



The Royal Australasian  
College of Physicians

**Submission  
to the  
Senate Standing Committee on Community Affairs'  
Inquiry into Excise Tariff Amendment (2009 Measures No. 1) Bill 2009 and Customs  
Tariff Amendment (2009 Measures No. 1) Bill 2009  
by the  
Royal Australasian College of Physicians**

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## **Submission to the Senate Standing Committee on Community Affairs' Inquiry into Excise Tariff Amendment (2009 Measures No. 1) Bill 2009 and Customs Tariff Amendment (2009 Measures No. 1) Bill 2009 by the Royal Australasian College of Physicians**

As a preface to our comments on the Excise and Customs Tariff Bills, we wish to make some general observations and recommendations on the alcohol situation in Australia with particular reference to taxation policy.

### ***Alcohol harm is at an unacceptable level.***

In our view, the absolute levels of harm due to alcohol in this country are at an unacceptable level, particularly amongst young people. Reducing this harm should be a major focus of research and policy.

- Collins and Lapsley estimated that 3,494 Australians died in 2004/05 because of their alcohol consumption. They also estimated that the cost to Australian society of alcohol related health harms, lost productivity, and crime was \$15.3 billion<sup>1</sup>.
- Begg and Voss estimated that 3.2% of the total burden of disease and injury in Australia in 2003 was attributable to alcohol<sup>2</sup>.
- In 2007, 37.4% of males and 41.2% of females aged 14-19 years reported that they 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)<sup>3</sup>.
- In the ten years to 2002 an estimated 5 persons aged 15-24 years died and 216 were admitted to hospital every week as a result of drinking alcohol<sup>4</sup>. People of this age account for 52% of all alcohol related serious road injuries<sup>5</sup>.

### ***Price is the most effective measure to control consumption and harm in a population.***

There is an indisputable and strong link between price, consumption of alcohol and harms<sup>6</sup>. Price is an effective measure in controlling consumption and consequent harms. A recent review of alcohol policy measures<sup>7</sup> found that

*An increase in the price of alcohol reduces alcohol consumption, hazardous and harmful alcohol consumption, alcohol dependence, the harm done by alcohol, and*

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<sup>1</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

<sup>2</sup> Begg S, Voss T, Barker B, Stevenson C, Stanley L and Lopez A. (2007) *The burden of disease and injury in Australia 2003*. PHE 82. Canberra: Australian Institute of Health and Welfare. Available from: [www.aihw.gov.au/publications/index/cfm/title/10317](http://www.aihw.gov.au/publications/index/cfm/title/10317).

<sup>3</sup> Australian Institute of Health and Welfare. The 2007 National Drug Strategy household survey. First results. Canberra: AIHW, 2008.

<sup>4</sup> Chikritzhs T, Pascal R. (2004). *Trends in youth alcohol consumption and related harms in Australian jurisdiction, 1990-2002*. National Alcohol Indicators, Bulletin no 6. National Drug Research Institute, Curtin University of Technology.

<sup>5</sup> Chikritzhs T, Stockwell T, Heale P, Dietze P, Webb M. (2000). *Trends in alcohol related road injury in Australia 1990-97*. National Alcohol Indicators, Bulletin no 2. National Drug Research Institute, Curtin University of Technology

<sup>6</sup> Babor, T.F., R. Caetano, S. Casswell, G. Edwards, N. Giesbrecht, K. Graham, J. Grube, P. Gruenewald, L. Hill, H. Holder, R. Homel, E. Österberg, E.J. Rehm and I. Rossow (2003). *Alcohol: No Ordinary Commodity – Research and Public Policy*, Oxford University Press, Oxford

<sup>7</sup> Anderson, P. & Baumberg, B. (2006), *Alcohol in Europe: a public health perspective. A report for the European Commission*, Institute of Alcohol Studies, UK, June.

*the harm done by alcohol to others than the drinker. The exact size of the effect will vary from country to country and from beverage to beverage. There is strong evidence for the effectiveness of alcohol taxes in targeting young people and the harms done by alcohol.*

A 2009 review of 112 studies of the relationship between alcohol taxes, prices and consumption found that higher taxes and prices led to reduced consumption of alcohol: this applied to overall consumption as well as measures of heavy drinking<sup>8</sup>. This review and other studies suggest that a 10% increase in price will reduce consumption by about 5% on average<sup>9</sup>. In particular, young people's drinking is very sensitive to price because their discretionary income is relatively small. A recent WHO expert committee concluded<sup>10</sup>:

*Policies that increase alcohol prices have been shown to reduce the proportion of young people who are heavy drinkers, to reduce underage drinking, and to reduce per occasion binge drinking. Higher prices also delay intentions among younger teenagers to start drinking and slow progression towards drinking larger mounts.*

### ***There is good Australian evidence of the effectiveness of public health focused alcohol taxes***

There is good evidence from Australia concerning the positive impact of alcohol taxation as part of a comprehensive program on consumption of alcohol, including of specific products. The Northern Territory's *Living with Alcohol* (LWA) program ran from 1991 to 2000 and led to substantial benefits in terms of alcohol consumption, consequent harms (alcohol related road crash deaths and hospitalisations, other alcohol related hospitalisations and alcohol related prison receptions) and economic savings<sup>11,12</sup>.

