive programs and services designed to reduce the harms from alcohol. As evidenced here, an increase in the real price of alcohol brought about by such economic strategies, even when seemingly minor, results in significant health and economic benefits. Without the support of a price increase, programs and services for reducing alcohol related harms may have limited benefits for reducing harms that tend to arise from episodes of drinking to intoxication, such as road injury and violent assault. Nevertheless, alcohol specific programs and services such as those provided by the LWA program may also have positive, longer term impacts on chronic alcohol-attributable disease. The most effective taxation strategy to prevent and reduce alcohol related problems is one where all alcoholic beverages are taxed according to their alcohol content. That all beverages are taxed in this way is important. Where discrepancies exist (e.g. the current wine equalisation tax), *some* drinkers – especially those for whom intoxication at the lowest cost is a major factor – may substitute with products that offer lower prices per standard drink. It is also crucial that such a tax is reassessed regularly to ensure it outpaces increases in disposable income.

A system which places an additional tax on beverages shown to be particularly problematic and/or associated with particularly high levels of harm could be even more effective. Such a tax would provide an incentive for production and consumption of lower-strength alcoholic beverages, which are associated with lower levels of alcohol-related harm than higher-strength alcoholic beverages. NDRI concludes that there is a strong evidence-based argument that the Australian Government go beyond increasing the excise on ready-to-drink beverages and consider applying a 'tiered' volumetric tax, where the base tax is determined according to alcohol content, and an additional 'harm index' is applied to beverages shown to be particularly problematic and/or associated with high levels of harm. Having said this, the research evidence suggests that the recent change in tax on ready-to-drink alcohol beverages is likely to reduce overall consumption of these products and thereby potentially reduce problems associated with their use. Previous reviews<sup>8</sup> of Australian alcohol restrictions indicate that the potential of a price increase to reduce harms will, in part, be affected by substitution (not only by drinkers but also by producers and sellers) with alternative products. But, it is important to place the issue of substitution in wider context. Although substitution practises will inevitably occur, the degree to which they actually undermine the overall impact of restrictions on the availability of alcohol – economic initiatives included – is likely to be limited. Moreover, as described in a recent NDRI review of alcohol restrictions:

*A minority of drinkers, retailers and producers will always seek to find a way around restrictions, but it is nonetheless possible to anticipate how and where substitution practices may occur and to implement strategies to limit their impact.*<sup>8</sup>

### **Other effective measures**

As indicated above, to adequately address alcohol problems in Australia, changes to alcohol taxation are best considered as part of a package of measures aimed at reducing the negative impacts of alcohol on public health. These responses need to be seen in the context of what research evidence tells us works. Outlined below are other key factors requiring consideration in the development of strategies to reduce alcohol-related problems.<sup>9</sup>

#### *Alcohol promotions and advertising*

The nature of alcohol promotions has become more diverse and sophisticated as electronic and other communications have developed. Greater exposure to alcohol promotions has been associated with increased product recognition, more positive attitudes to alcohol and drinking and, in some studies, heavy drinking. Unlike alcohol availability, promotions have largely been subject to voluntary as opposed to statutory regulation. The evidence is that self-regulation has been generally ineffective, but it is also important to note that the evidence regarding other models is also lacking.<sup>10</sup>

It is clear that Australian children and teenagers under the legal drinking age are exposed to high levels of alcohol advertising on television on a consistent, ongoing basis. Weekly data generated by OzTAM, the official Australian audience monitoring system, over a 12 month period between March 2005 to February 2006 to Sydney audiences showed that Australian children under the age of 12 were exposed to one in every three alcohol ads seen on average by mature adults (aged 25 years plus) and under-age teenagers (13-17 years) were exposed to levels that were virtually identical to that of young adults (18-24 years).<sup>11</sup>

#### *Education and persuasion*

These include mass media communication, communicating guidelines on low risk drinking and school- and college-based programs (e.g. information about the risks of alcohol; resistance skills). The political acceptance and popularity of these programs appears high but their ability to influence the behaviour of individuals may be lower than many would hope or expect. While some well-resourced programs show modest effects, often these do not persist, particularly if the programs are conducted in isolation and underpinned by abstinence-based models (e.g. US approach). As with other interventions, they might be more effective when combined with other approaches (e.g. mass media campaigns can build community support for drink-driving countermeasures).

The results of NDRI's School Health and Alcohol Harm Reduction Project (SHAHRP), which aimed to reduce alcohol-related harm (rather than exclusively promote abstinence) in secondary school students, bear scrutiny in the context of this inquiry.

The two-year evidence-based intervention incorporated harm reduction goals in a classroom school curriculum program. Students taking part in the SHAHRP<sup>12</sup> program developed significantly greater alcohol-related knowledge and significantly safer alcohol-related attitudes than students not taking part. In terms of consumption, the intervention group consumed significantly less alcohol (31% difference). Students taking part in the SHAHRP program were also less likely to consume to risky levels (33.8% difference) when followed up 20-months after the program. (For further information on SHAHRP, visit [www.ndri.curtin.edu.au/shahrp/index.html](http://www.ndri.curtin.edu.au/shahrp/index.html).)

