WHO’s Global strategy to reduce the harmful use of alcohol: An assessment of recent policies and interventions in Finland and Ontario, Canada

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ABSTRACT
AIM – This paper assesses alcohol policies and interventions in Finland and the Canadian province of Ontario, using the policy options and interventions recommended in WHO’s Global strategy to reduce the harmful use of alcohol (2010). DATA & METHODS – The information and data are based on archival sources, surveys, legislative and government documents, and published papers. The paper assesses both jurisdictions on 10 areas in the WHO document and their sub-topics: 1. leadership, 2. health services response, 3. community action, 4. drinking and driving policies and countermeasures, 5. availability of alcohol, 6. marketing of alcoholic beverages, 7. pricing policies, 8. reducing the negative consequences of drinking and alcohol intoxication, 9. reducing the public health impact of illicit alcohol and informally produced alcohol, and 10. monitoring and surveillance. RESULTS – Ontario had several recent noteworthy developments in line with WHO recommendations: health services response, controls of drinking and driving, pricing policies, reducing the negative consequences of drinking and intoxication, and monitoring and surveillance. Finland has emphasised pricing policies in recent years, and there have also been significant developments in community action, controls of drinking and driving, alcohol advertising, and monitoring and surveillance. CONCLUSIONS – Challenges and opportunities for strengthening the policy responses are noted, as well as topics for future research.

KEYWORDS – alcohol policy implementation, WHO alcohol strategy, comparative analysis, Finland, Canada

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recommended in the World Health Organization’s *Global strategy to reduce the harmful use of alcohol* (2010). In short, the paper provides a snapshot of the current situation in these two jurisdictions relative to the WHO (2010) strategy. Our second aim is to draw attention to topics in both jurisdictions where the policy response to the WHO (2010) strategy could be stronger. The paper not only describes the alcohol control situation in the two jurisdictions vis-à-vis the WHO (2010) strategy but also shows to what extent this strategy can be further implemented in industrial western demographic jurisdictions.

The targeted audience includes those working on alcohol policy research and public health promotion and advocacy. It also includes those in governmental and non-governmental (NGO) organisations whose work includes assessment of the harms from alcohol and consideration, promotion and implementation of options to reduce those harms.

Ontario, Canada, and Finland were chosen because they have a long history of government interventions as a means to controlling alcohol-related harm. Moreover they both have government off-premise retailing systems indicating that they belong to jurisdictions having taken alcohol control seriously. Furthermore, both have a strong research tradition focusing on alcohol issues, and both have experienced comparable trends in increasing access to alcohol in recent years (Giesbrecht & Österberg, 2012). These jurisdictions could therefore be expected to have implemented policies relevant to the WHO (2010) strategy document more thoroughly than many of the other WHO member states.

Two main contextual developments are evident in recent decades in Canada and Finland. The first is that availability of alcohol has increased, apparently driven by a combination of increased demand and relaxation of controls on supply. Real prices have dropped – with some exceptions, density of outlets is greater than a generation ago, and, especially in Canada, marketing is more pervasive (Giesbrecht & Thomas, 2010; Giesbrecht & Österberg, 2012). In Canada, overall per capita alcohol consumption has been increasing since 1996, from 7.2 litres of pure alcohol per person aged 15 and older in 1996 to 8.1 litres in the fiscal year 2010–2011, which represents a 12-percent increase in 15 years (Statistics Canada, 2012). The increase and evidence of chronic problems is most marked in regions where control systems have been eroded (Stockwell et al., 2009; 2011).

In addition, high-risk drinking is common and is highest among young adults (Adlaf, Begin, & Sawka, 2005). About one in five Canadians drink above recommended low-risk drinking guidelines (Adlaf et al., 2005) and over 32% experienced problems in the past year due to drinking by others (Giesbrecht et al., 2010). In 2002 there were an estimated 450,000 dependent drinkers in Canada and 1.3 million high-risk drinkers out of the population of 34 million (Thomas, 2010). There was also an excess of 8,300 alcohol-caused deaths (Stockwell et al., 2007), and this does not reflect the much greater impact of alcohol in areas such as social problems, trauma and disability (Rehm et al., 2006). Furthermore, the impacts of rising consumption and high-risk drinking also affect non-drinkers and innocent victims (Giesbrecht et al., 2010).
In Finland, with 5.3 million inhabitants, total per capita alcohol consumption, recorded and unrecorded, per adult population increased from 11.0 litres in 1995 to 12.1 litres in 2011, an increase of 10 percent in 16 years. The consumption peaked in 2007 with 12.7 litres per capita 15 years and older (Yearbook of Alcohol and Drug Statistics, 2012). Also, in Finland high-risk drinking to intoxication is common (Mäkelä et al., 2010). In 2011 there were 2,584 alcohol-caused deaths (Yearbook of Alcohol and Drug Statistics, 2012). Of these, 1,852 were deaths from disease, while 692 were accidental and violent deaths under the influence of alcohol. In 2008, half of women and a quarter of men reported that they had been afraid in public places because of drunkards (Mäkelä et al., 2010).

The second development involves ongoing initiatives to control or reduce the harm from alcohol. It involves specific interventions as discussed below, and also broader international (Babor et al., 2010), regional (Monteiro, 2007), national (National Alcohol Strategy Working Group, 2007; Canadian Public Health Association, 2012; Karlsson, 2009) and sub-national policy documents or recommended interventions (Nova Scotia Department of Health Promotion and Protection, 2007; Office of the BC Provincial Health Officer, 2008; April et al., 2010).

WHO’s Global strategy to reduce the harmful use of alcohol (2010) emerged at a time when there was strong evidence of the substantial global burden from alcohol. Furthermore, there were signals that this burden was growing and likely to grow in the coming years (Babor et al., 2003; Rehm et al., 2009). The WHO strategy was informed by recent epidemiological research on alcohol-related harm (Babor et al., 2003, 2010; Rehm et al., 2009) as well as by policy analyses and advocacy (Anderson et al., 2009; Casswell & Thamarangi, 2009).

