EDUCATION AND HEALTH STANDING COMMITTEE

INQUIRY INTO THE ADEQUACY AND APPROPRIATENESS OF PREVENTION AND TREATMENT SERVICES FOR ALCOHOL AND ILLICIT DRUG PROBLEMS IN WESTERN AUSTRALIA

TRANSCRIPT OF EVIDENCE TAKEN
AT PERTH
TUESDAY, 11 MAY 2010

SESSION FOUR

Members

Dr J.M. Woollard (Chairman)
Ms L.L. Baker (Deputy Chairman)
Mr P.B. Watson
Mr I.C. Blayney
Mr P. Abetz

Hearing commenced at 2.26 pm

WEERAMANTHRI, DR TARUN STEPHEN
Executive Director, Public Health Division, Department of Health,
examined:

The CHAIRMAN: On behalf of the Education and Health Standing Committee, I would like to thank you for your interest and appearance before us today. The purpose of this hearing is to assist the committee in gathering evidence for its inquiry into the adequacy and appropriateness of prevention and treatment services for alcohol and illicit drug problems in Western Australia. You have been provided with a copy of the committee's specific terms of reference. This committee is a committee of the Assembly. This hearing is a formal procedure and therefore commands the same respect given to proceedings in the house. Even though the committee is not asking you to provide evidence on oath or affirmation, it is important that you understand that any deliberate misleading of the committee may be regarded as a contempt of Parliament. This is a public hearing and Hansard will be making a transcript of the proceedings for the public record. If you refer to any document or documents during your evidence, it would assist Hansard if you could provide the full title for the record. Before we proceed to the questions we have for you today, I need to ask you a series of questions. Have you completed the "Details of Witness" form?

Dr Weeramanthri: I have.

The CHAIRMAN: Do you understand the notes at the bottom of the form about giving evidence to a parliamentary committee?

Dr Weeramanthri: I do.

The CHAIRMAN: Did you receive and read the information for witnesses briefing sheet provided with the "Details of Witness" form today?

Dr Weeramanthri: I did.

The CHAIRMAN: Do you have any questions in relation to being a witness at today's hearing?

Dr Weeramanthri: No, I do not.

The CHAIRMAN: Thank you very much, Tarun, for coming along today. We very much appreciate your joining us, and we appreciate the support that your department gave us last year in relation to the review into tobacco control. Once again, we acknowledge and thank you for coming on board to help us with this issue, which is becoming more of a major problem. As the statistics for tobacco use are starting to come down, we are now having a major problem with alcohol use and abuse. We might invite you to make a presentation and then the committee has some questions for you. After your presentation, we would love to ask you some questions.

Dr Weeramanthri: Thanks, Dr Woollard. First of all, thank you for the invitation to appear before you. I will just preface my remarks by saying that, in my position, I am a kind of generalist over a range of public health issues; I am not an alcohol specialist. You will have heard it from a range of people with specialist expertise relating to alcohol and illicit drugs. What I might try to do in my presentation is provide a more general public health approach without labouring it and also refer you to some documents that I found particularly helpful as a generalist in terms of giving a synthesis of information that I can get my head across, in the hope that that might help you as well. I will first of all say that there is an abundance of data in this area. We prepared our submission around the social and economic costs of alcohol, but there is an abundance of data internationally, nationally and in this state. The best synthesis I have found, which has probably already been tabled

before you, is "Technical Report 3: Preventing alcohol-related harm in Australia", which is a technical report of the national Preventative Health Taskforce. The overall title of that report is "Australia: The Healthiest Country by 2020". This came out in 2009 and basically gives a synthesis of all the evidence and all the possible interventions in a single document which is very readable and which I refer to as my first go-to document in this area. I am happy to provide that if it is useful if you do not have a copy already.

The CHAIRMAN: We have a copy, but we might take another and then we will get a full reprinted one.

Mr P. ABETZ: Everybody in the committee has one, but Hansard can have that one.

