THE DEVELOPMENT OF ALCOHOL POLICIES IN FEDERAL COUNTRIES

DIVISION OF MENTAL HEALTH
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The Development of Alcohol Policies in Federal Countries

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This document concerns the development of alcohol prevention policies in federal countries, with particular attention to initiatives that can be taken at the intermediate level of government to support national alcohol policy and local actions to prevent alcohol-related problems. There are advantages and disadvantages to systems in which policy making functions are shared among different levels of government. On one hand, national alcohol policy may be especially difficult to develop, coordinate and implement in federal systems. Alcohol policy development in such systems typically operates within a complex division of labour between federal, provincial and local governments. The division of authority between levels of government can create difficulties and ambiguities, as spheres of authority may be blurred or overlap. On the other hand, the involvement of provincial and local governments in alcohol policy formulation offers special opportunities for the initiation and implementation of prevention policies. In particular, federal systems may lead to more realistic consideration of regional and cultural diversities in policy-making and prevention programming. Further, federal systems can offer multiple points of access for prevention initiatives; economies of scale with regard to support services, research and training; and enhanced opportunities for experimentation in prevention programming.

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# Contents

<table>
<thead>
<tr>
<th>Section</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Introduction</td>
<td>1</td>
</tr>
<tr>
<td>1.1 Purpose and scope of document</td>
<td>1</td>
</tr>
<tr>
<td>1.2 Background</td>
<td>1</td>
</tr>
<tr>
<td>2. The structure of federal systems</td>
<td>2</td>
</tr>
<tr>
<td>2.1 General characteristics of federal systems</td>
<td>3</td>
</tr>
<tr>
<td>2.2 Division of authority in alcohol policy</td>
<td>3</td>
</tr>
<tr>
<td>3. Alcohol policy development</td>
<td>5</td>
</tr>
<tr>
<td>3.1 Opportunities for alcohol prevention in federal countries</td>
<td>5</td>
</tr>
<tr>
<td>3.1.1 Enhanced capability to take regional and cultural differences into account</td>
<td>5</td>
</tr>
<tr>
<td>3.1.2 Existence of multiple points of access for policy and programme initiatives</td>
<td>6</td>
</tr>
<tr>
<td>3.1.3 Enhanced economies of scale in prevention programming</td>
<td>7</td>
</tr>
<tr>
<td>3.1.4 Enhanced opportunity for piloting and evaluating prevention policies and programmes</td>
<td>8</td>
</tr>
<tr>
<td>3.2 Policy initiatives at the provincial level</td>
<td>8</td>
</tr>
<tr>
<td>3.2.1 Tax and price policy</td>
<td>9</td>
</tr>
<tr>
<td>3.2.2 Distribution and production</td>
<td>9</td>
</tr>
<tr>
<td>3.2.3 Alcohol education</td>
<td>11</td>
</tr>
<tr>
<td>3.2.4 Accident prevention</td>
<td>12</td>
</tr>
<tr>
<td>3.2.5 Public disorder</td>
<td>14</td>
</tr>
<tr>
<td>3.2.6 Promotion and advertising</td>
<td>14</td>
</tr>
<tr>
<td>3.2.7 Secondary prevention</td>
<td>15</td>
</tr>
<tr>
<td>3.3 Provincial initiatives and national policy objectives</td>
<td>16</td>
</tr>
<tr>
<td>4. Coordination of alcohol policy and programming</td>
<td>17</td>
</tr>
<tr>
<td>4.1 Coordination of federal and provincial prevention policy programming</td>
<td>17</td>
</tr>
<tr>
<td>4.2 Coordination of alcohol policy within federal and provincial governments</td>
<td>19</td>
</tr>
<tr>
<td>4.3 Coordination of alcohol policy with other health policy</td>
<td>20</td>
</tr>
<tr>
<td>4.4 Coordination of alcohol policy with other drug abuse policy</td>
<td>21</td>
</tr>
</tbody>
</table>
1. **Introduction**

1.1 **Purpose and scope of document**

This document concerns the development of alcohol prevention policies in federal countries, with particular attention to initiatives that can be taken at the intermediate level of government to support national alcohol policy and local actions to prevent alcohol-related problems. Particular attention is placed on variations among federal countries with regard to the division of authority in alcohol policy development, opportunities for the development of prevention policies in federal systems and issues regarding the coordination of alcohol prevention policy.

The document focuses on federal systems for a number of reasons. First, it should be noted that most of the world's population live in federal countries. Many highly populated member states of WHO, such as Brazil, China, India, Nigeria, the USA, and the USSR, have federal systems of government, as well as many less populous countries such as Canada and Switzerland. In federal countries a substantial share of alcohol regulation and programming is developed and implemented by intermediate level governments (referred to hereafter as "provincial" governments, whether called provinces, states, cantons or republics).

There are advantages and disadvantages to systems in which policy making functions are shared among different levels of government. On one hand, national alcohol policy may be especially difficult to develop, coordinate and implement in federal systems. Alcohol policy development in such systems typically operates within a complex division of labour between federal, provincial and local governments. The division of authority between levels of government can create difficulties and ambiguities, as spheres of authority may be blurred or overlap.

On the other hand, the involvement of provincial and local governments in alcohol policy formulation offers special opportunities for the initiation and implementation of prevention policies. In particular, federal systems may lead to more realistic consideration of regional and cultural diversities in policy-making and prevention programming. Further, federal systems can offer multiple points of access for prevention initiatives; economies of scale with regard to support services, research and training; and enhanced opportunities for experimentation in prevention programming.

1.2 **Background**

For the past fifteen years, the World Health Organization has strongly promoted a public health perspective in alcohol policy development. In 1975 an international group of alcohol researchers affiliated with the WHO/European Office critically reviewed the evidence regarding the relationship between legal controls on alcohol availability, mean levels of consumption and indices of alcohol-related problems (Bruun et al., 1975). To quote from their report:

"...our main argument is well substantiated: changes in the overall consumption of alcoholic beverages have a bearing on the health of the people in any society. Alcohol control measures can be used to limit consumption: thus, control of alcohol availability becomes a public health issue" (pp. 12-13).

In 1979 the World Health Assembly formally affirmed that alcohol problems are among the world's major public health problems (WHO, 1979a; 1979b; 1979c). In 1981, the WHO-affiliated International Study of Alcohol Control Experiences published a two-volume report presenting historical case studies on the development of alcohol policies in the post-World War II era in seven countries (Mäkelä et al., 1981; Single et al., 1981). In 1983 the World Health Assembly observed that increased alcohol consumption and alcohol-related problems are incompatible with the goals of achieving health for all by the year 2000.
To promote public health oriented alcohol policy, WHO has undertaken three interrelated activities. First, in 1985 WHO commissioned a "Review of National Policy Measures to Prevent Alcohol-related Problems" by Susan Farrell (WHO/MNH/ PAB/85.14). The review organizes national policy measures into three categories. Measures for which there is good evidence of effectiveness include increasing the relative price of alcoholic beverages, major restrictions in the distribution of alcohol, increasing the minimum legal drinking age and increasing the probability of detection and punishment for impaired driving. Measures widely believed to be effective despite the absence of confirming evidence include education of school children, the general public and professional health care workers. Measures for which the evidence of effectiveness is mixed include minor restrictions on the distribution of alcohol, regulation of advertising, promotion of low-alcohol content alternatives, and production controls (WHO/MNH/PAD/85.14).

Second, WHO has commissioned a paper by David Robinson and Philip Tether of the University of Hull on "Preventing Alcohol Problems: Local Prevention Activity and Compilation of 'Guides to Local Action'" (WHO/MNH/ADA/90.4). This document provides guidelines for local action on alcohol policy and prevention programming. Particular attention is given to public education, advertising, the media, safety issues, information and training of outlet staff, workplace, school programmes, professional education and law enforcement issues.

Third, in May of 1989 WHO convened a Consultation Group in Hull, UK, to discuss the special circumstances of alcohol policy development in federal systems (WHO/MNH/ PAD/89.3). Participants from Brazil, Canada, India, Nigeria, Switzerland, the United Kingdom, the United States of America, and the Union of Soviet Socialist Republics discussed the development of alcohol prevention policy in their respective countries, with special attention to the unique or particularly interesting aspects of the federal systems in each country. The Consultation Group recommended the preparation of a WHO review of alcohol policy development for federal countries, which would be based on the discussions at this meeting.

This document is the result of that recommendation. It begins with a discussion of differences regarding the division of authority between levels of government in federal systems. Opportunities for prevention initiatives in federal systems are then considered. Examples are provided of situations in which federal systems are able to enhance the capacity for regional and cultural differences to be taken into account in alcohol prevention programming.

The document then turns to the role of different levels of government in federal systems in various areas of alcohol policy, such as tax and price policies, educational programming, accident prevention efforts, and controls over the distribution and promotion of alcohol. Particular attention is placed on diverse initiatives that might be taken at the provincial level either independently or in support of national alcohol policy.

