EUROPE

Fact sheet EURO/10/05
Copenhagen, Bucharest, 12 September 2005

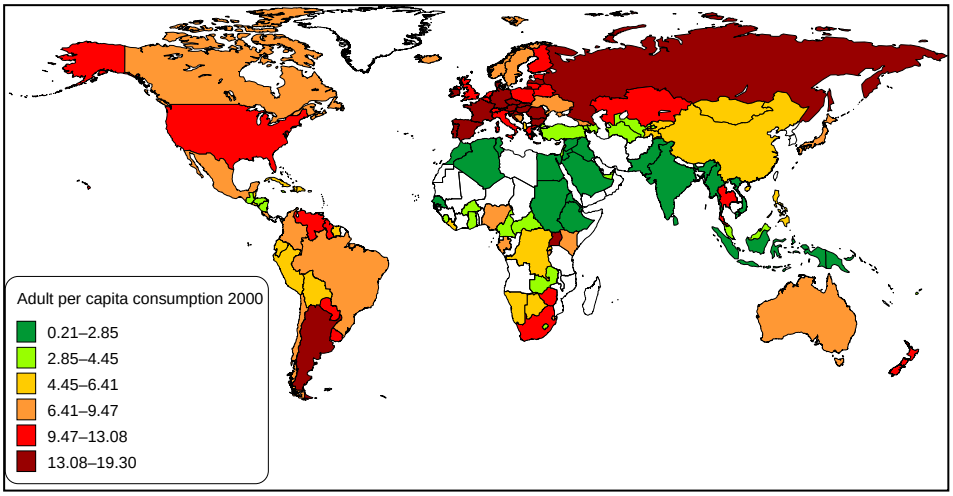
Alcohol policy in the WHO European Region: current status and the way forward

The WHO European Region has the highest alcohol consumption of all the WHO regions – twice as high as the world average. Alcohol consumption is also a major contributor to death and disability among European populations. Around 600 000 Europeans died of alcohol-related causes in 2002, representing 6.3% of all premature deaths in the Region that year; more than 63 000 of those deaths were of young people aged 15–29 years. The relative contribution to disability is even higher, alcohol use accounting for 10.8% of the total disease burden. This makes alcohol use the third leading risk factor for death and disability in the Region. Nevertheless, although the Region undoubtedly has an alcohol problem, measures to prevent the harm associated with its consumption are available. Alcohol policies at both regional and national levels should thus be a major public health priority.

Alcohol consumption in Europe[1]

The level of alcohol consumption in a population is an important determinant of health and social wellbeing. In any given society, the level of alcohol-related problems tends to rise and fall with the level of consumption. It is estimated that adults in the European Region drink on average 12.1 litres of pure alcohol per person per year, i.e. more than twice the global level of 5.8 litres (Fig. 1). Even though women account for only 20–30% of overall consumption, this again is the highest proportion in the world. There are large variations in per capita consumption among the countries in the Region, although these variations become much less significant if abstainers are excluded from the calculations.

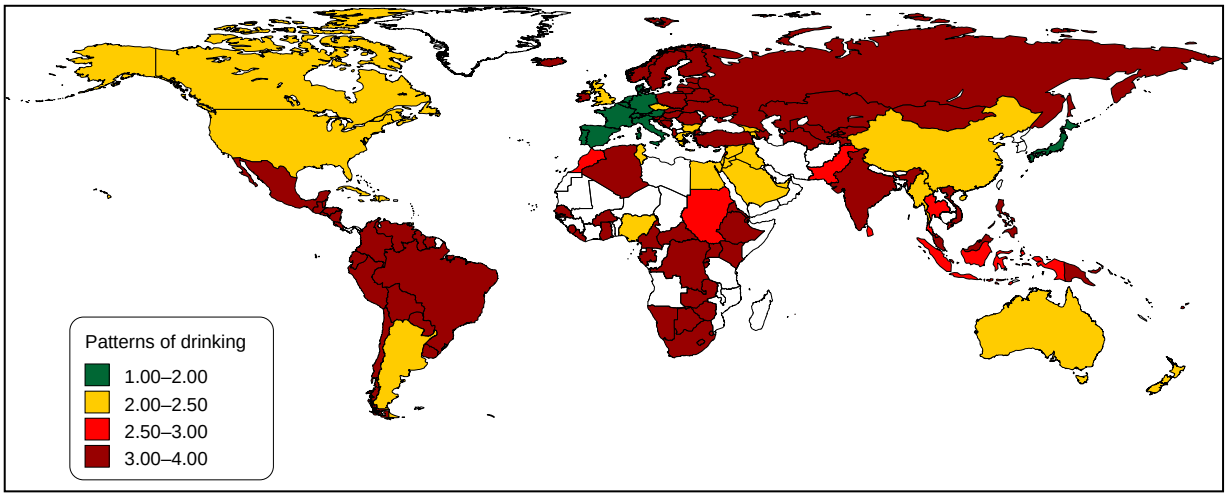
Fig. 1. Adult per capita alcohol consumption in the world measured in pure alcohol per person per year (estimates include unrecorded consumption)



