Alcohol and Public Health:
The Implications of Changes to Ontario's Beverage Alcohol System

submission to the

Beverage Alcohol System Review Panel

by the following Ontario public health organizations:

Addictions Ontario (AO)
Association of Local Public Health Agencies (alPHa).
Centre for Addiction and Mental Health (CAMH)
Mothers Against Drunk Driving (MADD Canada)
Ontario Drug Awareness Partnership (ODAP)
Ontario Public Health Association (OPHA)
Parent Action on Drugs (PAD)
Toronto Public Health

February 25, 2005

Executive Summary

Alcohol is a drug that causes about as much harm as tobacco. It is linked to more than 60 medical conditions and imposes a heavy burden on public health and finances. Alcohol should not be sold as an ordinary commodity.

Recent public discourse on alcohol has focused on increasing government revenues and has largely overlooked public health impacts. Public health and safety issues deserve to be at the forefront in a balanced review of beverage alcohol policy. The Ontario review should, as a guiding principle, seek to improve, not mortgage, public health and safety.

Alcohol policy research has come of age, and now provides governments a toolkit of policy options that research show to be effective in reducing alcohol-related problems. Policies that increase alcohol consumption generally lead to higher levels of public harm, while policies that decrease consumption reduce harm. Among the most effective policies to reduce alcohol problems are:

- **maintaining public alcohol retail monopolies with a strong duty of social responsibility, and**
- **increasing alcohol taxes.**

Relying on public education and persuasion alone is not effective in reducing alcohol-related harm.

A number of proposals have recently gained currency in public discourse. These include:

- **increasing alcohol sales to increase revenues,**
- **eliminating or transforming Ontario's public retail monopoly through privatization, franchising or establishing an income trust, and**
- **expanding access to alcohol by selling alcohol in corner stores.**

Each of these proposals is likely to increase alcohol problems and should be rejected on public health and safety grounds alone. When health and safety consequences are taken into account, these proposals are also likely to harm Ontario's future financial health.

Eight Ontario public health organizations jointly recommend:

1. **As a top priority, Ontario should retain intact its public monopoly on alcohol distribution and retail alcohol sales. The public monopoly should be extended to include beer and certain wine stores, and its activities re-balanced to moderate its current marketing emphasis and to take greater account of public health and safety priorities.**
2. **Provincial alcohol taxes should be increased by 10-20% in the short term to improve public health and safety and to increase government revenues derived from alcohol. The flat tax on beer, which has cost Ontario an estimated $177 million in foregone revenues, should be eliminated. The preferential tax treatment afforded to beer, which may currently be contributing to elevated death and injury from alcohol-related vehicle crashes, should be eliminated in favour of uniform tax policies for all alcoholic beverages more similar to those currently applied to spirits.**

If implemented, these recommendations would improve the health and safety, and the public finances, of Ontarians.

Alcohol is no ordinary commodity

Many of us derive pleasure from drinking alcohol. However, alcohol is not an ordinary commodity and should not be sold like one. Alcohol is a drug. It is linked to more than 60 different medical conditions and imposes a heavy burden on public health.[1]

According to research conducted for the World Health Organization (WHO), *alcohol-related harm is nearly equal to that caused by tobacco, and far greater than for illicit drugs*[2] Four percent of the global burden of disease is attributable to alcohol, compared with 4.1 percent to tobacco and 4.4 percent to high blood pressure.[3] *For adolescents and young adults in developed countries such as Canada, alcohol is the most significant avoidable health risk*.[4] In Ontario, the annual cost of alcohol-related lost productivity and increased health care and enforcement services is estimated at nearly $2.9 billion.[5]

Despite the prevalence and gravity of alcohol-related problems, they have attracted far less attention than health problems caused by tobacco. Many jurisdictions around the world are implementing tobacco policies to improve public health. For its part, the government of Ontario is demonstrating a commendable commitment to reducing tobacco problems. The government has recently:

- increased taxes on tobacco,
- introduced legislation to make workplaces and public places smoke-free, and
- increased spending on tobacco control.

