



Ontario Public Health Association

Resolution adopted at the 1988 Annual General Meeting

ALCOHOL POLICY FRAMEWORK: GUIDELINES FOR OPHA ACTION ON AND RESPONSE TO ALCOHOL AND HEALTH ISSUES

BACKGROUND

Alcohol abuse poses a severe threat to public health in Ontario. It is responsible for more problems than any other drug and is related to one in every ten deaths. Alcohol abuse is related to liver disease, hypertension, cardio-vascular diseases, some cancers as well as to alcoholism and accidents. Estimates of alcohol-related health care costs in Ontario exceed well over \$0.5 billion per year. The accompanying social costs of alcohol abuse involving family breakdown, violence, crime, fires and workplace problems are known to be great but their economic costs are more difficult to assess.

Since the 1940's, alcohol consumption rates in Ontario have increased fourfold, accompanied by an increase in alcohol-caused diseases and other problems. Over that time we have relaxed the societal controls on alcohol. Alcohol use is more acceptable, more often, by more people, in more places. Currently over 80 per cent of Ontario residents over age 15 drink alcohol. The price of alcohol has decreased relative to the cost of living. The drinking age has been lowered from 21 to 19 years of age.

Alcohol availability has increased with more off-premises outlets, more licensed establishments, longer hours of sale, and more easily obtained special liquor permits. Alcohol advertising has spread to almost all our media. The health care sector's approach to the resulting illnesses has been to increase alcohol treatment facilities.

EFFECTIVE APPROACHES

In the "Review of National Policy Measures to Prevent Alcohol-Related Problems" developed for the World Health Organization (1985), Susan Farrell outlines the policy measures for which there is reasonably good evidence of effectiveness as follows: (1) increasing the relative price of alcoholic beverages, (2) sharp restrictions on the distribution of alcoholic beverages, (3) increasing the minimum drinking age and (4) increasing the probability of detection and punishment for drinking and driving (pages 11-18).

Policy measures widely believed to be effective, though little scientific evidence is currently available were identified as follows (1) education of school children and the general public, and (2) education of health professionals and other primary health care workers (pages 19-23).

Policy measures for which there is mixed evidence of effectiveness were identified as follows: (1) other restrictions on the distribution of alcoholic beverages, (2) regulation of advertising and other promotion of alcoholic beverages, (3) encouraging consumption of beverages with lower alcohol content or no alcohol content at all, and (4) controls on production of alcoholic beverages (pages 24-30).

Policy measures for which there is virtually no evidence of effectiveness, though they seem promising were identified as: (1) efforts to reduce alcohol-related accidents in the workplace, (2) efforts to prevent physical and psychological problems among children whose parents are alcoholics and, (3) efforts to modify physical and social environments so that when drinking and drunkenness do occur certain harmful consequences will not also occur (pages 30 and 31).

POLICIES ON ALCOHOL AND HEALTH FOR THE ONTARIO PUBLIC HEALTH ASSOCIATION (OPHA)

RESOLUTIONS WHICH HAVE BEEN PASSED BY OPHA:

OPHA has already passed four resolutions regarding alcohol. They are as follows:

1. That the sales of beer and wine not be permitted in grocery store.
2. That alcohol and health education be improved for health professionals and for school children.
3. That all alcoholic beverages be labelled "Misuse of this product can be injurious to health".
4. That a person convicted of impaired driving be punished by suspension of the driver's licence for one year on first offense and subsequent offenses be punished by permanent suspension of the licence.

FURTHER POLICY GUIDELINES:

The following general guidelines will provide further policy direction for Public Health Association in future efforts to decrease problems associated with alcohol abuse;

a) GUIDELINES RELATED TO AVAILABILITY:

1. That there should be no increase in the hours of sale of alcoholic beverages.
2. That there should be no increases in the size of licensed establishments or outlets for the sale of alcohol, and no increase in the number of licensed establishments and outlets above the current per capita ratio.
3. That careful consideration should be given to curtail and monitor special occasion permits.
4. That alcohol should not be sold at sports events such as football and baseball games.
5. That there should be increases in the price of alcohol (or taxes) commensurate with discouraging use but not so much as to encourage an illicit trade in alcohol products.

Note — For a more detailed explanation of factors related to availability in Ontario please see Attachment (Simpson, 1988).

b) GUIDELINES RELATED TO ALCOHOL ADVERTISING AND HEALTH PROMOTION.