Taxes on specific alcohol products can also be effective in reducing consumption of those products. One aspect of the *Living with Alcohol* program was a tax increase of 5 cents per standard drink for products containing more than 3 per cent alcohol and a 35 cent per litre levy on cask wines. This was followed by a reduction in consumption of cask wines from 0.73 litres per year per person over the age of 15 to 0.49 litres. There was no accompanying increase in other alcohol products such as full strength beer. In the immediate period following removal of the levy, per capita consumption of cask wine increased to 0.58 litres<sup>13</sup>

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<sup>8</sup> Wagenaar A, Salois M. and Komro K. (2009) Effects of beverage alcohol price and tax levels on drinking; a meta-analysis of 1003 estimates from 112 studies. *Addiction* 2009; 104:179-190.

<sup>9</sup> Vandenberg B, Livingston M and Hamilton M. (2008) Beyond cheap shots: reforming alcohol taxation in Australia. *Drug Alc Rev* 27(6); 584-90.

<sup>10</sup> World Health Organisation (2007) *Expert committee on problems related to alcohol consumption, Second report*. WHO Technical Report Series 944, provisional edition. World Health Organisation, Geneva. [www.who.int/substance\\_abuse/activities/expert\\_comm\\_alcohol\\_2nd\\_report.pdf](http://www.who.int/substance_abuse/activities/expert_comm_alcohol_2nd_report.pdf)

<sup>11</sup> National Drug Research Institute (2007). *Restrictions on the sale and supply of alcohol: evidence and outcomes*. National Drug Research Institute, Curtin University of Technology.

<sup>12</sup> Crundall I. (1994) *Living with alcohol in the Northern Territory*, NT Dept of Health and Community Services. Available at [http://www.nt.gov.au/health/healthdev/aodp/lwap/lwa\\_in\\_nt.shtml](http://www.nt.gov.au/health/healthdev/aodp/lwap/lwa_in_nt.shtml) (downloaded 27 May 2008)

<sup>13</sup> Gray D, Chikritzhs T, Stockwell T. The Northern Territory's cask wine levy: health and taxation policy implications. *Aust NZ J Pub Health* 1999; 23(6): 651-3

### ***Alcohol tax policies are cost effective***

Beyond being effective in reducing consumption and harms, controlling price via taxation measures is also considered to be highly cost beneficial. A recent study by Collins and Lapsley<sup>14</sup> examined the potential cost savings for Australia of a range of interventions aimed at reducing alcohol related harm. In relation to alcohol taxation they found that there was strong evidence from a variety of settings for its effectiveness in reducing consumption and subsequent harms. Based on the experience of 3 other broadly similar countries (Norway, USA and Italy), they estimated that taxation measures could reduce the social costs of alcohol in Australia by between 14% and 39% (or between \$2.19 and \$5.94 billion in 2004/05 dollars). Doran et al<sup>15</sup> also examined the cost effectiveness of a range of interventions and found that volumetric taxation of alcohol had the lowest intervention costs and provided the greatest benefits in terms of Disability Adjusted Life Years (DALYS).

### ***A public health centred alcohol tax policy***

The RACP supports a comprehensive review and reform of alcohol taxation policy. The current alcohol tax system is complex, unwieldy and mainly reflects economic and commercial factors (with the exception of the alcopops tax). In our view alcohol tax policy should be strongly informed by public health considerations. There are several important measures which could be considered:

- a minimum price per standard drink (as has been adopted in the recent revision of alcohol taxation in Scotland<sup>16</sup>);
- an underlying volumetric based system;
- additional taxation based on evidence of harm associated with particular beverage types;
- increases in taxation should in principle be in small increments; and
- hypothecation of a proportion of revenue raised for alcohol and drug prevention and treatment.

In addition, there is a need for a collaborative approach to address some of the vertical fiscal imbalance issues that arise from the Commonwealth receiving alcohol tax revenues but the States and Territories being largely responsible for delivering alcohol treatment and prevention programs.

