
PROGRAMME ON
**SUBSTANCE
ABUSE**

Inter-regional
Meeting on
Alcohol-related
Problems

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Keynote Address
and
Recommendations



WORLD HEALTH ORGANIZATION

KEYNOTE ADDRESS

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Mr Chairman, Distinguished Colleagues, Ladies and Gentlemen.

Alcohol-related problems cause individual suffering and lead to the break-up of families and communities; they also cause substantial economic loss to society as a whole. Yet these problems are by no means diminishing, especially in developing countries, and there is an urgent need to take action. Compared with what is available to some programmes, we do have at our disposal the means to arrest and even to reverse these trends. This does not mean that there is a magic formula for solving all alcohol-related problems; rather, there is an array of public health measures that have shown sufficient evidence of effectiveness to be promoted with some confidence. The challenge is to find the right combination of measures to suit the particular needs of each Member State.

There is no organization in the United Nations system better able than the World Health Organization to take the lead in an international effort to reduce alcohol-related problems. There is no country better able to stimulate that effort than the country in which this meeting is taking place. Therefore, it is a very special privilege for me to be delivering this keynote address.

During 1990 unprecedented international attention was paid to questions of substance abuse. In February 1990 the United Nations General Assembly held a special session on the subject in New York. In April 1990 the Government of the United Kingdom, with the United Nations, convened a World Ministerial Summit in London. It dealt with both demand reduction and the particular threat posed by cocaine. At it, I was impressed by the new emphasis being given to strategies for reducing the demand for drugs, in addition to the traditional concern for repression and law enforcement. In May 1990, the World Health Assembly unanimously adopted a resolution on demand reduction, calling on me to strengthen WHO's action in this area.

In response to that resolution I decided to set up a new WHO programme on substance abuse, with effect from September 1990. Although much of the focus of international concern has been on the abuse of illicit drugs, I am convinced that WHO should address alcohol-related problems with equal force but in an entirely different dimension. Some organizations and bodies of the United Nations system - notably the recently regrouped bodies dealing with drugs, based in Vienna - have mandates which exclude action on alcohol. WHO's mandate has no such limitation. We know full well that, of all the so-called drugs of abuse, alcohol is the most frequently abused, often in combination with other licit and illicit drugs; and alcohol remains the cause of the greatest number of health and social problems. I do not say this to diminish, in any way, the seriousness with which illicit drug problems should be viewed, or indeed the abuse of licit pharmaceuticals. Rather, I wish to emphasize how, in the perspective of public health, the most compelling arguments are those that recognize the commonalities, as well as the differences, between psychoactive substances, regardless of their legal status.

The new WHO programme on substance abuse, despite its relatively short history, has already undertaken a number of important initiatives in the area of illicit drugs, particularly in stimulating the development of national demand reduction plans. This meeting provides a unique opportunity for bringing together all that WHO has accomplished in gathering experience on the prevention of alcohol-related problems and on the evaluation of comparative national programmes to reduce alcohol abuse. This experience must be applied to the urgent needs of those countries where the consumption of alcohol continues to escalate, and where integrated national action is becoming imperative.

Let us review briefly the medical and social consequences of excessive drinking. As well as the alcohol-dependence syndrome itself, a wide range of disabling and sometimes fatal physical and psychological conditions can be attributed, either wholly or partly, to the consumption of alcohol. In addition, in many countries, alcohol-related traffic accidents account for a significant proportion of deaths, especially among young people. Other accidents, including accidents at work, are more frequently related to alcohol consumption than is realized. In more general terms, the disruption of family life caused by the excessive drinking of one or more members results in distress, and can result in violence and neglect. Drinking by young people and by pregnant women is another area of concern; in both these cases there is the question of harm to vulnerable populations.

There is an area of special relevance to this meeting. Some developing countries do not have a tradition of consuming commercially-produced beverages of the type and strength available in most developed countries. In these countries, it is possible that alcohol-related problems are concentrated among people in the professions - the scarcest resource - or among young people, who represent a country's investment in its future. In such circumstances, the real cost to the community is greater than would be apparent from a simple statement of overall per capita consumption or of alcohol-related mortality.

It is well known that biochemical differences are reflected in the different capacities of individuals to absorb alcohol and in their varying degrees of predisposition to become dependent upon alcohol. Research under way, in association with WHO, into alcohol and aldehyde metabolizing enzymes, can provide insights into protective and predisposing factors in alcohol dependence. Differences between patterns of problems in different countries are related to biochemical variables in their populations, as well as to their cultural heritage and socioeconomic development. They are also related to drinking practices. For example, a country whose people have integrated relatively modest levels of daily wine consumption into everyday life would be expected to exhibit a quite different pattern of problems from one where the same amount of alcohol is consumed each week in bouts of heavy drinking. Even within a country, it cannot be assumed that drinking behaviour is uniform. Often, a small proportion of drinkers are responsible for a very large proportion of the total alcohol consumption, and they cause public health problems in addition to their individual problems. In New Zealand, for example, 11% of the population drinks more than half of all the alcohol consumed; in Scotland, 3% accounts for about 30% of total consumption.

