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Report on alcohol in the WHO European Region
Background paper for the Framework for alcohol policy in the WHO European Region

This background paper reviews the situation in the WHO European Region with regard to alcohol consumption and alcohol-related harm; it also includes a summary of the assessment of implementation of the European Alcohol Action Plan 2000–2005.

This paper should be read in conjunction with document EUR/RC55/11 on the *Framework for alcohol policy in the WHO European Region*.

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Contents

Page

Introduction – a decade of alcohol policy development 1

Alcohol consumption in Europe 2

- Per capita consumption 2
- Alcohol among young people 3
- The health burden of alcohol 5
- The social burden of alcohol 7

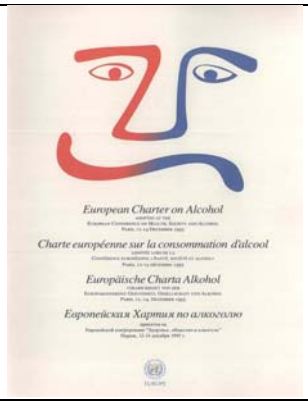
The policy response 8

- Assessment of the implementation of the European Alcohol Action Plan 2000–2005 8
- The challenges ahead 9

References 9

Introduction – a decade of alcohol policy development

1. In 1992, the WHO European Region was the first WHO region 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 the Member States. In 1994, a network of national counterparts for the Action Plan, nominated by the respective Member States, was created to exchange experiences, plan activities, evaluate actions and provide international support for action at national and regional levels.

			
1992: The first European Alcohol Action Plan	1995: The European Charter on Alcohol	1999: The second European Alcohol Action Plan	2001: The Declaration on Young People and Alcohol.

2. An important milestone in the Action Plan was reached in 1995, when the European Conference on Health, Society and Alcohol was convened in Paris. This was the first time that WHO had organized a pan-European conference at which health ministers and other officials from almost all the Member States addressed alcohol policy, one of the most difficult issues in public health. How could Europe come to grips with health problems related to alcohol in a way that was realistic, effective and acceptable? The outcome was the unanimous adoption of the European Charter on Alcohol *(1)*. The Charter provides Member States with five ethical principles and ten strategies for developing comprehensive alcohol policies and programmes. It also became a building block for the next phase of the Action Plan. In 1999, the Regional Committee discussed the need to continue action on alcohol and unanimously endorsed the second phase of the European Alcohol Action Plan 2000–2005 *(2)*.

3. In 2001, the WHO European Ministerial Conference on Young People and Alcohol was convened, focusing on specific targets, policy measures and support activities for young people. In the esteemed presence of Her Majesty Queen Silvia of Sweden, 37 ministers of health, a deputy prime minister, several deputy ministers and secretaries of state, and over 100 young people from an estimated total of over 600 participants from all Member States discussed how to ensure a better quality of life for young people in Europe by reducing the harm caused by alcohol. The Conference adopted the Declaration on Young People and Alcohol *(3)*, 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.

4. Since the adoption of the second Action Plan, there has been increased demand from Member States for technical assistance in the formulation and implementation of national alcohol policies and strategies. Many of the Regional Office's resources have been allocated to meeting this demand. In 2002, the European Alcohol Information System (EAIS) *(4)* was established to collect, analyse and distribute information on alcohol issues relevant to implementation of the Action Plan.

Alcohol consumption in Europe[1]

Per capita consumption

5. The level of alcohol consumption in a population is an important determinant of health and social well-being. In any given society, the level of alcohol-related problems tends to rise and fall with rises and falls in the level of consumption. Overall, alcohol consumption seems to be stable in the Region, but this hides the fact that the historically very large variations in per capita consumption between the countries in WHO's European Region have become smaller during recent decades. Data show that, while alcohol consumption levels have decreased in the traditionally wine-drinking countries of southern Europe, they have risen to historical highs in much of northern and eastern Europe, and remain high in the central areas of Europe. The central Asian republics traditionally have a very low level of consumption. However, the variation between countries becomes much less marked if abstainers are excluded from the figures.

