Alcohol: a global health priority

Most of the world's population abstains from alcohol.[1] This is good news for both the public health community, which seeks to reduce the harm caused by alcohol, and for industry, which seeks to expand its markets. A Series of three reports in *The Lancet* today provides strong evidence for greater public health efforts to reduce the harmful effects of alcohol. The Series updates the health and economic burdens caused by alcohol,[1] summarises the effectiveness and cost-effectiveness of interventions to reduce the harm caused by alcohol,[2] and ends with a call to action.[3]

Alcohol is an underappreciated risk factor for a wide range of conditions: it causes roughly 4% of all deaths worldwide (about half the number of deaths caused by tobacco) and 5% of the global burden of disease (about the same as that caused by tobacco). Alcohol is also an important cause of health inequalities. Poor populations and low-income countries have a higher relative burden than do high-income populations and countries. Alcohol causes large health-care costs in addition to substantial, but largely unmeasured, social costs.

Consumption of alcohol should never be encouraged on health grounds. The health benefits are outweighed by the harmful effects and might be overestimated because of confounding by other risk factors. Furthermore, any benefits are restricted to middle-aged and older adults in countries with high rates of cardiovascular disease.[4]

The potential for increased harm from alcohol is high, in view of the predatory nature of the alcohol industry. Because of the strong link between purchasing power and per-capita consumption, and aggressive marketing by the alcohol industry, consumption and associated harm are likely to increase in most societies in the future.

The challenge for public health practitioners is to reduce the harm caused by alcohol by strengthening global and national alcohol-control policies. The challenge for industry is to exploit markets, especially in countries with low and middle incomes, and increase profits. The alcohol industry will continue to affect policy by encouraging ineffective policies. Following the example of big tobacco, the alcohol industry is already trying to supplant the role of government in the alcohol policies in some parts of sub-Saharan Africa.[5]

Fortunately, there is strong evidence, albeit largely restricted to high-income countries, for the cost-effectiveness of a range of policies that have the potential to limit the harm caused by alcohol. The most powerful policies, which can be introduced in a step-wise manner, include making alcohol more expensive, less available, and less acceptable. Increases in taxation, especially if based on alcohol content, affect heavy drinkers more than they do light drinkers and therefore reduce harm.[6] In countries with a large illicit market, stronger enforcement of legal sales—eg, tax stamps on legal products to show that tax has been paid—will be effective. Other evidence-based measures include a ban on alcohol advertisement and promotion, strengthening of measures to counter driving while under the influence of alcohol, and individual interventions for at-risk drinkers. There is scope for redirection of scarce resources from ineffective to more cost-effective interventions.

Strong governmental action is vital to protect drinkers and non-drinkers from harm. A focus is needed on youth drinking,[7] the devastating situation in countries of the former Soviet Union,[8] and other countries where there is a weak capacity for creation and enforcement of effective policies. WHO has a key role in encouraging and supporting national and global actions. WHO, in collaboration and consultation with member states, is preparing a draft global strategy

See **Editorial** page 2171
See **Comment** page 2174 and 2176
See **Articles** page 2201
See **Series** pages 2223, 2234, and 2247

Gideon Mendel/CORBIS

Two men drink beer at a *shebeen* (unlicensed drinking establishment), in Soweto, South Africa

to reduce the harmful use of alcohol[9] for submission to the World Health Assembly in May, 2010. The strategy should address both national actions and crucial worldwide issues, including the effect of trade agreements on alcohol use.

Despite the strong parallels with tobacco control and the success of the WHO Framework Convention on Tobacco Control,[10] there seems to be little immediate chance of WHO or member states supporting the complex process of developing a Framework Convention on Alcohol Control.[11] To gain traction, this framework will need dedicated support and pressure from a few committed countries, underpinned by a strong global network of non-governmental organisations.[3] Non-governmental organisations in the alcohol field need to strengthen their international presence and learn from the tobacco-control area.

The power imbalance between industry and health groups is a key reason for the continuing neglect of alcohol as a global health issue.[12] Other impediments include the absence of clarity on the alcohol control message, the political context that gives priority to an individual's responsibility for health, and the close connection of alcohol with many aspects of social and cultural norms. Generation of political priority for alcohol as a global health issue is the crucial next step.

