



Alcohol-related Harms and Control Policy in Canada

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1. Introduction

On May 27, 2003, the Government of Canada announced the long-awaited renewal of Canada's Drug Strategy. As part of this initiative, several regional consultations are being held across Canada to provide stakeholders with the opportunity to provide input into the process of designing and implementing a renewed approach to problems associated with substance abuse in Canada. Within these consultations, alcohol policy has repeatedly emerged as a topic of national concern and Health Canada, along with the Canadian Centre on Substance Abuse, will be co-hosting a Thematic Roundtable on Alcohol Policy in Ottawa on November 18 and 19, 2004 to develop a focused discussion of matters related to alcohol policy.

Central to the redesign of Canada's Drug Strategy is the development of the National Framework for Action on Substance Use and Abuse. The Framework, as currently envisioned, will set out the guiding principles and structure of a process to design and implement an inclusive *national* approach to substance abuse in Canada. The purpose of the Thematic Roundtable on Alcohol Policy is to generate information to inform the development of the portions of the National Framework related to alcohol. The purpose of this paper, in turn, is to provide background information for the Roundtable. Four major topics will be covered in this paper: (1) background material on alcohol use and the economic and health benefits of alcohol, (2) an overview of best practice policies for the control of harms related to alcohol, (3) an overview of the trends and current levels of various health and social harms associated with alcohol misuse and (4) a discussion of the evolution and current status of alcohol control policy in Canada. Where data are available, comparisons with trends and conditions in other countries are also provided.

As a background document, this paper is not intended as a comprehensive literature review of all topics related to alcohol policy, but instead as a compact and accessible resource to inform the facilitated discussions that will take place at the roundtable meeting.

2. Executive Summary

The major findings of this background paper include:

Alcohol Consumption and Drinking Patterns

- In 2001, 77% of the population 15 years and older in Canada indicated that they were current drinkers¹. The percentage of current drinkers increased by approximately 3% between 1994 and 2001 (p. 5).

¹ This paper was prepared prior to the release of the Canadian Addiction Survey (CAS) on November 24, 2004 containing the most up-to-date prevalence rates available for alcohol use in Canada. The CAS, conducted between December 2003 and April 2004, is the most detailed and extensive survey of its kind ever carried out in Canada. An initial report, *CAS Highlights: Prevalence of Use and Related Harms*, is available at <http://www.ccsa.ca/pdf/ccsa-004804-2004.pdf> The full CAS report will be published early in 2005.

- Based on sales data, the annual per-capita consumption of alcohol in Canada has remained relatively stable at just over 100 litres a year since the early 1990s. Since 1996, annual sales per capita have increased 4.0% from 100.96 litres to 105.03 litres (p. 6).
- Approximately 80% of alcohol consumed in Canada is in the form of beer although wine and spirits have gained in popularity in recent years (p. 6).
- In 2002, Canada ranked 25th among 45 countries in annual per-capita consumption at 6.9 litres of pure alcohol. This was slightly below the average of 7.2 litres per capita for the 45 countries that were included in the study (p. 6).
- In 2003, 29% of men and 12% of women reported engaging in high-risk drinking practices defined as five or more drinks per occasion 12 or more times a year. Data indicate that there may be an upward trend in high-risk drinking since 1994 (p. 7).
- In 2003, about half of current drinkers reported no high-risk drinking and about 25% reported engaging in high-risk drinking less than once a month (p. 8).
- Males between the ages of 20 and 34 report the highest prevalence of high-risk drinking (p. 8).

Economic Benefits of Alcohol

- In FY2002/03, sales of alcoholic beverages totalled \$15.4 billion in Canada. Since FY 1992/93, the value of alcoholic beverages sold in Canada has increased by 47.5% (p. 8).
- Provincial and territorial government revenue from the control and sale of alcohol (not including revenue from provincial sales taxes) was \$4.0 billion in FY2002/03. This revenue has increased by an average of 2.55% a year since 1993/94 (p. 9).
- Excluding the Northwest Territories, Saskatchewan has the highest annual per-capita remittance of alcohol-derived revenue at \$228 while Quebec has the lowest at \$88. The average for all provinces and territories in Canada was \$133 per person in FY 2002/03 (p. 9).
- Provincial, territorial and federal commodity taxes on beer totalled \$3.8 billion in 2002 with \$1.3 billion going to the federal government and \$2.5 billion going to the provinces and territories (p. 10).
- Annual provincial, territorial and federal tax revenues from the sale of wine have totalled approximately \$750 million in recent years (p. 10).
- Taxes on alcohol and tobacco account for 2.5% of all tax revenue in Canada (p. 10).
- In 2001, the production, distribution and sale of beer contributed \$12.6 billion to the economy of Canada, which represented 1.2% of the GDP for that year (p. 10).

Health Benefits of Moderate Alcohol Consumption (p. 11)

- The health benefits of moderate alcohol consumption have been confirmed in multiple studies in recent decades.
- The health benefits of alcohol consumption derive mostly from the reduced risk of cardiovascular problems and these are particularly significant for men over the age of 45.
- Research from Australia, Canada and New Zealand suggests that alcohol consumption may prevent more deaths than it causes.
- However, there are many more hospitalizations caused by alcohol misuse than saved by moderate use, and there are more years of life lost due to alcohol than years of life saved.

Overview of Alcohol Control Policies

- There are two basic approaches that governments use to control the health and social harms of alcohol: (1) the **population health** approach, which targets overall drinking rates, and (2) the **harm reduction** approach, which targets high-risk drinking patterns at the individual level.

These approaches are not mutually exclusive as all countries employ a mix of policies, and policies that affect one can and do affect the other (p. 11).

- Historically speaking, Canada has taken a comparatively strong stance on the regulation and control of alcohol with the “Canadian Model” being based on strict licensing schemes for drink-sellers, restricted hours and days of sale, relatively high taxes or mark-ups and public monopolies for the distribution of alcohol (p. 11).
- In recent years some of these restrictive policies have been relaxed especially in the category of regulating the physical availability of alcohol (pp. 11-12).
- Babor et al., (2003) identified the following 10 public policies as “best practice” for reducing harms associated with alcohol misuse: **(1) alcohol taxes, (2) blood alcohol content laws, (3) administrative suspension of driver’s licences, (4) sobriety checkpoints, (5) graduated licensing, (6) brief interventions for hazardous drinkers, (7) public monopolies for the production or sale of beverage alcohol, (8) minimum legal purchase age, (9) restricted hours and days of sale and (10) outlet density restrictions** (p. 12).

Alcohol-related Health and Social Harms

- In 1992, the total direct and indirect costs of alcohol misuse in Canada were conservatively estimated at \$7.5 billion or \$265 per capita. This represented 40.8% of the total estimated costs of substance abuse in 1992. The largest economic costs for alcohol were \$4.1 billion for lost productivity due to illness and premature death, \$1.36 billion for law enforcement and \$1.3 billion in direct health care costs (p. 11).
- In FY 2000/01, 21,692 persons who separated from hospitals had been seen for alcohol-related diseases and 5,392 had been seen for external causes (e.g., injuries, etc.) related to alcohol (p. 13).
- In 2000/01, rates of hospitalization for alcohol-related diseases were highest for older Canadians and lowest for younger Canadians. Rates of hospitalization for external causes related to alcohol (except falls) were highest for younger Canadians and lowest for older Canadians (p. 14).
- In 2000/01, rates of alcohol-involved attempted suicides were highest among Canadians between the ages of 20 and 24 (p. 14).
- In 2000/01, hospital separations for alcohol dependency and abuse peaked in the 35-44 age group (p. 14).
- The number of persons who died in Canada of alcohol-related causes has remained relatively stable since 1994. Based on a review of 12 alcohol-related causes of mortality, men are approximately seven times more likely to die from causes related to alcohol than women (pp. 14-15).
- The overall rate of impaired driving incidents in Canada decreased by 60% from 1980 and 2002 (pp. 15-16).
- Impaired driving was the most common criminal offence in Canada in 2002, accounting for 12% of all criminal charges (p. 16).
- The percentage of drivers who self-reported driving after drinking and driving while impaired has fallen since 1998 (p. 17).
- The percentage of fatally injured drivers who test positive for alcohol has fallen by approximately 30% since 1982 (p. 18).
- Since 1999, there has been an increase in the percentage of fatally injured drivers who test positive for alcohol of about 3% a year (p. 18).
- In 2001, approximately 50% of fatally injured drivers between the ages of 26 and 35 tested positive for alcohol (p. 19).
- In 2002, the offences of impaired driving and common assault accounted for 23% of all criminal charges in Canada (12% for impaired driving and 11% for common assault). Alcohol was involved in at least 90% of impaired driving charges and approximately 40-45% of common

assault charges. Thus, alcohol was directly connected to at least 15% of all police reported criminal offences for that year (p. 19).

- At least 50% of all substance abuse treatment in Canada involves alcohol and this translates into costs of approximately \$30 million a year in the province of Alberta and \$65 million a year in Ontario (p. 19).

Alcohol Control Policies in Canada

Best Practice Policies

- Three different **alcohol taxes** affect the price of beverage alcohol in Canada: (1) federal excise taxes, (2) provincial mark-ups and environmental taxes and (3) federal and provincial sales taxes. Canada's federal excise taxes on alcohol are low by European standards. When all of the relevant taxes are considered, however, the percentage of the price of beverage alcohol accounted for by taxes is high for both beer and spirits in Canada. Federal excise taxes on alcohol in Canada have not changed since the early 1990s (pp. 20-22).
- Canada's **blood alcohol content laws** are in line with those of most other countries especially when the provincial 0.05-0.079 BAC temporary licence suspension policies are considered. Drinking and driving countermeasures in Canada continue to be strengthened over time although the impressive reductions in alcohol-involved harms related to driving may be difficult to sustain into the future (pp. 22-23).
- All provinces and territories except Quebec authorize the **administrative suspension of driver's licences** for 12 or 24 hours if drivers test between 0.05 and 0.079 BAC (the lower limit is 0.04 in Saskatchewan). All provinces and territories except New Brunswick and Nunavut have automatic 90-day suspensions for drivers who test at 0.08 BAC or above or who refuse to provide a breath sample. Finally, all provinces revoke driver's licences for impaired driving convictions; most commonly for 12 months for the first offence (p. 23).
- Only the province of Ontario has a systematic **sobriety checkpoint** program. The right to stop vehicles at random is the most common impaired driving enforcement countermeasure in Canada, although enforcement officers are not allowed to apply a blood alcohol test unless probable cause has been established (pp. 23-24).
- All provinces and territories in Canada except PEI and Nunavut have **graduated licensing** schemes for novice drivers. All provinces and territories in Canada have zero-tolerance BAC laws for novice drivers (pp. 24).
- Only the province of Manitoba (i.e., the Addictions Foundation of Manitoba) indicated that they had a program in place for training doctors and other health care professionals on the assessment and application of brief interventions for at-risk alcohol use. The College of Family Physicians of Canada created the Alcohol Risk Assessment and Intervention (ARAI) program in 1994 for just these purposes, however. According to the College of Family Physicians, the ARAI project was very popular when it was first introduced in the mid-1990s when approximately 4,000 physicians were trained across Canada for alcohol assessment and brief interventions. In recent years, however, only about 10-15 trainings are conducted every year (p. 25).
- The provinces and territories have varied regulations and practices for the sale of alcoholic beverages. Each province and territory has a liquor authority that is responsible for the control and sale of alcoholic beverages in that jurisdiction. In most provinces, these **public monopolies** manage retail stores and license agency stores. Agency stores are privately owned and operate under licence from the liquor authorities, usually to provide services to residents of small or remote communities (pg. 25).
- Only Alberta has fully privatized liquor sales, although BC plans to fully privatize by 2005 (p. 29).

