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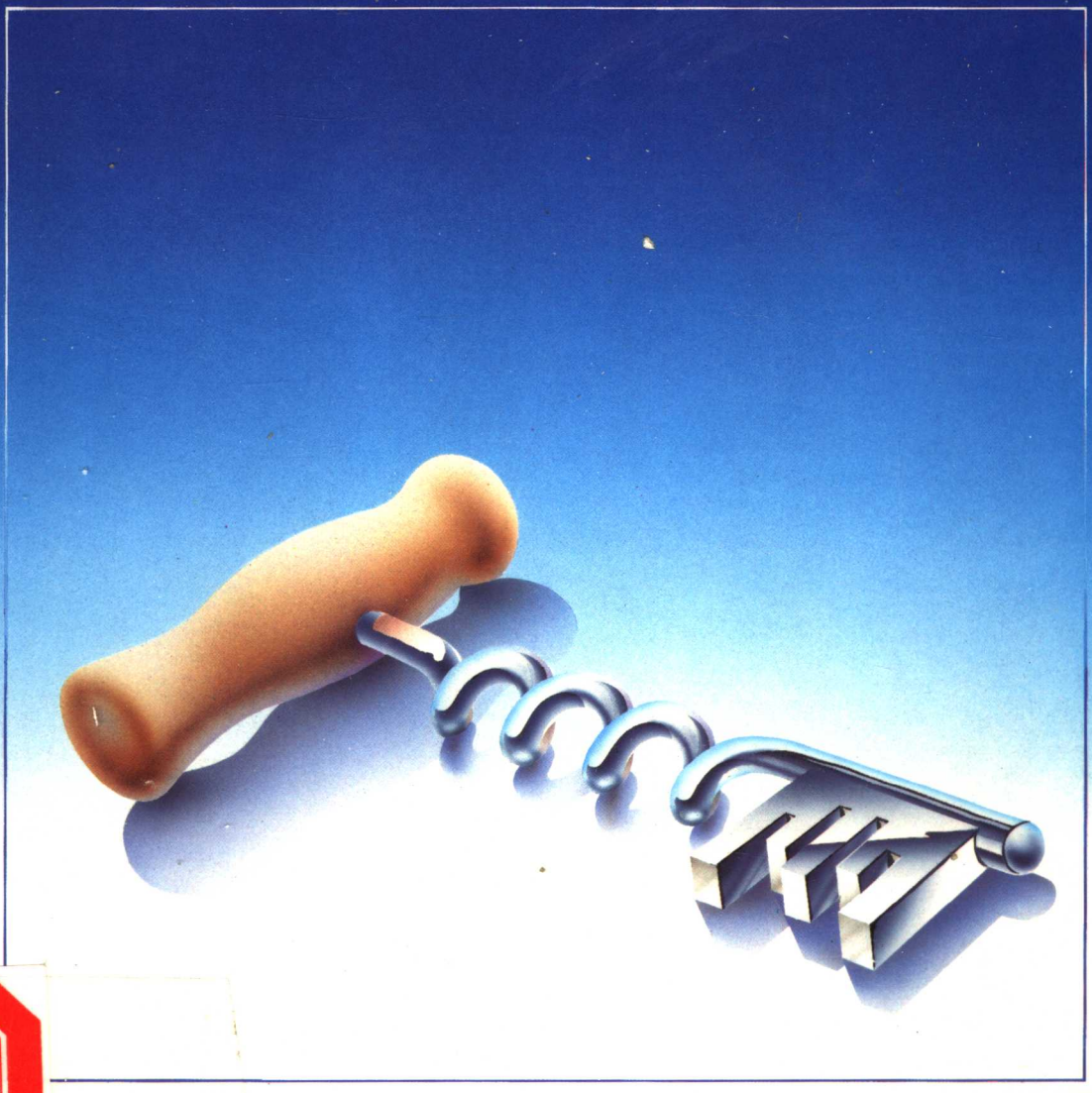
Regional Office for Europe
Copenhagen

Alcohol Policies



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World Health Organization
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Copenhagen

Alcohol policies

Edited by

Marcus Grant

Alcohol Education Centre
Institute of Psychiatry
London

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Alcohol policies

Foreword

If we are serious about the goal of health for all by the year 2000, then we cannot afford to ignore alcohol-related problems. Throughout the European Region, and in many other parts of the world, rates of alcohol consumption and of alcohol-related problems are now so high that they give rise to considerable concern. Piecemeal attempts to deal with these problems seem to have resulted in rather inadequate conclusions. In an effort to find a more lasting solution, WHO has begun to give special emphasis to the development of national alcohol policies.

