



# **NATIONAL ALCOHOL STRATEGY**

**2006 - 2009**

**Towards Safer Drinking Cultures**

# **National Alcohol Strategy 2006 - 2009**

Ministerial Council on Drug Strategy  
May 2006.

This document was endorsed by the Ministerial Council on Drug Strategy at its meeting in Perth on 15 May 2006.

The document was prepared for the Ministerial Council by the Strategy Development Team, with direction from the Project Management Group and four advisory groups appointed by the Intergovernmental Committee on Drugs (see Appendix 2).

For information on the National Drug Strategy  
<http://www.nationaldrugstrategy.gov.au>

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## CONTENTS

|                                     |           |
|-------------------------------------|-----------|
| <b>Executive Summary</b>            | <b>2</b>  |
| <b>1. Introduction</b>              | <b>4</b>  |
| <b>2. Strategy Framework</b>        | <b>6</b>  |
| <b>3. Context of the Strategy</b>   | <b>8</b>  |
| <b>4. Priority Areas</b>            |           |
| 4.1 Intoxication                    | 11        |
| 4.2 Public Safety and Amenity       | 15        |
| 4.3 Health Impacts                  | 20        |
| 4.4 Cultural Place and Availability | 25        |
| <b>5. Where to from here?</b>       | <b>30</b> |
| <b>Appendices</b>                   | <b>32</b> |
| <b>References</b>                   | <b>36</b> |

### Figures

1. Annual costs of alcohol abuse, Australia (\$AUD millions).
2. Alcohol-related harm: determinants, behaviours, and outcomes.
3. Total adult per capita alcohol consumption, selected countries (by rank out of 185).
4. Per capita alcohol consumption in Australia, various sources, 1989 to 2003.
5. Prices of alcoholic beverages relative to other consumption (1998/99 = 1.0), Australia, 1973-74 to 2003-04.
6. Per capita alcohol consumption by product type, Australian population aged 15+ years, 1989 to 2004 (year ending 30 June).
7. Per capita alcohol consumption by type of spirits, Australian population aged 15+ years, 2003 to 2004 (year ending 30 June).
8. Estimated number of deaths from acute conditions due to drinking at levels risky or high risk to health, Australia, 1992-2001.
9. Main alcohol and drug-related issues reported by local government.
10. Proportion of the population who are drinkers and non-drinkers, Australia, 2004.
11. Estimated number of lives lost and saved for chronic conditions due to drinking at levels risky or high risk to health, by sex, Australia, 1992-2001.
12. Estimated number of hospitalisations caused and prevented for chronic conditions due to drinking at levels risky or high risk to health, by sex, Australia, 1993/94 to 2000-01.
13. Hospital separation rates related to alcohol use by Aboriginal and Torres Strait Islander status, Australia, 2002-03.
14. Growth in the number of liquor licences in Victoria, 1986 to 2004.

### Tables

1. Alcohol in the leading 12 selected risk factors as global causes of disease burden.
2. Features of Australian drug policy.
3. Estimated number of hospitalisations from acute conditions due to drinking at levels risky or high risk to health, Australia, 1993-94 to 2000-01.
4. Principles for effective policing of licensed drinking environments.

## EXECUTIVE SUMMARY

Alcohol plays an important role in the Australian economy. It generates substantial employment, retail activity, export income and tax revenue. Alcohol also has an important social role. It is a familiar part of traditions and customs in this country and is often used for relaxation, socialisation and celebration. Eighty three percent of Australians reported drinking alcohol in 2004. It is a drug that can promote relaxation and feelings of euphoria. It can also lead to intoxication and dependence and a wide-range of associated harms.

The annual cost to the Australian community of alcohol-related social problems was estimated to be \$7.6 billion in 1998-99. Globally, alcohol-related death and disability accounts for 4.0 percent of the total cost to life and longevity (compared to 4.1 percent for tobacco), even after factoring in any health protective effects of alcohol consumption.

Although the per capita consumption of alcohol in Australia has declined since the 1980's it remains high by world standards. There are patterns of use that are of particular concern. For example, drinking to intoxication is associated with wide-reaching impacts on the health, safety and wellbeing of individuals and communities. Such drinking is not a random occurrence. Many of the dangers of alcohol for those who drink, and those around them, are misunderstood, tolerated or ignored. The harms associated with unsafe alcohol use, including drinking to intoxication, are now well documented in the research literature. There is also widespread concern about the drinking patterns associated with harm among those who are responding to those harms in some way on a day-to-day basis. Developing Australia's drinking cultures to produce healthier and safer outcomes is the key challenge for this Strategy.