- All provinces and territories license and regulate the sale of alcohol for on-premise consumption. Enforcement of regulations on liquor sales, however, is an ongoing issue in all provinces. The “big four” compliance issues for licensed premises in Ontario are: (1) over-crowding, (2) sale to minors, (3) sale to intoxicated patrons and (4) serving after hours (p. 26).
- The province of Alberta has recently taken steps to deal with systemic problems associated with illegal sales to minors (p. 26, footnote 19).
- Canada’s **minimum purchase age** (MPA) is 19 except in Manitoba, Alberta and Quebec where it is 18. MPA laws have not changed in Canada since 1987. No province has lowered its drinking age since 1972. Canada’s MPA is high by European standards. Only the US has a higher MPA at 21 (p. 27-28).
- Historically speaking, Canada has had relatively strict control over the **days and hours of alcohol sales** with Sunday sales still illegal in several provinces. In recent years, however, controls on hours and days of sale have been relaxed in some provinces. Sunday sales are now authorized in a majority of provinces and territories, for example, and BC now authorizes bars to serve alcohol until 4 a.m. (p. 28).
- No province or territory has statutory limits on the **density of alcohol outlets** although all use economic and social criteria when managing the physical distribution of outlets and licensed premises. Some municipal governments in Canada have enacted innovative zoning laws to limit the clustering of retail alcohol outlets in sensitive areas under their jurisdiction. Municipal alcohol policies (MAPs) are more common in Ontario than in other provinces (p. 29).

Non-Best Practice Policies

- Alcohol advertising is regulated at both the provincial and national levels in Canada. In recent years, the controls on alcohol advertising are moving toward the self-regulation approach with some provinces and the CRTC, for example, devolving the pre-screening of alcohol advertising to industry trade organizations such as Advertising Standards Canada. The enforcement of guidelines on alcohol advertising is largely driven by complaints from consumers. Between 1997 and 2003, an average of 68 complaints about broadcast alcohol ads were reviewed in Canada every year. Of these, an average of 23 were upheld against alcohol advertisers (pp. 30-31).
- Only the Yukon and the Northwest Territories require alcohol warning labels in Canada. In 2001, the House of Commons passed a resolution endorsing alcohol warning labels for pregnant women. On October 13, 2004, Bill C-206 was introduced in Parliament that would require warning labels on all alcoholic beverages sold with more than 1% alcohol by volume. The proposed warnings are directed at drinking and driving, negative health effects of alcohol and drinking while pregnant (p. 31).

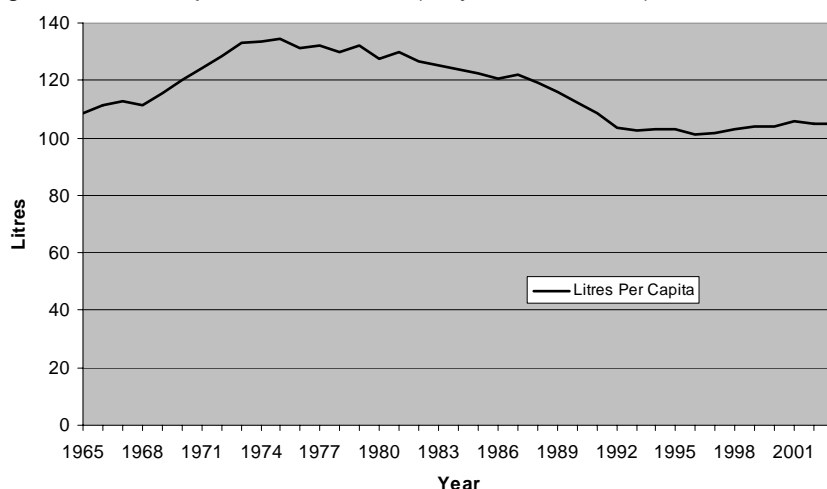
3. Background

Alcohol occupies an interesting and unique place in global society. Unlike many other powerful psychoactive substances, alcohol use is thoroughly integrated into the social customs and legitimate economies of many countries. Data on the levels and patterns of alcohol use and the economic and health benefits of alcohol in Canada are presented and discussed below.

3.1 Levels of Alcohol Consumption

The 2000-2001 Canadian Community Health Survey (CCHS) revealed that 77% of the population over the age of 12 were “current drinkers” (had consumed at least one drink in the previous year). In 1994, a similar survey found that about 74% were current drinkers. Figure 1 below provides data on the overall per-capita consumption of beverage alcohol in Canada from 1965-2002 based on recorded sales:

Figure 1: Per-capita Alcohol Sales (15 years and older), Canada, 1965-2003²



Source: Statistics Canada, 2004a.

These data indicate that current annual per-capita alcohol consumption in Canada is approximately the same as it was in the mid-1960s and below the peak levels seen during the 1970s and early 1980s. Since 1992, annual per-capita consumption has remained relatively stable at just over 100 litres. Between 1996 and 2003, annual per-capita consumption increased by 4.0% from 100.96 litres to 105.03 litres.

Approximately 80% of alcohol consumed in Canada is in the form of beer, although wine and spirits have gained in popularity in recent years. In terms of international comparisons, Canada ranked 25th among 45 countries surveyed in *World Drink Trends* with regards to per-capita consumption of alcohol in 2002.

Table 1 compares Canada's per-capita alcohol consumption rate with several other countries in the world:

Table 1: Per-capita Consumption of Alcohol, 2002

Country (rank out of 45)	Per-capita Consumption (litres of pure alcohol)
Luxembourg (1)	11.9
Ireland (3)	10.8
Germany (5)	10.4
France (6)	10.3
United Kingdom (9)	9.6
Denmark (10)	9.5
Russia (15)	8.6
Netherlands (17)	8.0
Finland (21)	7.7
Australia (23)	7.3
Average (of 45 countries)	7.2
Canada (25)	6.9
USA (26)	6.7
Sweden (34)	4.9
South Africa (38)	4.7
Norway (39)	4.4
Mexico (45)	3.1

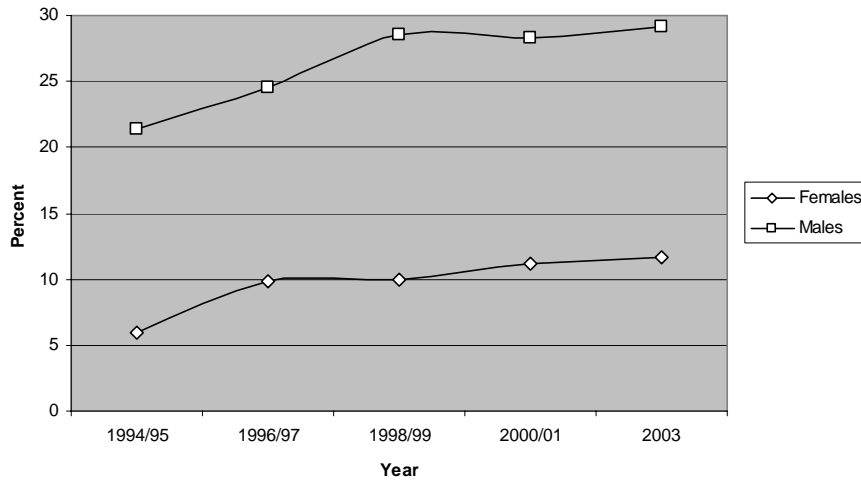
Source: CDS, 2004

² These data may understate actual consumption since they do not include consumption of home-made and brew-on-the-premises wine and beer or contraband alcohol.

3.2 Patterns of Alcohol Consumption

Research has determined that certain patterns of drinking are associated with increased risk of both health and social harms (Stockwell, et al., 1996). In particular, drinking to the point of intoxication and long-term, elevated consumption of alcohol both increase the likelihood of harms substantially. Based on these findings, it is possible to define “high-risk drinking” as regularly consuming five or more drinks on a single occasion and many countries use this as an indicator of hazardous drinking practices. Figure 2 depicts the percentage of current drinkers reporting high-risk drinking patterns in the last 12 months in Canada (defined as drinking five or more drinks on a single occasion 12 or more times in the past year).

Figure 2: Percentage of Current Drinkers Age 12 and Older Reporting Regular High-Risk Drinking, Canada, 1994/95-2003³



Sources: Statistics Canada 2004c, d, and e; used by permission.

The reported frequency of drinking varies considerably by age and sex, however, as indicated in Table 2 below:

³ The data for years 1994/95 to 1998/99 exclude the territories. Data for 2000/01 and 2003 include all provinces and territories. Thus, the trends depicted in Figure 2 should be interpreted with caution.

Table 2: Frequency of Drinking in the Past 12 Months, by Age Group and Sex, Household Population Aged 12 and Older who are Current Drinkers, Canada, 2003

Frequency of drinking	Total	Never 5 or more drinks on one occasion		5 or more drinks on one occasion, less than 12 times a year		5 or more drinks on one occasion, 12 or more times a year		Drinking frequency, not stated	
	Number	Number	%	Number	%	Number	%	Number	%
2003									
Total, 12 years and over	20,723,896	10,727,036	51.8	5,010,291	24.2	4,285,535	20.7	701,034	3.4
Males	10,703,114	4,384,672	41.0	2,824,195	26.4	3,121,240	29.2	373,008	3.5
Females	10,020,781	6,342,365	63.3	2,186,096	21.8	1,164,295	11.6	328,025	3.3
12-19 years	1,746,201	693,770	39.7	516,130	29.6	464,455	26.6	71,846	4.1
Males	909,069	317,966	35.0	255,229	28.1	295,127	32.5	40,748	4.5
Females	837,132	375,804	44.9	260,901	31.2	169,329	20.2	31,098	3.7
12-14 years	260,120	182,723	70.2	41,369	15.9	11,054 ^E	4.2 ^E	24,973	9.6
Males	134,592	94,034	69.9	20,592	15.3	5,391 ^E	4.0 ^E	14,576 ^E	10.8 ^E
Females	125,528	88,689	70.7	20,778	16.6	5,664 ^E	4.5 ^E	10,398 ^E	8.3 ^E
15-19 years	1,486,081	511,047	34.4	474,760	31.9	453,401	30.5	46,873	3.2
Males	774,477	223,931	28.9	234,637	30.3	289,736	37.4	26,173	3.4
Females	711,604	287,116	40.3	240,123	33.7	163,665	23.0	20,700	2.9
20-34 years	5,506,455	1,814,513	33.0	1,798,704	32.7	1,737,035	31.5	156,203	2.8
Males	2,872,546	673,718	23.5	900,951	31.4	1,212,978	42.2	84,899	3.0
Females	2,633,909	1,140,795	43.3	897,753	34.1	524,057	19.9	71,304	2.7
20-24 years	1,917,849	448,920	23.4	615,037	32.1	793,688	41.4	60,204	3.1
Males	1,015,969	162,783	16.0	302,465	29.8	516,697	50.9	34,024 ^E	3.3 ^E
Females	901,880	286,137	31.7	312,572	34.7	276,991	30.7	26,180 ^E	2.9 ^E
25-34 years	3,588,606	1,365,593	38.1	1,183,666	33.0	943,347	26.3	95,999	2.7
Males	1,856,577	510,936	27.5	598,485	32.2	696,281	37.5	50,875	2.7
Females	1,732,029	854,657	49.3	585,181	33.8	247,066	14.3	45,124	2.6
35-44 years	4,497,784	2,197,351	48.9	1,226,611	27.3	938,700	20.9	135,123	3.0
Males	2,345,330	869,031	37.1	704,926	30.1	702,091	29.9	69,282	3.0
Females	2,152,454	1,328,320	61.7	521,685	24.2	236,609	11.0	65,841	3.1
45-64 years	6,392,205	3,896,356	61.0	1,282,972	20.1	1,007,395	15.8	205,482	3.2
Males	3,308,401	1,579,978	47.8	819,420	24.8	795,986	24.1	113,016	3.4
Females	3,083,804	2,316,379	75.1	463,551	15.0	211,408	6.9	92,466	3.0
45-54 years	3,800,419	2,158,598	56.8	846,204	22.3	667,765	17.6	127,852	3.4
Males	1,927,458	824,902	42.8	518,041	26.9	515,247	26.7	69,268	3.6
Females	1,872,961	1,333,696	71.2	328,163	17.5	152,517	8.1	58,584	3.1
55-64 years	2,591,785	1,737,758	67.0	436,767	16.9	339,630	13.1	77,630	3.0
Males	1,380,943	755,076	54.7	301,379	21.8	280,739	20.3	43,748	3.2
Females	1,210,843	982,682	81.2	135,388	11.2	58,891	4.9	33,882	2.8
65 years and over	2,581,251	2,125,047	82.3	185,874	7.2	137,950	5.3	132,379	5.1
Males	1,267,769	943,979	74.5	143,669	11.3	115,058	9.1	65,063	5.1
Females	1,313,482	1,181,068	89.9	42,206	3.2	22,892	1.7	67,316	5.1
65-74 years	1,572,861	1,251,618	79.6	143,555	9.1	112,808	7.2	64,880	4.1
Males	809,543	568,357	70.2	111,962	13.8	94,259	11.6	34,966	4.3
Females	763,318	683,261	89.5	31,593	4.1	18,549	2.4	29,914	3.9
75 years and over	1,008,390	873,429	86.6	42,320	4.2	25,142	2.5	67,499	6.7
Males	458,226	375,622	82.0	31,707	6.9	20,799	4.5	30,097	6.6
Females	550,164	497,806	90.5	10,612 ^E	1.9 ^E	4,343 ^E	0.8 ^E	37,402	6.8

Source: Statistics Canada, 2004e; used by permission.

