POSITION PAPER

Retail Alcohol Monopolies[1] and Regulation:

Preserving the Public Interest

INTRODUCTION

Alcohol is not just another consumer product. It contributes to a wide range of health and social problems such as drinking and driving incidents, violence, and other hazards as well as chronic conditions such as liver cirrhosis, cancers and addiction. At the same time, it provides commercial benefits to private industries, employment for citizens and revenues for governments. This position paper by the Centre for Addiction and Mental Health (CAMH) asserts that retail alcohol monopolies with a strong regulatory agenda have a key role in preventing alcohol-related harm, and therefore should be maintained.

Governments have established legal frameworks to balance the interests of the consumer, commercial benefits from the production and sale of alcohol, and public health and safety concerns associated with alcohol use. In Canada, these potentially conflicting interests have led to the establishment of government-run monopolies for the retail distribution of alcohol. In Ontario, the Liquor Control Board of Ontario (LCBO) is the only off-premise retailer (package store) of liquor and imported wine. These products are sold through its regular stores and its agency store system of smaller outlets located in outlying communities. The Ontario Government, through the Alcohol and Gaming Commission of Ontario (AGCO), also controls the sale of beer through privately run outlets, and domestic wine through Ontario wine outlets operated by individual manufacturers. In addition, the AGCO regulates the sale of alcohol at licensed establishments (e.g., bars and restaurants) through Special Occasion Permit events and home delivery services.

In recent years, government alcohol monopolies have come under scrutiny in many provinces for a variety of reasons, including:

?? Pressure from the business community to privatise retail alcohol monopolies;
?? A general orientation to privatise government services and agencies
?? Perceived consumer pressure to expand access to alcohol and increase consumer choice;

---

[1] Retail monopolies refers to a range of systems from full government control of alcohol sales to mixed arrangements where both the government and private sectors are involved in alcohol management and retailing.

?? International free trade agreements, which tend to erode the ability of governments to control their domestic alcohol markets or to have government-run retail systems (e.g., Grieshaber-Otto & Schacter, 2002).

The following points are addressed in this paper:

?? Research demonstrates a strong association between increased sales, higher consumption rates and increased drinking-related problems in a population.
?? Alcohol monopolies are an important tool for governments to implement alcohol policies that control sales, promote public health, curtail risk and reduce drinking-related damage.
?? A central mandate of alcohol monopolies, namely controlling drinking-related harm, has been eroded as alcohol marketing and promotion agenda have gained ground.
?? Alcohol monopolies have the potential to facilitate the effective and efficient deployment of public health-oriented control policies and government measures, which are more complicated to initiate or maintain in a private system.

Therefore, an alcohol monopoly, with a strong public health and safety mandate, is an effective way to implement appropriate alcohol policies that reduce drinking-related harm.

A PUBLIC HEALTH PERSPECTIVE

Depending upon their orientation, alcohol policies can have a positive or negative influence on personal, social, economic and environmental contexts. A healthy public policy is widely recognized as a key goal of health promotion (e.g., Lalonde, 1974; CAMH, 2000). In this context, the key goal of a healthy approach with regard to alcohol is to encourage risk and harm reduction strategies in managing alcohol distribution. Research in other areas for example, tobacco control (Pacula & Chaloupka, 2001; Ranson et al., 2002), also demonstrates the impact of healthy public policies on changes in behaviour. Alcohol policies are the necessary cornerstone in balancing health and safety risks with the commercial aspects of alcohol distribution and sales. This approach is consistent with CAMH's health promotion framework, which emphasises the determinants of health, protective factors and risk factors within the social, political and cultural contexts in which people live (CAMH, 2000). CAMH also supports the principles of harm reduction and risk avoidance; an alcohol retail monopoly system – with strong control and regulatory agendas -- is central to promoting these principles with regard to alcohol (CAMH, 2001).

A review of the international evidence -- with a focus on Canadian experiences - indicates that retail alcohol monopolies, with a strong public health agenda and combined with alcohol regulation, have the potential to contribute significantly to the prevention of alcohol-related problems (e.g., Babor et al., 2003, p. 264). Government-run alcohol monopolies are uniquely positioned to play this important role (e.g., Room, 1993), and, as is indicated below, there is broad public support for them.

Based on this research, CAMH recommends that the ***Government of Ontario maintain the provincial alcohol monopoly with strong regulation as a means of preventing alcohol-related problems,*** that public health and safety objectives be an integral part of the alcohol

regulation mandate, and that the government strengthen its control and alcohol problem management agendas.

ALCOHOL: NOT JUST ANOTHER CONSUMER PRODUCT

Alcohol is not a benign consumer product. Alcohol-related problems impose a heavy burden on public health and safety. Alcohol abuse costs billions of dollars in additional health care, law enforcement, court cases and lost productivity. Many people drink at low-risk levels e.g., (Bondy et al., 1999) and many drinkers do not encounter serious problems with alcohol. Nevertheless, one in ten people in Ontario runs a high risk of alcohol dependence, and about 3% of the adult population are severely dependent on alcohol (Single et al., 1998).

Even moderate levels of alcohol use--such as taking several drinks a day over a number of years-- are not risk-free, and are associated with an increased risk of certain cancers (e.g., Corrao et al., 1999) and other chronic conditions (e.g., Babor et al., 2003; Edwards et al., 1994). Alcohol-related harm is associated with a variety of drinking behaviours, including alcohol dependence, regular consumption over longer periods of time, or with moderate drinking mixed with occasional heavy-drinking episodes. In one study, about 50% of alcohol-related costs were associated with drinking by people not classified as dependent or with a diagnosis of alcohol abuse or harmful use (Rehm, 1999). Therefore, even persons who may typically drink moderately, with occasional heavy-drinking episodes, can experience alcohol-related harm, whether to themselves or others (Room et al., 1995a). One Ontario-based community survey showed that during the previous 12 months over 70% of respondents had experienced a problem due to another person's consumption (Allen et al., 1998). Higher rates of alcohol consumption are associated with a higher incidence of injuries, increased risk of certain diseases, increased fetal alcohol syndrome/effects, increased risk of mental illness, more crime and reduced worker productivity (e.g., Edwards et al., 1994; Rehm et al., forthcoming).