Dr Weeramanthri: I want to make a few corrections to the other part of our submission that I will give to the committee. When I return the transcript, I will give you a written form of this. I will not go through it word by word. This submission deals with the specific data that we have inside particularly the epidemiology branch of the public health division which relates to Western Australia and which may complement data that will have been given to you by the Drug and Alcohol Office. We have tried to avoid giving you the same stuff.

[2.32 pm]

To go to a few of the specific points: first is that the health costs of alcohol are just one part of the spectrum of costs. A range of social and economic costs are as important. The health costs are probably the most well known. That report includes an estimate of the total costs of alcohol, which is between $10 billion and $15 billion a year nationally, broken down by the various health costs. Only 20 per cent of the total costs were due to alcohol. I emphasise that the current NHMRC guidelines are a change. I heard Professor Allsop refer to them compared with previous guidelines. In fact, the way in which those guidelines are written presents an important cultural challenge to Australians. I will come back to that as a public health issue later.

The data shows that the consumption of alcohol in WA, in both the long term and short term, is slightly higher than the national figures. That is a fairly consistent data finding. The data also shows that the prevalence of harmful alcohol consumption is particularly high in the young adult group. The data can target specific groups that are particularly affected. I will not go through the long and short-term health effects of alcohol, except to say that one area that has not been as well appreciated in the community is the relationship between alcohol and cancer. We can provide some further details on that, but you may wish to look at that as a new piece of evidence that potentially has a value in that it will present to the public a different kind of message.

For sometime it has been thought that alcohol at low levels has a protective effect in relation to heart disease. That assumption has not been overthrown in the past few year—I would not go so far as to say that—but there is increasing doubt about that. Again, I am not an expert in that area, but some serious methodological doubts have now been raised about the relationship of alcohol being protected at low levels of consumption. You may seek some more information about that, because it is relatively new.

The CHAIRMAN: I remember when the J-shape curve came in and the effect it had on the medical community that had been saying no alcohol for patients with hypertension, then, all of a sudden, that one or two drinks was safe for them. I would be interested to read more about that. What studies are showing that?

Dr Weeramanthri: I can find out some further information on that and provide it to you with specific references.

The other implication of that is that many of the studies around cost have actually offset the harms we know with a protective effective alcohol and come up with a net effective alcohol and, clearly, that is premised on the fact that there is an offsetting benefit. If you look at studies on alcohol and

the burden of disease, for example, it is premised on a protective effect at low levels. You may have to recalculate those studies if that protective effect is not there.

The CHAIRMAN: In relation to that point, if you are not aware of the studies in which it has been recalculated, who should we approach to look at those recalculated statistics?

Dr Weeramanthri: To the best of my knowledge it has not been recalculated. There is a large number of alcohol research people around. I would like to provide you with some further evidence about where people are sitting on this issue at the moment. It may not yet have reached a threshold whereby people have been willing to recalculate. I would like to give you a bit more information on that. The recent intelligence I have heard suggests that this area is slightly more in doubt now than previously. I will try and flesh that out for you.

The CHAIRMAN: Possibly Ian Puddey might be a person to approach.

Dr Weeramanthri: I heard Professor Puddey talk on this subject at a physicians conference the best part of 10 years ago. He was very expert in talking about this issue. He would be a good person to talk to.

I will not go through the details of hospital costs, emergency departments or deaths due to alcohol. However, I point out that all measures of disease burden-related alcohol consumption are highest among males between 20 and 44 years, and that is an overriding fact.

I also draw your attention to the very substantial evidence around foetal alcohol syndrome. Again, in terms of public understanding of the impact of alcohol people probably do not yet get what this means. People have a concern for children and infants and mothers because of the potential for whole-of-life effects for whatever we are talking about. I think the potential in terms of cognitive impairment is just so profound. When you think of your own children or other people's children the last thing you want to do is take off some of their cognitive ability, even if it is just a little bit, in terms of what that will mean for the rest of their life. The effects of alcohol on the developing brain and cognitive function over the whole life span is an area in which we will go to more in terms of the impact of alcohol in the future. We are already thinking of how do we do this in terms of public education awareness campaigns.

