



Alcohol misuse and global health: The case for an inclusive approach to harmful drinking

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Executive Summary

Alcohol and global disease in context

- **Not all alcohol consumption is harmful.** While some patterns of alcohol consumption pose an increased risk for harm, others do not (and may actually be linked to improvements in quality of life).
 - The WHO Global Strategy to Reduce the Harmful Use of Alcohol recognizes this distinction.
- NCDs affect all populations in every country, regardless of wealth.
 - The four most significant noncommunicable diseases (NCDs) affect 60% of the world's population and are involved in 80% of all NCD-related deaths.
 - Harmful alcohol consumption as a lifestyle factor is implicated in three of these four major NCDs—cardiovascular disease, cancer and diabetes.
 - **Alcohol misuse accounts for 4% of global disease burden.**

Flaws in the traditional argument

- **Alcohol is not tobacco.**
 - No tobacco use is healthful—patterns of consumption are irrelevant.
 - Light to moderate drinking can be a protective factor against certain NCDs for some groups.
- The traditional perspective in public health discourse on alcohol favors the clinical paradigm of reduced exposure as the basis for policy—this perspective cannot be reconciled with the reality that complexities in human behavior demand a more sophisticated, multi-faceted approach.

- **Taxation, reducing availability and banning advertising are touted as “best buy” practices but these approaches may not always be the most practical:**

- Supporting data come almost exclusively from a handful of developed countries.
- Arguments are often based on theoretical models and not empirically proven.
- Alternative approaches are always needed, particularly where enforcement of regulation is weak or non-existent, as we see in some developing countries.

Shift toward a more sophisticated policy paradigm

- A **reduction in heavy-drinking patterns** must rely on broader measures than simply limiting alcohol's physical and economic availability.
- **There is little to be gained from stigmatizing what is, for most people, a normal behavior.**
- The successful models of reducing harmful alcohol use will be complex and creative, engaging more stakeholders and, therefore, more resources.
- Again, alternative approaches are always needed, especially in developing countries where resources for prevention, treatment, and encouraging healthy lifestyles may be lacking.
- In the face of shrinking economies, **it is essential to broaden rather than narrow the resource pool.**
- The **WHO Global Strategy recognizes that alcohol producers have a role to play** in concert with policymakers, non-governmental organizations, civil society organizations, and others.

Introduction

The “recognition that health is central to the global agenda of reducing poverty as well as an important measure of human well-being” [1] is at the heart of the Millennium Development Goals (MDGs). Three of the eight current goals focus on health issues of particular saliency in the world’s poorest countries and that pose a significant impediment to improving welfare.

In the health area, the existing MDGs of HIV/AIDS and child and maternal health remain both global priorities and global challenges. They address what are recognized to be more vulnerable sections of the population and have helped reallocate health priorities towards areas that had previously been under-resourced. However, in the intervening years since the selection of the current MDGs, new priorities and challenges have emerged that are as relevant to developing countries as they are to the world’s wealthier nations. These health issues have not been given high priority within the current MDGs, and some broad areas of health have been neglected altogether.

Among these are noncommunicable diseases (NCDs), of which the four most significant – cardiovascular disease, cancer, diabetes and chronic respiratory illness – affect some 60% of the world’s population, are involved in 80% of all NCD-related deaths [2], and represent a significant burden on the health of individuals and wellbeing of society. NCDs also represent a significant obstacle to progress on implementing the current MDGs and are closely linked with poverty.

In September 2011, the UN Summit on NCDs served to raise the profile of these illnesses and focus attention across the international community. However, efforts around NCDs have been criticized in some quarters. A letter from the NCD Alliance to UN Secretary-General Ban Ki-moon [3] criticizes the effort for failing to generate sufficient political will among Member States. This shortcoming of the NCD effort may be, in part, symptomatic of tensions in resource allocation. It has been suggested that these tensions include the concern that a shift in focus towards NCDs will likely divert resources away from MDGs, currently high on the international list of priorities [4].

The setting of a post-2015 development agenda, therefore, offers a unique opportunity to bring NCDs into the next iteration of MDGs and to harness novel resources needed to address health challenges. It opens the door for moving towards a conceptual basis for a new set of health goals that are responsive to changing views of the relationship between individual behaviour, social norms and disease states. Furthermore, it paves the way for a pragmatic approach towards policy formulation

that reflects the reality of needs around health in different countries and settings, and allows for the selection of measures and interventions best able to meet these needs.

Within this new framework, a case can be made for shifting focus away from exclusive attention to groups at risk and towards broader consideration of risk factors for diseases. On balance, this approach to health may also create opportunities to address broader issues of poverty and social equity. Equally, a new framework allows the targeting of risk factors within their particular cultural, social and economic context, as appropriate in each new instance.

