

Spá um áhrif þess að einkasala ríkisins væri afnumin í Svíþjóð: If Retail Alcohol Sales in Sweden were Privatized, what would be the Potential Consequences?

[http://www.systembolagetkampanj.se/forskarrapport\\_en/downloads/Hela\\_rapporten.pdf](http://www.systembolagetkampanj.se/forskarrapport_en/downloads/Hela_rapporten.pdf)

Helstu niðurstöður í þessari greiningu eru:

**Findings** According to the projections, scenario 1 yields a consumption increase of 17% (1.4 litres/capita), which in turn would cause an additional 770 deaths, 8500 assaults, 2700 drinking driving offences and 4.5 million sick days per year. The corresponding figures for scenario 2 are a consumption increase of 37.4% (3.1 litres/capita) leading to an additional annual toll of 2000 deaths, 20 000 assaults, 6600 drinking driving offences and 11.1 million days of sick leave. **Conclusions** Projections based on the research literature suggest that privatization of the Swedish alcohol retail market would significantly increase alcohol consumption and alcohol-related harm.

**Table 1.** Annual harm from the alcohol consumption increases resulting from privatization, estimated using Swedish time series data.

Nature of Harm	Specialty Shops	% Increase	Grocery Stores	% Increase
Alcohol-related Illness Deaths	430	26%	1.000	61%
Fatal Accident	120	10%	250	22%
Suicides	130	14%	290	30%
Homicides	20	18%	40	40%
Total Deaths from Stated Causes	700	18%	1.580	41%
Nonfatal Assaults	6.700	10%	14.200	22%
Sickness Absence Days	7.300.000	18%	16.100.000	40%

Í skýrslu um tengsl áfengis og ofbeldis má glögglega sjá í strax upphafi þeirrar skýrslu (overview) samantekt um áhrifin og virkar aðgerðir.

[http://whqlibdoc.who.int/publications/2009/9789241598408\\_eng.pdf?ua=1](http://whqlibdoc.who.int/publications/2009/9789241598408_eng.pdf?ua=1)

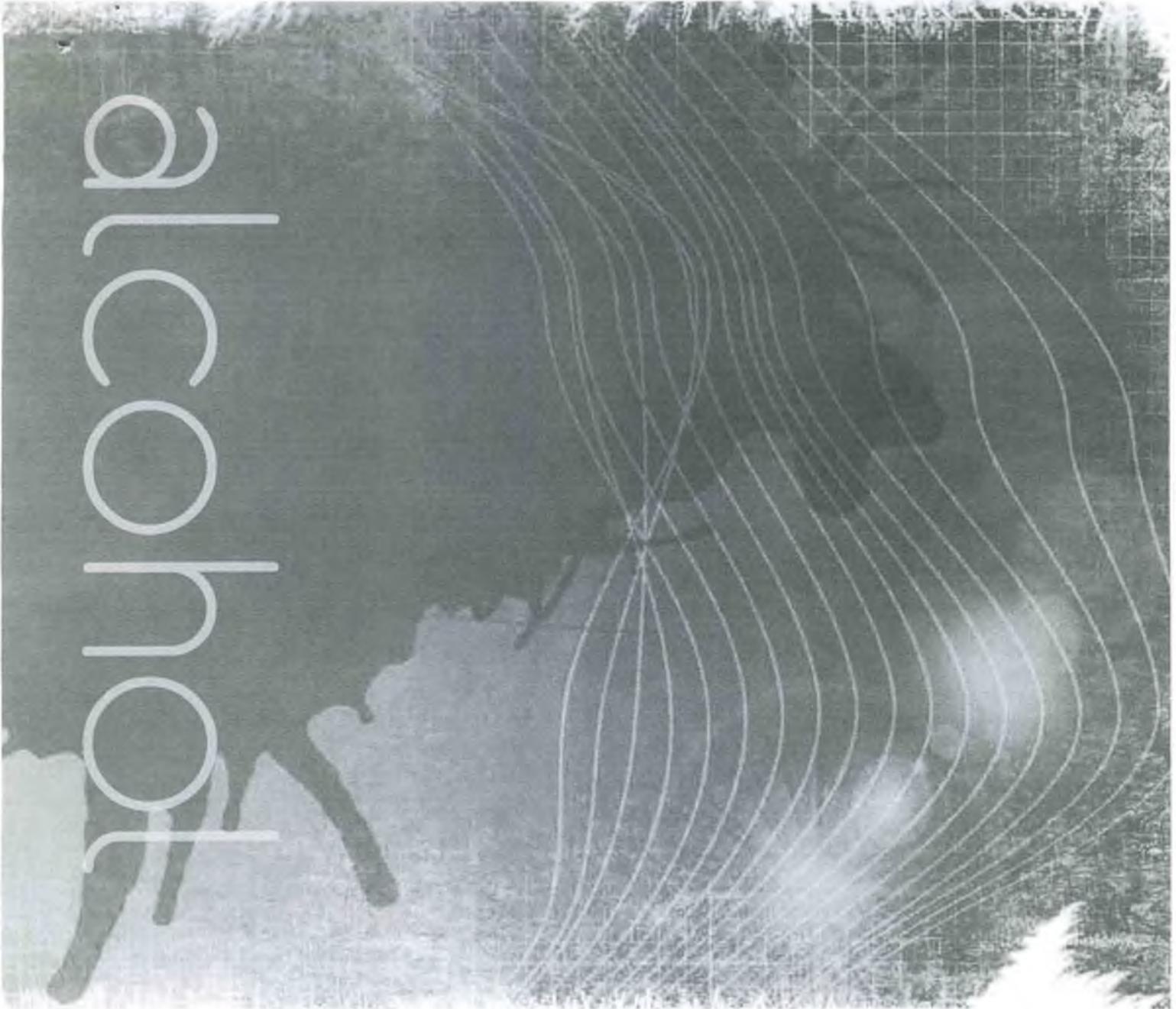
Helstu niðurstöður:

Given the strong links between alcohol and violence, measures to reduce the availability and harmful use of alcohol are important violence prevention strategies. This review summarizes the evidence for the impact of such interventions on violence and covers:

• **Regulating alcohol availability**

- Increasing alcohol prices
- Reducing alcohol use in problem drinkers
- Community interventions to improve drinking environments





alcohol

Global status report  
on alcohol and health  
2014



# EXECUTIVE SUMMARY

This report provides a global overview of alcohol consumption in relation to public health (Chapter 1) as well as information on: the consumption of alcohol in populations (Chapter 2); the health consequences of alcohol consumption (Chapter 3); and policy responses at national level (Chapter 4). The main messages of these chapters can be summarized as follows:

## CHAPTER 1: ALCOHOL AND PUBLIC HEALTH

Alcohol is a psychoactive substance with dependence-producing properties that has been widely used in many cultures for centuries. The harmful use of alcohol causes a large disease, social and economic burden in societies.

- Environmental factors such as economic development, culture, availability of alcohol and the level and effectiveness of alcohol policies are relevant factors in explaining differences and historical trends in alcohol consumption and related harm.
- Alcohol-related harm is determined by the volume of alcohol consumed, the pattern of drinking, and, on rare occasions, the quality of alcohol consumed.
- The harmful use of alcohol is a component cause of more than 200 disease and injury conditions in individuals, most notably alcohol dependence, liver cirrhosis, cancers and injuries.
- The latest causal relationships suggested by research are those between harmful use of alcohol and infectious diseases such as tuberculosis and HIV/AIDS.
- A wide range of global, regional and national policies and actions are in place to reduce the harmful use of alcohol.

## CHAPTER 2: ALCOHOL CONSUMPTION

- Worldwide consumption in 2010 was equal to 6.2 litres of pure alcohol consumed per person aged 15 years or older, which translates into 13.5 grams of pure alcohol per day.
- A quarter of this consumption (24.8%) was unrecorded, i.e., homemade alcohol, illegally produced or sold outside normal government controls. Of total recorded alcohol consumed worldwide, 50.1% was consumed in the form of spirits.
- Worldwide 61.7% of the population aged 15 years or older (15+) had not drunk alcohol in the past 12 months. In all WHO regions, females are more often lifetime abstainers than males. There is a considerable variation in prevalence of abstention across WHO regions.



- Worldwide about 16.0% of drinkers aged 15 years or older engage in heavy episodic drinking.
- In general, the greater the economic wealth of a country, the more alcohol is consumed and the smaller the number of abstainers. As a rule, high-income countries have the highest alcohol per capita consumption (APC) and the highest prevalence of heavy episodic drinking among drinkers.

