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World Health Organization

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**Comments on the second WHO Discussion Paper, dated 22 March 2012, on global monitoring, indicators and targets for the prevention and control of noncommunicable diseases**

IOGT-NTO is grateful for the opportunity to comment on the discussion on monitoring framework and targets for the prevention and control of NCDs within WHO and the UN.

IOGT-NTO is a Swedish Non-Governmental Organisation with around 32 000 members. We work with alcohol policy issues by promoting science-based policies independent of commercial interests, as well as with drug policy and preventive and social work, both internationally and in Sweden.

We support the growing international awareness and interest in NCDs and the corresponding risk factors. In this reply we focus on alcohol as a risk for public health, as this is the main issue for our organization. At the same time we recognize the importance of other risk factors for NCDs.

Until now, alcohol has maintained its position among the major risk factors for NCDs. The initial draft of the WHO monitoring framework and targets included a target of a 10 per cent relative reduction in per capita consumption of litres of pure alcohol among persons aged 15+ years. In the second WHO discussion paper dated 22 March 2012, which WHO now has invited comments on, this target has been omitted. It would be a substantial setback to the work for control and prevention of NCDs, if alcohol was to be dropped from the list of core factors in NCDs for which targets are set.

Our position is summarized below:

- Prioritize indicators and goals that prevent the occurrence of NCDs and related mortality
- Put public health first and adopt targets on all major risk factors, including alcohol
- Reduction of adult alcohol per capita consumption needs to be reinstated among the global priority targets and indicators.

- Stand firm by the Political Declaration adopted by the General Assembly in September 2011 that recognizes alcohol as one of the four main risk factors to non-communicable diseases and the critical importance of reducing the level of exposure of individuals and populations to these modifiable risk factors.
- Stand firm by the Political Declaration of the General Assembly to advance the implementation of population-wide interventions in order to reduce the impact of alcohol, together with the other main risk factors.
- Stand firm by the WHO global alcohol strategy on the influence on public health of the general level of consumption of alcohol in a population, and on the proposed interventions based on current scientific knowledge, such as availability and pricing policies.
- Agree to reporting progress every two years. This will make it possible to give NCDs the appropriate level of priority on national and global agendas.

### **Summary**

Reduction of adult alcohol per capita consumption needs to be reinstated as one of the global priority targets. Alcohol easily qualifies for priority on all five criteria to guide the selection of indicators and targets, stated in the WHO discussion paper of 22 March 2012.

Adult per capita consumption is an appropriate and relevant measure of harmful alcohol consumption and alcohol harm, given the scientifically well-established relation to excessive and heavy drinking. This is strengthened by the linear risk increase for many alcohol-related NCDs, where for e.g. cancers even a moderate consumption of alcohol entails an increased risk. As there is no apparent threshold for the risk there is no consumption of alcohol that can be said to be free from risk. Decrease of adult per capita consumption is therefore an important target in order to reduce the global burden of NCDs.

Even though only half the global population drinks alcohol, it is estimated to rank as high as the world's third leading cause of ill health and premature death, with an impact greater than tobacco. In France, a high-consuming country, alcohol is the second largest known factor for cancer after tobacco. It is important to prevent a similar development in developing countries with today lower levels of consumption.

There are many evidence-based alcohol policies available to reduce the harm caused by alcohol. There is strong support in the research literature for the effectiveness of population-wide, general interventions and strategies. This fits well with the importance of the level of consumption in a population for the level of harm. Interventions that regulate the environment in which alcohol is marketed (economic and physical availability and commercial communications) are effective in reducing alcohol-related harm. These interventions are also cost-effective. Increases in alcohol tax not only cost little to implement, but also strengthen public finances at the same time as they decrease the level of harm.

The book *Alcohol: No Ordinary Commodity* lists at least 22 strategies and interventions that have demonstrated effectiveness through scientific evaluation and that have been tested cross-nationally. The interventions include alcohol tax, minimum legal purchase age, restrictions on hours and days of sales, restriction on density of outlets,

government retail monopolies, lowered BAC levels, random breath testing and brief intervention.