[1] Country-level indicators of alcohol consumption can be found in the WHO Regional Office for Europe's alcohol control database: http://data.euro.who.int/alcohol.

While alcohol consumption has decreased in the traditional wine-drinking countries of southern Europe in recent decades, it has risen to historically high levels in much of eastern and northern Europe and remains high in central Europe. Apart from overall levels of consumption, drinking patterns are also important determinants for public health (Fig. 2). Differences in drinking patterns can help to indicate how much disease and death rates will change for a given change in the overall amount of drinking.

Fig. 2. Differences in drinking patterns in the world, ranging from 1 (least risky) to 4 (most risky)

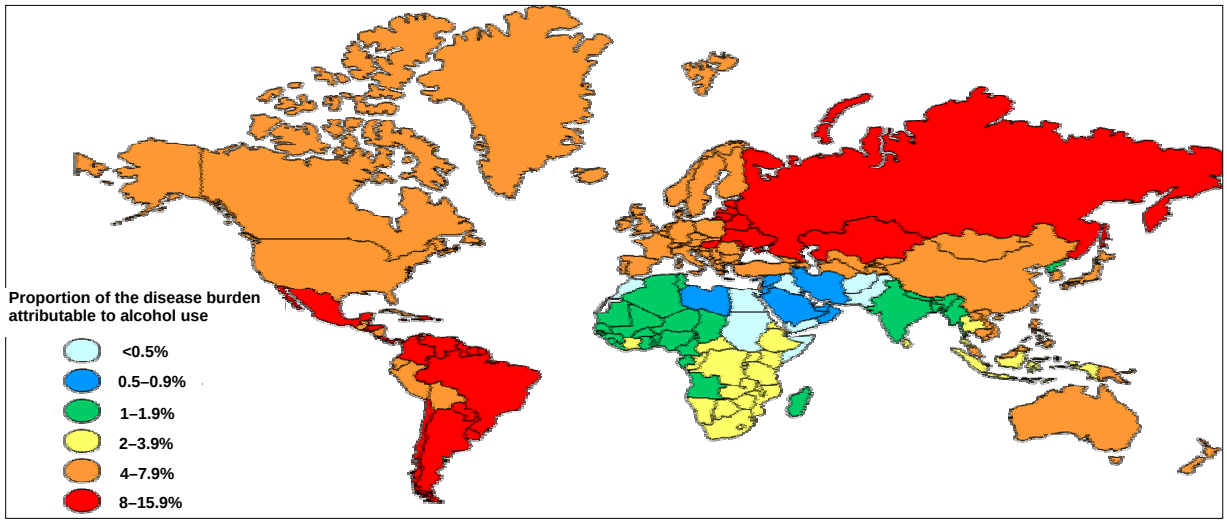


There are substantial differences in drinking patterns between different parts of the European Region. Measured by the number of heavy drinking occasions and episodes of intoxication, research shows that the Region has both the worst and the best drinking patterns in the world. The extent to which predominant drinking patterns are detrimental increases in general towards the north and east of the Region. Intoxication among young people continues at a very high level in the west of the Region and has now increased to a similar level in the east. It is also becoming a matter of concern in the south of the Region.