The final section of the document concerns the coordination of policy. Topics include mechanisms for the coordination of alcohol policy between different levels of government, the coordination of alcohol policy between different agencies at the provincial level, the coordination of alcohol and other health policies, and the coordination of policy regarding alcohol and other psychoactive substances.

2. The structure of federal systems

The principal characteristic of federal systems is the division of power between national and provincial governments. There is a large diversity in manner in which authority is differentiated between federal, provincial and local governments in federal systems. Indeed, every federal country is unique in this regard. In general, federal governments are typically responsible for defense, foreign affairs, external trade, transportation and national agricultural policy, while the provincial governments are primarily responsible for education, health, social welfare and (with local
governments) the police. Taxation is generally a shared responsibility, with sales taxes primarily directed toward the provincial governments and production or import taxes going to the federal governments.

2.1 General characteristics of federal systems

Two points should be noted regarding the general characteristics of federal systems. First, regardless of how they are structured, federal systems of government tend to be associated with cultural diversity and heterogeneity. This is not simply a matter of size. Brazil, Canada, India, the United States of America and the USSR might be expected to have federal systems, given their large geographic areas and cultural diversity. However, small countries also have federal systems. Perhaps Switzerland best illustrates this cultural diversity. Although small in size and population, there are three distinct language groups, as well as overlapping religious, regional and sociocultural distinctions between the 26 cantons of Switzerland. Thus, federal systems may be large or small in terms of geography and/or population size, but they are generally culturally heterogenous.

Second, in all federal countries the initiation and development of policy tends to be a responsibility which is shared between the executive and legislative arms of government. In many countries, the division of power between the executive and legislative branches of government is a prominent feature of the national constitution, as in the USA and the USSR. Even in parliamentary systems, where a large amount of power lies in the legislative arm of government, federal ministries in the executive branch of government typically play a major role in the initiation and development of policy. By the same token, even where the executive arm of the government holds the balance of power, the legislative arm generally plays a major role in policy development. Thus, for example, in Nigeria military rule has been in effect from 1966 to 1979 and from 1983 to the present. The parliamentary structures remain, but final authority rests with an Armed Forces Ruling Council. Nonetheless, the policy making process under military rule is otherwise similar to the previous procedures under the civilian government.

2.2 Division of authority in alcohol policy

With regard to alcohol policy, national governments in federal systems tend to have the greater share of responsibility for trade, interprovincial transportation, agricultural policy, production controls, national tourism, and excise or import taxation. Provincial governments (often with funding assistance and/or under federal guidelines) tend to be primarily responsible for regulation of conditions of sale, treatment, welfare programmes, education, and the police. In virtually all federal systems, the provincial level of government is minimally involved in a consultative role in policy development and always involved in policy implementation.

At one extreme are those countries where the provincial level of government is not only consulted, but primarily responsible for alcohol policy. In many policy arenas the federal government plays a very limited role in these countries. For example, compared with most other federations, the provincial governments in Canada have relatively more power and autonomy. The power to regulate municipal affairs, social welfare and education are all under the provincial jurisdiction. The provinces regulate the marketing and distribution of alcoholic beverages, while the federal government has jurisdiction over the manufacture, import, export, and interprovincial trade in alcoholic beverages. The ten provinces all have provincial monopolies on the off-premise sale of spirits, imported wines and imported beer. Domestic wine and beer are sold through monopoly outlets as well as private outlets in some provinces. The regulation of alcohol is part of the more general mandate of the provinces to maintain the public health and the economic well-being of the population.

The development of policy in Switzerland similarly has a strongly federal character. Switzerland is characterized by plebiscitary democracy in which policy issues are often resolved via popular initiative and referendum. Although the 26 cantons have considerable autonomy in health policy, alcohol policy is also a matter
of federal jurisdiction. Indeed, the federal government has operated a monopoly on the production and importation of spirits since 1887. Under the Swiss Constitution, 10% of the net monopoly proceeds are received by the cantons exclusively for "combating the causes and effects of alcoholism and drug abuse". However, the government monopoly is limited to spirits and the widespread domestic distillation of fruit spirits is exempt. Furthermore, various political forces make it very unlikely that the spirits monopoly will be broadened. Thus, the ability of the Swiss federal government to exercise control over access to alcohol through its monopoly is severely limited. The Constitution also explicitly grants cantons the right to regulate on-premise licensing and conditions of sale such as minimum legal drinking age. Given these constraints, federal initiatives for the prevention of alcohol problems have focused on utilizing general health promotion as a frame of reference.

India consists of 32 provincial level units (25 "states" and 7 "union territories"), each of which has a Governor, Council of Ministers and legislature. Under the Constitution, the provinces are responsible for raising the level of nutrition and standard of living and to improve public health (Article 47). Legislative powers are distributed between the federal and provincial legislatures, with residual powers not enumerated in the Constitution vested in the federal government. Some 66 different subjects are listed in which the provincial legislatures may enact laws, one of which is alcohol (intoxicating liquors). The production, possession, transport, purchase and sale of alcohol thus falls within the jurisdiction of the provinces.

Indeed, there is a specific mandate for the provinces to endeavor to bring about the prohibition of the nonmedical consumption of intoxicating drinks and drugs which are injurious to health. Two provinces (Gujarat and Lakshadweep) enforce total prohibition, a number of other provinces have partial prohibition and there are marked differences between provinces with regard to alcohol regulations.

Although alcohol regulation is primarily the responsibility of province governments in India, the federal parliament may exercise authority over province matters under a special constitution provision, and the federal government does impose excise and import taxes on alcohol. Furthermore, the central government has promoted alcohol prohibition and individual abstinence through a variety of administrative and welfare measures, and it has provided funding assistance to a large number of nongovernment organizations involved in the prevention and treatment of alcohol problems. In 1978 a comprehensive but ultimately unsuccessful programme was introduced to bring about total prohibition in four years. Thus, the central government plays an important, supplementary role in alcohol problem prevention, and authority over alcohol issues is very much a shared responsibility in India.

Nigeria, the most populous country in Africa, offers yet another example of the division of authority in a federal system. The central government is primarily concerned with defence, mining and energy, foreign affairs, national finance, customs and excise, transport and commerce. The 1979 Constitution lists a variety of subjects on which both the central and regional governments may legislate, provided that regional legislation is consistent with federal legislation. Health is one of the shared responsibilities, with the exception of external health relations, quarantine and the control of drugs and poisons, which are the exclusive responsibility of the federal government.

In the United States of America the federal government has taken certain initiatives regarding alcohol problem prevention. The USA Constitution is based on a division of powers between the three branches of the national government (legislative, executive and judicial) and between the national government and the provincial level of government (states). The national government is empowered to tax, to provide for the general welfare, and to regulate foreign and interprovincial commerce. It also provides substantial funding assistance for treatment, education and research on alcohol issues. However, the locus of alcohol control is with the provincial governments, which control the availability of alcohol and also have authority to tax alcoholic beverages.
Following the end of Prohibition in the USA in 1933, 32 provinces opted for the "license" system while 18 operate partial state monopolies over alcohol, typically involving a wholesale monopoly over distilled spirits and a retail monopoly over off-premise sale of spirits, or spirits and wine. There is considerable variation between provinces regarding conditions of sale and detailed alcohol control regulations.

In 1985, the federal government increased excise taxes on spirits by 19% over the previous level, established in 1951; federal excise taxes on beer and wine remain unchanged since 1951. Provincial taxes on alcoholic beverages have increased more frequently, but neither federal nor provincial taxes have kept pace with inflation. The federal government has taken a strong initiative to encourage the provincial level governments to adopt certain impaired driving countermeasures. Since 1982, provinces have been offered substantial financial incentives for adopting mandatory license suspensions for impaired drivers, mandatory jail terms or community service for recidivists, a 0.10% Blood Alcohol Concentration limit plus at least four of an additional 22 criteria, including the adoption of a 21-year minimum drinking age.

International economic alliances, such as the European Economic Community, the USA-Canada Free Trade Accord and the Australia-New Zealand New Economic Policy, have created pressure for the centralization of alcohol policy development and the elimination of provincial differences in controls over production and distribution. However, it would be premature to claim that there is a worldwide trend toward the centralization of alcohol policy development in the hands of national governments. In Mexico, the United Kingdom and in the USSR there is increased involvement in alcohol policy development by intermediate levels of government. In Canada, the federal government has explicitly rejected a national server training programme, instead choosing to promote the development of provincially based programmes in a variety of ways (Sing, 1990). Thus, there are numerous examples of decentralized prevention programming, and there is no clearly discernible trend toward the centralization of alcohol prevention policy.

These examples illustrate the diversity and complexity of arrangements regarding the division of authority on alcohol policy. If any pattern emerges, it would be that in federal systems, the national government tends to have greater responsibility for policies regarding the source of alcohol (production and international trade) while the provincial level of government is more concerned with policies and programmes concerned with distribution and demand. However, these are only general patterns. There is much overlap with regard to jurisdictional boundaries, and many if not most aspects of policy regarding both the supply and demand for alcoholic beverages involve the federal as well as provincial levels of government.