It would be regrettable if the public health improvements that will result from these laudable policies on tobacco were blunted or even reversed by policies on alcohol that failed to take into account a wealth of established public health information. Fortunately, recent research has contributed substantially to our understanding of alcohol's role in health and illness, the treatment of alcohol use disorders, and—critically—the importance and efficacy of alcohol policy options. Alcohol research is now well-established and recognized. (Please refer to the review article entitled "Alcohol and public health" in Feb. 5, 2005 issue of the British medical journal *The Lancet*, reproduced in Annex 2)

Dispelling myths about alcohol

People's view of alcohol policy is often inappropriately tainted by their perceptions of the prohibition-era. However, most modern alcohol policies bear little resemblance to prohibition—they have been "incremental, deliberate, and respectful of people's right to drink in moderation."[6] Alcohol policy has also had to contend with numerous misconceptions that are deeply embedded in society. These false notions continue to obscure the link between alcohol consumption and its many negative public health consequences. These myths have been summarized in a position paper published recently by the Ontario Public Health Association:[7]

> "[One] misconception is that *heavy drinkers cannot be influenced by broad-based control policies*. In fact, research has consistently found that the proportion of heavy drinkers is related to the alcohol consumption patterns of the entire population i.e. when population consumption levels are down, alcohol related problems at all levels of drinking are down…"
>
> "One of the most enduring misconceptions is that *only those who are dependent on alcohol (i.e. alcoholics) experience alcohol problems* and that *controls on alcohol availability unfairly*

restrict the freedoms of the vast majority of the population that drinks responsibly…. [However, t]raffic and crime statistics show that everyone in our society, including those who do not drink, are at risk of alcohol-related problems…"

"A third common misconception is that *alcohol-related problems result solely from drinking to or past the point of intoxication*. The World Health Organization, among others, notes that even low or moderate levels of alcohol use can impair workplace and traffic safety, increase the risk of certain cancers and harm the development of the fetus…"

"Finally, there is the myth that *if people only knew about the risks associated with alcohol they would make healthier choices*. Education is an important part of any comprehensive population-level health promotion/prevention strategy. However, the evidence indicates that on its own education is of limited value. Personal choice is not the only factor influencing alcohol-related problems; the consumption of alcoholic beverages is related to a range of social, cultural, economic and environmental determinants…"

Fortunately, as the responses to each myth suggests, the understanding of effective alcohol policy continues to deepen, and the study of alcohol policy is firmly rooted in the scientific method. Today, citizens and their governments possess an extensive toolkit of policy options that compelling international research demonstrate are effective in reducing alcohol-related problems. Policymakers can use the same strong body of research to avoid policy options that are likely to worsen the harm associated with alcohol consumption.

Policies that are most effective in reducing alcohol-related harm[8]

Extensive research published by the World Health Organization indicates that the following measures are effective in reducing alcohol-related harm.

Pricing and taxation

Regulating alcohol taxes and prices is one of the most common and effective methods of controlling alcohol-related health problems. Basic economic theory suggests that making alcoholic beverages more expensive by taxing them usually results in people consuming less alcohol, which in turn leads to fewer alcohol-related problems. In addition, moderate alcohol taxes are relatively easy to establish and enforce, and provide governments with significant revenues. Conversely, reducing alcohol taxes and prices generally leads to more alcohol problems.

Regulating the physical availability of alcohol

Controls that affect the convenience and accessibility of alcohol vary widely but can be instrumental in reducing alcohol-related harm. These include:

- government monopoly of retail sales
  Maintaining public alcohol retail distribution systems with a strong duty of social responsibility is one of the most effective ways of minimizing harm caused by alcohol. Balanced government retail monopolies can help reduce consumption. They are typically more restrained than their private counterparts in promoting alcohol sales and more likely to aggressively challenge and refuse to sell alcohol to underage youth and the already-intoxicated. Public monopolies also moderate the political influence of private corporate alcohol sellers that have a vested interest in boosting alcohol sales.[9] Finally, publicly-owned retailers can be held more directly accountable to the public.

