

Opening comments from Steve Allsop

While many in the community enjoy alcohol, it also contributes to a range of social, cultural, economic, and political 'pains'. Collins and Lapsley have estimated the dollar costs for Australia at over \$15 billion. Of course, this may be an underestimate because some harms have not yet been adequately described and accounted.

Alcohol has a significant impact on a large proportion of our population - not just a small number of heavy drinkers – a large proportion of the population drink in a risky manner, at least occasionally and across the whole population this contributes to a significant amount of the harm. Most of us, even those who do not drink or are low risk drinkers, are affected in some way – the costs impact on us through the significant impact on policing, on our emergency departments, on our actual and perceived safety – current alcohol harms cost the whole community.

Although not well documented, "collateral harm," or harm to others, can be experienced by families, friends and members of the broader community. For example, based on the National Drug Strategy Household Survey, it has been estimated that over a 12-month period, approximately three quarters of a million Australians will report they had been physically abused by someone who was perceived as alcohol affected and over 2 million reported they had been 'put in fear' by someone who was perceived as alcohol intoxicated (AIHW, 2008).

Some good news has been that we have seen a decline in alcohol related deaths, but many jurisdictions have seen a large increase

in alcohol related emergency department admissions and hospitalisations.

In terms of our responses, the evidence is consistent – availability is a critical lever in relation to alcohol related harm – we cannot simply make alcohol more readily available through reduced price, increased number of outlets and increased hours of sale without increasing adverse outcomes. The oft repeated argument that liberalising the laws will result in less harm is counterintuitive and more importantly contrary to the evidence. Some jurisdictions are discovering this to their cost.

It is also important to note that the way some people (in private homes and in retail outlets) make alcohol available is not conducive to good health. While many in the alcohol industry try and do the right thing, others do not – we should support the former and hold the latter to account.

What do we need to do?

Effective interventions are based on good data. We need good intelligence about use and harm – this means ensuring we capture sales data and combine these with better information about the impact of alcohol on policing and emergency admissions – WA has the advantage of having the former. Work is ongoing to ensure we have the latter two important sources of information.

Only with such data can we make meaningful decisions about the impact of increased hours and outlet density and in terms of use and, target our policing and other prevention activities and have a

rational liquor licensing system that takes into account public health and social impact, allowing us to monitor the impact of policy change.

We need more emphasis on prevention. As indicated, availability is at the core of alcohol prevention strategies. We also need to focus on connectedness – school connectedness, in terms of social and academic competence, can reduce risk of a range of later problems, including alcohol problems. Part of this will mean building our investment in early year engagement, especially in vulnerable populations and communities.

A large number of people who are drinking in a risky manner do not access intervention services. We should consider developing and implementing brief interventions with adolescents/young people. More broadly, we need to better target interventions to the majority of affected people who do not use our treatment services – this means investing in effective strategies to build the capacity of our primary health care services and using innovative technology to deliver interventions to this large at-risk group.

We are also not getting the best out of our treatment. There are a number of effective pharmacotherapies that we should promote to increase their uptake by clinicians and dependent drinkers.

If we are to better engage a wider group of clinicians, we need to invest in building the capacity of the health workforce to intervene. The Drug and Alcohol Office and the non-government sector are doing a good job in relation to continuing education, but we

probably need a re-investment in the post-secondary/tertiary sector, to reclaim the extensive undergraduate and postgraduate education in “addiction studies” that used to exist in WA.

People who experience co-existing mental health and alcohol disorders are more disadvantaged, use services more and have poorer treatment outcome. To respond effectively we need to enhance the capacity of the whole sector to respond, but importantly we must invest more resources in mental health. With limited resources they do not have the capacity to respond in the way we would wish

While the debate is often, appropriately on younger Australians, we should not neglect the ageing population. We know little about this domain, but the ageing population, and current and recent patterns of alcohol consumption suggest we are likely to have an increasing public health challenge with the ageing population.