Resolutions from the UN General Assembly as well as WHO World Health Assembly support the notion of the importance of the general level of alcohol consumption for the health problems caused by alcohol. Both UN and WHO resolutions commit to population-wide interventions as raised alcohol tax and restrictions in availability. This is not only expressed by UN and WHO, but also by many international organisations, e.g. by the World Bank, The World Medical Association, Chronic Disease Alliance and in the World Cancer Declaration.

### **Criteria for indicators and targets**

In the second WHO discussion paper of 22 March 2012 are stated five criteria to guide the selection of indicators and targets. The five criteria are:

1. High epidemiological and public health relevance.
2. Coherence with major strategies, notably the priorities of the Global Strategy for the Prevention and Control of NCD and its Action Plan, the Political Declaration, and the WHO framework for health systems priorities to monitor exposures, outcomes, and health systems response.
3. Availability of evidence-based effective and feasible public health interventions.
4. Evidence of achievability at the country level, including in low- and middle-income countries.
5. Existence of unambiguous data collection instruments and potential to set a baseline and monitor changes over time.

Alcohol easily qualifies for priority on all five of the criteria.

1. Even though only half the global population drinks alcohol, it is estimated to be the world's third leading cause of ill health and premature death, after low birth weight and unsafe sex (for which alcohol is a risk factor). The impact of alcohol use is estimated to be greater than tobacco and is especially large in middle income countries.<sup>1</sup>
2. Alcohol is stated as one of the four main shared risk factors for non-communicable diseases in the Global Strategy for the Prevention and Control of NCD and its Action Plan<sup>2</sup>, as well as in the Political Declaration of the High-level Meeting of the General Assembly on the Prevention and Control of Non-communicable Diseases<sup>3</sup>. There is also an established commitment in the WHO global alcohol strategy.<sup>4</sup>
3. There are many well researched, hence evidence-based, effective public health interventions available for alcohol. E.g. the book *Alcohol: No Ordinary Commodity*,

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<sup>1</sup> Global health risks, WHO 2009

<sup>2</sup> 2008-2013 action plan for the global strategy for the prevention and control of noncommunicable diseases, WHO 2008

<sup>3</sup> UN General Assembly Resolution, A/RES/66/2, adopted 19 September 2011

<sup>4</sup> Global strategy to reduce the harmful use of alcohol, WHO 2010

where 15 of the world's leading alcohol researchers summarize the scientific evidence of the effectiveness of alcohol policy interventions, describes 22 different interventions with moderate or high degree of effectiveness, according to the authors' classification.<sup>5</sup>

4. The interventions listed in *Alcohol: No Ordinary Commodity* are classified as to degree of cross-national testing. All of the 22 interventions mentioned above have high ratings on this aspect.<sup>6</sup>

5. Good surveillance and monitoring systems for per capita consumption of alcohol are already in place in many parts of the world. Where there is substantial unrecorded alcohol consumed, there are established methods used in WHO's Global Information System on Alcohol and Health for estimating its volume.<sup>7 8</sup>

### **The importance of alcohol as a risk factor for NCDs**

There is a strong link between alcohol and non-communicable diseases, particularly cancer, cardiovascular disease, liver disease, pancreatitis and diabetes. Alcohol is causally linked to eight different cancers, with the risk increasing with the volume consumed. Of the global NCD-related burden of deaths 3.4% can be attributed to alcohol. The corresponding figure for net years of life lost (YLL) is 5.0% and for net disability adjusted life years (DALYs) 2.4%. The burden is particularly high for cancer and liver cirrhosis.<sup>9</sup>

Alcohol takes an exceptionally high toll in the growing number of middle-income countries. In some regions, one in five male deaths is attributed to alcohol and nearly half of all alcohol-attributable deaths occur from non-communicable diseases.<sup>10</sup> Alcohol can also significantly drain family expenditures, since costs for non-communicable disease-related health care, medicines, and costs for alcohol diverts household income and resources from ensuring food and nutrition security and displace household resources that might otherwise be available for education.<sup>11 12</sup>

Alcohol is also associated with several infectious diseases like HIV/AIDS, tuberculosis and pneumonia.<sup>13</sup>

### **Adult per capita consumption and harmful alcohol consumption**

Given the scientifically well-established relation between adult per capita consumption and excessive and heavy drinking, decrease of adult per capita consumption is an important and appropriate target in order to reduce the global burden of NCDs. This is strengthened by the linear increase of risk for many alcohol-related NCDs, where for

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<sup>5</sup> *Alcohol: No Ordinary Commodity*, Second Edition, Thomas Babor et.al., 2010

<sup>6</sup> Ibid.