- age restrictions for individuals purchasing alcohol
  Almost all countries restrict the age at which young people may purchase alcohol. Research from many studies indicates that if adequately enforced, these laws can substantially reduce drinking and its associated harm among high school students, college students and other teenagers.
- restrictions on the hours and days of retail sale
  The international evidence suggests that if used strategically, restrictions on the hours and days of alcohol sales can reduce drinking and alcohol-related harm.
- restrictions on the density of outlets
  Regulating the number of outlets for alcohol sales, usually through licensing, increases the time and effort people must spend to obtain alcohol. The evidence indicates that large changes in the number of outlets can have a substantial influence on levels of alcohol consumption and harm, and that regulating outlet density even at the local level may provide public health benefits.
- regulating beverage availability according to alcohol content
  Many countries have recently encouraged the preferential consumption of lower-alcohol beverages by increasing their relative availability and by taxing alcoholic beverages according to the amount of alcohol they contain. While not conclusive, the evidence suggests that such policies can reduce both the amount of absolute alcohol consumed and associated health problems.

Drinking-driving countermeasures
In recent decades, measures to reduce the number of people driving a vehicle under the influence of alcohol have been very successful, reducing long-term health problems by between 5% and 30%. These types of measures, which have the strongest potential for success when combined, include the following:

- reducing legal limits for driving
  There is a strong relationship between the level of alcohol in a driver's blood (called the blood alcohol concentration, or BAC) and the risk of motor vehicle crashes. According to a recent World Health Organization survey[10], about 70% of responding countries maintain a legal BAC of around 0.5 or lower. Just over 25% maintain a BAC of 0.6 or higher (including Canada, at 0.8), and only 7% have no BAC. The available research suggests that BAC laws are generally positive, persistent and cost-effective.
- random breath testing
  The stopping by police of motorists for breath tests at random, usually in a highly-visible, widely-publicized operation, is effective in reducing alcohol-related crashes, injuries and deaths.
- remedial programs for convicted offenders
  The available evidence also supports mandatory treatment of repeat drinking-drivers.

Modifying the drinking context
Many jurisdictions seek to reduce the harm caused by alcohol consumption by focusing on changing the social, cultural and community context within which alcohol consumption takes place, particularly in bars and other places where purchased alcohol is consumed on the premises. Strategies include: community mobilization (to raise awareness of, and solutions to, problems linked to on-premise drinking), server training and liability (holding servers liable for the consequences of selling alcohol to underage individuals and the already-intoxicated), and enforcement of on-premise regulations and legal requirements not to serve youth and the already-intoxicated. This focus can have a significant impact on young people and those with high-risk drinking practices.

Treatment and early intervention services
There are many varied approaches for treating alcohol problems. Of these, brief interventions with high-risk drinkers can be effective in changing individuals' drinking behaviour. Other approaches, including specialist treatment in specialized facilities, and mutual help and self-help societies can also provide benefits.

Regulating alcohol advertising and other promotion
The evidence of the efficacy of restrictions on alcohol advertising and other promotion in reducing alcohol-relate harm remain equivocal. However, some recent studies suggest that such restrictions could prove beneficial. For example, a large econometric study conducted in the United States indicates that a ban on broadcast alcohol advertising alone could reduce motor vehicle fatalities in that country, saving between 2,000 and 3,000 lives per year.[11] The evidence clearly shows that industry self-regulation--for example, to limit exposure to underage youth[12]--is largely ineffective. As a result, many governments throughout the world pursue restrictions on alcohol advertising and other promotion as a precautionary measure to reduce the likely risk to the public generally, and to underage youth in particular.