The Australian Government's alcopops legislation has been criticised as a "tax grab". Any future changes to tax policy likely to benefit the public health would be in the nature of small tax increases (so as to increase price) and would probably suffer the same criticism. To avoid this criticism, hypothecation is vital to redress the large disparity between Government revenue from alcohol taxes and Government expenditure on alcohol harm prevention and treatment programs.

In the late 1990s the Australian Federal government derived A\$4.3 billion from excise on alcohol beverages. Less than two per cent of this funding was spent on reducing alcohol-related

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<sup>14</sup> Collins D and Lapsley H. (2008) The avoidable costs of alcohol abuse in Australia and the potential benefits of effective policies to reduce the social costs of alcohol. National Drug Strategy Monograph Series no 70. Commonwealth of Australia, Canberra.

<sup>15</sup> Doran C, Vos T, Cobiac L, Hall W, Asamoah I, Wallace A, Naidoo S, Byrnes J, Fowler G, Arnett K. (2008) *Identifying cost effective interventions to reduce the burden of harm associated with alcohol misuse in Australia*. Alcohol Education Rehabilitation Foundation

<sup>16</sup> Scottish Government (2009) Changing Scotland's relationship with alcohol: a framework for action. The Scottish Government, Edinburgh. Downloaded from: <http://www.scotland.gov.uk/Publications/2009/03/04144703/0>

harm.<sup>17</sup> Between 2000 and 2001, funding for the prevention of harmful or hazardous drug use was A\$146.2 million.

- Alcohol-related programs received A\$9.2 million;
- Tobacco-related programs received A\$3.6 million; and
- Illicit and other drugs of dependence program received A\$34.6 million.<sup>18</sup>

However there is evidence that the Australian people would support increases in alcohol taxes if they were confident that at least some of the funds went into alcohol programs. The 2007 National Drug Strategy Household Survey revealed that 24% of respondents supported an increase in the price of alcohol with 41% in favour of increased alcohol taxes to pay for alcohol prevention and treatment programs<sup>19</sup>. During the *Living with Alcohol* program, revenues from the alcohol levies were hypothecated to the program. An analysis of the program found that hypothecation of revenue contributed greatly to the quantum and sustainability of funding<sup>20</sup> and was considered to have been particularly important in public support for the program<sup>21</sup>

## RESPONSE TO SPECIFIC SUBMISSION QUESTIONS

### ***The revenues raised under the alcopops tax measure;***

It has been reported that the revenues received from the alcopops tax have not met the levels anticipated at its inception. This may well have been because the tax has had the desired effect of reducing consumption of these products. There has been considerable criticism made of the tax as merely being a revenue raising measure. Such criticism may be fuelled by the disparity that has existed for some time between alcohol tax revenues and expenditure on alcohol programs (see above). This could be countered and greater public acceptance gained by directly linking tax revenues to funding of alcohol programs.

### ***Substitution effects flowing from the alcopops tax measure***

It is extremely difficult to make an independent assessment on the impact on alcohol consumption given the difficulty of gaining access to relevant data. Australian Customs excise data are not easily accessible and industry data are even less so. Of all the states and territories, only Western Australia and the Northern Territory gather data on alcohol sales. This is a major impediment to the assessment of the impact of alcohol policies.

The recent article in the Medical Journal of Australia by Chikritzhs et al<sup>22</sup> provides the only available independent assessment of the impact on alcohol sales of the alcopops tax. Whilst the study period was relatively short, the analysis suggests that there was a substantial reduction in

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<sup>17</sup> Alcohol and other Drugs Council of Australia. *Drugs, money and governments*, Alcohol and other Drugs Council of Australia, Canberra 1999.

<sup>18</sup> Australian Institute of Health and Welfare (AIHW). *National public health expenditure report 2000–01*. Health and Welfare Expenditure Series no. HWE 25. Canberra, AIHW 2004.

<sup>19</sup> Australian Institute of Health and Welfare. (2008) *2007 National Drug Strategy Household Survey: first results*. Drug Statistics Series no. 20. Cat. no. PHE 98, AIHW, Canberra, pp. 42.

<sup>20</sup> D'Abbs P. Alignment of the policy planets: behind the implementation of the Northern Territory (Australia) Living With Alcohol programme. *Drug and Alcohol Review* 2004; 23: 55-66.

<sup>21</sup> Personal Communication Drs Shirley Hendy and Ian Crundall, former Directors of the NT Living With Alcohol program.