While results from studies on the effects of alcohol advertising and health promotion on alcohol consumption rates are not as demonstrable or convincing as the effects of availability, advertising and health promotion do play roles in molding attitudes towards alcohol use. Therefore, the Ontario Public Health Association endorses the following general guidelines on alcohol advertising and health promotion:

1. Opportunities should be sought to provide support for more health promotion strategies about alcohol and health.
2. Opportunities to curtail alcohol advertising — especially as it relates to sports should be sought. Equal advertising, time, space and money should be sought for health agencies to promote alcohol — related health messages, as is allowed for alcohol advertising. This would ensure that the public gets a balanced message.
3. Opportunities should be sought to ensure that the Ontario public, and especially those who

sell and serve alcohol, be made aware of the liquor licence laws and other alcohol-related laws (especially those to do with drinking and driving) and the responsibilities they entail. Information about the health effects of alcohol be integrated with information about legal responsibilities.

4. Opportunities should be sought to ensure that a standard method of noting the amount of alcohol in beverages be made available to the Ontario public and especially those who serve alcohol. Information about the health effects of alcohol in relation to amount consumed should be clearly detailed.

PURPOSE OF THESE GUIDELINES

The above guideline will serve as a policy framework for representatives of the Ontario Public Health Association as they provide leadership on alcohol and health issues in Ontario. That is not to say that OPHA will continue initiatives on all of these guidelines at once but rather that OPHA will seek propitious opportunities, often in conjunction with other agencies, to promote the policies. Furthermore, OPHA representatives will use the framework when initiating or responding to alcohol and health issues.

ATTACHMENT I

THE RELATIONSHIPS AMONG THE SUPPLY AND DEMAND FOR ALCOHOL, CONSUMPTION LEVEL, AND ALCOHOL PROBLEMS.

Robert Simpson September, 1988

In a heterogeneous society, the level of alcohol consumption per drinker is the result of an equilibrium or balance among those factors which influence both the supply of alcohol and the demand for it. This equilibrium is sensitive to changes on either side: an increase in the supply of alcohol will raise the per drinker level, as will an increase on the demand side. Conversely, a decrease in either the supply or demand side will be met with a reduction in the average amount consumed by drinkers.

The per drinker level of consumption is a key outcome variable because it determines the distribution of drinkers across a range of consumption levels. This range can be segmented into three categories; low risk, moderate risk, and high risk consumption. Low risk consumers drink fewer than 14 standard drinks per week on average and, all else being equal, have a relatively low probability of experiencing alcohol problems.

Moderate risk consumers drink between 15 and 34 drinks per week. Surveys and clinical studies suggest that the probability of experiencing alcohol problems is significantly higher among these people, all being equal. High risk consumers drink more than 35 drinks per week on average, and are highly likely to experience alcohol problems. (A full range of risk consumption behaviours is appended for reference. Many of these are cross-associated with consumption levels. For example, high average consumption levels can correlate with drinking to intoxication, and so on.)

Currently in Ontario, 72% of all drinkers fall into the low risk category. The remaining 28% comprise the "at risk" group, and are the potential from which problems are likely to emerge. These are the people who will require assistance from the health and social service systems, the police, employers, families and friends. Within this larger "at risk" group, the 9% of consumers that fall within the high risk category will almost certainly be experiencing various forms of alcohol problems. At present, our treatment systems around the province can accommodate fewer than 15% of the approximately 500,000 people in the high risk category.

In terms of health, social and economic goals, it is desirable to increase the proportion of drinkers who occupy the low risk category to the greatest extent possible, and to effect corresponding decreases in the moderate and high risk categories. The only way this shift can be realized is to decrease the per drinker level of consumption, which, over time, will effect a redistribution of consumers toward the lower end of the consumption continuum. Increasing the per drinker level will effect a redistribution into the moderate and high risk categories.

In light of these relationships, any policy or program initiative being considered by the provincial government should be assessed according to the following criterion:

Will the proposed initiative contribute to an increase or a reduction in the per drinker level of consumption?

In recognition of the profound implications for the health and social well-being of the people of Ontario, any policy or program initiative which cannot be shown to exert a depressing or, under some circumstance, a benign influence on the per drinker level of consumption, should be abandoned.

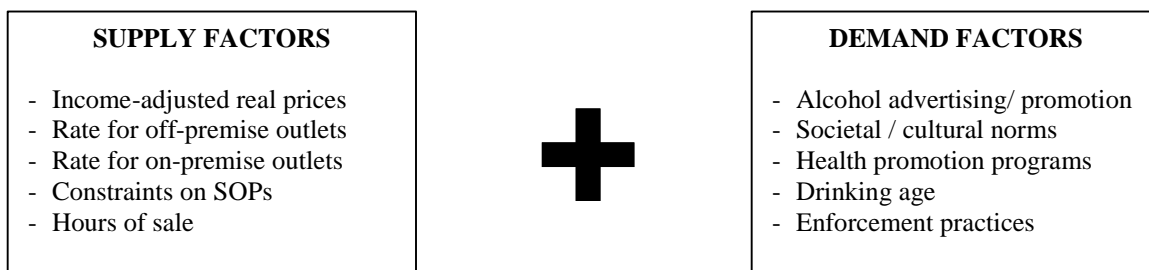
As is the approach with many health and environmental issues, proponents of new policy or program initiatives should be required to provide compelling evidence that the change, as a minimum, will not contribute to increased harm in the population at large.