As indicated in these data, about half of current drinkers in Canada reported never engaging in high-risk drinking in 2003 while approximately one-quarter (24.2%) reported engaging in high-risk drinking less than once a month. Significantly, over one-fifth of current drinkers (20.7%) reported engaging in high-risk drinking 12 or more times a year in 2003. These drinking patterns are most prevalent among men, and persons ages 20-34 in Canada.

3.3 Economic Benefits of Alcohol

In Fiscal Year 2002/03, sales of alcoholic beverages (beer, wine and spirits) totalled \$15.4 billion in Canada (Statistics Canada, 2004f). Since 1992/93, the total value of liquor products sold for consumption in Canada has grown by 47.5% (Statistics Canada, 2004f). Table 3 below shows the trends with regard to provincial and territorial profits from alcohol sales in Canada from 1993/94 to 2002/03:

Table 3: Provincial and Territorial Government Revenue from the Control and Sale of Alcoholic Beverages (excluding provincial sales taxes), 1992/93 to 2002/2003

	Net Income of Liquor Authorities		Revenue from the Control of Retail Sales (permits, etc.)		Total	
	Millions of \$	Growth Rate	Millions of \$	Growth Rate	Millions of \$	Growth Rate
1993/94	2,389	-0.2	709	-1.7	3,098	-0.5
1994/95	2,474	3.6	731	3.0	3,204	3.4
1995/96	2,526	2.1	736	0.8	3,262	1.8
1996/97	2,614	3.5	722	-2.0	3,336	2.3
1997/98	2,726	4.3	719	-0.3	3,446	3.3
1998/99	2,864	5.0	741	3.0	3,605	4.6
1999/00	2,958	3.3	769	3.8	3,727	3.4
2000/01	3,060	3.4	766	-0.4	3,825	2.6
2001/02	3,160	3.3	769	0.4	3,929	2.7
2002/03	3,236	2.4	766	-0.4	4,002	1.9

Source: Statistics Canada, 2004f

The per-capita remittance from alcohol profits varies greatly from province to province, however, as depicted below:

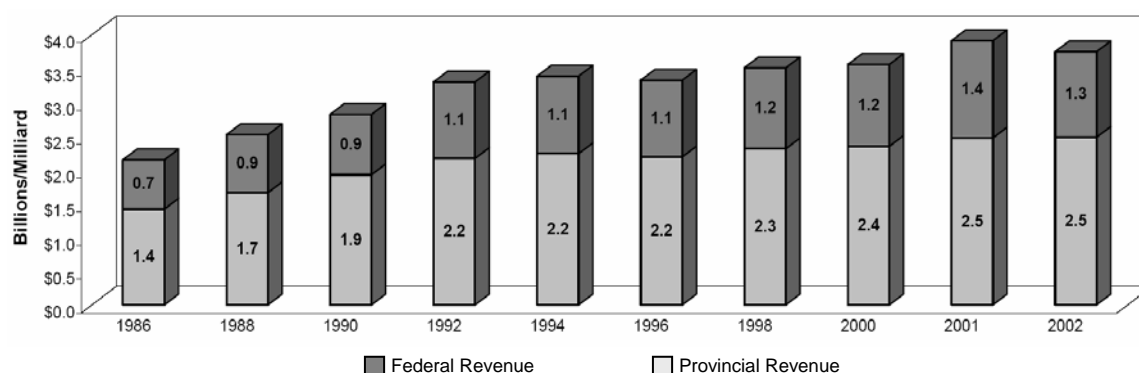
Table 4: Per-capita Remittance of Revenue from the Control and Sale of Alcoholic Beverages, 2003

Province/Territory	Per-capita Remittance (\$)
Northwest Territories	620
Saskatchewan	228
Alberta	215
Nova Scotia	205
British Columbia	192
Manitoba	181
New Brunswick	177
Yukon	166
Canada	133
Nunavut	109
Newfoundland and Labrador	104
Ontario	99
Prince Edward Island	90
Quebec	88

Source: Statistics Canada, 2004f.

The federal government and the provinces also collect substantial revenue from excise taxes, mark-ups, and sales taxes on alcohol. For example, Figure 3 depicts the federal and provincial commodity taxes collected on the sale of beer in Canada between 1986 and 2002:

Figure 3: Commodity Taxes Collected on the Sale of Beer in Canada, 1986-2002



Source: BAC, 2004; used by permission.

Similarly, in recent years the sale of wine in Canada added approximately \$125 million to federal revenue through federal excise taxes and \$625 million to the provinces through sales taxes, environmental taxes and mark-ups (Ross, 2004). In Canada, taxes on alcohol and tobacco account for approximately 2.5% of revenue for all governments combined. Table 5 depicts the five-year average of tax revenue by major sources:

Table 5: Five-Year Average of Tax Revenue for Federal, Provincial and Territorial Governments, FY99/00 – 2003/04

Tax Category	Revenue (millions)	% of Total	Growth Rate (% per year)
Personal income taxes	142,248	47.4	1.1
General sales tax	56,926	19.0	5.0
Corporation income taxes	38,245	12.8	2.1
General property taxes	34,676	11.6	2.9
Gasoline and motive fuel taxes	12,075	4.0	2.1
Payroll taxes	8,052	2.7	3.5
Alcoholic beverages and tobacco taxes	7,567	2.5	13.1 ⁴
Total	299,789		

Source: Statistics Canada, 2004g

In terms of contributions to the national economy of Canada, the Brewers Association of Canada (BAC) estimated that the production, distribution and sale of beer contributed \$12.6 billion to the economy in 2001. This represented 1.2% of the total Gross Domestic Product (BAC, 2001a).⁵ Recently, the Canadian Vintners Association reported that the more than 200 wineries operating in Canada sell more than \$1.1 billion worth of wine and create close to 10,000 direct and indirect jobs (Ross, 2004).⁶

⁴ The majority in the growth of tax revenue in this category is associated with increased tax rates on tobacco products.

⁵ Approximately 80% of the beverage alcohol consumed in Canada is in the form of beer, although wine and pre-mixed spirit-based drinks have gained in popularity in recent years.

⁶ Recent data on the contribution of the spirits industries to the Canadian economy are not available. In FY 1993-94, it was estimated that the spirits industry generated \$2.6 billion in economic activity and directly or indirectly employed 15,700 people (Conference Board of Canada, 1996).

3.4 Health Benefits of Alcohol

In recent decades, researchers have repeatedly documented significant positive health effects associated with moderate alcohol consumption, especially for men over the age of 45. These effects are derived from a reduced risk of cardiovascular problems for those who consume moderate amounts of alcohol on a daily or near-daily basis. Indeed, research in Australia, Canada, and New Zealand now suggests that the alcohol consumed in these countries may prevent more deaths than it causes (English, et al., 1995; Single, et al, 2000; Scragg, 1995). It should also be noted, however, that there are many more hospitalizations caused by alcohol misuse than saved by moderate use, and there are also many more years of life lost due to alcohol than years of lives saved. This is because so many alcohol-related deaths, particularly deaths associated with intoxication, involve relatively young persons.

4. Overview of Alcohol Control Policies

While the majority of alcohol is consumed in a safe and responsible manner, the misuse of alcohol is associated with a host of health and social harms, including impaired driving accidents, liver cirrhosis, crime, violence, domestic abuse, mental illness and alcohol dependency. In 1992, the total direct and indirect costs of alcohol misuse in Canada were conservatively estimated at \$7.5 billion or \$265 per capita (Single et al, 1996). This represented 40.8% of the total estimated costs of substance abuse in 1992. The largest economic costs for alcohol were \$4.1 billion for lost productivity due to illness and premature death, \$1.36 billion for law enforcement and \$1.3 billion in direct health care costs.⁷

While there is consensus that alcohol misuse contributes significantly to health and social problems in Canada and around the world (Babor et al., 2003, Single et al., 1996) considerable debate still exists as to the most appropriate way to further reduce the harmful consequences of alcohol. Some researchers recommend that the best way to address the negative consequences is to enact policies that lower overall alcohol consumption since some drinking problems tend to be correlated with per-capita consumption rates (Giesbrecht, 2003; Kendall, 2002). Other observers propose that the best way to reduce alcohol-related harms is to target problematic drinking patterns at the individual level (Grant & Litvak, 1997). The two approaches to alcohol control policy are sometimes referred to as the **population health** and **harm reduction** approaches, respectively. These approaches are not mutually exclusive, however, as all countries employ a mix of population health and harm reduction policies, and policies designed to affect one can and do affect the other.

Historically speaking, Canada has taken a comparatively strong stance on the regulation and control of alcohol with the “Canadian Model” being based on strict licensing schemes for drink-sellers, restricted hours and days of sale, relatively high taxes or mark-ups and public monopolies for the distribution of alcohol (Room, 1999; Room, 1997). In recent years, however, some of these restrictive policies have been relaxed with examples being the privatization of retail alcohol sales in Alberta in 1993, the extension of bar hours from 2:00 a.m. to 4:00 a.m. in British Columbia in December 2002, and the authorization of Sunday sales in several provinces since the mid-1990s.

Babor et al. (2003) recently reviewed the international evidence regarding the effectiveness of alcohol control policies and identified the following as best practice policies for reducing health and social

⁷ This estimate did not include direct estimates of costs for alcohol-related crime. In an extensive 2002 study, researchers estimated that between 40% and 50% of serious crime in Canada is directly associated with the intoxicating effects of, or dependency on, alcohol and illicit drugs. Specifically, between 10% and 15% of crime was attributed to illicit drugs only, between 15% and 20% was attributed to alcohol only, and 10% to 20% was attributed to both alcohol and illicit drugs (Pernanen, et al., 2002:9).

harms.⁸ These policies are categorized and discussed below based on whether they reduce overall drinking levels (population level), target problematic drinking patterns (individual level) or work at both at the same time.

Best Practice Alcohol Control Policies (Babor, et al., 2003)

Overall Consumption/Population-Level Policies:

1. *Alcohol Taxes:* Taxes on beverage alcohol increase the prices to consumers and therefore reduce overall alcohol consumption. Taxes also provide substantial revenue to governments, which can be used to address problems related to alcohol misuse.

Drinking Pattern/Individual-Level Policies:

2. *Blood Alcohol Content Laws (0.08 and lower):* Many developed countries set the maximum blood alcohol concentration (BAC) and use *per se* laws to enforce them. *Per se* laws give enforcement officers the right to charge a driver as impaired when their blood alcohol concentration is above the legal maximum no matter how much impairment actually exists.
3. *Administrative Suspension of Drivers Licence:* The administrative (as opposed to judicial) suspension of driving privileges increases the “celerity” or swiftness of punishment for those charged with impaired driving and therefore increases the “general deterrent” effect of drinking and driving laws.
4. *Sobriety Checkpoints:* Random or selective testing of drivers at roadside checkpoints increases the chances of detecting impaired drivers and therefore increases the general deterrent effect of drinking and driving laws.
5. *Graduated Licensing:* Graduated licensing schemes control the rate and manner by which young drivers gain access to full driving privileges. Restrictions can include lower limits on blood alcohol content, curfews on night-time driving and delayed access to full licences.
6. *Brief Interventions for Hazardous Drinkers:* Brief interventions are characterized by their low intensity and short duration and are intended to provide early intervention, before or soon after the onset of alcohol-related problems in an individual. Most programs are designed to motivate high-risk drinkers to moderate their use rather than to promote total abstinence.