The CHAIRMAN: As part of our previous review we were informed about second generation Aboriginal people suffering from foetal alcohol syndrome and the devastating effects it is having on some local communities.

[2.40 pm]

Dr Weeramanthri: We tend to talk about that because it is more at the extreme end of the spectrum there. But even the moderate end is still pretty devastating. You would not want that cognitive impairment for your own children. Again, you would have received, I think from the Drug and Alcohol Office, data on the specific impact of alcohol on Aboriginal people. We have not tried to reproduce that here.

Moving away from health effects, the impact through injuries is obviously profound. One in three road accidents is a staggering statistic. But it is also other types of injuries-falls, accidental drownings, domestic violence and then, of course, suicide and homicide. Each has a body of literature that you can go to. Also there is the impact of crime in terms of the day-to-day kind of work of the police. Alcohol is implicated in 25 per cent of threatening behaviour, 38 per cent of assaults, 53 per cent of aggravated assaults. Those are WA Police statistics.

That is just a very brief overview of some of the kinds of statistics. I refer you to two documents. One, as I have already said, is the preventive health strategy, the other is the "WA Health Promotion Strategic Framework", which covers the years 2007 to 2011. I am happy to talk to that document about what it says in terms of broad public health strategies. But one point I want to make is that, in general, public health would say always look at the whole population. Do not look at just those

individuals who are obviously affected by a problem. The reason is you can calculate the impact of a problem much better by looking at the shape of the distribution in the whole population. If you focus on just those with an obvious problem and try to affect their drinking behaviour, you do not get as much benefit at a public health level as you would if you tried to shift the shape of the whole curve. There is another more profound point here, which is that it is the culture that determines the shape of the curve and where it sits in terms of the average consumption. If you change the average consumption, in fact, you are changing the risk for those at the highest level because everyone moves down with it. So we all share in the responsibility for changing our drinking culture as a society, not just those with the problems. Again, it is an ethical issue. If you say, "It's only those people you can't treat them as other." Whereas if you say, "It's our problem," you look at it in a different way. The people with the problem might be our kids, our neighbours' kids or our neighbours. What we do and say or do not do or do not say as a society is crucial. In this area of alcohol in particular, changing the culture of the whole society and changing the drinking norms is a key public health strategy. I wanted to make that point in general.

I will stop there and say that the only other thing that is new is that, as I am sure you have already heard, we now have a report called the Henry Tax Review, which makes recommendations around volumetric taxation. That is an important new step in terms of the evidence base and what other people make of the evidence base in going forward in this country.

The CHAIRMAN: It is disappointing that it has not been adopted to date.

Mr P. ABETZ: It might happen tonight; you do not know!

The CHAIRMAN: I thank you for that explanation of the normal curve. We all talk about prevention being better than cure, but I have never looked at how important those preventive messages are in shifting that curve and bringing people back. That is something that will influence my thinking in this area, and I am sure that of others.

In relation to alcohol, and the report you mentioned, do you think the social impact of alcohol on WA has got worse over the past five or 10 years? We talked earlier today about the data that has been collected on the sale and consumption of alcohol. We are hoping we can eventually get hold of some of that data so we can have a close look at it. The social impact is certainly something we are more aware of now due to articles being reported and some of the legislation that has come to Parliament as a result of the effects of alcohol. How do you feel about the social impact of alcohol on the community?

Dr Weeramanthri: I think the answer to that is best given at a very specific level rather than trying to give a generic answer. One must get data on different parts of the community. The particular areas I would be interested in looking at are young people and Aboriginal people in particular. I do not have data to give you that relates to WA on either of those. But I can say that I think there is some data around risky drinking in young people Australia wide that shows that the problem has become worse in the past decade. I think there is also some relationship between different states' policies and that phenomenon. In Victoria for example, which has essentially liberalised some of its licensing laws to create a more cafe culture—drinking in a relaxed, informal environment—there has been a rise in both the rate of young people drinking, the age of onset of drinking and the harmful effects of that drinking. But I do not have data for WA.

