



**Response to request for further information by Alcohol Toll  
Reduction Bill Senate Standing Committee  
14 May 2008**

At the Senate Standing Committee hearing, the representative of the Australasian Faculty of Public Health Medicine (AFPHEM) was asked a number of questions pertaining to information contained in the submission by the Distilled Spirits Industry Council of Australia (DSICA). This mainly focused on data concerning alcohol consumption and health effects. Subsequently, the Standing Committee invited the AFPHEM to offer a critique of the 15 conclusions made in the DSICA submission, in particular of those concerning consumption and health effects.

Broadly, in relation to consumption and health effects, the DSICA submission suggests that alcohol consumption is declining or static and that there are health benefits of alcohol consumption which are not sufficiently emphasised when considering the negative effects of alcohol. They present a range of data concerning consumption patterns and a limited amount of data concerning alcohol related deaths and hospital bed days. This forms a large part of the basis on which DSICA asserts that there is no need or justification to adopt the measures of the Alcohol Toll Reduction Bill.

While consumption data is important, the AFPHEM takes the view that policy decisions should be principally informed by an assessment of the overall *effect* of alcohol on all aspects of the public well being including health or social well-being, effects of crime, or workplace productivity. We are of the view that the health effect and social cost data presented by DSICA is highly selective, does not represent the extent of alcohol related harm in the community and seems to seek to downplay it.

### *Consumption data*

Overall, in considering sales data and reliable surveys such as the National Drug Strategy Household Surveys and the Australian Secondary School Students surveys, the AFPHEM is of the view that the overall per capita consumption of alcohol in Australia has declined since the 1980s and has been approximately stable since about 1990. It is also of the view that some indicators of consumption in young people appear stable or in decline.

However, the more pertinent question is whether the level of consumption and more importantly the level of consequent harm is *acceptable*. For example, 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 a 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)<sup>1</sup>.

There are some issues worth noting concerning consumption data based on self-reports. Respondents will vary in their ability to recall or willingness to honestly report consumption data. Surveys will differ in their methodologies over time and between different research groups. Similarly there is variation in what is considered to be “low risk” or “high risk”. And one can argue about what are the most valid indicators to consider. While the AFPHM does not dispute the young peoples’ consumption survey data presented by DSICA, we do have a concern that it does not give the whole picture. For example, on page 21 of their submission, DSICA in their “Indicators of alcohol consumption amongst young people” table refer to data over the period 1984 to 2005 quoting as the source the 2004 Dept of Health and Ageing publication “Australian Secondary School Student’s use of alcohol in 2002”. Probably they are referring to the 2006 publication with the same focus and similar name containing data up to 2005<sup>2</sup>. Their “Indicator” of current drinkers is based on the data showing a decrease in the proportion of 12-15 year olds self reporting as current drinkers and a (statistically non significant) slight decrease in 16-17 year olds. Thus, this “Indicator” suggests an improvement in an aspect of young people’s drinking. However, the same graphs they rely on for this data (figures 2 and 3 from White and Hayman 2006) also show an *increase* in the proportion of both these age groups indulging in drinking that puts them at risk of short term harm.

### *Health benefits of alcohol consumption*

DSICA makes a considerable point of the putative health benefits of alcohol consumption in section 2 of their submission and in Conclusions 3, 4 and 10.

There has been an acceptance that low to moderate alcohol consumption confers some health benefits in relation to ischaemic heart disease since a study by Pearl in 1926<sup>3</sup>. The observation, made many times since, is that people who are abstainers from alcohol have higher mortality rates than do those who are light or moderate consumers. Heavier users of alcohol have the highest death rates. However, in recent years a number of researchers, beginning with Shaper et al in 1988<sup>4</sup> and more recently

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<sup>1</sup> Australian Institute of Health and Welfare. The 2007 National Drug Strategy household survey. First results. Canberra: AIHW, 2008.

