CANADIAN
PUBLIC HEALTH
ASSOCIATION

The Voice of Public Health

ALCOHOL CONSUMPTION IN CANADA

A Public Health Perspective

POSITION STATEMENT | JUNE 2022

THE VOICE OF PUBLIC HEALTH

The Canadian Public Health Association is the independent national voice and trusted advocate for public health, speaking up for people and populations to all levels of government.

We champion health equity, social justice and evidence-informed decision-making. We leverage knowledge, identify and address emerging public health issues, and connect diverse communities of practice. We promote the public health perspective and evidence to government leaders and policy-makers. We are a catalyst for change that improves health and well-being for all.

We support the passion, knowledge and perspectives of our diverse membership through collaboration, wide-ranging discussions and information sharing. We inspire organizations and governments to implement a range of public health policies and programs that improve health outcomes for populations in need.

OUR VISION

Healthy people and communities thriving in inclusive, equitable, sustainable environments

OUR MISSION

To enhance the health of all people and communities in Canada, particularly those who are structurally disadvantaged, and to contribute to a healthier and more equitable world

For more information, contact:
Canadian Public Health Association
404-1525 Carling Avenue, Ottawa, ON K1Z 8R9
T: 613-725-3769 | info@cpha.ca

www.cpha.ca

Alcohol Consumption in Canada: A Public Health Perspective

Between 1 April 2018 and 31 March 2019, people living in Canada consumed over 3 billion litres of alcohol, representing approximately 9.5 standard drinks per week per person over the legal drinking age in their province or territory.[1] This level of consumption corresponds to about 8.1 L of pure alcohol per person 15 years of age and older (8.9 L for males and 6.6 L for females) during 2016, placing Canada 57th in the world for alcohol consumption.[2] Approximately 80% of the population over the age of 15 consumed alcoholic beverages.

Sales of the alcoholic beverages industry in Canada during 2018-2019 were $23.6 billion, of which $7.5 billion (about 31.7%) was attributable to wine consumption, $9.4 billion to beer (39.8%) and $5.7 billion to spirits (24.2%). Coolers, ciders and other related products contributed an additional $1.1 billion (4.7%) of sales. The income to Canadian governments was $12.4 billion: approximately $6.57 billion (about 27.8% of sales) in net income to liquor authorities and $5.84 billion (about 24.7% of sales) in taxes and other revenues.[3] These sales numbers are from the period before the COVID-19 pandemic;* alcohol sales have risen in 2020-2022.[4]

Harms resulting from alcohol use in 2017 cost Canadians $16.6 billion, representing 36.2% of the total costs of harms resulting from substance use. It is the most societally costly substance used in Canada,[5] with $5.4 billion in associated health care costs and $2.8 billion in criminal justice costs, as well as losses in productivity and other direct costs. Almost 20% of violent crimes were associated with alcohol use.

CPHA's engagement on the topic of alcohol use produced a series of resolutions between 1974 and 2007 (Appendix 1). In 2011, CPHA released the position statement *Too High a Cost: A Public Health Approach to Alcohol Policy in Canada*. Major national policy and regulatory changes since 2011 include ongoing implementation of the National Alcohol Strategy (NAS);[6] development of low-risk alcohol drinking guidelines (LRDG);[7] and establishment of minimum pricing requirements.[8] Each province/territory now requires alcoholic beverage servers to complete 'Smart Serve' training and certification.

However, excessive alcohol consumption and its impacts remain of concern. As such, it is time for CPHA to update its position concerning the regulation of alcohol consumption in Canada.

* The COVID-19 pandemic has resulted in increased alcohol consumption that is likely the result of boredom and/or stress. Changes in sales structures and policies in some jurisdictions may also have affected this increase. Effects of the pandemic on alcohol consumption are examined in papers by Canadian Centre on Substance Use and Addiction, Canadian Institutes of Health Research and the Chief Public Health Officer of Canada, and are therefore not addressed in this position statement.

DEFINITIONS

Alcohol: A common name for ethanol (CH_3CH_2OH), which is the principal pharmacological agent in alcoholic beverages. The name also refers to ethanol-containing beverages. Ethanol is not to be confused with methanol (methyl alcohol) or isopropanol (isopropyl alcohol), neither of which are potable (drinkable) but are components of household products.

Heavy Episodic Drinking (HED) (Binge Drinking): Consuming more than three (for females) or four (for males) standard drinks on a single occasion, which is in excess of the Low-Risk Alcohol Drinking Guidelines. (Canadian Centre on Substance Use and Addiction (CCSA)) Alternatively, the World Health Organization defines HED as consuming more than 60 g of pure alcohol (equivalent to six standard alcoholic drinks) on one occasion in the last 30 days.

Heavy Drinking: Refers to males who report having five or more drinks, or women who report having four or more drinks, on one occasion, at least once a month over the past year. (CCSA) It is also defined as consuming five or more drinks on one occasion, 12 or more times over the past year. (Statistics Canada)

Low-Risk Alcohol Drinking Guidelines (LRDG) (2011): Women: Up to a maximum of 10 drinks per week with no more than two drinks per day most days. Men: Up to a maximum of 15 drinks per week with no more than three drinks per day on most days. There should be a minimum of two non-drinking days every week. Revised LRDG are in development. (CCSA)

Standard Drink: A standard drink is determined by the alcohol content of the beverage. In Canada a standard drink is: one 341 mL (12 fluid ounce) beer with 5% alcohol content; one 341 mL (12 fluid ounce) container of cider or cooler with 5% alcohol content; 142 mL of wine (5 fluid ounces) with 12% alcohol content; or 43 mL (1.5 fluid ounces) of a distilled alcohol spirit with 40% alcohol content. (CCSA)

A NOTE ON DATA

This position statement uses the best available data representing a national perspective on the issue. The current standards for these data, however, limit the collection of information concerning race, ethnicity and socio-economic status. Grey and research literature results were used when national data were unavailable.