### The National Alcohol Strategy 2006-2009

The *National Alcohol Strategy 2006-2009* (the *Strategy*) is a plan for action developed through collaboration between Australian governments, non-government and industry partners and the broader community. It outlines priority areas for coordinated action to develop drinking cultures that support a reduction in alcohol-related harm in Australia. The *Strategy* seeks to reflect the *National Drug Strategy: Australia's integrated framework 2004-2009* and build on the previous alcohol strategy. It also supports the key result areas of the *National Drug Strategy Aboriginal and Torres Strait Islander Peoples Complementary Action Plan 2003-2006*, which was endorsed by the MCDS in August 2003.

The *Strategy* is based on extensive consultations with over one thousand key stakeholders around Australia and a review of the most recent research literature and other data relating to trends in alcohol consumption and harm in Australia. The inclusion of liquor licensing authorities, police and local government in the consultation process represents an effort to integrate with other key groups including the health sector and the alcohol beverage and hospitality industry.

### Strategy Development Principles

Development of the *Strategy* has been guided by a set of principles that have influenced the research methods, the frameworks used for analysis, and decision-making on policy specific issues. The principles are:

- Build on past and present efforts
- Consult

- Seek evidence
- Contemplate future trends and issues
- Focus on some key areas
- Identify realistic responses.

### Strategy Goal

The goal of the *Strategy* is to prevent and minimise alcohol-related harm to individuals, families and communities in the context of developing safer and healthy drinking cultures in Australia.

### Strategy Aims

To achieve this goal, the *Strategy* has four aims:

1. Reduce the incidence of intoxication among drinkers.
2. Enhance public safety and amenity at times and in places where alcohol is consumed.
3. Improve health outcomes among all individuals and communities affected by alcohol consumption.
4. Facilitate safer and healthier drinking cultures by developing community understanding about the special properties of alcohol and through regulation of its availability.

In light of the evidence of alcohol-related harm in the general community and within specific sub-populations, both universal approaches to reduce overall consumption and strategies targeted to reduce harm are needed in Australia.

### Priority Areas for the Strategy

Reflecting these aims, the following four priority areas have been nominated as the focus of the *Strategy*:

- Priority Area 1: Intoxication
  - 1A Increase community awareness and understanding of the extent and impacts of intoxication.
  - 1B Improve enforcement of liquor licensing regulations.
  - 1C Ensure the inclusion of Aboriginal and Torres Strait Islander groups to identify specific responses for Aboriginal and Torres Strait Islander communities.
  - 1D Implement strategies to reduce the outcomes of intoxication and associated harm in and around late night (extended hours) licensed premises and outlets.
- Priority Area 2: Public Safety and Amenity
  - 2A Prevent and reduce alcohol-related injuries.
  - 2B Revise, develop where necessary, and disseminate best practice guidelines.
  - 2C Increase the capacity of local communities, including government, to address public health and safety issues associated with alcohol.
- Priority Area 3: Health Impacts

The following responses relate to the health system and therefore do not necessarily include other responses that can positively affect the health impacts of alcohol, many of which are recommended elsewhere in the *Strategy*.

- 3A Initiate a national effort to enhance the capacity and legitimacy of the nursing profession in addressing alcohol-related health problems.
  - 3B Promote primary care settings as an accessible and non-stigmatising opportunity for health promotion, prevention and treatment of alcohol use problems.
  - 3C Improve capacity and encourage a system-wide health response to people at risk of short-term and longer-term alcohol-related health problems.
  - 3D Support whole-of-community initiatives to reduce alcohol-related health problems.
- Priority Area 4: Cultural Place and Availability
    - 4A Strengthen the regulation of alcohol availability including liquor licensing controls.
    - 4B Investigate price-related levers to reduce consumption of alcohol at harmful levels.
    - 4C Monitor and review alcohol promotions.
    - 4D Develop and implement social marketing campaigns to reduce alcohol-related harms.
    - 4E Develop a shared vision for long-term culture change with the aim of reducing alcohol-related harm and developing safer and healthy drinking cultures in Australia.
    - 4F Examine the legal aspects of alcohol availability.

A fifth area of the *Strategy*, 'Where To From Here?' identifies actions required to support the implementation of the *Strategy*, including:

- Coordinated and integrated approaches
- Building the research agenda
- Data collection
- Monitoring and evaluation
- Developing the workforce
- Developing partnerships and links
- Shaping the future - providing strong leadership.

The recommended responses are listed under the four priority areas and the fifth section focussing on implementation of the *Strategy*.