3. Alcohol policy development

3.1 Opportunities for alcohol prevention in federal countries

Given the complexity and diversity regarding the development of alcohol policy in federal countries, it is not possible to draw conclusions which would apply to all federal systems. Nonetheless, there are certain common features to most of these countries which enhance opportunities for the development of policies aimed at the prevention of alcohol-related problems.

3.1.1 Enhanced capability to take regional and cultural differences into account

Alcohol policy under all systems of government, whether federal or unitary in structure, necessarily involves both national and local governments and/or agencies. Local governments can initiate or help implement prevention policy, even where the locus of control is at the national level. In federal countries, there is a significant intermediate level of government which can help bridge the gap between national and local prevention activities. The involvement of provincial governments in alcohol policy development permits each region of a country to shape its own
response to alcohol issues and focus on its own prevention strategy. While the federal government may set the direction of prevention policy, provincial governments implement, enforce and mold federal policy.

There are numerous examples of how provincial governments enhance the capability to take important regional and cultural variations into account. Indeed, federal systems permit marked variations in the alcohol control systems for provinces. Regional and cultural differences are reflected by prohibition in particular regions of many countries, including Canada, India and the USSR, the development of "monopoly" systems in some parts of the USA and "private systems" in others, and a more liberalized policy regarding viticulture and access to wine, e.g. in Quebec compared to the rest of Canada.

A common mechanism for taking regional and cultural differences into account in federal systems is for the federal government to provide the general direction and funding of prevention programmes with the detailed planning and implementation of programmes put in the hands of provincial governments. This is typical of alcohol prevention programming the USSR as well as other federal countries. The USA federal government initiative to stimulate the introduction of impaired driving countermeasures at the provincial level, noted earlier, is a variation of this approach.

Federal systems help developing countries design prevention programmes which take traditional cultures in account. In 1975 the federal government of India introduced a 12-point prevention programme, with special stipulations regarding "tribal" areas. The programme included a ban on advertising and sale of alcohol in public places, severe restrictions on off-premise sales of alcohol, special enforcement personnel and provisions, and a widespread educational campaign. In the "tribal" areas with strong cultural traditions involving home-brewed alcohol, the programme stipulated that there should be no liquor shops at all, and that special efforts would be made to educate the people about the problems of alcohol abuse. In areas of Nigeria where traditional medicine is widely practiced, provincial level governments are seeking to gain a better understanding of these practices and to work with traditional medicine providers. Traditional health practitioners are trained to improve their skills and integrate modern practices, and the governments support research to evaluate traditional practices.

3.1.2 Existence of multiple points of access for policy and programme initiatives

Another major advantage of federal systems with regard to alcohol policy is that they provide additional points of access for policy and programme initiatives. When action is not forthcoming at one level of government, prevention programmes may be initiated at another level. Although alcohol advertising is permitted by the federal government in Canada, it has been subject to prohibition in some provinces (e.g. Manitoba and British Columbia). On the other hand, in Brazil it is doubtful if provinces would act to prohibit advertising, but it is banned under the federal constitution.

Initiatives by either a national or a provincial government can stimulate actions by the other level of government. Recent policy developments in the United States of America provide examples of this flow of influence in both directions. As noted earlier, provincial impaired driving countermeasures were largely stimulated by federal incentives, and the introduction of minimum drinking age of 21 by many provincial governments in the USA was influenced by a threat of federal action, specifically the denial of highway funds. On the other hand, recent USA federal action requiring a warning label on all alcoholic beverages was encouraged in part by the prospect that several provinces would enact labelling requirements.

Provincial governments may also influence each other with regard to alcohol prevention initiatives. They may learn from each other's experience, both from observing the consequences of actions taken and from listening to the public debate concerning a policy or programme initiative. For example, a change in the drinking
age by one province creates pressure on neighboring jurisdictions to do likewise. This is partly because the enactment of a particular initiative demonstrates its political support and public acceptance. It is also in part due to potential problems that can arise from a lack of uniformity in regulations. Border areas where there are differences in drinking age tend to have severe problems with impaired driving by youth who may legally drink in one jurisdiction but live in another.

Finally, it should also be noted that the additional points of access for alcohol policy in federal systems are available not only to advocates of public health initiatives aimed at preventing alcohol-related problems, but also to other interest groups seeking to increase the availability of alcohol. The alcohol industry in Canada, for example, constantly monitors policy developments in other jurisdictions, and through trade publications publicizes regulatory measures which involve the liberalization of alcohol controls. Thus, the "domino" effect noted earlier, whereby an initiative in one area impacts on neighboring jurisdictions, can work either for or against public health oriented public policy.

3.1.3 Enhanced economies of scale in prevention programming

A major advantage of large scale prevention programmes is that such activities frequently involve substantial economies of scale. Local prevention activities need not duplicate efforts in programme development and implementation is relatively uniform. On the other hand, unitary programme development on a national scale may fail to take important regional and cultural differences into account. In federal systems, the existence of a provincial governments often provides opportunities to bridge this gap and enhance the economies of scale in programme development. For many alcohol prevention activities, coordination and standardization at the provincial level minimizes the duplication of effort, and at the same time, permits regional and cultural differences to be taken into account.

In federal systems, these economies of scale are seen most often with regard to treatment, education and research. Whereas primary treatment may be provided on a local basis, it would be impractical to provide secondary and tertiary care services locally, as these involve specialized treatment services and therefore are most efficient for large catchment areas. However, a uniform system of alcohol abuse treatment services directed by the national government may not be as effective as provincially based treatment systems, because the appropriate treatment modalities may vary according to regional differences in the nature of alcohol-related problems and the manner in which alcohol problems interact or are exacerbated by other social problems. Thus, a common solution to the problem of providing adequate treatment services in a cost efficient manner is to provide primary care on the local level, but specialized treatment in provincially based facilities.

Similar economies of scale are often realized in federal systems with regard to education and training programmes. The federal government of the United States of America provides substantial financial assistance to provincial and local governments for the development of alcohol education programmes in the schools. In addition, the federal government develops some educational materials which provincial and local governments may utilize, if they wish. Responsibility for selection of curricula rests solely with provincial and local governments. The federal government of the USA has also established five regional centres offering advice, information and guidance on alcohol and other drug education. In Canada, server training programmes aimed at prevention alcohol-related problems in licensed establishments involve two distinct kinds of curriculum elements. First, there are those aspects which are specific to the legal situation in each province, such as the civil liability of persons who serve alcohol and the provincial alcohol regulations. Second, there are curriculum elements which would apply everywhere, such as factual information about the effects of alcohol, and how to recognize and manage intoxicated patrons. Rather than attempt to develop a national programme which would satisfactorily encompass alcohol regulations in every province, the federal government is developing guidelines for programme development, which would provide an information base for those aspects of server training involving transferable knowledge. It has also sponsored an analysis
of the legal environment governing alcohol service for those aspects of server training which are specific to each province.

Finally, the results of research and evaluation can be effectively utilized in federal systems. The sharing of basic research and the evaluation of prevention initiatives at the provincial level reduces the need for each province to individually invest in such research. This is particularly true where there are major centres of alcohol research which are funded by or affiliated with provincial universities or governments, such as the Addiction Research Foundation of Ontario in Canada.

3.1.4 Enhanced opportunity for piloting and evaluating prevention policies and programmes

A further potential advantage of federal systems is the enhanced opportunity for testing and evaluating alternative prevention initiatives. Provincial variation in policy and programming provides feedback regarding the effectiveness of alternatives under different conditions. The very existence of significant differences in control policies between provincial governments provides researchers with rich data for evaluation. Thus, for example, USA jurisdictions which have a monopoly system and those with a private licence system have been compared in terms of consumption and alcohol-related problems (Popham et al., 1976). There are numerous examples of policy evaluations based on quasi-experimental designs comparing a particular jurisdiction where a particular intervention has occurred with a similar jurisdiction in which there was no such intervention (see, e.g., Cook & Tauchen, 1982). Research on drunk driving frequently uses time series designs to test intervention effects such as the introduction of a breathalyzer campaign (Ross, 1988). Similarly, research on the impact of alcohol advertising frequently compares jurisdictions which have introduced prohibition of advertising with similar jurisdictions where advertising is permitted (Smart, 1988).

Furthermore, provincial variations facilitate the piloting of prevention policy and programmes. This may be represent a deliberate trial where the outcome is uncertain, or it may be an unplanned, de facto piloting. There are also numerous examples of prevention programmes being tried in particular provinces before being introduced on a larger scale. In Switzerland two provinces adopted a law which requires bars and restaurants to make alternative beverages available at the same or lower prices than beer, which is generally the least expensive alcoholic beverage. Research indicated that this measure was successful, and 13 other provincial level governments have now adopted similar regulations. In Canada, the National Steering Committee on Impaired Driving was reluctant to support and promote server training programmes without firm evidence of its effectiveness in reducing alcohol-related problems in bars and restaurants. Therefore, it funded an controlled study which evaluated a provincially sponsored programme, the Addiction Research Foundation’s “SIP” programme (Glickman et al., 1988). Once the programme’s effectiveness was established, server training programmes received a great deal of support from both the federal government and other provincial governments (Single, 1990).

