The World Medical Association Statement on Reducing the Global Impact of Alcohol on Health and Society

Adopted by the WMA General Assembly, Santiago 2005

Preamble

1. Alcohol use is deeply embedded in many societies. Overall, 4% of the global burden of disease is attributable to alcohol, which accounts for about as much death and disability globally as tobacco or hypertension. Overall, there are causal relationships between alcohol consumption and more than 60 types of disease and injury including traffic fatalities. Alcohol consumption is the leading risk factor for disease burden in low mortality developing countries and the third largest risk factor in developed countries. Beyond the numerous chronic and acute health effects, alcohol use is associated with widespread social, mental and emotional consequences. The global burden related to alcohol consumption, both in terms of morbidity and mortality, is considerable.
2. Alcohol-related problems are the result of a complex interplay between individual use of alcoholic beverages and the surrounding cultural, economic, physical environment, political and social contexts.
3. Alcohol cannot be considered an ordinary beverage or consumer commodity since it is a drug that causes substantial medical, psychological and social harm by means of physical toxicity, intoxication and dependence. There is increasing evidence that genetic vulnerability to alcohol dependence is a risk factor for some individuals. Fetal alcohol syndrome and fetal alcohol effects, preventable causes of mental retardation, may result from alcohol consumption during pregnancy. Growing scientific evidence has demonstrated the harmful effects of consumption prior to adulthood on the brains, mental, cognitive and social functioning of youth and increased likelihood of adult alcohol dependence and alcohol related problems among those who drink before full physiological maturity. Regular alcohol consumption and binge drinking in adolescents can negatively affect school performance, increase participation in crime and adversely affect sexual performance and behaviour.
4. Alcohol advertising and promotion is rapidly expanding throughout the world and is increasingly sophisticated and carefully targeted, including to youth. It is aimed to attract, influence, and recruit new generations of potential drinkers despite industry codes of self-regulation that are widely ignored and often not enforced.
5. Effective alcohol social policy can put into place measures that control the supply of alcohol and/or affect population-wide demand for alcohol beverages. Comprehensive policies address legal measures to: control supply and demand, control access to alcohol (by age, location and time), provide public education and treatment for those who need assistance, levy taxation to affect prices and to pay for problems generated by consumption, and harm-reduction strategies to limit alcohol-related problems such as impaired driving and domestic violence.
6. Alcohol problems are highly correlated with per capita consumption so that reductions of use can lead to decreases in alcohol problems. Because alcohol is an

economic commodity, alcohol beverage sales are sensitive to prices, i.e., as prices increase, demand declines, and visa versa. Price can be influenced through taxation and effective penalties for inappropriate sales and promotion activities. Such policy measures affect even heavy drinkers, and they are particularly effective among young people.

7. Heavy drinkers and those with alcohol-related problems or alcohol dependence cause a significant share of the problems resulting from consumption. However, in most countries, the majority of alcohol-related problems in a population are associated with harmful or hazardous drinking by non-dependent 'social' drinkers, particularly when intoxicated. This is particularly a problem of young people in many regions of the world who drink with the intent of becoming intoxicated.
8. Although research has found some limited positive health effects of low levels of alcohol consumption in some populations, this must be weighed against potential harms from consumption in those same populations as well as in population as a whole.
9. Thus, population-based approaches that affect the social drinking environment and the availability of alcoholic beverages are more effective than individual approaches (such as education) for preventing alcohol related problems and illness. Alcohol policies that affect drinking patterns by limiting access and by discouraging drinking by young people through setting a minimum legal purchasing age are especially likely to reduce harms. Laws to reduce permitted blood alcohol levels for drivers and to control the number of sales outlets have been effective in lowering alcohol problems.
10. In recent years some constraints on the production, mass marketing and patterns of consumption of alcohol have been weakened and have resulted in increased availability and accessibility of alcoholic beverages and changes in drinking patterns across the world. This has created a global health problem that urgently requires governmental, citizen, medical and health care intervention.

Recommendations

The WMA urges National Medical Associations and all physicians to take the following actions to help reduce the impact of alcohol on health and society:

11. Advocate for comprehensive national policies that
    a. incorporate measures to educate the public about the dangers of hazardous and unhealthy use of alcohol (from risky amounts through dependence), including, but not limited to, education programs targeted specifically at youth;
    b. create legal interventions that focus primarily on treating or provide evidence-based legal sanctions that deter those who place themselves or others at risk, and
    c. put in place regulatory and other environmental supports that promote the health of the population as a whole.
12. Promote national and sub-national policies that follow 'best practices' from the developed countries that with appropriate modification may also be effective in

developing nations. These may include setting of a minimum legal purchase age, restricted sales policies, restricting hours or days of sale and the number of sales outlets, increasing alcohol taxes, and implementing effective countermeasures for alcohol impaired driving (such as lowered blood alcohol concentration limits for driving, active enforcement of traffic safety measures, random breath testing, and legal and medical interventions for repeat intoxicated drivers).

13. Be aware of and counter non-evidence-based alcohol control strategies promoted by the alcohol industry or their social aspect organizations.
14. Restrict the promotion, advertising and provision of alcohol to youth so that youth can grow up with fewer social pressures to consume alcohol. Support the creation of an independent monitoring capability that assures that alcohol advertising conforms to the content and exposure guidelines described in alcohol industry self-regulation codes.
15. Work collaboratively with national and local medical societies, specialty medical organizations, concerned social, religious and economic groups (including governmental, scientific, professional, nongovernmental and voluntary bodies, the private sector, and civil society) to:
    a. reduce harmful use of alcohol, especially among young people and pregnant women, in the workplace, and when driving;
    b. increase the likelihood that everyone will be free of pressures to consume alcohol and free from the harmful and unhealthy effects of drinking by others; and
    c. promote evidence-based prevention strategies in schools.
16. Undertake to
    a. screen patients for alcohol use disorders and at-risk drinking, or arrange to have screening conducted systematically by qualified personnel using evidence-based screening tools that can be used in clinical practice;
    b. promote self-screening/mass screening with questionnaires that could then select those needing to be seen by a provider for assessment;
    c. provide brief interventions to motivate high-risk drinkers to moderate their consumption; and
    d. provide specialized treatment, including use of evidence-based pharmaceuticals, and rehabilitation for alcohol-dependent individuals and assistance to their families.
17. Encourage physicians to facilitate epidemiologic and health service data collection on the impact of alcohol.
18. Promote consideration of a Framework Convention on Alcohol Control similar to that of the WHO Framework Convention on Tobacco Control that took effect on February 27, 2005.
19. Furthermore, in order to protect current and future alcohol control measures, advocate for consideration of alcohol as an extra-ordinary commodity and that measures affecting the supply, distribution, sale, advertising, promotion or investment in alcoholic beverages be excluded from international trade agreements.