The concern of Member States to reduce alcohol-related problems has repeatedly found expression in resolutions of the World Health Assembly — in 1975 (WHA28.81), 1979 (WHA32.40) and 1983 (WHA36.12). Of particular relevance to the theme of this book, the technical discussions at the Thirty-fifth World Health Assembly in 1982 emphasized the need for Member States to develop comprehensive alcohol policies within the context of their own national health planning.

During the technical discussions in 1982 and the Thirty-sixth World Health Assembly in 1983, serious concern was expressed about the worldwide trend of increasing alcohol consumption and alcohol-related problems. Specific mention was made of the promotional drives that are increasing the consumption of alcohol, especially in countries and population groups in which its use was not previously widespread. In this connection, the effects of international marketing strategies on traditional value systems were highlighted and the question of the need for some form of regulation of the global alcohol trade for health reasons was raised. Issues of this kind imply that it is not only comprehensive national policies that are urgently needed but concerted international action as well.

Two important issues emerge from this call to action. First, alcohol-related problems are so serious, so widespread and so diverse that nothing less than a comprehensive national approach is likely to be able to make a real and lasting impact on them. Second, since alcohol-related problems certainly are health problems, the control of alcohol consumption becomes a legitimate and essential health concern. It is up to WHO to support Member States in their efforts to integrate alcohol policies into their national strategies to achieve health for all through primary health care.

It is also up to WHO to give a lead through its constitutional commitment to the coordination of international efforts both globally and regionally. This can be done through the active promotion of relevant activities, in its own programmes and in its relationships with other international agencies and its Member States.

This is, of course, a global concern and this book has important global implications. It takes its place in the long line of publications that have been produced by or in association with the WHO Regional Office for Europe. Its clear and practical suggestions of what governments can do to prevent alcohol-related problems through the design and implementation of national policies are a fitting development from Alcohol control policies in public health perspective *(published by the Finnish Foundation for Alcohol Studies in 1975),* Alcohol, society and the state *(published by the Addiction Research Foundation in two volumes in 1981 and 1982) and* Alcohol-related medicosocial problems and their prevention *(published by the Regional Office in 1982). The reduction of alcohol-related problems and the decrease in alcohol consumption are important targets within the European regional strategy for health for all by the year 2000. It is our hope that the results of the activities and the lessons learned in the European Region can be usefully adapted in other parts of the world.*

Many of the contributions to this book have been developed from working papers presented at a meeting on the control of alcohol consumption, organized in Paris in 1983 by the Regional Office. What is presented here is an integrated approach to the whole question of policy formulation. Past experiences are analysed and research priorities are assessed. A real attempt is made to suggest the logical sequence of stages in national policy development. The contribution made by economists is particularly important, since one of the many conclusions of this book is that a reasonable balance needs to be achieved between economic interests and public health interests.

But alcohol-related problems must not be viewed in isolation. They need to be seen as a consequence of particular lifestyles and of choices made both by individuals and by societies. What this book achieves is a sharpening of the focus on the prevention of alcohol-related problems without any loss of a wider view of health. It is concerned not only with promoting alcohol policies in a general sense, but with demonstrating that they are indeed practical, necessary and comprehensive. I very much hope that its suggestions can be studied and adapted by all those, throughout the world, who are interested in improving health. This book is, in a real sense, a plan for action and its success will be measured by the extent to which it is actually used in developing and implementing alcohol policies.

Leo A. Kaprio

WHO Regional Director for Europe

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Establishing priorities for action

M. Grant

Alcohol-related problems are serious, widespread and show no signs of diminishing. Just how serious and widespread they are was acknowledged in resolution WHA36.12 of the Thirty-sixth World Health Assembly in 1983, which unequivocally ranked them among the world's major public health concerns. What is most alarming of all is that, as the worldwide trend in alcohol consumption continues to rise, there follow in its wake increases in a multitude of different alcohol-related problems that take their toll not only in countries that have traditionally experienced such problems but also, more and more often, in countries and population groups that have until recently seemed relatively immune. The need to tackle these problems is an urgent one. The World Health Assembly emphasized in that same resolution the necessity for countries to develop comprehensive national alcohol policies. In doing so, it followed the conclusions reached during the technical discussions the previous year, when it was recognized that such a flood of problems of so many different kinds is unlikely to be stemmed by any single strategy of intervention, no matter how effective.