<sup>7</sup> Global status report on alcohol and health, WHO, 2011

<sup>8</sup> Global Information System on Alcohol and Health (GISAH),

<http://www.who.int/gho/alcohol/en/index.html>

<sup>9</sup> Alcohol consumption and non-communicable diseases: epidemiology and policy implications, Charles D. Parry et.al., *Addiction*, Oct 2011

<sup>10</sup> Prevention and control of non-communicable diseases, Report of the UN Secretary-General, A/66/83, 19 May 2011

<sup>11</sup> Ibid.

<sup>12</sup> NCDs and MDGs – SUCCESS IN SYNERGY, 2011 UN High-level meeting on NCDs, 19-20 September 2011

<sup>13</sup> Global status report on alcohol and health, WHO, 2011

e.g. cancers even a moderate consumption of alcohol entails an increased risk. As there is no apparent threshold for the risk there is no consumption of alcohol that can be said to be free from risk.

### *1. Relation to excessive and heavy alcohol consumption*

That there is a relationship between adult per capita consumption and excessive or heavy consumption of alcohol is well established by several, independent scientific evaluations. Examples of such evaluations are mentioned below. Although alcohol can cause harm even when not consumed excessively or heavy, it should be uncontroversial that excessive or heavy consumption is considered harmful.

The US Center for Disease Control, CDC, under the US Department of Health and Human Services, has recently carried out systematic reviews on the effect on excessive alcohol consumption of e.g. alcohol taxes and government retail monopolies. The reviews have therefore considered the evidence for the relationship of per capita consumption and excessive drinking and states: “there is an extremely strong relationship between per capita alcohol consumption and various measures of excessive drinking”<sup>14</sup> and “excessive drinking and per capita alcohol consumption are strongly related both theoretically and empirically”.<sup>15</sup>

In a review of the evidence for the effectiveness and cost-effectiveness of policies to reduce the harm caused by alcohol, published in *The Lancet* 2009, the authors state: “Ecologically there is a very close link between a country’s total alcohol per head consumption and its prevalence of alcohol-related harm and alcohol dependence, implying that when alcohol consumption increases, so does alcohol-related harm and the proportion of people with alcohol dependence and vice versa.”<sup>16</sup>

In *Alcohol: No Ordinary Commodity*, second edition, the authors state that “there is a strong relationship between the total consumption of alcohol in a population and the prevalence of people who are heavy drinkers.” However, when total consumption increases, it is not only the consumption of heavy drinkers that increase, the consumption tends to increase in all consumer groups.<sup>17</sup>

As chronic excessive drinking is a well-established risk factor for cirrhosis, liver cirrhosis mortality is a classical indicator of harmful drinking in a population. In the European Comparative Alcohol Study, ECAS, published 2001, the relationship between liver cirrhosis mortality and adult per capita consumption was studied for 15 European countries in the postwar period. The study demonstrates that a higher level of per capita consumptions is associated with a higher rate of deaths by cirrhosis,<sup>18</sup> see figure below.

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<sup>14</sup> The Effectiveness of Tax Policy Interventions for Reducing Excessive Alcohol Consumption and Related Harms, Randy W. Elder et.al., *Am J Prev Med* 2010;38(2):217–229

<sup>15</sup> Effects of Alcohol Retail Privatization on Excessive Alcohol Consumption and Related Harms, Robert A. Hahn et.al., *Am J Prev Med* 2012;42(4):418–427

<sup>16</sup> Effectiveness and cost-effectiveness of policies and programmes to reduce the harm caused by alcohol, Peter Anderson et.al., *Lancet* 2009; 373: 2234–46

<sup>17</sup> *Alcohol: No Ordinary Commodity*, Second Edition, Thomas Babor et.al., 2010

<sup>18</sup> Alcohol-related mortality in 15 European countries in the postwar period, Mats Ramstedt, in *Alcohol in postwar Europe - Consumption, drinking patterns, consequences and policy responses in 15 European countries*, 2001