HEALTH EQUITY IMPACT ASSESSMENT

This draft position statement underwent a Health Equity Impact Assessment (HEIA) prior to final approval by CPHA's Board, using the methodology approved in December 2019. A group of volunteers from within CPHA's membership who did not participate in the development of the statement will conduct the assessment. The Association thanks these members for their work.

ACKNOWLEDGEMENT

The development of this position statement involved the efforts of volunteers and practicum students, each of whom added components to the work. The Association thanks them for their contributions.

RECOMMENDATIONS

CPHA calls on the federal government to:

- Thoroughly evaluate existing federal programs for alcohol regulation to assess their effectiveness; and
- Strengthen its leadership role in providing an evidence-based national perspective and direction in the development of alcohol control policy in Canada with the goal of minimizing the harms of alcohol consumption. Specifically:
  - Consider development of alcohol control approaches similar to that used for tobacco and cannabis; and
  - Provide national standards for data collection and reporting that encompass information concerning race, ethnicity and economic status.

CPHA calls on federal/provincial/territorial governments and municipal governments to:

- Strengthen regulations and enforcement of the marketing and promotion of alcohol, especially to populations most likely to experience negative effects of alcohol consumption, including:
  - Youth and young adults;
  - People who use alcohol to manage stress;
  - Women who are pregnant or about to become pregnant and who consume alcohol
  - Populations that historically exhibit harmful behaviours caused by alcohol over-consumption; and
  - People vulnerable to harms of polysubstance use, including alcohol consumption;
- Conduct performance evaluations, including cultural safety assessments, of existing programs to determine their effectiveness in reducing heavy drinking. Support and strengthen evidence-informed approaches that show effectiveness and eliminate those that do not;
- Conduct evaluations of programs designed to address heavy episodic drinking (HED) and high-risk drinking;
- Support research into the causes of alcohol over-consumption, and develop interventions based on harm reduction principles to address those issues;
- Support research into alcohol's relationship with intimate partner and other forms of violence, self-harm and suicide risk, and develop culturally appropriate interventions to mitigate these risks;
- Emphasize and integrate evidence-based public health protection, promotion and harm reduction approaches into policy, program and regulatory development; and
- Develop and implement equitable, trauma-informed, gender-informed and culturally-appropriate initiatives, including evidence-informed treatments and social supports, to prevent or moderate alcohol consumption and reduce its harms, targeted to populations most likely to experience negative effects of alcohol consumption (see list of populations above).*

CPHA encourages Indigenous (First Nations, Inuit and Métis) governance organizations to consider applying the above recommendations as appropriate to their own contexts, consistent with CPHA's recognition of the knowledge and governance systems of Indigenous Peoples and their right to self-determination.†

CPHA also calls on the alcohol beverages industry to support directly the work of non-governmental organizations to develop tailored interventions that consider gender and race/ethnicity in order to reduce alcohol over-consumption among populations more likely to over-consume.

---

* Equitable access to culturally appropriate alcohol-use disorder treatment programs is needed, but such initiatives are in the domain of primary practice and outside the ambit of public health.

† CPHA Policy Statement: Indigenous Relations and Reconciliation (October 2019).

CONTEXT

The historical prevalence of alcohol consumption

The consumption of ethanol (alcohol)*–containing beverages has existed across diverse cultures for most of the past 10,000 years. Berry wines were produced before 6400 BC, and Egyptians and Babylonians were drinking beers made from barley and wheat before the third millennium BC. Reasons for this use included hydration (given shortages of potable water) and caloric intake to meet human energy requirements. Distillation evolved around 700 AD in the Middle East or South Asia, leading to the development of beverages with higher alcohol concentrations. The introduction of distilled beverages tended to disrupt prior patterns of drinking wine and beer, bringing new social and health impacts.[9,10]

Alcohol was introduced to Canada by French and English explorers and settlers. It has become ubiquitous in Canadian society, with consumption levels fluctuating over time. The temperance movement accepted benefits of moderate drinking but condemned heavy drinking, and worked to introduce alcohol education in schools in several Canadian provinces. Later, individual provinces introduced prohibition until it became *de facto* national policy during World War I as a means of demonstrating patriotic duty and social sacrifice. By the 1920s, provincial policies shifted from prohibition to governmental control.[9]

* To reflect common practice, this paper uses 'alcohol' instead of the scientifically accurate 'ethanol'.

ALCOHOL CONSUMPTION IN CANADA

In 2015, the Chief Public Health Officer of Canada (CPHO) released an analysis of alcohol consumption in Canada[11] with the purpose of increasing societal awareness of alcohol's health effects. The report noted that:

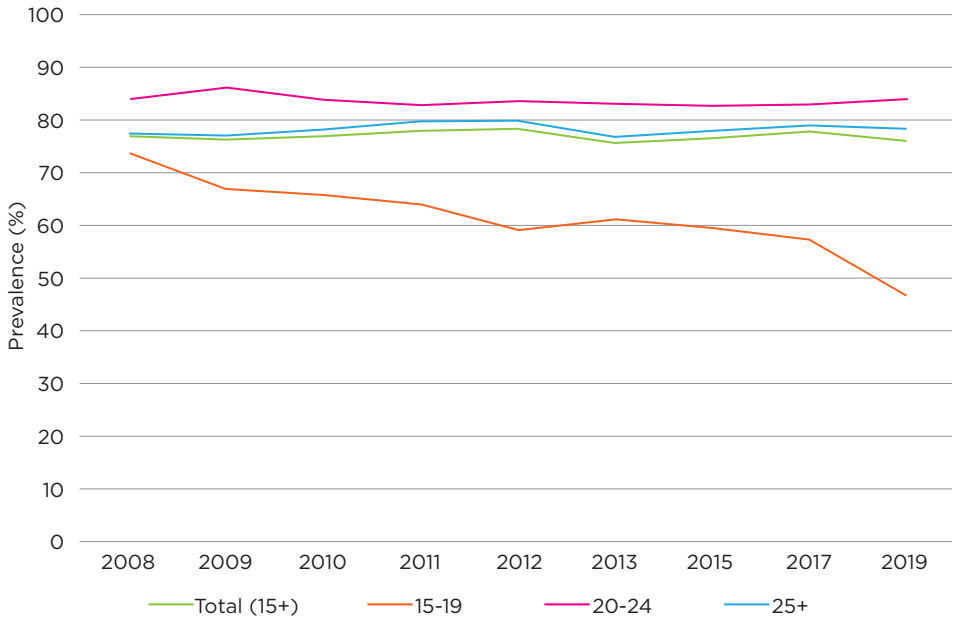
- In 2013, the CPHO report found that approximately 80% of the population drank alcohol in the previous year, with at least 3.1 million persons drinking enough to be at risk of immediate injury and 4.4 million being at risk of chronic effects;
- Volume and frequency of drinking influence health effects, and drinkers should consider Canada's Low-Risk Alcohol Drinking Guidelines (LRDG) as well as avoidance of alcohol during pregnancy;
- Social situations, family context and messaging can influence drinking patterns;
- Understanding is evolving of the dose-dependent nature of alcohol-related health effects;
- Youth are particularly vulnerable to the negative effects of alcohol; and
- Societal approaches could help control alcohol sales and consumption and reduce their negative impacts on Canadians.

The 2015 report also noted that gaps exist in the understanding of drinking patterns, risk factors, alcohol's impact on health, and the effectiveness of approaches to reduce these effects. More recently, the Public Health Agency of Canada (PHAC) published a plain-language summary of information about alcohol use in Canada.[12]

Alcohol Use

Health Canada and Statistics Canada collect data on alcohol consumption in Canada through the biennial Canadian Alcohol and Drugs Survey[13] (CADS) and

Figure 1 Past-year alcohol use, Canada 2008-2019



The 2019 estimate is a decrease from these years.

Source: Canadian Alcohol and Drugs Survey (CADS), 2019

the Canadian Student Tobacco, Alcohol and Drugs Survey[14] (CSTADS). The Canadian Community Health Survey (CCHS)[15] provides additional survey results, notably concerning heavy drinking. Unfortunately, these surveys are not directly comparable due to the different methodologies used to collect and analyze data. None of the surveys report data on race/ethnicity (including data concerning Indigenous Peoples), and only the CCHS collects baseline information on self-reported economic status. These data are summarized elsewhere.[16] Information about First Nations peoples living on reserve is available through the First Nations Regional Health Survey, with the most recent data found from the second round, dated 2008-10.[17]

These sources show that:*

- In 2019, about 76% of people in Canada aged 15 and over consumed alcohol, with the number of men and women roughly equal. Among drinkers, 23% exceeded the low-risk drinking guideline for chronic effects and 17% exceeded the guideline for acute effects.
- In 2019, 76% of Canadians (78% of men and 75% of women) reported drinking alcoholic beverages in the previous year. This included 84% in the 20 to 24 age group, 78% of adults over 24, and 46% of youth aged 15 to 19 (see Figure 1).
- About 44% of school-aged youths consumed alcohol at some point during 2018/19, with the proportion varying by grade. (Table 1)
- Data from Ontario show that the prevalence of alcohol consumption among students has decreased from 66% in 1999 to 41.7% in 2019.[18] Influencing factors associated with HED among post-secondary students in Canada include drinking being part of the culture; peer pressure; socializing/wanting to have fun; and lack of alternatives.[19] A review of the effect of drinking at the legal age of consumption identified the

* For this section, references are provided when information is included from sources other than the survey documents.

Table 1 Percent of students consuming alcohol by grade in Canada, 2018/19

Grade	% Drinking Alcohol
7	10.9
8	23.5
9	39.4
10	56.6
11	63.6
12	70.7

Table 2 Percentage of heavy drinking by age in Canada

Age	Percentage Heavy Drinking 2018	Percentage Heavy Drinking 2019
All persons over 12 years	19.1	18.3
12 to 17 years	3.4	2.7
18 to 34 years	28.7	26.9
35 to 49 years	22.9	22.2
50 to 64 years	19	18.8
Over 65 years	7.4	7.6

need for tailored interventions that consider gender differences, and the need to link such interventions to other effective policy responses targeting alcohol-related harms to young people.[20]

- The incidence of heavy drinking varies by age (Table 2), with individuals aged 18-34 years most likely to drink heavily. Approximately 2.3 times more men than women reported heavy drinking.
- Rates of alcohol consumption as a percentage of population varied by province, with the lowest levels in Prince Edward Island (68.4%) and Manitoba (71%) and the highest in Quebec (84.2%). In the other provinces, alcohol consumption ranged between 73.8% and 78.8% of the population aged 18 years and over. Manitoba reported the lowest rates of heavy drinking and Newfoundland and Labrador reported the highest, while those living in rural areas were more likely to report heavy drinking compared to those living in urban areas.[17]
- An additional measure of alcohol consumption is the absolute volume of alcohol sold per capita (to those over the legal age of consumption). In 2018-19, the Canadian average was 8.0 L. Volumes purchased ranged from 8.8 L (for British Columbia and Newfoundland and Labrador) to 6.8 L in New Brunswick, while those living in the Yukon purchased 13.0 L, Northwest Territories 11.9 L, and Nunavut (where alcohol sales are tightly controlled)* 3.6 L.[21]

* Regulations in Nunavut concerning importation, purchasing and consumption of alcohol vary across restricted and unrestricted communities.