In Canada, alcohol plays a role in thousands of deaths each year through heart and liver disease, cancer, suicide, traffic crashes and other accidents. In Ontario, the estimated annual cost of alcohol-related lost productivity, health care and enforcement services was $ 2,861,926, 000 in 1992 (Single et. al., 1996).[2] Also, in Ontario, the number of people reporting at least one alcohol-related problem as a result of their drinking was about 350,000 in 1995– roughly the population of London, Ontario (Kavanagh & Bondy, 1995). Over half of the people convicted of assault, murder or attempted murder in Ontario had been drinking before they committed the crime (Addiction Research Foundation, 1994). Alcohol was used by the aggressor in 50% of cases of spousal assault, and in 38% of child abuse cases in Ontario (Addiction Research Foundation, 1994). These health, social and economic costs highlight the need for socially responsible and effective control measures in the matter of alcohol sales and use.

Extensive research over the past thirty years shows a strong positive relationship between per capita consumption and levels of drinking-related harm in the population (e.g., Bruun et al., 1975; Moore & Gerstein, 1981; Edwards et al., 1994). More recent research using Canadian and European data provides current new support for these key findings. These studies found strong associations between population level drinking rates and death rates from all causes (Norström,

[2] For further information see also Xie et al. (1996; 1998).

2001, 2002), and acute events (Ramstedt, 2002b; Rossow, 2001, 2002; Skog, 2003) and chronic conditions associated with alcohol (e.g., Xie et al., 2000; Ramstedt, 2002a, 2002c, 2003).

Of particular relevance is recent research focusing on several Canadian provinces that examined alcohol consumption rates and damage indicators from the 1950s to the late 1990s. This work demonstrated that there was a positive association between population level drinking rates and mortality from all causes (Norström, 2002), liver cirrhosis (Ramstedt, 2003), alcohol-related mortality (Ramstedt, 2002c), violent deaths (Rossow, 2002), drinking and driving crashes (Skog, 2003) and suicides (Ramstedt, 2002b). A main conclusion from this research -- which is also in line with earlier work noted above -- is that if there is more drinking in a population, the risks of serious consequences increase. Therefore, public health and safety policies that regulate accessibility to alcohol have beneficial implications for people with a wide range of drinking experiences and practices, and for others in the community who do not drink alcohol or drink very little.

PRIVATISATION, DEREGULATION, AND ALCOHOL CONSUMPTION

Experiences in other jurisdictions demonstrate that a privatised system with little government regulation and open competition among private retailers typically leads to an increased number of outlets, longer opening hours, and increased consumption (e.g. Smart, 1986; Macdonald, 1986; Wagenaar & Holder, 1991; Her et al., 1999a). These outcomes are of concern in light of their links with higher rates of acute and chronic problems related to drinking (e.g. Holder & Edwards, 1995; Edwards et al., 1994; Babor et al., in press). As indicated below, there are risks to public health associated with privatisation and benefits associated with alcohol monopolies that have strong public health and safety agendas.

Two examples from Canada provide preliminary information on the impact of partial or full privatisation on alcohol consumption and other variables. In Quebec, wine was introduced into grocery stores in 1978 but restricted to wines bottled by the SAQ or manufactured in Quebec. This arrangement was expanded in 1983 to include imported wines, and in 1984 larger grocery store chains were allowed to sell wine as well. These policy changes were analyzed by Adrian et al. (1996) who found a non-significant and temporary increase in wine sales in 1978 but no effect from the 1983 change. The estimated effect of the 1978 policy change is rather modest in comparison with studies of privatisation of wine sales in other non-Canadian jurisdictions. This is likely because the 1978 change impacted only a limited number of wines, and their volume accounted for a fraction of the total alcohol sales market in the province.

The other Canadian example comes from Alberta, where retail alcohol outlets were privatised between the fall of 1993 and spring of 1994, generating a number of changes, including increased density of outlets, longer hours of sale and higher prices, particularly among the more popular brands (Consumers' Association of Canada, 2003). The change in retail prices is one effect of privatisation also found in other jurisdictions (Her et al., 1999a). In the short run, prices generally go up, although this typically does not generate more revenue for the government.

The experiences in Alberta illustrate these divergent patterns: higher average prices, which tend to deflate consumption, and greater access through higher outlet density and other changes that tends to stimulate consumption. For example, privatisation led to an average 8.5% increase in the price of all alcohol from October 1993 to January 1996[3] due primarily to a government-imposed flat tax and higher wholesale costs associated with the purchase of smaller quantities by some retailers.[4]

This pattern of relatively higher prices for beverage alcohol -- noted by West (2000, 2003) Laxer et al. (1994) and the Consumers' Association of Canada (2003) -- is also evident in comparing real price basket indices, by beverage, for four provinces: British Columbia, Alberta, Ontario and Quebec, for 1994 to 2000. For beer, Alberta had the highest index per year for five out of seven years, for wine all seven years, and for spirits six of the seven years. While higher prices on alcoholic beverages would be expected to deflate their consumption, there were several factors, noted below, that likely stimulated alcohol sales.

It is noteworthy that in fiscal 1993-94 when privatisation was introduced in Alberta, it was the only province of the jurisdictions examined -- B.C., Alberta, Ontario, Quebec, and total for Canada -- that experienced an increase in the per adult consumption rate compared to 1992-93 just prior to privatisation.[5] In Alberta the rate went from 8.5 to 8.7 litres of absolute alcohol per adult (aged 15 and older), whereas the other jurisdictions experienced a decline: B.C. – 8.9 to 8.8, Ontario—7.5 to 7.3, Quebec – 6.9 to 6.8, and Canada stayed at 7.5 (Statistics Canada , 1996). In recent years, Alberta has had the highest per adult consumption rate among the Canadian provinces, between 8.5 and 8.7 litres of ethanol alcohol per adult for fiscal years 1997-98 to 2001-2002 (Statistics Canada, 2002; Flanagan, 2003, Figure 2.1).