Risk factors for NCDs have been clearly described and well documented. In this paper, we concentrate on only one of these risk factors – namely harmful alcohol consumption – and policy approaches that can adequately address it. A shift in emphasis in how harmful use of alcohol is addressed and how progress is measured is applicable across different areas of health. Furthermore, the garnering of much-needed resources to address the harmful use of alcohol can offer a useful model for similar efforts in other areas relevant to MDGs. We propose, therefore, that the harmful use of alcohol may serve as a model not only for combatting NCDs, but, within the context of MDGs, can also help with setting the policy agenda in other priority areas, including those that relate in particular to the world’s poorest nations and vulnerable groups.

A model for action: harmful drinking as a risk factor

Three of the four main NCDs – cardiovascular disease, cancer and diabetes – are closely linked with lifestyle issues, culture and context. One of the lifestyle factors implicated in all three is the consumption of alcohol. According to estimates, alcohol misuse accounts for 4% of the global burden of disease, measured in Disability-Adjusted Life Years (DALYs) [5]. It is important to clarify, however, as does the WHO Global Strategy to Reduce the Harmful Use of Alcohol [6], for example, that there is a distinction between patterns of drinking that pose an increased risk for harm, including NCDs, and those that do not.

This distinction poses a paradox: the risks associated with much of the drinking that goes on in the world are negligible, whilst the risks associated with harmful patterns of drinking are very serious, indeed. It should also be noted that light to moderate drinking can be a protective factor against certain NCDs for particular groups of individuals, and has been linked with improvements in overall quality of life [7]. This dichotomy distinguishes alcohol from tobacco, where it can reasonably be argued that any

consumption is injurious to health. It does, however, offer parallels with the relationship between food and NCDs. It is self-evident that moderate food intake and a balanced diet are essential for health and integral to healthy lifestyles. Excessive food intake, on the other hand, like harmful drinking, is a risk factor for cardiovascular disease, cancer and diabetes. This distinction in consumption patterns offers a sound basis for public health policy and a model that is more widely applicable within the health field.

The relationship between alcohol consumption and health outcomes also offers a useful template for intervention that can be applied to other areas of NCD risk. Harmful and beneficial drinking patterns have as much to do with culture and attitudes as with the amounts of alcohol consumed. They are a reflection of societal views about alcohol, of attitudes around behaviour and lifestyle, and about risk taking, broadly. They are also a reflection of the degree of awareness and knowledge that individuals have about their own behaviours and the impact these have on health.

Therefore, attempts to change behaviours linked with lifestyle must include efforts aimed at individuals, but also broader changes to societal norms. Understanding this relationship is an essential basis for selecting realistic policies and for crafting prevention approaches. Little headway can be made unless the goals of intervention and the means by which to attain them are appropriate and pragmatic and can be readily understood both by those implementing them and those for whom they are intended. In setting targets for measuring the impact of policy, therefore, it is important to identify those most compatible with a broad goal addressing NCD risk factors.

In the case of alcohol, efforts to reduce harmful outcomes have traditionally relied on reducing overall levels of consumption, largely by restricting physical and economic availability. In reality, given the direct link between drinking patterns and outcomes, a reduction in heavy-drinking patterns is clearly more relevant to public health aspirations than a reduction in alcohol consumption per se. Not only is such a target more logical and consistent, there is little to be gained from stigmatizing what is, for most people, normative behaviour. While there is increasing recognition of the validity of these considerations among researchers and those engaged in prevention, the policy arena continues to be the victim of the forces of inertia, seemingly incapable (or unwilling) of recognizing that the complexity of human behaviour requires a multi-faceted approach if change is to occur.

Over the last several decades, the public health discourse on alcohol has been dominated by a perspective that favours the clinical paradigm of reduced exposure as the basis for policy. According to this view, increasing prices

through taxation, reducing availability, and banning advertising and promotion are held up as the most effective and cost-effective approaches. However, although these policy measures are touted as “best buys,” purportedly reflecting evidence-based practice, the foundation on which this position rests is demonstrably precarious and fails to consider that a clinical model may not always be the best approach when dealing with human behaviour.

The pivotal arguments around “best buys” are derived largely from a single source [8] that disregards the balance of the available evidence around the impact of individual regulatory measures. Supporting data come almost exclusively from a handful of developed countries and are in large part based on models and not empirically proven. Cost-effectiveness rests on cost-estimate studies that have been described as so value laden and crude that their worth for policy purposes is limited [9]. Most importantly, perhaps, assessments of effectiveness and cost-effectiveness that make up “best buys” are not neatly transferrable from wealthy, developed countries to poor countries with dramatically different policy landscapes, sophistication in responding to health challenges, and huge disparities in resources available for implementation. The theoretical basis for extrapolating a one-size-fits-all policy without regard for the specifics of circumstances and context is increasingly being questioned, as is the appropriateness of comparing the nature of alcohol problems and approaches to addressing them across different and widely differing countries. The main utility of the evidence base supporting “best buys,” it has been argued, is in their propaganda value.

