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Alcohol and NCDs: time for a serious international public health effort

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Together with smoking, diet and physical inactivity, consumption of alcohol is among the four most important risk factors for non-communicable disease (NCD). Alcohol consumption, especially heavy consumption, impacts on cancer, liver cirrhosis and stroke. To reduce the burden of NCD, effective alcohol policies should be implemented locally, nationally and internationally.

Each year, in connection with the opening of the General Assembly sessions, the United Nations holds a special session on an agreed-on topic. In 2011, the topic is Non-Communicable Diseases (NCDs), arguing for their inclusion in the Millennium Development Goals, with the primary goal of emphasising the importance of addressing such diseases in order to reduce the global burden of illness, not only in rich countries but also in poor countriesas a consequence of major epidemiological transitions.[1,2,] (Parry et al, unpublished data)

While NCDs as a category covers a broad range of illnesses, primary emphasis has been put on cancer, heart disease, chronic respiratory diseases and diabetes.[3] Despite the fact that each disease has its own specific etiology, there are risk factors which reach across many of the major NCDs, including in particular several behavioural risk factors: unhealthy diet, lack of exercise, tobacco smoking and alcohol use.

One approach to limiting the play of such behavioural risk factors is based on a perspective of individual choice and responsibility. The premise is that educated consumers will act in their own long-term interests, even in the face of heavy marketing and promotion; controlling behaviour in such an environment may even be regarded as a test of virtue.[4] A

perspective that educating the consumer is all that is needed has been the approach in recent times globally, not only in market economies. Many low and middle-income countries have also adopted this approach, especially the emerging economies in Asia with high economic growth rates. The experience of the second half of the 20th century was that such laissez-faire approaches are not a successful strategy for limiting NCDs.

A second approach has been to proscribe particular forms of consumption altogether. While this has obvious difficulties in the case of diet, for tobacco and alcohol there have been prohibitions on use in various forms and times. Again, the experience has been cautionary; such prohibitions tend to succeed only when backed up strongly by religion and culture.

A third approach is through regulating the market to channel and influence consumer behaviour towards restrained and less harmful use.[5] Addressing such "upstream" factors can be quite effective, as has been shown for alcohol and tobacco.[6,7] But this strategy of balancing conflicting interests is inherently unstable. Since it involves tolerating a certain level of NCDs and other harm from the behaviour, it involves compromises and is easily seen as unprincipled. Regulating the actions of private interests in the market became more difficult in the late 20th century, in an era of globalisation, free trade agreements and free market ideology.[8,6 (pp.71-101)] Given the political influence of market interests, substantial and sustained counter-pressure from public health interests is required to prevent regulatory capture.

A regulatory approach thus requires substantial and sustained efforts in the public health interest. It will not be enough for the United Nations to pass a resolution at the Special Session and leave it at that. This is an issue for all of the behavioural risk factors for NCDs, but it is especially an issue for alcohol. Alcohol is now regularly included in NCD discussions such as the preparatory meeting for the September session in Moscow in April 2011,[9] but it regularly receives the least attention of the major risk factors. There are several reasons for this. For instance, the health-protective effects of alcohol in ischaemic disease for the middle-aged and older persons[10] has confused and inhibited efforts to curtail harmful use of alcohol, even though the net effect of alcohol on cardiovascular disease – setting all else aside – is negative. Furthermore, moving on alcohol is more difficult because it is so much more part of the daily life of decision-makers: the affluent and powerful regularly use alcohol, whereas smoking tobacco or being overweight are increasingly characteristics of the poor and socially excluded. Finally, alcohol industry interests operate effectively in political spheres to minimise the efforts of public health proponents to address the impact of alcohol use on NCDs, among other harms. This occurs both at international levels, with increased global concentration in the spirits and beer industries,[11] and nationally and locally, with widespread nets of producers and distributors – whether cider makers and whisky distillers in the UK, vintners in Australia and southern Europe, fruit wine producers in Finland, or brewers in Belgium, India and China.

Against these forces the public health effort on alcohol is weak, particularly at the international level. To counter the pressures from globalised industries and from free-trade

treaties and settlements, there is no Framework Convention on Alcohol Control[12] with a secretariat to increase its effectiveness, as there is for tobacco. As a first step forward, there is a new WHO Global Strategy on Alcohol,[13] which sets out an initial framework for action on an international basis. But the resources available for implementing the strategy are puny. Whether as a reflection of behind-the-scenes pressure from the alcohol industry to starve the effort, of the ambivalence of political classes about alcohol, or of a withering of national commitments to international aid, the WHO alcohol programme is forced to operate on a shoestring budget, with minimal staff and programme resources.