Policies that Impact Both:

7. *Public Monopolies on the Production and/or Distribution of Alcohol:* Some countries grant state-owned companies a monopoly over the production and/or distribution of beverage alcohol. This is done to improve control over levels of production, imports and exports, alcohol sales and tax collection.
8. *Minimum Legal Purchase Age:* Most countries restrict the sale of beverage alcohol to minors. For those who do have minimum legal purchase ages, the range varies from 14 in Switzerland to 21 in the U.S. (see below).
9. *Restricted Hours and Days of Sale:* Since some alcohol-related harms are associated with the timing of consumption (i.e., drinking outside of meals, drinking late into the night, etc.) restrictions on the days and hours of sale are effective policies for controlling health and social harms.
10. *Outlet Density Restrictions:* The clustering of retail alcohol outlets has been associated with increased health and social harms. Restrictions on outlet density, which are usually set by local governments, have been shown to reduce harms related to alcohol.

The next section presents an overview of the trends and current levels of health and social harms associated with alcohol misuse in Canada.

5. Alcohol-Related Harms in Canada

The health and social harms related to alcohol misuse are associated with three properties or effects of alcohol consumption: toxicity, intoxication and dependence. The negative acute health effects of alcohol can include alcohol poisoning, acute pancreatitis, acute cardiac arrhythmia and accidents. Long-term chronic use of alcohol is directly linked to cirrhosis of the liver and an increased risk of some types of

⁸ Rated “best” on: (1) effectiveness at reducing harms, (2) strength of research support, (3) extent of testing across diverse cultures, and (4) relative costs of implementation in terms of time, money and other resources. The reader should bear in mind that this list is not exhaustive of all policies that can be used to reduce alcohol-related harms.

cancers. Chronic alcohol use has also been associated with an increased risk of hypertension, wasting of the limb and heart muscles and brain damage of various kinds (Babor et al., 2003:20-21). Finally, alcohol dependence syndrome is a condition recognized under standard international disease classification systems and it affects a non-trivial number of persons in Canada.⁹ The social harms associated with alcohol misuse include interpersonal violence, crime, alcohol-involved traffic casualties and other accidents involving alcohol. Data on trends and current levels of several important types of alcohol-related harms are presented below.

5.1 Alcohol-related Morbidity and Mortality

5.1.1 Morbidity

Hospitalization is one of the more serious negative outcomes that can be associated with alcohol misuse and tens of thousands of people are hospitalized every year in Canada from alcohol-related causes. The Canadian Institute of Health Information (CIHI) collects and publishes data on hospital separations related to alcohol for both disease and externally caused conditions (i.e., injuries, poisoning, etc.) via the Health Person-Oriented Information Database (HPOI). Table 6 presents alcohol-related morbidity statistics for 2000/01.

Table 6: Number of Hospital Separations Involving Alcohol-related Conditions, Canada, 2000/01

	Number of Hospital Separations		
	Women	Men	Both Sexes
Disease Conditions	6,215	15,447	21,692
External Causes	1,802	3,590	5,392
Total	8,017	19,067	27,084

Source: Health Person-Oriented Information Database, 2000/01

Patterns of alcohol-related hospitalizations in Canada differ significantly according to sex and age, however, as depicted in Table 7 below:

⁹ Results from the Canadian Community Health Survey (Cycle 1.2) estimate that in 2002, 2.6% of the Canadian population over the age of 12 were “highly probable” and 6.2% were “slightly probable” in terms of being dependent on alcohol. These estimates represented 640,000 and 1.5 million persons, respectively.

Table 7: Rates of Alcohol-related Hospitalizations per 100,000, Canada, 2000/01

	15 - 19	20 - 24	25 - 34	35 - 44	45 - 54	55 - 64
Women	29.8	23.7	26.6	53.2	54.7	51.5
Men	39.1	41.0	59.3	109.6	140.8	174.1
All Hospitalizations	34.6	32.6	43.1	81.5	97.6	111.8
Disease Conditions						
Alcohol Dependence or Abuse	22.5	17.3	22.1	39.1	38.3	32.1
Alcoholic Psychosis	0.8	2.4	7.4	18.1	21.1	23.2
Alcoholic Liver-related Diseases	0.1	0.4	1.8	7.6	19.2	28.6
Other Alcohol-related Diseases	1.5	2.1	2.8	4.9	4.8	5.6
All Disease Conditions	24.9	22.2	34.0	69.6	83.3	90.1
External Causes						
Alcohol Toxicity and Poisoning	3.2	1.5	1.4	1.6	1.5	0.9
Falls	1.9	2.5	2.9	5.9	9.9	19.1
Attempted Suicide	2.7	3.5	2.8	2.2	1.3	0.6
Other External Causes	1.9	2.7	2.2	2.0	1.6	0.9
All Externally Caused Conditions	9.7	10.1	9.3	11.7	14.2	21.4

Source: Health Person-Oriented Information Database, 2000/01

Table 7 shows that, with the exception of abuse and dependence, alcohol-related disease conditions are generally more prevalent among older Canadians while alcohol-related external causes of hospitalization are more prevalent among younger Canadians. This pattern holds for all external causes except injuries associated with falls, which are also relatively common for those over 45 years of age. Significantly, alcohol-related attempted suicides appear to peak between the ages of 20 and 24 at the rate of 3.5 per 100,000. Finally, men are much more likely to require hospital care than women as a result of alcohol misuse and this is particularly true for older Canadians.

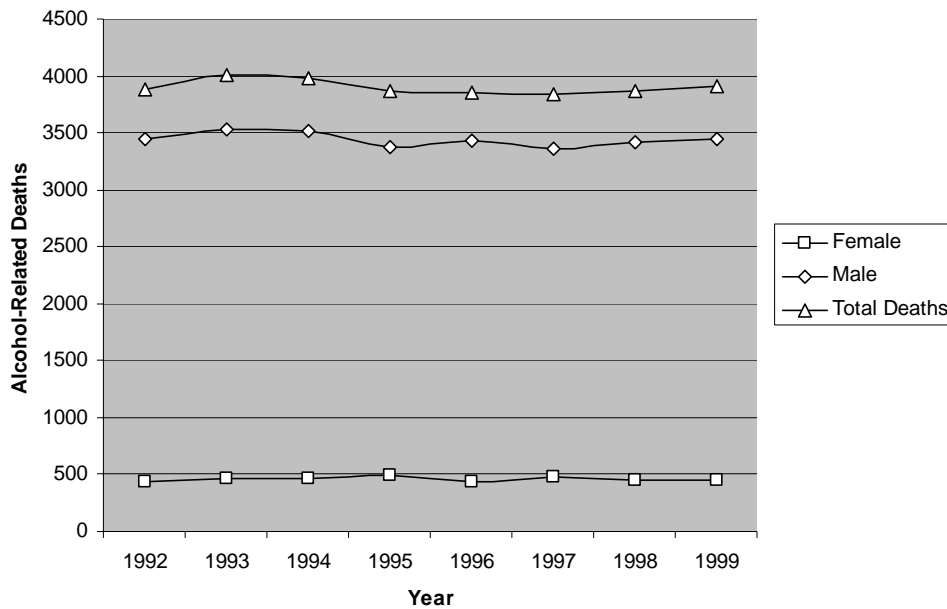
5.1.2 Mortality

Alcohol misuse can cause death due to both acute (e.g., impaired driving) and chronic effects (e.g., cirrhosis of the liver). Statistics Canada collects and publishes data annually on the causes of death based on the International Classification of Disease (ICD) with several classifications involving direct references to alcohol. Figure 4 reports alcohol-related mortality statistics for Canada based on the following 12 ICD-9 causes: (1) alcoholic psychosis, (2) delirium tremens, (3) Korsakov's psychosis, (4) other alcoholic dementia, (5) alcohol dependence syndrome, (6) alcoholic gastritis, (7) alcoholic fatty liver, (8) acute alcoholic hepatitis, (9) alcoholic cirrhosis of the liver, (10) alcoholic liver damage, unspecified, (11) accidental poisoning by alcohol, NEC and (12) toxic effects of alcohol.^{10,11}

¹⁰ The data reported in Figure 4 include a subset of the diseases and conditions directly attributable to alcohol. The most advanced alcohol cost studies also use "attributable fractions" to estimate the percentage of other diseases, such as certain types of cancer, that are likely to be caused by the misuse of alcohol. This type of methodology was used in the 1992 Costs of Substance Abuse in Canada study (Single, et al., 1996), which estimated the total health and social costs of alcohol to be at least \$7.5 billion a year. A second major cost study using this methodology is now underway for Canada with findings to be reported in fall 2005. See: <http://www.ccsa.ca/pdf/ccsa-newrel-20040510-e.pdf>

¹¹ In 2000-2001, the International Classification of Disease regime was updated to ICD-10. Since some of the disease classification categories were changed, direct comparisons with ICD-9 and ICD-10 data are not possible. Thus, trend data are only available through 1999 on these measures. Data on causes of death from 2000 and 2001 are available online here: <http://www.statcan.ca/english/freepub/84-208-XIE/free.htm>

Figure 4: Alcohol-related Mortality in Canada, 1992 to 1999¹²



Sources: Statistics Canada, *Causes of Death*, Yearly Issues 1994-2002.

5.2 Impaired Driving

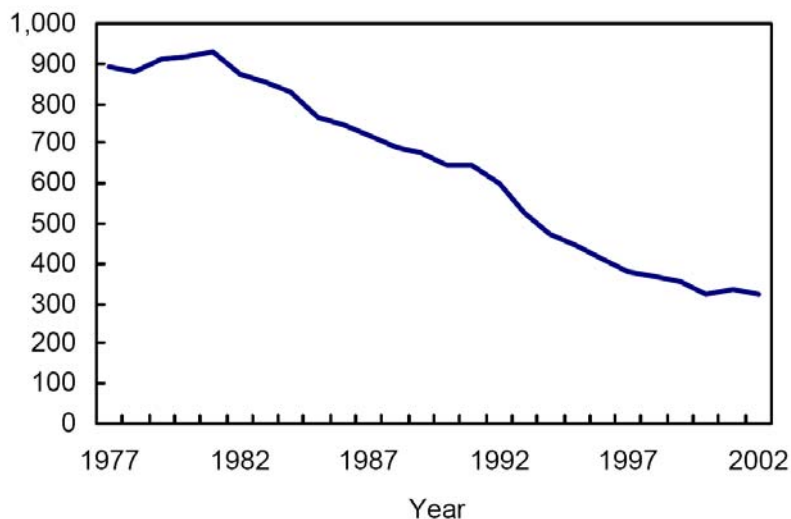
The issue of impaired driving can be viewed as one of the great public policy success stories of the modern era. Between 1980 and 2002, rates of impaired driving incidents in Canada fell by approximately 60% from over 900 per 100,000 population over the age of 16 to just over 300.¹³ These data are depicted graphically in Figure 5 below:

¹² These data most likely provide a conservative estimate of mortality related to alcohol because alcohol's involvement in death may be missed by those certifying death. For example, Puffer and Griffith (1967) conducted supplementary analysis on deaths associated with liver cirrhosis in 12 cities and 10 countries and found that alcohol was involved in 135% more cases than were reported in standard ICD-9 statistics. The majority of new cases recorded were from the categories of cirrhosis without mention of alcohol. The datedness of this study is problematic, of course, but this author is not aware of any more recent efforts to replicate this type of analysis.

¹³ Similar reductions have been reported in other countries as well, although there is some evidence that rates have started to increase marginally in recent years. See: Sweedler, B., et al., 2004.

Figure 5: Rates of Impaired Driving Incidents, Canada, 1977-2002¹⁴

Rate per 100,000 population 16 years and older



Source: Statistics Canada, 2003b; used by permission.