6. The exact level of total consumption in a country is difficult to retrieve from the data, and direct comparison between countries can thus be difficult. Relatively few countries have conducted studies to estimate the level of unrecorded consumption, but a group of alcohol experts has attempted to estimate the level of unrecorded consumption globally. These estimates indicate that the adult population in WHO's European Region drinks, on average, 12.1 litres of pure alcohol per person per year, more than twice the global adult per capita consumption of 5.8 litres. Even though women account for only between 20% and 30% of overall consumption, this is the highest proportion in the world.

Table 1: Characteristics of adult alcohol consumption in different subregions of WHO's European Region in 2000 (population-weighted averages across countries) *(5,6,7)*

WHO subregion[a]	Total consump-tion[b]	% unrecorded of total[c]	% heavy drinkers[d]	% drinkers among males	% drinkers among females	Consumption per drinker[e]	Average drinking pattern[f]
Euro A	12.9	10%	15.7	90	81	15.1	1.3
Euro B 1	9.3	40%	9.9	77	57	14.3	2.9
Euro B 2	4.3	51%	4.5	54	33	9.9	3.0
Euro C	13.9	38%	18.6	89	81	16.5	3.6
World	5.8	40%	5.1	60	32	12.3	2.5

a **Euro A**: 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.

Euro B: Albania, Armenia*, Azerbaijan*, Bosnia and Herzegovina, Bulgaria, Georgia, Kyrgyzstan*, Poland, Romania, Slovakia, The Former Yugoslav Republic Of Macedonia, Tajikistan*, Turkmenistan*, Turkey, Uzbekistan*, Yugoslavia *(* subsumed as B2; rest is B1*).

Euro C: Belarus, Estonia, Hungary, Kazakhstan, Latvia, Lithuania, Republic of Moldova, Russian Federation, Ukraine.

b Estimated total alcohol consumption per resident aged 15 and older in litres of absolute alcohol (recorded and unrecorded).

c Percentage of total adult per capita consumption which is estimated to be unrecorded.

d Estimated % rate of heavy drinking (males ≥ 40g and females ≥ 20g) among those aged 15+.

e Estimated total alcohol consumption (in litres of absolute alcohol) per adult drinker aged 15+.

f Estimated average pattern of drinking (1–4 with 4 being the most detrimental pattern).

[1] Country-level indicators of alcohol consumption can be found in the WHO Regional Office for Europe Alcohol Control database (http://data.euro.who.int/alcohol/ accessed 17 August 2005).

7. In addition to the overall consumption of alcohol, drinking patterns are also important determinants for public health. The differences in drinking patterns hold implications for the extent by which levels of disease and death will change with a given change in the overall amount of drinking. As Table 1 shows 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 towards the east of the Region.

Alcohol among young people

8. Alcohol consumption among young people has been of particular concern among European countries in the Region and manifested itself in the WHO Ministerial Declaration on Young People and Alcohol in 2001. There are two large-scale European-wide studies available to compare alcohol use among young people in the Region. In 1982, the Regional Office established the Health behaviour in school-aged children (HSBC) study. The study is conducted every fourth year, and the most recent survey in 2001/2002 involved 11-to-15-year-olds in 35 countries in the Region. The second study is the European school survey project on alcohol and drugs (ESPAD), which examines drinking, smoking and illicit drug use among 15-to-16-year-old school students in Europe. The ESPAD study has been conducted in 1995, 1999 and 2003.

9. The 2001/2002 HBSC study shows that the average age of onset of drinking alcohol is 12.3 among boys and 12.9 among girls in the 35 countries. The first episode of drunkenness appears on average at age 13.6 for boys and 13.9 for girls. When looking at regular drinking among young people, 5% of 11-year-olds, 12% of 13-year-olds and 29% of 15-year-olds report drinking alcohol on a weekly basis *(8)*.

Figure 1: Percentage of young people who have been drunk two or more times.
Source: HBSC study *(8)*