An Agenda for the Future

Alcohol policies do not drop ready-made out of the sky. They have to be stimulated, developed and negotiated afresh for each country. They have to be sensitive to the history of the country, its culture and its drinking practices. They require imagination, tolerance, hard work and a sense of vision. They need to be prepared, formulated and promoted, taking into account a wide variety of legitimate but sometimes competing interests. All this is a formidable task, but a necessary one, if alcohol-related problems are really to be reduced in any worthwhile way.

Although each country needs to develop its own alcohol policy, designed to tackle its own problems in its own way, there are lessons that can be learned from the past and from the efforts other countries have made. The purpose of this book is to gather together some essential background information, to provide case studies of different kinds of approach and to

set out the key steps, both nationally and internationally, that lead towards the development of effective alcohol policies.

This book has grown out of a meeting on the control of alcohol consumption, held in Paris in 1983 by the WHO Regional Office for Europe. It is important to emphasize, however, that in no sense is this merely a collection of the working papers presented at that meeting. To take account of the very active and forward-looking discussions that occurred there, the papers included here have all been very extensively revised, re-edited and, in some cases, completely rewritten. In addition, new material, not presented at the meeting, has been included. The result, it is to be hoped, is a book with the kind of coherence that will enable it to be used in a practical way in developing national alcohol policies. Much more, of course, needs to be done in this area. This book is not a set of comprehensive guidelines but it does, at least, establish an agenda for future action.

The Case for National Alcohol Policies

It is possible to see the world of alcohol problems as a battlefield. As far as one can see, from horizon to horizon, there are casualties. Some are already dead, some are dying, and others are still making desperate and pitiful efforts to save themselves. They are the casualties of the damage caused or exacerbated by excessive drinking, such as liver cirrhosis, cancer of the digestive tract and hosts of other physical diseases. They are the victims of road traffic accidents, of fires and of crimes. They are the victims of domestic violence, including child abuse. They are suicides. They suffer from anxiety, depression and a whole range of mental health problems. Despite the severity of the condition of these casualties, despite the apparent ubiquity of the battlefield, there seems little sign of any abatement in the hostilities. The great heaps of dead and dying mount daily higher.

There is, of course, concern. Faced with such carnage, it would be difficult to maintain indifference, either at a national or at an international level. But concern does not in itself presume effective action. It seems, indeed, that there has been some disagreement about how best to proceed in dealing with the costly and distressing problem of this global battlefield.

Various strategies have been suggested. There are, first, the *laissez-faire* free market economists whose view is that man is by nature a warlike animal; that the carnage is indeed distressing but that, given the right approach, it need not necessarily be quite so costly as seems inevitable at first sight. They point to the long history of the hostilities and to the indications that they are, if anything, increasing. In such circumstances, the elasticities of demand being favourable, they see worthwhile opportunities for the state to maximize revenue. If the battle is a fact of life, then it can be taxed to the hilt. A proportion of the revenue thus generated may have to go to financing services to alleviate the suffering of the casualties, but in aggregate terms, the world population problem being what it is, it is probably no bad thing to allow the scale of the battle to continue to escalate.

Such a view, of course, is incompatible with the public health perspective, incompatible with a sense of common humanity and incompatible,

certainly, with the aims of WHO. What, then, are the health options that are advanced as alternative strategic approaches? There are those who see the most urgent need as the improvement of the efficiency of the treatment systems. Confronted by the horrifying spectacle of all those casualties, they argue that the first priority must be the welfare of those already damaged. They plead for better hospitals, better accident and emergency units, better psychiatric care, more staff and new technology. Then there are those who, without wishing to ignore the plight of the present sufferers, believe that the priority must be the prevention of future suffering. There are two separate camps within this group. Supporters of one of these, arguing for health promotion, seek to persuade the combatants to lay down their arms or, at the very least, to use them for sporting purposes only. They are also anxious to counsel those who, though wounded, may yet recover if only they see the error of their ways and crawl away from the battlefield. The other camp, still in sympathy with the broad aim of prevention, have little faith in the likely effectiveness of these persuasive efforts, however eloquent or rational they may be. This camp holds the view that the only way to reduce the battle is to reduce the means with which to fight it. They argue for control policies that would restrict the number of cartridges issued daily to combatants, or limit the number of official munitions stores or, like the economists but with a different aim in mind, charge such a high fee for the privilege of fighting that few would be prepared to pay it.

