

Briefing Note-Alcohol Policy: Getting Alcohol on the Agenda & Higher Priority for Effective Interventions

Alcohol policies are authoritative decisions made by governments and other leaders through laws, rules and regulations, and can be directed at individuals, populations, organizations or systems. Policies may involve the implementation of a specific strategy with regard to alcohol problems, such as increasing alcohol prices, or the allocation of resources with regard to prevention or treatment efforts. A policy decision may increase harm from alcohol rather than reduce it.

Alcohol policy is particularly important in Ontario and other jurisdictions, since it has been shown to be a particularly powerful tool in reducing damage from alcohol.¹ However, if there is low or passing attention to alcohol as a risk factor for traumatic events or chronic disease, it is challenge to find the resources, institutional commitment and social support to develop and implement effective alcohol polices. Therefore, alcohol must first be on the agenda before significant progress can be made in reducing the damage from high risk drinking through appropriate effective policy measures.

This Briefing Note addresses the following topics:

- Evidence that alcohol is a risk factor
- Signals that alcohol is not considered a very serious problem
- Some implications if this does not change
- Steps forward

Is alcohol a risk factor?

There is evidence that alcohol is associated with a number of social problems, acute or traumatic experiences and chronic conditions. Both level of consumption and drinking patterns have a bearing on the scale and type of damage arising from alcohol.² For example, recent studies focusing on Canada have shown that trends in consumption are associated with overall mortality (from all causes), drinking and driving mortality, liver cirrhosis and alcohol specific diagnoses.³ As consumption increases, the rates of damage tend to increase.

On a global level, a recent World Health Organization (WHO) sponsored publication⁴, noted that major alcohol-related health conditions contributing to morbidity and mortality include: cancers, neuropsychiatric conditions, cardiovascular conditions, gastrointestinal conditions, and maternal and perinatal conditions.

Furthermore, the Global Burden of Disease project, also undertaken by the WHO, found that alcohol was among the leading risk factors for disease and disability. Alcohol contributed to 9.2% disability adjusted life years (DALYS) in developed countries – such as Canada, just below tobacco (12.2%) and blood pressure (10.9%) and more than cholesterol (7.6%), body mass index (7.4%), low fruit and vegetable intake (3.9%), and physical activity (3.3%). Also, in some developing countries the contribution to DALYS

was higher from alcohol, than from blood pressure or tobacco. It is important to note that these estimates are for the net damage from alcohol in that they have taken into account the benefits for cardiovascular disease prevention for some adults from drinking small amounts of alcohol.⁵

Therefore, there is ample evidence at the national and international levels that alcohol is an important risk factor with regard to both acute and chronic problems. However, recent developments indicate that activities are out of step with this evidence.

Is alcohol considered a serious problem?

Despite the fact that alcohol contributes to a wide range of traumatic experiences and chronic conditions, as noted above, there are signals that drinking alcohol has become increasingly normalized, in Canada and Ontario, and by default, concern about the risks associated with drinking are not of high priority. Thus, while there is lip service to an evidence-based approach, when priorities are set it seems that alcohol often comes up short. There are three signals of this.

First, extensive alcohol marketing and sponsorship are not a common topic of debate, critique or assessment. Promotion of alcohol and drinking, through many means, such as almost weekly inserts of colourful advertising in daily newspapers, seems to be accepted as a matter of course, and considered benign. Despite the growing epidemiological and other evidence of alcohol as a risk factor, the marketing and promotion of alcohol, and sponsorship by producers and distributors, appears to have become more extensive and intensive of recent years. Public discussion about the links between selling and promotion practices and damage from alcohol is uncommon.

Second, there appears to be an unfortunate imbalance between the marketing and control mandates of government alcohol management and retailing systems, with increasing emphasis being given to the former. The most effective controls (as is indicated below) have modest or even minimal priority, and controlling overall consumption is not of concern among liquor authorities. Indeed, a prime focus appears to be that of selling more alcohol each year⁶, despite the fact that there is long-standing and well-established association between overall consumption in a population and damage from alcohol.⁷

Third, in general public health initiatives at the provincial and federal levels, for example, give at best passing reference to alcohol, and much less than is currently given to risk factors that do not contribute as much to disease, disability and death. For example, despite the well-intended and much needed moves to prevent chronic disease through collective efforts, only one province, namely Ontario, formally recognizes that alcohol needs to be included as a risk factor in chronic disease. The laudable level of effort at the provincial level to control tobacco consumption and damage from tobacco has no equivalency when it comes to alcohol, for example.

What are the implications if this does not change?