Our paper focuses on the following ten areas of policies and interventions indicated in the WHO’s (2010) global strategy document: 1. leadership, awareness and commitment, 2. health services response, 3. community action, 4. drinking and driving policies and countermeasures, 5. availability of alcohol, 6. marketing of alcoholic beverages, 7. pricing policies, 8. reducing the negative consequences of drinking and alcohol intoxication, 9. reducing the public health impact of illicit alcohol and informally produced alcohol, and 10. monitoring and surveillance.

To our knowledge, there have not been public reports to date which have sought to see how a jurisdiction “measures up” to the ten areas in the WHO’s (2010) Global strategy to reduce the harmful use of alcohol. The WHO document includes specific goals and targets, but does not provide indicators of change and how to achieve change in the desired public health direction. It is also an open question as to how widely the WHO recommendations on alcohol have been incorporated into, or informed regional, national or sub-national planning of alcohol policies and interventions.

**Design and Methods**

This paper is based on a qualitative analysis of the current situation with regard to ten alcohol policy areas highlighted in the WHO 2010 document Global strategy to reduce the harmful use of alcohol. It focuses on one Nordic country, Finland, and the most populous province in Canada.
Ontario. It provides a snapshot of the alcohol policy activities in these two jurisdictions, with the activities assessed organised along the ten areas of the WHO (2010) document.

Like the Nordic alcohol monopoly countries – Finland, Iceland, Norway and Sweden, as well as the Faroe Islands – all Canadian provinces have a tradition of off-premise alcohol retail monopolies in their alcohol management experiences. Both Canada and the Nordic countries have a long history of comprehensive alcohol control. This provides a useful context to comparing Finland and the Canadian province of Ontario. Also, the alcohol control systems in both Finland and the Canadian provinces, Ontario included, have been affected by global trends in alcohol distribution and marketing (Giesbrecht & Österberg, 2012).

In the alcohol policy field, Ontario and Finland may be considered exemplary cases when viewed in a global context and they should therefore prove helpful in showing how the WHO (2010) alcohol policy measures can be implemented in practice.

Canada is a federation with three northern territories and ten provinces. Many of the alcohol policies and interventions that are the focus of the ten areas in the WHO document are under provincial rather than federal jurisdiction. When they do fall under federal jurisdiction, these policies and interventions, such as regulations on electronic advertising, are interpreted and implemented by each province. National initiatives, such as the National Alcohol Strategy (National Alcohol Strategy Working Group, 2007), while providing guidance to provincial and territorial jurisdictions, nevertheless depend largely on sub-national decision-makers for their implementation, tracking and enforcement. In short, an examination of Canada as a whole would offer very little substantive material, and it is beyond the scope of this paper to examine the current status in all 13 Canadian jurisdictions on WHO’s ten areas on alcohol policy options and interventions. In Finland, alcohol policies and most interventions in the alcohol field are under national jurisdiction. Even if some alcohol-related activities are implemented at a municipal level, the Finnish alcohol control system is very heavily based on decisions at the national level (Karlsson et al., 2013).

We drew on several resources in developing this qualitative paper. First, a number of resource documents were used (Giesbrecht & Österberg, 2012; Giesbrecht & Thomas, 2010; Giesbrecht et al., 2011; Giesbrecht et al., 2013; National Alcohol Strategy Working Group, 2007) as well as those noted in text and tables. Second, we relied on such data bases as the Global Information System on Alcohol and Health.

**Results**

The summary results are provided in tables, organised and numbered according to the 10 areas of the WHO document, under the heading “Policy Options and Interventions”. For each table, the left-hand column provides the text from the WHO document on these ten areas. The next two columns provide a synopsis of the current status in Finland and Ontario with regard to these ten areas. Significantly, the comparison is between Finland and the WHO strategy and Ontario and the WHO strategy. Furthermore, this is not an analysis...
of long-term trends, but rather a snapshot of the current status of each jurisdiction on these ten areas. The tables and the highlights below are designed to show how the policy options and interventions noted in the WHO (2010) strategy can be implemented.

Area 1. Leadership, awareness and commitment

The two jurisdictions have quite different approaches to alcohol issues; a top-down approach in Finland with National Alcohol Action programmes providing a stimulus for specific interventions, in contrast to a more ad hoc issue-specific approach in Ontario (see Table 1).

In Finland, alcohol policy falls under the jurisdiction of the Ministry of Social Affairs and Health. Its fundamental objective is to reduce alcohol-related harm. Currently the key objectives are to reduce alcohol-induced harm to the wellbeing of children and families, to reduce hazardous use of alcoholic beverages and related harm, and to turn the trend in alcohol consumption downwards. Since 1995 Finland has had special National Alcohol Action programmes. The latest one governs the current government period 2011–2015. It continues such activities of the earlier programmes as developing measures preventing alcohol-related harm and supporting local preventive work, producing high-quality material and arranging training. The plans also include reforming the Alcohol Act.

There has been a Canadian alcohol strategy since 2007 (National Alcohol Strategy Working Group, 2007), supported by many institutions but not officially approved by federal government. However, to date, Ontario does not have a provincial alcohol strategy, in contrast to overarching initiatives or provincial strategies in Alberta (Alberta Health Services, 2007), British Columbia (Office of the BC Provincial Health Officer, 2008), Nova Scotia (Nova Scotia Department of Health Promotion and Protection, 2007) and Quebec (April et al., 2010).

Area 2. Health services response

Both jurisdictions have extensive activities in this area with a wide range of services. Finland has a range of specialised in-patient and out-patient services, with high capacity to deliver care, dependent on municipal economic resources. Similarly in Ontario, there are plenty of in-patient and out-patient resources, as well as counselling services (see Table 2).

It appears that there is room to expand initiatives on three areas: screening and brief interventions, services relevant to foetal alcohol spectrum disorder (FASD), and, possibly more so in Ontario, services for a multicultural clientele. Furthermore, given the high burden of alcohol to society, there is room to expand resource commitments to health services. Also, the percentage of high-risk or dependent drinkers who access services annually is relatively small in light of the total number of high-risk and dependent drinkers. Challenges remain in closing this gap.

