THE JOURNAL OF
GLOBAL DRUG POLICY AND PRACTICE

WHO's Global Strategy to Reduce Alcohol-Related Harm: Can the Potential be Realized?

David H. Jernigan PhD

Financial support: Johns Hopkins Bloomberg School of Public Health

Abstract

Alcohol-related harm is a significant factor in global death and disability. The World Health Organization is currently developing a global strategy on alcohol-related harm. Working documents for the strategy are promising and contain key elements of what research suggests will be a successful approach. However, the strategy will have little impact if resources are not identified to implement it. One possible source is increased taxation on alcohol. However, the tobacco experience suggests that increased taxes and other effective control policies will only come about through substantial investments on the part of governments, private individuals and charities, and civil society in documenting and raising awareness about alcohol-related harm and building support for evidence-based alcohol control policies.

The Context

According to World Health Organization (WHO) estimates, in 2004 alcohol was responsible for 4.6 percent of global death and disability, causing 2.5 million deaths, including 320,000 deaths among young people between the ages of 15 and 29.(1, 2) When WHO compared the burden of disease from alcohol, tobacco and 24 other risk factors in 2000, alcohol ranked just below tobacco in its impact on global health and had a greater share of the global burden of disease than unsafe water and sanitation, cholesterol or obesity.(3) Alcohol's impact on health is even greater in some regions and populations: in Latin America, 14 percent of male death and disability is caused by alcohol.(1) In Eastern Europe, 19.2 percent of males have alcohol use disorders.(4) All these estimates incorporate adjustments for alcohol's possible protective effects against cardiovascular and other diseases in some persons above age 40. In the U.S. alone, the economic costs of alcohol use were estimated at $234.8 billion in 2007 dollars, or 2.7 percent of the gross domestic product. These include costs of health care, law enforcement, property damage and loss, social work services and lost productivity.(1)

Although throughout the world men do much of the drinking, women suffer the bulk of the consequences.(5) Social harms are not included in the estimates above, and they are not evenly distributed. They affect the poorest families as well as those with the heaviest drinkers, impinging on family budgets and contributing to domestic violence and divorce.(5) Alcohol use among youth affects human capital development and has been related to educational failure, unsafe sex and criminal behavior.(6) Costs of alcohol use are generally even higher in the criminal justice and social welfare sectors than in the health sector, as problem drinkers are often more likely to encounter these systems than health care settings.(6)

Worldwide, development and economic prosperity have generally led to higher rates of alcohol use in the absence of mitigating factors such as, for example, the influence of Islamic injunctions against drinking. Consumption of alcohol has been declining in most of the developed nations in the past two decades, while it is increasing elsewhere, particularly in the countries of Asia, Eastern Europe and the former Soviet Union.(5) At the same time, rapid market transitions and liberalization have contributed to a political environment in which policies that have shown effectiveness in limiting alcohol-related harm either do not exist or are being eroded and repealed, resulting in increased risk from alcohol use for youth and other vulnerable populations.

Several recent research reviews have established an evidence-based menu of policy options for reducing and preventing alcohol-related harms (6-8), and there is a track record of global organizations such as WHO and the World Bank echoing these recommendations.(9, 10) These options include:

Higher taxes on alcoholic beverages – this strategy is particularly effective in reducing youthful consumption, if there is not a substantial informal market for alcohol

Regulating physical availability of alcohol through minimum legal purchase age; government monopoly of retail sales; restrictions on the density, locations, and laws that make providers of alcohol liable for harms from drinking by those they serve; and restrictions on product types (e.g. products clearly targeting underage drinkers)

Altering the drinking context by enforcing on-premise policies such as proscriptions against serving intoxicated patrons, training bar staff and managers, and promoting community mobilization

Limiting alcohol promotion through comprehensive bans on advertising and promotion or strong restrictions combined with counter-advertising

Deterrence through sanctions on drinking-driving, such as laws against driving while at or above a defined blood-alcohol level, sobriety checkpoints and random breath-testing, graduated licensing for novice drivers, lower blood-alcohol limits for young drivers and administrative license suspension for violation of blood-alcohol limits

Treatment and early intervention, including brief interventions in primary care settings as well as access to treatment for alcohol dependence, whether professional or voluntary (e.g. Alcoholics Anonymous)

The Opportunity

In May 2008, the World Health Assembly, in resolution WHA61.4, commissioned WHO to design a global strategy to reduce and prevent the harmful consequences of alcohol use. This strategy will have been developed through extensive consultations with Member States, non-governmental and intergovernmental organizations, and "economic operators" (i.e. various segments of the alcohol industry). The strategy is due to be presented to WHO's Executive Board in January 2010 and will be adopted or rejected at the World Health Assembly in May of 2010.

The global strategy will set the global course on alcohol problems prevention for the next decade. Currently, resources for global alcohol work are minimal, at WHO and elsewhere. Investment in global alcohol policy development and research translation at this time has the potential to influence this strategy so that it reflects the best research evidence available, is developed free of commercial interests and has the strongest possible chance of success in reducing the global burden of alcohol problems.