3.2 Policy initiatives at the provincial level

Thus, federal systems offer a number of opportunities for prevention initiatives. In many circumstances federal countries are able to take important regional and cultural differences into account, they provide multiple points of access for policy and programme initiatives, they offer certain economies of scale in programme development and implementation, and they provide a rich environment for research and evaluation. The discussion will now consider some specific kinds of alcohol prevention policies and programmes. Particular attention will be given to the initiatives that can be taken at the provincial level to reduce alcohol problems and support national policy and/or local prevention efforts.
3.2.1 Tax and price policy

The WHO "Review of National Policy Measures to Prevent Alcohol-related Problems" identifies tax and price policy as a prevention measure for which there is good evidence of effectiveness:

"The sum of scientific evidence and historical experience affirms that, other factors being constant, an increase in the price of alcoholic beverages relative to other commodities generally reduces per capita consumption ... More recently, there is also explicit evidence that the price of alcohol, acting through its effects on consumption, influences the level of alcohol-related problems." (WHO/MNH/FAD/85.14, p. 11)

The WHO Project on the Potential Contribution of State Monopoly Systems to the Prevention of Alcohol-related Problems found that, regardless of whether there is a federal or unitary structure, those countries with government owned alcohol monopolies tend to have greater control over the price and availability of alcohol and they have lower rates of consumption (Kortteinen, 1989). However, this is not a simple causal relationship. Cultures predisposed to lower alcohol consumption are in many ways more likely to adopt a monopoly system. Further, the simple existence of a government alcohol monopoly will not result in low rates of consumption unless the alcohol monopoly is used for this purpose.

In those federal systems with government monopolies, the alcohol monopoly may be either at the federal level (e.g. Finland, Sweden, Norway, the USSR and Switzerland) or at the provincial level (Canada and the USA "monopoly states"). In any event, tax and price policy almost always involves both the federal and provincial governments. Even in those countries where most or all alcohol tax revenue flows to the national government (e.g., Brazil, Nigeria, Switzerland, and the USSR), much of these revenues are returned to the provincial and local levels of government. In some federal systems, the bulk of alcohol taxation is collected by provincial governments (e.g. Canada and the USA), even though the federal governments may still collect substantial excise, import and sales taxes.

Provincial governments can do much to promote a public health oriented tax and price policy. In addition to supporting national initiatives for preventive tax measures, provinces can initiate their own initiatives, e.g. to link provincial alcohol taxation to the consumer price index so that the real price of alcohol is not permitted to decline and thereby spur consumption. They can adjust the relative provincial taxation on different types of alcoholic beverages to reduce the incidence of more harmful drinking patterns particular to the province. Thus, for example, in 1972 the Ontario government increased the taxes on fortified wines in order to reduce consumption by Skid-row inebriates (Single et al., 1981). Provinces may even be able to influence the very definition of alcohol and thereby determine the scope of alcohol control measures generally and alcohol taxes in particular. This is particularly relevant to those countries where particular types of alcoholic beverages are exempt from taxation and other alcohol regulations.

3.2.2 Distribution and production

It has generally been found that alcoholic beverages behave like other commodities on the market in that there is a positive relationship between the availability of alcoholic beverages and levels of consumption (Broun et al., 1973; Macdonald & Whitehead, 1983; Smith, 1983; Single 1988). The WHO "Review of National Policy Measures to Prevent Alcohol-related Problems" identifies sharp restrictions on distribution as having relatively good evidence of effectiveness while the evidence regarding other restrictions on distribution is mixed (WHO/ MNH/FAD/85.14).

Production controls are more often under the jurisdiction of the national government rather than provincial governments in federal systems. Nevertheless, in many federal countries there are opportunities for provinces to impose additional controls over production. Even where the regulation of production is mainly or
exclusively a matter of federal authority, provincial governments are typically involved in the planning and policy making process. This is especially true for socialist countries, where production controls represent a potential mechanism for controlling consumption and thus reducing alcohol-related problems. Thus, the planning processes of the USSR provide the provincial level governments with opportunities to influence production of alcoholic beverages.

While the provincial role in regulating production is somewhat limited, provincial governments often have a significant influence on the distribution of alcoholic beverages. In most federal systems, decision-making regarding licensing of on-premise outlets is in the hands of provincial and/or local governments. Thus they may control the density of licensed establishments. There are several recent reviews of research on the relationship between the number of alcohol outlets and alcohol problems (Macdonald & Whitehead, 1983; Smith, 1983; Single 1988), all of which reach the same basic conclusion. As stated by Macdonald & Whitehead:

"The weight of evidence, especially when one takes into account the quality of the studies, is on the side of the availability of outlets accounting for some of the variance in the extent of alcohol consumption. The availability of outlets for off-premise consumption appears to be more sensitive than the availability of on-premise consumption, but the impact of the latter cannot be treated as trivial without further study".

It should be noted that it is not always clear whether a greater number of on-premise and off-premise outlets stimulates increased alcohol consumption or whether it is merely a response to increased demand. The available evidence indicates that the density of outlets is both a cause and a consequence of consumer demand.

Licensing authority also enables either provincial or local governments to determine hours and days of operation. There is considerable variation with regard to days of operation between Mexican provinces, for example, with special bans on selling alcohol on weekends or special occasions such as election days and during festivals in particular areas. Controls on hours of operation of alcohol outlets have been found in a number of settings to be related to consumption patterns and alcohol problems. Arrests for public drunkenness are correlated with hours of tavern operation in Toronto (Popham, 1982). In Victoria, Australia, tavern hours were changed in 1969 in an attempt to reduce the problems associated with a 6 p.m. closing time. Workers had been drinking large quantities so rapidly during the brief time after work when drink was available that the time immediately prior to closing was known as the "six o'clock swill". When the closing time was extended to 10 p.m., there was not only a corresponding change in the temporal pattern of traffic accidents, but there was also an 11.5% increase in the total number of casualty accidents from 6:01 p.m. to 2:00 a.m. (Smith, 1988).

Provincial governments frequently determine important conditions of sale which represent potential prevention measures such as the minimum drinking age. Research regarding the impact of age restrictions indicates that the lower the drinking age, the lower the age at which adolescents first use alcohol, the higher the alcohol consumption (Smart & Schmidt, 1975; Rooney & Schwarz, 1977; Smart, 1977; Smart, 1980; Wagenaar, 1982) and the higher the indices of alcohol-related problems among teenagers (Douglas et al., 1974; Smart & Goodstadt, 1977; Smith, 1986). Thus, provinces can initiate higher minimum drinking ages as a preventive measure to support national policy and reduce alcohol problems.

Another aspect of distribution concerns the availability of alternative low-alcohol or nonalcoholic beverages. Provincial governments can develop policies to promote low-alcohol content or nonalcoholic alternatives. Thus, for example, Ontario is promoting very low alcohol content beers and wine in its monopoly stores, even though these products would not normally qualify to be kept in stock because they would fail to meet minimum sales requirements.
There are yet other, perhaps less obvious, ways in which provincial governments can influence alcohol distribution and thereby prevent alcohol-related problems. For example, provinces can enact statutes which make licensed establishments legally responsible for damages and injuries caused by intoxicated patrons or guests. In several countries there has been a growing number of such liability law suits against bars and taverns. Many of these suits have been brought under special statutes establishing the liability of bars and restaurants as alcohol providers (referred to as “dram shop laws” in the USA and “provider liability” statutes in Canada) and as owners of premises (referred to as “occupier’s” liability laws). The Prevention Research Center in California has drafted a “model dram shop act” (Moshier, 1984) which has been enacted in several USA jurisdictions and similar provincial legislation has been enacted in Canada (Solomon & Uspicht, 1990).

Civil law can thus been used as a mechanism for the prevention of alcohol-related problems in commercial alcohol outlets. Furthermore, in Canada and in some provincial level jurisdictions within the USA, the civil liability of persons who provide alcohol to others applies to social hosts as well as commercial providers (Solomon & Uspicht, 1990). While the widespread use of civil suits is thus far limited to only a few countries, these developments point out other ways in which provincial level of government can act to prevent alcohol-related problems.

3.2.3 Alcohol education

Alcohol educational programming represents another area of prevention policy in which provincial governments are heavily involved. The WHO document on national policy measures (WHO/MNH/PAB/85.14) listed education of school children and the general public as a prevention measure which is widely believed to be effective, though little scientific evidence is currently available. In many federal systems, the province is the most appropriate level for the development of curriculum for school-based programmes and for the delivery of public messages in media campaigns. The province may be large enough to offer significant economies of scale and avoid unnecessary duplication of efforts by local communities, yet small enough to allow the educational messages to be tailored to the particular conditions, problems and audiences in the area.