Area 3. Community action

Both jurisdictions have a multi-decade history of community action initiatives (e.g. Holmila, 2001; Giesbrecht et al., 1990). Currently there are on-going and increasing activities in Finland in the aftermath of the PAKKA project in the years
Table 1. Leadership, awareness and commitment

| WHO: Policy options and interventions | Finland | Ontario |
|--------------------------------------|---------|---------|
| **18.** Sustainable action requires strong leadership and solid base of awareness and political will and commitment. The commitment should ideally be expressed through adequately funded comprehensive and intersectoral national policies that clarify the contributions, and division of responsibility, of the different partners involved. The policies must be based on available evidence and tailored to local circumstances, with clear objectives, strategies and targets. The policy should be accompanied by a specific action plan and supported by effective and sustainable implementation and evaluation mechanisms. The appropriate engagement of civil society and economic operators is essential. |
| **19.** Policy options and interventions: a) create national or sub-national strategies; b) establish or appoint a main institution; c) coordinate strategies with other sectors; d) insure wide access to information about full range of alcohol-related harms; e) raise awareness about harm to others and among vulnerable populations. |
| Alcohol policy falls under the jurisdiction of the Ministry of Social Affairs and Health. The fundamental objective of the Finnish alcohol policy according to the Alcohol Act is to reduce alcohol-related harm. The Government Resolution includes the following key objectives: to reduce alcohol-induced harm to the wellbeing of children and families, to reduce hazardous use of alcoholic beverages and related harm, and to change the trend in alcohol consumption in a downward direction. Since 1995, Finland has had special National Alcohol Action Programmes. The latest one governs the current government period 2011–2015. It continues the activities of earlier programmes but also promises to reform the Alcohol Act, retain the current off-premise alcohol retail sale monopoly and retain its reporting to the Ministry of Social Affairs and Health. This programme is coordinated by the Department of Alcohol, Drugs and Addiction at the National Institute for Health and Welfare (Karlsson, 2013; Yearbook of Alcohol and Drug Statistics, 2012). National Alcohol Action Programmes have developed measures preventing alcohol-related harm, supported local preventive work, created a regional organisation for the whole country, produced high-quality material and arranged training. Many non-governmental organisations and one economic operator are involved in the latest Alcohol Action Programme. The implementation of the Alcohol Action Programme is monitored by tracking several indicators such as trends in recorded and unrecorded alcohol consumption and related harm, including alcohol-related accidents, violent offences and domestic violence as well as alcohol-related deaths. In addition to the Alcohol Action Programmes, alcohol-related harms have been strongly emphasised in the Government’s Policy Programme on Health Promotion and the Internal Security Programme (Karlsson et al., 2010). These also consider alcohol-related harm to third parties. |
| There is no overarching inter-departmental policy on alcohol issues, and no apparent a priori division of responsibilities. It is not clear where institutional leadership is located on alcohol policy issues. The Centre for Addiction and Mental Health (CAMH) is a leader on research on alcohol consumption, problems and interventions. Public Health Ontario (PHO) and Cancer Care Ontario have recently shown increasing interest in alcohol policy topics. CAMH, Ontario Public Health Association (OPHA) and Mothers Against Drunken Driving (MADD) Canada have collaboratively assumed leadership roles in the past with regard to specific issues such as responding to proposals to privatise alcohol retailing, as well as controlling drinking and driving. However, currently there is no a provincial alcohol policy document with an action plan, and sustainable implementation and evaluation mechanisms. There is nevertheless engagement of economic operators (licensed premises) on initiatives to reduce barroom violence and to promote server interventions. There is recent action on prevention of alcohol-related chronic disease (Cancer Care Ontario & Public Health Ontario, 2012). There are publications on alcohol & vulnerable populations (Baliunas et al., 2010) and on harm to others from alcohol (Giesbrecht et al., 2010). |

2004–2007 (Holmila et al., 2009). In Ontario there is research project underway involving community-level surveillance and specific indicators at the local level focusing on server intervention, barroom behaviour and via some municipal public health units. However, there is currently not extensive community capacity at the
local level – in contrast to that for tobacco control in Ontario (see Table 3).

Area 4. Drinking and driving policies and countermeasures
There has been substantial progress in both jurisdictions involving numerous interrelated interventions, tracking, regulation, enforcement and treatment. These measures include changes in the road environment, international changes in car safety features and changes in laws and regulations impacting detection of drinking and driving and penalties. There is a strong tradition of evaluated and evidence-based initiatives. In Finland the blood alcohol concentration limit is lower (0.05 per cent) than in Ontario (0.08 per cent). In Ontario

### Table 2. Health services response

| WHO: Policy options and interventions | Finland | Ontario |
|---------------------------------------|---------|---------|
| 20. Health services are central to tackling harm at the individual level among those with alcohol-use disorders and other health conditions caused by harmful use of alcohol. Health services should provide prevention and treatment interventions to individuals and families at risk of, or affected by alcohol-use disorders and associated conditions. An important role of health services and health professionals is to inform societies about the public health and social consequences of harmful use of alcohol, support communities in their efforts to reduce the harmful use of alcohol, and to advocate effective societal responses. Health services should reach out to, mobilize and involve a broad range of players outside the health sector. Health services response should be sufficiently strengthened and funded in a way that is commensurate with the magnitude of the public health problems caused by harmful use of alcohol. | In Finland the responsibility for organising services to tackle alcohol-related health harm rests with municipalities. This health service system includes general non-institutional services provided by health and social care units, such as health centres, occupational health care, school and student health care, mental health clinics and social welfare offices, and institutional care such as hospital care and housing services. Specialised non-institutional services for alcohol abusers are provided by, for example, A-clinics, youth clinics, drop-in centres, health counselling centres and day centres. Specialised institutional care for alcohol abusers is offered by, for example, detoxification and rehabilitation centres and housing services (Yearbook of Alcohol and Drug Statistics, 2012). Also AA and other self-help networks offer services for individuals suffering from alcohol-related harm and for their families. The capacity to deliver care is quite extensive but it is affected by the municipalities’ economic resources. Brief intervention does not have a long tradition in Finland but it is gaining more ground. Prevention of FASD is currently an important activity. Morbidity and mortality statistics are reporting the role of alcohol on several morbidity and mortality items. However, the health service sector is not a central actor in the prevention and advocating of effective social responses (Karlsson, 2009). | There is an extensive network of services involving out-patient and in-patient options including AA and other self-help networks, too. In collaboration with staff of the local public health offices, the OPHA, and PHO, there are initiatives to inform professionals and general public of alcohol issues and social consequences of alcohol. Compared to the high number of disability-adjusted life years associated with alcohol, the specific funding appears to be modest and likely not adequate to substantially increase public awareness on alcohol issues or to reduce alcohol-related harm. There is extensive capacity for care, but less so for prevention. The public health service conducts Rapid Risk Assessments. There is growing interest in brief interventions although it is not yet standard practice with universal funding (Giesbrecht et al., 2013). There is interest in detection of FASD but there is no comprehensive system of documentation. There is universal access to affordable treatment. There is also substantial progress on monitoring alcohol-attributable harm in Ontario via numerous peer-reviewed publications, but not a standardised reporting system with periodic, e.g. biannual, reports. There is progress in the provision of culturally sensitive services. |
Table 3. Community action