Other alcohol policies

Of the many other available alcohol policies, the popular approach of relying on ***public education and persuasion*** to address alcohol problems warrants particular attention. Initiatives involving the media include: public service announcements, counter advertising to reduce alcohol's appeal and use, media literacy programs designed to enable young people to better resist the persuasive appeals of alcohol advertising, warning labels about alcohol, and guidelines for low-risk drinking. Extensive evidence indicates that public education, when pursued in isolation, is not effective in reducing the harm associated with alcohol consumption. Education and persuasion can play a positive role when implemented with health-based policies in which alcohol access and availability is controlled by public monopoly. In environments in which they are not supported by such policies, any positive impact they may have is likely to be overshadowed by the harm that increased access to alcohol creates. Thus, extensive research on public health impacts shows that *exchanging effective alcohol policies for increased educational efforts cannot be supported*.

Viewing alcohol revenues in a broader context

The social harm and financial costs that alcohol causes fully justifies governments' efforts to derive revenues—and indeed, *increasing* revenues—from alcohol's production, distribution, promotion and use, in part to fund initiatives to prevent and treat alcohol-related harm. Revenue generation should not be viewed in isolation, however. Increasing alcohol revenues should not be viewed as the sole, or even the primary, objective of Ontario's beverage alcohol system.

Firstly, the revenues that governments derive from alcohol should be considered in the context of the social and financial costs associated with its use. For example, Ontario would be ill-served by policies that merely increased alcohol revenues if those policies increased public harm and associated costs to an even greater extent.

Secondly, alcohol policy and the province's fiscal situation need to be considered from the perspective of an extended period of time. It would be regrettable, for example, if governments pursued short-term infusions of cash if this were achieved to the detriment of public health and safety, and the province's overall financial situation, in subsequent years and decades. In short, *it is crucially important that changes to Ontario's beverage alcohol system improve—not mortgage—the public's health, safety and finances.*

A prudent, balanced approach to alcohol policy requires, as a matter of priority, the examination of measures that increase government revenues while simultaneously decreasing government expenses by enhancing public health and safety.

Specific proposals raise public health and financial concerns

Prior to, and in response to the creation of the Beverage Alcohol System Review Panel, several suggestions for changes to the alcohol system have gained currency. Among these are the following proposals:

- Increasing alcohol sales to further increase revenues;
- Eliminating or transforming Ontario's public alcohol retail monopoly, by privatizing or franchising the LCBO, or by establishing an income trust;
- Expanding access to alcohol, in part by selling alcohol in corner stores.

Recent public opinion research conducted over the past 15 years indicates that Ontarians generally oppose increasing access to alcohol. A recent report on this research by the Centre for Addiction and Mental Health[13] (which is appended to this submission, in Annex II) concludes that:

> "Ontarians continue to be aware of and concerned about the social, health, legal and economic consequences of alcohol abuse and continue to support interventions and controls that will reduce alcohol-related risks and harms…."
>
> "Ontario residents are very supportive of a monopoly-based retail system and related control measures."
>
> "In general, public opinion does not favour increased marketing of alcohol products or greater access to alcohol

In particular, between 1989 and 1998, when asked whether "alcoholic beverages should be sold in corner stores" the percentage of respondents expressing opposition remained at or above 69% each year, rising to 78% in the final year.[14] When responses to these and more recent CAMH surveys are considered together, the results indicate that the Ontario public strongly supports a balanced approach where access to alcohol is controlled by a government run monopoly. Results from a 2002 survey[15] show that

- 72% of respondents disagreed that the government should "close all LCBO stores, and allow privately run stores to sell alcohol."

- 80% of respondents believed that "the number of places where you can buy alcohol in your community" is "about right"; a further 9% felt there are "too many."

- 92% of respondents considered it “somewhat” or “very convenient” “to get to the nearest liquor or beer store”

- 73% agreed that “before making legislative or policy changes to the way alcohol is sold… governments should be required to consult with health experts.”

