

### Health, Social and Economic Impact of Alcohol

#### **COMMENTS**

on the scientific and policy issues discussed at the Stakeholder's workshop held on 20 January 2005 in Luxembourg.

#### Introduction

At the above mentioned meeting, Dr Peter Anderson, on behalf of the Contractor for the report entitled "Reporting and analysis of public health issues: health social and economic impact of alcohol", made a detailed presentation following twelve points that he felt would certainly lead to a debate amongst stakeholders.

The comments here below are based on several interventions that Messrs. Piero Perron, Adrian Botha and Pierre-Olivier Bergeron made during the meeting. They also include remarks which the secretariat of The Brewers of Europe received from its Members after the meeting. The Brewers of Europe takes this opportunity to also refer to its <u>First Submission in the context of DG SANCO's First Draft Working Paper on a Coordinated Approach in Europe to Tackle Alcohol-Related Harm"</u>, which was handed to DG SANCO on 22<sup>nd</sup> September 2004.

Finally, we would like to stress that we share the views that were expressed by The Amsterdam Group at the above mentioned meeting.

#### 1. Public health purpose of alcohol policy

The science and art of preventing disease, prolonging life and promoting health through the organised
efforts of society (Acheson 1988)
The process of mobilising local, state, national and international resources to ensure the conditions in
which people can be healthy (Oxford Textbook of Public Health 2002)
The central purpose of alcohol policies is to serve the interests of public health and social well-being
through their impact on health and social determinants, such as drinking patterns, the drinking
environment and the health services available to treat problem drinkers (Babor et al 2003)

## Discussion point: how well does this describe the purpose of alcohol policy?

The purpose as defined here does not comprehend the potential benefits of alcohol consumption. Thus the whole spectrum of alcohol-related public health is not considered. There is strong evidence that people who are moderate consumers of alcoholic drinks have a substantially reduced risk of coronary heart disease when compared to teetotallers and heavy drinkers. The well-known "J-shaped" curve illustrates the effect that this reduction in the risk of coronary heart disease has on the risk of deaths from all causes. In populations with high rates of coronary heart disease, the risk reductions associated with low-to-moderate drinking are of public health importance. For instance, it has been estimated that, because of the cardioprotective properties of alcoholic drinks, there are approximately 2% fewer deaths annually in England and Wales than would be expected in a non-drinking population. Also, population studies usually show that the beverage most widely consumed in the population being studied shows the greatest benefits.

Rehm J, Sempos CT and Trevisan M. (2003). "Average volume of alcohol consumption, patterns of drinking and risk of coronary heart disease – a review". Journal of Cardiovascular Risk, 10:15-20.

<sup>&</sup>lt;sup>2</sup> Bofetta P and Garfinkel L (1990). "Alcohol consumption and Mortality amongst men enrolled in an American Cancer Society prospective study". Epidemiology. 1(5): 342-348.

<sup>&</sup>lt;sup>3</sup> Britton A and McPherson K (2001). "Mortality in England and Wales attributable to current alcohol consumption". Journal of Epidemiology and Community Health, 55(6): 383-388.

For example, in Germany<sup>4 5</sup> and the Czech Republic<sup>6</sup>, where beer is the favourite drink, research has confirmed the beneficial effect of beer. Finally, alcohol moderate consumption should be seen as contributing to social well-being since "one of the main reasons why the moderate drinking of alcoholic beverages is a common practice is that many people enjoy the relaxing, pleasant effect produced by one or two drinks" and the "psychotherapeutic value of this should be regarded as a potential health benefit". <sup>7</sup>

## 2. Terminology

☐ The ICD 10 classification of mental and behavioural disorders of the World Health Organization (endorsed and accepted by the Member States) includes alcohol use disorders and defines them under the headings of harmful use, intoxication and alcohol dependence. As this is the standard accepted and recommended nomenclature, presumably this should be the preferred terminology rather than terms such as alcohol misuse and alcohol abuse, which are not part of ICD 10 nomenclature.

(and slides Nr 11 to 15)

# Discussion point: as ICD 10 is the standard accepted and recommended nomenclature, should this be the preferred terminology?