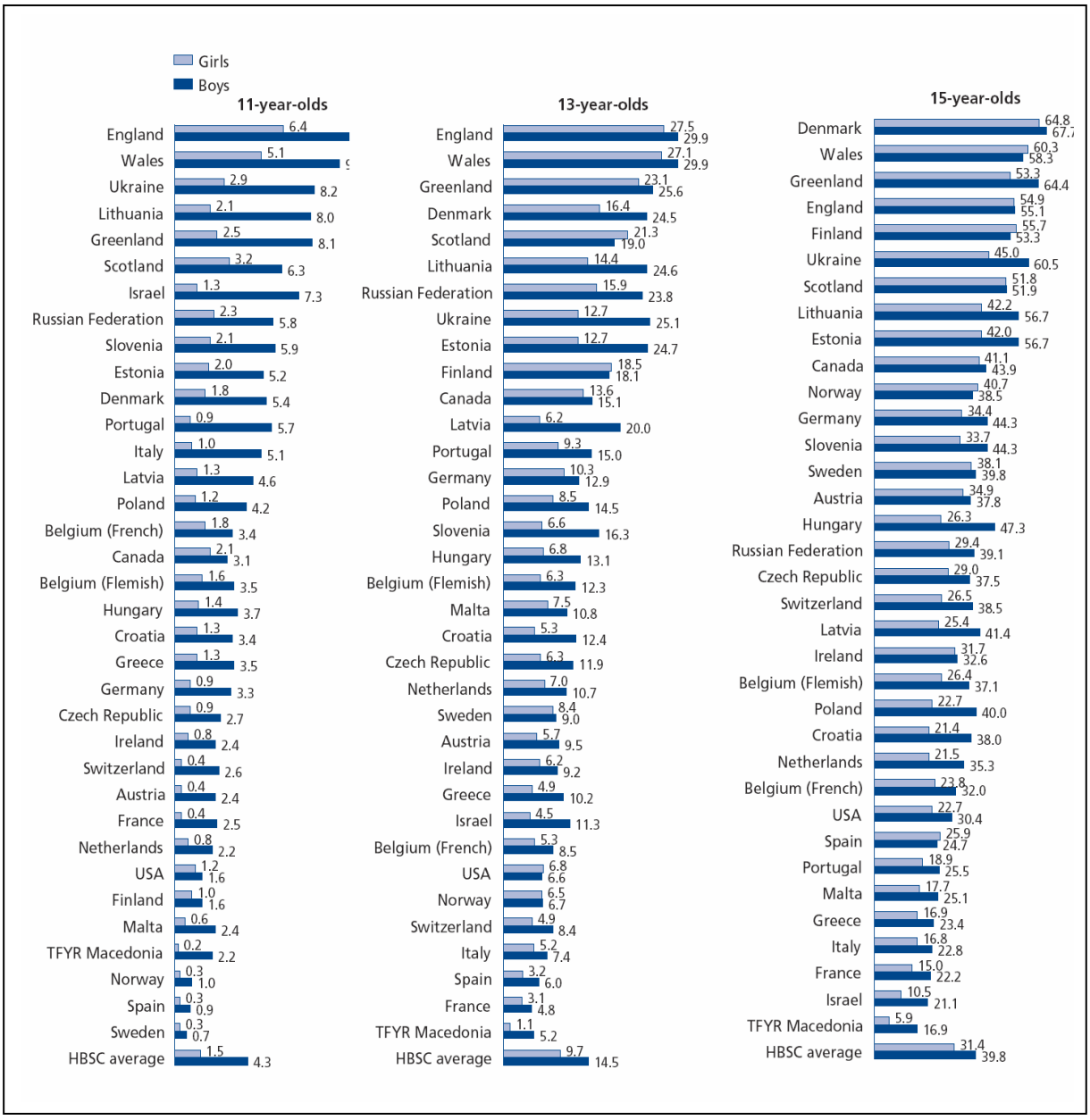
