National Healthcare Agreement: PI 05-Levels of risky alcohol consumption, 2017 QS

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Identifying and definitional attributes

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Data quality

Institutional environment: The 2014–15 National Health Survey (NHS) and the 2014–15 National Aboriginal and Torres Strait Islander Social Survey (NATSISS) were collected, processed, and published by the Australian Bureau of Statistics (ABS). The ABS operates within a framework of the *Census and Statistics Act 1905* and the *Australian Bureau of Statistics Act 1975*. These ensure the independence and impartiality from political influence of the ABS, and the confidentiality of respondents.
For more information on the institutional environment of the ABS, including the legislative obligations of the ABS, financing and governance arrangements, and mechanisms for scrutiny of ABS operations, see ABS institutional environment.

Timeliness: The NHS is conducted approximately every 3 years. The 2014–15 NHS was conducted between July 2014 and June 2015. The previous NHS was collected as part of the Australian Health Survey (AHS) in 2011–13. Results from the 2014–15 NHS were released in December 2015.

The NATSISS is conducted approximately every 6 years. The 2014–15 NATSISS was conducted between September 2014 and June 2015. The previous NATSISS (2008) was conducted between August 2008 and April 2009. Results from the 2014–15 NATSISS were released in April 2016.

Accessibility: See *National Health Survey: first results, 2014–15* (ABS 2015) and *National Aboriginal and Torres Strait Islander Social Survey: 2014–15* (ABS 2016a) for an overview of results. Other information from these surveys may also be available on request.

Interpretability: Information to aid interpretation of the data from the *National Health Survey: first results, 2014–15* (ABS 2015) and the *National Aboriginal and Torres Strait Islander Social Survey: user guide, 2014-15* (ABS 2016b) are available.

Many health-related issues are closely associated with age; therefore data for this indicator have been age-standardised to the 2001 total Australian population to account for differences in the age structures of the states and territories. Age-standardised rates should be used to assess the relative differences between groups, not to infer the rates that actually exist in the population.

Relevance:

The 2014–15 NHS and 2014–15 NATSISS collected self-reported information on alcohol consumption from persons aged 15 years and over.
In the 2014–15 NHS, lifetime risk (2009 National Health and Medical Research Council (NHMRC) guidelines) was assessed using average daily consumption of alcohol, derived from the type, brand, number and serving sizes of beverages consumed on the 3 most recent days of the week prior to interview, in conjunction with the total number of days alcohol was consumed in the week prior to interview. The following formula for average daily amount of alcohol consumed (that is, an average over the 7 days of the reference week) was used:

- average consumption over the 3 days for which consumption details were recorded x number of days consumed alcohol / 7.

In the 2014–15 NATSISS, lifetime risk (2009 NHMRC guidelines) was based on a person's reported usual daily consumption of alcohol and the frequency of consumption in the 12 months prior to interview.

Intake of alcohol refers to the quantity of alcohol contained in any drinks consumed, not the quantity of the drinks.

To measure against the 2009 NHMRC guidelines, in both surveys, reported quantities of alcoholic drinks consumed were converted to millilitres (mls) of alcohol present in those drinks, using the formula:

- alcohol content of the type of drink consumed (%) x number of drinks (of that type) consumed x vessel size (in millilitres).

Individuals are defined as at risk of long-term harm if they consume more than 2 standard drinks a day (2009 NHMRC alcohol guidelines).

Accuracy:

The 2014–15 NHS was conducted in all states and territories, excluding *Very remote* areas and discrete Indigenous communities. These exclusions are unlikely to affect national estimates, and will only have a minor effect on aggregate estimates produced for individual states and territories, excepting the Northern Territory where the population living in private dwellings in *Very remote* areas accounts for around 28% of persons. Non-private dwellings such as hotels, motels, hospitals, nursing homes and short-stay caravan parks were also excluded from the survey. The response rate for the 2014–15 NHS was 82%. Results are weighted to account for non-response.

The 2014–15 NATSISS was conducted in all states and territories, including *Very remote* areas. Non-private dwellings such as hotels, motels, hospitals, nursing homes and short-stay caravan parks were excluded from the survey. The response rate for the 2014–15 NATSISS was 80%. Results are weighted to account for non-response.

As they are drawn from a sample survey, data for indicators are subject to sampling error. Sampling error occurs because only a small proportion of the population is used to produce estimates that represent the whole population. Sampling error can be reliably estimated as it is calculated based on the scientific methods used to design surveys. Indications of the level of sampling error are given by the relative standard error (RSE) and 95% margin of error (MOE). Estimates with an RSE of 25–50% should be used with caution. Estimates with an RSE over 50% are generally considered too unreliable for general use. Margins of error are provided for proportions to assist in assessing the reliability of these data. The proportion combined with the MOE defines a range which is expected to include the true population value with a given level of confidence. This is known as the confidence interval. Proportions with an MOE of greater than 10 percentage points indicate that the range in which the true population value is expected is relatively wide.