- 1. Our comment on Discussion Point Nr 1 also applies to the present section. We take this opportunity to recall that the specifications attached to the invitation to tender for the above mentioned report quite rightfully include a specific section on moderate consumption (healthy lifestyle);
- 2. The ICD 10 (Mental and Behavioural Disorders due to use of alcohol) classification includes not less than 9 subdivisions i.e. acute intoxication, harmful use, dependence syndrome, withdrawal state, withdrawal state with delirium, psychotic disorder, amnesic syndrome, residual and late-onset psychotic disorder, other mental and behavioural disorders and unspecified mental and behavioural disorder. This is a cumbersome classification and, as a result, not all WHO member countries have so far reported regularly to the WHO. For example, countries reporting data by ICD 10 do not include Belgium, France, Greece, Italy, Portugal, UK-England (see ICD 10 implementation). The terminology used by the UK National Health Service has the merits of putting the different terms under one single heading, i.e. MISUSE.

#### 3. The economic cost of alcohol

The UK government's costs:

Based on prevalence-based estimates of heavy drinking (500/360 g alcohol plus for men and women)
and alcohol dependence.
Follows the international guidelines for estimating the costs of the harm done by substances (Single et
al, 2001) and utilises the "Cost-of-Illness" methodology.
In this framework alcohol use disorders are treated as an illness that gives rise to costs and consumes

In this framework alcohol use disorders are treated as an illness that gives rise to costs and consumes resources, which in its absence would have been used in another way.

(and slides Nr 18 to 21)

## Discussion point: is the England methodology an acceptable methodology to adopt?

- 1. The England methodology is not an acceptable methodology to adopt for a variety of reasons including the following:-
  - The reference to "emotional impact", for which a satisfactory definition/calculation is practically and objectively impossible;

Meister KA, Whelan EM and Kava R. (2000). "The health effects of moderate alcohol intake in humans. An epidemiologic review". Critical Reviews in Clinical Laboratory Sciences, 37(3):261-247.





<sup>&</sup>lt;sup>4</sup> Keil U, Chambless LE, Döring A et al. (1997). "The relation of alcohol intake to coronary heart disease and all-cause mortality in a beer drinking population". International Journal of Epidemiology, 8(2):150-156.

<sup>&</sup>lt;sup>5</sup> Hoffmeister H, Schelp F-P, Mensink GBM et al. (1999). "The relationship between alcohol consumption, health indicators and mortality in the German population". International Journal of Epidemiology, 28(6):1066-1072.

Bobak M, Skodova Z and Marmot M. (2000). "Effect of beer drinking on risk of myocardial infection: Population based control study".

British Medical Journal, 320:1378-1379.

- As was acknowledged by the Contractor, there are huge uncertainties with cost estimates; this is not surprising given the number of assumptions and approximations needed in such "calculations".
- 2. The comparison on slide 18 between drinking alcoholic beverages and environmental pollution is inappropriate in that it a priori excludes (as confirmed on slide 19) societal benefits, which may very well be in an environmental context. But the proven positive health benefits of moderate alcohol consumption make this an inappropriate comparison;
- 3. Regarding social costs alternative methodologies could include the Netherlands Economic Institute (NEI)'s "public expenditure plus" methodology;<sup>8</sup>
- 4. We take this opportunity to recall that the specifications attached to the invitation to tender for the above mentioned report emphasise the need for an analysis of the economic <u>role</u>. At the above mentioned meeting, we noted with interest the suggestion made by the Contractor that the report could recommend that in-depth research be conducted in relation to economic and social benefits.

## 4. Alcohol Consumption in Europe

(Slides 23 to 26)

**Discussion point:** What are the explanations for the decline since the mid 1970s, and the plateau during the late 1990s?