A number of factors might have contributed to the rise in the alcohol consumption rates. For example, in the early 1990s, several provinces, such as Alberta and B.C., had strong economies and growing populations, but their alcohol consumption experiences differed, as noted above. [6] Thus while general economy and workforce changes cannot be fully ruled out as partial explanations for changes in per adult consumption rates at that time, they do not offer the full story. Based on experiences in other jurisdictions with privatisation it would appear that particularly pertinent factors were the three-fold increase in density of retail outlets and longer hours of sale that accompanied privatisation of alcohol retailing in Alberta.

---

[3] http://www.fcpp.org/publications/policy_notes/hpg/role_of_government/ august/282000.html

[4] By shifting from an *ad valorem* (alcohol excise tax as a percentage of price) to a per unit tax, the amount of tax is independent of the price of the product. Thus tax does not change with price fluctuations, so if retail prices rise the government revenue from alcohol does not necessarily increase, and a unit tax will favour expensive products over cheap ones (Flanagan, 2003, p. iv).

[5] The longstanding international convention is to calculate these rates as litres of ethanol per capita aged 15 and older: ethanol as the active ingredient and 15 plus since by age 15 a significant portion of individuals have consumed alcohol – see Statistic Canada, Control and Sale of Alcoholic Beverages reports.

[6] In 1993, the GDP per capita was only slightly lower in BC than the Prairies and the Real Personal Disposable Income per capita – using the a 1992 index of 100 shows BC at about 101.5 and the Prairies at 102.5. As of 1995 it is noted that B.C. had an almost unbroken string of expansion so far this decade, much of this growth reflecting a burgeoning population. (Canadian Economic Observer, Statistics Canada, 1997, 1996, 1997, 2000, 2001/2002) The real disposable income per population aged 15 and older was as follows in 1993: B.C. 99.03, Alberta 101.40, Ontario 102.72, Quebec 99.03 and Canada 98.88.

Nevertheless, several factors that might have dampened the impact of privatisation on alcohol sales in Alberta, including that alcohol was not available in supermarkets and grocery stores, that wholesale trade was controlled by the Alberta government, that uniform transportation charges were maintained, and that the store mark-up increased after privatisation. Such factors may explain why Alberta's experience was not fully consistent with international literature, which associates privatisation with increased consumption (e.g. Macdonald, 1986; Wagenaar & Holder, 1991; Her et al., 1999a; Babor et al., 2003). .

A reasonable hypothesis is that full privatisation with associated greater access to alcohol in a jurisdiction with a strong economy and growing work force -- as was the case in Alberta in the early 1990s - is more likely to result in higher consumption than partial privatisation in a weak economic context -- as was the case in Quebec. Despite the somewhat higher retail prices, overall consumption rose in Alberta, and the best explanation is that increased density of retail outlets plus longer hours of sale were primary factors. On balance, it appears that increased accessibility had a greater impact on stimulating sales than the increased average prices had on deflating sales. Thus, taxation or price policies and general socio-economic conditions can limit or enhance, in the short run, some of the effects of privatisation (Macdonald, 1986; Her et al. 1999a).

In Alberta, there is also evidence that privatisation has been associated with an increase in criminal offences, such as liquor store break-ins and more relaxed enforcement of laws pertaining to underage purchases (Laxer et al., 1994).[7] Furthermore, within Canada, Alberta continues to have some of the highest rates of alcohol-related problems, such as drunk driving fatalities (Traffic Injury Research Foundation, 2002). In other countries, either full or partial privatisation has been shown to result in an increase in alcohol consumption in studies using data from the U.S., Sweden, Finland and Iceland (Her et al., 1999a; Macdonald, 1986).

A simulation study – conducted several years ago -- of the likely consequences of privatisation in Ontario indicates that privatisation could result in an increase in per capita alcohol consumption of 11% to 27% (Her et al., 1999b). International research demonstrates that an increase in consumption of this magnitude would result in an increase in alcohol-related problems (Bruun et al., 1975; Edwards et al., 1994; Babor et al., 2003).

Under a privatised system there are strong incentives to deregulate alcohol controls and focus on the business side at the expense of public health and safety considerations. In such a system, the owners of business emerge with common interests in selling more alcoholic beverages, and they often act as a lobby group in their contacts with public authorities. This lobbying focuses on removing barriers that restrict trade rather than raising barriers that control the problems associated with sales. Furthermore, a strong orientation towards seeking competitive advantage and avoiding business failure is likely to encourage some owners to employ marginally skilled and low-paid staff. Owners may be less likely to arrange for time to train staff properly and refuse service to minors and intoxicated patrons. In the case of small family-run alcohol retail businesses that are open late at night, it may be easy for patrons to circumvent service regulations. It is feasible, in principle, to have a regulated and well managed private alcohol retail system that places high priority on public health and safety, but the

---

[7] http://www.gaming.gov.ab.ca

dominance of the profit motive with the potential for business failure means a number mechanisms work against this possibility in a privately run system. (e.g., Flanagan, 2003; Consumers' Association of Canada, 2003).

On balance, then, a privatised system of alcohol retailing is expected to increase risks of drinking-related harm. It will likely lead to increased consumption, it will erode or dismantle controls and make it more difficult to implement public health-oriented policies, and it will create new vested interest groups, such as private retailers, that are oriented to the commercial aspects of alcohol management and not to public health agendas.

In contrast, publicly controlled alcohol management systems with strong public health and safety agenda can moderate access to alcohol through legislation, regulation, and enforcement and thus are in a better position than other kinds of systems to have a positive impact on alcohol-related problems. As noted in the attached table, in principle, under a public system there is a counterbalance to profit and business-oriented agendas, and this counterbalance is supported by dedicated staff that are available to promote public health and safety.