Creative resources for health

A novel framework for addressing NCDs within the new generation of MDGs can also be used to open the door for involvement by a wider array of stakeholders in policy and prevention aimed at improving global health. Diversification of stakeholders also means diversification of resources, much needed in many areas of health and social development.

NCDs affect the poor and wealthy alike in every country around the world. What distinguishes the impact of NCDs in developed and developing countries is the availability of resources for prevention, treatment, and for encouraging healthy lifestyles. By and large, such resources are severely strained in the world's poorer nations. This constraint means that action is all too often confined to select areas that need to be addressed with particular urgency. This prioritization of resources also leaves little room for a concerted effort at global level, unless global priorities are also national-level priorities. In the face of

shrinking economies and a time of economic crisis, the focus and available resources are narrowing even further.

Creative mobilization of alternative resources, therefore, is required to fill the space created by this shrinkage. A useful and pragmatic point of departure is to recognize that addressing health priorities is a shared responsibility across society and not solely the domain of government. Action and buy-in at government level are without question essential, but so is engagement by others who can make a useful contribution: business, civil society, communities, and health experts. Global engagement through intergovernmental bodies, even if only symbolic, is helpful in encouraging these various stakeholders to take action. However, calls to action at global level must be inclusive, leaving room for each group of stakeholders to do its part.

In aiming to reduce alcohol-related harm and improving health outcomes associated with drinking, the WHO Global Strategy offers a useful model for engaging non-traditional stakeholders in global issues, including producers of beer, wine and spirits. Specifically, the Strategy states:

The diversity of alcohol-related problems and measures necessary to reduce alcohol-related harm points to the need for comprehensive action across numerous sectors. Policies to reduce the harmful use of alcohol must reach beyond the health sector, and appropriately engage such sectors as development, transport, justice, social welfare, fiscal policy, trade, agriculture, consumer policy, education and employment, as well as civil society and economic operators. ([6], p. 6)

Producers of alcohol have a long track record of engagement at national and local level in supporting initiatives aimed at reducing risk and improving health outcomes associated with drinking [10]. Their engagement is also demonstrated by a significant investment of human resources and capital into prevention. However, the adoption of the WHO Global Strategy, aside from being a powerful catalyst for engagement, is of great symbolic value. It has legitimated industry's ongoing efforts and has opened the door to the inclusion of producers as equal stakeholders.

Even the most strident critics of both the WHO Global Strategy and of industry must acknowledge that inclusion builds goodwill, and, less than two years into the process of the implementation of the strategy, there is already tangible proof that inclusion has paid off. The resources of the private sector are being harnessed for the public good at an increasing rate. In a landmark announcement

made in October 2012, some of the leading global producers of beer, wine and spirits took a voluntary and historic step in committing themselves to a series of ten targets in five areas intended to reduce harmful alcohol consumption. These areas are well in keeping with the spirit of the WHO Global Strategy, and the targets include some significant changes to industry's core businesses.

Conclusions

A new agenda for global health, under the umbrella of post-2015 MDGs, therefore, offers a unique opportunity for a fresh start. There is room to bring into the fold previously excluded priority areas that are integral to addressing the needs of the world's poorest countries, as well as the needs of the more affluent ones, which are facing their own challenges during a period of social and economic upheaval. NCDs are but one area where health is closely linked with a range of factors undergoing their own changes in an increasingly complex and global world.

Setting a new agenda through the post-2015 MDGs also affords room to build on the impressive achievements of past years that have witnessed dramatic improvements in global health. The successes of the past constitute a solid foundation from which new and increasingly pragmatic approaches to policy can emerge, adaptable to the needs of the moment and to specific contexts and demands of a changing world.

In the 1980s, WHO's mantra of "health for all by the year 2000" was widely misunderstood to signify something akin to a prelapsarian paradise in which all people would enjoy perfect health. Even in its more limited sense of setting as a target universal access to primary healthcare services, this goal stretched the capacity of governments in many parts of the world as they strove even to come close to achieving it. The capacity of the public sector continues to be stretched, at times even beyond its limits. Creative thinking in addressing the health challenges of the next millennium also requires creative thinking in how to avoid this in the future, whilst harnessing the resources that are available.

But creative thinking is not enough. The time has come to let go of ideological encumbrances and face a new world with new players who are here to stay. The pragmatic approach is to embrace what they have to offer, to build on their goodwill, and to put the diversity of resources to work for the collective good.

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