National Healthcare Agreement: PI 05-Levels of risky alcohol consumption, 2013 QS

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Identifying and definitional attributes

Metadata item type:	Data Quality Statement
METEOR identifier:	511908
Registration status:	Health!, Superseded 14/01/2015

Data quality

Institutional environment:	The Australian Health Survey (AHS) was 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, please see ABS Institutional Environment.
Timeliness:	The AHS is conducted every three years over a 12 month period. Results from the 2011-12 National Health Survey (NHS) component of the AHS were released in October 2012.
Accessibility:	See *Australian Health Survey: First Results* (cat. no. 4364.0.55.001) for an overview of results from the NHS component of the AHS. Other information from this survey is also available on request.
Interpretability:	Information to aid interpretation of the data is available from the *Australian Health Survey: Users' Guide* (cat. no. 4363.0.55.001) on the ABS website. 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 2011-12 NHS component of the AHS collected self-reported information on alcohol consumption from persons aged 15 years and over.

Respondents were asked to report the number of drinks of each type they had consumed, the size of the drinks, and, where possible, the brand name(s) of the drink(s) consumed on each of the most recent three days in the last week on which they had consumed alcohol.

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 National Health and Medical Research Council guidelines, 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).
- An average daily amount of alcohol consumed was calculated (i.e. an average over the 7 days of the reference week), using the formula:
- Average consumption over the 3 days for which consumption details were recorded x number of days consumed alcohol / 7.

According to average daily alcohol intake over the 7 days of the reference week, persons who consumed more than 2 standard drinks on any day were at risk of long term health problems.

The AHS is conducted every three years over a 12 month period. Results from the 2011-12 NHS component of the AHS were released in October 2012.

Accuracy:

The AHS is conducted in all States and Territories, excluding very remote areas. Non-private dwellings such as hotels, motels, hospitals, nursing homes and short-stay caravan parks were also not included in the survey.

The exclusion of persons usually residing in very remote areas has a small impact on estimates, except for the Northern Territory, where such persons make up a relatively large proportion of the population. The response rate for the 2011-12 NHS component was 85 per cent. Results are weighted to account for non-response.

As it is drawn from a sample survey, the indicator is 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. Rates should be considered with reference to their Relative Standard Error (RSE).

Estimates with RSEs between 25 per cent and 50 per cent should be used with caution. Estimates with RSEs greater than 50 per cent are generally considered too unreliable for general use.

Data for Northern Territory in 2011-12 is not comparable to previous years due to the increase in sample size in 2011-12.

This indicator generally has acceptable levels of sampling error for State/Territory and Remoteness Areas, except for remote areas where some rates are considered too unreliable for general use. The breakdown by State/Territory and SEIFA quintiles in general has sampling error within acceptable limits, except for the two lowest quintiles in Australian Capital Territory which should either be used with caution or are considered too unreliable for general use.

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 one week reference period (with collection of data for the most recent three 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. 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.

Coherence:

The AHS collected a range of other health-related information that can be analysed in conjunction with alcohol risk level. For more detailed information see the *Australian Health Survey: Users' Guide* (cat. no. 4363.0.55.001) on the ABS website.

Aggregate levels of alcohol consumption implied by the AHS are somewhat less than the estimates of apparent consumption of alcohol based on the availability of alcoholic beverages in Australia from taxation and customs data, see *Apparent Consumption of Alcohol, 2010-11* (cat. no. 4307.0.55.001). This suggests a tendency towards under-reporting of alcohol consumption in self-report surveys.

Other collections, such as the National Drug Strategy Household Survey (NDSHS), report against the same National Health and Medical Research Council (NHMRC) guidelines. Results from the most recent NDSHS in 2010 show slightly lower estimates for long-term harm from alcohol than in the 2011-13 AHS. 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

Relational attributes

Related metadata references:	Supersedes National Healthcare Agreement: P07-Proportion of adults at risk of long-term harm from alcohol, 2010 QS Health!, Superseded 12/03/2015 Has been superseded by 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, 2013 Health!, Superseded 30/04/2014