Both current patterns of alcohol use and approaches to harm reduction must be considered comprehensively through a public health lens, as articulated in CPHA's Conceptual Framework. Such an approach aimed at addressing upstream factors and reducing health inequities implicitly informs this entire paper, even where only specific factors and interventions are discussed.

Further analysis is required to understand how inequities are linked to high alcohol consumption. A 2018 review of available data showed that:[22]

- Bisexual and lesbian women reported heavier drinking than heterosexual women, while rates were similar between bisexual or gay men and heterosexual men.
- Consumption rates among Black, South Asian, East/Southeast Asian and Arab/west Asian populations were lower than among white Canadians.
- People who were permanently unable to work reported less heavy drinking than those who worked.
- On average, heavy drinking becomes more prevalent as income increases (about 29% at the highest income level) compared to the lowest income group (about 20%), although rates of hospitalization due to alcohol among the lowest income group were approximately twice that among the highest income groups.[23] Another study observed a higher mortality rate among relatively young, mostly urban, lower-income

people with frequent alcohol-related emergency department visits.[24] However, further research is needed to understand the effect of co-variates such as the influence of nutrition or binge drinking patterns.

- Managers and those in skilled, technical and supervisory occupations had higher rates of heavy drinking than those in professional occupations.

A 2015 study showed that immigrant populations entering Ontario generally reported drinking less alcohol and having fewer related problems, with alcohol consumption rates representative of their country of origin. These levels tended to adjust to general population levels as their time in Ontario lengthened. In addition, the level of alcohol consumption adjusted to general population levels with each passing generation.[25]

With respect to Indigenous Peoples, results from the second phase of the First Nations Regional Health Survey (2008-10)[17] showed that 35.3% of First Nations adults living on reserve reported abstaining from alcohol (compared to about 23% of the non-Indigenous population at that time). During this time, however, 63.6% of First Nations adults reported HED monthly or more, while the rate of HED among non-Indigenous populations was 32% for persons 20 to 34 years old and 19% for those 35 to 44 years old.[26] These results were relatively unchanged from 2002-3. During 2008-10, 61% of First Nations youth living on reserve reported being abstinent while about half of youth who reported consuming alcohol reported binge drinking monthly or more often; this compares to an overall rate of about 20% for Ontario students in grades 7-12. The prevalence of heavy drinking among First Nations people living off reserve, Métis, and Inuit adults was 1.3 or 1.4 times that of non-Indigenous adults.[23] Studies also show high rates of alcohol use among some Métis youth and adults in various Canadian provinces.[27-29]

Underlying these statistics are the social and cultural effects resulting from racism, colonialization, cultural genocide and structural violence, and the results of dislocation from land, culture, spirituality, languages, traditional economies and governance systems. This trauma results in the erosion of family and social structures, and intergenerational trauma resulting in increased susceptibility to future illness. However, cultural interventions offer hope and the promise of healing from alcohol misuse for Indigenous Peoples.[30] *Honouring our Strengths* is a national framework to address substance use issues among First Nations peoples in Canada.[31]

Health Impacts

A 2021 review of current scientific literature described both benefits and harms of alcohol consumption.[32] Social and psychological benefits were associated with low to moderate alcohol consumption, while the physiological benefits included a potential reduced risk of heart disease, better sensitivity to insulin, and improvements in factors that influence blood clotting.[33] Genetic predisposition influenced these benefits and the effects were dose-dependent based on how much, what type and how often alcohol was consumed.

By contrast, a more recent study found that any level of alcohol consumption is linked with higher risk of cardiovascular disease, with risk rising exponentially as drinking levels increase. It also finds that previously-identified health benefits among light drinkers are actually due to lifestyle factors common to this population.[34]

However, heavy drinking harms various physiological systems as well as human behaviour. A 1981 report indicated a U-shaped relationship between alcohol and mortality, with low consumption levels possibly reducing mortality while high levels increased it.[35] In 2017, the rate of hospitalizations entirely caused by

Table 3 Overview of the dose-dependent health and behavioural effects of alcohol consumption
(Reproduced from *Alcohol Consumption in Canada*[11])

Direct Effects	Disease and Conditions	Functions and Systems	Behaviour
Risky drinking can cause: • Alcohol use disorders • Amnesia (e.g., Korsakoff's syndrome) • Memory loss and blackouts • Delirium due to a severe form of withdrawal • Fetal Alcohol Spectrum Disorder (FASD)	Drinking alcohol is linked to: • Other drug use disorders • Brain damage • Liver disease • Various cancers • Pancreatitis • Mental health disorders • Suicide • Stomach ulcers • Hypertension • Stroke • Cardiovascular disease • Diabetes • Sexually transmitted infections	Drinking alcohol affects the following systems: • Immune • Cognitive • Digestive • Cardiovascular • Respiratory • Neurologic • Endocrine • Musculoskeletal • Reproductive • Dermatological	Risky drinking can lead to: • Risky behaviour • Impulsivity • Violence • Injury • Poor memory • Impaired decision-making • Lack of coordination • Poor academic performance • Impaired social and occupational functioning

alcohol was comparable to that resulting from heart attacks.[36] These health effects (which are described elsewhere[11] and summarized in Table 3) are dose-dependent, with the likelihood of harm increasing as consumption increases.

This dose-dependent relationship influences the risk of various cancers, including oral, esophageal, larynx, liver, female breast and colorectal cancers.[33] In 2015, about 3,282 cancer cases in Canada were attributable to alcohol;[37] the risk of these cancers was approximately similar for light drinkers and non-drinkers, but it was significantly higher for heavy drinkers. Risk increases were highest for oral cavity and esophageal cancers, and were lowest for colorectal and female breast cancers. The combination of alcohol use with other risk factors such as tobacco use, unhealthy eating and lack of physical exercise further elevates risks.