I would be interested also if there is any national data on Aboriginal people and the impact of alcohol. In the absence of such data I would look for particular areas and evidence of restrictions, for example, working or not working. I think there is some data from licensing restrictions in particular areas of WA that we can look at. I am aware of the data from Fitzroy Crossing since, I think, 2007 when licensing restrictions were introduced that shows there has been a dramatic fall in alcohol sales and, I believe, a fairly dramatic reduction in health presentations and other impacts in that area. You can compare that to different areas where those things have not worked. I do not have

an overall answer for you. I think it is an important question if you break it down into particular groups.

The CHAIRMAN: You just talked about licensing restrictions. One of the things we are obviously interested in is the effect of the changes made to the Liquor Control Act by the previous government. The primary objects of the act were to regulate the sale, supply and consumption of liquor and minimise harm or ill health. Subsection (3) was inserted, and reads —

> If, in carrying out any of its functions under this Act, the licensing authority considers that there is any inconsistency between the primary objects referred to in subsection (1) and the secondary objects referred to in subsection (2), the primary objects take precedence.

I will pass a copy of that around to you. One of the things that members of Parliament have been made aware of in the community is the problems in terms of increased usage. You yourself mentioned the Victorian experience.

[2.50 pm]

Can you give us any evidence that you have become aware of, since the insertion of that subsection (3) in the act, of the effect that has had on the control of alcohol and the abuse of alcohol within the community?

Dr Weeramanthri: I am not aware of any evidence that goes to that point, Dr Woollard.

The CHAIRMAN: Has your department been made aware of any problems that have arisen because of the insertion of that subsection?

Dr Weeramanthri: Not directly. I mean, we work within the legislative framework that is provided for us by government, and we are very active in working with the Drug and Alcohol Office in jointly developing arguments for why a particular proposal should be allowed or not allowed or why it should be challenged or not challenged in terms of licensing. So that is a very active part of our work. It is done on my delegation by Dr Andy Robertson in my division, who works with the Drug and Alcohol Office and processes a lot of that. We make a lot of applications each year; and, again, if you are interested, we can provide details of that. But I actually had assumed that that would be provided to you by the Drug and Alcohol Office in terms of the number of applications being made.

Ms L.L. BAKER: For liquor licensing?

Dr Weeramanthri: Yes.

Ms L.L. BAKER: Not so far.

Dr Weeramanthri: The volume of that kind of work is quite noticeable.

The CHAIRMAN: That would be helpful. Is that assistance that your department is asked to give in terms of community groups that want to oppose a liquor licensing application? I am not sure what you mean by that.

Dr Weeramanthri: Sorry. I will clarify that. Under the legislation as I understand it, the Executive Director of Public Health, which is the position that I hold as a statutory position, is asked to comment on licensing applications that are made. The process is that I have delegated that to Dr Robertson, who works with the Drug and Alcohol Office, in order to formulate our obligation under the act to either object or not object.

The CHAIRMAN: So each application for a new liquor licence comes via the Department of Health to Dr Robertson, who would then put in a submission to liquor licensing either supporting or opposing an application?

Dr Weeramanthri: That is my understanding, yes.

The CHAIRMAN: In relation to that —

Dr Weeramanthri: Excuse me. I am not sure if he actually supports it. He either put in an objection or does not. I am not sure whether there is an active support for it, if you know what I mean.

The CHAIRMAN: Yes. It would be interesting to get some statistics over the last few years—possibly over the last eight years—so that we can see the number of applications prior to the insertion of that part of the act and after the insertion of that part of the act. I know that certainly my local community does not want a large increase in the number of licensed liquor outlets. I am involved with a couple of community campaigns at the moment. One of those groups is opposing an application for an old IGA store to be turned into a liquor warehouse, and another group is opposing an application by a restaurant to serve alcohol 100 per cent without a meal. So I know that some community groups certainly do not believe that that was a good insertion into the act, because of the effects that that has had. So if we could know the number of applications that were made four years before that subsection was introduced, and the number of applications that were made four years after that subsection was introduced, and how many of those were successful, that would be very useful.