These public opinion trends are supported by another, more recent poll. A random telephone survey of 500 Ontario voters conducted in January 2005[16] indicates that citizens have important misgivings about allowing the sale of beer and wine at local corner stores:

- 70% believe the proposal would
  ”likely increase” “*beer and wine being sold to underage persons*”
  (fewer than 3% think it would likely decrease this);

- 64% believe the proposal would
  “likely increase”… “*beer and wine being sold to intoxicated persons*”
  (fewer than 3% think it would likely decrease this); and

- 53% of respondents believe the proposal would
  “likely increase”… ”*the number of drinking and driving incidents*”
  (4% think such incidents are likely to decrease).

The available research provides scientific justification for public concerns about expanding access to alcohol. If implemented, each of the proposals noted above would likely increase alcohol consumption. For example, a fully privatized alcohol system would result in more outlets selling alcohol, longer hours of sale and, critically, more sales to underage individuals and higher consumption of alcohol overall.[17] Similar increases in consumption would result from the sale of alcohol in corner stores, the proliferation of LCBO franchise outlets, and the sanctioning of private profit imperatives in the sale of alcohol that an income trust would embody. In each instance, increased consumption would worsen the health, social and legal problems that alcohol creates in Ontario.

Decades of international research[18] show that increased consumption generally leads to higher levels of public harm. In Ontario, increased access and consumption would, for example, lead to a greater number of citizens suffering from liver cirrhosis, alcohol-related cancers and other chronic diseases. More people would be injured or die in drunk-driving crashes; there would be more alcohol-related drownings, more falls resulting in injury or death. More families would suffer from domestic violence, and there would be more incidents of public disorder.

On the sole basis of public health and safety, each of the above proposals should thus be rejected.

In addition, however, such initiatives would lead to greater financial expenditures—by both individuals and governments—to address alcohol-related problems. For example, selling alcohol in myriad corner stores would entail substantial increases in distribution and recycling costs, and increased costs for: staff security; crime prevention; policing; and regulating dispersed outlets over extended hours to ensure compliance with rules against the sale of alcohol to minors and the already-intoxicated. Implementing the proposal for an income trust would divert alcohol-generated revenues—over a billion dollars a year in dividends to the Province—to private investors. After an initial infusion, Ontario would have even less money to deal with the greater health problems caused by increased alcohol consumption.

Moreover, while the LCBO is now allowed to place far too much emphasis on glamorizing liquor consumption at the expense of its broader social responsibility, relinquishing substantial control of the Crown corporation to private investors and reducing its public accountability would make public health matters worse. The lucrative priority of selling more alcohol would prevail.

When public health consequences are taken into consideration, it is clear that proposals that would increase alcohol consumption and public harm are also likely to have grave consequences for Ontario's future financial health.

Conclusion

Most recent public discourse on alcohol policy has centred on increasing government revenues in the short term. Regrettably, public health issues have not received the attention they deserve. Public health and safety is not a mere 'externality.' It cannot legitimately be treated as a side-effect of the primary goal of increasing government revenues. Public health and safety impacts deserve to be placed at the forefront of a balanced review of beverage alcohol policy. Indeed, the guiding principles for this alcohol policy review should be to ensure that alcohol problems are not made worse and, indeed, that public health is enhanced by alleviating the harm caused by alcohol. In considering alcohol policies generally and initiatives to increase provincial revenues in particular, *the overarching priority should be to improve, not mortgage, public health and safety*.

Recommendations

The endorsing Ontario public health organizations make the following recommendations to the Beverage Alcohol System Review Panel:

Public alcohol retail monopoly
Extensive World Health Organization research shows that one of the most effective ways to minimize alcohol-related harm is to maintain public alcohol retail distribution systems with a strong duty of social responsibility.[19]

1. Retain, expand public alcohol retail monopoly; re-balance its priorities

As a top priority, Ontario's public monopoly on alcohol distribution and retail sale should be retained intact. The current public monopoly should also be extended to include beer and certain wine stores. These initiatives would:

- facilitate the government's ability to raise increased revenues from alcohol;
- simplify the alcohol distribution system in the province—thereby reducing government overhead; and
- provide for a stronger provincial mechanism for implementing public health initiatives related to alcohol.