| WHO: Policy options and interventions | Finland | Ontario |
|--------------------------------------|---------|---------|
| 22. The impact of harmful use of alcohol on communities can trigger and foster local initiatives and solutions to local problems. Communities can be supported and empowered by governments and other stakeholders to use their local knowledge and expertise in adopting effective approaches to prevent and reduce the harmful use of alcohol by changing collective rather than individual behaviour while being sensitive to cultural norms, beliefs and value systems. | The Finnish National Alcohol Action Programme encourages municipalities to recognise alcohol-related harm at the local level and to draft alcohol action programmes for their jurisdiction. Municipalities are offered information on effective approaches and practices for preventing and reducing the harmful use of alcohol and related harms. The National Alcohol Action Programmes have provided material to mobilise communities to prevent selling alcohol to underage youth and intoxicated adults. | In Ontario there is a long history of promoting and implementing municipal alcohol policies in many communities. There are several current local initiatives, although at times the constraints of the provincial jurisdiction can be a barrier to local change. A research project is underway involving community-level surveillance. The public health service conducts Rapid Risk Assessments. There are initiatives in several municipalities to document and recognise alcohol-related harm and a resource is available by an ad hoc group of the Ontario Safer Bars network on recent changes in the provincial liquor act. A general challenge and refusal programme by the Liquor Control Board of Ontario (LCBO) is evident in all communities. Staff in licensed premises are trained in “Smart Serve” to prevent service to minors or intoxicated patrons. Building capacity for implementation of community-based programmes occurs mainly through the public health unit and its capacity in setting priorities to reach goals set by the province. Treatment facilities are available in all major urban centres, along with detoxification facilities. There are programmes in some communities for youth and adolescents and also for First Nations (Aboriginal) populations. |

| 23. Policy options and interventions: a) guarantee rapid assessments to identify gaps and priority areas; b) support recognition of alcohol-related harm at the local level and cost-effective responses to them; c) strengthen capacity at the local level; d) provide information about effective community-based interventions, and build capacity for their implementation; e) mobilize communities to prevent selling of alcohol to underage youth; f) provide community care and support for affected individuals; g) support community programs and policies for subpopulations at particular risk. | The rule in Alko shops is that the employees should check an official identity card of everyone who looks younger than 25 even if the age limits are 20 year for distilled spirits and 18 years for beer and wine. | |

there is a zero limit for young and novice drivers whereas in Finland there are no reduced limits for young and professional drivers. To date, neither jurisdiction has paid much attention to safety of intoxicated pedestrians (see Table 4).

Area 5. Availability of alcohol

The tradition of government-run off-premise retailing systems in both jurisdictions has contributed to relatively low density of off-premise outlets compared to countries or provinces where alcohol sales are totally in private hands. In both jurisdictions, governments manage alcohol retail systems and control the hours and days of sale. They also license other outlets. Survey results from both jurisdictions indicate strong support for government-run systems (Karlsson et al., 2013; Giesbrecht & Ialomiteanu, 2013).

Alcohol access has increased in both jurisdictions during several decades. Moreover, lower-strength beer and cider is available in convenience and grocery stores in Finland, which is not the case in Ontario. In contrast, in recent years the Liquor Control Board of Ontario (LCBO), in combination with producers, has been quite aggressive in marketing their stores.


Table 4. Drinking and driving policies and countermeasures

| WHO: Policy options and interventions | Finland | Ontario |
|---------------------------------------|---------|---------|
| 24. Driving under the influence of alcohol seriously affects a person’s judgment, coordination, and other motor functions. Alcohol-impaired driving is a significant public health problem that affects both the drinker and in many cases innocent parties. Strong evidence-based interventions exist for reducing drunk-driving. Strategies to reduce harm associated with drunk-driving should include deterrent measures that aim to reduce the likelihood that a person will drive under the influence of alcohol, and measures that create a safer driving environment in order to reduce both the likelihood and severity of harm associated with alcohol-influenced crashes. | Strategies to reduce harm associated with drunk-driving include legal blood alcohol concentration limits and their enforcement including quite severe penalties for those who break the drink-driving laws. Measures to create a safer driving environment include: speed limits, safety belts, and better and safer roads. While these measures affect harms related to drink-driving, their implementation has not been driven by precautionary impact on drink-driving. The safety of intoxicated pedestrians has not had a high priority in traffic-related injury prevention. There is an upper blood alcohol concentration limit of 0.05 per cent on driving a motor vehicle. The limit for aggravated drink-driving is 0.12 per cent with more severe penalties than committing an ordinary drink-driving crime. In motor boating, the blood alcohol limit is 0.1 per cent. There are no reduced limits for professional and young drivers. Random breath testing is quite common. Administrative suspension of driving licence is a rule if a person is caught for drinking and driving. Using an ignition interlock devise to reduce drink-driving is under serious discussion but there are not yet any legal provisions. There are no special public transportation alternatives or possibilities related to restaurant closing times. The state does not run public awareness or mass media campaigns on drinking and driving, but there are mass media campaigns against drinking and driving run by non-governmental organisations. | Ontario has a long history of planning, implementing and evaluating evidence-based interventions focusing on drink-driving. These initiatives are promoted by Mothers Against Drunk Driving (MADD, 2011), as well as federal and provincial departments, provincial and local police and non-governmental advocacy groups. There is federal legislation in the Criminal code of Canada regarding a legal limit of 0.08% BAC, with zero limit for young and novice drivers in Ontario. There are regular sobriety check points, especially around holiday periods when many social events involve drinking. There is administrative suspension of driving licences at 0.05 BAC. There is graduated licensing for novice drivers with zero tolerance for drivers under age 22. Ignition interlock can be purchased. For those convicted of drinking and driving, driver-education, counselling and treatment can be offered at the discretion of the court. Alternative transportation is encouraged, especially during festive events, such as free public transit on New Year’s eve in some cities. There are extensive public awareness campaigns by MADD, LCBO, non-governmental organisations and local public health departments. There are special mass media campaigns during holiday seasons, including those focusing on youth. |