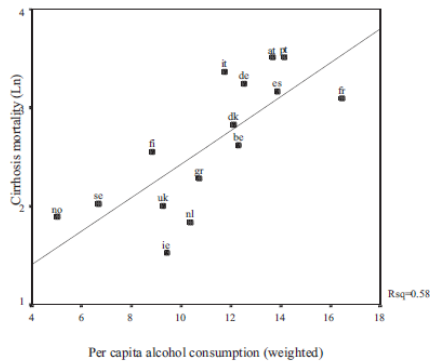


Figure 6.2. Relationship between alcohol consumption (litres 100% per capita 15+) and liver cirrhosis mortality (men and women). Average figures for each country for 1987-1995. (at=Austria, be=Belgium, de=Germany, dk=Denmark, es=Spain, fi=Finland, fr=France, gr=Greece, ie=Ireland, it=Italy, nl=The Netherlands, no=Norway, pt=Portugal, se=Sweden, uk=United Kingdom).

### From Alcohol in postwar Europe, p. 154

In a review of articles published between 1994 and 2005 on mortality and population drinking, the authors state that “Research during the past decade has strengthened the notion of a relationship between population drinking and alcohol-related harm”. The study looked not only at liver cirrhosis and alcohol-related diseases, but also heart disease mortality and acute harms as accidents and alcohol poisonings.<sup>19</sup>

There are several examples from the countries of northern Europe that changes in per capita consumption are associated with similar changes in consumption of heavy drinkers. When prices of spirits increased in Denmark in 1917 a considerable reduction in total consumption followed as well as a dramatic decrease in alcohol-related deaths associated with heavy drinking.<sup>20</sup> During Gorbachev’s anti-alcohol campaign in Moscow in 1985-1987, total consumption decreased by estimated 29 per cent, which was accompanied by a 63 per cent reduction in hospital admissions for alcohol-related mental and behavioural disorders.<sup>21</sup> When the retail sale of beer was privatized in Finland at the end of 1968, per capita consumption, in litres of pure alcohol, increased by 46% in a year. Consumption increased at all levels of consumption, but the increase was larger among heavy drinkers.<sup>22</sup>

As the British epidemiologist Geoffrey Rose has demonstrated, the total burden of disease in a population depends on the number of people exposed to a particular risk factor. In the Intersalt study, which studied 52 populations sample from 32 countries, including Brazil, Kenya, China and the United States, it is demonstrated that the mean

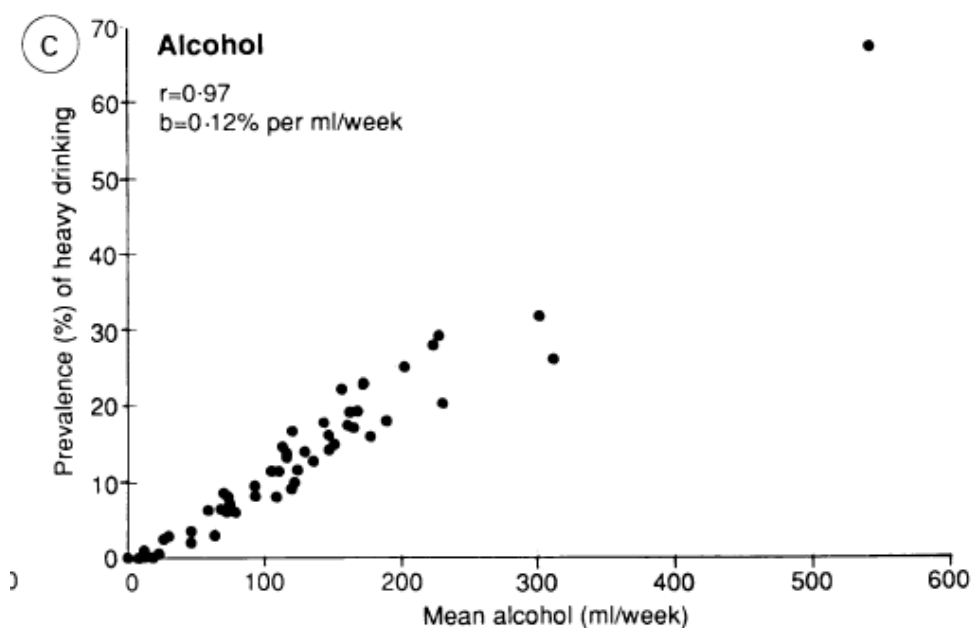
<sup>19</sup> Mortality and population drinking: a review of the literature, Thor Norström & Mats Ramstedt, *Drug and Alcohol Review* (November 2005), 24, 537 – 547

