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Research Paper

A qualitative exploration of Thai alcohol policy in regulating availability and access

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ABSTRACT

Background: Despite abundant alcohol control regulations and measures in Thailand, prevalence of alcohol consumption has been relatively steady for the past decade and alcohol-related harm remains high. This study aims to explore, through the perspectives of key public health stakeholders, the current performance of regulations controlling alcohol availability and access, and the future directions for the implementation of Thai alcohol policy.

Methods: Semi-structured interviews were conducted with public health stakeholders from three sectors; the government, academia and civil society. Their perceptions about the current alcohol situation, gaps in the current policies, and future directions of alcohol policy were discussed. Audio data were transcribed verbatim, systematically coded and analysed.

Results: The three key concerning issues were physical availability, economic availability and commercial access, which referred to outlet density, taxation and pricing, and compliance to stipulated regulations, respectively. First, Thailand failed to control the number of alcohol outlets. The availability problem was exacerbated by the increased numbers of liquor licences issued, without delineating the need for the outlets. Second, alcohol tax rates, albeit occasionally adjusted, are disproportionate to the economic dynamic, and there is yet a minimum pricing. Finally, compliance to age and time restrictions was challenging.

Conclusions: The lack of robustness of enforcement and disintegration of government agencies in regulating availability and access hampers effectiveness of alcohol policy. Comprehensive regulations for the control of availability of and access to alcohol are required to strengthen alcohol policy. Consistent monitoring and surveillance of the compliances are recommended to prevent significant effects of the regulations diminish over time.

Introduction

Harmful use of alcohol is a causal factor for intentional and unintentional injuries, and contributes to more than 200 alcohol-related health conditions, substantial avoidable disease burden and premature deaths worldwide (World Health Organization, 2014). The harmful use could also lead to criminal liabilities, especially among adolescents and young adults (Wicki, Kuntsche, & Gmel, 2010). Recognising the close links between harmful use of alcohol and socioeconomic development, the World Health Organization (WHO)'s Global strategy to reduce the harmful use of alcohol was endorsed by its member states in 2010 (World Health Organization, 2010). Following the endorsement, several countries have adopted appropriate and feasible evidenced-based alcohol policies and recommended legislative options to address these public health problems (World Health Organization, 2011). Among the ten recommended areas for policy options and interventions, two areas are relevant to availability of and access to alcoholic beverages; namely physical availability of alcohol and alcohol pricing policies. These interventions and policy measures to restrict availability and access are designed to help reduce consumption of and exposure to alcohol, hence

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leading to reductions in alcohol-related harm (World Health Organization, 2011), including alcohol-related hospital admissions (Callaghan, Sanches, & Gatley, 2013; Callaghan, Sanches, Gatley, & Cunningham, 2013) and deaths (Callaghan, Sanches, Gatley, & Stockwell, 2014).

First, the restrictions of alcohol availability and access have been found to be associated with many adverse outcomes among a variety of population, especially young people, such as increased risk of alcohol consumption (Rowland et al., 2014), binge drinking (Ahern, Margerison-Zilko, Hubbard, & Galea, 2013), underage drinking, interpersonal violence, and increased alcohol-related hospital admission rates (World Health Organization, 2011). Young people, especially the underage, who reside in high outlet density neighbourhoods have increased risk of early drinking initiation, which partly due to their limited mobility (Chen, Grube, & Gruenewald, 2010). Social implications are also present in the neighbourhoods with high alcohol outlet density. Mounting evidence supports the relationship between the amount of alcohol consumed and violent behaviour among a variety of populations (Duke, Giancola, Morris, Holt, & Gunn, 2011). Because of the unique characteristics of alcohol outlets or their density, they not only attract, but are likely to influence both violent and non-violent crimes (Grubesic, Pridemore, Williams, & Philip-Tabb, 2013; Toomey et al., 2012). Besides restricting the supply of alcohol, the demand of alcohol can also be regulated by establishing a barrier to commercial access to alcohol such as setting an appropriate minimum age for alcohol purchase or consumption. The specified minimum age could increase difficulties for sales to or consumption by young people (World Health Organization, 2010). To differentiate between the restrictions of supply and demand of alcohol, the term 'commercial access' will be used in this study to refer to the control of the ease to obtaining alcohol through purchases.