#### *Physical availability*

Consistent national and international evidence indicates that the physical availability of alcohol influences alcohol use and related problems. The ease or difficulty of accessing alcohol can affect alcohol consumption. Typically, as physical accessibility to alcohol within a community increases, overall alcohol consumption and related problems also increase. Alcohol may be totally banned (e.g. 'dry areas' or discrete 'dry community' declarations) or controls placed on the type of alcohol available at certain times or events (e.g. at some sporting events there are controls on the types of alcohol available and alcohol content as well as limitations on how many drinks an

individual can purchase at one time). There are usually limitations on the days and hours of sale and, in some communities, there are restrictions on the nature of purchases (e.g. no bulk packaged liquor sales). Increases and decreases in the minimum purchase age have been associated with corresponding changes in levels of consumption and harm. Longer trading hours and greater numbers of licensed premises have both been demonstrated as strongly related to higher levels of consumption and alcohol-related problems (especially violence and road crashes).<sup>8</sup>

#### *Early intervention and treatment*

A range of treatments for alcohol problems, including opportunistic and brief interventions for hazardous drinkers (e.g. in GP surgeries and hospitals or through self-help programs) or intensive treatments for people who are alcohol dependent, have been demonstrated to be effective. However, this does not always translate to widespread adoption. For example, only a minority of GPs embrace brief interventions.<sup>13</sup>

#### *Drinking context*

Different drinking contexts are associated with different levels of risk<sup>8</sup>. For example, overcrowded, late night venues with poor crowd control techniques have higher risk than venues with well-trained staff who comply with responsible service practises. Risk is significantly reduced when training in responsible service of alcohol (e.g. not serving drunk people; not engaging in promotions and other practices that encourage risky consumption; engaging skilled crowd controllers) is combined with enforcement strategies (e.g. through police and licensing authority activity).

#### *Drink-driving and enforcement*

Random breath testing reduces drink-driving if there is a perceived high probability of detection followed up by substantial consequences. There are some (such as those who record very high blood alcohol levels and who are alcohol dependent) who can be resistant to these strategies and additional approaches may be helpful (e.g., diversion to treatment; installation of devices that prevent car activation if a breath test is 'positive').

As well as being crucial in drink-driving and supporting hospitality staff to exhibit responsible serving practices, enforcement is a critical area in relation to access to alcohol for underage drinkers.<sup>8</sup> According to the National Drug Strategy Household Survey, about two thirds of Australian teenagers aged 14-17 years drink alcohol and one in five of these teenagers drinks at least weekly. While the most common means of obtaining alcohol is from friends or relatives, almost half (about 47%) of 14-17 year olds have purchased alcohol from a retail outlet despite the illegality of sales to minors across all Australian jurisdictions. This highlights the need for better enforcement and other measures to address the supply of alcohol to minors.



## **SUMMARY**

Alcohol taxation is an important source of government revenue and influences the price of alcohol over and above market forces. Even small changes in taxation and prices affect levels of alcohol consumption and related problems. The evidence consistently indicates that higher priced alcohol is associated with per capita declines in consumption and that particular subgroups, such as young people, are sensitive to price changes. Price and excise regimes are also effective in encouraging drinkers to consume lower-alcohol content beverages, which are associated with lower levels of alcohol-related harm.<sup>14,15</sup>

For these reasons, NDRI recognises the potential value of an increase in the excise on ready-to-drink alcoholic beverages. However, NDRI also recognises the strong body of evidence indicating that measures to address alcohol-related harm in the Australian community could go further through the application of a 'tiered' volumetric tax, to reduce current unacceptably high levels of alcohol-related harm that affect drinkers and the broader community. Under a 'tiered' volumetric tax system, the base tax is determined according to alcohol content. This approach can result in incentives for industry to produce lower alcoholic beverages, for individuals to consume such beverages and for an overall reduction in per capita consumption and related problems. An additional 'harm index' could also be applied to beverages shown to be particularly problematic and/or associated with particularly high levels of harm. Furthermore, the evidence shows that introducing a package of measures, such as those outlined above, will be much more effective than any single measure introduced in isolation.

It is also noteworthy that Australians currently appear more receptive to landmark action to address alcohol-related harm than in previous years. According to the 2007 National Drug Strategy Household, there has been a significant increase over the past three years in public support for changes in alcohol-related policy. For example, almost a quarter of Australians 14 years and older support increasing the price of alcohol (24.1%, up from 20.9% in 2004) and 41.3% support increasing tax on alcohol to pay for health, education and treatment of alcohol-related problems<sup>16</sup>.

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