<sup>22</sup> Chikritzhs, T.N, Dietze, P.M, Allsop, S.J, Daube, M.M, Hall, W.D and Kypri, K. (2009) Editorial: The "alcopops" tax: heading in the right direction *eMJA - Rapid Online Publication*, 2 March 2009:1-2

the sales of alcopops with a relatively small shift to other beverages and a net reduction in overall sales.

***Changes in consumption patterns of ready-to-drink alcoholic beverages by sex and age group following the introduction of the alcopops tax***

We are not aware of any reliable surveys that have focused on this since the introduction of the alcopops tax.

However, there is evidence that suggests a substantial increase in the sales and consumption of ready to drink (RTD) products occurred after 2000 when the excise on them was reduced. In its submission to the Senate Standing Committee on Community Affairs concerning the Alcohol Toll Reduction Bill<sup>23</sup>, the Distilled Spirits Industry Council of Australia presented data concerning the growth of the RTD market. Graphic no 6 on page 17 of that submission, shows that sales of RTDs were growing at 50% per year in the years 1999-2000 to 2000-01. Thereafter growth rates declined but sales were *continuing to grow* at 4.9% in the years 2005-06 to 2006-07. At the same time the proportion of 12-17 year old girls stating that RTDs were their preferred beverage increased from 23% in 1999 (just before the reduction in tax and price of RTDs) to 48% in 2005. Those preferring bottled spirits fell from 42% to 30%<sup>24</sup>.

Sales of these products continued to rise from 13,589,000 litres in 2004 to 16,383,000 litres in 2006. During this time total spirit consumption rose by approximately 2.6 million litres while consumption of other spirits declined by approximately 200,000 litres<sup>25</sup> indicating that the total increase in all spirit consumption was entirely due to increased consumption of RTDs.

***Changes in consumption patterns of all alcoholic beverages by sex and age group following the introduction of the alcopops tax.***

See responses to points above.

***Any unintended consequences flowing from the introduction of the alcopops tax, such as the development of so-called 'malternatives' (beer-based ready-to-drink beverages).***

We are unable to comment.

***Evidence of the effectiveness of the Government's changes to the alcohol excise regime in reducing the claims of excessive consumption of ready-to-drink alcohol beverages.***

The article by Chikritzhs et al in the recent MJA<sup>26</sup> provides an indication of reduced total sales of alcohol which is a reliable indicator of actual consumption. However, we are unaware of any studies that have focused on patterns of consumption since the introduction of the alcopops tax.

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<sup>23</sup> Distilled Spirits Industry Council of Australia. (2008) *Submission to the Senate Standing Committee on Community Affairs. Alcohol Toll Reduction Bill 2007*. Downloaded from [http://www.aph.gov.au/SENATE/COMMITTEE/clac\\_ctte/alcohol\\_reduction/submissions/sub93.pdf](http://www.aph.gov.au/SENATE/COMMITTEE/clac_ctte/alcohol_reduction/submissions/sub93.pdf)

<sup>24</sup> White V, Hayman J. *Australian secondary school students' use of alcohol in 2005*. Melbourne: The Cancer council Victoria, 2006.

<sup>25</sup> Australian Bureau of Statistics 4307.0.55.001 *Apparent Consumption of Alcohol, Australia, 2005-06*. Available at <http://www.abs.gov.au/ausstats/abs@.nsf/mf/4307.0.55.001/>

<sup>26</sup> Chikritzhs et al op cit

***Any evidence of changes to at risk behaviour or health impacts (either positive or negative) as a result of the introduction of the alcopops tax.***

As far as we are aware, the only attempt to answer this question has been the study by Access Economics at the behest of the Distilled Spirits Industry Council of Australia<sup>27</sup>. Their final conclusion was that there was no evidence that alcohol related hospitalizations or emergency department presentations had declined since the introduction of the alcohol tax. However, throughout the document they suggest that various aspects of episodes of care have increased since the tax and in their conclusions suggest that they may have overall increased.

We find important flaws in the methods used and implications drawn by Access Economics. The choice of the F.10 ICD codes as the principal indicator of alcohol related harm is inappropriate. These codes generally account for a very small proportion of all alcohol related conditions for which people present to hospital, and an even smaller proportion of all presentations. They mostly involve a highly subjective judgement on the part of the clinician, and these judgements can be highly influenced by the level of awareness of clinicians of alcohol issues at the time. Injuries form a much larger proportion of alcohol related presentations in young people. A recent study of emergency department coding of alcohol related presentations found that only one quarter of all alcohol related presentations were coded as such by the treating doctor. Injury presentations were 3 times less likely to be coded as alcohol related<sup>28</sup>.