and products. In Finland, Alko is not involved in such marketing activities and is not advertising at all (Giesbrecht & Österberg, 2012). There is public support for the current alcohol control systems in both jurisdictions (see Table 5).
Table 5. Availability of alcohol

| WHO: Policy options and interventions | Finland | Ontario |
|--------------------------------------|---------|---------|
| 27. Public health strategies that seek to regulate the commercial or public availability of alcohol through laws, policies, and programs are important ways to reduce the general level of harmful use of alcohol. Such strategies provide essential measures to prevent easy access to alcohol by vulnerable and high risk groups. Commercial and public availability of alcohol can have a reciprocal influence on the social availability of alcohol and thus contribute to changing social and cultural norms that promote harmful use of alcohol. The level of regulation on the availability of alcohol will depend on local circumstances, including social, cultural and economic contexts as well as existing binding international obligations. In some developing and low- and middle-income countries, informal markets are the main source of alcohol and formal controls on sale need to be complemented by actions addressing illicit or informally produced alcohol. Furthermore, restrictions on availability that are too strict may promote the development of a parallel illicit market. Secondary supply of alcohol, for example from parents or friends, needs also to be taken into consideration in measures on the availability of alcohol. | Restricting physical availability of alcohol has a long history in Finland. These regulations have however been substantially relaxed during the last fifty years. Off-premise retail sale of distilled spirits, and fermented beverages over 4.7 percent ethyl alcohol by volume is via state stores. Production, import, wholesale, on-premise retail sale of all alcoholic beverages as well as off-premise retail sale of fermented alcoholic beverages of no more than 4.7 percent ethyl alcohol by volume requires a licence. This licence can be granted to ordinary grocery stores, petrol stations and kiosks also selling food. When granting the licence there are no assessment criteria. Days and hours of retail sale are regulated. Off-premise sale of alcoholic beverages can start at 9am and must end at the latest at 9pm. The off-premise retail shops of the state alcohol monopoly Åika close at 8pm on weekdays and at 6pm on Saturdays. On Sundays they are closed. Grocery stores can sell alcoholic beverages up to 4.7 percent by volume also on Sundays. On-premise retailing can start at 9am and should finish as a rule at 1:30am. The opening time of the restaurants can however be prolonged to 4am, with the last sale at 3:30am. On-premise sales of alcoholic beverages can also take place in sports stadiums, theatres and opera, but not in cinema theatres (Österberg & Karlsson, 2002 Karlsson et al., 2010). Distilled spirits cannot be sold off the premise to persons under 20 years and other alcoholic beverages to persons younger than 18. The 18-year age limit concerns all alcoholic beverages in on-premise sale. There are no home delivery options of alcoholic beverages in Finland. | Periodic surveys of representative samples of Ontario adults examine public opinion on alcohol policy interventions. There is general support for these interventions, with less support for the more intrusive interventions such as alcohol taxes, with greater support among women, abstainers and light drinkers (Giesbrecht & Lalomiteanu, 2013). While there is some supply of unrecorded alcohol. It currently receives less attention than 15–20 years ago. This includes illegal transportation of spirits from the US, illegal production and sale of wine, and unrecorded consumption via licensed businesses where patrons make their own beer or wine for personal consumption (u-vin and u-brew facilities). There is an elaborate system of regulating the production, wholesaling and serving of alcohol in Ontario. The licensing system is oriented to managing retail sales but does not have a strong public health mandate. Ontario has a mixed system of off-premise sale with a combination of government-run stores and privately run beer stores and domestic wine stores. There is no official limit on the number of on-premise outlets. There are no limitations on proximity of on- or off-premises to schools, for example, although restrictions on placement of stationary outdoor liquor advertising. On-premise outlets are open from 11am to 2am, most off-premise outlets from 9am to 11pm, and 11am to 6pm on Sunday. A network of smaller “Agency Stores” is open from 7am to midnight and from 11am to 6 pm on Sunday. Hours and days of sale are regulated, although there has been a relaxation of on-premise selling times in recent years, and extended late night hours during special events such as the Toronto International Film Festival. There are restrictions on which types of businesses can sell alcohol, and these have been relaxed in recent years. Alcohol sales are restricted to specific types of off-premise outlets, licensed premises, specific events such as festivals and special occasion permits. There are also home delivery options where the seller is expected to refuse to sell to minors or intoxicated customers. The minimum age of purchase in Ontario is 19, although those younger can be served alcohol in a private place by a parent or guardian who is above the legal age of 19 and who is present. |
actual advertisements are judged to be by the national guidelines, although many advertising on radio and television is governed advertisements. In Ontario, alcohol advertising. Exposure of adolescents to alcohol is also limited by restrictions on advertisements. In Ontario, alcohol advertising on radio and television is governed by the national guidelines, although many actual advertisements are judged to be breaches of the guidelines (Heung et al., 2012).