<sup>2</sup> White V, Hayman J. (2006). *Australian Secondary School Student’s use of alcohol in 2005*. National Drug Strategy Monograph Series No. 58. Canberra: Australian Government Department of Health and Ageing.

<sup>3</sup> Pearl N. 1926. Alcohol and longevity. New York. Knopf.

<sup>4</sup> Shaper AG, Wannamethee G, Walker M. Alcohol and mortality in British men: explaining the U shaped curve. *Lancet*. 1988;2:1267-73

Fillmore et al in 2006<sup>5</sup> have begun questioning the validity of this observation. The main basis for this is the observation that former drinkers who become abstainers have higher death rates than those who have always been abstainers, and that in most studies these two different groups of people (with different mortality rates) have been lumped together as “abstainers” with the net effect of erroneously increasing the observed death rates of “abstainers”. The meta-analysis of 54 studies by Fillmore et al found that in studies where this potential error did not take place, no significant reduction either in cardiac or all cause mortality was seen amongst low/moderate drinkers compared to abstainers. Any benefits seem to be concentrated in middle aged and older populations, with mortality due to injury outweighing any other benefits in younger people as demonstrated by Andreasson et al<sup>6</sup>. In relation to cancers, high blood pressure, stroke, liver disease, and injury there is a direct relationship with alcohol consumption and no evidence of benefit at lower levels of consumption<sup>78</sup>.

The Fillmore study has provoked considerable debate amongst alcohol authorities and researchers<sup>9</sup>. An overview of the 8 responses published indicates, at the very least, a need to re-consider the way such research is conducted in future, and most likely a need to question the degree to which light consumption of alcohol does confer health benefits.

DSICA make frequent reference to the publications by Collins and Lapsley published in 2002<sup>10</sup> and 2008<sup>11</sup> concerning costs of alcohol and other drugs to society. In section 2.2 of the DISCA submission they present data from these reports in support of their contention that analysis of the social costs of alcohol must be compared to the benefits of alcohol consumption (Conclusion 3). They seem to imply that the health benefits come close to comparing to the costs. However, when one considers the full range of alcohol related impacts in these reports (see tables 1-3 below) one gains a very different impression about the balance of harms and benefits.

In their 2008 report, Collins and Lapsley highlight that different attributable fractions methods were used in estimating health and workplace absenteeism impacts in the 2008 report compared to the earlier one and that therefore these data are not directly comparable. However, the methods for estimating crime related costs were the same

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<sup>5</sup> Fillmore KM, Kerr WC, Stockwell T, Chikritzhs T, Bostrom A. Moderate alcohol use and reduced mortality risk: Systematic error in prospective studies. *Addiction Research and Theory* 2006; 14: 101-32.

<sup>6</sup> Andreasson S, Allebeck P, Romelsjo A. Alcohol and mortality among young men: longitudinal study of Swedish conscripts. *British Medical Journal*. 1988;296:1021-5

<sup>7</sup> NHMRC. (2007) Australian alcohol guidelines for low-risk drinking. Draft for public consultation, October 2007. Australian Government, Canberra.

<sup>8</sup> Borges G, Cherpitel C, Orozco R, Bond J, Ye Y, Macdonald S, Rehm J and Poznyak V (2006). Multicentre study of acute alcohol use and non-fatal injuries: data from the WHO collaborative study on alcohol and injuries. *Bull WHO* 84:453-460.

<sup>9</sup> “Commentaries on Fillmore, Kerr, Stockwell, Chikritzhs, Bostrom” *Addiction Research and Theory* 2007; 15:1, 3-33.

<sup>10</sup> Collins D and Lapsley H. (2002) *Counting the costs: estimating the social costs of drug abuse in Australia in 1998-9*. National Drug Strategy Monograph series No. 49. Australian Government Department of Health and Ageing, Canberra.

<sup>11</sup> Collins D and Lapsley H. (2008) *The costs of tobacco, alcohol and illicit drug abuse to Australian society in 2004/05*. Australian Government Department of Health and Ageing, Canberra.

for both reports. These costs rose by 7.8% in real terms when the data from both periods are converted to 2004-05 dollars (table 2)<sup>12</sup>.