Many Indigenous Australians do not drink. Included amongst those who do are some very risky drinking patterns. In some communities things are possibly getting worse, not better. If we wish to close the gap, we must of course focus on issues such as tobacco, but we must also address harmful alcohol use.

Trends in estimated alcohol-attributable deaths and hospitalisations in Australia, 1996-2005

Summary Points

- Over the last 10 years (1996–2005), an estimated 32,696 Australians aged 15 years and older died from alcohol-attributable injury and disease caused by risky/high risk drinking.
- An estimated 813,072 Australians aged 15 years and older were hospitalised for alcohol-attributable injury and disease over the 10-year period 1995/96 to 2004/05.
- In 2005, estimated alcohol-attributable death rates in the NT, Tas, the ACT, SA and Qld exceeded the national average. The NT, Qld and NSW also exceeded the national average for alcohol-attributable hospitalisations.
- Male death rates showed generally declining trends in most states/territories, except the ACT and Tas which both indicated more upward trends since the late 1990s.
- Female death rates declined steadily in the larger states/territories. Downward trends were less consistent in the NT, Tas and the ACT.
- Rates of alcohol-attributable hospitalisations increased in all jurisdictions, especially in Vic, Tas, the NT and the ACT.
- In 2005, the most common cause of alcohol-attributable death was alcoholic liver cirrhosis. Other common causes of death included non-pedestrian road injury, haemorrhagic stroke, suicide and colon cancer.
- Alcohol dependence, falls, assaults and alcohol abuse were the most common causes of alcohol-attributable hospitalisation in 2004/05.
- The ACT was the only jurisdiction where overall alcohol-attributable deaths increased between 1996 and 2005, a larger increase than for non-alcohol-attributable deaths.
- Vic had the largest increase in alcohol-attributable hospitalisations in the country from 1995/96 to 2004/05. Relative to non-alcohol-attributable hospitalisations, increases in alcohol-attributable hospitalisations were larger in the ACT, NSW, Vic and Tas.
- In WA, the rate of increase in alcohol-attributable hospitalisations between 1995/96 and 2004/05 was substantially lower than the concurrent increase in non-alcohol-attributable hospitalisations.

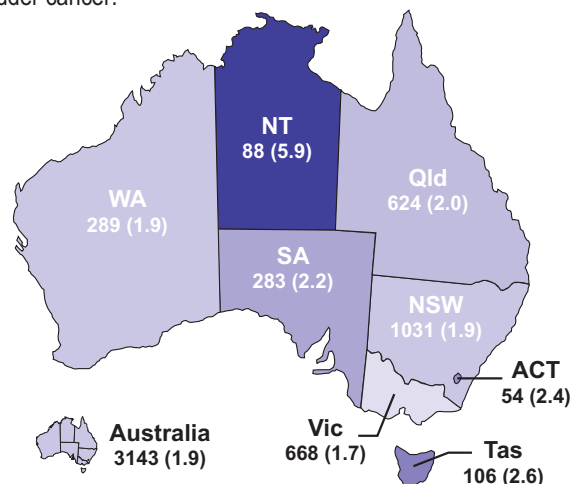
Introduction

Alcohol was estimated to cost the Australian community some \$15 billion in 2004/05 – about twice the social cost of illicit drug use (Collins & Lapsley, 2008). Alcohol is a major cause of death and injury for many Australians and especially “at-risk” populations such as young, elderly and Indigenous populations (see previous NAIP bulletins).