It is always possible that presentations for a particular condition are seen to increase, not because of a real increase, but because all presentations have increased. Access Economics make no comparison with any form of controls such as total hospitalization or emergency department numbers to see whether any trends in the chosen alcohol related presentations were part of a broader trend. A simple perusal of figures 2 – 13 suggests that alcohol related presentations have increased overall each year from 2005 to 2008.

It is worth noting that Access Economics frequently refer to an apparent rise in alcohol related presentations after the alcopops tax introduction and highlight it as being more than a standard deviation above the mean. This would imply that this is “significant”. However, this is not an accepted indicator of statistical significance. As an example, the United States Centers for Disease Control and Prevention in its reports of infectious disease surveillance use a measure of two standard deviations above or below the five year means as indicating a significant change in the occurrence of disease.

Furthermore as pointed out in the critique of the Access Economics study by Chikritzhis and Allsop<sup>29</sup>, the appropriate time series analyses were not performed on the data to determine whether a longer term trend is apparent. When such analysis was applied, it revealed that a longer term increasing trend was apparent and it is not possible to suggest that any change after April 2008 is other than part of that trend.

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<sup>27</sup> Trends in alcohol related hospital use by young people. Report by Access Economics for the Distilled Spirits Industry Council of Australia. Access Economics, 2009

<sup>28</sup> Indig D, Copeland J, Conigrave KM, Rotenko I. Why are alcohol-related emergency department presentations under-detected? An exploratory study using nursing triage text. *Drug Alcohol Rev.* 2008; 27(6):584-90.

<sup>29</sup> Chikritzhis T & Allsop S. (2009) *Review: Trends in alcohol related hospital use by young people by Access Economics*. Perth, National Drug Research Institute, Curtin University of Technology.  
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***Comparison of the predicted effects of the introduction of the alcopops tax, with the data of actual effects, with a particular focus on evidence (or lack thereof) collected by the relevant department.***

In our view the almost overwhelming body of evidence and expert opinion that raising alcohol prices leads to reduced consumption and harms including for young people was a sound basis for considering that the alcopops tax might be effective in reducing consumption.

The sales data reported by Chikritzhs et al in the MJA, while not conclusive, do suggest that alcohol sales may have changed in the right direction. Reports by the Australian Government (based on excise duty data) and the liquor industry (based on their own sales data) are not able to be verified independently as these data sources are not accessible. The only data concerning harms of alcohol comes from an industry sponsored study which has important methodological and analytical flaws (see above).

Resources (perhaps derived from tax receipts) should be dedicated to allow independent evaluation of an intervention as important as this. Access to data should be improved and work needs to be done to encourage all states to collect sales data and for health services to modify their data systems to allow for the collection of more appropriate data.

***The value of evidence-based decision-making in the taxation of alcoholic products.***

Some criticism has been levelled at the Government for its perceived rationale of seeking to protect young drinkers (ie including many under 18 years) and especially young women from the effects of RTDs. DSICA has stated that the majority of the RTD market is so-called “dark spirits” which it asserts are favoured by young men rather than young women. Consistent with this the Alcohol Consumption in Australia Snapshot 2004-05 showed that of risky/high risk drinkers aged 18-24 years, 75% drank ready to drink spirits and liqueurs.

While this group may appear less “vulnerable” to the effects of alcohol, they still suffer a great deal of alcohol related harm and also cause a great deal of harm in the areas of road crashes, interpersonal violence and crime. Males account for approximately 70% of all injured persons taking into account all injury types and for the great majority of drivers in road crashes and perpetrators of violence. Alcohol has been consistently found to be a major contributor to all injury types<sup>30</sup> and crime<sup>31</sup>. Government’s concern should quite rightly be not just for young girls and women but also for young males as well.

**CONCLUSION**

Controlling (ie increasing) price should be part of a comprehensive suite of actions, including reducing access, specific road crash measures and education and health promotion to reduce alcohol related harm. Governments have generally been reluctant to raise prices and restrict access and have preferred to support voluntary industry measures and education in spite of the overwhelming body of evidence and expert opinion being that the former measures are effective and the latter measures much less so if at all<sup>32</sup>.

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<sup>30</sup> National Public Health Partnership (NPHP). 2004. The National Injury Prevention and Safety Promotion Plan: 2004-2014. Canberra: NPHP.

<sup>31</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

<sup>32</sup> Babor et al op cit



The RACP is of the view that the Government's increase in excise on RTD products was a step in the right direction that was soundly based on evidence. The preliminary evidence available suggests that the effect has been positive and in the direction suggested by the evidence. The RACP urges the Government to persist with this measure and to undertake a comprehensive review of alcohol tax policy, founded on public health concerns, with hypothecation of a proportion of the revenues to expanded alcohol prevention and treatment programs.