None of these strategies is ridiculous. All have their advantages and would, in one way or another, lead to improvements in the present intolerable state of affairs represented by the alcohol problems battlefield. What is, however, immediately apparent is that, while *any* strategy might have *some* effect, all are partial. If, indeed, the level of casualties is to be reduced, then the economists, the treatment agencies, the health promoters and the control policy advocates all need to be brought together. Researchers also need to be persuaded to come out of their bullet-proof hides to help in forming a concerted and integrated approach to the development of a range of linked strategies that can be continuously evaluated. That, in essence, is what a national alcohol policy is all about.

Changing Patterns in Alcohol-related Problems

Since, as has been implied both in the opening sections of this chapter and by the wording of the resolution of the Thirty-sixth World Health Assembly, alcohol-related problems are essentially a global concern, it is important to understand the special relevance of the predominantly European perspective of this book. Its central thesis is that, in developing their own alcohol policies, countries can learn something from the successes and failures of those who have already attempted to make similar efforts. Purely in historical terms, the greatest wealth of experience in the development of alcohol policies has been within the European Region. It is, therefore, almost inevitable that this book should have to rely rather heavily on what is essentially European experience and European expertise. Since, however, it is a very mixed picture that emerges, with a range of different approaches to

different priorities, and with as many failures as successes, there is certainly no sense in which these European paradigms are being imposed on countries in other parts of the world. Indeed, what is offered in this book is offered in full recognition of the extent to which the lessons it contains are less inflexible rules than they are suggestions for future action derived from the struggles of the past.

Looking, however, at the factors that have had the most profound effect on alcohol-related problems in the European Region, there is no doubt that the most significant trend in the postwar period has been the same as in most of the rest of the world — namely, a general increase in aggregate alcohol consumption. An important point, in relation to this global trend, is that increases in aggregate consumption are associated with a growth in whichever problems are most common to each particular culture. Reporting in this book on international projects undertaken by or in collaboration with WHO, Mäkelä (Chapter 2) points out that in a very wide range of countries, including Zambia and Mexico and various European countries as well as two regions in North America (California and Ontario), it is adult males who still have by far the largest number of alcohol-related problems.

There are, nevertheless, some other groups of people who are currently of special concern in many countries. Foremost among them are women and young people. Clearly, while national alcohol policies have to be sensitive to their special needs, since they may well be particularly vulnerable to the problems that can result from increasing consumption, it is essential not to lose sight of the distribution of alcohol-related problems in the population as a whole. Within this wider context, the needs of groups, such as women and young people, and of particular regions within countries may well require health promotion or other approaches specifically designed to counter whatever influences are contributing to their particular problems.

Some other factors that may have substantial impact on the pattern of demand for alcoholic drinks and that may also influence the pattern of consequent problems have been identified as being of special current concern in the European Region. The first of these is unemployment. Although recent research seems to show that, perhaps because of increased social passivity and reduced spending power, the unemployed actually have fewer alcohol-related problems, there remains a powerful argument that suggests that their increasing sense of frustration and hopelessness could contribute to higher rates of social and health problems, including alcohol problems. What is perhaps more likely is that drinking, especially excessive drinking, by the unemployed could come to be seen by society as a different kind of social problem from the drinking of other sections of the community and therefore something that requires different kinds of social control.

Another area of concern is the possible influence of mass tourism. It has long been noted that the trend towards greater harmonization of drinking within the European Region has been associated with a process of addition rather than substitution of habits. Mass tourism may be playing some part in this process, both through its effect on tourists, in whom relaxed controls and lower prices can lead to increased consumption, and through its effect on the indigenous population, within which especially

impressionable subgroups such as young people may be prone to imitating the cosmopolitan drinking patterns of the tourists.