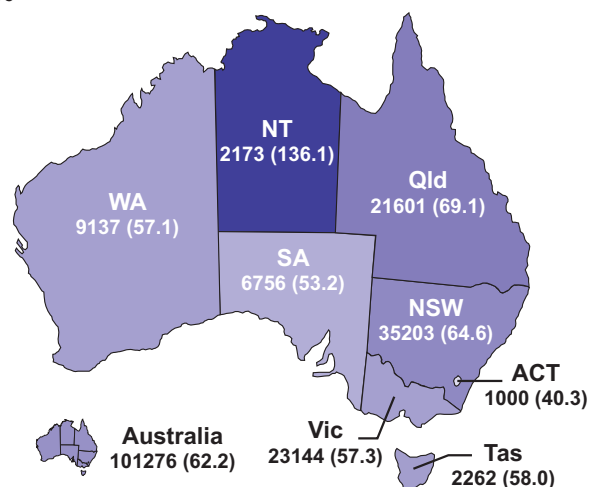
This bulletin shows trends in estimated population adjusted rates of deaths and hospitalisations attributable to risky/high risk alcohol

consumption (based on NHMRC 2001 drinking guidelines) across all jurisdictions for a period of 10 years (1996-2005). The rates shown here are for adults (15+ years) and are based on the aetiologic fraction method for quantifying alcohol-attributable mortality and morbidity (English *et al.* 1995; WHO 2000). As such, these rates are considered estimates of deaths and hospitalisations ‘caused’ as opposed to the more loosely defined estimates of ‘alcohol-related’ events. Rates have been directly age-standardised to the 2006 national population aged 15 years and older (ABS 2008).

This Bulletin also includes estimates of non-alcohol-attributable deaths and hospitalisations as a comparison measure (page 4). Non-alcohol-attributable conditions were those not currently considered to be attributable to either alcohol or tobacco use (changes in population tobacco use may influence underlying mortality/morbidity trends). Non-alcohol-attributable conditions include for example; pancreatic cancer, unspecified dementia, and cataracts but exclude tobacco-attributable conditions such as lung cancer, peptic ulcer, chronic bronchitis, peripheral vascular disease, renal pelvic cancer and bladder cancer.



Map 1: Estimated numbers and age standardised population rates (per 10,000) of alcohol-attributable deaths for adults (15+ years), 2005



Map 2: Estimated numbers and age standardised population rates (per 10,000) of alcohol-attributable hospitalisations for adults (15+ years), 2004/05

Figure 1: Alcohol-attributable deaths for adults (15+ years), males and females, 1996–2005

Legend: ■ males; ● females. Y Axis: Alcohol-attributable death rate per 10,000 15+ yr olds.