PRIVATISATION AND GOVERNMENT REVENUE

As well as promoting public health, provincial/state alcohol monopolies are an efficient and powerful means of raising government revenue. Government retail monopolies generate high government revenues. In 2000, the Liquor Control Board of Ontario (LCBO) reported revenues of $2.7 billion of which $1.1 billion was transferred back to the Government of Ontario (LCBO, 2001).

Privatisation of alcohol sales, on the other hand, can result in a net loss for governments. While there may be short-term revenue gains with the sale of government property, once costs related to managing health and safety aspects of alcohol use are considered, they overshadow short-term profits.

Privatisation can also result in a decline in government revenue from alcohol sales. In Iowa, privatisation led to higher consumer prices and lower state revenue after a newly created interest group of retailers successfully lobbied to lower the taxation so that the private retailers could increase their profit. In Alberta, government revenue from the sale of alcohol has been 8%-15% below that of the last full year of the monopoly system in 1992. The drop in government revenue took place despite higher prices and increased sales.[8] Lobbying efforts of private retailers resulted in a change in Alberta's tax policies that reduced liquor taxes from $1.00 to $0.50 per bottle (Wine Council of Ontario, 1994).

This decline in taxes from alcohol may not have been a concern to political leadership in a province, such as Alberta, which has had significant surpluses in recent years and is projected to have zero debt in 2005; however, it is of concern from a public health and safety perspective.

---

[8] The report by Flanagan (2003, p. v) notes: "Alberta Government revenue from the sale of alcohol has stayed constant in absolute current dollars. This means that, with inflation, population growth, and growth in sales, revenues have fallen between 1993 and 2001. Prices have increased, but not to the degree they might have because of the share taken as government revenue has fallen."

International research over the past decades has shown that higher alcohol taxes are associated with controlling alcohol consumption and drinking-related damage (e.g. Bruun et al., 1975; Edwards et al. 1994; Babor et al., 2003, p. 264). An increase in government revenue from higher taxes thus offers two advantages: as a policy lever to control drinking-related problems and as a resource to pay for some of the social and health costs related to the ongoing damage from alcohol consumption.

Generating government revenue is an important function of a monopoly system. However, if generating revenue becomes the primary consideration, it is likely that public health and safety considerations will be eroded or devalued, and costs related to alcohol-related problems will increase. Therefore, a more comprehensive perspective with regard to alcohol takes into account both revenue and costs of managing the health, social and public order problems related to drinking. Rather than seeking to increase revenue by selling more alcohol, a more responsible approach would either maintain revenue or seek to increase revenue from the same volume of alcohol sold – for example, by increasing prices and reducing operating expenses. For the greater social good, the health and safety considerations of alcohol monopolies must be balanced with the interest in revenue generation from alcohol.

ALCOHOL MONOPOLIES, REGULATIONS AND PUBLIC HEALTH CONCERNS

Alcohol monopolies can provide an effective balance between public health and safety concerns, fiscal interests and quality customer service. However, the struggle between commercial agendas (e.g., product promotion) and health and safety considerations determines whether that balance is achieved. Under the current system in Ontario, the provincial government has the potential to control problems and reduce drinking-related harm. However, given the strong orientation to promotion and marketing agendas in recent years, there are concerns about how much priority is currently being given to the harm reduction agendas of alcohol control systems.

Over the past decades, Ontario has seen a number of changes involving greater access to alcohol, including, for example, an increase in the number of retail outlets, longer hours of sale, and sale of alcohol on Sundays in retail stores. In recent years there have been changes which have included, for example, bar hours extended to 2:00 a.m., liquor and beer store hours extended to include opening on Sunday, no restrictions on the amount of alcohol in a drink, stadiums allowed to have alcohol in the bleachers, and elimination of the pre-approval process for alcohol advertising. Considered separately, some of these changes may seem inconsequential, but together they send the message that alcohol is like any other commodity and that greater promotion of alcohol and drinking and easier access do not involve any significant health or social risks. These experiences in Ontario suggest a persistent shift away from health and safety considerations, as former control functions are downgraded and commercial and marketing agendas are increasingly more dominant.

Several underlying factors have contributed to these changes in Canada's alcohol monopolies: the perception that the private sector is a major competitor with the public sector in alcohol retailing and distribution; the threat of privatisation; the assumption that customer

demand for greater convenience and service is limitless; and the expectation that alcohol sales should generate more revenue each year.

There are four linked risks associated with the shift in mandate and orientation toward commercial agendas. First, an increase in access to alcohol leads to the 'normalization' of alcohol use, thus increasing the perception that risks associated with drinking are modest and inconsequential. Second, an increase in access to alcohol is likely to lead to an increase in per capita consumption (e.g., Edwards et al., 1994; Holder et al. 1995; Holder, 2003). Third, as per capita sales increase there will likely be an increase in mortality and morbidity associated with drinking (e.g., Edwards et al., 1994; Xie et al., 2000; Norström, 2002; Ramstedt, 2002c). Fourth, this shift in orientation erodes the attention due to an important agenda and function of the control system, devalues some of the prevention strategies noted above, and hampers the ability of the government and its partners to respond effectively to alcohol problems. Considered together, these changes promote higher rates of alcohol consumption and higher rates of drinking-related problems.

Commercially driven changes are likely to conflict with the goal of controlling rates of alcohol consumption in order to decrease alcohol-related problems. It is important to routinely review and revise monopoly policies and practices in light of this important goal. More attention and resources need to be directed to health and safety concerns at the population level, and innovative ways sought to provide consumer convenience without increasing alcohol-related problems. When involved in prevention and control initiatives, monopolies need to direct more attention and resources to those interventions that have a demonstrated potential to curtail overall consumption and reduce drinking-related harm, and less attention to those with little potential to reduce drinking-related harm (see Babor et al., 2003).