## 1. INTRODUCTION

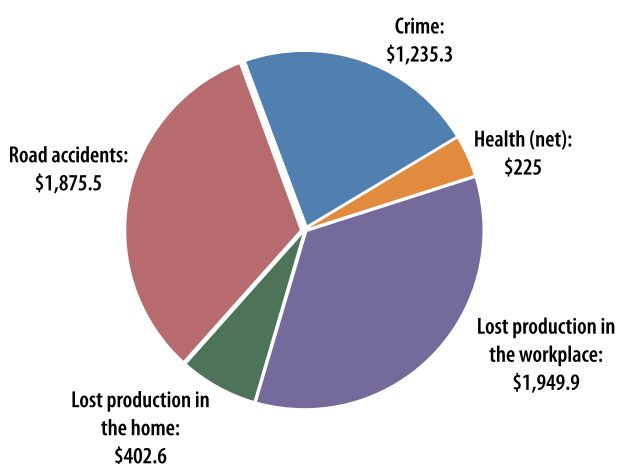
### 1.1 Why does Australia need a National Alcohol Strategy?

Alcohol enjoys enormous popularity and special significance in Australian society. It is used for relaxation, socialisation and celebration. Alcohol also plays a significant role in the Australian economy, generating substantial employment, retail activity, export income and tax revenue. There is also evidence that alcohol can benefit the health of some individuals, if consumed at low levels, by contributing to the reduction of cardiovascular disease risk from middle-age onwards. Everyday, thousands of Australians benefit in some way from alcohol.

Alcohol also has great significance because it is a drug. It is a psychoactive substance that can promote relaxation and feelings of euphoria. However, it can also impair motor skills and judgement, produce intoxication and dependence, cause illness and death and have other harmful effects on our daily social, economic and living environments. Globally, alcohol-related death and disability accounts for 4.0 percent of the total cost to life and longevity (compared to 4.1 percent for tobacco). This figure is adjusted to reflect any health protective effects but it does not include other costs, such as alcohol-related social harms (Babor et al. 2003).

In Australia, the annual cost to the community of alcohol-related social problems was estimated to be \$7.6 billion (\$5.5 billion tangible) in 1998-99. The greatest costs are borne by workplaces as a result of reductions in the size and capacity of the workforce and worker absenteeism due to alcohol-related issues (see Figure 1). These costs are partly offset by the net government revenue from alcohol-related taxes, which is estimated to be \$5.5 billion in 2004/05 (DSICA 2005). The alcohol industry is also a significant contributor to the broader Australian economy, contributing \$18.3 billion in 2004-05, and directly employing 36,000 people and indirectly contributing to the employment of 205,000 people in pubs, taverns and bars (DSICA 2005).

**Figure 1. Annual tangible costs of alcohol abuse, Australia (\$AUD millions)**  
(Source: Collins and Lapsley 2002).



Many of the dangers of alcohol for Australians who drink, and for those around them, are misunderstood, tolerated or ignored. This is particularly apparent with regards to intoxication. The paradoxical affinity that Australians have for a drug that is harmful to so many, so often, has become the hallmark of many of the nation's drinking cultures.

Today there is not a single drinking culture in Australia, but a great diversity, reflecting the varied and changing meanings that alcohol occupies in our lives. Common among these cultures, however, is an unsafe approach to alcohol. To put it plainly, too many Australians now partake in 'drunken' cultures rather than drinking cultures. The harms that result from this include deaths, injuries, disease, crime, violence, fires, drowning, verbal abuse, unemployment and family breakdown. To continue in this direction is in nobody's interests; not individual Australians, their families and wider communities nor the alcohol beverage and related industries. Developing Australia's drinking cultures to produce healthier and safer outcomes is the key challenge for the *National Alcohol Strategy 2006-2009*.

### 1.2 What is the National Alcohol Strategy?

The National Alcohol Strategy is a plan for action developed through collaboration between Australian governments, non-government and industry partners and the broader community. It outlines priority areas for coordinated action to develop drinking cultures that support a reduction in alcohol-related harm in Australia. The *National Alcohol Strategy 2006-2009* has been developed following consultation with key stakeholders and a review of the most recent research literature and other data relating to trends in alcohol consumption and harm in Australia. The *Strategy* seeks to reflect the *National Drug Strategy: Australia's integrated framework 2004-2009*, which was endorsed by the MCDS in May 2004.

#### Priorities of Australia's *National Drug Strategy 2004-2009*:

1. Prevention
2. Reduction of supply
3. Reduction of drug use and related harms
4. Improved access to quality treatment
5. Development of the workforce, organisations and systems
6. Strengthened partnerships
7. Implementation of the *National Drug Strategy Aboriginal and Torres Strait Islander Peoples Complementary Action Plan 2003-2006*
8. Identification and response to emerging trends.  
(MCDS 2004)

The *National Alcohol Strategy 2006-2009* is consistent with the National Drug Strategy, although the status of alcohol as a legal drug requires that the priorities be more specifically developed to address particular aspects of supply and certain patterns of use. The *National Alcohol Strategy 2006-2009* also supports the six key result areas of the *National Drug Strategy Aboriginal and Torres Strait Islander Peoples Complementary Action Plan 2003-2006*, which was endorsed by the MCDS in August 2003.