A "working document" for developing the draft global strategy has been posted on the WHO web site in six languages (the English version is available at http://www.who.int/substance_abuse/activities/msbwden.pdf). This document is a very good start. Drawing on the consultation process, it identifies ten target areas for Member States: awareness and commitment, health services' response, community action, drink-driving policies and countermeasures, availability of alcohol, marketing of alcoholic beverages, pricing policies, harm-reduction approaches, reducing the public health impact of illegal or informal alcohol and monitoring and surveillance. The working document outlines evidence-based strategies and policies under each of these subheads. Coverage is comprehensive, although the setting of priorities based on research support in each area could be clearer.

The Potential

The draft strategy document does a good job of laying out the "what" as in "what should be done." Assuming that its recommendations survive the process of debate and compromise among Member States that will ensue between now and May 2010, a second step will be needed: the "how." How will Member States get from here to adoption and enforcement of the mix of policies and programs the strategy lays out? Translating the evidence-based policies into public health practice will require an investment in public health infrastructure in activities similar to what has been done to promote global tobacco control. These strategies include:

organizing regional meetings and trainings of alcohol policy advocates in developing and transitional regions of the world in order to highlight the burden of alcohol problems in those regions and disseminate effective tools for their reduction and prevention;

developing and compiling training and scientific materials to support efforts to implement effective problem reduction strategies;

employing aggressive public communications to raise the global profile of alcohol problems and policies;

providing technical assistance and mini-grants to local organizations in resource-poor countries to aid in building awareness of and support for effective problem reduction strategies;

conducting case study and translational research into the implementation of local prevention programs to assess their effectiveness in differing cultural, social, political, and economic settings, and disseminating the findings;

building and promoting use of web-based tools to support local action to prevent alcohol-related problems;

furthering partnerships at regional and global levels that raise visibility of alcohol-related problems as a global health issue, and promote effective action to prevent them.

Where will this investment come from? An obvious source is increased alcohol taxes, which serve the dual function of raising much-needed funds for the strategy and reducing alcohol consumption and related harm.(11) Tobacco taxes have risen significantly in recent years across the United States, and implementing health-enhancing tobacco taxes is one element to which governments that are signatory to the Framework Convention on Tobacco Control commit themselves.(12) However, the road to that Framework Convention, and to those tax increases, was paved with non-tax investments in tobacco

control. There is near-global consensus that tobacco control requires support and resources from government and civil society. There is far less consensus (and far less funding) for global alcohol control. Where are the public health charities that will lead the way, the individual philanthropists who will take courageous stands and make substantial investments? Where are the visionary national governments willing to pressure their peers into greater recognition of and funding to reduce alcohol problems in low- and middle-income countries?

Significant advances in the last eight years in epidemiology and prevention research have established both an unprecedented scientific base for and a well-documented picture of the urgency of national, regional and global action. The time is ripe, and the need is great not only for the development of an effective global strategy that will support national, regional and global action to raise awareness about alcohol problems, but also for the identification of the resources to encourage, enact and enforce the policies that can reduce and prevent them.

Author Information

David H. Jernigan PhD
Associate Professor, Department of Health, Behavior and Society, Johns Hopkins Bloomberg School of Public Health

References

1. Rehm J, Mathers C, Popova S, Thavorncharoensap M, Teerawattananon Y, Patra J. Global burden of disease and injury and economic cost attributable to alcohol use and alcohol-use disorders. The Lancet. 2009;373:2223-33.

2. World Health Organization. Working document for developing a draft global strategy to reduce harmful use of alcohol. Geneva: World Health Organization; 2009 [updated 2009; cited September 12, 2009]; available from: http://www.who.int/substance_abuse/activities/msbwden.pdf.

3. World Health Organization. World Health Report 2002: Reducing Risks, Promoting Healthy Life. Geneva: World Health Organization; 2002.

4. Rehm J. Death and disability attributable to alcohol among youth. In: Jernigan D, editor. Washington, D.C.; 2003.

5. Room R, Jernigan D, Carlini Cotrim B, Gureje O, Mäkelä K, Marshall M, et al. Alcohol in developing societies: a public health approach. Helsinki and Geneva: Finnish Foundation for Alcohol Studies and World Health Organization; 2002.

6. Jernigan D, Room R. Alcohol in development and in health and social policy. Washington, DC: World Bank Discussion Papers Series; 2004.

7. Babor TF, Caetano R, Casswell S, Edwards G, Giesbrecht N, Graham K, et al. Alcohol: no ordinary commodity. Oxford: Oxford University Press; 2003.

8. WHO Expert Committee on Problems Related to Alcohol Consumption. Second report / WHO Expert Committee on Problems Related to Alcohol Consumption. Geneva: World Health Organization; 2007.

9. World Health Organization. Global Status Report on Alcohol. Geneva: WHO, Substance Abuse Department, WHO/HSC/SAB/99.11; 1999.

10. World Bank. PH @ a Glance: Alcohol. World Bank; 2003 [updated 2003; cited May 25, 2004]; available from: http://wbln0018.worldbank.org/HDNet/hddocs.nsf/0/09174c13bbe34c9f85256df3004ee21a?OpenDocument.

11. Cook PJ. A free lunch. Journal of Drug Policy Analysis. 2008;1(1):1-5.

12. World Health Organization. Framework Convention on Tobacco Control. 2005 [cited October 11, 2008]. Available from: http://www.who.int/tobacco/framework/WHO_FCTC_english.pdf.