What can be done to insure that harm reduction and health promotion agendas are fostered by alcohol monopolies? First, it is necessary to note that alcohol sales and harm reduction are not necessarily divergent agendas. It is feasible to provide alcohol in a socially responsible way without increasing per capita consumption or increasing the risk of drinking-related harm as long as key principles are maintained. Second, it is important that the principle of balance between economic and health interests be central to alcohol management. Third, in order to reduce drinking related harm, it is essential that promotional, marketing and alcohol management strategies be assessed from a public health perspective as to whether they will increase or control the inherent risks of alcohol distribution.

Fourth, several options for enhancing health promotion and harm reduction, outlined below -- using effective policies and a monopoly system – are recommended for higher priority than is currently the case. There are various strategies that are particularly accessible to an alcohol monopoly system that also fit in with their long-standing mandate. Some of these strategies include: (a) monitoring trends in per capita sales and taking steps to insure that they do not increase; (b) controlling the price of alcohol to insure that it does not decline relative to the cost of other goods and services; (c) limiting the number and location of retail outlets and on-premise venues such as bars; (d) limiting hours of operation; (e) curtailing and scaling down aggressive promotion and social marketing of alcohol products, and (e) preventing sale to minors, intoxicated persons and third parties who sell or give alcohol to minors or the

intoxicated. While there is some attention to the last point, in light of recent developments it is clear that greater attention needs to be devoted to all of these aspects of alcohol management.

These policy or regulatory interventions have been linked to lower levels of alcohol-related problems. Research has shown that as the price of alcohol decreases and the number of outlets and days and hours of operation increase, so do rates of problems such as alcohol dependence, liver cirrhosis, traffic crashes, arrests for public drunkenness and drinking-related violence (e.g. Chaloupka, 1993; James, 1994; Österberg, 1992; Scribner et al., 1994; Smith, 1992; Xie et al., 2000). Regulations that limit availability of alcohol and control prices play an important role in reducing alcohol consumption and related harm. A monopoly system has the regulatory power and orientation to promote these measures and to do it in an efficient way.

Monopolies can also contribute to social responsibility. Underage and young-looking adults have been shown to have a good chance (over 50%) of purchasing alcohol from private retailers in Wisconsin, Minnesota, Australia and Switzerland (Forster et al., 1995; Schofield et al., 1994; Vaucher et al., 1995). In the Swiss example (Vaucher et al., 1995), more than 80% of underage drinkers were served. In Ontario, every LCBO retail store employee and LCBO Agency store staff who serves the public takes a mandatory responsible service training program. Every challenge and refusal is recorded. In fiscal year 2001-2002, store staff challenged 1.2 million potential customers and 76,000 were turned away because they could not provide valid proof of age or because they appeared to be intoxicated.

In principle, either a fully privatised system for alcohol retailing or a government-run system may serve social responsibility functions. In practice, this will depend largely upon the rationale for the system and how it works. As noted above, under a privatised system there tend to be fewer incentives and checks and balances to insure that high priority is given to control and social responsibility agendas.

A system of government-run stores provides a readily available, cost-effective setting for distribution of health-related educational materials and campaigns about issues such as drinking and driving. In general, because of their centralised administration and ability to undertake initiatives that do not directly contribute to profits, provincial retail monopolies are in a better position than private-sector systems to undertake harm reduction activities.

PUBLIC OPINION

Ontario residents are very supportive of a monopoly-based retail system and related control measures. Research focusing on public opinion over the past 10 years[9] has indicated that Ontarians continue to be aware of and concerned about the social, health, legal and economic consequences of alcohol abuse and continue to support interventions and controls that will

[9] Most of these studies were sponsored by the Addiction Research Foundation and more recently by the Centre for Addiction and Mental Health, and conducted by the Institute for Social Research, York University. For a few years the studies were conducted by University of Michigan for the Alcohol Research Group, Berkeley. All the questions were posed in a neutral way without a lengthy preamble that might bias the response. A comparison of responses to the same question across years indicates that there is not a significant variation that might be ascribed to changes in the sponsor or field institute conducting the study.

reduce alcohol-related risks and harms (Room et al., 1995b; Giesbrecht & Greenfield, 1999; Giesbrecht et al., 2001).

Of specific relevance are recent surveys of representative samples of Ontario adults, which showed that 73% of Ontario adults were opposed to the privatisation of retail alcohol sales. Most felt there were already enough, or too many, places to buy alcohol in their communities and 79% of the public does not want alcohol sold in corner stores (Anglin et al., 2001; see also Anglin et al., 2003).

When opposing privatisation, some respondents may be reflecting a positive response to public relations initiatives, but this is not the full story. When responses to several questions are considered together, it is clear that the Ontario public strongly supports a balanced approach where access to alcohol is controlled by a government-run monopoly. Furthermore they find current access to alcohol convenient and the majority are only are a few minutes away from the nearest alcohol outlet. In general, public opinion does not favour increased marketing of alcohol products or greater access to alcohol.

THE FUTURE OF ALCOHOL MONOPOLIES AND REGULATION

Alcohol monopolies are likely to face continued pressure from economic interests. An emerging example involves concessions being contemplated by the World Trade Organization (WTO) to reduce or eliminate the regulation of domestic alcohol retail and distribution markets (Grieshaber-Otto & Schacter, 2002). Governments should, however, have an interest in preserving and even strengthening existing alcohol monopolies because they are uniquely positioned to prevent alcohol problems, provide customer service in a responsible way, and maintain tax revenue. Through regulation, controlling availability, establishing minimum prices and refusing to serve minors and intoxicated persons, monopolies are able to address public health concerns, while still providing alcohol in a way that is convenient to consumers.

The evidence is clear that, other factors being equal, increasing alcohol availability and accessibility will increase alcohol consumption, which in turn will increase alcohol-related morbidity and mortality, as well as alcohol-related social problems (e.g., Edwards et al., 1994; Norström, 2001; Babor et al., 2003). These relationships provide a sound scientific basis from which to propose and evaluate potential policy initiatives, including those that affect the sale and distribution of alcohol.