**Table 1: 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 in 2004-05 dollars
	Total in \$m	Proportion	Total in \$m	Proportion	
Alcohol	7,560.3	22%	15,318.2	27.3%	n/a
Tobacco	21,063	61.2%	31,485.9	56.2%	23.5%
Illicit Drugs	6,075.8	17.6% <sup>13</sup>	8,189.8	14.6% <sup>14</sup>	11.3%

In addition to the total costs, Collins and Lapsley present data on costs incurred in different sectors of society. See table 2. While the AFPHM acknowledges that there are some health benefits associated with alcohol consumption (although perhaps not as many as has been previously thought), we are not aware of any benefits of alcohol consumption in terms of preventing crime or road crashes, nor in increasing workplace productivity.

**Table 2: Selected tangible costs of alcohol abuse 1998-99 and 2004-05 (from Collins and Lapsley 2002 and 2008)**

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

<sup>12</sup> Using a conversion figure of 21% as per p77 of Collins and Lapsley 2008

<sup>13</sup> Percentages as reported in Collins and Lapsley 2002 p IX

<sup>14</sup> 2008 report also included "Alcohol and Illicits together" comprising 1.9% of total

**Table 3: Alcohol related deaths and hospital bed days in Australia 1998-99 and 2004-05 (from Collins and Lapsley 2002 and 2008)**

		1998-99	2004-05
Deaths	Caused	4,286	3,494
	Prevented	7,029	2,437
	Net total	2,744 (net saving)	1,057 (net loss)
Hospital bed days	Caused	394,417	1,031,660
	Prevented	255,433	114,726
	Net total	138,974 (net loss)	916,934 (net loss)

Conclusion no 4 in the DSICA submission could mislead the reader. It states that the *latest* DHA publication on the *social* costs of alcohol indicated that more deaths were prevented than were caused by alcohol consumption. In referring to DHA surveys, DSICA refer to the two publications by Collins and Lapsley in 2002 and 2008. The latest of these two publications indicates that, for the years 2004-05, in fact deaths caused by alcohol *exceeded* those prevented. However, the title of the later publication is the “... costs of tobacco, alcohol and illicit drug abuse to Australian society ...” whereas the title of the earlier study concerned “... *social* costs”. It may be that DSICA has confused these two publications.

Deaths due to alcohol, while important and dramatic, are not the whole story of alcohol related harm. Relying solely on death data in understanding the alcohol toll can be misleading. Improvements in access to first aid and medical care can and do save lives, and will reduce the death toll without reducing the amount of high risk alcohol consumption or events in the first place. For example, a substantial part of the alcohol death toll is due to road crashes. The road crash death toll has been reducing steadily over the past 2 decades probably in part to changes in alcohol use. But there are many other factors such as engineering of cars and roads, increased enforcement of road rules and improved medical care as well.

In focusing on deaths due to alcohol, one must take into account the age at which deaths might occur or be averted. The loss to society of a young person killed at age 21 in a car crash outweighs the benefit to society of the death prevented of an older person who does not have a heart attack at age 60. DSICA presents data in graphic no 2 drawn from a paper by Chikritzhs et al in 2002<sup>15</sup> in which more deaths were prevented than lost due to alcohol consumption. A paper also from Chikritzhs et al at about the same time<sup>16</sup> presented data showing a net gain of 1,459 deaths prevented from alcohol consumption in Australia in 2001. However, when the age at which death occurred was taken into account, there was a net *loss* of 19,565 years of life due

<sup>15</sup> Chikritzhs T, Stockwell T, Jonas H, Stevenson C, Cooper-Stanbury M, Donath S, Single E, Cataoline P. Towards a standardised methodology for estimating alcohol caused death, injury and illness in Australia. *Aust NZ J Pub Health* 2002; 26(2): 443-50.