### **Key Result Areas of the *Aboriginal and Torres Strait Islander Peoples Complementary Action Plan 2003–2006*:**

1. Enhance community capacity to address current and future issues and promote their own health and wellbeing.
  2. Whole-of-government effort in collaboration with non-government organisations to reduce drug-related harm.
  3. Substantially improved access to health and wellbeing services that address drug issues.
  4. Holistic approaches, from prevention to treatment and continuing care, that are locally accessible.
  5. Workforce initiatives to enhance capacity of community-controlled and mainstream service organisations.
  6. Improved ownership and partnerships of research, monitoring, evaluation and dissemination of information.
- (MCDS 2003)

### **1.3 How has the Strategy been developed?**

A project management group and four advisory groups, comprising representatives from a variety of jurisdictions and sectors, have developed the *National Alcohol Strategy 2006–2009*.

#### **The four advisory groups are:**

- Health and Social Issues Advisory Group
- Research Advisory Group
- Alcohol Beverage and Hospitality Advisory Group
- Regulation, Enforcement and Public Amenity Advisory Group

The inclusion of liquor licensing authorities, police and local government in the consultation process represents an effort to engage these with other key groups including the health sector and the alcohol beverage and hospitality industry. Strategy development has also been guided by a set of principles that have influenced the selection of process and priority setting.

#### **Principles**

- Build on past and present efforts.
- Consult.
- Seek evidence.
- Contemplate future trends and issues.
- Focus on some key areas.
- Identify realistic responses.

The third of these principles cannot always be met. While an evidence base should always be sought in developing alcohol policy, this is sometimes not possible because new issues and questions can emerge ahead of the answers. In this






context, it is necessary to approach policy decisions with some caution, akin to a public health concept termed the 'precautionary principle' (Babor et al 2003).

The main method used in developing the *Strategy* was analysis of information and opinions collected from:

- the project management group and advisory groups;
- public comments on the consultation paper;
- national consultation forums with key stakeholders;
- consultations with experts;
- a review of the local and international literature;
- a review of recent trends in alcohol consumption and harm in Australia; and
- a review of recent developments and achievements in alcohol policy at the international, national, state/territory and local level.

A summary of the findings of the national consultations for the development of the *National Alcohol Strategy 2006–2009* is provided within the four priority areas of the *Strategy*.

#### **Snapshot of the consultations**

-  **Consultations with more than 1,000 stakeholders**
-  **23 consultations forums around Australia**
-  **600 feedback forms received**
-  **42 written submissions received**
-  **10 Web responses received**

## 2. STRATEGIC FRAMEWORK

### 2.1 What are the priority areas of the Strategy?

A major challenge in developing the strategic direction for the *National Alcohol Strategy 2006-2009* is setting the key priorities for action. Given the many and diverse issues and responses identified in the national consultation, the review of recent literature and data, and in the previous National Alcohol Strategy, clear priorities for action are needed. While there is significant overlap and links between the issues identified, some emerge as higher priorities than others because of their broad and continuing impact. Most of these offer opportunities for collaborative action.

The following four priority areas have been nominated as the focus of the *National Alcohol Strategy 2006-2009*:

- Priority Area 1: Intoxication
- Priority Area 2: Public Safety and Amenity
- Priority Area 3: Health Impacts
- Priority Area 4: Cultural Place and Availability

Focusing on these four priority areas does not mean that some issues, such as those outlined as 'key strategic areas' in the previous National Alcohol Strategy, will not receive attention. Instead, many issues will be integrated across the strategic framework in an effort to build linkages and encourage complementary responses. In addition to the responses recommended in each of the priority areas, Section 5 of the *Strategy* focuses on 'Where to from here?' and includes implementation issues and priorities in research, evaluation and workforce development.

Figure 2 summarises the relationships between the priority areas. It illustrates that although the determinants, behaviours and outcomes of alcohol-related harm are distinct, many are linked and interact.