<sup>20</sup> Hundrede års alkoholisbruk - Alkoholforbrug og alkoholproblemer i Danmark (One Hundred Years of alcohol consumption and alcohol problems in Denmark), Thorsen T., Danish Council on Alcohol and Narcotics, 1990

<sup>21</sup> Suicides and alcohol consumption in Russia, 1965-1999. Alexander Nemtsov *Drug Alcohol Dependence*, August 2003

<sup>22</sup> Whose drinking does the liberalization of alcohol policy increase? Change in alcohol consumption by the initial level in the Finnish panel survey in 1968 and 1969, Pia Mäkelä, *Addiction*, June 2002

value of a risk factor is correlated to the prevalence of corresponding disease, not only for issues like mean blood pressure to hypertension, or mean body mass index to overweight, but also in the case of behavioural variables like alcohol consumption. The relationship between mean alcohol consumption and the percentage of heavy drinking was closely correlated in the 52 population samples, see figure below. Even when excluding the high values of drinking from the estimates of the mean, the relationship is highly correlated and statistical significant, i.e. the per capita consumption of “normal”, non-heavy consumers, is correlated to the percentage of heavy consumers in a population.<sup>23 24</sup>



*Relation between population mean and the prevalence of deviant (high) values across 52 population samples from 32 countries (men and women aged 20-59)*

From The population mean predicts the number of deviant individuals, Geoffrey Rose and Simon Day, *BMJ*, 3 November 1990

## 2. Relation to individual risk, the example of cancer

When there is a dose-response relationship between alcohol consumption and harm at individual level, an increase in per capita consumption must necessary entail an increase in harm, as the consumption of at least some individuals must increase. That the average volume of alcohol consumption at the individual level increase the risk for several major chronic diseases, as mouth and oropharyngeal cancer, oesophageal cancer, breast cancer, unipolar major depression and hypertensive disease, has been shown in meta-analyses.<sup>25</sup>

<sup>23</sup> The population mean predicts the number of deviant individuals, Geoffrey Rose and Simon Day, *British Medical Journal*, 3 November 1990

<sup>24</sup> Rose's Strategy of Preventive Medicine, Geoffrey Rose, 1992 (reprinted 2011)

<sup>25</sup> The relationship of average volume of alcohol consumption and patterns of drinking to burden of disease: an overview, Jürgen Rehm et.al., *Addiction*, September 2003

That the risks increase linearly with the amount of alcohol drunk, without any threshold below which no effect is evident, has especially been shown for cancers of the oral cavity, pharynx and larynx, of oesophageal cancer, colorectal cancer and breast cancer.<sup>26 27 28</sup>

As an example the relation between alcohol consumption and cancer in British women have been studied in the British Million Women Study. The study included over 1.2 million middle-aged women with an average follow-up time of more than 7 years. For every additional drink of 10 grams of alcohol regularly consumed per day, the increase in incidence was estimated to be about 15 cancers per 1000 women, 11 for breast cancer, 1 for cancers of the oral cavity and pharynx, 1 for cancer of the rectum, and 0.7 each for cancers of the oesophagus, larynx and liver.<sup>29</sup>

The International Agency of Cancer Research, IARC, of the WHO has in a report from 2007 estimated the causes of cancers in France for the year 2000. Alcohol is here the second largest known factor for cancer after tobacco. Alcohol is attributed to 8.1% of the numbers of cancer cases and 6.9% of the numbers of cancer deaths. The third largest factor is infectious agents with 3.3% and 3.7% of cases and deaths, respectively.<sup>30</sup> Alcohol consumption in France is higher than in most countries, but this example demonstrates the importance to not increase alcohol consumption in countries with lower levels of consumption.