<sup>16</sup> Chikritzhs T, Catalano P, Stockwell T, Donath S, Ngo H, Young D, Matthews S. (2003) *Australian alcohol indicators, 1990-2001: patterns of alcohol use and related harms for Australian states and territories*. National Drug Research Institute, Curtin University of Technology, Perth.

to alcohol consumption. Moreover, they showed that the trend over the years 1990-2001 was for increasing net years of life lost due to alcohol consumption.

DSICA in its “Indicators of alcohol consumption amongst young people” has one indicator relating to actual harm: that of alcohol attributable deaths in 14-17 year olds. They refer to a substantial reduction in such deaths in the 10 years to 2002. From their source<sup>17</sup>, the death rate in 2002 was 0.4 deaths per 10,000 population. However, the same source also contains data on alcohol related hospitalisations on a state-by-state basis almost all of which showed *increasing* rates for both males and females. The rates of hospitalisations ranged between 10 and 40 per 10,000 population: that is between 25 and 100 times as many people were admitted to hospital for alcohol related causes as died from them. So while deaths were declining, many more people were admitted to hospital and the proportions (ie rates per population number) rose over the reported time period.

### *Summary*

When one considers consumption data and social cost data together, a number of points are worth making. While per capita alcohol consumption data indicates a substantial decline since the 1980s, since about 1990 consumption has been essentially stable with small variations from year to year. However, the proportion of people, especially young people, regularly engaging in risky drinking is unacceptable in absolute terms and of great concern. On the basis of the two Collins and Lapsley reports, one cannot confidently assert a worsening of health related harms due to different methodologies used in the two reports, but one’s impression is that it is so. That impression is reinforced by the real worsening of crime related costs. It is also reinforced by the worsening trends in alcohol related hospitalisations in young people and years of life lost from other sources quoted above. Overall, the level of health, crime and productivity related harm is substantial, would seem to greatly outweigh any health benefits, and is, in our view, completely unacceptable.

The 2008 Collins and Lapsley report suggested that in 2004/05 alcohol use caused 3,494 deaths but prevented 2,437. As they point out: “When examining the potential benefits of policies designed to prevent alcohol misuse, the relevant number of deaths is 3,494, not the net figure of 1,057” (p 37). The effects of the Alcohol Toll Reduction Bill, or indeed any of the other measures often recommended to reduce the toll of alcohol to our society are highly unlikely to have a substantial impact on the amount of “low risk” drinking in society and so are unlikely to lead to a loss of any health benefits that might result from such drinking. The focus should be on preventing those deaths that alcohol causes.

### *Conclusion*

In this critique we have focused mainly on the alcohol consumption and social costs aspects of the DSICA submission for reasons of time constraints and because that is

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<sup>17</sup> Chikritzhs T, Pascal R, Jones P. (2004) Under-aged Drinking Among 14–17 year olds and Related Harms in Australia. National Alcohol Indicators Bulletin no 7. National Drug Research Institute, Curtin University, Perth.

what the Standing Committee asked of us. While we have not closely examined the DSICA arguments and data concerning the role of warning labels and the effectiveness of current system of regulation of alcohol advertising, we would disagree with their general position on the basis of our original submission and oral evidence.

We are of the view that the alcohol consumption and social costs data presented in DSICA submission are too limited to allow a true understanding of the negative impact of alcohol on society. In addition, we believe that these aspects of the DSICA submission lack credibility as a “compelling base of evidence” basis for DSICA’s assertion that the Standing Committee should recommend to the Senate that it not pass the Bill.

We believe that when one considers the totality of information concerning consumption of alcohol and its impact on society, the quantum of harm is already unacceptable, and the harms in health terms far outweigh the benefits to say nothing of crime and productivity related harms. As there are many facets of the consumption and harm of alcohol, so there needs to be many facets of our interventions to address them. We support the objectives of the Alcohol Toll Reduction Bill as an important part of our society’s efforts to do so and re-affirm our support for it.

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