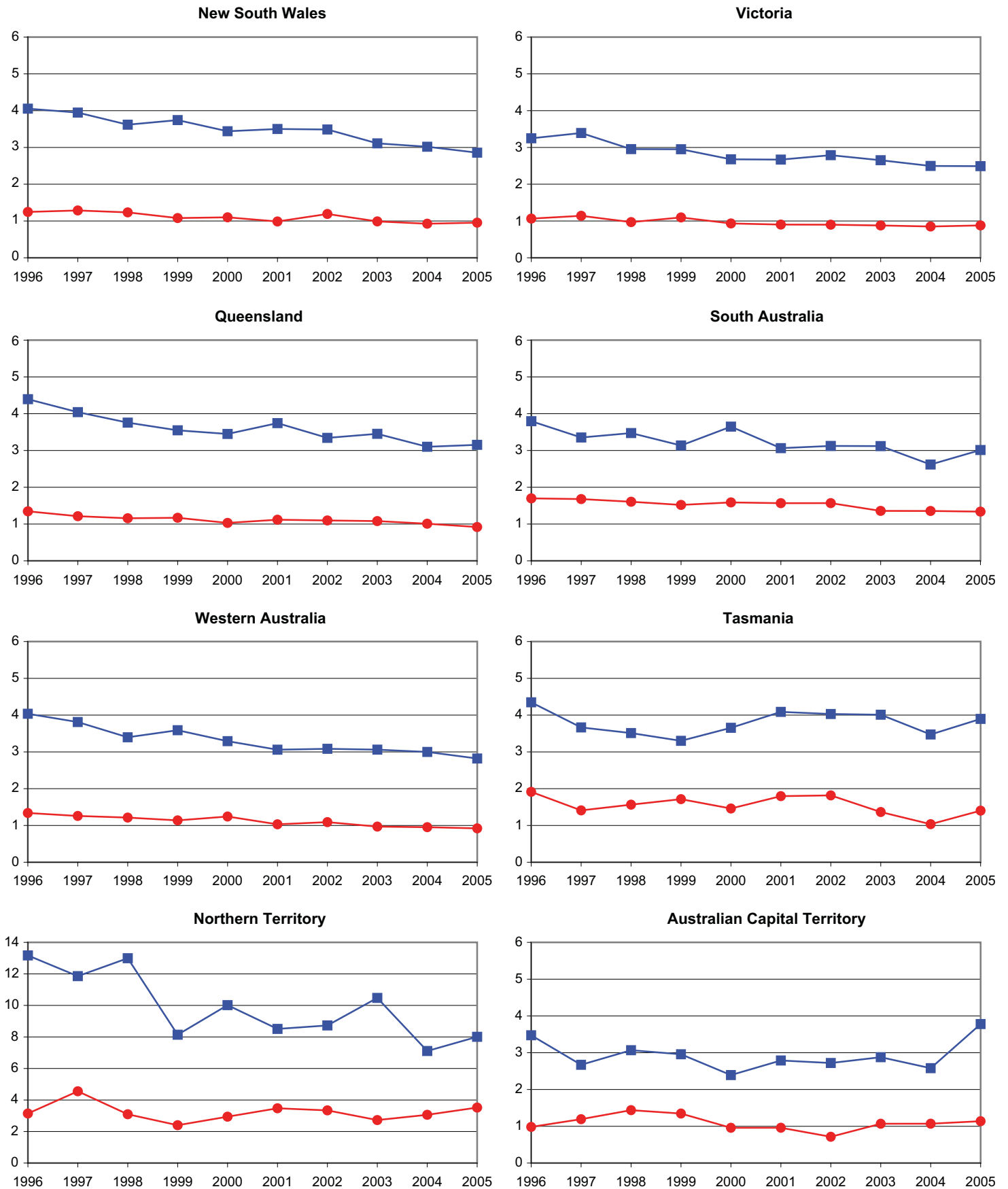
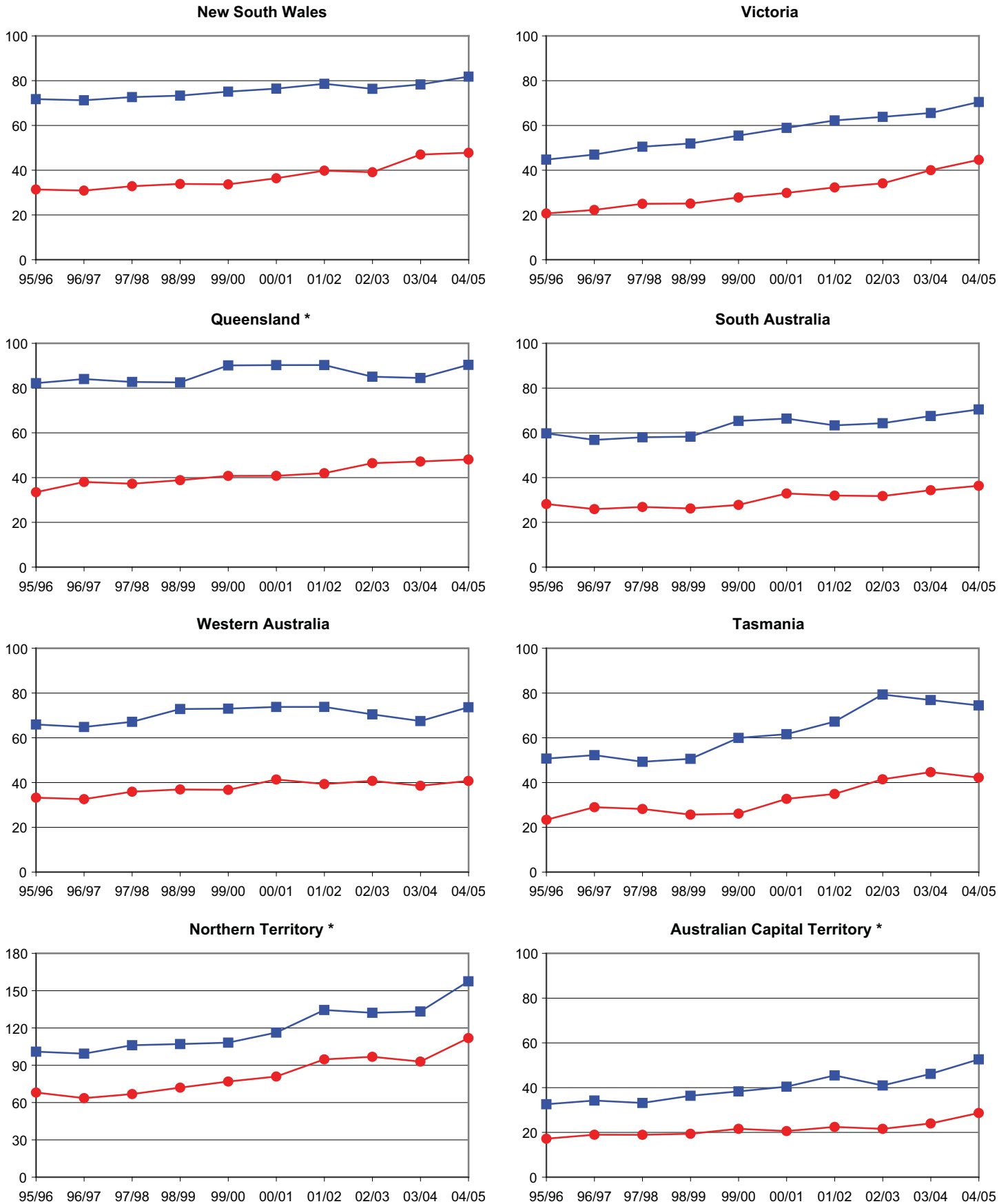


