

ALCOHOL POLICY – BACKGROUNDER

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.ⁱ 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.ⁱⁱ

On a global level, a recent World Health Organization (WHO) sponsored publicationⁱⁱⁱ, 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, 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.^{iv}

In light of the increase in alcohol consumption in Canada in recent years it is expected that the burden from alcohol, and social, health and safety costs associated with it, will increase if our interventions and policies do not become more effective. All citizens deserve effective evidence-based policies at the international, national and regional or local levels.

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.

A recent WHO report by Babor and colleagues^v 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 sales
- ?? 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, there remain a number of challenges. 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 increase.

Of some 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. Also, 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.

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:

- ?? A current challenge at the national and provincial levels is that of getting alcohol on the agenda – e.g. that governments see alcohol as a risk factor in chronic disease prevention initiatives.
- ?? Opportunities for combining interventions and effective partnerships need to be further explored.
- ?? 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.
- ?? Therefore, 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.

Questions

- 1. How does this background information apply to what is going on at the local level in your jurisdiction?**
- 2. In recent years the rate of alcohol consumption has been increasing in Canada, What might be some factors contributing to this increase in consumption and what impact has/or will this have at the local level?**
- 3. It appears that it is difficult to get alcohol on the agenda in some health and safety contexts? Why is this the case?**
- 4. What might be done to have a closer match between the damage from alcohol and prevention priorities?**
- 5. Are there specific alcohol-related problems that are not given sufficient attention in current prevention and policy endeavours?**
- 6. Has the issue of alcohol and its relation to cancer been addressed in prevention and health promotion in your community? If so, how?**
- 7. What acute or traumatic impacts from alcohol need to be highlighted in future alcohol policy initiatives?**
- 8. Who should be involved in developing alcohol policies?**
- 9. What interventions have been considered at the local level to affect problems associated with drinking at home or before going to bars?**
- 10. What are some local examples of effective coordination between several alcohol policy efforts?**

[Norman Giesbrecht & Janet McAllister, November 22, 2004]

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

ⁱⁱ T. Norström (2004) Per capita alcohol consumption and all-cause mortality in Canada, 1950-98. *Addiction*, 99, 1274-1278. M. Ramstedt (2003) Alcohol consumption and liver cirrhosis mortality with and without the mention of alcohol – the case of Canada. *Addiction*, 98, 1267-1276. M. Ramstedt (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. O-J, Skog (2003) Alcohol consumption and fatal accidents in Canada, 1950-98. *Addiction*, 98, 883-893.

ⁱⁱⁱ T. Babor et al. (2003) *Alcohol: No Ordinary Commodity. Research and Public Policy*. Oxford: Oxford University Press.

^{iv} J Rehm et al. (2003) Alcohol as a risk factor for Global Burden of Disease. *European Addiction Research*, 9, 157-164. R. Room & J. Rehm (2004) "The Alcohol-Related Global Burden of Disease." Presented at the Research Society on Alcoholism, Vancouver, BC. 26-30 June 2004.

^v T. Babor et al. (2003) *Alcohol: No Ordinary Commodity. Research and Public Policy*. Oxford: Oxford University Press.