Dr Weeramanthri: I think that would be possible. I have seen data presented in this area that is of that form. But I would like to get some clarification about the dates so that I can understand the before and the after.

The CHAIRMAN: This subsection was inserted in 2006, so if we could have the data from 2002 so that we will have at least four years.

Dr Weeramanthri: I cannot promise you, but I will ask for it.

The CHAIRMAN: Thank you very much. That would be very useful.

The CHAIRMAN: Another matter that is often brought to us as local members is what is seen as an escalation in the number of liquor outlets. I do not want to put you in a difficult position here, so if you are not able to answer this question, that is fine. The government has recently tabled in Parliament a report from the Red Tape Reduction Group. I am not going to ask us for your opinion of that, because I certainly do not want to get you in any trouble with your minister. However, since that report has been tabled, have any concerns been brought to you in relation to the consequences that could occur for the control of alcohol if the recommendations in that report are adopted?

Dr Weeramanthri: I think people understand that there is a constant balancing between the regulation of any activity and allowing that activity to fulfil legitimate social purposes. The sale of alcohol is a legitimate social purpose. The purpose of regulation is to put a frame around that so that there is a trade-off between the benefit and the downside of it. The balance of that can only be decided by our Parliament. I am aware of arguments in favour of more restrictive regulation and in favour of less restrictive regulation. Those arguments involve different decisions about where the optimal trade-off is. Clearly there will be people with a more industry viewpoint who will argue that there should be less legislation rather than more, and there will be people who value public health outcomes and who will argue that there should be more regulation rather than less. The red tape report clearly gave rise to a discussion about the appropriate balance.

Dr J.M. WOOLLARD: Thank you. In relation to alcohol consumption, we appreciate that we have the Drug and Alcohol Office. The Drug and Alcohol Office does a wonderful job, and your department does a wonderful job. But one of the concerns that I have is that alcohol affects almost every agency. Who is looking at how the issue of alcohol control is dealt with by all the other agencies? Does that come under your direction? If not, who has the oversight to try to encourage some of those other agencies, which possibly are not putting as much funding into this issue as may be required, to try to combat some of the problems that we have with alcohol abuse in our community?

[3.00 pm]

Dr Weeramanthri: Thank you. That is a fair question. I think it is fair to say that in Western Australia a decision has been made that there would be an independently structured statutory Drug and Alcohol Office. I will just note to the committee that apart from the position in which I am appearing before you, I am also on the board of the Drug and Alcohol Office, which provides some connection, if you like, between the activities. But, in a statutory sense, it is the Drug and Alcohol Office that has primary responsibility for drug and alcohol policy from a governmental perspective, and they report, as you know, through to the Minister for Mental Health, who also has the drug and alcohol portfolio, which is different from the Minister for Health. Of course, there is a requirement to look at the best workings together of the Drug and Alcohol Office and the department. We are not separate in the sense of them working over there and of us working over here. But it is not dissimilar to this issue: if mental health sits separately, how does the health department work with mental health to get the best outcomes for people, and it is not dissimilar to how any two government agencies have to work together for the benefit of the public. It is actually a very close working relationship. They do have primary responsibility, but, for example, in a health promotion strategic framework, we include alcohol. When we are looking at the implementation of community level policies in the country or the metro area, it is integrated at a service level. Rehab facilities, treatment facilities and brief interventions are all delivered often in an integrated manner, just like mental health and health services are delivered in an integrated manner. At a policy level, clearly the Drug and Alcohol Office as prime responsibility, but at a working officer level, we work across all the time, and we meet together and make sure that our approaches are complementary. In fact, the level of integration gets better and better the closer you get to the ground.

