

COMMENTARY

Alcohol controls in the aftermath of the COVID-19 pandemic in India: Commentary on Stockwell *et al.* 2020

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Abstract

The COVID-19 pandemic and subsequent restrictions have resulted in additional challenges for persons with alcohol use disorders as well as for the effective operation of alcohol controls in different societies. The challenges are different in different systems and economies. Crises such as these often provide governments with opportunities to remake systems. We use the recent experience from India, which rapidly shifted between total countrywide prohibition of alcohol and unrestricted sales during this brief period, to argue against using the present crisis to bring about quick changes in alcohol policy in India. Instead, we advocate sustained, incremental pressure to develop and enforce alcohol control measures in public health delivery systems, in addition to demand reduction measures. [Mahadevan J, Shukla L, Benegal V. Alcohol controls in the aftermath of the COVID-19 pandemic in India: Commentary on Stockwell *et al.* 2020. *Drug Alcohol Rev* 2020]

Key words: COVID-19, alcohol, India, policy, harm reduction.

We read Stockwell *et al.*'s recommendations [1] for alcohol policy in current times with interest and some concern. The suggestion that the 'COVID-19 crisis provides the perfect time to confront dysfunctional societal relationships with alcohol' echoes a sentiment recently heard in India: that the drinking population had got used to abstinence during the six week state of lockdown-induced-prohibition without demur or incident; and that the government should not lose this opportunity to press on with prohibition. At the outset, let us clarify that our comments in no way indicate a shift from our position that alcohol use contributes to significant health burden and societal costs, and that governments and societies, more so in lower- and middle-income countries like India, should move urgently but deliberately to implement effective alcohol control strategies.

However, we aver that a number of the assumptions by Stockwell *et al.* may not be universally applicable. Unlike countries from the global North that they mention, more than 20% of the world population underwent complete prohibition of alcohol for varying

periods during the pandemic. We feel it is crucial to examine the data emerging from these instances for a more comprehensive understanding of whether sudden policy changes amidst a humanitarian crisis deliver intended outcomes.

The experience from India may be informative, since it witnessed the implementation of at least two of the major alcohol policy measures suggested by the authors, namely nation-wide prohibition and increased taxation, at different points during this brief period.

The initial nationwide lockdown, arguably the world's biggest and strictest, came into force on 25 March, with just six hours notice, and continued until 3 May 2020. All private and public transport except emergency, utility and essential services were banned. Services outside of essential sectors – food, medical/pharmacies, utilities, communications and financial services – were closed. This included liquor shops, pubs, bars and restaurants [2]. In effect this resulted in a sudden imposition of a state of prohibition across the country.

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We reported a spike in the incidence of complicated alcohol withdrawal in the immediate aftermath [3], as did others across the country [4,5]. Consequent to the prevailing difficulties in treatment access due to travel restrictions and diversion of already meagre healthcare resources to pandemic control, most people could not reach medical care, and the numbers we reported were merely the tip of the problem [6]. Assuming that even 1% of the 86 million individuals estimated to suffer from alcohol use disorders in India [7] developed complicated alcohol withdrawal, the potential suffering is sizeable, given a pre-existing 91% treatment gap for alcohol use disorders [8]. It raises ethical questions about the state suddenly stopping access to alcohol when it lacks the capacity and resources to provide adequate care to 9 of 10 who are likely to suffer the ill-effects of such discontinuation [9].

There were indeed many reports of increased domestic violence. Paradoxically, domestic and interpersonal violence doubled in the first two weeks after the imposition of lockdown, and continued to be reported in higher than usual numbers after resumption of alcohol sales [10]. While alcohol worsens all forms of violence, one must be cautious in ascribing domestic violence solely to alcohol use, especially in the lockdown context. It may also be erroneous to attribute a crude decrease in numbers of trauma and vehicular accidents during the lockdown solely to unavailability of alcohol, when there are other more obvious reasons such as restricted movement and curfews.

There are limits to the effectiveness of alcohol prohibition as a public health measure [11] and the unintended adverse consequences are many. Inevitably, there was also an increase in reports in the popular media about large-scale thefts from alcohol stores and warehouses, black marketing of alcohol and illicit alcohol deaths, and occasional stories on consumption of hand sanitizers [9].