In addition, when an attempt is made to assess which population groups in any country consume above-average amounts of alcohol, it is important to be aware that some groups are likely to be at particular risk. This is sometimes because of constitutional factors, as in the case of women, who suffer liver damage at lower quantity and frequency thresholds than men.

Life-style may be involved, as in the case of young people, who, if under the influence of alcohol, are especially likely to be injured or to cause injuries to others on the roads. Even without increased consumption, problems may become worse because of the increased complexities of modern life. Protracted high levels of alertness are required, for example, in traffic, in factories, and on construction sites. Alcohol reduces the intensity and span of attention, and increases reaction time. This may be of particular importance in developing countries experiencing rapid socioeconomic growth, where there is a consequent expansion of opportunities for working in precisely those environments where drinking is most hazardous.

I have emphasized how timely this meeting is, in that it provides an opportunity for drawing up guidelines for transfer of the technology required to reduce problems such as those I have just described. However, I want to make it clear that WHO has not neglected this area in the past. Ever since the First World Health Assembly in 1948, WHO has recognized that it has a role to play as the focus for international concern about alcohol-related health problems. In the WHO Constitution health is defined as a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity. Since alcohol-related problems affect virtually every area of psychosocial functioning, it is evident that WHO's mandate implies a clear commitment to their alleviation.

In setting about this task, WHO's aim is to investigate and develop technology for the earlier identification of individuals suffering from the alcohol-dependence syndrome and its associated problems. A further challenge is to develop preventive strategies that will reduce alcohol-related mortality and morbidity, and to promote these strategies to Member States. WHO is also investigating treatment approaches, focusing particularly on simple interventions.

It is not sufficient to try to repair the damage caused by excessive drinking: it is also necessary to seek methods of preventing such damage, such as by attempting to influence the pattern of demand for alcoholic beverages, achieving a fuller understanding of the mechanisms of supply, and making suggestions for public health action.

WHO is concerned about all stages in the production and distribution of alcoholic beverages, including the way in which they are advertised and marketed. This concern arises from the fact that changes in the availability of alcohol have been shown to have profound implications for health. Although the precise relationship between advertising and aggregate consumption remains problematic, we know that some marketing practices are contrary to the public health, particularly when advertising is directed towards previously abstinent subgroups of the population, or those known to be vulnerable to higher rates of alcohol-related problems. In this situation, the alcoholic-drinks industry has to accept responsibility for reducing the magnitude of alcohol-related problems. Both the production and hospitality industries need to adopt a philosophy that will enable them to play a major role in preventive programmes in the future.

Alcohol-related problems are being reported in increasing frequency from countries previously little affected, while rates of alcohol consumption and alcohol-related problems are beginning to level off in some developing countries of Africa, the Americas, and the Western Pacific. Growing concern is being expressed in many countries of these regions at the extent to which such problems are increasing. WHO has a particular responsibility to prevent

disease and to promote health in developing countries; hence such expressions of concern must be taken very seriously indeed. Since it is not enough to recommend improvements in the provision of treatment services, cooperation will be given in relation to all pertinent aspects of alcohol policies, including the question of availability.

The continuation of current trends in alcohol production and consumption would have far-reaching public health consequences in many countries. Awareness of the implications should allow countries to take the action necessary to halt or reverse these trends. Since governments, by means of legislation, can control the supply of alcoholic beverages, and thus influence the rates of associated health and social problems, there is an urgent need for action in those countries where per capita consumption rates are high, or where the increase in per capita consumption is particularly steep.

It is certainly not the function of international bodies such as WHO to tell countries what they must or must not do. This is as true of the area of preventing alcohol abuse as it is of any other. What can be done is to assemble information on the experience of countries that have, in one way or another, attempted to introduce national alcohol policies. On the basis of this information, guidelines can be drawn up and cooperation can be extended among countries and within WHO. It is important to recognize that some countries may well choose not to develop preventive policies at all, and that others may choose to develop them without seeking advice from international organizations. In maintaining their ability to respond to a range of different requests from different countries, but mindful of the danger inherent in clinging to concepts becoming redundant through lack of use, international organizations can legitimately act in two ways. They can, through advocacy, encourage governments to develop their own national alcohol policies and programmes, and they can transfer the appropriate technology to enable countries that do decide to act to make their programmes as effective as possible.