Figure 2: Alcohol-attributable hospitalisations for adults (15+ years), males and females, 1995/96–2004/05

Legend: ■ males; ● females. Y Axis: Alcohol-attributable hospitalisation rate per 10,000 15+ yr olds.



* Rates for the NT (00/01-04/05), Qld (02/03-04/05) and the ACT (04/05) had to be estimated as parts of the data could not be obtained. The rate for the NT (98/99) was extrapolated as data was unavailable for that year.

Trends in alcohol-attributable deaths and hospitalisations

As shown in Figure 1 (overleaf) all jurisdictions, except Tas and the ACT, indicated declining trends in alcohol-attributable deaths for males. Deaths among females also declined but were less consistent in the NT, ACT and Tas. All states and territories showed increasing trends in alcohol-attributable hospitalisation rates between 1995/96 and 2004/05 but trends appeared markedly steeper for Vic, Tas, the NT and the ACT.

Causes of alcohol-attributable death and hospitalisation

In 2005, the most common cause of death due to risky/high risk drinking was alcoholic liver cirrhosis. The top 5 types of disease and injury account for about 54% of all deaths attributable to risky/high risk drinking in that year. The most common conditions leading to hospitalisation in 2004/05 were alcohol dependence, falls, assault and alcohol abuse and accounted for about 61% of all alcohol-attributable hospitalisations in that year. A breakdown of the most common conditions by sex is shown in Table 1 below.