Second, pricing policies are used to reduce affordability of alcoholic beverages through pricing and taxation to influence levels of consumption (World Health Organization, 2011). In this study, the alcohol pricing and taxation are collectively referred to as 'economic availability' because of their apparent relevance to the availability and access to alcohol. Two evidence-based principals about alcohol pricing are (i) the higher the prices of alcoholic beverages, the greater the reduction in consumption and (ii) the greater the reduction in consumption, the lower the level of alcohol-related harm (Wagenaar, Salois, & Komro, 2009; World Health Organization, 2011). Systematic review of the effectiveness of price-based alcohol policy interventions, such as minimum unit pricing, illustrates that alcohol pricing could reduce alcohol consumption and so alcohol-related morbidity and mortality (Boniface, Scannell, & Marlow, 2017). The increased alcohol prices could lower levels of youth drinking through its effect on potential reduction of adult harmful drinking (Xuan et al., 2013). Not only tax burden and increased prices of alcoholic beverages could reduce health inequalities across diverse income groups (Meier et al., 2016), they also could lower availability of alcoholic beverages, especially among heavy drinkers (Vandenberg & Sharma, 2016). Currently, Thailand is using alcohol taxation system called One-Plus-One which was introduced since September 2017. The system combines the two major taxation methods, ad valorem taxation and specific taxation, when alcoholic beverages are taxed. Ad valorem taxation calculates the excise tax based on the value of alcoholic beverages sold, while specific tax is calculated based on the volume of pure alcohol in a beverage (Sornpaisarn, Shield, Österberg, & Rehm, 2017). Previously, Two-Chosen-One (2C1) system was used to excise alcohol where only the higher of the two methods was applied.

Along with the supporting evidence of the effectiveness in the availability and access control to reduce alcohol consumption in many high-income countries, the alcohol research in the low- and middle-income countries is growing to establish evidence-based alcohol policies (World Health Organization, 2014). For Thailand, Alcoholic Beverage Control Act B.E. 2551 (the Act) was enacted in 2008, aiming to discourage drinking among current drinkers and prevent drinking initiation among youth so as to reduce risks of alcohol-related harm (Royal Thai Government Gazette, 2008). Since then, an extensive range of these alcohol control regulations and measures has been developed. Despite this, the prevalence of alcohol consumption has been steady at 30–33% in the Thai population aged 15 and older (15+) for the past decade (National Statistical Office, 2015). At 7.2 L of pure alcohol, Thailand's alcohol per capita consumption in 15+ is the fourth highest in Asia and the highest in WHO South-East Asia region (World Health Organization, 2014). The global average is at 6.2 L of pure alcohol per year. Moreover, albeit high abstention and low unrecorded alcohol consumption rates in Thailand, its alcohol-related harm is comparatively greater than many countries with higher per capita consumption. In 2010, Thailand's prevalence of alcohol use disorders is twice the average prevalence in WHO South-East Asia region and its alcohol-attributable deaths was the highest (World Health Organization, 2014). The alcohol use among Thai youth reportedly leads to increased risks of drink-driving, violence, injuries, acute health problems, and unsafe sexual behaviours as well as increased tendency to other unhealthy behaviours such as smoking, prescription drug misuse and illicit substance use (Assanangkornchai, Mukthong, & Intanont, 2009; Chaveepojnkamjorn & Pichainarong, 2011).

Given that Thailand has abundant and various alcohol control regulations and policy options, a discourse of the performance of Thai alcohol control policy should be initiated to identify gaps for future improvements of measures regulating availability and access. Moreover, as alcohol control policy involves many regulations across different sectors, such as the public health, commerce, social development, and law enforcement agencies, the interactions between these agencies in the implementation of the alcohol policy should also be determined. Since public health sector is the main actor in the development and implementation of alcohol policy, this study aims to explore, through the perspectives of key public health stakeholders, the current performance of regulations controlling alcohol availability and access and the future directions of Thai alcohol policy. The exploration of the gaps in regulating alcohol availability and access could provide important insight for future alcohol policy dialogue and development.

Methods

Semi-structured interviews were conducted between May and August 2016. The respondents were key stakeholders who have involved in the alcohol policy process and/or have been actively involved in alcohol research and policy development. The stakeholders were from three sectors; the government (policymaker), academia and civil society. The three interconnected sectors simultaneously strengthen capacity in three interrelated areas, namely political involvement (the government), creation of knowledge (academia) and social movement (civil society) (Thamarangsi, 2009). These three sectors are collectively called the "triangle that moves the mountain" as proposed by a well-known medical, public health and social scholar in Thailand, Professor Prawase Wasi. Pragmatic purposive sampling through policy networks and snowball referrals were used. List of the members of the National Alcohol Policy Commission as appointed by the Alcohol Control Act was used for initial sample selection. The members of the Commission consisted of representatives from government agencies, non-governmental organisations, and persons whose knowledge, competence and experience pertaining to the fields of either social science, law or information and communication technology. A summary of respondents' areas of work and/or expertise is presented in Table 1. The ethical approvals were granted by the Human Research Ethics committees of the University of Wollongong (HE15/480) and of Mahidol University in Thailand (MUPH 2016-034).