### *3. Heart disease, harm and interventions*

The possible positive effect of moderate alcohol consumption on heart disease is not seldom used as an argument against the harmfulness of alcohol and against efficient interventions. It is not reasonable on an individual level to try to reduce the risk for heart disease by using a known carcinogenic, especially as there are other, less risky methods, to reduce the risk for heart disease, as physical activity or eating more vegetables and fruit. Therefore, it is not reasonable to use this possible effect to influence the implementation of alcohol policy interventions. The possible positive effect on the heart is also scientifically questioned. E.g. a recently published systematic review and meta-analysis of 84 articles on moderate alcohol consumption and health benefits<sup>31</sup> was critically assessed and all but two<sup>32</sup> articles were found to suffer from at least one of six serious methodological problems. The remaining two studies are equivocal in their results.<sup>32</sup>

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<sup>26</sup> European Code Against Cancer and scientific justification: third version (2003), Peter Boyle et.al., *Annals of Oncology* 14: 973–1005, 2003

<sup>27</sup> Food, Nutrition, Physical Activity, and the Prevention of Cancer: a Global Perspective, World Cancer Research Fund / American Institute for Cancer Research, 2007

<sup>28</sup> The Risks Associated With Alcohol Use and Alcoholism, Jürgen Rehm, *Alcohol Research & Health*, no. 2 2011

<sup>29</sup> Moderate Alcohol Intake and Cancer Incidence in Women, Naomi E. Allen et.al., *Journal of the National Cancer Institute*, 4 March 2009

<sup>30</sup> Attributable causes of cancer in France in the year 2000, IARC Working Group Reports Volume 3, 2007

<sup>31</sup> Association of alcohol consumption with selected cardiovascular disease outcomes: a systematic review and meta-analysis, Paul E Ronksley et.al., *BMJ* 2011;342:d671

<sup>32</sup> Moderate alcohol consumption and health benefits: how good is the science?, Tim Stockwell et.al. *BMJ Rapid responses* 21 January 2012



The possible effect of alcohol consumption on heart disease is not seen in population level studies<sup>33</sup>, i.e. heart disease does not increase when per capita consumption is lowered. Not only is this a challenge to reconcile with the positive result of moderate drinking, this also adds strength to the argument of using population-wide, effective interventions to lower adult per capita consumption.

#### *4. Conclusion*

As has been shown above, adult per capita consumption is closely linked to harmful and heavy drinking on population level. On individual level the risk for many chronic diseases increase with increased consumption without any apparent threshold level. Adult per capita consumption is therefore a most relevant measure of harmful alcohol consumption and alcohol harm.

#### **Measuring per capita consumption**

Per capita consumption, recorded and unrecorded, is monitored globally and registered in WHO's Global Information System on Alcohol and Health (GISAH). Where there is substantial unrecorded alcohol consumed, there are established methods used by WHO for estimating its volume. Although estimates are of varying degree of precision, that is true for estimates of almost all factors for NCDs and other areas, risks as well as outcomes. This is not a sufficient reason not to use estimates. Good surveillance and monitoring systems for per capita consumption of alcohol are already in place in many parts of the world.

Figures for total per capita consumption for the world's countries are listed in the GISAH database, as well as published in WHO reports, e.g. WHO Global status report on noncommunicable diseases 2010 and WHO Global status report on alcohol and health 2011.

#### **Alcohol policy interventions**

Contrary to the belief of many people, the harm caused by alcohol can be effectively reduced. Many evidence-based alcohol policies and prevention programmes are shown to work. Alcohol policy interventions are unusually well researched, among the risk factors for NCDs perhaps surpassed only by policy research in the tobacco field. As mentioned above Alcohol: No Ordinary Commodity lists 22 strategies and interventions that have demonstrated effectiveness through scientific evaluation and that have been tested cross-nationally. The interventions include alcohol tax, minimum legal purchase age, restrictions on hours and days of sales, restriction on density of outlets, government retail monopolies, lowered BAC levels, random breath testing and brief intervention.<sup>34</sup>

There is strong support in the research literature for the effectiveness of population-wide, general interventions and strategies.<sup>35 36 37</sup> This fits well with the importance of the level of consumption in a population for the level of harm. Interventions that

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<sup>33</sup> Mortality and population drinking: a review of the literature, Thor Norström & Mats Ramstedt, *Drug and Alcohol Review* (November 2005), 24, 537 – 547

<sup>34</sup> Alcohol: No Ordinary Commodity, Second Edition, Thomas Babor et.al., 2010