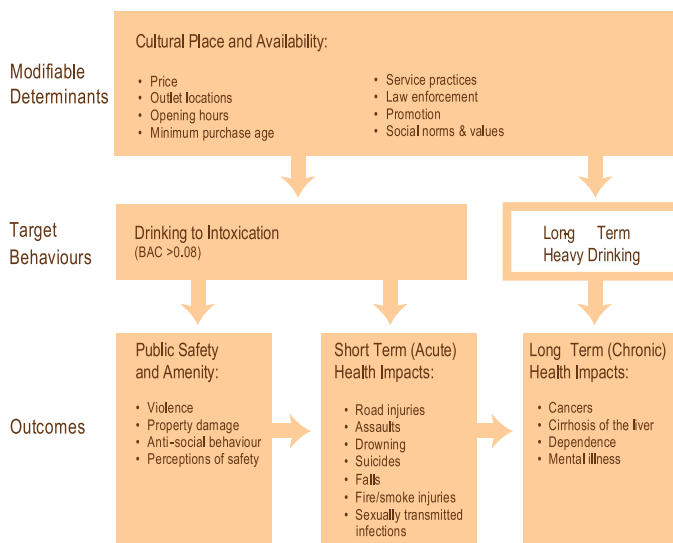
The underlying premise of the *Strategy* is that the cultural place and availability of alcohol represent major determinants, or influences, of behaviours that lead to alcohol-related harm. Throughout the national consultations and the *Strategy* development process there was broad consensus that the most harmful of these behaviours is drinking to intoxication. Therefore, *Intoxication* is targeted as the first priority area of the *Strategy*.

The impact of intoxicated behaviour on public safety and amenity has been increasingly recognised as a major social problem in Australia today. Therefore, *Public Safety and Amenity* is recommended as the second priority area.

As the health outcomes of drinking at harmful levels, both in the short and long-term, continue to be identified as a major preventable disease burden in Australia, *Health Impacts* is identified as the third priority area of the *Strategy*. The *Cultural Place and Availability* of alcohol is addressed specifically in the fourth priority area, underpinning and reinforcing efforts in the other priority areas.

**Figure 2. Alcohol-related harm: determinants, behaviours, and outcomes**

Source: Adapted from Kypri, K. A social ecology of alcohol-related harm (in preparation).



There are other social and structural determinants of patterns of alcohol consumption and of alcohol-related harm including socio-economic status, availability of opportunities for education and employment, disposable income, housing and access to public transport. When examining alcohol consumption and its impacts globally as well as within communities in Australia, the stage of development of the community can significantly influence benefits and burdens associated with alcohol and highlight particular issues. These factors are beyond the scope of this *Strategy* but might be significant for some sub-groups.

**Table 1. Alcohol in the leading 12 selected risk factors as global causes of disease burden**

| <u>DEVELOPING COUNTRIES</u> |                      | <u>DEVELOPED COUNTRIES</u> |
|-----------------------------|----------------------|----------------------------|
| <u>High Mortality</u>       | <u>Low Mortality</u> |                            |
| Underweight                 | Alcohol              | Tobacco                    |
| Unsafe sex                  | Blood pressure       | Blood pressure             |
| Unsafe water                | Tobacco              | Alcohol                    |
| Indoor smoke                | Underweight          | Cholesterol                |
| Zinc deficiency             | Body mass index      | Body mass index            |
| Iron deficiency             | Cholesterol          | Low fruit & veg. intake    |
| Vit A deficiency            | Lo fruit/veg intake  | Physical inactivity        |
| Blood pressure              | Indoor smoke         | Illicit drugs              |
| Tobacco                     | Iron deficiency      | Unsafe sex                 |
| Cholesterol                 | Unsafe water         | Iron deficiency            |
| Alcohol                     | Unsafe sex           | Lead exposure              |
| Lo fruit /veg intake        | Lead exposure        | Childhood sexual abuse     |

Source: Adapted from *Alcohol in the Global Burden of Disease, 2000 (% total DALYS) (WHO, 2002)*

## 2.2 What are the goals and aims of the Strategy?

The following goal and aims have been developed to reflect and support the strategic intent of the *National Alcohol Strategy 2006–2009*.

### Goal

- Prevent and minimise alcohol-related harm to individuals, families and communities in the context of developing safer and healthy drinking cultures in Australia.

### Aims

- Reduce the incidence of intoxication among drinkers.
- Enhance public safety and amenity at times and in places where alcohol is consumed.
- Improve health outcomes among all individuals and communities affected by alcohol consumption.
- Facilitate safer and healthy drinking cultures by developing community understanding about the special properties of alcohol and through regulation of its availability.

## 2.3 What is the scope of the Strategy?

Through the consultations and research for the *Strategy*, a wide variety of issues and recommended responses have been identified, including new and innovative responses. All of the potential responses identified have been scrutinised in relation to what are known to be the critical factors for successful drug policy in Australia, as recognised by the *National Drug Strategy 2004–2009* (see Table 1).

**Table 2. Features of Australian drug policy**

|  |
|--|
| Harm minimisation – recognises the need to use a wide range of approaches in dealing with drug-related harm, including supply reduction, demand reduction (including abstinence oriented interventions) and harm reduction strategies. |
| Comprehensive approaches – encompasses the harmful use of licit drugs (tobacco, alcohol and pharmaceutical drugs), illicit drugs and other substances (inhalants, kava).   |
| Inter-sectoral partnerships – between health, law enforcement and education agencies, affected communities, business and industry.   |
| A balanced approach – across all levels of government, between supply reduction, demand reduction and harm reduction strategies, between preventing use* and harms and facilitating access to treatment.<br><i>MCDS (2004)</i>         |

\* In relation to alcohol, ‘preventing use’ includes preventing risky and high risk drinking and preventing underage drinking.