The harm caused by alcohol use

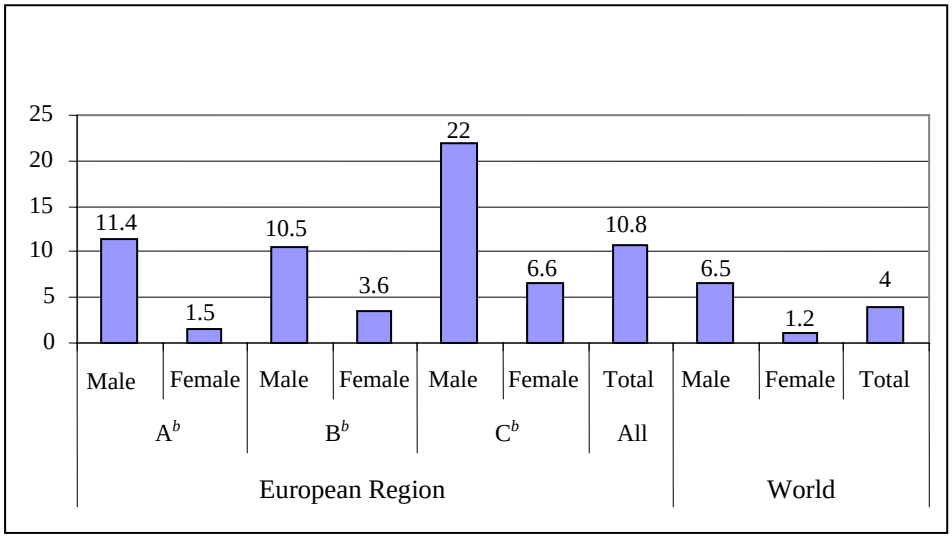
The hazardous or harmful use of alcohol is associated with a wide range of health and behavioural problems. It also has social consequences, affecting the lives and indeed the mental health of people who live or work with an alcohol-dependent person or who are injured or harassed by an intoxicated person.

Fig. 3. Burden of disease attributable to alcohol use worldwide in the year 2000, measured as a percentage of the disease burden from 27 selected risk factors



Globally, alcohol use is estimated to account for 1.8 million deaths and 4% of the disease burden (Fig. 3). In the European Region as a whole, however, the figure in 2002 was more than twice as high at 10.8%; it is estimated that 600 000 people died prematurely that year from alcohol-related causes. Alcohol use was thus the third most important risk factor for disease burden comparatively assessed in the European Region, being surpassed only by hypertension and tobacco use. There are also striking differences between the different parts of Europe: while alcohol use accounts for only 1.5% of the disease burden among women in some countries in the west of the Region, it accounts for as much as 22% among men in some of the countries of eastern Europe (Fig. 4).

Fig. 4. Alcohol-related disease as a percentage of all disease, measured in DALYs[a]



[a] The disability-adjusted life year (DALY) is an indicator of time lived with a disability and of time lost owing to premature mortality.

[b] The constitution of the subgroupings A, B and C in the European Region is given at the end of this fact sheet.

The burden of alcohol-related disease is several times higher among men than among women in all parts of the Region (Fig. 4). Nevertheless, women figure more prominently among those who are injured or have social problems caused by other people's drinking. Contrary to most other

risk factors for developed countries, such as tobacco use, hypertension and high blood cholesterol level, alcohol use has a detrimental effect on health relatively early in life. Alcohol use is the most important risk factor in the age group 15–29 years, and it is estimated that some 63 000 young Europeans died from alcohol-related causes in 2002. Table 1 shows the alcohol-related disease burden by disease category.

Table 1. Alcohol-related disease burden in DALYs (000s) in 2002 by disease category (numbers are rounded to full thousands)

	European Region		World	
	Total	Percentage of all alcohol-attributable DALYs	Total	Percentage of all alcohol-attributable DALYs
Maternal and perinatal conditions	14	0.1	111	0.2
Cancer	858	5.5	4 175	7.0
Neuropsychiatric conditions	5 195	33.2	22 701	38.2
Vascular conditions	1 169	7.5	3 693	6.2
Other noncommunicable diseases	1 607	10.3	4 175	7.0
Unintentional injuries	4 867	31.1	17 044	28.7
Intentional injuries	1 933	12.4	7 452	12.6
All alcohol-attributable DALYs	15 643	100.0	59 351	100.0
Alcohol-attributable DALYs as a percentage of all DALYs	10.8		4	