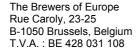
- 1. In the past decades the relevance of per capita consumption as a public health indicator has been seriously questioned because it does not take account of drinking patterns;
- 2. Explanations for these trends differ from one region of Europe to another, or even from one country to another;
- 3. Interestingly enough, the two trends i.e. decline or plateau have similar explanations e.g. economic development/societal change and therefore change in consumers' expenditure. For example in Western Europe economic development in the long term has led consumers to devote less resources to food and drinks and more to leisure activities including travelling abroad, whereas the short term consequences of economic development in countries that joined the EU more recently have been to devote more resources to food and drinks simply because of more resources being available;

In any event the question is a complex one. In the latest ECAS report on Alcohol Policies in EU Member States and Norway<sup>9</sup> no less than four country reports (France, Italy, Spain and Portugal) state that the overall trend downwards in terms of alcohol consumption could not be explained by the introduction of control measures, but rather by social and cultural factors:-

- France "Even if these measures have had an effect on the alcohol consumption among youngsters, in sport arenas and in relation to driving a car, the decrease in the total alcohol consumption cannot be explained by alcohol control measures" (page 187):
- Italy "It would be a huge exaggeration and misinterpretation to claim that the decrease in the
  consumption of wine and distilled spirits, and in the total alcohol consumption, during the last
  three decades could be explained by stringent alcohol control restrictions. On the contrary,
  social and cultural factors seem to have more explanatory power than legislative and control
  measures affecting Italian drinking practices and in explaining the sharp decline of alcohol
  consumption in Italy from the 1970s" (page 282);
- Portugal "It is still totally clear that developments in alcohol consumption cannot be explained by changes in alcohol control measures" (page 357);
- Spain "As with other Mediterranean countries, the decrease in wine consumption cannot be explained by stricter alcohol control measures" (page 381).

Osterberg E and Karlsson T. eds (2002). « Alcohol Policies in EU Member States and Norway. A collection of country reports ». STAKES, Helsinki.



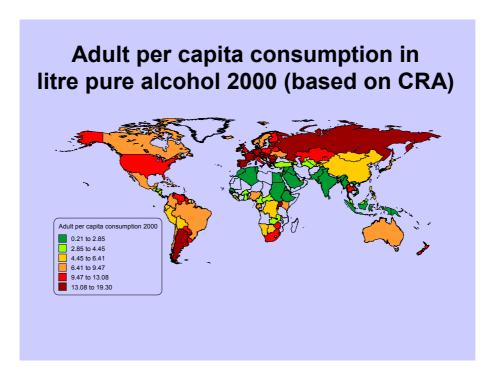


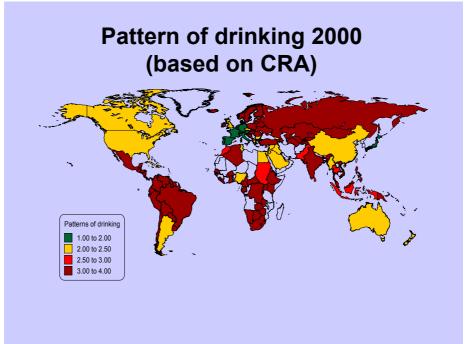


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Muizer AP and Rood-Bakker DS. 1996. Social Costs: Externalities of alcohol consumption, costs and benefits for third parties. NEI on behalf of STIVA.

4. The Brewers of Europe also wishes to draw the attention of the Commission and the Contractor to the two slides here below, produced and regularly used by Dr Jürgen Rehm and the World Health Organisation. Looking at Europe, these slides clearly show the difficulty establishing a relationship between overall consumption on the one hand and drinking patterns on the other.









#### 5. What determines young people's drinking

Systematic reviews (for example Australia's Ministerial Council on Drug Strategy's review of the prevention of substance use, risk and harm in Australia) consistently find that it is parental and community role models that are of the utmost importance in encouraging alcohol use and alcohol-related harm among children and adolescents. The report of the Ministerial Council on Drug Strategy thus suggested the need for whole-population strategies to address overall levels of use and to break intergenerational patterns.