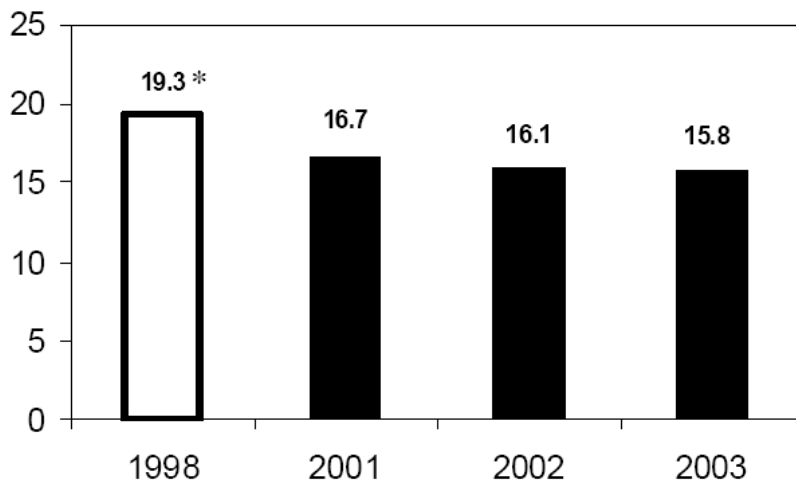
With these successes in mind, however, it is important to recognize that impaired driving accounts for approximately 12% of all criminal charges in Canada (69% of all driving-related criminal charges) and remains the number-one criminal offence with approximately 66,500 charges laid in 2002. This puts impaired driving just ahead of common assault, which accounts for the next highest percentage at approximately 11% (Statistics Canada, 2003c).

The Traffic Injury Research Foundation (TIRF) conducts a yearly survey of drivers in Canada regarding behaviours related to impaired driving. In general, these surveys reveal that the self-reported prevalence of drinking and driving and driving while impaired have declined marginally since 1998. These data are presented in Figures 6 and 7 below¹⁵:

¹⁴ The *per se* statutory limit for blood alcohol concentration (BAC) is set by federal law at 0.08 in Canada, but all provinces except Quebec allow police to immediately suspend driving privileges for either 12 or 24 hours if a driver's blood alcohol concentration is between 0.05 and 0.079 (see below). This policy is unique to Canada. The increase in impaired driving incidents in 2001 is at least partially due to changes in reporting whereby some police jurisdictions began including these temporary roadside suspensions in their impaired driving incident reports (Statistics Canada, 2003c:3-4). Beginning in 2002, all police jurisdictions in Canada were required to include these types of suspensions in their reports.

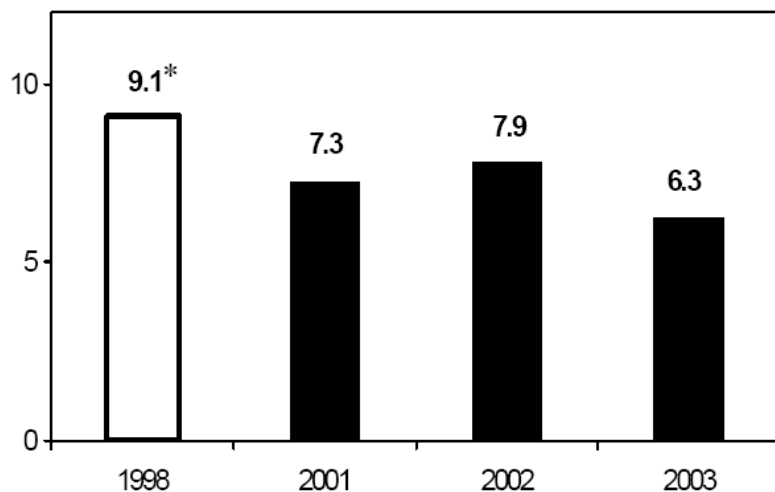
¹⁵ These data most likely provide a conservative estimate of the prevalence of these behaviours since it is common to under-report negative behaviours in self-reported surveys.

Figure 6: Percentage of Drivers Self-Reporting Driving Within Two Hours of Drinking



* Includes only drivers 18 years and over

Figure 7: Percentage of Drivers Self-Reporting Driving While Impaired



* Includes only drivers 18 years and over

Source: TIRF, 2003

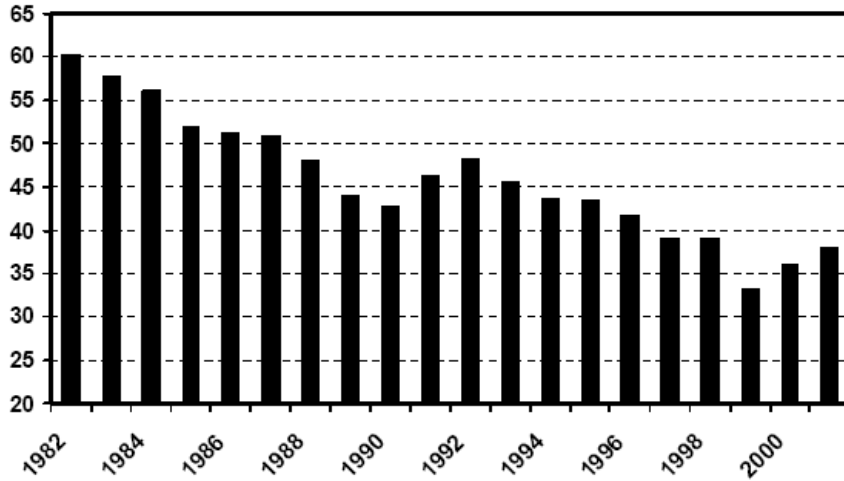
Using official population estimates for 2003, these data suggest that 3.5 million Canadians had driven after drinking at least once in the 30 days prior to the survey, and 1.5 million had driven when they thought they were impaired at least once in the 12 months preceding the survey. Based on these findings, TIRF estimated that there were more than 5.5 million impaired driving trips in 2003 in Canada and that 86% of all impaired driving trips were accounted for by approximately 3% of drivers (TIRF, 2003:iii).¹⁶

¹⁶ Using data from the Road Safety Monitor research, TIRF estimated that there were more than eight million impaired driving trips in Canada in 2002 (TIRF, 2002). In that same year, police reported approximately 81,000 impaired driving incidents, which led to 66,682 persons being charged (Statistics Canada, 2003b). Roughly speaking then, enforcement officers detect less than 1% of all impaired driving that occurs in Canada over the course of a year.

5.3 Driving Fatalities Involving Alcohol

The 1992 Costs of Substance Abuse in Canada study (Single, et al., 1996) revealed that the 1,477 motor vehicle deaths involving alcohol in 1992 accounted for 22% of all alcohol-related deaths and 33% of all potential years of life lost to alcohol misuse. Figure 8 depicts the trends regarding alcohol-related traffic fatalities in Canada since 1982:

Figure 8: Percentage of Fatally Injured Drivers with Positive Blood Alcohol Concentrations in Canada, 1982-2001



Source: TIRF, 2003

Figure 8 suggests that there has been a significant downward trend in deaths associated with alcohol-impaired driving in Canada since 1982. More specifically, from 1982 to 1999 the percentage of fatally injured drivers with positive BACs fell from 60% to 33%.¹⁷ Since 1999, however, there has been an increase in the percentage of fatally injured drivers who test positive for alcohol of about 3% a year suggesting some potential losses in earlier gains. In 2001, there were approximately 1,200 road fatalities that involved alcohol (CCMTA, 2004).

While it is encouraging that there has been an overall decline in percentage of fatally injured drivers testing positive for alcohol in Canada since 1982, there are significant variations among drivers of various age groups as depicted in Table 8:

¹⁷ According to Sweedler et al. (2004), the upward trend in the percentage of fatally injured drinking drivers in the early 1990s was caused by a fall in the number of fatally injured non-drinking drivers compared with a relatively stable number of fatally injured drinking-drivers. This caused the *percentage* of fatally injured drinking drivers to increase as reported.

Table 8: Percentage of Fatally Injured Drivers Tested and Found Over the Legal Limit (0.08 BAC), Canada, by Age, 1987 - 2001

Age Group	1987	1988	1989	1990	1991	1992	1993	1994	1995	1996	1997	1998	1999	2000	2001
<19	29.7	38.6	31.2	30.6	31.2	35.0	29.6	32.5	29.6	31.9	29.2	26.3	20.5	27.5	25.3
20-25	51.1	46.4	47.5	39.4	50.0	44.1	44.3	46.0	47.0	46.9	46.3	43.5	32.7	36.2	42.6
26-35	55.0	56.3	49.8	48.6	48.4	52.8	48.4	48.8	47.5	42.7	41.6	45.7	41.6	40.0	47.8
36-45	46.4	39.5	41.6	41.9	45.1	45.4	44.3	41.9	43.6	44.1	37.8	40.1	33.5	36.9	38.4
46-55	37.6	33.7	28.6	36.3	34.3	37.9	27.5	28.8	25.1	29.6	22.8	30.2	22.5	27.2	26.8
>55	24.4	13.7	18.7	15.8	22.2	14.7	21.0	12.5	11.8	14.5	12.3	10.3	11.9	11.9	14.9
Total	43.2	40.4	38.9	36.6	40.3	40.1	37.9	36.0	35.5	34.9	31.7	32.8	27.1	27.1	32.2

Source: CCMTA, 2004

As shown above, the rates of fatally injured drivers tested and found over the legal limit of 0.08 were between 40 and 50% for those between the ages of 20 and 35 in 2001. This indicates that there remains room for improvement with regards to this significant alcohol-related harm.

5.4 Costs of Enforcement

The 1992 Costs of Substance Abuse in Canada study (Single, et al., 1996) identified the costs associated with law enforcement (\$1.36 billion annually) as a major component of the overall costs of alcohol misuse. In fact, enforcement-related costs were second only to the \$4.1 billion associated with lost productivity due to illness and premature death. Although recent estimates of enforcement costs related to alcohol are not available, it is significant to note that two offences, impaired driving and common assault, accounted for approximately 12% and 11% of all criminal charges laid by police in Canada in 2002 respectively (Statistics Canada, 2003c). Given the fact that at least 90% of impaired driving is alcohol-related (ARES, 2003), and that an estimated 40-45% of assault cases directly involve alcohol (Pernanen, et al., 2002:15), it can be concluded that at least 15% ($0.9 \times 12\% + 0.4 \times 11\% = 15.2\%$) of all criminal charges laid in Canada in 2002 can be directly related to the acute effects of alcohol. This analysis confirms that alcohol continues to account for a non-trivial component of law enforcement costs in Canada today.

5.5 Costs of Treatment

There are no reliable national data related to substance abuse treatment in Canada. Most provinces have systems for tracking the usage of substance abuse treatment although these systems are of various levels of sophistication. In Ontario, for example, the DATIS/CATALYST system collects near-real-time data on substance abuse treatment from approximately 200 treatment programs that receive at least part of their funding from the province. Data collected from the DATIS/CATALYST system indicate that about 75% of clients who entered substance abuse treatment in Ontario in FY1999/00 listed alcohol as a problem substance. Overall, approximately 40% of clients entering treatment in Ontario were admitted exclusively for alcohol, 10% for alcohol and cannabis, 10% for alcohol and cocaine and 7% for alcohol and other drugs (Rush, 2002). Data from Alberta for FY2002/03 indicate that 54% of clients entering treatment indicating alcohol as a problem substance (AADAC, 2004). Using 50% as a low estimate of the amount of treatment resources devoted to alcohol abuse in these provinces, this translates into \$30 million a year in Alberta and \$65 million in Ontario. The current status of alcohol policy in Canada and comparisons with policies in other countries is covered in the next section.

6. Alcohol Control Policy in Canada

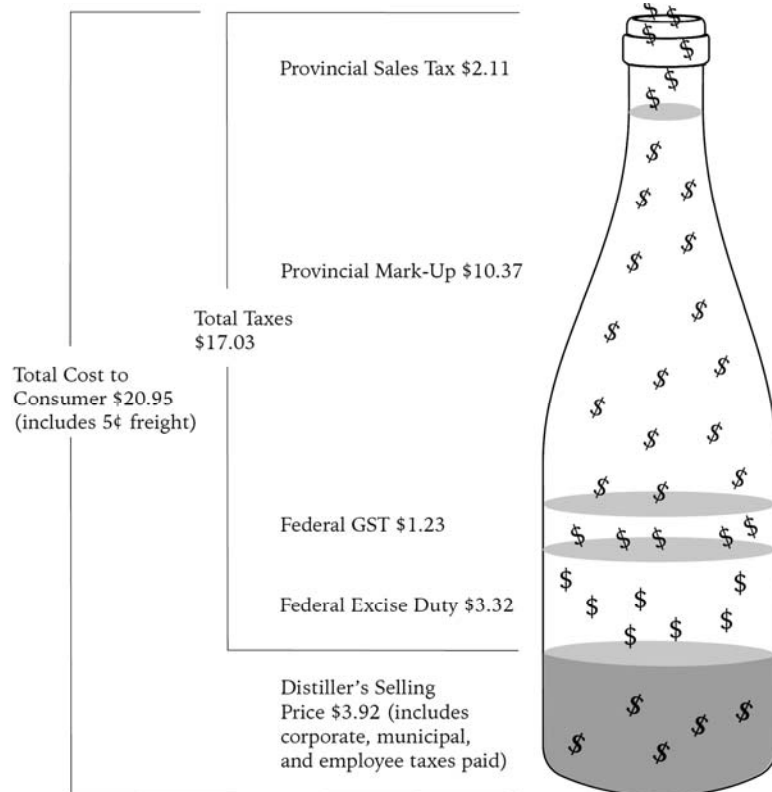
As discussed above, Babor, et al. (2003) reviewed the international evidence and identified 10 best practice policies for reducing the health and social harms associated with alcohol misuse. The next section reviews each of these policies in terms of both trends and current status for Canada. International comparisons are presented where data are available and relevant.