In light of the evidence of alcohol-related harm in the general community and within specific sub-populations, both universal approaches to reduce consumption and strategies targeted to reduce harm are needed in Australia.

What is proposed represents a public health approach and it should be recognised that ‘public health often competes with other social values such as free trade, open markets and individual freedom’ (Babor et al 2003). Australia has provided leadership and received international acclaim for public health and social policies designed to reduce morbidity and mortality associated with drink driving, speeding and not wearing seatbelts, to nominate just a few. Striking the balance is a significant challenge for the development of an effective National Alcohol Strategy.

## 2.4 What type of response is recommended?

A set of characteristics emerges as essential in developing responses to the four priority areas of the *National Alcohol Strategy 2006–2009*. It is intended that all responses recommended for implementation possess the following characteristics:

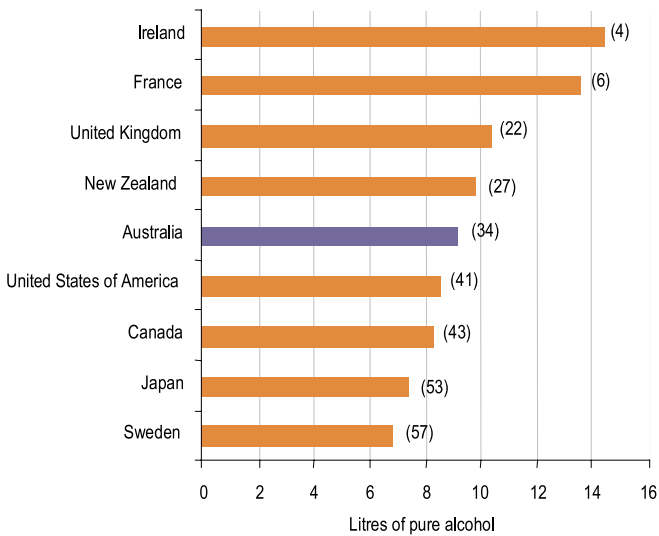
1. Evidence-based with capacity for process, impact, and outcome evaluations.
2. Achievable within *Strategy* timeframe.
3. Balance of whole-of-population and targeted strategies.
4. Link to or build upon existing responses.
5. Clearly relate to a longer-term vision to reduce harm.

Where there is limited or no evidence base, the precautionary principle could apply and expert opinion may be sought.

There are many different groups that need to be involved in taking action to achieve the goal and aims of this *Strategy*. Some responses will require partnerships while government or interest group action might achieve others. It will be important to engage the broader community in contemplation of, and conversations about, alcohol issues in developing some responses.

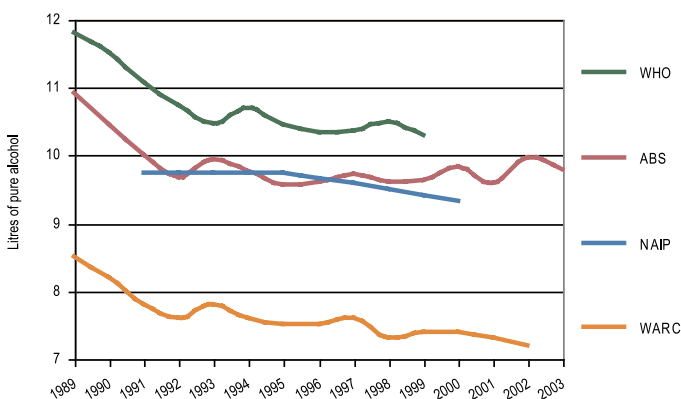


**Figure 3. Total adult per capita alcohol consumption, selected countries (by rank out of 185) (Countries selected with similar cultural, social and economic profile) (Source: WHO 2005)**



The availability of reliable data on alcohol consumption in Australia remains a contentious issue. While there are estimates of per capita alcohol consumption in Australia, there are no longer any accurate records of actual consumption since the collection of wholesale alcohol sales data ceased in some jurisdictions in 1997. Consequently, there are now at least four different estimates published from four different sources using four different methodologies (see Figure 4). The main reasons for differences between estimates relate to the source of the primary data and assumptions about the drinking population. For instance, while both the World Advertising Research Centre's (WARC) and Australian Bureau of Statistics (ABS) estimates are derived using the same source data of total litres of pure alcohol consumed each year, the WARC estimates are derived using the total population of Australia, while the ABS estimates are derived using the population aged 15 years and over. The result is that the WARC estimates are likely to be a significant underestimate of per capita alcohol consumption in Australia. However, it must still be emphasised that the estimates from the ABS, the National Alcohol Indicators Project (NAIP), and the WHO are also likely to contain some inaccuracies.