In many federal countries the provincial government is particularly suited for the development of alcohol education programmes aimed at professionals and primary care workers, as specialized treatment facilities and teaching hospitals are rarely available at the local level.

With regard to education programming aimed at school children and the general public, the federal government may provide leadership by indicating desirable programme directions and goals, as well as by funding programme development and evaluation. In the USSR alcohol education programmes are developed by member republics, under guidelines established by the national government. In Canada, India, the United States of America, and, indeed, most federal countries, alcohol education programmes are developed at the provincial and local level either by government or nongovernmental agencies, but the federal government provides funding and technical assistance. This permits significant variation in alcohol education programming. For example, in Nigeria there is no alcohol education in the northern, Moslem provinces where alcohol consumption is very low.

In many systems, provincial governments also work in collaboration with nongovernmental organizations on alcohol education programming. In some countries nongovernmental organizations actually develop and carry out most or all of alcohol education, with funding channeled through the provincial governments. The provincial government is often in a better position than the federal government to make funding decisions between alternative programmes in a particular region.
3.2.4 Accident prevention

The prevention of accidents is another area of alcohol prevention in which provincial governments can and do play an important role. Alcohol use is a major contributory factor in home accidents, industrial accidents, fires and traffic accidents. Alcohol use is responsible not only for a high toll in road traffic injuries, death and damage, but also for many boating, airplane, railroad and other transport accidents. In some underdeveloped countries, the prevention of impaired operation of boats may be as important as the prevention of alcohol-related road accidents. For most societies, however, the most salient public concern about alcohol-related accidents is the prevention of drunk driving. Indeed, in all societies where there is significant alcohol consumption and any appreciable volume of road traffic, impaired driving is a major public concern and a primary target of prevention programming.

The two major approaches to the prevention of drinking and driving have been deterrence through criminal sanctions, and education or rehabilitation of impaired drivers. Increasing the probability of detection and punishment for drinking and driving was identified in the WHO document on national policies (WHO/MNH/PAD/85.14) as a prevention measure for which there is good evidence of effectiveness. This conclusion is based on short-term reductions in traffic deaths and injuries following the adoption of such laws in several European countries, Canada and New Zealand. For example, roadside breathalizer campaigns in the United Kingdom in 1987 resulted in marked short-term reduction in impaired driving accidents (Ross, 1988).

Provincial governments have played a leadership role in promoting successful campaigns to deter impaired driving. Since 1982, alcohol-related traffic fatalities declined markedly following a random breathalizer testing instituted by the government of New South Wales in Australia, with a 36% decrease in a five-year span (Homel, 1988; Prescott, 1988). However, no similar trend was found in other Australian provinces when random breath testing was introduced (Armstrong & Howell, 1988). The success of the New South Wales government has been attributed to the vigor of enforcement and the influence of other control measures, particularly the lowering of the permitted Blood Alcohol Concentration levels (Armstrong & Howell, 1988). In Canada there are a number of examples of provincially sponsored enforcement campaigns which generally showed similar, if somewhat less dramatic, results. The Check-Stop programme in Alberta resulted in a 10% decrease in fatal accidents and a 16% decrease in alcohol involvement in fatal accidents (Alberta Solicitor General, 1984). The experience of Project Counterattack in British Columbia and the Ontario "RIDE" (Reduce Impaired Driving Everywhere) is similarly considered to be effective.

However, it must also be noted that despite the extensive allocation of law enforcement resources to impaired driving countermeasures in many countries, the use of criminal sanctions to deter drunk driving has generally met with only limited, short-term success. Nor is it likely that impaired driving can be reduced simply by increasing penalties (Ross, 1988). Rather, the failure of many drinking and driving programmes to achieve a major and lasting deterrent effect is largely due to difficulties in raising the chances of apprehension to a point where the ordinary drivers feel that the chances of apprehension are more than negligible.

Given the limited success of deterrence, there has been increasing interest in voluntary methods to ensure compliance-education and rehabilitation. In North America and elsewhere there are many school programmes aimed at the prevention of impaired driving (see Mann et al., 1988). These programmes focus on alternatives to drinking and driving (e.g. alcohol-free parties, responsible hosting), improved decision-making skills, improved skills at resisting peer pressures to drink excessively or to drink and drive, and critical examination of peer and community attitudes regarding drinking and driving. The evidence concerning the effectiveness of school programmes is limited, largely to short-term changes in attitudes and knowledge, but it is nonetheless encouraging (Mann et al., 1988).
Rehabilitation programmes for convicted impaired driver have been mandated by provincial level governments (e.g. California and Alberta). Evaluation studies have found that rehabilitation programmes tend to have positive effects on knowledge and attitudes and that some programmes have succeeded in reducing future violations of impaired driving laws. However, no study has yet reported a positive effect on drinking behaviour and lifestyle (Mann et al., 1983). The apparently positive, but modest effects of rehabilitation indicate that it should be viewed as a potentially effective supplement, but not a replacement, for punitive sanctions such as licence suspension.

There are several other approaches which provincial governments could take to support national and local programmes against impaired driving. First, provincial legislation can supplement national laws against impaired driving. Thus, for example, in a number of Brazilian and USA provinces, alcohol may not be sold at gas stations. Australian provinces have special statutory limitations regarding permitted blood alcohol levels for probationary drivers, ranging from 0 to .02%. Although the legal blood alcohol limit for impaired driving under federal criminal legislation is .08% in Canada, Ontario has a statutory 12-hour licence suspension for drivers found to have blood alcohol levels over .05%. Thus, Ontario drivers found to have blood alcohol levels below the federal limit but over .05% are not charged with impaired driving, but they must immediately stop driving, find another method to reach their destinations and arrange to come back the next day to retrieve their automobiles.

Second, any effective efforts on the part of provincial governments to generally improve highway and vehicle safety would undoubtedly help to reduce the toll of injuries and deaths caused by impaired drivers.

Third, provincial regulations and prevention programmes which impact on the availability of alcohol can also affect levels of impaired driving. After all, drinking and driving is by definition a combination of two key elements: drinking alcohol and driving a motor vehicle. Any measure which reduces drinking or the use of motor vehicles will likely reduce drinking and driving incidents. Thus, for example, during World War II production shortages led to a marked reduction in the availability of alcohol in many countries in Europe. This, combined with the scarcity of cars and petrol, led to a dramatic decrease in drinking and driving (Bruun et al., 1975). Drinking and driving incidents declined during the oil shortage of 1973 in Canada and the USA. Similarly, provincial support for public transportation can reduce drinking and driving.

Finally, a relatively new approach to the prevention of drunk driving by provincial governments is the use of server training programmes to influence the behaviour of persons who serve alcohol to others. In part as a response the increasing threat of civil liability law suits, noted earlier, in Canada and the USA programmes have been developed to train serving staff in drinking establishments with regard to their legal obligations, the effects of alcohol, how to recognize intoxication, how to prevent intoxication and how to manage an intoxicated patron to minimize problems such as aggressive behaviour and impaired driving. Similar programmes have also been developed in Australia. These server training programmes have had widespread support from provincial governments in these countries (Single, 1980), and five provincial level governments (Oregon, Utah, Vermont, British Columbia and Ontario) have made it mandatory for serving staff in on-premise establishments to be trained in responsible beverage service.

There is preliminary evidence from Canada and the USA that server training has had positive results. To date there have been four evaluation studies, all of which indicate that server training helps serving staff understand their rights and obligations under the law, increases compliance with alcohol regulations, and successfully develops skills necessary to prevent problems from occurring in licensed establishments (Saltz, 1987; Geller et al., 1987; USA National Highway Traffic Safety Administration, 1987; Gliksonman et al., 1988). However, the long-term effects of server training and the net impact on rates of impaired driving have yet to be determined. Nevertheless, the use of civil law and server training, which focus on
the drinking environment rather than the individual drinker, represents a new and potentially effective supplement to other countermeasures against impaired driving.

### 3.2.5 Public Disorder

Problems of public disorder include public drunkenness and alcohol-related violence. There is considerable evidence from both experimental and natural situations that drunkenness is strongly associated with aggressiveness, even though it may not inevitably produce violence. Experiments have found that intoxicated subjects tend to be more aggressive in their behaviour towards others than were placebo or non-drinking subjects (see, e.g., Zeichner & Pihl, 1980). In natural barroom settings, several studies have observed a significant correlation between alcohol consumption and aggressiveness (Graham et al., 1978; Graham et al., 1980, Graves et al., 1981; Single, 1988). The research literature on the tavern has identified a number of situational variables which correlate with aggressiveness (Single, 1985), but it is not clear whether particular environments inspire aggression or whether violent people are attracted to particular environments.

The major mechanism for deterring alcohol-related aggression is deterrence via criminal sanctions for the violent behaviour per se. Provincial and local governments can help reduce alcohol-related violence by licensing regulations which prohibit selling or serving alcohol to the intoxicated and by initiating or supporting special measures to prevent alcohol-related aggression at large public events such as political rallies and sporting events. Provincial prohibitions against alcohol on election days or the in vicinity of soccer matches are examples of such measures.