## Discussion point: What whole population strategies could be adopted?

- 1. Parental influence is indeed a key factor 10;
- 2. This presents us with an automatic contradiction: how can whole-population strategies be used to target only one section of the population: young people and their influencers. What is the link between the observation that parents are of the utmost importance and the proposed whole-population approach? If parents need to be targeted then special initiatives should target the parents (e.g. schemes aimed at encouraging dialogue between parents and children):
- 3. We need to be careful when choosing Australia as an example/model: it is one country with 18 million inhabitants. The current EU is composed of 25 countries totalling 450 million inhabitants and representing a wide variety of drinking cultures;
- 4. The ESPAD survey (including the <u>2003 edition</u>) provides clear indications in terms of the persisting differences between Northern and Southern Europe. Northern European countries that have so far focused on whole-population strategies continue to report very significantly more binge drinking.

## 6. The individual harm done by alcohol

(Slides 31 to 33)

**Discussion point:** What are the policy implications of this?

- For a balanced view on this complex subject The Brewers of Europe draws the attention of the Commission and the Contractor to its <u>Benefits of Moderate Beer Consumption</u> brochure which provides a referenced picture of the beneficial effects associated with moderate consumption of alcoholic drinks, and beer in particular;
- 2. The calculation which leads to advocate abstention before the age of 34 for men is unrealistic. Any strategy that would focus on recommending not drinking at all, for young adults, for example, would not help solve the problems.

## 7. Disability Adjusted Life Years

(Slides 35 to 39)

**Discussion point:** Although there are other summary measures of population health, since DALYs are the most frequently used, is it reasonable to use them?

- The Brewers of Europe notes that the upcoming Commission's Communication on the Lisbon process will include DALYs as a standard measure. The Brewers of Europe also notes that in this context the Commission asked the Contractor to base figures on the EUROSTAT calculation of DALYs instead of the WHO calculation;
- 2. The Brewers of Europe agrees with The Amsterdam Group that harm should equally be described in terms of mortality, alcohol consumption being associated with more deaths being prevented than caused in the European region.

Miller P and Plant M (2003). "The family, peer influences and substance use: findings from a study of UK teenagers." Journal of Substance Abuse, 8:19-26.



#### 8. A population's level of drinking

☐ There is a relationship between the levels of alcohol consumed by a population and the proportion of heavy drinkers.

(and Slides Nr 42 to 50)

Discussion point: How can the message that to deal with the harm done by alcohol one needs a mix of targeted and overall strategies best be conveyed to civil society and its governments?

- 1. The presentation made by the Contractor exclusively refers to studies that retrospectively demonstrate a relationship between the overall level of alcohol consumption and problems. Hence the temptation to consider trying to reduce everyone's drinking level in an attempt to reduce problems. There is no evidence that attempts to reduce per capita consumption have been effective in reducing problems and such measures would interfere unnecessarily with people's legitimate right to drink.1
- 2. In this context, the demonstrative strength of the reference to the Finnish reforms at the end of the 1960s is weak. As indicated by The Brewers of Europe at the meeting, these reforms did not lead to any change in the drinking patterns that characterise this country<sup>12</sup> and other Northern European countries.
- 3. The Brewers of Europe questions the accuracy of the population-based approach when, for instance looking at a country like France, per capita consumption has constantly decreased over the past 40 years whereas the problematic drinkers' population remained unchanged (i.e. circa 5 million individuals).

### 9. Violence to families, women and children

(Slides Nr 52 to 55).

Discussion point: What are the best policy options to reduce alcohol related family violence from occurring?

- 1. Latest reviews of the literature in this area seem to directly contradict the ECAS findings regarding the alleged higher rates of homicides in the higher consuming southern European countries. In particular the majority of aggregate level studies show a stronger association in drinking cultures where intoxication is a more prominent characteristic. 13
- 2. One should also look at overall numbers of homicides in Europe. In this context one should note that, for instance, the number of homicides per 100,000 population (average per year 1999-2001) is 2.86 in Finland or 10.6 in Estonia versus 1.12 in Spain.
- 3. It could be useful to estimate the number of situations which are diffused thanks to the consumption of alcoholic beverages.
- 4. Qualifying and quantifying the harm caused to third parties is extremely difficult because in most cases the problems are intrinsically linked with a wide spectrum of parameters ranging from psychological damage, family history, social status, to stress at work, education, living in economically disadvantaged regions etc.
- 5. Measures to reduce violence would include brief interventions, awareness campaigns and meaningful sanctions against repeatedly violent individuals. Across Europe The Brewers of Europe is involved in initiatives that include training on social norming and design of premises to minimise the possibility of anti-social or dangerous behaviour; partnerships with local crime and disorder bodies as well as communications aimed at both servers and customers.