**Figure 4. Per capita alcohol consumption in Australia, various sources, 1989 to 2003 (Sources: WHO 2005; ABS 2005b; NAIP=Chikritzhs et al 2003; WARC 2005).**

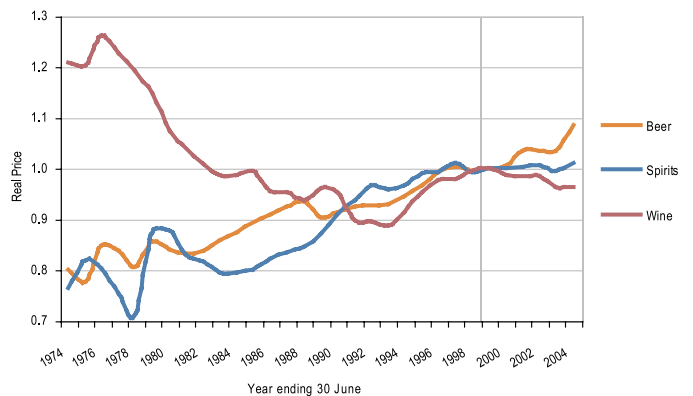


While estimates of per capita consumption of alcohol in Australia over the past 20 years vary depending on the source and basis of analysis used, they do show a similar trend.

The available consumption estimates for Australia show:

- Per capita alcohol consumption in Australia steadily declined from the late 1980s until early 1990s when the consumption began to fluctuate.
- Over the past decade there has been a steady increase in the proportion of the Australian population who drink, reaching 83 percent in 2004 (AIHW 2005).
- 1.46 million Australians consume alcohol on a daily basis, 600,000 (41 percent) of whom are aged sixty years or older (AIHW 2005).
- The real price of alcohol in Australia has remained relatively low, and dropped in some cases. For example, a glass of wine costing \$1.00 in 1998-99 has dropped in real terms, to \$0.96 in 2003-04.

**Figure 5. Prices of alcoholic beverages relative to other consumption (1998/99 = 1.0), Australia, 1973-74 to 2003-04 (Source: ADCA 2005)**

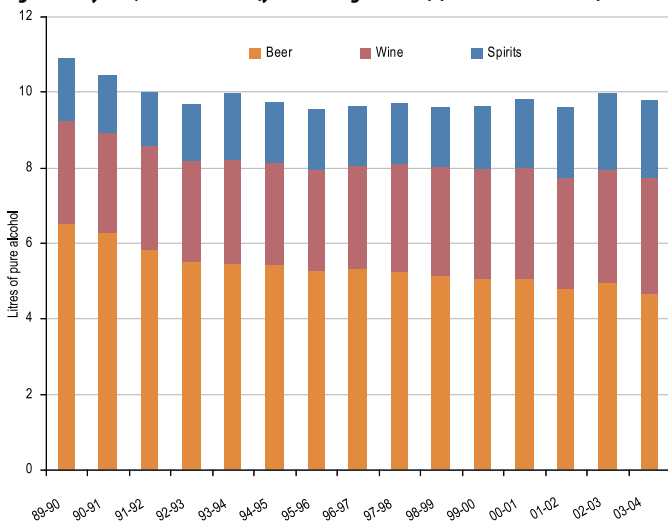


- The price of spirits in Australia, in real terms, has remained almost unchanged over the past decade.
- One in five (20.6 percent) Australians drink at levels that are risky or a high risk of harm in the short-term at least once a month. This is particularly evident among young adults (AIHW 2005)<sup>1</sup>.
- Australians aged 20–29 are the most likely of all age groups to drink at levels that are risky or a high risk of harm in the short-term (AIHW 2005).
- Between 2001 and 2004, the proportion of Australian women who drank at least weekly increased from 33 percent to 35 percent (AIHW 2005).
- Around one third of males (30.5 percent) and one quarter of females (25 percent) aged in their 20s drink at risky or high risk levels for short-term harm at least once per month (AIHW 2005).
- In 2001, 85 percent of the total alcohol consumed by 14–17 year old females was drunk at risky/high risk levels for short-term harm. For males this figure was 80 percent (Chikritzhs et al 2003).

<sup>1</sup> See Appendix 3 for explanation of low risk, risky, and high risk drinking.