Our drinking patterns do not seem to be getting less risky⁸ and in recent years, the rate of consumption has increased in Canada⁹. In light of the increase in alcohol consumption, and continuation of high risk drinking it is expected that the burden from alcohol will increase¹⁰. If our interventions and policies do not become more effective, the damage from alcohol is expected to increase. Also social, health and safety costs¹¹ associated with alcohol use will also likely increase.

Furthermore, if two recent developments continue as they have, namely that of increasing normalization of alcohol promotion and drinking, and neglect of alcohol as a risk factor, then it will, indeed, be very difficult to control the damage from alcohol and attendant costs, once the state of affairs begins to receive the priority that it deserves.

What are some steps forward?

A recent WHO report by Thomas Babor and colleagues¹² identified the following 10 policies where there was sufficient evidence to indicate that they have potential to either reduce consumption, modify drinking patterns to encourage lower risk drinking, and/or reduce harm associated with alcohol consumption:

- Minimum legal purchase age
- Government monopoly of retail sales¹³
- Restriction on hours or days of sale
- Outlet density restrictions
- Alcohol taxes
- Sobriety check points
- Lowered BAC limits
- Administrative license suspension
- Graduated licensing for novice drivers
- Brief interventions for hazardous drinkers

These 10 were selected after 31 policies were assessed on the following four criteria: evidence of effectiveness (quality of scientific information); the breadth of research support (quality and consistency of the evidence); tested across cultures (e.g. countries, regions, subgroups); and cost to implement and sustain (monetary and other costs).

There are a number of examples in Canada where these kinds of policies have been, or are being, implemented. Of particular interest is the drinking and driving arena where a number of effective interventions are in place or are being promoted at the national and provincial levels.

Nevertheless, a number of challenges remain to be addressed. For example, there are no restrictions on outlet density and as the number of outlets is increased the size of the workforce to inspect premises and monitor sales typically does not keep pace. Hours and days of sale have been expanded in recent years. Also, more effort needs to be devoted to insuring that alcohol prices keep pace with cost of living, since it has been shown that

the “real price” of alcohol is associated with both acute and chronic damage from drinking – for example, as price declines the damage from alcohol tends to increase¹⁴.

Of considerable concern is the apparent imbalance between the marketing and control mandates of government alcohol management and retailing systems, with increasing emphasis being given to the former. As previously mentioned, it appears that controlling overall consumption is not of concern among liquor authorities.

Surveys of public opinion have shown that there is support for a number of control measures, but that it has declined. The majority of respondents to recent surveys in Ontario support interventions with low impact (e.g. warning labels) and also those with modest potential (e.g. such as server interventions). However, it is only a minority that supports interventions, such as higher prices on alcohol or fewer outlets, which have been broadly associated with a reduction in drinking-related problems.¹⁵

In general, greater social support for the most effective policies would be a significant step forward, as would more efficient enforcement of these policies.

There are a number of challenges facing those who are interested in reducing the harm from alcohol through promoting effective policies, but they can be boiled down to two: getting alcohol on the agenda and giving higher priority to the most effective interventions. Suggestions on how to cope with these challenges follows.

- A current challenge at the national and provincial levels is that of getting alcohol on the agenda – e.g. that all governments see alcohol as a risk factor in their health and safety risk prevention initiatives. A step forward would be the creation of a multi-sectorial time-limited task force to assess the situation and develop a plan for more effective prevention of alcohol-related problems.
- Opportunities for combining interventions and effective partnerships need to be further explored, and the relevant lessons from other arenas, e.g., the tobacco control experiences, provide a useful resource for developing and implementing effective alcohol policies.
- Much of government alcohol policy-making is still based mainly on commercial agendas. For example, the associations between increasing alcohol distribution and promotion and alcohol-related damage are typically not considered when policy decisions are made. Public health and safety experts should seek a place at the table at the early stages when policy initiatives are being discussed.
- An ongoing challenge is that of having both evidence of the damage from alcohol and studies of effectiveness of different interventions provide a stronger basis for priorities in alcohol policies and prevention practice. In short, higher priority needs to be given to the more effective alcohol policies.

¹ Babor, T., Caetano, R., Casswell, S., Edwards, G., Giesbrecht, N., Graham, K., Grube, J., Gruenewald, P., Hill, L., Holder, H., Homel, R., Österberg, E., Rehm, J., Room, R., and Rossow, I. (2003) *Alcohol No Ordinary Commodity: Research and Public Policy*. Oxford: Oxford University Press.

² Rehm J. & Gmel G. (2002) Average volume of alcohol consumption, patterns of drinking and mortality among young Europeans in 1999. *Addiction*, 97, 105-109.