Table 1: Top 5 causes of alcohol-attributable death and hospitalisation (%), males and females

	Deaths (%)	Hospitalisations (%)	
Males		Males	
1	Alc. liver cirrhosis 25	Alc. dependence 17	
2	Non-pedestrian RI 12	Falls 16	
3	Suicide 7	Assault 10	
4	Haemorrhagic stroke 6	Alcohol abuse 10	
5	Colon cancer 6	Non-pedestrian RI 8	
Females		Females	
1	Alc. liver cirrhosis 22	Alc. dependence 24	
2	Haemorrhagic stroke 9	Falls 20	
3	Female breast cancer 7	Alcohol abuse 10	
4	Colon cancer 7	Assault 7	
5	Non-pedestrian RI 5	Suicide 6	

Based on 2005 (deaths) and 2004/05 (hospitalisations) data

Change in alcohol- and non-alcohol-attributable rates

A comparison of 1996 and 2005 death rates (Fig 3) indicates that apparent declines in alcohol-attributable deaths for most states/territories exceeded concurrent changes in non-alcohol-attributable deaths (which have typically increased). The exception was the ACT which recorded a 12% increase in alcohol death rates compared with an 8% increase for non-alcohol-attributable death rates. Conversely, the percentage change in alcohol-attributable hospitalisation rates from 1995/96 to 2004/05 (Fig 4) appeared to exceed the percentage change in non-alcohol-attributable hospitalisation rates in all jurisdictions except Qld and WA. At more than double the national average, Vic recorded the largest increase in alcohol-attributable hospitalisation rates. The ACT, NSW, Vic and Tas all reported increases in alcohol-attributable hospitalisation rates that were at least twice as large as the concurrent increases in non-alcohol-attributable hospitalisation rates from 1995/96 to 2004/05.

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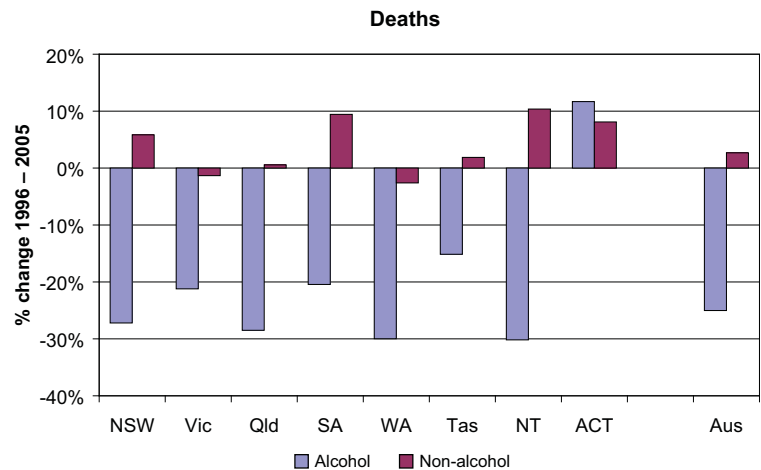


Figure 3: Percentage change in death rates for alcohol-attributable and non-alcohol-attributable conditions, from 1996 to 2005, by state.

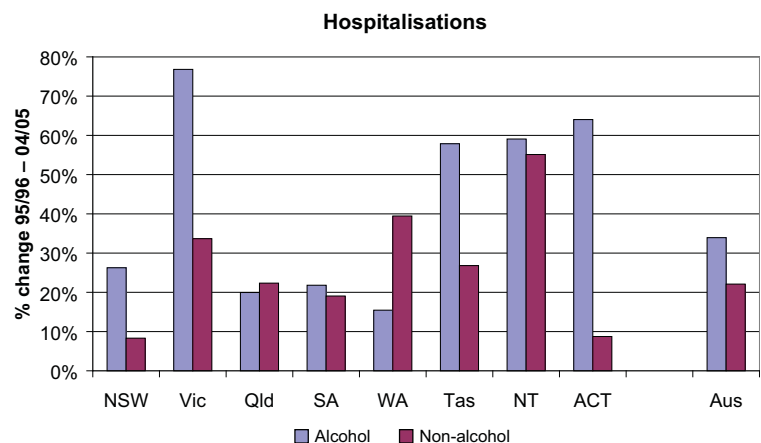


Figure 4: Percentage change in hospitalisation rates for alcohol-attributable and non-alcohol-attributable conditions, from 1995/96 to 2004/05, by state.

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