Because alcohol monopolies have a mandate to control the sale and distribution of alcohol, they offer an effective means for controlling accessibility for health purposes while providing customer service. However, alcohol monopolies may be losing sight of some aspects of their public health function and instead may be primarily oriented to generating revenue for governments or as protectors of the interests of the alcohol producers (e.g., Becker, 1983; Sloan et al., 2000). Recent developments in alcohol promotion in Ontario would also suggest that commercial and market interests have outweighed public health and safety interests in influencing the decisions of regulatory agencies.

The evidence summarized above supports the position that retail alcohol monopolies with a strong regulation mandate are an important mechanism for the control of alcohol problems in society. The evidence also indicates that relinquishing those controls will lead to increases in alcohol-related morbidity, mortality, and social problems. Thus, alcohol monopolies provide an effective means to reduce alcohol problems in society and must be maintained. However, if their mandates of controlling consumption and reducing drinking-related risk and harm are eroded, the justification for a monopoly system is similarly eroded (Romanus, 1992). While modernization is occurring in monopolies, it is especially important for them to focus on an essential aspects of their function: reducing drinking-related harm through control of per capita consumption rates and promoting other alcohol policy measures that will reduce risks and harm associated with alcohol consumption.

RECOMMENDATIONS

In light of the associations among alcohol availability, rates of consumption and drinking-related problems, and considering the unique role that monopolies can play in controlling drinking-related harm, the Centre for Addiction and Mental Health offers five recommendations.

- Governments should maintain and strengthen provincial alcohol monopolies as a means of preventing alcohol-related problems.
- Ontario and other provincial governments should ask the federal government to reject requests from the European Union or other parties to the WTO to remove the exception for provincial alcohol monopolies from the General Agreement on Trade in Services (GATS) or other trade agreements.
- The federal government of Canada should seek formal recognition in international trade agreements of the status of alcohol as a unique and potentially harmful commodity. It should also seek to maintain the right of government agencies to regulate domestic alcohol markets for the sake of public health, and to use government monopolies as a central tool to achieve this goal.
- Public health objectives must become integral parts of provincial and federal mandates and policies on alcohol. Retail alcohol monopolies should explicitly recognize their public health mandate and act accordingly.
- The retail distribution of alcohol should be under monopoly control with a strong mandate to control and prevent alcohol problems through regulation.

REFERENCES

Addiction Research Foundation (1994). **Drugs in Ontario**. Ontario, Addiction Research Foundation.

Adrian, M., Ferguson, B.S. & Her, M. (1996). Does allowing the sale of wine in Quebec grocery stores increase consumption. **Journal of Studies on Alcohol** 57 (4): 434-448.

Allen, B., Anglin, L. & Giesbrecht, N. (1998). Effect of others' drinking as perceived by community members. **Canadian Journal of Public Health** 89 (5): 337-344.

Anglin, L., Giesbrecht, N., Kobus-Matthews, M., McAllister, J. & Ogborne, A. (2001). **Public Opinion of Ontario Adults on Alcohol Policy Issues: Findings from a 1999 General Population Survey, Ontario.** Centre for Addiction and Mental Health Research Document Series No. 145.

Anglin, L., Giesbrecht, N., Ialomiteanu, A., McAllister, J. & Ogborne, A. (2003). Public perception of alcohol policy issues relating directly or indirectly to privatisation. Results from a 1999 Ontario survey. **Canadian Journal of Public Health.** 94 (3): 201-206.

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

Becker, G.S. (1983). A theory of competition among interest groups for political influence. **Quarterly Journal of Economics** 98: 371-400.

Bondy, S.J., Ashley, M.J., Rehm, J.T. & Walsh, G. (1999). Do Ontarians drink in moderation? A baseline assessment against Canadian low risk drinking guidelines. **Canadian Journal of Public Health** 90 (4): 272-276.

Brownsey, K. (1995). The spirits of Alberta: Privatizing Alberta's liquor stores. **Management** 6: 16-18.

Bruun K., Edwards G., Lumio M., Mäkelä,K., Popham, R.E., Room, R., Schmidt, W.; Skog O-J., Sulkunen, P., & Österberg, E. (1975). **Alcohol Control Policies in Public Health Perspective: The Finnish Foundation for Alcohol Studies**, Vol. 25. Helsinki, Finland; Finnish Foundation for Alcohol Studies.

Canadian Economic Observer (1996). **Feature Article.** Statistics Canada--Catalogue no. 11-010-XPB (July 1996)

Canadian Economic Observer (1997). **Feature Article.** Statistics Canada--Catalogue no. 11-010-XPB (June 1997)

Canadian Economic Observer (2000). **Feature Article.** Statistics Canada--Catalogue no. 11-010-XPB (December 2000)

Canadian Economic Observer (2001/2002). Statistics Canada--Catalogue no. 11-210-2001/2002.

Centre for Addiction and Mental Health (2000). **Enhancing Health Promotion and Prevention: Final Report.** Toronto: Centre for Addiction and Mental Health.

Centre for Addiction and Mental Health (2001). **CAMH Position on Harm Reduction: A background paper on its meaning and applications for substance abuse issues.** Toronto: Centre for Addiction and Mental Health.

Chaloupka, F. J. (1993). Effects of price on alcohol-related problems. **Alcohol Health & Research World** 17: 46-53.

Consumers' Association of Canada - BC (2003). **Privatisation of BC's Retail Liquor Store System--Implications for Consumers.** A report by the Consumers' Association of Canada--BC, May, 2003.

Corrao, G., Bagnardi, A., Zambon, A. & Arico, S. (1999). Exploring the dose-response relationship between alcohol consumption and the risk of several alcohol-related conditions: a meta-analysis. **Addiction** 94 (10): 1551-1573.

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.

Flanagan, G. (2003). **Sobering Result: The Alberta Liquor Retailing Industry Ten Years after Privatisation.** Edmonton: Canadian Centre for Policy Alternatives and Parkland Institute, June 2003.