All this presumes a serious sustained commitment on the part of the governments concerned. It requires both imagination and a great deal of hard work. The delicate act of balancing economic and public health interests is perhaps the central challenge, but it is certainly not the only one. Cooperation among many different interest groups will be necessary, within and outside government. Government ministries with responsibility for education, agriculture, trade, employment and social affairs, among others, will need to be involved. The ministry of finance must be deeply involved in the implications of any suggested policy changes. Equally, interested bodies outside government will have a part to play. Treatment agencies, self-help organizations and other voluntary bodies, religious institutions, and teachers and parents' organizations will be likely to want to contribute to the process of policy development. In some countries the list of those involved will be longer still. In addition, not only the alcoholic-beverage industry, but also other industries, including catering, tourism, advertising and the media generally, will have essential contributions to make. The exclusion of any significant interested party is likely to prejudice the subsequent successful implementation of any preventive programme.

It would be naive to suppose that the points of view of all the different interest groups will be compatible with one another. Even within government, there will be conflict among some ministries and agreement among others. Nor will the areas of agreement or disagreement be the same in every country. In this complex interplay of different forces within countries, it

is clear that advice or international guidelines are likely to be of importance in distinct ways. Essential principles, such as the need to balance economic and public health interests, can be established, and basic agendas can be drawn up for the areas in which decisions have to be made; but the substance of these decisions is, and will remain, the prerogative of the countries themselves.

I have emphasized the vast public health challenge posed by current trends in alcohol-related problems, and the special role that WHO can play in confronting and reversing those trends. Let me also emphasize that this is an area in which WHO has been active since 1948. In the whole United Nations family, it is WHO that has taken the lead in documenting the nature and extent of alcohol-related problems, in promoting the exchange of national experience in dealing with those problems, and in developing guidelines for effective national and international action. The purpose of this meeting is to take that process an essential step further. We need to focus on the specific technology available, so that countries can make choices on the basis of their needs and capabilities. When I reviewed the background materials assembled for this meeting, to say nothing of the impressive array of expertise assembled here, I realized that you already have available all the elements necessary for designing the guidelines that countries need for making their own plans to reduce alcohol-related problems.

My task has therefore been to outline what I hope will be a useful framework for future endeavours. I have placed alcohol-related problems in the context of problems associated with other drugs of abuse. I have reminded you of the far-reaching consequences of current trends, not merely for health, but also for social and economic development, and of what needs to be done to turn the tide. I have tried to avoid the fashionable vocabulary of the war against drugs or the campaign against alcohol abuse, not only because I think we have already seen and heard too much about war this year, but also because I believe that our success in this area is likely to depend on our ability to build partnerships rather than to find enemies.

You have a difficult but challenging task ahead of you. I shall be waiting impatiently to learn of the outcome of your deliberations. Finally, I would remind you that your recommendations for action should be based on the principles that guide all WHO's work. We must respect the sovereignty of Member States; we must help to sustain economic and social development; and we must ensure the protection of individual human rights.

RECOMMENDATIONS

As the Director-General of WHO stated in his opening address, "of all the so-called drugs of abuse, alcohol is the most frequently abused ... and remains the cause of the greatest number of health and social problems". Although alcohol consumption has recently stabilized or even declined in some industrialized countries, it has continued to increase globally in the last decade, and there has been a corresponding increase in adverse health, social and economic consequences.

The meeting welcomed the decision of the Director-General to establish the new WHO Programme on Substance Abuse.

The following recommendations are proposed for Member States, WHO, and other organizations interested in reducing alcohol-related problems. It is recognized that countries will differ in the strategies and technologies they choose, and that this will depend on the magnitude of alcohol-related problems as well as on economic, social, political and religious traditions. WHO should make every effort to promote consideration of these recommendations.

1. Member States should develop and regularly update national alcohol policies and programmes, with the involvement of all concerned sectors of society. Such policies and programmes should promote health and well-being, and should achieve measurable goals by specified dates.

Advocacy and education to heighten public awareness and popular support for alcohol policies and programmes should be undertaken at international, national, regional and local levels.

2. Alcohol policies and programmes should be developed on the basis of assessment of the costs of alcohol-related problems to a nation, in health, social and economic terms, and their implications for sustained economic development.

WHO should play a leadership role in improving the methods of estimating these costs in both developed and developing countries.

3. If alcohol consumption per head of population rises, a wide range of adverse health and social effects also rise. If consumption per head of population falls, these adverse effects are reduced also. Per capita consumption is therefore a useful indicator of the level of alcohol-related problems in both developing and developed countries.

WHO should continue to collaborate with Member States in developing their capacity to gather the information needed for describing and measuring alcohol consumption and alcohol-related problems, especially among high-risk groups.