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Roche AM (1997). "The shifting sands of alcohol prevention: rethinking population control approaches". Australian and New Zealand

Journal of Public Health, 21 (6); 621-625.

12 Osterberg E and Karlsson T. eds (2002). « Alcohol Policies in EU Member States and Norway. A collection of country reports ». STAKES, Helsinki.

<sup>&</sup>lt;sup>13</sup> Babor et al. (2003). "Alcohol: no ordinary commodity. Research and public policy". Oxfor Medical Publications. Page 77. <sup>14</sup> 2001. International comparisons of criminal justice statistics based on data collected by the UK Home Office and the Council of

#### 10. The impact of school based education

(Slides Nr 57 to 60)

**Discussion point**: Where would the released resources be better invested to reduce the harm done by alcohol?

- 1. Many of the education programmes studied in the literature did not include evaluation schemes;
- 2. Many education programmes were too short to produce tangible results in the long term;
- 3. Longer education programmes did not include booster sessions to ensure the process is moving forward:
- 4. Recent literature reviews (including Babor) do not exclude a priori the promising approach of "normative education" (i.e. social norming). These approaches have been scarcely introduced in Europe and therefore should be further tested in European countries;
- 5. The success of education in changing behaviour needs to be assessed over many years. For example, education about the dangers of drinking and driving in the UK.<sup>15</sup>
- 6. School based education is part of the picture, not the whole picture;
- 7. It would seem contrary to common sense to exclude education a priori: if education does not work, why is it one of the founding establishments of society?

# 11. Brief interventions for hazardous and harmful alcohol consumption

(Slides Nr 62 to 65)

**Discussion point**: How important is it for the health care sector to take up these interventions, and how can they best be widely implemented?

The Brewers of Europe acknowledges the very high degree of efficiency of brief interventions. There is a large and robust evidence base to substantiate the claim that brief intervention in primary care is an effective and cost-effective means of reducing the health and social costs of heavy drinking.<sup>16</sup>

#### 12. Choosing different policy options

(Slides Nr 67 to 74)

**Discussion point**: If countries are to be serious about reducing the harm done by alcohol, is there not a compelling case for increasing taxes (which also increase government revenue)?

- 1. In his presentation, the Contractor cites Chisholm et al 2004. It is difficult for us to comment on this presentation without cite of the original data but we would question the impact of taxation on preventing (reducing) DALYs per million people.
- 2. The Contractor states that the protection of children might be the most compelling argument for higher taxes. Enforcement of existing laws regarding underage purchase would seem a more effective measure than increasing taxation to protect the minority who should not have access to the product.
- 3. On the specific issue of beer and excise duties, The Brewers of Europe wishes to recall beer's relative price inelasticity;<sup>17</sup>

Babor et al. (2003). « Alcohol : no ordinary commodity. Research and public policy ». Oxford Medical Publications. Page 108.



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<sup>&</sup>lt;sup>15</sup> UK Cabinet Office Strategy Unit (2003). Interim Analytical Report.

Moyer et al (2002). "Brief interventions for alcohol problems: a meta-analytic review of controlled investigations in treatment seeking and non-treatment seeking populations". Addiction, 97(3):279-92.

4. Moderate drinkers should be allowed to socialise without unreasonable restrictions and at a reasonable cost. The Brewers of Europe strongly believes that high rates as practiced in Northern European countries have failed as an instrument to improve public health and restrict immoderate consumption. Whilst the second report of the European Commission on the rates of excise duty applied to alcoholic beverages states that, in one Member State (Sweden), health objectives are predominant in determining duty levels, this country continues to be characterised by the presence of a large black market and high levels of unrecorded consumption. For further information on this subject, please consult the latest publication of The Brewers of Europe on the subject of excise taxes, "Bringing the Northern High Tax Member States into the Single Market".

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