We can only speculate whether the continuation of the liquor ban would have led to the well-known, unintended consequences of total prohibition, since most state governments decided to lift restrictions on off-license liquor shops, but not on bars and restaurants, after the first lockdown ended. Alcohol sales and taxation are the prerogative of state governments and not the federal government in India. Previously, alcohol taxes accounted for between 15% and 58% of individual states' income. Recently, with India shifting to a central goods and services tax (GST), the independent resource-generating capacity of individual states has been drastically reduced. Alcohol is one of three items outside the ambit of GST through which states continue to generate their own funds, and the main revenue source of constantly strained state government

finances, given delays and shortfalls in GST share accrual. India's states, put together, earned about ₹2.25 trillion from taxes on alcohol in the last fiscal year (2019–2020) [12]. The sudden, shock closure of the economy coincided with a big shortfall in GST collections and a delay in federal government payments to states. As the economy and tax collections slumped, states started clamouring to allow liquor sales to reopen.

The re-opening led to hectic buying of alcohol and a rush on the liquor shops, making a mockery of social distancing rules. Record, unprecedented sales figures were registered in the first 48 hours. Hectic buying also led to dramatic rises in alcohol industry shares – against the trend on a day when the Sensex stock index crashed by 6% [13]. Some state governments tried to stem the tide by increasing taxes by 15–70%, levying a 'corona fee' (Delhi: 70%, Odisha: 50%, Karnataka: 17%). This managed to reduce demand in the short term, by between 30 and 90% of peak sales, but most states quickly rolled back the taxes as excise-revenues slumped. Given the peculiar practice of taxation by volume, beer is taxed 60% higher than spirits, so beer prices increased disproportionately to spirits, leading to a 60% fall in beer sales compared to a 15% fall in spirits [14,15]. This prompted a shift of consumption from lower to higher alcoholic beverages [16]. Surveys showed that many consumers adjusted to steeper prices by shifting to lower-priced beverages. Price elasticity of alcohol consumption in developing countries is low (–0.14 to –0.46), and people usually switch to unhealthier forms or divert money from household expenses to buying costlier alcohol [17]. Additionally, since bars and restaurants remained closed, there was also an increase in solitary, non-convivial drinking worsening patterns of harmful drinking [16]. In the foreseeable future, with the economy contracting, states are going to depend more heavily on alcohol markets for revenue. The COVID-19 crisis has even forced state governments to allow deliveries of alcohol at doorsteps, through e-commerce and online food delivery platforms [18]. We agree with Stockwell *et al.* that governments, certainly in India, will be unwilling, in the near term, to turn off the taps of alcohol supply.

In the absence of a formal uniform nation-wide alcohol policy, most Indian states, in the best of times, swing periodically between two policy poles: total prohibition (often motivated by political favour with women voters before elections) and increasing sales (motivated by tax considerations and aided by the industry). Unfortunately, the health imperative rarely figures in these considerations. The brief interlude thus played out the usual swing. This is never helpful for the cause of long-term rational alcohol controls.

It is tempting to see an opportunity in the current crisis. But well-meaning attempts to reduce harm by controlling people's behaviours, often get enmeshed in wider political 'shock-doctrine' strategies of using large-scale crises to push through policies, which expand emergency powers and surveillance programs and promote disaster capitalism [19].

Unfortunately, the information about the extent of alcohol-related harms and their impacts on healthcare services has never been the focus of sustained public engagement and health-planning. Neither have screening, brief intervention, and referral to treatment models [20] targeting hazardous and harmful use of alcohol. It is probably these and other evidence-based control measures, which highlight alcohol's role in health burden and social costs, which need to be encouraged, steadily and persistently, with the additional post-pandemic appreciation that alcohol use negatively affects immunity. There is a silver lining in the recent experience, which demonstrates that there may be some price elasticity with increased taxes at the higher end of the market, which may help to reduce aggregate consumption – although governments are strangely loath to raise prices of cheap alcohol. Likewise, it has been difficult to convince excise authorities in most states to change to alcohol content-based taxation.

We hope that in the post-COVID world, populations and governments will be more favourable towards public health preventive measures and scientific evidence.

Conflicts of Interest

The authors have no conflicts of interest.

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