The CHAIRMAN: I know that you would work very closely. My question is in relation to the Department of Corrective Services, the Department for Child Protection, the Department for Communities, the police department—all those other departments for which a large percentage of their budget is spent on the problems that result from alcohol use. So I am wondering: does the Drug and Alcohol Office have someone from those departments? Is there a mechanism to ensure that other agencies are picking up on the good messages that your department and the Drug and Alcohol Office are wanting to get out to the community and incorporating them into their own departmental guidelines and funding for their departments?

Dr Weeramanthri: You may wish to ask the Drug and Alcohol Office specifically, but I would say, being a member of their board, that clearly it is in their mandate to foster that cross-agency collaboration, and they do. I would say that they would have the prime responsibility to do that, more than the health department would, for example, because they are the independent, statutory Drug and Alcohol Office, and their whole purpose is to do their work, but also to work with other agencies. Exactly how they do that and what the outcomes are and what the cross-government mechanisms are, I would suggest you would probably get a more accurate answer from them.

The CHAIRMAN: Thank you. I will ask that, because, as a committee, we are interested in the funding that is going into each government department to try to help both you and the Drug and Alcohol Office in relation to this problem.

Mr P. ABETZ: My understanding—correct me if I am wrong—is that the drug and alcohol area in other states is under the direct umbrella of the health department, whereas I think in 1970-something in WA we set up the Alcohol and Drug Authority as a separate statutory body. Do you see advantages in that structure? By the way, is it okay to ask that question?

The CHAIRMAN: Yes.

Mr P. ABETZ: I do not want to ask any questions that might be awkward. But do you see any value in that structure? It just seems to me that at times there has been a disconnect between, say, the hospital system and the Drug and Alcohol Office and the expectations and integration. Would it perhaps be better if it were under the umbrella of the health department so that there would be a freer slow of information, of personnel and so on?

Dr Weeramanthri: My understanding is that what you said is correct. I am not sure which other state governments have this independent arrangement. I believe that in most other states and territories—I cannot give you chapter and verse—it is integrated into the health department. That is my understanding. Without wishing to take a position on it, I think it is clear that there are pros and cons for both options, just like there are—I am not trying to avoid the question. I just think that you get a greater specialist clout. You attract people who are very focused and interested in that area. You allow for some kind of development of thinking that is highly specialised if you have a separate agency, and to some degree it is a little bit closeted away from some of the other influences in the wider agency. But what you have to do then is manage the problems that come with being separate by having very well developed integrated mechanisms. Equally, if you go to the other view where you structurally foster the integration, you also then have to make sure that you deliver very clearly on the drug and alcohol outcomes, without having those outcomes diluted by other priorities within the agency. There is no right way, but whichever way you do it, you have to be aware of the disadvantages and have a strategy to overcome them.

The CHAIRMAN: Has the department researched the impact of raising the legal age of drinking?

Dr Weeramanthri: Not to my knowledge, Dr Woollard.

The CHAIRMAN: So there have been no discussions in relation to that area.

Dr Weeramanthri: Not that I have ever heard.

The CHAIRMAN: The other thing in relation to the legal age of drinking is: has the department investigated or researched the impact of lowering the blood alcohol level?

Dr Weeramanthri: Our department has not since I began at the beginning of 2008.

The CHAIRMAN: Are you aware of any research on that within WA?

Dr Weeramanthri: I am not aware of any research, no.

The CHAIRMAN: The Drug and Alcohol Office reported that the cost of alcohol-related hospitalisations has increased significantly. You actually mentioned that data as part of the report, and you said that you did not want to go into fine detail. However, I do not believe that the report that you referred to, which I believe we were given a copy of six months ago—I had a look through it when it was released—goes down to the finer details. I think that the costs would be something that would probably go to you rather than to the Drug and Alcohol Office. Are we able to get an indication of those costs? Professor Allsop said that for most of the people being treated for liver cirrhosis, it would be for alcohol-related problems.

