National Indigenous Reform Agreement: PI 04-Levels of risky alcohol consumption, 2015-16; Quality Statement

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Identifying and definitional attributes

Metadata item type: Data Quality Statement

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Data quality

Institutional environment: The National Aboriginal and Torres Strait Islander Health Survey (NATSIHS) and National Health Survey (NHS) 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 Australian Aboriginal and Torres Strait Islander Health Survey (AATSIHS) is conducted approximately every six years over a 12-month period. Results from the 2012-13 NATSIHS component of the AATSIHS were released in November 2013. The previous NATSIHS was conducted in 2004–05.

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.

Accessibility: See *Australian Aboriginal and Torres Strait Islander Health Survey: First Results* (ABS 2013a) for an overview of results from the NATSIHS component of the AATSIHS. See *Australian Health Survey: First Results* (ABS 2012b) for an overview of results from the NHS component of the AHS. Other information from this survey may also be available on request.

Interpretability: Information to aid interpretation of the data is available from the *Australian Aboriginal and Torres Strait Islander Health Survey: Users' Guide* and Australian *Health Survey: Users' Guide* 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 and Indigenous and non-Indigenous populations. 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 2012-13 NATSIHS and NHS component of the Australian Health Survey (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 3 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 NHMRC guidelines (NHMRC 2009), 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, consumption of more than 2 standard drinks per day on average equated to risky or high-risk consumption.

Accuracy:

The AATSIHS 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 final response rate for the 2012-13 NATSIHS component was 80.2%. Results are weighted to account for non-response.

The AHS was 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 only a minor effect on estimates for individual states and territories, except for the Northern Territory where such persons make up approximately 23% of the population. The response rate for the 2011-12 NHS component was 84.8%. Results are weighted to account for non-response.

As they are drawn from a sample survey, data for the indicator 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. Rates should be considered with reference to their Relative Standard Error (RSE). Estimates with RSEs between 25% and 50% should be used with caution. Estimates with RSEs greater than 50% are generally considered too unreliable for general use.

For the non-Indigenous population, data for Northern Territory for 2007–08 should be used with caution due to large RSEs resulting from the small sample size for Northern Territory in 2007–08.

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 AATSIHS and AHS collected a range of other health-related information that can be analysed in conjunction with alcohol risk level.

Aggregate levels of alcohol consumption for the total population 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* (ABS 2012a). 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 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

Reference documents:

ABS (Australian Bureau of Statistics) 2012a. Apparent Consumption of Alcohol, 2010–11. ABS Cat. no. 4307.0.55.001. Canberra: ABS.

ABS 2012b. Australian Health Survey: First Results, 2011–12. ABS Cat. no. 4364.0.55.001. Canberra: ABS.

ABS 2013a. Australian Aboriginal and Torres Strait Islander Health Survey: First Results, Australia, 2012–13. ABS Cat. no. 4727.0.55.001. Canberra: ABS.

ABS 2013b. Australian Aboriginal and Torres Strait Islander Health Survey: Users' Guide, 2012–13. ABS Cat. no. 4727.0.55.002. Canberra: ABS.

ABS 2013c. Australian Health Survey: Users' Guide, 2011–13. ABS Cat. no. 4363.0.55.001. Canberra: ABS.

NHMRC (National Health and Medical Research Council) 2009. Australian guidelines to reduce health risks from drinking alcohol. Canberra: NHMRC.

Relational attributes

Related metadata references:

Supersedes National Indigenous Reform Agreement: PI 04-Levels of risky alcohol consumption, 2014 QS
Indigenous, Superseded 17/02/2016

Has been superseded by National Indigenous Reform Agreement: PI 04-Levels of risky alcohol consumption, 2018; Quality Statement
Indigenous, Superseded 07/02/2019

Indicators linked to this Data Quality statement:

National Indigenous Reform Agreement: PI 04—Levels of risky alcohol consumption, 2017
Indigenous, Superseded 06/06/2017