6.1 Overall Consumption/Population-Level Policies

6.1.1 Alcohol Taxes

There are three types of taxes that affect the price of beverage alcohol in Canada: (1) federal excise taxes, (2) provincial mark-ups and environmental taxes, and (3) federal and provincial sales taxes. The various taxes constitute a large proportion of the purchase price of beverage alcohol products in Canada as depicted for the “typical bottle” of distilled spirits and 5% alcohol beer shown below:

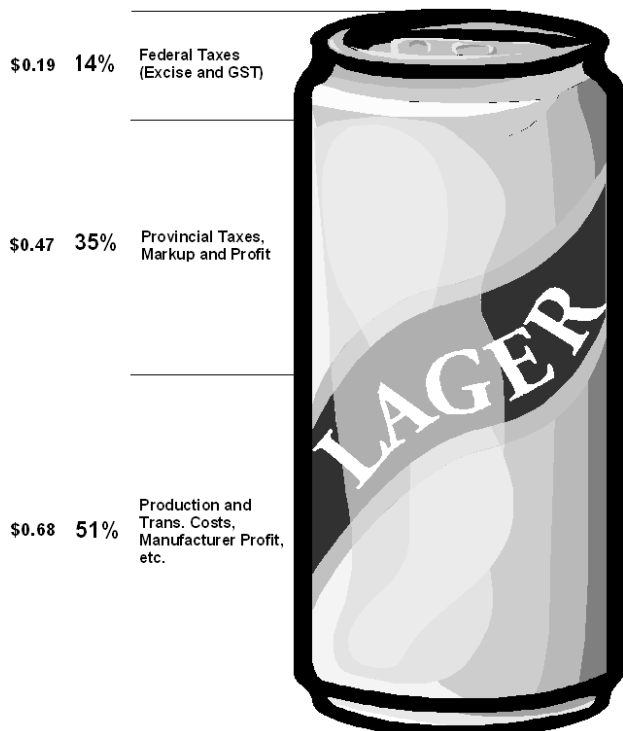
Figure 9: Components of the Retail Cost of a Typical Bottle of Distilled Spirits, Canada 2002



Source: Emes, et al., 2004; used by permission.

Figure 10: Components of the Retail Cost of a Typical Bottle of 5% Alcohol Beer, Canada, 2000

Total Selling Price: \$1.33



Source: Average component costs calculated by author from data provided in BAC, 2001b.

Federal excise taxes in Canada are administered under the *Excise Act*, which was last updated in 2001. Excise taxes on alcohol have not increased since the early 1990s in Canada. In terms of international comparisons, Canada's rate of federal excise tax for spirits is relatively low by European standards as shown below:

Table 9: Excise Duties on Distilled Spirits per Hectolitre of Ethyl Alcohol, 2004

Country	Excise Duty (\$CDN)
Sweden	8,550
Ireland	6,080
Finland	4,376
United Kingdom	4,300
Denmark	3,129
Netherlands	2,750
France	2,246
Germany	2,018
Luxembourg	1,612
Canada	1,106

Source: CDS, 2004; value in Canadian dollars calculated by author based on live exchange rate, October 7, 2004

When all relevant federal/provincial taxes and mark-ups are considered, however, Canada's tax rates on beverage alcohol move to the higher end of the scale internationally as shown below for beer and distilled spirits:

Table 10: Commodity and Sales Taxes on Beer and Spirits as a Percentage of Retail Price

Country	Taxes as a % of Retail Cost of Beer (c. 1996)	Taxes as a % of Retail Cost of Spirits (c. 2003)
Finland	60	67.0
Norway	57	n/a
Canada	52	81.3
Sweden	46	67.1
Ireland	44	41.3
Australia	43	50
Denmark	41	41.5
United Kingdom	40	n/a
<i>Average</i>	<i>35</i>	<i>n/a</i>
South Africa	34	38.6
Netherlands	34	45.8
Mexico	27	60.0
France	24	33.2
Germany	20	13.8
United States	19	n/a
Luxembourg	17	n/a

Sources: Emes, et al., 2004; WHO 2004; BAC, 1997

6.2 Drinking Patterns/Individual-Level Policies

6.2.1 Blood Alcohol Concentration (BAC) Laws

Canada's blood alcohol concentration (BAC) laws involving criminal penalties are under federal jurisdiction. The national *per se* BAC limit in Canada is 0.08 mg/ml, but all provinces and territories except Quebec also have laws that allow for the temporary (12 or 24 hour) suspension of licences for drivers with BACs between 0.05 and 0.79 (the limit is 0.04 in Saskatchewan) (MADD Canada, 2003).¹⁸ These laws are unique to Canada and greatly extend the range of enforcement options against impaired driving. Table 11 provides a comparison of Canada's BAC laws with those of several other countries:

¹⁸ Although Alberta does not have specialized legislation related to lower BAC limits, if enforcement officers in the province have reasonable grounds to believe that, at any level of alcohol consumption, ability to drive is affected, licences can be suspended for up to 24 hours.

Table 11: Permissible BAC Level (mg/ml), by Country

Country	Lowest BAC Limit
Australia	0.05
Canada	0.08 – Criminal Code Limit 0.05 range – most provinces
Denmark	0.05
Finland	0.05
France	0.05
Germany	0.05
Netherlands	0.05
Norway	0.02
Sweden	0.02
Ireland	0.08
Luxembourg	0.08
South Africa	0.05
United Kingdom	0.08
United States	0.08 in 26 States 0.10 in 21 States

Source: Paciocco, 2002, ICAP 2002

6.2.2 Administrative Suspension of Driver’s Licence

As described above, all provinces except Quebec authorize temporary licence suspensions for drivers between 0.05 and 0.08 BAC. In addition, most provinces have laws that allow for the automatic 90-day administrative suspension of licences for drivers who refuse to provide a breath sample or who test over the 0.08 BAC limit. The exceptions are New Brunswick and Nunavut. All provinces have the authority to revoke driver’s licences (usually for 12 months for the first offence) for all *Criminal Code* driving offences, including impaired driving, once guilt has been determined by due process. Finally, all provinces have graduated penalties for repeat impaired driving offenders and all but the Yukon Territory, British Columbia and Nunavut require remedial training (such as completion of an impaired driving course) as a requirement of licence reinstatement for repeat offenders. For example, in Manitoba drivers with a single 90-day suspension or multiple 24-hour suspensions within three years may be required to complete an alcohol assessment and any prescribed remedial programs before they are allowed to drive again.

6.2.3 Sobriety Checkpoints

Only the province of Ontario has a systematic sobriety checkpoint system: the Reduce Impaired Driving Everywhere (RIDE) program. Other provinces authorize impaired driving enforcement powers according to Table 12 below:

Table 12: Impaired Driving Enforcement Powers, Provinces, 2004¹⁹

Enforcement Powers	MB	ON	QC	SK	NS	YK	AB	BC	NL	NB	PEI	NWT	NU
Stop Vehicles at Random	✓	✓	✓	✓			✓	✓				✓	✓
Systematic Sobriety Checkpoints		✓											
Passive Alcohol Sensors													
Demand Standard Field Sobriety Testing	✓		✓										

Source: MADD 2003, updated September 2004

Canada's impaired driving enforcement powers can be compared with those in other countries via Table 13 below:

Table 13: Use of Random Breath Testing (RBT), by Country, c. 2003

Country	Use of Random Breath Testing
Australia	Often
Canada (Ontario)	Never
Denmark	Never
Finland	Often
France	Often
Germany	Never
Mexico	Sometimes
Netherlands	Often
Norway	Often
Sweden	Often
Ireland	Never
Luxembourg	Sometimes
Russia	Rarely
South Africa	Rarely
United Kingdom	Never
United States (California)	Never

Source: WHO, 2004

6.2.4 Graduated Licensing

All provinces and territories in Canada except PEI and Nunavut have graduated licensing programs for novice drivers (MADD, 2003). The three most common provisions of graduated licence systems are: (1) roadway restrictions (e.g., novice drivers are not allowed on "400 series" highways in Ontario), (2) time of day restrictions, and (3) 0.00% BAC levels for novice drivers. All provinces and territories in Canada have zero tolerance BAC levels for novice drivers (WWBA, 2004).

¹⁹ MADD rated the provinces on their impaired driving countermeasures and the rankings are displayed across the top of Table 12. Thus, Manitoba, Ontario and Quebec received the highest ratings while PEI, Northwest Territories and Nunavut received the lowest.

6.2.5 Brief Interventions for Hazardous Drinkers

The provinces and territories in Canada were queried for this background paper as to the existence of programs for training medical doctors and other health professionals for the routine screening of clients for alcohol problems and the implementation of brief interventions. Only the province of Manitoba (i.e., the Addictions Foundation of Manitoba) indicated that they had such a program. However, the College of Family Physicians of Canada created the Alcohol Risk Assessment and Intervention (ARAI) program in 1994 for just these purposes (CFPC, 2004). The ARAI curriculum consists of a resource manual, flowchart, patient workbook and pamphlet. It provides family physicians and other health care professionals with the resources to provide brief, reliable and effective assessment and intervention when dealing with patients whose drinking places them at risk. According to the College of Family Physicians, the ARAI project was very popular when it was first introduced in the mid-1990s when approximately 4,000 physicians were trained across Canada for alcohol assessment and brief interventions. In recent years, however, only about 10-15 trainings are conducted every year. The “state of the art” of assessment and intervention has improved since the mid-1990s and many doctors feel that the ARAI project needs to be updated to reflect the improved state of knowledge (Selig, 2004).

6.3 Policies that Impact Both Overall Consumption and Drinking Patterns

6.3.1 Public Monopolies for the Production and/or Sale of Beverage Alcohol

The provinces and territories have varied regulations and practices for the sale of alcoholic beverages. Each province and territory has a liquor authority that is responsible for the control and sale of alcoholic beverages in that jurisdiction. In most provinces, these liquor authorities manage retail stores and license agency stores. Agency stores are privately owned and operate under licence from the liquor authorities, usually to provide services to residents of small or remote communities.

In all provinces and territories, imported beer is sold only through the liquor authorities’ stores and agencies. Domestic beer is sold under many different arrangements across Canada. In Ontario, the majority of beer is sold through Brewers Retail Inc., a company owned jointly by the major breweries. Some domestic beer is sold through Ontario liquor stores but more than 90% of sales are through Brewers Retail. In Quebec, breweries sell beer directly to licensed establishments and to the general public in grocery stores and convenience stores. No domestic beer is sold in liquor authority outlets. In Newfoundland and Labrador, domestic beer is sold in grocery stores and convenience stores as well as in liquor stores. In all other provinces and both territories, domestic beer is sold in the liquor authorities’ stores and agencies. As well, in Manitoba, Saskatchewan, Alberta, British Columbia and Northwest Territories, cased beer is sold by appropriately licensed hotels for consumption off the premises. In some provinces, wineries, breweries, microbreweries and their outlets also sell domestic wine and beer at the retail level under licence from the liquor authorities. In the past five years, “brew-on-premises” operations have opened in Ontario, British Columbia and the Yukon for the production of both wine and beer. As well, brewpubs have opened in many provinces. Table 14 provides an outline of the various types of wineries and brewing establishments in the provinces and territories.