4. Heavy drinkers are more likely than moderate drinkers to experience severe alcohol-related problems, but those experienced by moderate drinkers are the more numerous, because there are very many more moderate than heavy drinkers. Therefore, to reduce alcohol-related problems, both heavy and moderate drinkers should be targeted.

It is recommended that national policies and programmes on alcohol-related problems should address all sectors of the population.

5. No single approach to the reduction of alcohol-related problems is likely to be successful in isolation. A variety of measures in combination are likely to be more effective. Cooperation between government, industry, professionals and the community is essential in the planning and execution of such measures.

It is recommended that Member States select the combination of measures that best suits their needs. Educational, legislative and technological measures should be used to complement and reinforce one another.

6. Certain legislative control measures have been found effective in reducing alcohol-related problems. The following have been shown to be particularly effective:

- A minimum legal drinking age
- Price and tax increases
- Control of availability.

It is recommended that Member States consider banning the sale of alcohol at petrol stations, motor-way refreshment stops, and vending machines. It is particularly difficult to prevent high-risk groups, such as young people, from purchasing alcohol from vending machines. It is further recommended that increased attention be paid to enforcing existing laws and, through education and information, encouraging public acceptance of the need for well-targeted control policies.

7. Education has an important role in national alcohol policies and programmes. Although education alone may not directly affect drinking behaviour, it can increase knowledge, foster social norms, and mobilize societal forces and political will in support of preventive measures.

It is recommended that those educational programmes and methods that show promise, such as peer education, comprehensive school health education, and training in responsible beverage service, in combination with community-based education programmes, be promoted.

8. Member States are encouraged to consider the adoption of procedures for regulating the advertising and promotion of alcohol.

It is recommended that special attention be given to ensuring that public-health interests receive adequate consideration in alcohol marketing strategies, especially those targeted at special populations, such as women and youth. Particular attention should be focused on the likely impact of advertising and promotion aimed at the expansion of markets in developing countries.

9. It is in the interests of the alcoholic beverage industry to collaborate in efforts to reduce alcohol-related problems.

It is recommended that opportunities be sought for dialogue with the alcohol-beverage industry, particularly in relation to its capacity to promote more responsible drinking practices.

10. The following topics require research:

- The effects of the forthcoming harmonization of alcohol taxation in the European Economic Community.
- The size, characteristics and time-trends of populations of special concern, such as known problem-drinkers.
- The characteristics of prevention and intervention programmes and of the persons they affect.
- Efficacy rates or outcome measures of prevention and rehabilitation.
- The expanded use of breathalysers and recently developed dry chemical technologies for estimating the alcohol content of blood, urine and saliva, and using them to determine the contribution of alcohol to road-traffic and other accidents, and crimes of various kinds.

11. WHO collaborating centres play an essential role in the transfer of technologies for the reduction of alcohol-related problems in their countries. However, the mechanisms for transferring technologies between countries are not well developed. Therefore, it is recommended that WHO collaborating centres increase their activities in research and training for the prevention and treatment of alcohol-related problems, as well as their cooperation with one another.

Special technical and financial support should be sought from national and international sources to facilitate exchange of these technologies between WHO collaborating centres working for the reduction of alcohol-related problems.

12. In many countries, alcohol-impaired driving is a major cause of injury and death, particularly among young people. There are many opportunities for interventions to reduce these injuries and deaths. The range of alcohol-specific and general measures with evidence of effectiveness includes reducing per capita alcohol consumption, raising the minimum drinking age, establishing maximum permissible levels of alcohol in the breath and blood, random breath-testing, and licence suspension. Another measure worth considering is to hold responsible for the behaviour of intoxicated patrons, or for serving minors, those who serve alcohol.

It is recommended that special attention be given to the development of national alcohol policies and programmes aimed at reducing alcohol-impaired driving.

13. The association of excessive alcohol consumption with violence and criminal activity is a cause of concern in developing and developed countries.

To reduce these problems, it is recommended that opportunities be sought for collaboration between the health, law-enforcement, education, and social-welfare sectors and the alcoholic beverage and hospitality industries.

14. There is increasing evidence of the effectiveness of early identification of problem drinkers and of minimal intervention. Brief questionnaires have been shown to be useful in primary-health-care settings for identifying "at risk" drinkers. WHO has devised screening tests for this purpose. The technology for early identification and minimal intervention can be used easily in both developed and developing countries.

It is recommended that Member States take steps to ensure that health and other professionals acquire necessary skills to implement early identification and minimal intervention.

These measures are particularly recommended for special populations, including young people, women, and the elderly; and special situations, including the work-place and road traffic; and in relation to criminal behaviour.

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