In addition, the activities of the expanded public monopoly should be re-balanced to moderate its current marketing emphasis and to take greater account of public health and safety priorities.

Alcohol Taxes
Increasing alcohol taxes and prices is one of the most common and effective methods of controlling alcohol-related health problems. (See *Alcohol and Public Health*, published this month in the British medical journal *The Lancet*, which is appended in Annex II.) Basic economic theory suggests that making alcoholic beverages more expensive by taxing them usually results in people consuming less alcohol. This in turn, according to decades of international research, leads to fewer alcohol-related problems.[20]

2. Increase alcohol taxes, especially on beer

Alcohol taxes in Ontario should be increased by between 10-20% in the short term, with subsequent gradual increases tied to provincial economic indicators. This initiative would increase government revenue derived from alcohol. Extensive research shows that a tax increase would also reduce alcohol consumption—reducing costly alcohol-related problems and improving public health and safety throughout Ontario.

- As a first step in this initiative, the flat tax on beer, which was introduced in 2001, should be eliminated. This would increase provincial revenues; the flat tax is estimated to have cost the province $177 million in foregone revenues between 2001-02 and 2004-05.[21]
- In addition, beverage alcohol should be taxed uniformly at a rate more similar to that for spirits. This would also increase provincial revenues by eliminating the minimum pricing policies that now favour beer over other forms of alcohol.

There are strong public policy and scientific justifications for increasing taxes on beer. Beer currently enjoys preferential tax treatment in Ontario, being taxed at a lower rate (54 %) than wine (60%) or spirits (81%)[22]. Beer is the alcoholic beverage of choice of youth, who are particularly vulnerable to alcohol-related harm. Finally, the preferential tax rate for beer may currently be contributing to elevated death and injury from alcohol-related vehicle crashes caused by beer consumption.[23] [24]

Annex I Endorsing organizations

Addictions Ontario (AO) –formerly the Alcohol and Drug Recovery Association of Ontario (ADRAO)—is a non-profit, charitable organization representing individuals and facilities providing addiction services. AO is involved in and supports all aspects of the addictions field including prevention, education, advocacy, harm reduction and treatment. It is also inclusive of all addictions issues including alcohol, drugs and problem gambling.

The **Association of Local Public Health Agencies (alPHa)** is a non-profit organization that provides leadership to boards of health and public health units in Ontario. Its members include boards of health, members of health units, medical and associate medical officers of health, and senior public health managers. alPHa advises and lends expertise to members on the governance, administration and management of health units. The Association also collaborates with governments and other health organizations, advocating for a strong, effective and efficient public health system in the province. Through leadership, participation, partnership and promotion, alPHa facilitates the improvement of public health programs and services that better the health of Ontario's population.

The **Centre for Addiction and Mental Health (CAMH)** is Canada's leading addiction and mental health teaching hospital. CAMH succeeds in transforming the lives of people affected by addiction and mental illness, by applying the latest in scientific advances, through integrated and compassionate clinical practice, health promotion, education and research. CAMH has central facilities in Toronto and 26 community locations throughout the province. CAMH is fully affiliated with the University of Toronto and is a Pan American Health Organization and World Health Organization Collaborating Centre.

Mothers Against Drunk Driving (MADD Canada) is a non-profit, grassroots organization that is committed to stopping impaired driving and supporting the victims of this violent crime. At the heart of MADD Canada is our volunteers who include not only mothers, but fathers, friends, business professionals, experts in the anti-impaired driving field and concerned citizens who want to make a difference in the fight against impaired driving.