Marketing of alcohol seems to have increased in Ontario, in line with changes in other Canadian jurisdictions. Beer, wine and distilled spirits companies advertise

| Table 6. Marketing of alcoholic beverages |
|------------------------------------------|
| WHO: Policy options and interventions     | Finland | Ontario |
| 29. Reducing the impact of marketing, particularly on young people and adolescents, is an important consideration in reducing harmful use of alcohol. Alcohol is marketed through increasingly sophisticated advertising and promotion techniques, including linking alcohol brands to sports and cultural activities, sponsorships and product placements, and new marketing techniques such as e-mails, SMS and podcasting, social media and other communication techniques. The transmission of alcohol marketing messages across national borders and jurisdictions on channels such as satellite television and the Internet, and sponsorship of sports and cultural events is emerging as a serious concern in some countries. | All alcohol advertising was totally prohibited by law from 1977 to 1995. However, the 1994 Alcohol Act made it possible to advertise light alcoholic beverages, beverages with an alcohol content at most 22 percent by volume (Österberg & Karlsson, 2002). The exposure of adolescents is decreased by: forbidding advertisements aimed specifically at minors and in particular if they depict minors consuming alcoholic beverages. Alcohol advertisement on television and in cinemas is only allowed after 9 pm (Karlsson et al., 2010). The regulations of alcohol advertising in Alcohol Act are supervised by the National Supervisory Authority for Welfare and Health, which is under the authority of the Ministry of Social Affairs and Health. The restrictions of the content of alcohol advertisement in Finland follow the EU directive 89/352: that advertisements shall not link alcohol consumption to enhanced physical performance or to driving or that alcohol consumption contributes towards social or sexual success. Furthermore, alcohol advertisement shall not place emphasis on high alcohol content as being a positive quality of alcoholic beverages nor shall it encourage immoderate alcohol consumption or present abstinence or moderation in a negative light (Österberg & Karlsson, 2002). The Ministry of Social Affairs and Health has just published a draft law for further restrictions on alcohol advertisement. | In Ontario there is extensive marketing of alcoholic beverages by way of social media, radio and television, print advertising (newspaper inserts by the LCBO), as well as on-site promotions and the distribution of product samples (Wettlaufer, Cukier, Giesbrecht, & Greenfield, 2012). There is high exposure to alcohol marketing and promotion among all age groups. While the Canadian Radio-television and Telecommunications Commission (CRTC) has guidelines about electronic alcohol advertising to underage youth, a recent study indicates that a number of alcohol advertisements on TV do not comply with CRTC guidelines (Hauge et al., 2012). The mandatory review of story-boards for ads by CRTC was discontinued in 1996 (Ogborne & Stoduto, 2006). There is a complaints system regarding apparent breaches of CRTC regulations, but it is not highly efficient. There is a private sector body, Advertising Standards Canada, which will review, when asked to see if an advertisement complies with CRTC guidelines. There are regulations about messages about alcohol and drinking, which apply to advertising, but not necessarily to the content of depictions of alcohol on TV or radio shows, movies or social media. The content of marketing is regulated, but not the volume, and compared to substantial funds used by alcohol companies to market alcohol there are currently modest resources to promote messages about health and safety risks associated with alcohol, including social responsibility campaigns by the Liquor Control Board of Ontario. There is extensive alcohol sponsorship, in some cases with NGOs that deal with alcohol-related disease such as cancer. |
Table 7. Pricing policies

| WHO: Policy options and interventions | Finland | Ontario |
|---------------------------------------|---------|---------|
| 32. Consumers, including heavy drinkers and young people, are sensitive to changes in the price of drinks. Pricing policies can be used to reduce underage drinking, to halt progression towards drinking large amounts of alcohol and/or episodes of heavy drinking, and to influence consumers’ preferences. Increasing the price of alcoholic beverages is one of the most effective interventions to reduce harmful use of alcohol. A key factor for the success of price-related policies in reducing harmful use of alcohol is an effective and efficient system for taxation matched by adequate tax collection and enforcement. | Alcohol pricing and taxation has been one important part of Finnish alcohol control for a long time. The system for fixing prices and taxes has been matched by adequate tax collection and enforcement. (Holder et al., 1998). Unrecorded alcohol consumption in the form of home-distilled spirits or home-made wine as well as smuggled alcohol and surrogates has been an important part of the Finnish reality. Nowadays the key unrecorded alcohol source is travellers’ alcohol imports, from neighbouring Estonia in particular after Finnish quotas for alcohol imports from other EU countries were abolished in January 2004 and Estonia became an EU member in May 2004 (Mäkelä & Osterberg, 2009). Finland has an efficient and controlled system of domestic taxation. The EU-induced taxation systems and principles came into force in 1993 (Holder et al., 1998). Excise duty per litre alcohol is about the same for beer and wine, while the rate for distilled spirits is 45 percent higher than for beer and wine (Osterberg, 2011). There is no automatic system to adjust alcohol taxes on inflation. Nor are there minimum alcohol prices. There is a current law forbidding discount sales of alcoholic beverages in selling several units of alcoholic beverages at lower unit price than selling only one unit (Karlsson et al., 2010). Subsidies to economic operators in the area of alcohol are minimal, including only reduced tax on beer for small producers. | Ontario has a long history of using taxes on alcohol to generate revenue, and the LCBO provides about $1.4 billion annually to the provincial government based on taxes and mark-ups. While there is research demonstrating the public health benefits of taxes on alcohol (e.g. Rehm et al., 2008), the underlying government rationale for taxes on alcohol is not to reduce alcohol-related harm. A recent exception was during a transition from a generic two-tax system (provincial and federal) to a harmonised tax system (HST). In this context the Ministry of Finance decided not to reduce the price of alcoholic beverages to consumers in the interests of social responsibility. General population surveys indicate that about 25 percent of Ontario adults support an increase in alcohol taxes and a similar percentage oppose it, although support for higher alcohol taxes was gradually decreasing in the 1990s (Giesbrecht et al., 2001). There does not appear to be a recent or current campaign to provide information or awareness-building to counter resistance to taxes or promote population-based benefits. There is a system of taxation, with some variation, by alcohol content of beverage (Giesbrecht et al., 2012). With the exception of spirits, excise taxes for all products over 7.5 percent alcohol by volume are based on flat rates per litre of product. For off-premise sales, a minimum price is indexed annually to a three-year average of Ontario’s consumer price index. Promotions and discount sales are evident. All-inclusive packages are permitted for licensed establishments. There are restrictions that state that the price of one drink cannot be dependent on the purchase of other drinks, i.e. no “two for one” specials and promotions that target certain segments of the population, such as students or women, are not permitted. Minimum prices for beverages implemented in 1993 for off-premise and 2007 for on-premises, with significant changes in 2010 indexed annually [off-premise outlets]. There are noteworthy loopholes, including provision of free samples (Wettlaufer, Giesbrecht et al., 2012). There are significant subsidies including incentives to domestic wine producers (Giesbrecht et al., 2012). |
in print, on television and radio and via sponsorship. In collaboration with the Liquor Control Board of Ontario, they have periodic multi-page newspaper inserts which promote their products. In this area there are currently more restrictive controls and practices in Finland than in Ontario (see Table 6).