[3.10 pm]

Therefore, what are the costs that impact on our tertiary and secondary hospitals because of liver cirrhosis and pancreatitis? You have said that there are incidences of cancer. That obviously is a concern to the committee. From our last report we know that more funding needs to go into the care of, and treatment for, people who suffer cancer. We were looking at general chronic diseases including cancer but we were not necessarily relating that to alcohol in our previous report. You have now possibly opened our eyes about the need to think about what the costs will be in 20 or 30 years because of the problems with alcohol. If we are already expecting the number of people with cancer and other chronic diseases to double over the next 15 or 20 years because of the aging population, what happens when we factor in cancers related to alcohol consumption? Are you able to provide us with an indication of the costs of alcohol consumption to the tertiary and secondary hospitals?

Dr Weeramanthri: Dr Woollard, I think that the primary author of the 2008 report that you referred to is J. Xiao, and others, and that the report is titled the "Impact of Alcohol on the Population of Western Australia". That report came out of our division. I think that is the report you mentioned. The report says that the hospitalisation rates for alcohol-related chronic disease

increased from 1997 to 2006 while those for alcohol-related acute conditions remained unchanged. That was a specific analysis of hospitalisation. Associated with that was a national study done by Collins and Lapsley that talked about hospital costs accounting for 36 per cent of the total health costs. I will see if there is any further work in terms of hospitalisation data or costs that were not published in that report. I am not aware of any. I have not seen any further work programs or documents from the epidemiology branch that suggests that there has been work done subsequent to that report but there may be more detail that was not in the report or we may draw your attention to certain bits of it that may not have been obvious but which goes to your question. If I understand it, you would like as much data as is available on the costs in Western Australia in terms of secondary and tertiary hospitals. Is that correct?

The CHAIRMAN: Yes.

Dr Weeramanthri: And any projections that relate to alcohol and cancer.

The CHAIRMAN: I am also interested in that because one of the concerns that has been brought to my attention is that when people attend hospital, because they have broken their arm, for example, the hospital does not record that when the patient was admitted the patient was under the influence of alcohol. Therefore, we may not have an accurate picture of the cost of alcohol-related presentations to our tertiary and secondary hospitals. Is that something that your department has some control over? Are you able to provide the committee with a response about whether that data is currently being collected? If it is not, what strategies are likely to be introduced in the future to try to gather that data so that we can see the true cost? Because, as you have said, we must change the normal curve and thinking about alcohol, we have to be able to provide the community with the true cost of our acute sector and our community health services and admissions to general practice and the other community services.

Dr Weeramanthri: I will refer to the previous witness, Professor Allsop. This goes back to an answer that he gave about etiological fractions. I will try to explain that. If you were to make an assessment of every individual who attended an emergency department, you could do it in a standardised way about when that presentation was or was not related to alcohol. You would be directly assessing each case. If you could capture that in some kind of information system in every emergency department in every hospital every day of the year, it would be possible but it would be very, very hard and very expensive. That is not possible in the real world. You just cannot get that level of resource intensiveness by collecting all of that type of information all the time from everyone. Having said that, what you can do—this has been done—is a specific research study that samples the next 200 or 2 000 presentations that come into an emergency department. You can then get an etiological fraction for the various conditions that show an average figure. If we take the Fremantle Hospital emergency department as being representative because that is where you collected the data, the data might show that 25 per cent of the cases of patients who presented with broken legs or whatever was related to alcohol. That becomes an etiological fraction that can be applied to the number of broken legs across Australia to make an estimate. The quality of that estimation depends on the presumptions of representiveness. If you collected all that data on people aged between 20 and 40, who were the catchment area of Fremantle Hospital, and you then went to a different area with an older population, the etiological fraction might be different. You have to make a whole lot of assumptions but it is still our best way of estimating. You do not need an exact number; you need a broad estimate. In fact, that work has been done in terms of our hospital costs. That is what Collins and Lapsley did in their 2008 report. They applied etiological fractions and gave estimates for Australia. I would not personally consider it much of a gain for the Department of Health to do that type of research work again just to finesse a number that we know the broad magnitude of.