The **Ontario Drug Awareness Partnership (ODAP)** increases the awareness of the effects of alcohol and other drugs in communities throughout Ontario by supporting the initiatives and programs of drug awareness committees (DACs). There are currently 170 DACs throughout the province. Their significant target groups are youth, parents and seniors. ODAP coordinates the annual drug awareness week campaign in Ontario.

Founded in 1949, the **Ontario Public Health Association (OPHA)** is a voluntary, charitable, non-profit association. OPHA is an organization of individuals and Constituent Associations from various sectors and disciplines that have an interest in improving the health of the people of Ontario. The mission of the Ontario Public Health Association is to provide leadership on issues affecting the public's health and to strengthen the impact of people who are active in public health and community health throughout Ontario.

Parent Action on Drugs (PAD)—formerly Parents Against Drugs—helps parents and others make informed choices about substance abuse issues that affect their children. For the past 20 years, PAD has provided parents, teens and the community with the tools they need to prevent the abuse of alcohol and other drugs.

As the largest health unit in Canada, **Toronto Public Health (TPH)** works to promote and protect the health of all communities and individuals who live, work and play in Toronto. TPH is a Division within the City of Toronto with a mandate under the provincial Health Protection and Promotion Act. Throughout its history, TPH has been a leading advocate for healthy public policy in Ontario.

<u>Annex II Enclosures</u>

Room, R., Babor, T., and Rehm, J. (2005) Alcohol and Public Health, *Lancet* 365: 519-30.

Centre for Addition and Mental Health (2004) *Retail Alcohol Monopolies and Regulations: Preserving the Public Interest*.

Bador, T., et al. (2003) *No Ordinary Commodity: Alcohol and Public Policy*, Oxford: Oxford University Press.

Endnotes

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[1] World Health Organization (2002), *The World Health Report 2002, Reducing Risks, Promoting Healthy Life*, Geneva, Switzerland: World Health Organization, p. 66.
[2] The World Health Organization recently identified alcohol as one of the world's top ten health risks.
World Health Organization (2002), *The World Health Report 2002, Reducing Risks, Promoting Healthy Life*, Geneva, Switzerland: World Health Organization. See p. 82, Figure 4.9: "Global distribution of burden of disease attributable to 20 leading selected risk factors."

Of the 26 risk factors examined in the WHO 2000 Global Burden of Disease study, alcohol ranks as fifth most detrimental, accounting for about the same amount of global burden of disease (4.0%) as fourth-ranked tobacco (4.1%).
World Health Organization (1999) *Global Status Report on Alcohol*. Geneva, Switzerland: World Health Organization.
See also:

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

[3] *No Ordinary Commodity: Alcohol and Public Policy*, *supra*, note 2, Sect. 4.3.6
[4] Ibid.
[5] Addiction Research Foundation, *The economic costs of alcohol, tobacco and illicit drug abuse in Ontario: 1992*. For media highlights, visit http://sano.camh.net/announce/htscost.htm .
See also:

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

[6] *No Ordinary Commodity: Alcohol and Public Policy*, *supra*, note 2 .
[7] Ontario Public Health Association (2003) *Promoting Health Communities: A framework for alcohol policy and public health in Ontario*, A position paper adopted by the Ontario Public Health Association (OPHA), Code 2003-03 (PP), pp. 3-4, italics added in each case, available at http://www.opha.on.ca/ppres/2003-03_pp.pdf ; accessed Feb. 17, 2005).
[8] This section highlights information contained in *No Ordinary Commodity*, *supra* note 2, Sections 7, 8, 9, 12 and 16. It is drawn from Grieshaber-Otto, J., Schacter, N. and Sinclair, S. *Looming Challenges: international trade treaties and the regulation of alcohol to improve public health*, paper prepared for the World Health Organization, in preparation.
[9] Room, R. (2002) *Why Have a Retail Alcohol Monopoly?,* Paper presented at an International Seminar on Alcohol Retail Monopolies, Harrisburg, Pennsylvania, August 19-21, 2001.
[10] World Health Organization (2004) *Global Status Report: Alcohol Policy*, Geneva, Department of Mental Health and Substance Abuse. (available free online at http://www.who.int/substance_abuse/publications/en/Alcohol%20Policy%20Report.pdf)
[11] Saffer, H. (1997) Alcohol Advertising and Motor Vehicle Fatalities, *The Review of Economics and Statistics*, Vol. 79, No. 3, pp. 431-442.
[12] The Center on Alcohol Marketing and Youth's October 2004 report, *Alcohol Advertising on Television, 2001 to 2003: More of the Same*, indicates that television alcohol advertising in 2003 resulted in alcoholic beverage advertising exposing young people to alcohol products, sometimes to an even greater extent per capita than adults. The report is available at http://camy.org/research/tv1004/ ; accessed Feb. 17, 2005. Also, see the CAMY report entitled *Clicking with Kids: Alcohol Marketing and Youth on the Internet*, available at http://camy.org/research/internet0304/ ; accessed Feb. 17, 2005.
[13] Centre for Addiction and Mental Health, *Retail Alcohol Monopolies and Regulation: Preserving the Public Interest*, Position Paper, available online at http://www.camh.net/public_policy/retailalcoholmonopolies.html
[14] The percentages in these surveys exclude respondents who chose "don't know" as a response and those who did not answer. The total sample for the surveys ranged from a low of 573 to a high of 1,947.
[15] Anglin, L., Giesbrecht, N., Ialomiteanu, A., Grand, L., Mann, R., and McAllister, J. (2003) *Public opinion on current alcohol policy issues: International trade agreements, advertising and access to alcohol. Findings from a 2002 Ontario Survey*, CAMH Research Document Series No. 201, pp. 11, 12, 21, Table 1. In this survey, the total sample consisted of 1206 individuals.
[16] The survey was conducted between January 21 and January 27, 2005 by SES Canada Research Inc. and is considered accurate to plus or minus 4.5 percentage points, 19 times out of 20.
[17] *Retail Alcohol Monopolies and Regulation*, *supra*, note 13, p. 6.
[18] See, for example:

Edwards, G., Anderson, P., Babor, T.F., Casswell, S., Ferrence, R., Giesbrecht, N., Godfrey, C., Holder, H.D., Lemmens, P., Makela, K., Midanik, L.T., Norstrom, T., Osterberg, E., Romelsjo, A., Room, R., Simpura, J., & Skog, O.-J. (1994) *Alcohol Policy and the Public Good*, New York, Oxford University Press.

[19] *No Ordinary Commodity: Alcohol and Public Health*, *supra*, note 2.
[20] Ibid.
[21] MADD Canada calculations based on Ontario Government Budget Documents, 2001-2.
[22] LCBO Annual Report, 2003-04, p. 49, available online at http://www.lcbo.com/images/pdfs/lcbo_an_report.pdf ; accessed Feb. 21, 2005.
[23] Mann, R., Smart, R., Flam-Zalcman, R., and Suurvali, H. (2004) *Beverage-Specific Associations with Drinking Driving Charges and Fatalities in Ontario*, paper presented at the 17th International Conference on Alcohol, Drugs and Traffic Safety, August 9-13, 2004 and in press in *Alcohol, Drugs, and Traffic Safety*. This study examined the relationship between alcohol consumption by beverage type and drinking-related charges and fatalities in Canada between the years 1963 and 1996.
[24] A regression and simulation study conducted using U.S. data suggests that increasing taxes on beer would be one of the most effective policies to reduce alcohol-related motor-vehicle crashes. The authors conclude that "[a]n increase in the beer tax to its real 1951 value would decrease fatalities [in the U.S.] by 11.5%."
Chaloupka, F., Saffer, H., and Grossman, M. (1993) Alcohol Control Policies and Motor-Vehicle Fatalities, *The Journal of Legal Studies*, Vol. 22, No. 1, pp. 161-186.