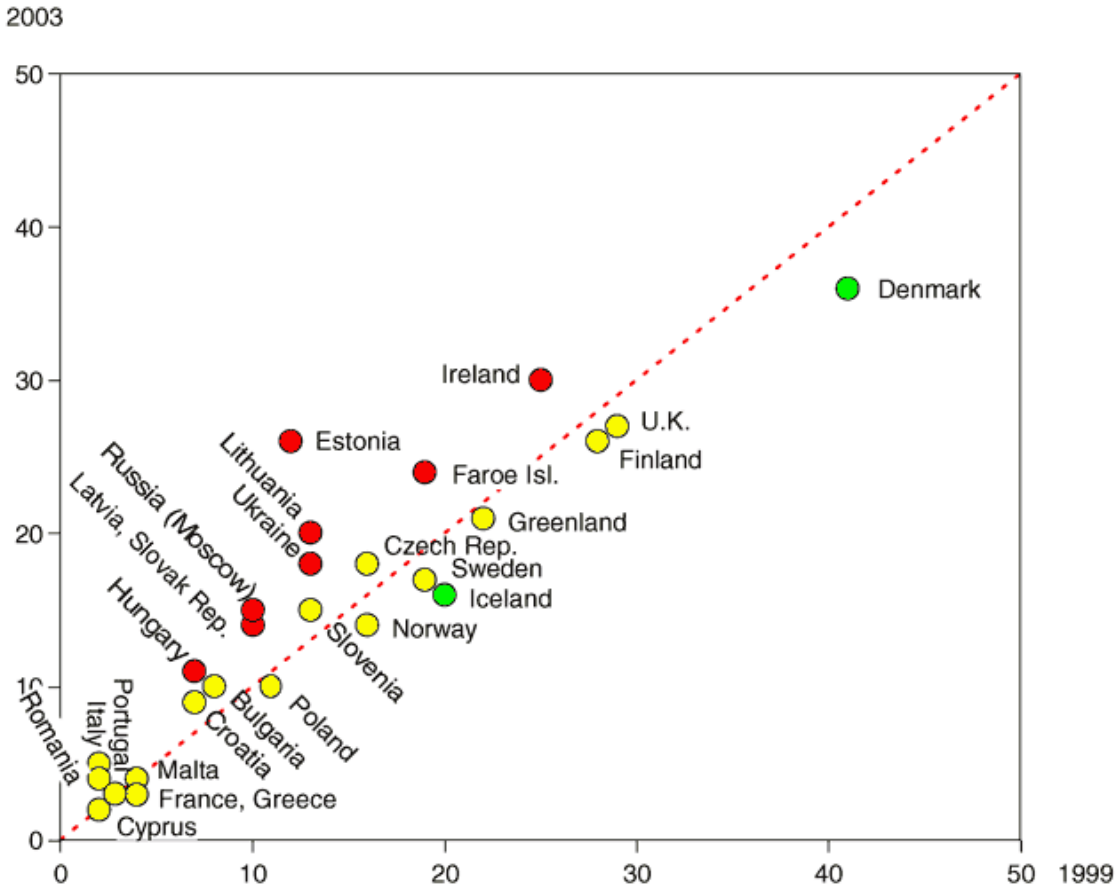