Area 7. Pricing policies

In both jurisdictions there is evidence of alcohol pricing being used as a tool to control alcohol-related harm (see Table 7). There is evidence of social responsible pricing in Finland such as restrictions on discount pricing, and in Ontario such as indexed minimum pricing. Nevertheless, there are loopholes in Ontario (Wettlaufer, Giesbrecht, & Stockwell, 2012), and changes in Finland related to relaxation of travellers’ alcohol imports. In the European Union, Finland belongs to the countries with the highest alcohol excise duties (Österberg, 2011).
Area 8. Reducing the negative consequences of drinking and alcohol intoxication

Both jurisdictions have policies and initiatives to curtail the sale of alcohol to minors and intoxicated patrons. In Finland there is no legal liability associated with such sales. Neither jurisdiction has mandatory warning labels on alcoholic beverage containers. An attempt to introduce labels by the Finnish Parliament was cancelled after pressure from the alcohol industry and some EU member states. Several attempts to introduce warning labels on beverage alcohol in Canada have failed. Ontario has warning signs in licensed premises. New Canadian low-risk drinking guidelines were introduced in 2012 (Butt et al., 2011). They indicate no more than 15 standard drinks a week for men, 10 for women, and a maximum of several a day, of 13.6 grams pure ethanol per standard drink (see Table 8).

Area 9. Reducing the public health impact of illicit alcohol and informally produced alcohol

At present, illicit or informal alcohol does

| WHO: Policy options and interventions | Finland | Ontario |
|--------------------------------------|---------|---------|
| 37. Consumption of illicitly or informally produced alcohol could have additional negative health consequences due to a higher ethanol content and potential contamination with toxic substances, such as methanol. It may also hamper governments’ abilities to tax and control legally produced alcohol. Actions to reduce these additional negative effects should be taken according to the prevalence of illicit and/or informal alcohol consumption and the associated harm. Good scientific technical and institutional capacity should be in place for the planning and implementation of appropriate national, regional and international measures. Good market knowledge and insight into the composition and production of informal or illicit alcohol are also important, coupled with an appropriate legislative framework and active enforcement. These interventions should complement, not replace, other interventions to reduce harmful use of alcohol. | Currently, illicit or informally produced alcohol is not a special health problem in Finland. The great majority of current unrecorded alcohol consists of travellers’ alcohol imports or alcoholic beverages consumed outside Finland, and these beverages are in most cases legally produced and their quality is controlled (Yearbook of Alcohol and Drug Statistics, 2012). There are, however, occasional fatal poisoning incidents from smuggled beverages including methanol. The share of illegal alcohol sold in restaurants is very small. The amount of travellers’ alcohol imports are followed by weekly Gallup polls. Legally sold alcoholic beverages are quality controlled. | From the early 1990s to mid-1990s there was considerable concern about illicit alcohol coming into Ontario, as well as some concern about illicitly produced wine in Ontario. In the past decade this has not been a major issue, possibly because of greater border security related to 9/11 and stronger Canadian dollar which is now on par with US currency. There were awareness campaigns by the LCBO in the 1990s around smuggled alcohol and high risks of low-quality illegal wine. Legally produced and distributed alcoholic beverages are quality controlled, and main efforts have been taken to block sales of informally produced alcohol. The LCBO issues warnings on contaminants and other health threats from informal or illicit alcohol. |
| 38. Production and sale of informal alcohol are ingrained in many cultures and often informally controlled. Thus control measures could be different for illicit alcohol and informally produced alcohol and should be combined with awareness raising and community mobilization. Efforts to stimulate alternative sources of income are also important. | | |
| 39. Policy options and interventions: a) introduce a good quality control with regard to production and distribution of alcoholic beverages; b) regulate sales of informally produced alcohol and bringing it into the taxation system; c) introduce an efficient control and enforcement system including tax stamps; d) develop or strengthen tracking and tracing systems for illicit alcohol; e) ensure necessary cooperation and exchange of relevant information on combating illicit alcohol among authorities at national and international levels; f) issue relevant public warnings about contaminants and other health threats from informal or illicit alcohol. | | |

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| WHO: Policy options and interventions | Finland | Ontario |
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Table 10. Monitoring and surveillance