<sup>35</sup> Effectiveness and cost-effectiveness of policies and programmes to reduce the harm caused by alcohol, Peter Anderson et.al., *Lancet* 2009; 373: 2234–46

<sup>36</sup> Alcohol: No Ordinary Commodity, Second Edition, Thomas Babor et.al., 2010

<sup>37</sup> WHO Expert Committee on Problems Related to Alcohol Consumption, 2<sup>nd</sup> report, WHO technical report series; no. 944, 2007

regulate the environment in which alcohol is marketed (economic and physical availability and commercial communications) are effective in reducing alcohol-related harm. These interventions are also cost-effective. Increases in alcohol tax not only cost little to implement, but also strengthen public finances at the same time as they decrease the level of harm.

### **Support for alcohol policy interventions**

Resolutions from the UN General Assembly as well as WHO World Health Assembly express clearly an awareness of the influence of the general level of alcohol consumption on the health problems caused by alcohol, as well as commitment to population-wide interventions as raised alcohol tax and restrictions in availability. This is not only expressed by UN and WHO, but also by many international organisations, e.g. by the World Bank, The World Medical Association, Chronic Disease Alliance and in the World Cancer Declaration.

#### *World Bank*

In connection with discussions on the World Bank's involvement in projects related to alcohol beverages, a task force was appointed 1998 to review the economic benefits of such projects as well as health and social consequences of alcohol, and public policy options to prevent alcohol-related problems. The outcome regarding general alcohol policy of this work is summarized in a World Bank fact sheet, Alcohol at a glance. The fact sheet states e.g.

- Alcohol abuse is one of the leading causes of death and disability worldwide
- Many deaths and much disease and suffering could be prevented by reducing alcohol use and related problems
- The level of harm from alcohol is related to the pattern, including level, of drinking in a country
- Alcohol should not be treated like other commodities, but should be classified as a special substance because of its dependency producing properties and severity of associated problems
- Price increases are among the most effective tools to reduce/deter use of alcohol by young people
- Government monopolies have often been effective mechanisms for implementing alcohol control measures for many reasons:
  - the limited number of sales outlets and restricted hours of opening
  - a stable and professional staff help avoid sales to the under-aged and already drunk
  - private profit motivations for expanding sales are absent.

In its report *The Growing Danger of Non-Communicable Diseases: Acting Now to Reverse Course*, published in September 2011 the World Bank lists

- increase taxes
- ban advertising
- restrict access

as examples of priority interventions to address NCDs from alcohol use.

#### *World Medical Association*

The World Medical Association, WMA, adopted in 2005 a statement on reducing the global impact of alcohol on health and society, which states e.g.

- Alcohol consumption is the leading risk factor for disease burden in low mortality developing countries and the third largest risk factor in developed countries
- Alcohol cannot be considered an ordinary beverage or consumer commodity since it is a drug that causes substantial medical, psychological and social harm by means of physical toxicity, intoxication and dependence
- Alcohol problems are highly correlated with per capita consumption so that reductions of use can lead to decreases in alcohol problem
- Population-based approaches that affect the social drinking environment and the availability of alcoholic beverages are more effective than individual approaches (such as education) for preventing alcohol related problems and illness
- Promote national and sub-national policies that follow 'best practices' from the developed countries that with appropriate modification may also be effective in developing nations
- Promote consideration of a Framework Convention on Alcohol Control similar to that of the WHO Framework Convention on Tobacco Control that took effect on February 27, 2005.

#### *Chronic Disease Alliance*

The Chronic Disease Alliance, representing 10 not-for-profit European organisations with over 100,000 health professionals, issued in 2010 a statement *Chronic Disease Alliance: A Unified Prevention Approach*, which states e.g.

- Excessive consumption of alcohol is a major cause of cirrhosis and liver failure and also cancer, cardiovascular diseases and brain damage
- Ban alcohol advertising, promotion and sponsorship of events via TV radio programmes and sports
- Reduce the availability of alcohol through restriction in the number of outlets for alcohol purchase

### *World Cancer Declaration*

The World Cancer Declaration, launched 2011 and for which the Union for International Cancer Control, UICC, is custodian, states as one of the targets by 2020:

- Global tobacco consumption, obesity and alcohol intake levels will have fallen significantly

### *UN*

The UN resolutions and report on non-communicable diseases acknowledge the role of alcohol for NCDs and support population-wide interventions like raising alcohol taxes, restricting access to retail alcohol and enforce bans on advertising, as well as promoting the implementation of the WHO global alcohol strategy and the strategy on non-communicable diseases, see below.