Although unemployment and mass tourism have been identified as issues of particular concern to countries in the European Region, this is certainly not to suggest that they are irrelevant to the rest of the world. On the contrary, both are factors that are coming to exercise increasing influence on the economies of many other countries as well. Other problems, too, have been recognized as having potential importance, although they have as yet been inadequately studied. Among these, attention needs to be paid to the drinking problems of migrant workers and the impact of population movements away from rural areas.

Costs and Benefits of Alcohol Consumption

It is clear from the preceding section how many alcohol-related problems have important economic dimensions. Indeed, one of the most striking features of alcohol studies during the early 1980s has been the increasing attention paid to alcohol economics. Among the many questions that have engaged the interest of researchers, none has greater relevance to the process of policy formulation than the estimation of alcohol-related costs and benefits. It is also, however, an area that is often bedevilled with imprecise analysis and exaggerated claims by those seeking, for whatever reason, to emphasize the importance of either the costs or the benefits of alcohol to society.

To be able to distinguish between legitimate efforts to make realistic cost–benefit estimates on the one hand and, on the other, doubtful justifications for partisan positions, it is important to recognize the basic economic principles that underlie this area of study. The first and most fundamental of these is the concept of the rational consumer. Since consuming goods provides satisfaction or utility to the consumer and since the rational consumer arranges his consumption so as to achieve maximum satisfaction, it can be inferred that people derive utility from drinking alcohol simply because they do it. This, of course, assumes that the consumer has all the information he requires to enable him to make a rational choice and also, given that information, that he will act in a rational way.

Both these assumptions have been questioned *(1)* in relation to alcohol. It can certainly be argued that, far from having perfect information, most drinkers are only very vaguely aware of the hazards of excessive consumption or of the levels of regular consumption that are associated with those hazards; nor are drinking choices always made on the basis of pure rationality. The pleasure people gain from activities such as skiing or motorcycle racing help them to discount more risks than can be accommodated under the rubric of rationality. In the case of alcohol, further confounding complications are introduced by its addictive nature.

The second basic economic concept that is linked to that of the rational consumer is economic efficiency. This does not merely refer to minimizing costs and maximizing profits, but is concerned with making as many people as possible as well off as possible, not just financially but also in terms of the

quality of their life. As such, its underlying principle is that of consumer sovereignty: that it is individual choices that matter most. The problem here is, of course, that individual benefits may involve social costs.

Thus, in assessing the efficiency in economic terms of any system or programme, it is necessary to be able to compute individual and social costs and benefits using a common unit of measurement. Here the economic concept of exchange value is used to be able to ascribe monetary values not only to goods that are regularly exchanged at specific market prices, but also more complex factors, such as human suffering and loss of life, that are not normally measured in cash terms.

The costs

Using these three basic concepts — the rational consumer, economic efficiency and exchange value — it is possible to approach the question of cost–benefit estimation. Many difficulties arise in determining precisely which costs need to be included and, as a result, empirical cost estimates often fail to take account of the extent to which alcohol-related problems overlap with other kinds of health and social problem. Since it is generally acknowledged that heavy drinkers impose disproportionate demands on health care systems, the prevalence of heavy drinkers needs to be clearly established so that the costs they incur can be disentangled from the costs incurred by moderate drinkers and non-drinkers. Equally, since heavy alcohol use seems to reduce life expectancy by about 10–12 years, its elimination (were that possible) would increase some health care costs, given that health service use is highest among the elderly.

Accepting these difficulties at face value, it can be seen that alcohol-related costs fall into two major categories. The first of these — production costs — is the value of the resources used to produce alcoholic drinks. It is, however, the second category — the social costs of alcohol consumption — that is generally the basis for cost–benefit estimations. Social costs are made up of both private and external costs, to both of which monetary values need to be ascribed. Granted that the more intangible the costs, the more difficult it will be to ascribe precise values, there is general agreement that four kinds of loss are quantifiable. These are:

- loss in total production due to alcohol-related problems;
- the commitment of health service resources to the treatment of people with alcohol-related problems;
- real losses to society from traffic and other accidents, fires and criminal acts in which alcohol is a factor; and
- expenditure on social welfare and education services for the prevention or alleviation of alcohol-related problems *(2)*.

The benefits

Estimating the benefits of alcohol consumption is no less fraught with difficulties. In essence, from an economic perspective, the benefits of alcohol consumption are simply the satisfaction or utility that consumers derive