The exception to this dose relationship is the effect of alcohol consumption during pregnancy. Fetal Alcohol Spectrum Disorder (FASD) is a range of health and behavioural problems that affect individuals exposed to alcohol prenatally. It is characterized by lifelong physical, learning and developmental disabilities, including hearing, speech and vision challenges, as well as learning, memory and coordination challenges. There is no known safe amount or time for alcohol consumption during pregnancy. Approximately 11% of Canadian women continue to consume alcohol during pregnancy.[38-40] Two factors that correlate with alcohol consumption during pregnancy are consumption levels before pregnancy and being in an abusive relationship.[41] In 2013, the economic burden of FASD in Canada was estimated at $1.8 billion.[42] A 2017 report estimated that more than 3000 babies are born with FASD in Canada each year, and about 300,000 people currently live with FASD.[43]

Of particular concern is the prevalence of FASD among Indigenous children. The available epidemiology provides mixed results, but FASD is known to have a disproportionate effect in some Indigenous communities in Canada, and is related to the pervasive and persistent effects of colonization, racism and cultural genocide.[44] *Truth & Reconciliation Call to Action #34: A Framework for Action* provides background on the complex issue of individuals with FASD in the justice system, with the aim of advancing the Truth and Reconciliation Commission's Call to Action to help improve outcomes for all individuals with FASD.[45]

Table 4 WHO global strategy to reduce harmful use of alcohol[52]

National Policy Options and Interventions	Global Action Priority Areas
• Leadership, awareness and commitment • Health services response • Community action • Driving under the influence (Drink Driving) policies and countermeasures • Availability of alcohol • Marketing of alcoholic beverages • Pricing policy • Reducing the negative consequences of drinking and alcohol intoxication • Reducing the public health impact of illicit alcohol and informally produced alcohol • Monitoring and surveillance	• Public health advocacy and partnership • Technical support and capacity building • Production and dissemination of knowledge • Resource mobilization

Economic and Social Effects

Health care and criminal justice costs are measures of the economic and social effects of alcohol. A 2017 report noted that hospitalizations from alcohol exceeded those from heart attacks, but the rates of hospitalizations due solely to alcohol varied by province.[46] Research and analysis into the differences in policies and interventions across Canada were identified as being important in reducing these costs, as was the need to develop policy alternatives. Two additional documents[47,48] have provided a longitudinal perspective on the costs and harms of substance use, including alcohol. One of the reports examining the period 2007-2014 found that hospitalization costs increased over time and that alcohol was the leading cause of lost productivity, resulting in $1.35 billion in other costs (e.g., research and prevention, fire damage, motor vehicle damage and workplace costs not covered by lost productivity). Health care costs attributable to alcohol increased 4.8% from 2015 to 2017.

These analyses also estimated the criminal justice costs associated with alcohol at $3.2 billion in 2014 and $2.8 billion in 2017. Despite an overall decrease in the incidence of alcohol-associated crime, criminal justice spending increased 6% from 2007 to 2014 but decreased 2.7% from 2015 to 2017. In 2015, there were 72,039 incidences of impaired driving as compared with 69,047 instances in 2017, with 96% of these cases involving alcohol.[33,43] Overconsumption of alcohol has been associated with consistent or recurring social and interpersonal issues, enhanced aggression and violence,[49] and intimate partner violence.[50] Research suggests that family members who are victims of alcohol-related harms may suffer social problems later in life,[49] while adverse childhood experiences may increase the risk of alcohol dependence.[51] A 2012 report by PHAC cites the World Health Organization (WHO) perspective on the relationship between excessive alcohol consumption and increased intimate partner violence.[52]

MANAGING ALCOHOL SALES AND CONSUMPTION

International Perspective

In 2010, the WHO identified ten national policy options and four priority areas for global action (Table 4).[53] Subsequently, five strategies were identified to reduce alcohol-related health and social harms:[54]

- Strengthen restrictions on alcohol availability;
- Advance and enforce alcohol-impaired driving measures;
- Facilitate access to screening, brief interventions, and treatment;
- Enforce bans and restrictions on advertising, sponsorship and promotion; and
- Increase alcohol pricing through excise taxes and pricing policies.

While the WHO study gives guidance from a global perspective, its applicability to higher-income countries with pre-existing legislation, regulation and policies similar to these interventions is uncertain. Appendix 2 presents a short summary of alcohol control strategies used by high-income nations similar to Canada.

Canadian Perspective — Federal

A complex matrix of roles and responsibilities at federal and provincial/territorial levels of government have evolved to manage the sale of alcohol, reflecting both the assignment of responsibilities within the *Constitution Act, 1867* and the responsibility of the provinces/territories (PTs) to act in the best interests of their populations.