There are often provincial and/or local laws against public drunkenness. However, over the past two decades these laws have been repealed, modified or enforced less vigorously in many countries so that public inebriates are more often sent to detoxification or other treatment centres instead of jail (Mäkelä et al., 1981). Whether public inebriates are directed to the criminal justice system or to the treatment system, it is the provincial level of government which often bears the burden of responsibility for the management of this problem.

### 3.2.6 Promotion and Advertising

An on-going issue concerning alcohol policy is the impact of controls over the advertising of alcoholic beverages. On one hand, citizen groups and many health professionals have advocated a ban on all forms of alcohol advertising on the grounds that it increases alcohol consumption and alcohol problems. On the other hand, the media and the alcoholic beverage producers have argued that alcohol advertising only affects brand preferences and does not increase overall alcohol consumption.

There is an increasing volume of research concerning the impact of advertising on alcohol consumption. A recent review (Smart, 1988) distinguished four types of studies on this topic: studies of advertising bans, econometric studies on the impact of incremental changes in advertising expenditures, studies on individual exposure to advertising, and experimental research on the effects of advertising. In general, this body of advertising research has produced inconclusive results. While some econometric studies have reported a small effect of advertising on sales and some experimental studies have found an impact either among persons already drinking or up to a certain level of exposure, there is contrary evidence from other studies. On balance, therefore, it cannot be claimed research supports the conclusion that advertising increases alcohol consumption.

By the same token, however, it also cannot be claimed that there is sufficient research evidence to reject the contention that advertising affects alcohol consumption. All of the research on the impact of advertising suffers from certain key limitations. First, advertising is only one of many factors which may influence alcohol consumption. Even if advertising did have an impact, its influence would likely be small relative to other factors such as price and disposable income. A
relatively small advertising effect could easily be masked by these confounding influences. Second, advertising is typically targeted at particular groups whereas the research on its effects is not. Thus, impacts on youth or other target groups might fail to appear in research evaluations. Finally and perhaps most importantly, all of the research to date has focussed on very short-term impacts of advertising. It may well be that most important consequences of advertising are cumulative effects which are extremely difficult to detect and require expensive, long-term research designs.

Clearly then, research on the impact of advertising is equivocal. The regulation of advertising and promotions tends to be an area of joint responsibility for the national and provincial levels of government in federal systems. In those countries where advertising is permitted but must be approved in advance, federal agencies typically involve provincial officials in a consultative role or as participants in a review process. In many situations, the provincial governments can initiate more restrictive measures than the federal government. Thus, e.g., some Canadian provinces have legislated a ban on alcohol advertising in the broadcast media. The Ontario government requires that alcohol producers spend at least 10% of their advertising budgets on public service messages promoting responsibility in drinking. Provincial governments may also enact regulations governing special promotions, such as conditions under which free product may be distributed, prohibitions or restrictions against alcohol sponsorship of sporting events or events associated with minors.

3.2.7 Secondary prevention

Treatment and prevention are occasionally portrayed as entirely separate concepts which represent alternative strategies for public policy. Whereas the primary purpose of treatment is to alleviate suffering and return the patient to a state of good health, prevention aims to ensure that a person does not become ill in the first place. On closer consideration, it is apparent that treatment and prevention are not so distinct from one another. The provision of treatment services in fact constitutes a prevention programme because successful treatment prevents the recurrence of alcohol-related health and social problems. This function of treatment is referred to as secondary prevention.

Federal systems typically involve a pyramiding of treatment services in the which primary health care is provided at the local level (with funding and technical assistance from the provincial and federal governments), while more specialized services are provided at the regional or provincial levels.

Nigeria offers an excellent example of a the correspondence between government levels and primary areas of responsibility with regard to health care. There is a three-tier system of health care, characterized by multisectoral inputs, community involvement and collaboration with non-governmental organizations. Primary health care is provided locally, with provincial support in accord with overall national health policy. Secondary health care, often involving specialized services, is made available at the district levels of the provinces; and tertiary health care, generally even more specialized, is provided at a higher level, at hospitals distributed geographically throughout the country.

Thus, provincial programmes to improve and upgrade health care services generally, and alcohol services in particular, represent potentially important components to a prevention strategy to reduce problems and support national alcohol policies. Provincially based community development and social support programmes may also be viewed as contributing to national alcohol policy where the positive benefits of these programmes helps prevent the recurrence of health and social problems among persons treated for an alcohol problem.
3.3 Provincial initiatives and national policy objectives

To this point a variety of alcohol prevention initiatives that can be taken at the provincial level have been identified. In this section the relationship of these initiatives to national alcohol policy measures is discussed.

It should be noted from the outset that provincial alcohol policy is not merely an instrument of national policy. In most federal systems, provincial governments can, do and should act independently of national governments to promote policies and programmes aimed at the prevention of alcohol problems. Indeed, one of the key advantages of federal systems is the potential for particular provinces to develop unique and independent prevention initiatives. Further, certain national policy objectives may be irrelevant or given low priority by a provincial government. National alcohol policy may differ significantly from provincial priorities with regard to particular issues. In some policy arenas, national policy may actually exacerbate problems which provincial governments are seeking to address, such as when the federal government permits alcohol taxes to remain very low.

Indeed, in some areas of alcohol problem prevention, such as alcohol education curricula, there may be no national policy at all. National alcohol policies rarely involve explicit statements of objectives and prevention activities. In most countries, whether federal or unitary in structure, national alcohol policy is best characterized as an implicit, de facto set of policies and programmes in a wide variety of government agencies.

Thus, in federal systems, provincial governments are generally much more than intermediaries for the implementation of national policy. Provinces are permitted and, indeed, encouraged to act independently, in their own interests and according to their own priorities, but within the limits of their constitutional authority.

With this caveat in mind, Table 1 summarizes the relationship of the potential provincial prevention initiatives to national alcohol policy objectives. The major policy objectives are summarized into four broad categories: (1) preventing alcohol-related trauma, such as impaired driving incidents and alcohol-related aggression; (2) reducing morbidity and mortality of alcohol-related disease; (3) reducing aggregate levels of alcohol consumption; and (4) reducing high volume alcohol consumption by individuals.

The relationship of the provincial prevention initiatives to national policy objectives is indicated in the table. The projected impact of particular measures should be treated as rough approximations at best, as the effectiveness of any policy measure will be influenced by the particular cultural conditions in which it is applied. Furthermore, the table only indicates the focal aims of particular measures. Any measure which impacts on one policy goal will likely impact on the other policy objectives as well. Thus, for example, a measure which reduces overall alcohol consumption is likely to thereby reduce alcohol-related trauma and disease.

Price policies and regulations of alcohol availability are directed at controlling overall rates of consumption. Although the most direct and observable effect of these measures may be to reduce overall consumption levels, price policy and controls over alcohol availability also represent important prevention mechanisms for the reduction of alcohol-related social and health problems. This is largely because controls not only impact on moderate or infrequent drinkers. Indeed, controls over alcohol availability may have an even greater impact on high risk or "heavy" drinkers than on moderate drinkers. The evidence for a differential impact on heavy drinkers stems mainly from econometric studies on the impact of price changes (Cook & Tauchen, 1982; Grossman et al., 1987; Coate & Grossman, 1988) and from a research literature on the impact of strikes by alcohol workers on heavy drinkers (Room, 1984).

Not all distribution controls are broadly aimed at all policy objectives. The promotion of low-alcohol or nonalcoholic beverages, for example, would not be expected to have a major impact on chronic heavy drinkers. On the other hand, certain
provincial initiatives with regard to distribution are directed mainly at reducing intoxication or heavy drinking and thereby preventing acute alcohol-related problems such as impaired driving or violent behaviour. This would apply to the enactment of liability laws making persons who serve alcohol share in the responsibility if an innocent third party is suffers injury or damage from an intoxicated patron or guest.

While the evidence regarding the effectiveness of alcohol education programming is mixed, provincial initiatives in education and training offer the potential for support national alcohol policy objectives. Public order policies can help prevent acute intoxication. Although the effectiveness of restrictions on advertising and promotions has yet to be conclusively demonstrated, provincial initiatives to control advertising and promotional activities may help achieve a reduction in consumption and heavy drinking. Finally, provincial initiatives to provide or improve the provision of secondary health care supports national prevention policy by reducing heavy drinking and reducing alcohol-related morbidity which results from chronic heavy drinking.

4. Coordination of alcohol policy and programming

Thus far it has been noted that federal systems offer a number of potential advantages and opportunities for the development of alcohol prevention programmes and policies. The key issue in successful prevention programming in federal systems is whether alcohol policy can be effectively coordinated without underlining the advantages of federal systems.