³ Norström T. (2004) Per capita alcohol consumption and all-cause mortality in Canada, 1950-98. *Addiction*, 99, 1274-1278. Ramstedt, M. (2003) Alcohol consumption and liver cirrhosis mortality with and without the mention of alcohol – the case of Canada. *Addiction*, 98, 1267-1276. Ramstedt, M. (2003) Alcohol consumption and alcohol-related mortality in Canada: A regional analysis of the period 1950-2000. *Canadian Journal of Public Health*, 95 (2): 121-126. Skog, O.J. (2003) Alcohol consumption and fatal accidents in Canada, 1950-98. *Addiction*, 98, 883-893.

⁴ Babor, T., Caetano, R., Casswell, S., Edwards, G., Giesbrecht, N., Graham, K., Grube, J., Gruenewald, P., Hill, L., Holder, H., Homel, R., Österberg, E., Rehm, J., Room, R., and Rossow, I. (2003) *Alcohol No Ordinary Commodity: Research and Public Policy*. Oxford: Oxford University Press.

⁵ Rehm, J., Room, R., Monteiro, M., Gmel, G., Graham, K., Rehn, N., Sempos, C.T. & Jernigan, D. (2003) Alcohol as a risk factor for Global Burden of Disease. *European Addiction Research* 9:157-164.

Room, R. & Rehm, J. (2004) "The Alcohol-Related Global Burden of Disease." Presented at the Research Society on Alcoholism, Vancouver, BC. 26-30 June 2004.

⁶ Liquor Control Board of Ontario (2003) *Annual Report 2002-2003. Our eighth straight record year*. Toronto: Liquor Control Board of Ontario, Government of Ontario

⁷ Babor, T., Caetano, R., Casswell, S., Edwards, G., Giesbrecht, N., Graham, K., Grube, J., Gruenewald, P., Hill, L., Holder, H., Homel, R., Österberg, E., Rehm, J., Room, R., and Rossow, I. (2003) *Alcohol No Ordinary Commodity: Research and Public Policy*. Oxford: Oxford University Press.

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⁸ Canadian Centre on Substance Abuse (CCSA) (2004) *Canadian Addiction Survey. Prevalence of Use and Related Harms. Highlights*. Microdata eGuide. Canadian Centre on Substance Abuse, Ottawa. Available at: www.ccsa.ca

MacNeil, P. and Webster, I. (1997) *Canada's Alcohol and Other Drugs Survey 1994: A Discussion of the Findings*. Ottawa: Health Canada: Minister of Public Works and Government Services Canada.

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Rehm, J., Room, R., Graham, K., Monteiro, M., Gmel, G. & Sempos, C.T. (2003). The relationship of average volume of alcohol consumption and patterns of drinking to burden of disease: an overview. *Addiction* 98: 1209-1228.

⁹ Statistics Canada (2002) Cat. 63-202, Control and Sale of Alcoholic Beverages in Canada. Table 1.5

¹⁰ Rehm, J. (2003). Keynote Address: Ontario Public Health Association, Annual Meeting, November 2003, Windsor, Ontario.

¹¹ Single, E. Robson, L., Xie, X., Rehm, J. et al. (1996) *The Costs of Substance Abuse in Canada – Highlights*. Ottawa: Canadian Centre on Substance Abuse.

¹² Babor, T., Caetano, R., Casswell, S., Edwards, G., Giesbrecht, N., Graham, K., Grube, J., Gruenewald, P., Hill, L., Holder, H., Homel, R., Österberg, E., Rehm, J., Room, R., and Rossow, I. (2003) *Alcohol No Ordinary Commodity: Research and Public Policy*. Oxford: Oxford University Press.

¹³ For more information see: CAMH. 2004. *Position Paper on Retail Alcohol Monopolies and Regulation: Preserving the Public Interest*. Centre for Addiction and Mental Health, Toronto.
http://www.camh.net/public_policy/retailalcoholmonopolies.html

¹⁴ Edwards, G. Anderson, P., Babor, T.F., Casswell, S., Ferrence, R., Giesbrecht, N., Godfrey, C., Holder, H.D., Lemmens, P., Mäkelä, K., Midanik, L.T., Norström, T., Österberg, E., Romelsjö, A., Room, R., Simpura, J. and Skog, O.-J. (1994) *Alcohol Policy and the Public Good*. Oxford: Oxford University Press.

Holder, H.D. & Edwards, G. (eds.) (1995) *Alcohol and Public Policy: Evidence and Issues*. Oxford: Oxford University Press.

¹⁵ Giesbrecht, N., Ialomiteanu, A., Room, R. and Anglin, L. (2001) Trends in public opinion on alcohol policy measures: Ontario 1989-1998. *Journal of Studies on Alcohol* 62(2): 142-149.

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