The collection of accurate data on quantity of alcohol consumed is difficult, particularly where recall is concerned, given the nature and possible circumstances of consumption. The use of the 1-week reference period in the NHS (with collection of data for the most recent 3 days in the last week on which the person drank) is considered to be short enough to minimise recall bias but long enough to obtain a reasonable indication of drinking behaviour. In the 2014–15 NATSISS, information was collected in terms of standard containers or measures (e.g. stubbie, nip, 10-oz glass). Interviewers were trained to record as much information as possible when questioning about quantities, as the calculation of standard drinks was done during data processing.

While the last-week-exact-recall method may not always reflect the usual drinking behaviour of the respondent at the individual level, at the population level this is expected to largely average out.

The collection and coding of individual brands and container size ensures that no mental calculation is required of the respondent in reporting standard drinks, and is considered to eliminate potential for the underestimation bias which is known to occur when people convert drinks into standard drinks.

The following comments apply to data for the general and non-Indigenous populations only.

Adult alcohol consumption longer term risk rates by state/territory and remoteness (Table NHA 5.1):

- RSEs for *Remote* New South Wales, Victoria, Queensland and Western Australia are greater than 50% and data are considered too unreliable for general use.

Adult alcohol consumption longer term risk rates by state/territory and Socio-Economic Indexes for Areas (SEIFA) quintiles (Table NHA 5.2):

- RSEs for quintile 1 in Western Australia, quintile 2 in the Northern Territory, and quintiles 2 and 3 in the Australian Capital Territory are greater than 25% and data should be used with caution.
- RSEs for quintile 1 in the Australian Capital Territory and the Northern Territory are greater than 50% and data are considered too unreliable for general use.

The following comments apply to data for the Aboriginal and Torres Strait Islander population **(Table NHA 5.3)**:

- This indicator has acceptable RSE levels of less than 25% for all states and territories.

Coherence:

The 2014–15 NATSISS alcohol consumption data are not comparable with either the 2014–15 NHS or 2012–13 National Aboriginal and Torres Strait Islander Health Survey (NATSIHS) data due to differences in collection methodology, including use of a different reference period to determine average alcohol consumption (lifetime risk). In the 2014–15 NHS and 2012–13 NATSIHS, average alcohol consumption was determined based on the amount of alcohol consumed in the 3 most recent drinking days in the last week. In the 2014–15 NATSISS, average alcohol consumption was determined based on the amount of alcohol consumed on a usual drinking day.

The 2014–15 NHS and 2014–15 NATSISS collected a range of other health-related information that can be analysed in conjunction with alcohol risk level. Other collections, such as the National Drug Strategy Household Survey (NDSHS), report against the same NHMRC guidelines. Results from the most recent NDSHS in 2013 show slightly different estimates for long-term harm from alcohol than in the 2014–15 NHS. These differences may be due to the greater potential for non-response bias in the NDSHS and the differences in collection methodology.

Source and reference attributes

Submitting organisation: Australian Bureau of Statistics

Reference documents:

ABS (Australian Bureau of Statistics) 2015. National Health Survey: first results, 2014–15. ABS cat. no. 4363.0.55.001. Canberra: ABS. Viewed 22 June 2017, http://www.abs.gov.au/ausstats/abs@.nsf/PrimaryMainFeatures/4364.0.55.001?OpenDocument.

ABS 2016a. National Aboriginal and Torres Strait Islander Social Survey: 2014–15. ABS cat. no. 4714.0. Canberra: ABS. Viewed 22 June 2017, http://www.abs.gov.au/AUSSTATS/abs@.nsf/mf/4714.0.

ABS 2016b. National Aboriginal and Torres Strait Islander Social Survey: user guide, 2014-15. ABS cat. no. 4720.0 Canberra: ABS. Viewed 22 June 2017, http://www.abs.gov.au/ausstats%5Cabs@.nsf/0/880A750EFFDE2611CA2570BF007B1CD4?Opendocument.

Relational attributes

Related metadata references:

Supersedes National Healthcare Agreement: PI 05-Levels of risky alcohol consumption, 2014 QS
Health, Superseded 31/01/2017

Indicators linked to this Data Quality statement:

National Healthcare Agreement: PI 05–Levels of risky alcohol consumption, 2017
Health, Superseded 30/01/2018