In this context, the term "coordination" refers to the development of common or complementary actions toward policy goals. Coordination does not necessarily mean a perfect consensus or synchrony of action. It can be very productive for federal and provincial policy makers simply to agree on agendas and a common sense of purpose, even if each government chooses to pursue different strategies to achieve the goals. Nor does coordination have to involve formal intergovernmental structures or conferences; informal contacts can achieve the same results. Therefore, although the following discussion focuses on formal arrangements for alcohol policy coordination, it should not be assumed that the coordination of policy necessarily involves structural arrangements.

Furthermore, it should not be assumed that coordination invariably contributes to the prevention of alcohol problems. First, in many circumstances coordination may not be particularly desirable or necessary at all. Coordination, particularly formal coordination by intergovernmental agencies and committees, can represent obstacles and cause delay to prevention initiatives. Second, the complexity of the policy making process in federal systems is not always counter to the interests of public health. Complexity favours inertia: the more complex the system, the more difficult it tends to be to change the status quo. This can be an obstacle or a benefit for public health oriented alcohol prevention policy. A lack of coordinated alcohol policy development process may at times contribute to the failure of prevention initiatives, but it also represents an obstacle for economic interests seeking to increase the availability of alcohol.

With these caveats in mind, the discussion will now consider four aspects of alcohol policy coordination in federal systems. First, there is the coordination of alcohol policy between different levels of government. Second, within each level of government there is the coordination of opposing economic and problem management interests. Third, alcohol policy may be viewed within the context of overall health policies, particularly with regard to national health policy. And finally, there is the coordination of alcohol policy with policy and programmes aimed at the prevention of problems associated with the use of other psychoactive drugs.
4.1 Coordination of federal and provincial prevention policy and programming

At both the federal and provincial level, alcohol policy typically involves a large number of federal government ministries and agencies concerned with various aspects of economic and social policy related to alcohol, including finance, the treasury, regional development agencies, industry, labour, employment, small business administration, agriculture, external affairs, transport, consumer and corporate affairs, health, welfare, special agencies for minority or native affairs, justice and law enforcement agencies, and correctional services.

In order to coordinate federal and provincial policy, there is a wide variety of structural arrangements in federal systems. In the USSR policy and programmes are coordinated via a detailed, highly formalized layering of national, provincial and local committees which meet on a regular basis to plan and coordinate policy and programmes. Nigeria's National Council of Health, which includes both federal health officials plus key provincial health officials, coordinates health programmes for the entire country.

Coordinating mechanisms tend to be more diffuse in countries with more of a "cooperative" rather than an "executive" form of federalism. Indeed, in Switzerland, nongovernmental organizations often take the initiative to coordinate prevention programmes. In Canada, where the provinces also have a relatively large amount of autonomy in many areas of public policy, there is a complex set of intergovernmental committees and agencies (Pollard, 1986). Indeed, since 1977 the federal government has a Minister of State for Federal Provincial Relations, and five provinces have similar ministries (Quebec, Alberta, Newfoundland, Ontario and Saskatchewan). Many federal and provincial ministries also have specialized intergovernmental affairs units within their structures. Thus there has emerged a cadre of administrative officials who specialize in coordinating governmental policies and programmes.

Regardless of the particular structural arrangements for policy coordination, intergovernmental relations in most federal countries can be characterized as "interdependence". Many areas of concern, including those regarding alcohol issues, involve an overlapping of authority and responsibility. Thus, both the federal and provincial governments are involved in treatment delivery, educational and informational programmes, and the regulation of the alcohol production and trade.

There are positive and negative consequences to this interdependence of policy making in federal systems. On the positive side, there can be harmonization of policy and fruitful exchange of information concerning programme and policy development. On the negative side, intergovernmental policy negotiations can become vehicles for the expression of regional interests unrelated to alcohol problem prevention.

As a result of this "interdependence", federal governments may be somewhat cautious in the development of alcohol policy and reluctant to act without a consensus from the provinces. Thus, in the USSR many of what were formerly considered to be directives from the federal government to the republics are now deemed to be recommendations. The Canadian government explicitly "marketed" a new federal health policy to the provinces (Pinder, 1988). It was described as "a deliberately low-key process of discussion and debate instead of consultation and negotiation" (Pinder, 1988:210).

Intergovernmental coordination of alcohol policy and prevention programming may be deemed desirable or necessary in particular circumstances. In federal systems, the very same structures which permit important regional and cultural differences to be taken into account can create inequities in prevention programming and treatment, or exacerbate alcohol problems due to the lack of uniform regulations throughout a country. The problem of drunk driving by youth in border areas between two provinces with different minimum drinking ages illustrates this point. For those countries seeking to implement a national alcohol policy, a certain degree of consistency in alcohol policy and programmes within different regions of a country would seem
desirable. Formal coordinating mechanisms with and among provincial governments may help to minimize problems arising from inconsistent or different policies.

While improved coordination of federal and provincial alcohol policy may be desirable in particular circumstances, intergovernmental relations are necessarily highly complex and inherently ineffective (Simeon, 1979:10). Representatives on intergovernmental committees sometimes lack full authority to commit their governments to policies and programmes. In those instances where they do have authority (as with high level meetings at the ministerial or Premier level), a complex series of steps are needed to carry out coordinated implementation and evaluation.

Thus, while the coordination of federal and provincial policy is often preferable to uncoordinated policy, it is necessarily a cumbersome process at best. Therefore, as a general priority, it may be preferable in many situations to avoid the process of intergovernmental policy coordination rather than seek to improve it. This would involve clarification of jurisdictional boundaries and areas of provincial versus federal authority, particularly with respect to the regulation of advertising, interprovincial and international trade, and educational programming in the schools, in those situations where there is a great deal of overlapping authority between federal and provincial governments. In many areas of alcohol prevention, however, overlapping authority is unavoidable, as with educational programming in general, taxation and the provision of treatment services, and in these areas improved efforts to coordinate policy and programmes between federal and provincial governments may be deemed appropriate.

4.2 Coordination of alcohol policy within federal and provincial governments

There is a further complexity regarding alcohol policy development, which applies to both federal and unitary systems of government. There is an inherent conflict in the goals of alcohol policy for all levels of government. Alcohol policy is necessarily a balancing of opposing considerations. The government has an economic interest in maximizing revenues, and at the same time it is responsible for the management of problems associated with alcohol use. At both the federal and provincial levels, the agencies responsible for revenue generation generally report to an economic ministry, while the agencies responsible for treatment and the management of problems associated with alcohol tend to located in health or social welfare ministries. Conflicts are resolved at Cabinet level where short-term economic considerations often carry greater weight than long-term public health considerations. Thus, even within the federal and provincial governments, there is often a striking need for better coordination in alcohol policy formation.

The WHO-affiliated "International Study of Alcohol Control Experience", conducted in seven countries, offered the following as its first conclusion:

"In our study, we found a duality in the state's action on alcohol. On the one hand, preventive considerations have carried little weight in the formation of economic policies affecting alcoholic beverages. On the other, the social and health agencies responsible for the handling of alcohol problems have had little interest in the economy of alcohol. There is an urgent need to combine these two agendas in alcohol policy decisions. In some cases a reorganization of responsibilities among branches of government may be required to achieve a successful combination of economic, social and health considerations." (Mäkelä et al., 1981: 110)

The problems of intragovernmental policy coordination are particularly acute in federal systems, where several governments are involved in alcohol policy and prevention programming. While it is beyond the scope of this document to prescribe mechanisms for improved coordination of alcohol policy between different sectors of government, there are examples of relatively successful integration of the economic and public health aspects of alcohol policy. In many countries government alcohol monopolies combine these two key aspects of policy. Thus, for example, the Nordic alcohol monopolies incorporate many public health oriented policies in their marketing
strategies, such as restrictions on the number of outlets and the promotion of de-
alcoholized beverages. The WHO Project on the Potential Contribution of State
Monopoly Systems to the Prevention of Alcohol-related Problems noted that there are
many aspects of government owned alcohol monopolies which favour the development of
public health oriented policies (WHO/PAD/87.15). In other countries where alcohol is
produced and distributed privately, policy can be coordinated by special intermini-
sterial councils. For example, in 1986 the Mexican federal government created a
General Council on Alcoholism which includes representatives from a wide variety of
government agencies dealing with both the economic and social aspects of alcohol
issues, as well as private and social sector representatives.

4.3 Coordination of alcohol policy with other health policy

A further consideration is that alcohol policy is necessarily a component of a
larger health strategy. Alcohol consumption is associated with a wide variety of
health and social problems. The probability and severity of adverse health effects is
strongly related to level of consumption. This "dose-response" relationship is most
clearly seen with respect to cirrhosis of the liver. Adverse effects of high doses of
alcohol have also been demonstrated for many other disorders, including delirium
tremens, cancer of the mouth, pharynx, larynx and esophagus, chronic calcifying pan-
creatitititis, and adverse consequences to the fetus among pregnant women. High alcohol
intake is also strongly related to social consequences such as drunk driving injuries
and fatalities, aggressive behaviour, family disruptions, industrial absenteeism, and
poor productivity.