The recent epidemiological finding that a low level of alcohol consumption protects against heart disease is often erroneously interpreted as cancelling out the findings on the negative effects of drinking. In fact, recent calculations from WHO's global burden of disease project data show that even when these positive effects are taken into account, the negative consequences are still huge. Furthermore, studies have found that although there are some positive effects from low-level consumption at the individual level, they do not translate into positive trends for the population as a whole. Information on the global burden of disease project can be found at http://www.who.int/evidence/bod.

Work estimating the role of alcohol in the burden of death and disease, as part of the WHO estimates for 2002, has contributed significant new information on problems resulting from drinking. However, these estimates cover only health problems (including injury) and thus do not reflect many of the social consequences of drinking, and much of the harm caused to others. Estimates of the burden of social harm from alcohol use are much less commonly available and much less complete. Social problems resulting from drinking should be considered equally as important for policy formulation as health problems.

Thus policies that affect the rates of alcohol-related harm are not only concerned with improving the health and saving the lives of whose who drink, but potentially have a broader impact on the health and well-being of families, communities and society at large.

The available solutions

In recent years there has been substantial progress in knowledge about the effects of specific alcohol control measures – in terms not only of what works but also of what does not work. Governments now have much stronger evidence than they had 20 years ago on which to base alcohol policies.

A recent review rates 32 strategies or interventions in terms of their degree of effectiveness, the breadth of their research support, the extent to which they have been tested cross-culturally, and the relative expense of implementation. At one end of the spectrum are strategies that have been shown to be broadly effective. These include alcohol control policies, drink–driving countermeasures and brief interventions for hazardous and harmful drinkers. At the other end of the spectrum are a series of measures for which it has been difficult to find a direct positive effect on drinking patterns or problems. Such measures include education in schools, public service announcements and voluntary regulation by the alcohol industry. These measures should be used only as part of a comprehensive strategy to tackle alcohol-related harm.

In the longer term, there is a need for sustainable alcohol policies and programmes that reduce both hazardous and harmful patterns of drinking, reduce the overall volume of drinking, separate drinking from certain activities and situations (such as driving or operating machinery, at the workplace and during pregnancy) and provide adequate help for people with alcohol problems and their families.

The growth of trade agreements and common markets and, more generally, the processes of globalization have substantially weakened the ability of governments to use some of the most effective tools to prevent and reduce alcohol-related problems appropriate to their own cultures. There is thus a need, from a public health perspective, for concerted international action to clearly recognize that alcohol is a special commodity in terms of the very substantial harm associated with its use.

WHO continues to face the challenges

In 1992, the Regional Office for Europe was the first of the WHO regional offices to take the initiative of launching a Region-wide action plan on alcohol. The Office has since played a substantial role as a catalyst and facilitator of policy formulation and of health and welfare advocacy on alcohol-related issues in Member States.

In 1994, a network of national counterparts for the action plan, nominated by the Member States, was created to exchange experience, plan activities, evaluate action and provide international support for action at national and regional levels.

In December 1995, the WHO European Conference on Health, Society and Alcohol, held in Paris, adopted the European Charter on Alcohol. The Charter provides Member States with five ethical principles and ten strategies for developing comprehensive alcohol policies and programmes.

In 1999, the WHO Regional Committee for Europe discussed the need to continue action on alcohol in the Region and endorsed the third phase of the European Alcohol Action Plan for 2000–2005 (resolution EUR/RC49/R8).

In February 2001, the WHO European Ministerial Conference on Young People and Alcohol focused on specific targets, policy measures and support activities for young people. The Conference adopted the Declaration on Young People and Alcohol, which was then endorsed by the Regional Committee in September 2001 as the leading policy statement of the WHO European Region on young people and alcohol (resolution EUR/RC51/R4).

Since the adoption of the Action Plan, there has been an increased demand from Member States for technical assistance in the formulation and implementation of national alcohol policies and strategies. As such, many of the resources in the Regional Office have been allocated to meet this demand.

