EDITORIAL

World Health Organization’s global action on alcohol: resources required to match the rhetoric

This January the World Health Organization’s (WHO) Executive Board recommended a resolution, for consideration and adoption by the World Health Assembly (WHA) in May, on ‘public health problems caused by harmful use of alcohol’ (WHO 2005). In 2000 alcohol use was responsible for 4.0% of the global disease burden, comparable in its impact on death and disability to such risk factors as tobacco use (4.1%) and high blood pressure (4.4%) (WHO 2004). In its preamble, the resolution recognizes both the social and the health consequences of drinking, and the importance both of the overall level of alcohol consumption in a population and of intoxication and other ‘harmful drinking’ patterns. The main text calls on member states ‘to develop, implement and evaluate effective strategies and programmes for reducing the negative health and social consequences of harmful use of alcohol’. The WHO’s Director General is encouraged to strengthen WHO’s capacities in various ways, and ‘to produce a report on evidence-based strategies and interventions’ as well as ‘a comprehensive assessment of public health harms caused by harmful use of alcohol’ for the WHA in May 2007.

If passed (the resolution currently has 49 countries as cosponsors), this will be the first WHA resolution devoted to alcohol since 1983. This sign of elevated concern at WHO’s Geneva headquarters is matched by increased activity at the regional offices for the Americas, the Western Pacific and Europe. In the last case, a further renewal of the European Alcohol Action Plan will be proposed this autumn.

We are hopeful about these new initiatives but also, as long-term observers of WHO, a little cautious. Promising starts (Anonymous 1991) have petered out before. In the European region, a crescendo to the joint EU–WHO Stockholm meeting on alcohol and young people in 2001 was followed by a period of quiescence which went as far as dropping most of the alcohol material from the WHO–EURO website. In Geneva, 1983 was also a high point of activity which had included among the substantial WHO commitments an Expert Committee (WHO 1979) and Technical Discussion on alcohol. However, for many years afterwards the total commitment to alcohol in the whole of the WHO system (which essentially means the whole UN system) was, at most, the equivalent of two positions.

In the interim, however, the evidence on the importance of alcohol as a global health problem has grown, due in considerable part to the WHO’s own efforts in estimating the contribution of risk factors to the global burden of disease. The climate also seems to have changed in a number of member states, with an increased recognition of the problems that the ready availability of cheap alcohol can bring. So we travel in hope. Those of goodwill must wish the WHO well in its new initiatives.

For WHO to mount an effective programme, however, will take more than hope and goodwill. The basic problem with alcohol programming at WHO has been a lack of resources. More funds need to be committed to the work from the regular budget; but a full programme will also require substantial ‘extra-budgetary funds’; that is, dedicated supplemental monies from governments, foundations or other donors. Countries such as the United States and the United Kingdom, which have contributed funds for alcohol programming in the past, need to be persuaded not only to support the resolution but also to commit resources for WHO’s work in this area.

A second problem, more recent in its emergence, is the aggressive role adopted by sections of the alcohol beverage industry. Industry-funded ‘social aspects organizations’ such as the Portman Group, the Amsterdam Group and the International Centre on Alcohol Policy (Anderson 2002), have been progressively insinuating themselves into public health policy-making in relation to alcohol. They conduct and disseminate their own research, question the value of independent scientific studies, regularly monitor WHO activities and demand an equal seat at the table when important public health policies are being formulated. Based on past history with industries such as the tobacco producers and the baby-food industry, we would strongly advise WHO to maintain an arms-length relationship with any stakeholders that have an obvious financial conflict of interest.

One issue not covered in the resolution, but which needs attention by WHO, is the handling of alcohol in cross-border trade and trade agreements and disputes. There is no international agreement recognizing that national and local regulation of alcohol, as a hazardous commodity, need to be protected from undermining by other countries. The WHO needs to face the need for a
companion treaty for alcohol, to match the Framework Convention for Tobacco Control.

In summary, alcohol has now emerged as a prominent part of the WHO global agenda, having achieved this recognition because of the compelling evidence of its enormous impact on disease, disability and social problems. If WHO and its member states are really serious about alcohol, now is the time to demonstrate their concern with both their votes and their wallets.

ROBIN ROOM
Director
Centre for Social Research on Alcohol and Drugs
Stockholm University, 10691 Stockholm
Sweden
E-mail: robin.room@sorad.su.se

THOMAS F. BABOR
Department of Community Medicine
University of Connecticut School of Medicine
Farmington
CT 06030–6325
USA
E-mail: Babor@nso.uchc.edu

References