Figure 2: Changes between 1999 and 2003 in the proportion of 15-to-16-year-old students who reported having been drunk 20 times or more in lifetime. Countries with more intoxication in 2003 than in 1999 are above the dotted line. The higher up a country is, the more intoxication among young people it had in 2003. Source: ESPAD *(9)*



10. When looking at the development from 1999 to 2003, the ESPAD survey shows that youth lifetime intoxication in the Region has either increased or stayed at the same level as in 1999. Only two countries, Denmark and Iceland, showed a significant decline in youth lifetime intoxication over that period. Youth intoxication remains at a very high level in the west and has increased to a similar level in the east. The trend in youth intoxication is also a matter of concern in the south *(9)*.

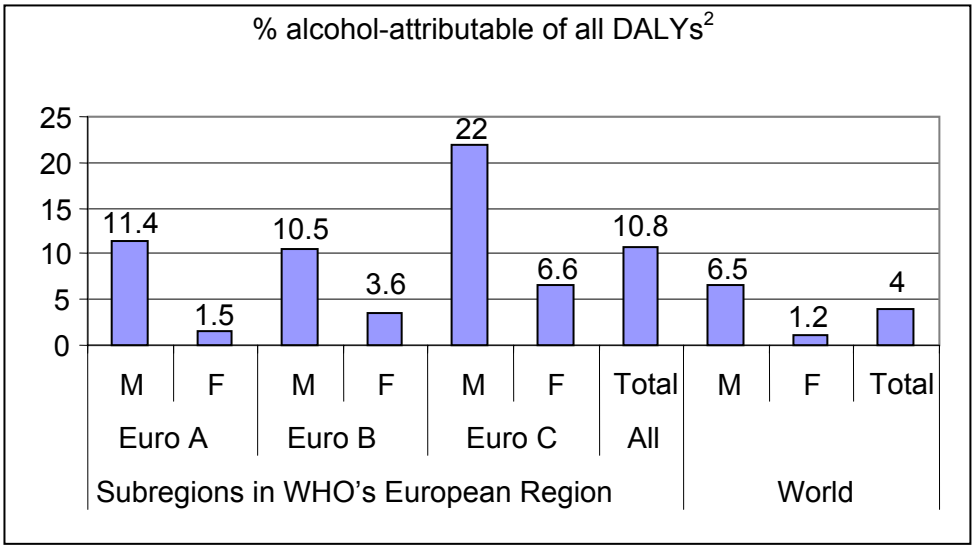
The health burden of alcohol

11. Hazardous and harmful use of alcohol is associated with a wide range of health and behavioural problems. In addition, it has social consequences, affecting the daily lives and indeed the mental health of people who live or work with an alcohol-dependent person and those injured or harassed by an intoxicated person.

12. Globally, alcohol is estimated to account for 1.8 million deaths and 4% of the burden of disease *(10)*. However, in the European Region, the figure in 2002 was more than twice as high at 10.8%, and it is estimated that 600 000 people died prematurely from alcohol-related causes that year *(11)*. Alcohol was thus the third most important of 26 risk factors for burden of disease comparatively assessed in the European Region, only surpassed by hypertension (1) and tobacco (2). There are also striking differences between the different parts of Europe. While alcohol accounts for only 1.5 per cent of the disease burden among women in some countries in the western parts of the

Region, it accounts for as much as 22 per cent of the disease burden among men in some of the countries in eastern Europe.

Figure 3: Alcohol-related disease as percentage of all disease as measured by the Global Burden of Disease project *(12)*.



13. The burden of alcohol-related disease is several times higher among men than among women in all parts of the Region. However, women figure more prominently among those who experience casualty and social problems due to others' drinking. Contrary to most other risk factors for developed countries such as tobacco, high blood pressure or high cholesterol, alcohol has a detrimental impact on health relatively early in life. Alcohol constituted the most important risk factor for the 15–29 age group and it is estimated that 63 000 young European adults died of alcohol-related causes in 2002.

Table 2: Alcohol-related disease burden in thousands of DALYs in 2002 by disease category.

	WHO Europe region		World	
	Total	% of all alcohol-attributable DALYs	Total	% of all alcohol-attributable DALYs
Maternal and perinatal conditions	14	0.1%	111	0.2%
Cancer	858	5.5%	4 175	7.0%
Neuro-psychiatric 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 injury	4 867	31.1%	17 044	28.7%
Intentional injury	1 933	12.4%	7 452	12.6%
All alcohol-attributable DALYs	15 643	100.0%	59 351	100.0%
% alcohol-attributable of all DALYs	**10.8**		**4**	

[2] DALY: Disability-adjusted life-year: health gap measure developed for the WHO Global Burden of Disease study to estimate the burden of a disease on a defined population. DALYs are measured in terms of mortality and morbidity. Morbidity is weighted to reflect the severity of the condition. DALYs are the sum of years of life lost (YLL) to the disease and years of life lived with disability (YLD).

14. Table 3 below shows the relative proportion of alcohol-related deaths to all deaths by gender and age. This proportion is highest in all subregions and for both genders in the 15–29 age group (with a small exception for females in Euro B). In other words, for young adulthood alcohol constituted the most important risk factor for young adulthood. This is also the age period for which no protective effects of alcohol have been found.

Table 3: Proportion of alcohol-related deaths among all deaths in WHO European subregions.

	Age in years					
	0 to 4	5 to 14	15 to 29	30 to 44	45 to 59	60 to 69
Euro A						
Males	1.3%	7.1%	26.2%	19.0%	10.4%	4.0%
Females	0.8%	3.5%	10.1%	8.6%	6.4%	0.3%
Euro B						
Males	0.7%	4.0%	23.1%	18.5%	13.0%	9.6%
Females	0.4%	1.3%	7.1%	7.2%	6.1%	3.6%
Euro C						
Males	2.5%	9.6%	37.3%	27.7%	21.1%	14.6%
Females	1.2%	5.2%	19.1%	15.1%	11.5%	5.9%

15. The recent epidemiological findings of a protective effect of alcohol at low levels of use for heart disease are often erroneously interpreted as neutralizing the findings about the negative effects of drinking. In fact, recent calculations from WHO Global Burden of Disease data show that, even when the positive effects of low-level alcohol consumption are taken into consideration, the negative consequences are still very substantial. 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 *(12)*.