Forster, J. L., Murray, D.M., Wolfson, M. & Wagenaar, A.C. (1995). Commercial availability of alcohol to young people: Results of alcohol purchase attempts. **Preventive Medicine** 24: 342-347.

Giesbrecht, N. & Greenfield, T.K. (1999). Public opinions on alcohol policy issues: a comparison of American and Canadian surveys. **Addiction** 94 (4): 521-531.

Giesbrecht, N. (2000). Roles of commercial interests in alcohol policies: recent developments in North America. **Addiction**, 95, (suppl. 4), S581-S595.

Giesbrecht, N. & Mackenzie, B. (2000). Alcohol retailing by government liquor boards in Canada in the 1990s. In: Österberg, E. (Ed.) **Themes from Finland**, pp. 47-82. International Seminar on Alcohol Retail Monopolies: Exchange of Information and Experience, Ivalo,

Finland, September 21-23, 1999. Helsinki: National Research and Development Centre for Welfare and Health.

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

Grieshaber-Otto, J. & Schacter, N. (2002). The GATS: impacts of the international "services" treaty on health-based alcohol regulation. **Nordic Studies on Alcohol and Drugs** 19 (English supplement): 50-68.

Her, M., Giesbrecht, N., Room, R. & Rehm, J.(1999a). Privatizing alcohol sales and alcohol consumption: evidence and implications. **Addiction** 94(8): 1125-1139.

Her, M., Giesbrecht N., Room, R. & Rehm, J. (1999b). Implications of privatizing/deregulating alcohol retail sales: a projection of alcohol consumption in Ontario. **Journal of Substance Abuse** 10 (4): 315-373.

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

Holder, H.D., Giesbrecht, N., Horverak, Ø, Nordlund, S., Norström, T., Olsson, O., Österberg, E. & Skog, O.-J. (1995). Potential consequences from possible changes to Nordic retail alcohol monopolies resulting from European Union membership, **Addiction** 90:1603-1618.

Holder, H. (2003). Editorial: Population drinking and alcohol harm: what these Canadian analyses tell us. **Addiction** 98 (7): 865-866.

http://www.fcpp.org/publications/policy_notes/hpg/role_of_government/ august/282000.html

http://www.gaming.gov.ab.ca/who/before_after.asp

James, D. (1994). **Alcohol Availability and Control: A Review of the Research Literature.** Edmonton, Alberta, Alberta Alcohol and Drug Abuse Commission.

Kavanagh, L. & Bondy, S. (1995). Alcohol-related harm. In: Anglin, L. (ed.), **The Ontario Experience of Alcohol and Tobacco: New Focus on Accessibility, Violence and Mandatory Treatment. A Report of the Ontario Alcohol and Other Drug Opinion Survey** (OADOS), Addiction Research Foundation, Toronto, 1995.

Lalonde, M.A. (1974). **New Perspectives on the Health of Canadians.** Ottawa: Ministry of Health and Welfare.

Laxer, G., Green, D., Harrington, T. & New, D. (1994). **Out of Control: Paying the Price for Privatizing Alberta's Liquor Control Board.** Ottawa, Canadian Centre for Policy Alternatives.

LCBO Communications (2001). **LCBO Annual Report 2000-2001- Our sixth straight record year.** Ontario.

Macdonald, S. (1986). The impact of increased availability of wine in grocery stores on consumption: Four case histories. **British Journal of Addiction** 81: 381-387.

Moore, M.H. & Gerstein, D.R. (1981). **Alcohol and Public Policy: Beyond the Shadow of Prohibition.** Washington, D.C.: National Academy Press.

Norström, T. (2001). Per capita alcohol consumption and all-cause mortality in 14 European countries. **Addiction** 96 (Supplement 1): S113-S128.

Norström, T. (2002). "Per capita alcohol consumption and all-cause mortality in Canada, 1950-1998." Paper presented at the Seminar: Canadian Alcohol Experiences & Nordic Perspectives. December 12-13, 2002, Voksenåsen Hotel, Oslo.

Österberg, E. (1992). Effects of alcohol control measures on alcohol consumption. **International Journal of the Addictions** 20: 209-225.

Pacula, R.L. & Chaloupka, F.J. (2001). The effects of macro-level interventions on addictive behavior. **Substance Use & Misuse** 36 (13): 1901-1922.

Ramstedt, M. (2002a). Alcohol-related mortality in 15 European countries in the postwar period. In: Norström, T. (ed.) **Alcohol in Postwar Europe. Consumption, drinking patterns, consequences and policy responses in 15 European countries** (pp. 137-156). Stockholm: Almqvist & Wiksell International.

Ramstedt, M. (2002b). "Are suicide rates in Canada related to changes in alcohol consumption? A time series analysis of postwar experience." Paper presented at the Seminar: Canadian Alcohol Experiences & Nordic Perspectives. December 12-13, 2002, Voksenåsen Hotel, Oslo.

Ramstedt. M. (2002c). "Alcohol consumption and alcohol-related mortality in Canada -- a regional analysis of the postwar period." Paper presented at the Seminar: Canadian Alcohol Experiences & Nordic Perspectives. December 12-13, 2002, Voksenåsen Hotel, Oslo.

Ramstedt. M. (2003). Per capita alcohol consumption and liver cirrhosis mortality--the case of Canada. **Addiction** 98: 1267-1276.

Ranson, M.K., Prabhat, J., Chaloupka, F.J. & Nguyen, S.N. (2002). Global and regional estimates of the effectiveness and cost-effectiveness of price increases and other tobacco control policies. **Nicotine and Tobacco Research** 4 (3): 311-319.

Rehm, J. (1999). Ökonomische Aspekte von Sustanzmißbrauch. In: Gastpar, M., Mann, K. & Rommelspacher, H. (Eds.) **Lehrbuch der Suchterkrankungen** (pp. 118-127). Stutgart: G. Thieme Verlag.