In the Resolution adopted by the UN General Assembly, Political Declaration of the High-level Meeting of the General Assembly on the Prevention and Control of Non-communicable Diseases (A/RES/66/2), adopted in September 2011, the General Assembly

- Recognize harmful use of alcohol is linked to non-communicable diseases
- Recognize the critical importance of reducing the level of exposure of individuals and populations to the harmful use of alcohol
- Advance the implementation of population-wide interventions to reduce the impact of harmful use of alcohol
- Promote the implementation of the Global Strategy to Reduce the Harmful Use of Alcohol including the full range of options as identified in the Global Strategy and call upon the World Health Organization to intensify efforts to assist Member

The Report of the Secretary-General , Prevention and control of non-communicable diseases (A/66/83), May 2011, notes that

- The harmful use of alcohol takes an exceptionally high toll in middle-income countries. In some regions, one in five male deaths is attributed to alcohol and nearly half of all alcohol-attributable deaths occur from non-communicable diseases.
- Alcohol can significantly drain family expenditures and non-communicable disease prevention and control may also contribute to the achievement of universal primary education, since costs for non-communicable disease-related health care, medicines, tobacco and alcohol displace household resources that might otherwise be available for education
- The greatest reductions in non-communicable diseases will come from population-wide interventions to address the harmful use of alcohol
- Best buys to reduce major risk factors include:
  - Raising excise taxes on alcohol
  - Restricting access to retail alcohol
  - Enforcing bans on alcohol advertising
- It is recommended that Member States
  - Implement cost-effective population-wide interventions

- Implement international agreements and strategies to reduce risk factors, including the Global Strategy to Reduce the Harmful Use of Alcohol;

In the resolution adopted by the General Assembly, Prevention and control of non-communicable diseases (A/RES/64/265) May 2010, the General Assembly

- Underlines the importance for Member States to continue addressing key risk factors for non-communicable diseases through the implementation of the 2008–2013 Action Plan for the Global Strategy for the Prevention and Control of Non-communicable Diseases and the evidence-based strategies and interventions to reduce the public health problems caused by the harmful use of alcohol
- Notes that the conditions in which people live and their lifestyles influence their health and that risk factors for non-communicable diseases as alcohol abuse have economic, social, gender, political, behavioural and environmental determinants, and stresses the need for a multisectoral response

#### *WHO*

The WHO global alcohol strategy states e.g.

- The harmful use of alcohol has a serious effect on public health and is considered to be one of the main risk factors for poor health globally
- The concept of the harmful use of alcohol is broad and encompasses the drinking that causes detrimental health and social consequences for the drinker, the people around the drinker and society at large
- Harmful drinking is a major avoidable risk factor for neuropsychiatric disorders and other noncommunicable diseases such as cardiovascular diseases, cirrhosis of the liver and various cancers
- For some diseases there is no evidence of a threshold effect in the relationship between the risk and level of alcohol consumption
- The harmful use of alcohol and its related public health problems are influenced by the general level of alcohol consumption in a population, drinking patterns and local contexts
- Policy options and interventions include:
  - introducing a licensing system on retail sales, or
  - public health oriented government monopolies
  - regulating the number and location of on-premise and off-premise alcohol outlets
  - regulating days and hours of retail sales
  - regulating the content and the volume of marketing
  - regulating direct or indirect marketing in certain or all media
  - regulating sponsorship activities that promote alcoholic beverages
  - restricting or banning promotions in connection with activities targeting young people
  - regulating new forms of alcohol marketing techniques, for instance social media

- establishing a system for specific domestic taxation on alcohol
- regularly reviewing prices in relation to level of inflation and income
- banning or restricting the use of direct and indirect price promotions, discount sales, sales below cost and flat rates for unlimited drinking or other types of volume sales
- establishing minimum prices for alcohol
- providing price incentives for non-alcoholic beverages
- reducing or stopping subsidies to economic operators in the area of alcohol.



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President