### CHAPTER 3: HEALTH CONSEQUENCES

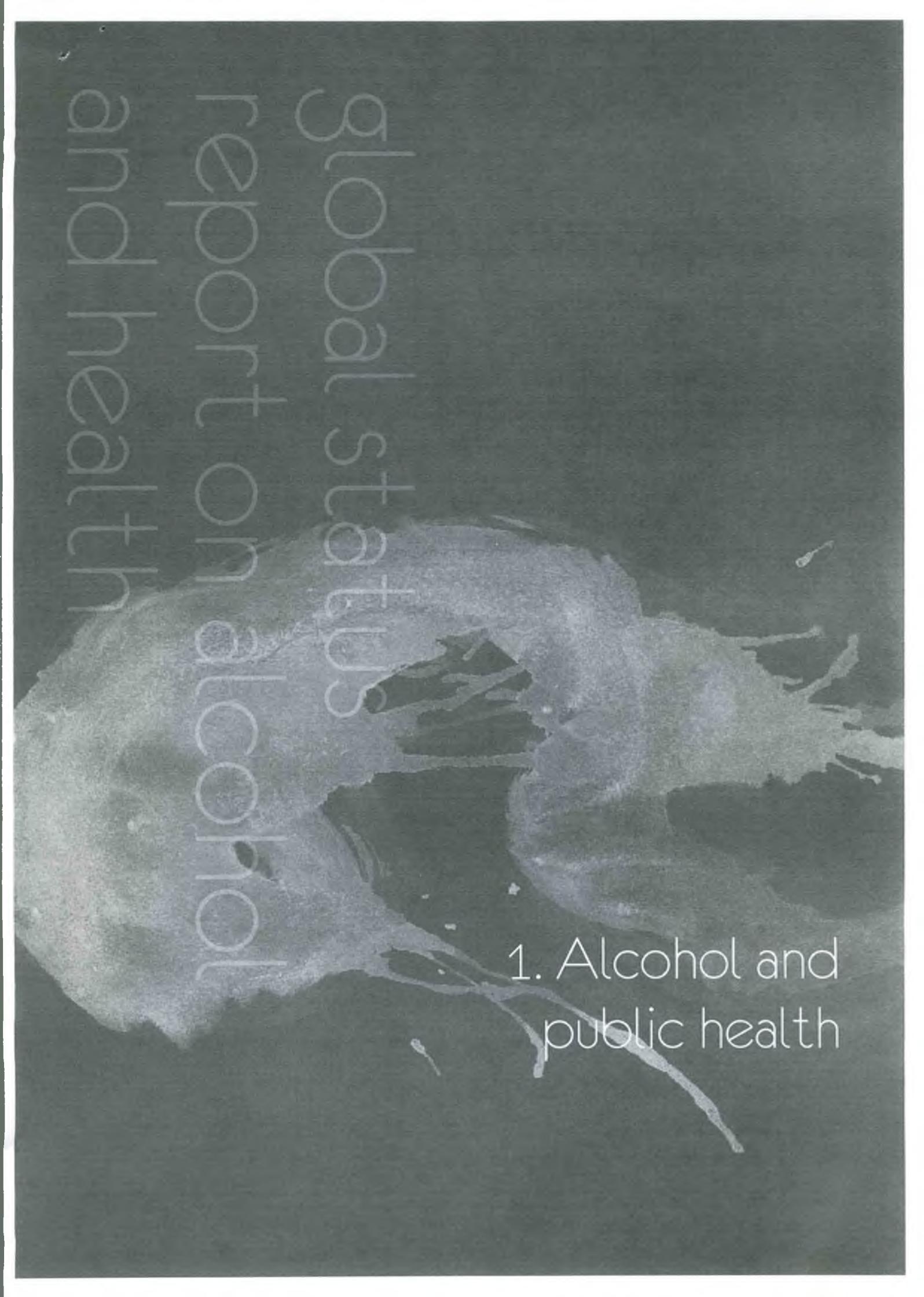
- In 2012, about 3.3 million deaths, or 5.9% of all global deaths, were attributable to alcohol consumption.
- There are significant sex differences in the proportion of global deaths attributable to alcohol, for example, in 2012 7.6% of deaths among males and 4.0% of deaths among females were attributable to alcohol.
- In 2012 139 million DALYs (disability-adjusted life years), or 5.1% of the global burden of disease and injury, were attributable to alcohol consumption.
- There is also wide geographical variation in the proportion of alcohol-attributable deaths and DALYs, with the highest alcohol-attributable fractions reported in the WHO European Region.