Robert Beaglehole, Ruth Bonita
Devonport, North Shore City, New Zealand 0624
r.beaglehole@auckland.ac.nz

We declare that we have no conflicts of interest.

1 Rehm J, Mathers C, Povova S, Thavorncharoensap M, Teerawattananon Y, Patra J. Global burden of disease and injury and economic cost attributable to alcohol use and alcohol-use disorders. *Lancet* 2009; **373:** 2223–33.
2 Anderson P, Chisholm D, Fuhr DC. Effectiveness and cost-effectiveness of policies and programmes to reduce the harm caused by alcohol. *Lancet* 2009; **373:** 2234–46.
3 Casswell S, Thamarangsi T. Reducing harm from alcohol: call to action. *Lancet* 2009; **373:** 2247–57.
4 Jackson R, Broad J, Connor, J, Wells S. Alcohol and ischaemic heart disease: probably no free lunch. *Lancet* 2005; **366:** 1911–12.
5 Endal D. Drinks industry supplanting government role in alcohol policies in Sub-Saharan Africa. May 5, 2008. http://www.add-resources.org/drinks-industry-supplanting-government-role-in-alcohol-policies-in-sub-saharan-africa.4484341-76586.html (accessed April 30, 2009).
6 The Lancet. UK alcohol policy: a costly decision for public health. *Lancet* 2009; **373:** 1312.
7 Toumbourou JW, Stockwell T, Neighbors C, Marlatt GA, Sturge J, Rehm J. Interventions to reduce harm associated with adolescent substance abuse. *Lancet* 2007; **369:** 1391–1401.
8 Leon DA, Saburova L, Tomkins S, et al. Hazardous alcohol drinking and premature mortality in Russia: a population based case-control study. *Lancet* 2007; **369:** 2001–09.
9 WHO. Towards a global strategy to reduce harmful use of alcohol. Discussion paper for regional consultation on harmful use of alcohol. 2009. http://www.who.int/substance_abuse/activities/msbdiscussionpaper.pdf (accessed April 30, 2009).
10 Bettcher D, DeLand K, Schlundt J, et al. International public health instruments. In: Detels R, Beaglehole R, Lansang MA, Gulliford M, eds. Oxford textbook of public health, 5th edn. Oxford: Oxford University Press (in press).
11 The Lancet. A Framework Convention on Alcohol Control. *Lancet* 2007; **370:** 1102.
12 Shiffman J, Smith S. Generation of political priority for global health initiatives: framework and case study of maternal mortality. *Lancet* 2007; **370:** 1370–79.

Action needed to tackle a global drink problem

See **Editorial** page 2171
See **Comment** pages 2173 and 2176
See **Articles** page 2201
See **Series** pages 2223, 2234, and 2247

Postwar Britain smugly thought that alcohol misuse was someone else's problem. Despite earlier rumblings of concern in the health community, the wake-up call came in 2001 when the Chief Medical Officer reported that deaths from cirrhosis in the UK, predominantly caused by alcohol, were rising and set to overtake the European Union mean.[1] In some age groups, the increase was nearly ten-fold over one generation of 30 years. While our continental neighbours had succeeded in cutting back over this period, per-person consumption had almost doubled in the UK, fuelled by falling prices and increasing availability.[2] But 8 years after the nation's problem with alcohol was accepted, where are the policies to tackle it? In the UK they are largely absent, but some signs suggest a change; and the Series in *The Lancet* today is timely for the UK and other countries, both rich and poor.

Although cirrhosis is a good surrogate marker of damage and resonates with the public, the focus on physical diseases might overlook the huge burden of dependence, damage to third parties through passive drinking (so-called collateral damage), and the social and economic costs of alcohol misuse. This danger is made clear in today's first article, in which Jürgen Rehm and colleagues[3] estimate that 3·8% of all global deaths and 4·6% of global disability-adjusted life-years are attributable to alcohol. These numbers are almost certainly conservative, particularly for developing countries where illicit manufacture is poorly controlled and disease registers are limited.

Sally Casswell and Thaksaphon Thamarangsi[4] make telling parallels with the fight against tobacco and the rearguard actions against a powerful, well-funded,