In 2002, the European Alcohol Information System was established to collect, analyse and distribute information on alcohol issues relevant to the implementation of the Action Plan. Data are presented by country, and intercountry comparisons on situations and policies are also available. There are seven data sets per country, including information on restrictions on alcohol consumption, drink–driving, sales restrictions, promotion, and treatment of alcohol-related problems. There is also a link to the Regional Office's health for all database on consumption and alcohol-related harm.

Recent developments in other areas of work at the Regional Office are important in the formulation of the next phase of the Action Plan. These include current developments towards a European strategy on noncommunicable diseases, the European Strategy on Child and Adolescent Health and Development, and a recently adopted European declaration and action plan on mental health. In addition, raising awareness of the need for a revised strategy on nutrition in the Region and the renewed focus on injuries and violence are important linked processes.

Alcohol has also been put on the agenda at WHO's global level. For the Fifty-eighth World Health Assembly in 2005, the WHO secretariat produced a report entitled *Public health problems caused by harmful use of alcohol* (document A58/18)[2] and the Health Assembly subsequently adopted resolution WHA58.26 [3] on the subject. The resolution, among other things, requests the Director-General to produce a report on evidence-based strategies and interventions to reduce alcohol-related harm, including a comprehensive assessment of public health problems caused by harmful use of alcohol, to be presented to the Sixtieth World Health Assembly in 2007.

Developments and initiatives in the European Union (EU), with its 25 Member States, have important consequences for public health policy development in the Region. There have been several significant public health initiatives by the EU in recent years, including partnership in the WHO European Ministerial Conference on Young People and Alcohol; Council Recommendation 2001/458/EC on the drinking of alcohol by young people; Council Conclusion 2001/C 175/01 for an EU strategy to reduce alcohol-related harm, reiterated in 2004; and the alcohol component of the Public Health Programme. All these initiatives show the growing active role of the EU in reducing alcohol-related harm in Europe.

Alcohol will be one of the main topics for discussion at the fifty-fifth session of the Regional Committee in Bucharest. A draft framework for alcohol policy in the WHO European Region will be presented to the meeting. The framework aims to encourage and facilitate the development and implementation of global, regional, national and local community policies and actions to reduce the harm done by alcohol. It reinforces and creates continuity to the European Alcohol Action Plan, the European Charter on Alcohol and the Declaration on Young People and Alcohol, but also takes into account recent data and developments and new challenges in this field.

[2] http://www.who.int/gb/ebwha/pdf_files/WHA58/A58_18-en.pdf.

[3] http://www.who.int/gb/ebwha/pdf_files/WHA58/WHA58_26-en.pdf.

Additional information

Further information on alcohol-related issues is available at the following web sites.

WHO Regional Office for Europe
http://www.euro.who.int/alcoholdrugs

WHO headquarters
http://www.who.int/substance_abuse/en/
http://www3.who.int/whosis/alcohol/

European Commission
http://europa.eu.int/comm/health/ph_determinants/life_style/alcohol_en.htm

Bridging the Gap project
http://www.eurocare.org/btg/index.html

Definition of subgroupings

The following regional subgroupings of countries, as used in Fig. 4, have been defined by WHO (in *The world health report 2000*) based on level of childhood and adult mortality.

EUR-A	EUR-B	EUR-C
Very low childhood, very low adult mortality	**Low childhood, low adult mortality**	**Low childhood, high adult mortality**
Andorra, Austria, Belgium, Croatia, Czech Republic, Denmark, Finland, France, Germany, Greece, Iceland, Ireland, Israel, Italy, Luxembourg, Malta, Monaco, Netherlands, Norway, Portugal, San Marino, Slovenia, Spain, Sweden, Switzerland, United Kingdom	Albania, Armenia, Azerbaijan, Bosnia and Herzegovina, Bulgaria, Georgia, Kyrgyzstan, Poland, Romania, Serbia and Montenegro, Slovakia, Tajikistan, The former Yugoslav Republic of Macedonia, Turkey, Turkmenistan, Uzbekistan	Belarus, Estonia, Hungary, Kazakhstan, Latvia, Lithuania, Republic of Moldova, Russian Federation, Ukraine

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Press materials can be found on the Regional Office web site (http://www.euro.who.int).