The CHAIRMAN: Peter tells me that Professor Allsop gave us that information. I will read back through his notes. Does the department run any in-house programs to lower the alcohol intake of your staff?

Dr Weeramanthri: We have guidelines about how one behaves as a public servant. Generally speaking, one would never purchase alcohol out of any departmental funds. One would have to get special permission from the director general if one were to do so. In that kind of public service way there are general rules that apply. In terms of a specific work health program, if that is what you are asking for, no. It is reasonable to say that we are looking at work health programs as part of the Council of Australian Governments National Partnership Agreement on Preventive Health, which is one of the largest investments in preventive health made by the commonwealth and which started last year.

[3.20 pm]

Dr Weeramanthri: One of the streams of that work is healthy workplaces. There is going to be the development of the national healthy workplace charter with programs in all states and territories. We are looking to work that up now, and that work is going on inside my division in terms of what that might look like for WA. I would like to see key government agencies taking the lead in that. Just like we take the lead on healthy food supplies et cetera in our canteens, it would be a reasonable thing for us to take some lead in terms of the large number of employees we have in WA Health.

The CHAIRMAN: I have one more question, but I might check with the committee first. This is the cup with all the golden coins in it. If the government were to say that it had these additional funds and asked you what initiative could be introduced to decrease the problems and reduce the harms from alcohol, what initiatives would you suggest?

Dr Weeramanthri: I would not presume to give advice to government publicly, but if I was to be giving a lecture at a university to a public health group, the answer I would give—I will give you the top three things—without trying to be comprehensive is: first, is as I started, that we actually have to reduce the community acceptance of drunkenness. Whatever we do, we have to address the drinking culture amongst mainstream, middle-class people who see themselves as not problem drinkers, as well as everyone else. I am saying that if we do not address that group, I do not think we have a public health approach—I will not go into what I said at the beginning. That clearly requires a range of strategies, but always with the knowledge that we are actually trying to change social norms. If we are not challenging people and not getting people to think again, then we are probably not going to achieve a change—that is, if it is not challenging enough. It is as simple as that. We do have some campaigns like "Alcohol Think Again", which really is asking everyone to think about their attitudes, and also then the messages they give to other people in society about what is acceptable and what is not acceptable. That is the first thing.

The second thing is alcohol pricing, which is an absolute key issue. There are three elements to that. One is the actual level of taxation on alcohol, and there is very, very strong evidence that the higher the taxation, the lower the overall consumption of alcohol. The second is volumetric and moving to a volumetric taxation basis, which evens the playing field in terms of different types of alcohol. Thirdly, is the floor price issue. There should be a minimum floor price for alcohol so that we do not get heavy discounting and the happy hours, because that goes to culture. The second element is price. The third is pretty straightforward and is about effective enforcement of what we have in place at the moment. I am particularly thinking about responsible service of alcohol, which, for me, is a key determinant at the final interaction between the consumer and the beverage. If we really did give consistent enforcement about responsible serving, we would get a change in community attitudes. That is already on the books. What we really need to do is make sure we are doing that. Like with all regulation and legislation, enforcement is the key. There is no point in having this unless we do something about them.

The CHAIRMAN: I would like to thank you very much for the evidence you have given before the committee today. A transcript of this hearing will be forwarded to you for correction of minor errors. Any such corrections must be made in the transcript and returned within 10 days of the date of the letter attached to the transcript. If the transcript is not returned within this period, it will be deemed to be correct. New material cannot be added by these corrections in the sense that your evidence cannot be altered. Should you wish to provide additional information—we appreciate the fact that you will be forwarding us a copy of your initial presentation—or elaborate on particular points, please include a supplementary submission for the committee's consideration when you return your corrected transcript. If there are any additional comments, could they be separate because it would be nice if we could put up your initial presentation as a submission on the internet? Any reports that were not given in that initial presentation could maybe be a separate addendum to that submission. We would very much appreciate that. Thank you once again.

Hearing concluded at 3.26 pm