The social burden of alcohol

16. The work evaluating alcohol's role in the burden of death and disease as part of the WHO estimates for 2002 has contributed significant new information on health problems from drinking. However, these estimates only cover health problems (including casualties) and thus ignore much of the social harm that arises from drinking and much of the harm caused to others. Policies which affect rates of alcohol-related harm are thus not only a matter of improving the health and saving the lives of those who drink, but potentially have a broader impact on the health and well-being of families, communities and society at large.

17. Estimates of the burden of social harm from alcohol are much less commonly available and much less complete. In some countries where social harm has been estimated, the alcohol-related disease burden was actually less significant than the social harm caused by alcohol *(13)*. Thus, effective alcohol policy and other interventions aimed at reducing the alcohol-related disease burden may have additional effects that reduce the burden of social harm *(14)*. Social problems from drinking should be considered as equally important for policy as are health problems. Given this, the Regional Office, in collaboration with the Ministry of Health in Sweden, has initiated a study on the social cost of alcohol in Europe.

The policy response

18. Recent years have seen substantial steps forward in our knowledge about the effects of specific alcohol control measures – in terms not only of what works, but also of what does not work. Governments are thus in a much stronger position than they were 20 years ago to build their alcohol policies on an evidence base. A recent review rates 32 strategies or interventions in terms of the degree of their effectiveness, the breadth of their research support, the extent to which they have been tested cross-culturally, and the relative expense of their implementation *(7)*.

19. At one end of the spectrum are strategies that have been shown to be broadly effective. These strategies 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 strategies for which it has been difficult to find a direct positive effect on drinking patterns or problem. Such strategies include education in schools, public service announcements and voluntary regulation by the alcohol industry. These strategies should thus only be used as part of a comprehensives strategy to tackle alcohol-related harm.

20. 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 like driving or operating machinery, the workplace, and during pregnancy, and provide adequate help to people with alcohol problems and their families.

21. 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 as appropriate in their own cultures. There is thus a need, from the perspective of public health, for concerted international action to clearly recognize that alcohol is a special commodity in terms of the very substantial harm associated with its use.

Assessment of the implementation of the European Alcohol Action Plan 2000–2005

22. The European Alcohol Action Plan 2000–2005 sets out five main objectives to be achieved by Member States and lists ten areas, with accompanying outcomes and actions, for national alcohol policy development. In addition, it details five key areas where the Regional Office should actively support Member States in their implementation processes. An assessment of the Action Plan 2000–2005 has been carried out by analysing the information provided in the European Alcohol Information System (EAIS) and conducting a survey among the national counterparts for alcohol policy.

23. The latest update of the EAIS was made in connection with the annual meeting of the national counterparts for alcohol policy in Stockholm in April 2005. The EAIS now contains data from 44 Member States. A comparison with the data set for 2000 shows that, for most Member States, alcohol control policy has not changed much in the past five years. For European Union Member States, overall picture is a less restrictive alcohol control policy since 2000. This analysis hides individual variations in Member States and does not reflect the increased awareness and concern about young people's drinking which have been seen in many European countries.

24. In an effort to produce a more detailed picture of the level of implementation of the Action Plan in Member States, a survey among the national counterparts for alcohol policy was conducted in the first quarter of 2005. The counterparts were asked about both the degree of implementation of the Action Plan at national level and the performance of the Regional Office. Thirty-six counterparts completed the survey. It is important to remember that the assessment does not give a picture of the actual level of implementation or achievement, but only the perception of the counterparts concerning changes in alcohol policy between 1999 and 2005 in their respective countries.

25. Overall, the counterparts report a movement towards greater achievement of the objectives of the Action Plan, but there are huge differences between countries and subregions. When looking at achievement of the outcomes in the 10 areas of the Action Plan, the highest score is registered in information and education, while reducing availability of alcohol products gets the lowest score. This would seem to contrast with the available evidence base, which rates strategies to reduce availability as among the most effective. It is also worth noting that implementation of the responsibilities of the alcoholic beverage industry, as outlined in the Action Plan, is perceived by the counterparts to be unsatisfactory. The reported increase in the industry's activities on the social aspects of alcohol has thus not met the Plan's objectives regarding efforts by the industry to reduce alcohol-related harm.