Alcohol-related problems account for a high proportion of total health care
costs in many countries. Thus, for example, it has been estimated that more than one
half of all admissions in psychiatric facilities and more than one fourth of all
hospital admissions in France are for alcohol-related problems, primarily liver cirr-
hois (Single, 1984). A major methodological difficulty in estimating the magnitude
of alcohol-related problems is the problem of attribution. It is difficult to
pinpoint the effects of drinking when it is not the sole cause of a problem. By
examining the prevalence of health and social problems among known alcoholics and
applying the results to the number of persons consuming at comparable levels in
society at large, it is possible to derive an estimate of the "excess" prevalence of a
given problem that can be attributed to alcohol abuse. In Canada it has been
estimated that approximately 80% of liver cirrhosis mortality is attributable to
alcohol use. In the USA, alcohol use is a contributing cause of 30-50% of all motor
vehicle fatalities, 44% of accidental falls, 25% of all fires, about one-third of all
homicides and 29-60% of all suicides (Moore & Gerstein, 1981).

These figures would not necessarily apply to other countries. The extent to
which a particular problem can be attributed to alcohol use will vary over time and
between societies. Nonetheless, these estimates indicate the enormous magnitude of
alcohol problems in many societies today. The Addiction Research Foundation of
Ontario has estimated that total adverse costs of alcohol use to be more than $1.6
billion, a figure which exceeds the annual revenues which the provincial government
receives from the sale of alcohol.

Thus, overall health services and prevention policy necessarily involve policies
for the treatment and prevention of alcohol problems. In many societies, treatment
services for alcohol dependence and other alcohol problems have become more integrated
into the general health care system over the past decade. There is a general trend
away from specialized hospital-based treatment services and an increased tendency to
view the problems of alcohol dependence in the larger context of the individual's
social, economic and emotional well-being.

Furthermore, there is a trend in health policy toward general health promotion as
a preventive strategy. In Mexico, for example, the concept of health has evolved from
an emphasis on curing illness to an emphasis on "integral health", which includes not
only the genetic and biological characteristics of the individual, but also the
effects of the physical and social environment. In many countries, it has been found
that a piecemeal, fragmented approach of developing special prevention programmes for each of a wide variety of health disorders is impractical and less cost efficient than a holistic approach promoting a healthy lifestyle. Excessive drinking is not strictly an individual phenomenon; it is behaviour which is influenced by social norms concerning appropriate comportment. Health policy aims generally at enhancing the quality of life by promoting health and avoiding unhealthy behaviour. Alcohol prevention programmes which are integrated into such an overall health promotion strategy are generally believed to be more effective and less expensive.

4.4 Coordination of alcohol policy with other drug abuse policy

Alcohol policy is not only a component of overall health promotion strategies, it is also a key component of national strategies for the prevention of substance abuse problems.

The predominant approach in the past has been to develop substance specific policies and prevention programmes. This is a reflection of the fact that alcohol, tobacco, prescribed medications, non-prescriptive drugs and illicit drugs vary widely with regard to their legal status and the priority given to them in national prevention policy. Many countries have separate agencies for alcohol and drug programming, e.g., the National Institute on Alcoholism and Alcohol Abuse (NIAAA) and the National Institute on Drug Abuse (NIDA) in the USA. Indeed, in the USA alcohol and tobacco are excluded from a national drug strategy currently under development.

In many countries, greater attention has been given to the development of more comprehensive prevention programmes which cover a variety of psychoactive substances. Thus, for example, the Canadian federal government has developed a unified prevention policy which encompasses alcohol and other drugs. After the federal Ministry of Health conducted a series of cross-country community workshops and consulted with provincial alcohol and drug agencies, alcohol was added to illicit drugs as a focal point to a new National Drug Strategy (Pinder, 1988). Although there are separate alcohol and drug research agencies in the USA (the National Institute on Alcoholism and Alcohol Abuse and the National Institute on Drug Abuse), they are considered "sister" agencies, coordinated within one umbrella agency (the Alcohol, Drug Abuse and Mental Health Administration). Furthermore, funding and technical assistance for prevention and treatment services are provided by another federal agency, the Office for Substance Abuse Prevention, whose mandate encompasses alcohol and other drugs.

There are a number of reasons for the general trend toward a more comprehensive approach to the prevention of substance dependence and abuse. It is becoming more generally recognized that all psychoactive substances can lead to substantial harm. Alcohol and even medications are no longer viewed as benign in comparison with illicit drugs. Certainly there has been a marked increase in the public recognition of the dangers in tobacco addiction in many countries.

Another factor underlying the trend toward a more comprehensive approach toward alcohol and other drugs is the growing recognition that many persons are multiple drug users. In general, the higher one's consumption of any particular psychoactive substance, the higher the probability that he or she is a user of another psychoactive substance (Singlet al., 1974). Drugs may interact and thereby magnify effects or otherwise create special problems. Individuals may substitute one drug for another.

Further, treatment and research have found many commonalities to the abuse of different psychoactive substances. Persons suffering from addiction to illicit drugs, legally prescribed drugs or alcohol tend to share many of the same associated problems and obstacles to recovery. Just as licit and illicit drug addicts tend to be socially isolated, alcohol dependent persons gradually dissociate themselves more and more from family and friends as their drinking becomes heavier (Sopham, 1982). Primary health care workers thus face many of the same problems with regard to early detection and treatment. Both the illicit drug user and the alcohol dependent person have to be reintegrated back into normal social life, and health care workers require considerable skill not only as health practitioners dealing with the patient, but also with
regard to promoting the patient’s acceptance back into the community. For both illicit drug users and alcohol dependent persons, follow-up and supervision are needed to ensure that the patient does not relapse. Social support programmes to aid recovering abusers benefit both former addicts and alcohol dependent persons.

There are also cost efficiencies involved when encompassing alcohol, tobacco, licit and illicit drugs in preventive educational programming aimed at the general public and at school populations, rather than developing specialized programmes for each psychoactive substance.

Perhaps the major impetus for more comprehensive substance abuse policies, however, has come from policy makers. In most countries illicit drug policy has focussed on supply reduction while alcohol policy has focussed on the reduction of demand. While there are still major differences in policies regarding alcohol and other types of drug abuse, there has been some convergence in attitudes regarding the most effective and appropriate prevention strategies. Among policy-makers, law enforcement officials and the general public in many countries, there has been an increased emphasis on demand reduction strategies for the prevention of illicit drug abuse and an increased emphasis on supply reduction strategies for the prevention of alcohol problems. For alcohol as well as all psychoactive substances, the most effective prevention policies are those aimed at reducing both supply and demand.
Table 1
Provincial Policy Initiatives
As They Relate to National Policy Objectives

National Alcohol Policy Objective:

<table>
<thead>
<tr>
<th>Provincial Measures:</th>
<th>Prevent Alcohol-Related Trauma</th>
<th>Reduce Alcohol-Related Disease</th>
<th>Reduce Alcohol Consumption</th>
<th>Reduce Heavy Drinking</th>
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</thead>
<tbody>
<tr>
<td>Tax and price policy</td>
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<td>●</td>
<td>●</td>
<td>●</td>
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<tr>
<td>- Prevent price decline</td>
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<tr>
<td>Distribution &amp; production</td>
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<tr>
<td>- Support production controls</td>
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<td>- Prevent high outlet density</td>
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<td>- Restrict hours of operation</td>
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<tr>
<td>- Increase minimum drinking age</td>
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<tr>
<td>- Promote nonalcoholic drinks</td>
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<td>- Enact liability statutes</td>
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<tr>
<td>- Promote server training</td>
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<tr>
<td>Alcohol education</td>
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<tr>
<td>- Implement federal programmes</td>
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<td>- Develop education programmes</td>
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<td>- Support NGO programmes</td>
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<td>- Provide professional training</td>
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<tr>
<td>Accident prevention</td>
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<tr>
<td>- Support enforcement efforts</td>
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<tr>
<td>- Develop education programmes</td>
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<tr>
<td>against drunk driving</td>
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<tr>
<td>- Rehabilitate impaired drivers</td>
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<td>Public order policies</td>
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<tr>
<td>- Provide care for public inebriates</td>
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<td>- Prohibit sale to minors and intoxicated persons</td>
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<tr>
<td>- Develop prevention programmes for sports and special events</td>
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<td>Promotion and Advertising</td>
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<tr>
<td>- Restrict advertising</td>
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<td>- Restrict promotions and sponsorships</td>
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<tr>
<td>Provide secondary health care</td>
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<td>●</td>
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</tr>
</tbody>
</table>

"●" denotes reasonably good evidence of effectiveness
"○" denotes widely believed to be effective but evidence is not conclusive
"O" denotes that evidence of effectiveness is equivocal or unavailable
"" blank indicates that measure is not related or directed at this policy objective
References:


Saltz, R., The Roles of Bars and Restaurants in Preventing Alcohol-impaired Driving, Evaluation and Health Professions 10(1), March 1987, 5-27;