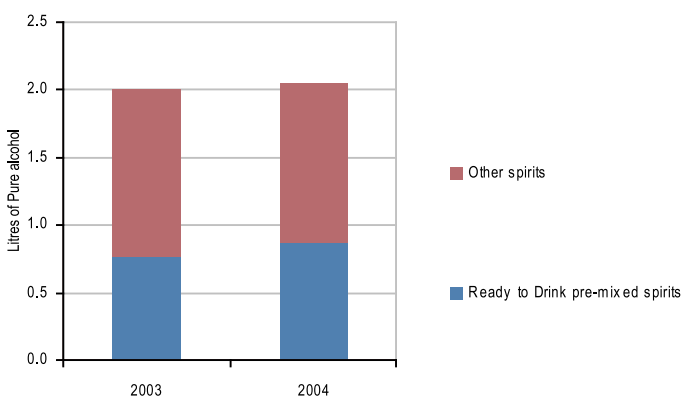
- Between 1990 and 2003, the trend in total alcohol-caused deaths showed a general decline, similar to that for per capita consumption (Chikritzhs et al 2003).
- Following a period of national decline in youth alcohol-attributable deaths during the 1990s, in more recent years, several states and territories have begun to record increases (Chikritzhs & Pascal 2004).
- Aboriginal and Torres Strait Islander peoples are less likely to be current drinkers compared to the general population, although those who do drink are more likely to do so at risky levels. Aboriginal and Torres Strait Islander youth, compared to their non-Aboriginal and Torres Strait Islander counterparts, are 2.3 times more likely to die from alcohol-related causes (Chikritzhs & Pascal 2004).
- There have been significant shifts in the alcoholic product preferences in Australia, characterised by declines in the consumption of beer and increases in the consumption of wine and spirits (see Figure 6).

**Figure 6. Per capita alcohol consumption by product type, Australian population aged 15+ years, 1989 to 2004 (year ending 30 June) (Source: ABS 2005b)**



- The increases in consumption of spirits have been driven by increased consumption of 'Ready to Drink' (RTDs) pre-mixed spirits products (see Figure 7).

**Figure 7. Per capita alcohol consumption by type of spirits, Australian population aged 15+ years, 2003 to 2004 (year ending 30 June) (Source: ABS 2005b)**



- Recent research into the alcohol beverage preferences of 15-17 year olds (about their drinking within previous three months) has found that amongst males, there has been a decrease in the proportion who reported consuming full-strength beer, from 46 percent in 2000 to 36 percent in 2004, but an increase in the proportion who reported consuming pre-mixed spirits, from 14 percent to 36 percent over the same period (King et al 2005).
- This trend was even more pronounced among females, where there has been a decrease in the proportion who reported consuming full-strength beer, from 15 percent to 8 percent, but an increase in the proportion who reported consuming pre-mixed spirits, from 14 percent to 62 percent (King et al 2005).

In summary, these data show that Australia's per capita alcohol consumption, as best it can be estimated, remains relatively high in comparison to many other developed countries and has fluctuated since the mid to late 1990s. A reduction in negative consequences associated with alcohol consumption can be expected if a downward trend in risky and high risk consumption patterns occurs. Reductions in harm would also be expected from per capita decline along with targeted interventions to address some specific sub-populations (youth, including underage drinkers, Aboriginal and Torres Strait Islander peoples and those drinking to intoxication).

### 3.3 What are the public perceptions about alcohol consumption and how to respond?

There has been a recent increase in public concern about alcohol. Respondents to the 2004 National Drug Strategy Household Survey (AIHW 2005) were asked: *When people talk about 'drug problem', which are the first two drugs you think of?* Ten percent of respondents nominated alcohol, compared to 7.8 percent in 2001 (AIHW 2005).

When the general population was asked to nominate possible measures to reduce alcohol-related harm the following responses were given by more than half of those surveyed:

- increasing the number of alcohol-free events (63.3 percent);
- increasing the number of alcohol-free dry zones (63.3 percent);
- Serving only low-alcohol beverages at sporting events (60.6 percent);
- limiting TV advertising until after 9.30 pm (71.4 percent);
- more severe penalties for drink driving (85.9 percent);
- stricter laws against serving drunk customers (83.8 percent);
- restricting late-night trading of alcohol (51.9 percent);
- strict monitoring of late-night licensed premises (72.1 percent);
- increasing the size of standard drink labels on alcohol containers (66.4 percent); and
- adding national drinking guidelines to alcohol containers (69.9 percent).

One third or more supported reducing pub and club trading hours, banning alcohol sponsorship at sporting events and increasing the tax on alcohol to pay for health, education and treatment of alcohol problems (AIHW 2005).

Research that relates to the four priority areas is presented in the next sections. Key findings from the national consultations are also reported in these sections. While not from a general population sample, these data do capture frequently expressed views and opinions. A brief outline of the consultation methodology can be found in Appendix 4.