26. The counterparts were then asked to rate the role of the Regional Office as outlined in the Action Plan. The Regional Office gets the highest score for being a centre for information on alcohol-related issues. It is evident that the Regional Office has been successful in providing relevant information about alcohol-related issues to Member States. The establishment of the European Alcohol Information System and the maintaining and updating of the Health for All database are important contributors to this. The lowest, although still positive, scores for the Regional Office are given for being the "health conscience" in the Region and working as a catalyst for action, both very important roles in the policy formulation process regarding alcohol.

The challenges ahead

27. The WHO Regional Office for Europe has played a substantial role over the past twenty years as a catalyst and facilitator of policy formulation and of health and welfare advocacy on alcohol issues in Member States. Two consecutive regional action plans (1992–2000 and 2000–2005) and two ministerial conferences, resulting in the 1995 European Charter on Alcohol and the 2001 Stockholm Declaration on Young People and Alcohol, have all offered paths for the development and implementation of effective measures in the field of alcohol and therefore contributed to overall health policy in the Region.

28. In much of the European Region, alcohol is a familiar accompaniment to the rhythm of the week, and the serious health and social problems that it causes, both immediately and in the longer term, are often overlooked. From this perspective, the WHO's Global Burden of Disease analysis is an important reminder that the European Region still has a serious problem with alcohol. If the negative changes in patterns of drinking that have been seen in many parts of the Region continue, we can expect further increases in alcohol-related disease burden in the European subregions, even if current levels of consumption do not rise.

References[3]

1. *European Charter on Alcohol*. Copenhagen, WHO Regional Office for Europe, 1995 (http://www.euro.who.int/document/E57528.pdf).

2. *European Alcohol Action Plan 2000–2005*. Copenhagen, WHO Regional Office for Europe, 2000 (http://www.euro.who.int/document/E67946.pdf).

3. *Declaration on Young People and Alcohol*. Copenhagen, WHO Regional Office for Europe, 2001 (http://www.euro.who.int/AboutWHO/Policy/20030204_1/).

4. European Alcohol Information System [web site]. Copenhagen, WHO Regional Office for Europe, 2005 (http://www.euro.who.int/alcoholdrugs/20020611_1).

5. Rehm J et al. The global distribution of average volume of alcohol consumption and patterns of drinking. *European Addiction Research*, 2003, 9(4):147–156.

[3] Websites accessed 17 August 2005.

6. Rehm J et al. Alcohol as a risk factor for burden of disease. In: Ezzati M et al., eds. *Comparative quantification of health risks: Global and regional burden of disease due to selected major risk factors*. Geneva, World Health Organization, 2004:959–1108.

7. Babor T et al. *Alcohol: No Ordinary Commodity – Research and Public Policy*. Oxford, Oxford University Press, 2003.

8. Currie C et al., eds. *Young people's health in context. Health Behaviour in School-aged Children (HBSC) study: international report from the 2001/2002 survey*. Copenhagen, WHO Regional Office for Europe, 2004 (http://www.euro.who.int/eprise/main/who/informationsources/publications/catalogue/20040518_1).

9. Hibell B et al. *The ESPAD Report 2003. Alcohol and Other Drug Use Among Students in 35 European Countries*. Stockholm, Modin Tryck AB, 2004.

10. *The world health report 2002: Reducing risks, promoting healthy life*. Geneva, World Health Organization, 2002 (http://www.who.int/whr/2002/en/).

11. Rehm J, Taylor, B. *Volume of alcohol consumption, patterns of drinking and burden of disease in the European Region – implications for alcohol policy*. WHO Regional Office for Europe meeting on Alcohol Policy in the WHO European Region, Stora Brännbo, Sweden, 13–15 April 2005.

12. Global Burden of Disease project [web site]. Copenhagen, WHO Regional Office for Europe, 2005 (http://www3.who.int/whosis/menu.cfm?path=evidence,burden).

13. *Alcohol misuse in Scotland: trends and costs. Final report*. Northwood, Middlesex, Catalyst Health Consultants, 2001.

14. Room R et al. Drinking and its burden in a global perspective: policy considerations and options. *European Addiction Research*, 2003, 9(4):165–175.