Table 14: Retail Trade of Alcoholic Beverages in the Provinces and Territories, FY 2002/03

	MB	ON	QC	SK	NS	YK	AB	BC	NL	NB	PEI	NT	NU
Wineries	N	Y	Y	N	N	N	Y	Y	Y	Y	N	N	N
Micro-Breweries	N	Y	Y	Y	Y	N	Y	Y	N	Y	N	N	N
Brew Pubs	N	Y	Y	Y	N	N	Y	Y	N	N	N	N	N
Brew on Premises	N	Y	N	N	N	Y	N	Y	N	N	N	N	N
Cased Beer Sold in Hotels	Y	N	N	Y	N	Y	Y	Y	N	N	N	Y	N
Beer Sold in Grocery Stores	N	N	Y	N	N	N	N	N	Y	N	N	N	N

Source: Statistics Canada, 2004f

Beverage alcohol is also sold in licensed establishments and at special events throughout Canada. For example, currently in Ontario there are approximately 18,000 licensed premises (restaurants, bars, clubs) selling wine, beer and spirits. In addition, approximately 80,000 special occasion permits (SOPs) are issued every year. SOPs allow for the sale of alcohol to the public on a temporary basis. Enforcement of the laws involving alcohol service and production in Ontario is managed by a staff of 42 full-time officers at the Alcohol and Gaming Commission of Ontario (AGCO). The AGCO has a policy of performing “routine” inspections on every licensed establishment once every two years. This means that each enforcement officer must visit approximately one establishment per workday throughout the year. According to the AGCO, the “big four” compliance issues for licensed bars and restaurants are: (1) overcrowding, (2) serving to minors,²⁰ (3) serving to intoxicated patrons²¹ and (4) serving after hours (Cooper, 2004).

Most of the alcohol produced in Canada is regulated and taxed under the federal *Excise Act 2001*. The exceptions are wine and beer brewed at home for personal use. The provinces also regulate and tax the production of beverage alcohol at “brew your own” operations of which there were approximately 600 in Ontario in FY 2002/03 (AGCO, 2003). Canada’s policies with regard to public monopolies and licensing for the production and/or sale of beverage alcohol are compared with several other countries below:

Table 15: Policies for the Control of Retail Sales and Production of Beverage Alcohol, c. 2004

Country	Monopoly on Production of			Monopoly on Sales of			Licence for Production of			Licence for Sale of		
	Beer	Wine	Spirits	Beer	Wine	Spirits	Beer	Wine	Spirits	Beer	Wine	Spirits
Australia	No	No	No	No	No	No	Yes	Yes	Yes	Yes	Yes	Yes
Canada (Ontario)	No	No	No	No	No	Yes	Yes	Yes	Yes	Yes	Yes	No
Denmark	No	No	No	No	No	No	No	No	No	Yes	Yes	Yes
Finland	No	No	No	No	Yes	Yes	Yes	Yes	Yes	Yes	-	-
France	No	No	No	No	No	No	Yes	Yes	Yes	Yes	Yes	Yes
Germany	No	No	No	No	No	No	No	No	No	No	No	No
Mexico	No	No	No	No	No	No	Yes	Yes	Yes	Yes	Yes	Yes
Netherlands	No	No	No	No	No	No	No	No	No	No	No	Yes
Norway	No	No	Yes	No	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Sweden	No	No	No	Yes	Yes	Yes	Yes	Yes	Yes	-	-	-
Ireland	No	No	No	No	No	No	Yes	Yes	Yes	Yes	Yes	Yes
Luxembourg	No	No	Yes	No	No	No	Yes	Yes	Yes	Yes	Yes	Yes
Russia	-	-	-	-	-	-	Yes	Yes	Yes	Yes	Yes	Yes
South Africa	No	No	No	No	No	No	Yes	Yes	Yes	Yes	Yes	Yes
UK	No	No	No	No	No	No	-	-	-	Yes	Yes	Yes
United States (California)	No	No	No	No	No	No	Yes	Yes	Yes	Yes	Yes	Yes

Source: WHO, 2004

²⁰ In 2002, the province of Alberta implemented an audit to determine the effectiveness of its “Under 25 Initiative” which mandates that all persons under the age of 25 must show ID proving their age when they purchase alcohol. The results of the audit determined that, on average, only 23% of stores and licensed premises challenged patrons to establish their age when they attempted to purchase alcohol. As a result, the Alberta Gaming and Liquor Commission implemented a major education campaign and a year later the compliance rate had risen to 67%. See: AGLC, 2004.

²¹ A recent study in the United States revealed that 79% of establishments involved in the retail sale of alcohol sold to patrons who exhibited signs of intoxication. This was in spite of the fact that in 51% of the cases, the server made some indication that he/she noticed the intoxication level of the buyer (Toomey, et al., 2004).

6.3.2 Minimum Legal Purchase Age

Minimum legal purchase age is set by provincial/territorial law in Canada. Table 16 below depicts the current, former and date of change of legal purchase age laws in the provinces/territories. Those provinces/territories that have most recently changed their minimum purchase age laws are highlighted in italics.

Table 16: Current and Former Minimum Legal Alcohol Purchase Ages in Canada and Dates of Change

Province	Minimum Legal Purchase Age	Former Minimum Legal Purchase Age	Date of Change
Alberta	18	21	April 1971
British Columbia	19	21	April 1970
Manitoba	18	21	August 1970
New Brunswick	19	21	August 1972
Newfoundland and Labrador	19	21	July 1972
Northwest Territories	19	21	July 1970
Nova Scotia	19	21	April 1971
<i>Ontario</i>	<i>19</i>	<i>18</i>	<i>January 1979</i>
<i>Prince Edward Island</i>	<i>19</i>	<i>18</i>	<i>July 1987</i>
Québec	18	20	July 1972
<i>Saskatchewan</i>	<i>19</i>	<i>18</i>	<i>September 1976</i>
Yukon	19	21	February 1970

Source: CCSA, 1999

As shown above, the minimum legal purchase ages in the provinces and the Yukon Territory were reduced from 21 to either 18 or 19 in the early 1970s. Subsequently, in the latter half of 1970s Ontario and Saskatchewan raised their minimum purchase ages by a year to 19. The last province to change its minimum legal purchase age in Canada was PEI, raising it from 18 to 19 in 1987.²² Currently, three jurisdictions have 18 as the minimum legal purchase age and the rest have it set at 19. Table 17 below depicts minimum legal purchase ages for several other countries for comparison:

Table 17: Minimum Legal Alcohol Purchase Ages for Selected Countries, 2002

Country	Minimum Purchase Age (MPA)	Notes
Luxembourg	18	17 if accompanied by an adult.
Ireland	18	Individuals under 18 are allowed in bars, but those under 15 must be accompanied by a parent or guardian.
France	16	The MPA for alcoholic beverages on-premises is 16 unless accompanied by a parent or guardian.
Germany	16, 18	The MPA for beer and wine is 16, 18 for spirits. Beer and wine may be served to people under 16 only if they are accompanied by parents.
Denmark	15	Alcohol may be purchased at age 15 for off-premises consumption, but not until age 18 at on-premises establishments.
Russia	18	
United Kingdom	18	In bars and off-licensed premises the MPA is 18. The

²² A Member of Legislative Assembly (MLA) in Manitoba introduced a motion in May of 2004 to raise the minimum purchase age to 19 in that province. As of this writing, however, the purchase age has not been changed.

		MPA for beer and cider is 16 when purchased for consumption with meals (except when in a bar). Children over five may consume alcoholic beverages at home with a parent's consent.
Netherlands	16, 18	The MPA for spirits is 18, 16 if accompanied by an adult. The MPA for beer and wine is 16.
Australia	18	
Finland	18	
USA	21	The USA has the highest minimum purchase age in the world.
Canada	18, 19	Drinking by minors under adult supervision is permitted in licensed premises in provinces of Manitoba and New Brunswick and at home in Prince Edward Island, Alberta, British Columbia, Ontario and Saskatchewan.
Sweden	18, 20	Off-licence purchases have different age limits, the MPA for buying beer from food stores is 18, the MPA for buying other alcohol beverages at Systembolaget stores is 20.
South Africa	18	
Norway	18, 20	The MPA for spirits is 20. For beer and wine the MPA is 18.
Mexico	18	The minimum drinking age in Mexico is 18. No information on minimum purchase age was available.

Source: ICAP, 1998 (updated in 2002)

6.3.3 Restricted Hours and Days of Sale

Restrictions on the days and or hours of sale are one of the most effective ways to manage and control alcohol consumption (Babor, et al., 2003). Historically speaking, Canada has had relatively strict control of hours and days of sale with Sunday sales, for example, being authorized only recently in some provinces.²³ All provinces set limits with regard to operating hours for both package sales and licensed establishments although the exact nature of these limits varies considerably across the country. For example, bars in British Columbia are allowed to serve alcohol until 4 a.m. while bars in Ontario can only serve until 2 a.m. (except on December 31 when patrons can be served until 3 a.m.). Generally speaking, there has been a movement in recent years to extend both days of sale (e.g., authorizing Sunday sales) and hours of operation in Canada as part of a general trend to improve consumer convenience around alcohol sales for both off-premise and on-premise consumption.²⁴

²³ Newfoundland, Nova Scotia, PEI and the Yukon Territory still do not allow Sunday sales of alcohol.

²⁴ This trend is fairly universal in Canada and has caused some critics to suggest that even though most package alcohol is sold through public monopoly arrangements, “back door” privatization is occurring under the guise of business development and consumer convenience. A scan of the annual reports and performance plans of several of the provincial alcohol corporations lends some credence to this claim. For example, one of the main “corporate objectives” set out in the 2004-2005 Performance Plan for the Saskatchewan Liquor and Gaming Authority is to “support fair access to liquor and gaming products and services” (Government of Saskatchewan, 2004:8). Saskatchewan suggests using “retail alcohol outlets per capita and number of video lottery terminals (VLT’s) in operation...and number of communities with VLTs” as “performance measures” for this objective. From a public health perspective, there are likely to be some legitimate concerns about a provincial liquor and gaming authority promoting “fair access to alcohol and gambling” as a major corporate objective when their mandate also includes controlling the harms associated with these activities.

6.3.4 Outlet Density Restrictions

No province or territory in Canada places a statutory limit on the density of alcohol outlets, although all except Alberta (where retail sales were privatized in 1993²⁵) have licensing procedures that control the geographical distribution of outlets to manage competition and promote responsible use. Quebec currently has the highest per-capita density of liquor outlets followed by Saskatchewan, which has a ratio of one outlet per 1,314 people. By comparison, Alberta has a ratio of one outlet per 2,090 people (Government of Saskatchewan, 2004).

In recent years, several provinces in Canada have expanded the number of retail alcohol outlets by licensing established businesses, such as general stores and gas stations, to sell liquor products in rural areas. These “agency stores,” as they are called in Ontario, allow liquor authorities to open outlets in lightly populated regions where the high cost of building stand-alone outlets cannot be justified.²⁶ For example, the Liquor Control Board of Ontario (LCBO) began licensing agency stores in northern regions of the province in 1962 to service these very rural populations. Between 2002 and 2004, however, approximately 115 new agency stores were opened in southern Ontario to improve access to alcohol for people living in smaller communities there. The number of retail outlets in each province and territory is depicted below for both 2002 and 2003.

Table 18: Number of Provincial and Territorial Liquor Authorities Stores and Agencies - Fiscal Years Ending March 31

Province or territory	Fiscal Year 2002			Fiscal Year 2003		
	Liquor stores	Agency stores	Total liquor and agency stores	Liquor stores	Agency stores	Total liquor and agency stores
Newfoundland and Labrador	25	101	126	23	103	126
Prince Edward Island	18	1	19	20	1	21
Nova Scotia	101	9	110	101	8	109
New Brunswick	49	72	121	49	73	122
Quebec	380	399	779	398	403	801
Ontario	599	105	704	597	155	752
Manitoba	45	180	225	44	175	219
Saskatchewan	81	190	271	81	190	271
Alberta ¹	-	-	-	-	-	-
British Columbia	225	460	685	222	571	793
Yukon	7	0	7	6	0	6
Northwest Territories	0	5	5	0	5	5
Nunavut	0	0	0	0	0	0
Canada	1,530	1,522	3,052	1,541	1,684	3,225

1. Alberta retail stores were privatized in 1994.

Source: Statistics Canada, 2004f; used by permission.