Within this framework, the federal government has responsibility for controlling the import of alcoholic beverages (*Importation of Intoxicating Liquors Act* and *Spirit Drinks Trade Act*) and establishing and collecting excise duties on wine, beer and spirits (*Excise Act*). It is also responsible for implementing the requirements and associated regulations of the *Food and Drugs Act* as well as the *Safe Foods for Canadians Act* and its associated regulations. These acts and regulations address the manufacturing and labelling of alcoholic beverages in Canada. In addition, legal provisions for controlling impaired driving and violence, including that resulting from alcohol use, fall under the *Criminal Code of Canada*. The Canadian Radio and Television Commission implements the *Code for Broadcast Advertising of Alcoholic Beverages*.[55]

The Canadian Centre on Substance Use and Addiction (CCSA) leads in developing consistent information and policy direction with PTs, partners and stakeholders. CCSA steered development of the National Alcohol Strategy (NAS), which was in place from 2007 to 2017;[6] a renewed NAS is currently in development. The 2007 NAS provided 41 recommendations in four areas: health promotion, prevention and education; health impacts and treatments; availability of alcohol; and safer communities. A 2017 status report of the monitoring project for NAS indicated that several resources were developed with uptake and implementation in several provinces. Data availability to evaluate program effectiveness was limited and made program assessment difficult.[56]

The NAS resulted in development of the LRDG, which provides evidence-based information concerning the amount and timing of alcohol consumption to reduce the likelihood of harmful effects. In 2009, 12.7% of persons who reported consuming alcohol in the previous year exceeded the daily or weekly LRDG, while in 2017, 14.8% of this population exceeded the LRDGs for acute effects, and 20.8% exceeded the level for chronic effects. These results may be an underestimate, as many Canadians underreport their alcohol consumption.[33]

Canada's federal regulatory approach to managing alcohol differs from approaches used to manage tobacco and cannabis, two other legal substances of public health concern. To manage tobacco and cannabis, the federal government has promulgated acts and regulations that provide authority to control their manufacturing, advertising, packaging, and labelling. Strengths and weaknesses of the approaches used for tobacco and cannabis are presented in CPHA's position statement concerning tobacco and vaping devices and cannabis legalization.

In 2019, the Canadian Institute for Substance Use Research (CISUR) at the University of Victoria assessed the federal activities using a set of indicators that included the WHO criteria.[57] It gave Canada's federal government an overall failing grade and recommended improvements to strengthen federal actions (although some fell outside the federal mandate). While these proposals may improve the federal rating, the question

remains whether they will actually reduce the level of harms related to alcohol consumption, given the current regulatory structure. The WHO also provided a summary of Canadian alcohol control activities against the WHO criteria, noting that Canada's activities address many of them with the exception of regulations concerning product placement and health warnings on advertisements and labelling.[2] Thorough evaluation of existing federal programs for alcohol regulation is needed to assess their effectiveness.

Provinces and Territories

Provinces and territories are principally responsible for managing alcohol in their jurisdictions through the establishment of a legal drinking age, controls on sales of alcoholic beverages, and controls on the public consumption of alcohol.[58,59] In addition, municipalities can establish policy and bylaws to support these laws. The objectives of these actions include:

- Keeping neighbourhoods safe and enjoyable;
- Addressing concerns about the risks and liability related to alcohol;
- Setting community expectations about alcohol consumption;
- Providing community ownership through engagement;
- Setting conditions about the availability of and access to alcohol; and
- Supporting healthy lifestyles through community groups.

A review of the overarching approaches used by PTs was completed by CISUR using the approaches developed for their federal government assessment, and overall each PT received a poor evaluation.[60] The existing programs would benefit from evaluations of their effectiveness at reducing the harms associated with alcohol consumption. Those programs that work or show signs of working should be retained (and potentially enhanced or expanded) while ineffective ones should be eliminated.

MOVING FORWARD

The majority of Canadians use alcohol. When consumed in moderation, alcohol may provide social and psychological benefits, and have some health benefits. Excessive alcohol use can result in health and social harms including FASD, increased incidence of various health conditions, violence, and impaired driving, each with associated structural costs.

Policy, regulatory and other structures have evolved in an effort to reduce access, limit harms associated with over-consumption, and address the needs of those who drink heavily. Current approaches have resulted in about 78% of the population consuming alcohol, with many exceeding the LRDG. In addition, specific populations are more susceptible to heavy drinking.

Given the ubiquity of alcohol consumption in Canadian society, it is essential to develop and implement approaches focussed on those who are more likely to drink heavily and to address effects on their health and well-being, as well as that of their intimate partners, families and society. Harm reduction efforts should aim at moderating consumption among those who over-consume, using evidence-informed, gender-informed and culturally appropriate initiatives that address underlying reasons for over-consumption. These approaches are used in other public health contexts, such as substance use and sexual health interventions, and they are applicable to understanding why people drink alcohol and to addressing the circumstances that lead to overuse.

APPENDIX 1

CPHA Resolutions Concerning Alcohol, 1974-2007

1974	Policy Statement 2: Health Promotion
1991	Motion 3: Warning Labels on Alcoholic Beverages
1996	Discussion Paper: The Health Impacts of Unemployment
1997	Position Paper: Homelessness and Health
1999	Resolution 6: Video Lottery Terminals
2002	Position Paper 1: Position Paper on Injury Prevention and Control in Canada: The need for a Public Health Approach and National Leadership
2004	Resolution 3: Psychoactive Drugs – A Public Health Approach
2007	Resolution 2: Regulation of Psychoactive Substances in Canada

APPENDIX 2

Summary of Alcohol Control Provisions in Selected Countries

Australia

Australia's national alcohol strategy focuses on four priorities:

1. Protect the health, safety, and social well-being of alcohol drinkers and individuals around them by working towards less injury and violence, creating safer drinking settings, and providing improved offender treatment and rehabilitation.
2. Strengthen the control and access of alcohol to reduce availability, reduce promotion of risky and inappropriate alcohol marketing, and enhance pricing and taxation reforms of alcohol.
3. Promote the use of evidence-based information and support services, provide high-quality, responsive, safe and effective treatment, as well as implement the National FASD Strategic Action Plan.
4. Improve the awareness and communication of alcohol harms.

These guidelines were released in 2019. A formal evaluation of their effectiveness is not available.