| WHO: Policy options and interventions | Finland | Ontario |
|---------------------------------------|---------|---------|
| **40.** Data from monitoring and surveillance create the basis for the successes and appropriate delivery of other nine policy options. Local, national and international monitoring and surveillance are needed in order to monitor the magnitude and trends of alcohol-related harms, to strengthen advocacy, to formulate policies and to assess impact of interventions. Monitoring should also capture the profile of people accessing services and the reason why people most affected are not accessing prevention and treatment services. Data may be available in other sectors, and good systems for coordination, information exchange and collaboration are necessary in order to collect the potentially broad range of information needed to have comprehensive monitoring and surveillance. |
| In Finland, the local and national alcohol situation is monitored for instance by the National Institute for Health and Welfare (THL) both by studying the alcohol field regularly and collecting and publishing alcohol related data, for instance, in the Yearbook of Alcohol and Drug Statistics. National surveys of Finnish drinking habits have been conducted since 1968 at eight-year intervals (Mäkelä et al., 2010). Underage drinking has been studied in Adolescent Health and Lifestyle Surveys at two-year intervals since 1977. THL is also collecting survey data on alcohol consumption by the elderly. The Yearbook of Alcohol and Drug Statistics has been published under different names since 1932. It deals with consumption of alcohol, detrimental effects of alcohol use and regulating the consumption of alcoholic beverages. Some of the data published in the Yearbook of Alcohol and Drugs Statistics has also been published under different names since 1932. It deals with consumption of alcohol, detrimental effects of alcohol use and regulating the consumption of alcoholic beverages. Some of the data published in the Yearbook of Alcohol and Drugs Statistics has also provided data on consumption and risk-taking. CAMH produces the reports on these two surveys, as well as numerous publications on associations between access to alcohol, consumption and alcohol-related social problems, trauma and chronic disease. However, no one institution is designated to provide an overview of alcohol issues in Ontario. The Drug and Alcohol Treatment Information System (DATIS) collects data from approximately 150 agencies and produces standard reports to the Ministry of Health and Long-Term Care. DATIS has produced specialised software which functions as the client information system for many of the participating agencies. A bi-annual monitoring report on alcohol issues in Ontario would be a useful tool for community networks, prevention planning and research proposal development. There is regular dissemination of information on alcohol consumption, harm and policy analyses to policy makers and other stakeholders such as public health organisations and non-government agencies. Collected data are available in various locations but not assembled into a single repository. There are evaluations of changes in alcohol policy, such as introduction of longer selling hours, or beer workers’ strikes. Annual population surveys include information on the opinions on alcohol policy measures. These protocols could be assembled into a generic evaluation mechanism to be initiated when new policy measures are introduced. | There is extensive documentation and monitoring of the utilisation of treatment services. There were bi-annual reports on alcohol and drug problems in Ontario, using a combination of archival data and survey findings. However, these were discontinued in the late 1990s. Currently, an annual general population survey of Ontario adults provides data on trends, patterns and personal consequences of alcohol consumption. A bi-annual student survey provides data on consumption and risk-taking. CAMH produces the reports on these two surveys, as well as numerous publications on associations between access to alcohol, consumption and alcohol-related social problems, trauma and chronic disease. However, no one institution is designated to provide an overview of alcohol issues in Ontario. The Drug and Alcohol Treatment Information System (DATIS) collects data from approximately 150 agencies and produces standard reports to the Ministry of Health and Long-Term Care. DATIS has produced specialised software which functions as the client information system for many of the participating agencies. A bi-annual monitoring report on alcohol issues in Ontario would be a useful tool for community networks, prevention planning and research proposal development. There is regular dissemination of information on alcohol consumption, harm and policy analyses to policy makers and other stakeholders such as public health organisations and non-government agencies. Collected data are available in various locations but not assembled into a single repository. There are evaluations of changes in alcohol policy, such as introduction of longer selling hours, or beer workers’ strikes. Annual population surveys include information on the opinions on alcohol policy measures. These protocols could be assembled into a generic evaluation mechanism to be initiated when new policy measures are introduced. |
not appear to be a significant source of alcohol in either Finland or Ontario. Unrecorded and smuggled alcohol has been a significant issue in Finland for a number of decades and in Ontario in the 1990s. Both jurisdictions have quality control of alcoholic beverages sold through their legal systems (see Table 9).

Area 10. Monitoring and surveillance
There is extensive monitoring in both jurisdictions, including a combination of annual or periodic surveys focusing on youth and adults, reports and peer-reviewed publications. These concentrate on alcohol consumption, treatment statistics and alcohol-related harm. They also include periodic assessment of the impacts of changes in alcohol policy on alcohol-related consumption and/or harm. Finland has an annual yearbook of alcohol and drug statistics, whereas Ontario has not had one since the late 1990s. There are periodic adult and student surveys of drinking behaviour in both places (see Table 10).

Discussion
Caveats and limitations: WHO’s Global strategy to reduce the harmful use of alcohol was adopted in May 2010. Three years is likely not sufficient time for the strategy to be widely disseminated, discussed and adopted and for policy changes to be implemented. Therefore, it may not be appropriate to seek to summarise changes and even a jurisdiction’s status on these ten areas at this time. On the other hand, a number of the key areas in the WHO document are strongly informed by evidence-based assessments that have been in the public domain for several decades (Bruun et al., 1975; Edwards et al., 1994; Babor et al., 2003). The interpretations of the situation in Finland and Ontario may therefore be seen appropriately as a baseline snapshot.

Three general recommendations are offered in the following paragraphs.

Monitoring
The WHO Global strategy to reduce the harmful use of alcohol (2010) is an impressive resource for justifying policy changes and providing guidance for those countries seeking to enhance their response to alcohol issues. A supplementary resource might be developed which would provide an operational tool that countries could use for organising baseline information on the specific variables in each area. This would facilitate country-based reports and the tracking of developments over time. It would also highlight specific areas where policy work was underdeveloped and concentrated effort was required to make a change. Finland and Ontario might be encouraged to provide a positive example and resource by introducing a bi-annual report in each place that summarises key statistics on consumption, drinking patterns, harm from alcohol, recent policy and prevention activities and highlights of research on these 10 areas. In jurisdictions where the capacity for alcohol policy is currently less developed, an initial focus might be on a few areas that together address a combination of population-level and more focused interventions (Canadian Public Health Association, 2011). At the population level, these could include alcohol pricing and alcohol availability, while questions of road safety and alcohol, and offering screening and brief intervention could be covered as more focused interventions.
Research
While all of the ten areas in the WHO document are informed by research, the strength of the evidence varies. Areas 2 to 9 are based on a body of evidence about the outcomes of specific interventions or policies (e.g. Babor et al., 2003; Anderson et al., 2009), and this evidence is most convincing with regard to availability of alcohol, drinking and driving interventions and pricing policies. This is not the case for areas 1 and 10, as they are underlying dimensions that facilitate the other interventions. It would require innovative research to indicate how the opportunity for planning and implementing alcohol policies is influenced by type of leadership and data on hand and accessible to policy-makers.

Policies
The WHO document Global strategy to reduce the harmful use of alcohol is about policies and interventions. What are the implications of this summary of activities in two jurisdictions? Three things stand out. First, secular changes – those not strictly speaking designed as alcohol policy interventions but which may have an impact on alcohol issues, such as international trade – can erode a long tradition of socially responsible alcohol policies. Second, sound policies with the potential of reducing alcohol-related harm typically do not emerge overnight. For instance, decades of advocacy, policy, research and evaluation of drinking and driving has produced a body of evidence that points to concrete interventions in this field (e.g., Babor et al., 2010). Third, a comparative approach can point to lessons from other jurisdictions that can be fine-tuned and adopted elsewhere. The WHO document Global strategy to reduce the harmful use of alcohol (2010) provides a roadmap of what is feasible and useful in reducing alcohol-related harm. It does not indicate how specifically these policies and interventions are best implemented in jurisdictions where they are weak or absent. For this, one must turn to accounts and case studies of policy advocacy.

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