Alcohol consumption among low risk consumers is generally considered to be an accepted and positive

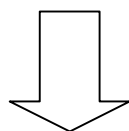
Alcohol Policy Framework: Guidelines for OPHA action on and response to alcohol and health issues

contribution to the quality of life in Ontario. Among moderate and high risk consumers, however, it is responsible for more premature death, disease, disability, and social breakdown than any other preventable factor. There is no question that a reduction in the per drinker level of consumption should be among the highest priority goals for the health and social well-being of Ontarians.

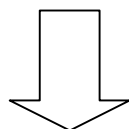
ALCOHOL CONSUMPTION AND RELATED PROBLEMS



EQUILIBRIUM



PER DRINKER CONSUMPTION



DISTRIBUTION OF CONSUMERS

	LOW RISK	MODERATE RISK	HIGH RISK
Standard Drinks Per Week	1 – 14	15 – 34	35 +
% Ontario Drinkers	72	19	9
# Ontario Drinkers (approx.)	4,287,000	1,143,000	510,000

APPENDIX A
RISK CONSUMPTION BEHAVIOURS

ALCOHOL

1. **AVERAGE LEVELS OF CONSUMPTION:** Consuming 14 or fewer standard drinks per week or 4 per drinking occasion has a low association with alcohol problems. Consuming 15 or more standard drinks per week has a significantly higher association with problems. The level of risk increases with the amount consumed. At the individual level, variables such as lean body weight and gender will influence this risk threshold. For example, all else being equal, women develop complications of alcohol use at lower consumption levels than men.
2. **DRINKING TO INTOXICATION:** Consuming four or fewer standard drinks per drinking occasion has a low association with alcohol problems. Consuming five or more standard drinks per occasion has a significantly higher association with problems. Beyond this parameter, weekly consumption should not exceed 14 standard drinks. At the individual level, variables such as lean body weight and gender will influence the level of intoxication.
3. **DRINKING AND DRIVING:** Any alcohol in the bloodstream impairs the ability to drive. Consequently, driving with a positive Blood Alcohol Concentration (BAC) is a risk behaviour. The level of risk increases with the BAC, which is calculated as a function of the number of drinks consumed and the rate of intake. At the individual level, variables such as lean weight and gender will influence BACs for any constant intake of alcohol.
4. **DAILY DRINKING:** Consuming alcohol on three days or fewer per week has a low association with alcohol problems. Daily consumption of alcohol has a significantly higher association with problems.
5. **DRINKING AND RECREATIONAL ACTIVITIES:** Any alcohol in the bloodstream impairs the psychomotor coordination required for many recreational activities such as swimming, skiing, and hunting. Drinking in conjunction with these activities increases the risk of accidents. The level of risk increases with the amount consumed.
6. **DRINKING AND HOUSEHOLD ACTIVITIES:** Psychomotor coordination is required for many household activities, such as climbing a ladder, using power tools, or using sharp kitchen utensils. Drinking in conjunction with these activities increases the risk of accidents. The level of risk increases with the amount consumed.
7. **DRINKING DURING PREGNANCY:** No level of alcohol consumption is known to be safe during pregnancy. The level of risk increases with the amount consumed.
8. **DRINKING WHILE ON MEDICATION:** Alcohol, in conjunction with many prescription and over-the-counter drugs, can result in high levels of impairment. When on medication, alcohol should only be consumed with the agreement of a physician or pharmacist.
9. **DRINKING AND WORK PERFORMANCE:** High average levels of consumption and drinking to intoxication can interfere with many activities, including the ability to perform satisfactorily at work. Within certain occupations, however, consuming even small amounts of alcohol either during or immediately prior to work hours can place the individual or others at risk. Consequences may be related to safety, the ability to make sound decisions, or the performance of other functions in accordance with job expectations.

OTHER DRUGS

10. **ANY USE OF ILLICIT DRUGS OR INHALANTS:** The composition and strength of illicit drugs, and the presence of harmful contaminants are seldom known. Many illicit drugs and all inhalants are, in themselves, harmful to health and social well-being, even at low doses. All possession and use of illicit drugs is against the law and subject to severe legal consequences. Accordingly, any use of illicit drugs or inhalants is most appropriately defined as risk behaviour.
11. **INAPPROPRIATE USE OF PRESCRIPTION DRUGS:** The use of prescription drugs as indicated in the product monograph has a low association with problems. Any use other than as indicated is a risk behaviour. Physicians and pharmacists are charged with the responsibility of conveying appropriate use to the patient. Accordingly, appropriate use can be interpreted as use that is in compliance with the appropriate instructions of a physician or pharmacist. A notable exception occurs when the patient visits more than one physician in order to receive multiple prescriptions for the same complaint.