New Zealand

New Zealand has outlined several strategies, including: pricing and taxation, regulating physical availability, restricting hours of sale, restricting sales in retail outlets such as grocery stores, enforcing off-premise regulation and legal requirements, bar staff training, policy around not serving intoxicated customers, codes of bar practice, community mobilization, lowering the blood alcohol concentration for driving and for youth, random breath test, license suspensions, designated rider and drive services, advertising bans and controlling advertising content, school-based education, and public service announcements. Its updated Sale and Supply of Alcohol Act came into effect in December 2013.

United Kingdom

The UK has a national alcohol strategy (dating from 2012) that outlines a minimum unit price of alcohol, bans the sale of multi-buy alcohol discounting, enhances the power of local areas to control the number of licensed premises, and introduces sobriety efforts. The objectives of these efforts are to reduce the "binge drinking" culture, reduce violence and disorder, as well as significantly reduce the levels of drinking that could damage individuals. Evaluation of its effectiveness were not found.

United States

In the US, some of the strategies used to reduce alcohol consumption include regulating alcohol outlet density, increasing alcohol taxes, increasing commercial shop liability, limiting days of sale, limiting hours of sale, using electronic screening and brief interventions, and enhancing the enforcement of laws prohibiting sales to minors. The Centers for Disease Control and Prevention recommends against privatizing the sale of alcohol because this would allow the government less control over the sale of alcohol.

Evaluation criteria for these proposals were not found.

REFERENCES

1. Statistics Canada, 2020. Control and sale of alcoholic beverages, year ending March 31, 2019.
2. WHO, 2018. Global status report on alcohol and health 2018. Geneva: World Health Organization, page 196.
3. Statistics Canada, 2021. Net income of liquor authorities and government revenue from sale of alcoholic beverages (x 1,000).
4. MHCC and CCSA, 2020. Mental Health and Substance Use during COVID-19. Summary report.
5. Canadian Substance Use Costs and Harms working group (2020). Canadian substance use costs and harms 2015-2017. Canadian Centre on Substance Use and Addiction.
6. Canadian Centre on Substance Use and Addiction, 2007. Reducing Alcohol-Related Harm in Canada: Toward a Culture of Moderation. Ottawa, ON: CCSA.
7. Canadian Centre on Substance Use and Addiction, 2018. Canada's Low-Risk Alcohol Drinking Guidelines [brochure]. Ottawa, ON: CCSA.
8. CPAC, 2018. Minimum pricing on alcohol: Provincial and territorial pricing policies.
9. Casper, R.L., 2015. Alcoholism. The Canadian Encyclopedia. Accessed October 16, 2020.
10. Stewart, S.H. 2004. The History, Current Prevalence, and Consequences of Drinking Problems in Canada.
11. CPHO, 2016. The Chief Public Health Officer's Report on the State of Public Health in Canada 2015. Alcohol consumption in Canada. Ottawa.
12. PHAC, 2021. Alcohol. Public Health Agency of Canada, Ottawa, ON.
13. Statistics Canada, 2019. Canadian Alcohol and Drugs Survey (CADS): Summary of results for 2019.
14. Statistics Canada, 2020. Detailed tables for the Canadian Student Tobacco, Alcohol and Drugs Survey 2018-2019.
15. Statistics Canada, 2020. Heavy drinking, by age group.
16. CCSA, 2019. Canadian Drug Summary Alcohol. Canadian Centre on Substance Use and Addiction. Ottawa. 17 p.
17. FNIGC, 2010. The First Nations Regional Health Survey (RHS) Phase 2 - 2008/10 Selected Results. First Nations Information Governance Centre.
18. Boak, A., Elton-Marshall, T., Mann, R.E., and Hamilton, H.A. 2020. Drug use among Ontario students, 1977-2019: Detailed findings from the Ontario Student Drug Use and Health Survey (OSDUHS). Toronto, ON: Centre for Addiction and Mental Health.
19. Meister, S.R., Barker, B., & Flores Pajot, M.-C. 2018. Heavy Episodic Drinking Among Post-secondary Students: Influencing Factors and Implications. Ottawa, ON: Canadian Centre on Substance Use and Addiction.
20. CCSA, 2017. The Impact and Effectiveness on Minimum Legal Drinking Age Legislation in Canada. Ottawa, ON: Canadian Centre on Substance Use and Addiction.
21. Statistics Canada, 2021. Sales of alcoholic beverages types by liquor authorities and other retail outlets, by value, volume, and absolute volume.
22. Public Health Agency of Canada and the Pan-Canadian Public Health Network, 2018. Key Health Inequalities in Canada: A National Portrait.
23. CIHI, 2017. Alcohol Harm in Canada. Canadian Institutes of Health Information, Ottawa.
24. Hulme, J., Sheikh, H., Xie, H., Gatov,E., Nagamuthu, C., and Kurdyak, P. 2020. Mortality among patients with frequent emergency department use for alcohol-related reasons in Ontario: a population-based cohort study. *CMAJ* 192 (47) E1522-E1531; DOI: https://doi.org/10.1503/cmaj.191730.
25. Agic, B., Mann, R.E., Tuck, A., Ialomiteanu, A., Bondy, S., Simich, L., and Ilie, G. 2015. Alcohol use among immigrants in Ontario, Canada. *Drug and Alcohol Review* 35 (2): 196-205.
26. CAMH, 2021. Partying and getting drunk.
27. Tourand, J., Smith, A., Poon, C., Stewart, D. & McCreary Centre Society (2016). Ta Saantii: A profile of Métis youth health in BC. Vancouver: McCreary Centre Society.
28. Martens, PJ., et al, Profile of Metis Health Status and Healthcare Utilization in Manitoba: A Population-Based Study. Winnipeg, MB: Manitoba Centre for Health Policy, June 2010, updated November 2012).
29. Métis Nation of Ontario and Cancer Care Ontario. Cancer in the Métis people of Ontario: Risk Factors and Screening Behaviours. Ottawa, 2015.
30. Rowan, M., Poole, N., Shea, B., et. al. 2014. Cultural interventions to treat addictions in Indigenous populations: Findings from a scoping study. *Substance Abuse Treatment, Prevention and Policy* 9: 34.
31. Thunderbird Fellowship Foundation, 2021. Honouring Our Strengths: A Renewed Framework to Address Substance Use Issues among First Nations People in Canada.
32. Anonymous, 2021. Alcohol: Balancing Risks and Benefits. Harvard University. T.H. Chan School of Public Health.
33. CPAC, 2021. Alcohol Policy and Cancer in Canada: Background and Key Statistics. Canadian Partnership against Cancer. Toronto.
34. Biddinger, K.J., Emdin, C.A., Haas, M.E., et al. Association of habitual alcohol intake with risk of cardiovascular disease. *JAMA Netw Open*. 2022;5(3):e223849.
35. Marmot, M.G., Shipley, M.J., Rose, G., and Thomas, B.J. 1981. Alcohol and Mortality: A U-shaped curve. *The Lancet* 317(8220) 580-583.
36. CCSA, 2019. Alcohol. Canadian Drug Summary. Canadian Centre on Substance Use and Addictions. Ottawa.
37. Grevers, X., Ruan, Y., Poirier, A.E., Walter, S.D., Villeneuve, P.J., Friedenreich, C.M., Brenner, D.R., and ComPARe Study Team. 2019. Estimates of the current and future burden of cancer attributable to alcohol consumption in Canada. *Preventive Medicine* 122:40-48.
38. Government of Canada, 2017. Fetal alcohol spectrum disorder (FASD).
39. FNHA, 2021. Fetal Alcohol Spectrum disorder (FASD).
40. Popova, S., Lange, S., Shield, K., Mihic, A., Chudley, A.E., Mukherjee, R.A.S., Bekmuradov, D., and Rehm, J. 2016. Comorbidity of fetal alcohol spectrum disorder: A systematic review and meta-analysis. *Lancet* 387(10022):978-987.
41. BC Centre of Excellence for Women's Health, 2021. Alcohol Use and Pregnancy.
42. Popova, S., Lange, S., Burd, L., and Rehm, J. 2016. The Economic Burden of Fetal Alcohol Spectrum Disorder in Canada in 2013. *Alcohol Alcohol*, 51(3):367-75.
43. Government of Canada, 2017. Fetal Alcohol Spectrum Disorder.
44. CanFASD, N.D. Indigenous.
45. Stewart, M. and Glowatski, K. 2018. Truth and reconciliation call to action #34: A framework for action. Canada FASD Research Network, Regina, SK.
46. Canadian Institute for Health Information, 2017. Alcohol Harm in Canada: Examining Hospitalizations Entirely Caused by Alcohol and Strategies to Reduce Alcohol Harm. Ottawa, ON: CIHI.
47. Canadian Substance Use Costs and Harms Scientific Working Group. (2020). Canadian substance use costs and harms 2015–2017. (Prepared by the Canadian Institute for Substance Use Research and the Canadian Centre on Substance Use and Addiction.) Ottawa, ON: CCSA.
48. Canadian Substance Use Costs and Harms Scientific Working Group, 2018. Canadian Substance Use Costs and Harms in the