Rehm, J., Room, R., Monteiro, M., Gmel, G., Graham, K., Rehn, N., Sempos, C.T., Frick, U. & Jernigan, D. (forthcoming). **Alcohol as a Risk Factor for Burden of Disease.** Geneva: World Health Organization.

Romanus, G. (1992). The role of the state alcohol monopoly, and its relationship to other government bodies. In: Ferris, J., Dunning, R., Giesbrecht N. & West, P. (eds.) **International Symposium on Alcohol Monopolies and Social and Health Issues** (pp. 187-193). Proceedings of a Symposium, Toronto, October 27-30, 1992. Toronto: Addiction Research Foundation and the Liquor Control Board of Ontario.

Room, R. (1993). The evolution of alcohol monopolies and their relevance for public health. **Contemporary Drug Problems** 20:169-187.

Room, R., Bondy, S. J. & Ferris, J. (1995a). The risk of harm to oneself from drinking, Canada, 1989. **Addiction** 90, 499-513.

Room, R., Graves, K., Giesbrecht, N. & Greenfield, T.K. (1995b). Trends in public opinion about alcohol policy inittiatives in Ontario and the U.S.: 1989-91. **Drug and Alcohol Review** 14: 35-47.

Rossow, I. (2001). Alcohol and homicide -- a cross-cultural comparison of the relationship in 14 European countries. **Addiction** 96 (Supplement 1): S77-S92.

Rossow, I. (2002). "Alcohol consumption and homicides in Canada 1950-1999." Paper presented at the Seminar: Canadian Alcohol Experiences & Nordic Perspectives. December 12-13, 2002, Voksenåsen Hotel, Oslo.

Schofield, M. J., Weeks, C. & Sanson-Fisher, R. (1994). Alcohol sales to minors: A surrogate study. **Preventive Medicine** 23 (6): 827-831.

Scribner, R. A., MacKinnon, D. P. & Dwyer, S.H. (1994). Alcohol outlet density and motor vehicle crashes in Los Angeles County cities. **Journal of Studies on Alcohol** 55: 447-453.

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.

Single, E., Robson, L., Xie, X. & Rehm, J. (1998). The economic costs of alcohol, tobacco and illicit drugs in Canada, 1992, **Addiction** 93 (7): 991-1006.

Skog, O-J. (2003). Alcohol consumption and fatal accidents in Canada, 1950-1998. **Addiction** 98 (7): 883-894

Sloan, F.A., Stout, E.M., Whetten-Goldenstein, K. & Liang, L. (2000). **Drinkers, Drivers and Bartenders: Balancing Private Choices and Public Accountability.** Chicago: University of Chicago Press.

Smart, R. (1986). The impact on consumption of selling wine in grocery stores. **Alcohol and Alcoholism** 21: 233-236.

Smith, D. I. (1992). Relationship between the number and type of alcohol outlets and mortality due to liver cirrhosis and traffic accidents. **Drug and Alcohol Review** 11: 145-151.

Statistics Canada (1996) **The Control and Sale of Alcoholic Beverages in Canada.** Fiscal year ended March 31, 1996. Catalogue no. 63-202-XPB Ottawa: Statistics Canada.

Statistics Canada (2002) **The Control and Sale of Alcoholic Beverages in Canada.** Fiscal year ended March 31, 2002. Catalogue no. 63-202-XIB Ottawa: Statistics Canada.

Traffic Injury Research Foundation (2002). **The Alcohol Crash Problem in Canada: 2000.** Ottawa: Canadian Council of Motor Transportation Administrators.

Vaucher, S. Rehm, J., Benvenuti, J. & Müller, R. (1995). Young teenagers and access to alcohol in a Swiss canton. Evidence from observational testing and from a telephone survey. **Addiction** 90: 1619-1625.

Wagenaar, A. C. & Holder H.D. (1991). A change from public to private sale of wine: Results from natural experiments in Iowa and West Virginia. **Journal of Studies on Alcohol** 52: 162-173

West. D. (2000). **The Privatisation of Liquor Retailing in Alberta.** The Fraser Institute, Vancouver.

West, D. (2003). **The Privatisation of Liquor Retailing in Alberta.** The Fraser Institute, Vancouver.

Wine Council of Ontario (1994) "The privatisation experience in North America: An overview." Manuscript. St. Catharines, Ontario.

www.adassoc.org.uk/briefs/alc.btml.

Xie, X., Rehm, J., Single, E. & Robson, L. (1996). **The economic costs of alcohol, tobacco and illicit drug abuse in Ontario: 1992.** ARF Research Document Series No. 127. Toronto: Addiction Research Foundation.

Xie, X., Rehm, J., Single, E., Robson, L. & Paul, J. (1998). The economic costs of alcohol abuse in Ontario. **Pharmacological Research** 37: 241-249.

Xie, X., Mann, R.E. & Smart, R.G. (2000). The direct and indirect relationships between alcohol prevention measures and alcoholic liver cirrhosis mortality. **Journal of Studies on Alcohol**: 61: 499-506.

Summary: Alcohol Retail Monopolies & Private Systems

Issue	Monopolies		Private	
	+	-	+	-
Sales	Tool to control alcohol sales	Tool is only as strong as the policies and enforcement		Less control on sales because not directly monitored by one employer i.e. sales of tobacco to minors
Public Health Agenda	Simple system to promote public health	Must ensure that the monopoly is not sending strong conflicting messages about drinking alcohol (ie promotion of alcohol vs. campaign against binge drinking	Public health could be promoted through the private stores	Lower incentive to promote public health because of stronger concern for profit Less cohesion to implement a public health campaign re lowering consumption of alcohol More effort to gain participation from retailers

Issue	Monopolies		Private	
	+	-	+	-
Risk	Easier system to train employees to not serve minors or people who have consumed too much alcohol	The system is only as strong as what and how the monopoly implements controls		Tend to increase number of outlets, opening hours, consumption levels