Meanwhile, recognition of the necessity of addressing harmful use of alcohol in order to attain public health objectives increases. Alcohol plays an important causal role in the etiology of NCDs. While this is particularly the case in countries in the former Soviet Union,[3] the problems extend across the globe. Alcohol is the third leading risk factor in the global burden of disease for death and disability in general.[14] And this is calculated primarily in terms of the adverse effects of drinking on the drinker. There are also large adverse effects of drinking on others,[15] not counted in the health statistics. The case for increased priority being given to act on alcohol to address NCDs and other public health concerns is now very strong. In this context, the relative lack of action on alcohol is increasingly indefensible. The September meeting at the United Nations is an occasion for remedying this and for taking concrete steps to increase the resources at the international level devoted to alcohol policy issues.

Keywords Alcohol, alcohol policy, international control, non-communicable disease (NCD), risk factor.
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REFERENCES

1. Omran, A.R. (1971) The epidemiologic transition: A theory of the epidemiology of population change. *Milbank Memorial Fund Quarterly* 49(4):509-38.

2. Room, R., Rehm, J. (2011) Alcohol and non-communicable diseases – cancer, heart disease and more. *Addiction* 106(1):1-2.

3. Alwan, A., Ed. (2011). *Global Status Report on Noncommunicable Diseases 2010*. Geneva: World Health Organization.

4. Room, R. (2011) Addiction and personal responsibility as solutions to the contradictions of neoliberal consumerism. *Critical Public Health*, 21(2): 141-151.

5. Thaler, R.H., Sunstein, C.R. (2008) *Nudge: Improving Decisions about Health, Wealth and Happiness*. New Haven & London: Yale University Press.

6. Babor, T., Caetano, R., Casswell, S., Edwards, G., Giesbrecht, N., Graham, K., Grube, J., Hill, L., Holder, H., Homel, R., Livingston, M., Österberg, E., Rehm, J., Room, R., Rossow,

I. (2010) *Alcohol: No Ordinary Commodity - Research and Public Policy*. 2nd ed. Oxford, etc.: Oxford UP.

7. Chaloupka, F., Strait, K., Leon, M.E. (2011) Effectiveness of tax and price policies in tobacco control. *Tobacco Control* 20:235-238.

8. McGrady, B. (2011) *Trade and Public Health: The WTO, Tobacco, Alcohol, and Diet*. Cambridge, etc.: Cambridge University Press.

9. First Global Ministerial Conference on Healthy Lifestyles and Noncommunicable Disease Control, Moscow, 28-29 April 2011. *Moscow Declaration*. Moscow: World Health Organization and Ministry of Public Health and Social Development, Russian Federation. http://www.who.int/nmh/events/un_ncd_summit2011/en/index.html (accessed 11 June, 2011)

10. Rehm, J., Roerecke, M. (2011). Alcohol, the heart and the cardiovascular system – what do we know and where should we go? *Drug and Alcohol Review 30*(4): 335-337.

11. Jernigan, D. (2010) The extent of global alcohol marketing and its impact on youth. *Contemporary Drug Problems* 37:57-89.

12. Room, R., Schmidt, L., Rehm, J., Mäkelä, P. (2008) International regulation of alcohol. *British Medical Journal* 337 (Nov. 6):a2364.

13. WHO. (2010) *Global Strategy to Reduce the Harmful Use of Alcohol*. Geneva: World Health Organization. http://www.who.int/substance_abuse/activities/globalstrategy/en/index.html (accessed 10 June, 2011)

14. WHO (2009) *Global Health Risks: Mortality and Burden of Disease Attributable to Selected Major Risks*. Geneva: World Health Organization. http://www.who.int/healthinfo/global_burden_disease/global_health_risks/en/index.html (accessed 10 June, 2011)

15. Laslett, A.-M., Room, R., Ferris, J., Wilkinson, C., Livingston, M. & Mugavin, J. (2011) Surveying the range and magnitude of alcohol's harm to others in Australia. *Addiction* 106(9):1603-1611.