Provinces and Territories (2007–2014). (Prepared by the Canadian Institute for Substance Use Research and the Canadian Centre on Substance Use and Addiction.) Ottawa, ON: CCSA.
49. Gerhard, G., Rehm, J. Harmful Alcohol Use. National Institute on Alcohol Abuse and Alcoholism. December 2003.
50. GreenFacts: Facts on Health and the Environment. Alcohol: 5. What social and economic problems are linked to alcohol use? Accessed October 30, 2020.
51. Pilowsky, D.J., Keyes, K.M., and Hasin, D.S., 2009. Adverse Childhood Events and Lifetime Alcohol Dependence. *Am J Public Health*, 99(2): 258–263.
52. PHAC, 2012. WHO Facts on Alcohol and Violence: Intimate partner violence and alcohol.
53. WHO, 2010. Global strategy to reduce harmful use of alcohol. Geneva: World Health Organization.
54. WHO, 2018. SAFER. Geneva: World Health Organization.
55. CRTC, 1996. Code for broadcast advertising of alcoholic beverages. Ottawa, ON: Canadian Radio and Television Commission.
56. CCSA, 2017. The National Alcohol Strategy Monitoring Project. A Status Report. Ottawa, ON: Canadian Centre on Substance Use and Addiction.
57. Wettlaufer, A., Vallance, K., Chow, C., Stockwell, T., Giesbrecht, N., April, N., Asbridge, M., Callaghan, R.C., Cukier, S., Hynes, G., Mann, R., Solomon, R., Thomas, G., Thompson, K. (2019). Strategies to Reduce Alcohol-Related Harms and Costs in Canada: A Review of Federal Policies. Victoria, BC: Canadian Institute for Substance Use Research, University of Victoria.
58. Canadian Free Trade Agreement, 2020. Alcohol Laws in Canada.
59. CCSA, 2021. Policy and Regulations (Alcohol). Ottawa, ON: Canadian Centre on Substance Use and Addiction.
60. CAPE, 2019. Canadian Alcohol Policy Evaluation. Canadian Institute for Substance Use Research.

CANADIAN
PUBLIC HEALTH
ASSOCIATION

The Voice of Public Health

The Canadian Public Health Association is the independent national voice and trusted advocate for public health, speaking up for people and populations to all levels of government.

For more information, contact:
Canadian Public Health Association
404-1525 Carling Avenue, Ottawa, ON K1Z 8R9
T: 613-725-3769 | info@cpha.ca

www.cpha.ca