Some local and municipal governments in Canada have enacted zoning laws to attempt to control outlet “clustering” in their jurisdictions. The City of Edmonton, for example, introduced innovative zoning laws that restricted the placement of liquor outlets in sensitive areas (such as near schools and other public facilities) after the privatization of liquor sales in 1993 (City of Edmonton, 2000). Local government policies related to alcohol are most common in Ontario with approximately 250 of more than 800 city councils enacting specific policies or strategies related to alcohol.

²⁵ The number of retail alcohol outlets in Alberta nearly doubled after the privatization of liquor sales in 1993.

²⁶ The Brewers Retail stores in Ontario also use the agency store model to improve access to alcohol in the more rural regions of the province. On their Web site the beer retailers claim: “90% of the population of Ontario lives less than five minutes from a Beer Store.”

6.4 Non-Best Practice Policies

6.4.1 Regulation of Alcohol Advertising

Although the regulation of alcohol advertising was not identified as a “best practice” policy by Babor, et al. (2003), the issue has been the topic of discussion in Canada in recent years. Most provinces and territories have regulations or guidelines related to alcohol advertising and the Canadian Radio- television and Telecommunications Commission (CRTC), which regulates advertising at the national level, also publishes guidelines for alcohol advertisers.

The figure below depicts provincial regulations and guidelines related to alcohol advertising *circa* 1999. One recent change not reflected in these data is that the province of Ontario no longer pre-screens alcohol advertising. This follows a similar policy change that occurred at the national level in 1996 when the CRTC turned its pre-clearance function over to Advertising Standards Canada (ASC), an advertising industry-sponsored non-profit organization. Between 1997 and 2003, an average of 68 complaints about broadcast alcohol ads were reviewed in Canada every year. Of these, an average of 23 were upheld against alcohol advertisers every year.

Exhibit 2
**Broadcast Advertising of Alcoholic Beverages:
 Summary of Provincial Guidelines¹**

Issue	Rule	B. C.	Albta.	Sask.	Man.	Ont.	Que.	N. B.	N. S.	P.E.I.	Nfld.
Legislation	Date	1996	1997	1995	1995	1994	1994	1994	1989	1997	1996
Compliance	CRTC Code		√	Pre-clear	√	√	√	√	√	ASC ³	√
	All Canadian law		√	√	√	√		√	√	√	
	Pre-Clearance	√		√	voluntary	√	√		√	voluntary	
Underlying Principles:	Responsible use or service		√		√	√		√	√		
	Moderate use		√		√						√
	Safe use		√		√						√
ADVERTISING CONTENT											
Ads:	Within the limits of good taste and propriety		√		√						√
	Accurately portray alcoholic beverages		√			√	√				
	Accurately describe product details		√	√				√			√
	Showing liquor in a prohibited setting can include a beauty shot without people		√			√					
	Encourage food		√	√							
Ads cannot promote:	Based on normal drinking situations permitted in the province	√	√			√					
	Drinking in general	√	√	√		√		√	√		√
	Non-drinkers to drink		√	√				√	√		√
	Non-drinkers to buy			√				√	√		√
	Personal endorsements					√			√		
	Illegal sale, purchase, or drinking of alcohol					√					

¹ If the provincial regulations state that advertising practices must comply with the "CRTC Code for Broadcast Advertising of Alcoholic Beverages", the CRTC provisions are listed.

² The advertising regulations for the Northwest Territories are currently being revised (Delilah St. Arneault, Personal Conversation, 1999).

³ ASC - Advertising Standards Canada's "Canadian Code of Advertising Standards", 1999.

Source: Apolnet, 2000. More complete information on provincial advertising guidelines is available at: <http://www.apolnet.org/resources/adexhibit2.pdf>

In 1996, the Centre for Information on Beverage Alcohol conducted a survey of 119 countries and found that 37.8% used statutory legislation to control alcohol advertising, 19.3% had no controls over advertising, 17.6% used a combination of statutory legislation and self-regulation, 14.3% used self-regulation, 5.9% banned alcohol advertising outright and 4.2% were listed as having “some controls” over alcohol advertising (ICAP, 2001). Canada was listed as controlling alcohol advertising through statutory legislation.

6.4.2 Alcohol Warning Labels

The topic of alcohol warning labels has also surfaced in Canada in recent years, although there is little or no evidence to support their impact on overall drinking levels. In 2000, both the Canadian Medical Association and the Canadian Paediatric Society issued policy statements urging the government to pass legislation requiring warning labels about the hazards of drinking while pregnant. Further, in April 2001, the House of Commons passed a motion from MP Judy Wasylycia-Leis endorsing warning labels for pregnant women. To date, only the Northwest Territories and the Yukon mandate the use of warning labels on beverage alcohol in Canada. Alcohol warning labels are currently required in several countries, including the United States—which has required them since 1989—Brazil, Colombia, Costa Rica, Ecuador, France, Honduras, India, Mexico and South Korea.

There have been some significant events related to alcohol warning labels recently. First, on October 13, 2004, MP Paul Szabo introduced a private member’s bill (C-206) *An Act to Amend the Food and Drugs Act* (warning labels regarding the consumption of alcohol). The purpose of Bill C-206 is to require alcoholic beverages to bear a warning regarding the effects of alcohol on the ability to operate vehicles and machinery and on the health of the consumer, and the possibility of birth defects when consumed during pregnancy. Second, starting in November 2004 the United Kingdom’s largest brewer, Scottish and Newcastle, will voluntarily begin placing warning labels on its beverage alcohol, which, among other things, will provide information on low-risk drinking guidelines for beer consumers in the UK. Scottish and Newcastle is the first major brewer in the world to voluntarily put general health warnings on their products.

7. Discussion

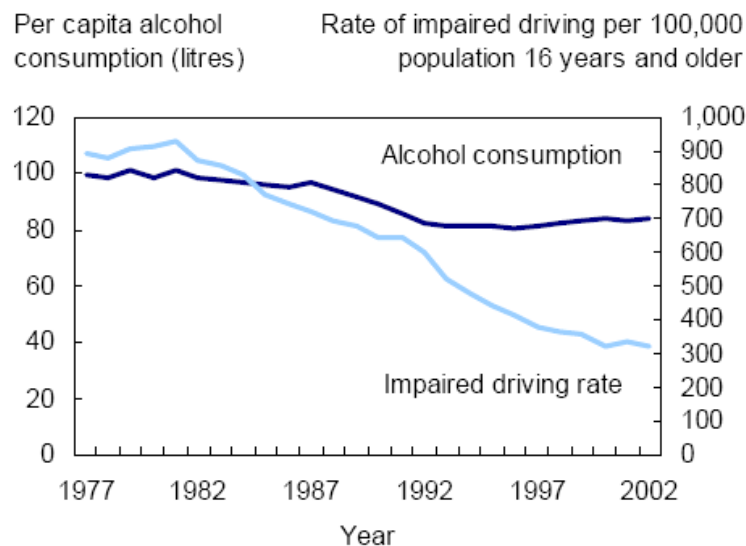
This discussion paper has reviewed the current status and trends of the benefits and harms related to alcohol and the current status of alcohol control policy in Canada. This review has revealed that alcohol continues to account for both substantial economic and health benefits and substantial health and social harms. These findings concur with what was reported in the 1992 Costs of Substance Abuse in Canada report which found that alcohol accounts for 40% of all harms associated with substance misuse (Single, et al, 1996). Per-capita alcohol use in Canada is just below the global average and yet a substantial proportion of current drinkers (20%) report engaging in high-risk drinking practices on a regular basis. Indeed, data suggest that high-risk drinking may be increasing over time. In addition, the best estimate for the prevalence of alcohol dependency is somewhere between 2.6% and 6.2% of the population. These percentages correspond to 640,000 and 1.5 million Canadians, respectively.

Generally speaking, alcohol control policy in Canada is relatively strong by international standards with high taxes, a majority of provinces and territories maintaining public controls on the sale of beverage alcohol, strict drinking and driving countermeasures and relatively high minimum purchase ages. With the exception of drinking and driving countermeasures, however, the strictness with which Canada approaches alcohol policy appears to be eroding over time. Policies regulating the physical availability of alcohol (i.e., days and hours of operation, number of retail outlets) have changed the most in recent years. The enforcement of regulations regarding the sale of alcohol is also an issue in some provinces as was demonstrated in Alberta where an audit of policies designed to control illegal sales to minors revealed that

only 23% of alcohol retailers demanded identification from patrons who appeared under the legal age (see footnote 20 above). In addition, there are concerns related to the so-called “back door” privatization of retail alcohol sales: there is a general trend among liquor control authorities to emphasize business development and consumer convenience as major corporate goals at the expense, some critics would argue, of goals associated with social responsibility.

This paper provides a picture of where Canada is currently with regards to alcohol policy and harms with some references to the path we have taken to get here and how it compares with the approaches of other countries. What this paper does not answer is the question: **Where do we want to be with regard to alcohol policy in Canada?** To start that discussion, it may be important to consider the information provided in Figure 11 below:

Figure 11: Annual Per-capita Alcohol Consumption and Rates of Impaired Driving Incidents, Canada, 1977 to 2002



Source: Statistics Canada, 2003c; used by permission.

In particular, it is revealing to focus on the years after 1992 when the annual per-capita consumption of alcohol levelled off at about 90 litres per person. What Figure 11 shows is that harms associated with impaired driving fell in the face of stable, or slightly increasing, alcohol use in Canada. In short, the case of impaired driving shows us that **it is indeed possible to disconnect specific harms associated with alcohol misuse from overall consumption rates**. This change took many years to occur, but it did occur. The central task of alcohol control policy in the future, then, is to consider if and how we should replicate this result for other major sources of harms associated with alcohol misuse.

One further point can be made as we consider where we want to go with alcohol policy in Canada: it is probable that if we were to develop and promote policies and programs to reduce the prevalence of intoxication and dependency, overall rates of drinking would decline since a significant proportion of current consumption occurs within high-risk drinking patterns. On this point it may be revealing to consider the following analyses. Most countries promote what are called low-risk drinking guidelines. The most frequently cited guidelines in Canada are as follows:

- No more than two standard drinks per day;

- No more than 14 standard drinks per week for men and 9 for women.²⁷

If 77% of the population over the age of 20 (i.e., current drinkers) in 2003 drank to the upper limit of these guidelines in Canada, alcohol sales would have totalled approximately 10.875 billion standard drinks. In 2003, approximately 9.862 billion standard drinks were sold. Since these calculations do not account for those with pre-existing conditions, pregnant women and others who should avoid alcohol altogether, it is possible to conclude that the overall alcohol consumption rate in Canada is already at or above the “theoretical” threshold implied by the low-risk drinking guidelines. Further, since we know that a significant amount of alcohol is currently being consumed by a minority of drinkers in risky situations (recall that about 20% of current drinkers are classified as “at-risk”), it is likely that if the prevalence of drinking to intoxication and alcohol dependence were to be reduced in Canada, overall alcohol consumption would likewise be reduced to some degree.

The following section outlines several “questions for consideration” based on the information presented above.

8. Conclusion: Questions for Consideration

- What are the biggest issues that have to be addressed in order to enable the development and implementation of effective alcohol policy in Canada?
- What is making this process complex?
- What are some “enabling forces” on which we should capitalize to move forward on this issue?
- What are the main topic areas that should be the target of policy development and action to further reduce the harms related to alcohol in Canada?
- Which of these topic areas can be addressed through a collaborative approach to policy development and research? In other words, on what issues can we agree to work together on, and which ones will get us the biggest “bang for the buck” in terms of reducing alcohol-related harms?
- Within these topic areas:
 - what are some specific questions that need to be addressed as we work on designing and implementing effective public policy?
 - what are some specific policy directions that should be taken?
 - what needs to be taken into consideration for each of these policy directions?
 - where does responsibility lie and who is best placed to act on this policy direction?
- What ideas do you have for moving forward on the development and implementation of effective alcohol policy in Canada? In particular, what thoughts do you have on the process, mechanisms and structure for moving forward on the recommendations from the Roundtable?
- Are there organizations or people who should be included who are not represented at this Roundtable?

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²⁷ For more information on these guidelines see: http://www.camh.net/about_addiction_mental_health/low_risk_drinking_guidelines.html

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