### CHAPTER 4: ALCOHOL POLICY AND INTERVENTIONS

- Alcohol policies are developed with the aim of reducing harmful use of alcohol and the alcohol-attributable health and social burden in a population and in society. Such policies can be formulated at the global, regional, multinational, national and subnational level.
- Many WHO Member States have demonstrated increased leadership and commitment to reducing harmful use of alcohol in recent years. A higher percentage of the reporting countries indicated having written national alcohol policies and imposing stricter blood alcohol concentration limits in 2012 than in 2008.

The report also contains country profiles for all 194 WHO Member States as well as data tables to support information provided in chapters 2–4 (Appendices I–III) and a section explaining data sources and methods used in this report (Appendix IV).





global status  
report on alcohol  
and health

1. Alcohol and  
public health

drinking are likely to be less widely available. Drink-driving may also have a worse outcome because less affluent societies have less safe streets and vehicles.

### 1.5.6 CULTURE AND CONTEXT

The degree of risk for harm due to use of alcohol varies with the drinker's age, sex, familial factors and SES, as well as the drinker's behaviour and alcohol exposure (volume, patterns and quality of alcohol consumed; as discussed in section 1.2). However, it also varies with the physical and socioeconomic context in which a given drinking occasion and the ensuing hours take place. Moreover, the nature and extent of the harm that results from drinking can vary widely depending on the context.

In some contexts, drinkers will be vulnerable to alcohol-related social harm, disease, injury or even death if any volume of alcohol is consumed. This is the case for instance if a person drinks before driving a car or piloting an aeroplane, when consuming alcohol can result in serious penalties and harm. Also, in many countries there can be serious social or legal consequences for drinking at all, due to laws and regulations or cultural and religious norms, which can increase the vulnerability of drinkers to alcohol-related social harm. Studies showing differences in consumption or alcohol-related harm between different ethnicities within countries have underlined the importance of further research on culture-related vulnerabilities (Neumark et al., 2003; Chartier et al., 2013).

### 1.5.7 ALCOHOL CONTROL AND REGULATION

As discussed in greater detail in section 1.7 of this chapter and in chapter 4, another critical factor in determining the level of vulnerability to harmful use of alcohol and alcohol-related harm across countries is the level and effectiveness of alcohol control and regulations in each country, and within countries, in each jurisdiction with the ability to set alcohol policies (Babor et al., 2010).

## 1.6 ALCOHOL-RELATED HARMES

Alcohol consumption can have both health and social consequences for the drinker. The harmful use of alcohol can also result in harm to other individuals, such as family members, friends, co-workers and strangers. Moreover, the harmful use of alcohol results in a significant health, social and economic burden on society at large.

### 1.6.1 HEALTH CONSEQUENCES FOR DRINKERS

As mentioned in section 1.2, alcohol consumption has been identified as a component cause for more than 200 health conditions covered by ICD-10 disease and injury codes (see Box 3 for the main disease and injury categories causally linked to alcohol; WHO, 1992; Rehm et al., 2010a, Shield et al., 2013; see also Appendix IV for details on which of these disease and injury outcomes have been modelled in this report). Most notably, new evidence points to a causal link between alcohol and infectious diseases such as tuberculosis and pneumonia (Rehm et al., 2009b; Samokhvalov et al., 2010a). Also, it is important to note that alcohol consumption can contribute to more than one type of disease or injury in the drinker.

### Box 3. Major disease and injury categories causally impacted by alcohol consumption

Green: Overall beneficial effects from low-risk patterns of drinking, while heavy drinking is detrimental

Red: 100% alcohol-attributable

**Neuropsychiatric conditions:** alcohol use disorders (AUDs, see Box 4) are the most important neuropsychiatric conditions caused by alcohol consumption. Epilepsy is another disease causally impacted by alcohol, over and above withdrawal-induced seizures (Samokhvalov et al., 2010b). Alcohol consumption is associated with many other neuropsychiatric conditions, such as depression or anxiety disorders (Kessler, 2004; Boden and Fergusson, 2011), but the complexity of the pathways of these associations currently prevents their inclusion in the estimates of alcohol-attributable disease burden (Rehm et al., 2010a).

**Gastrointestinal diseases:** liver cirrhosis (Rehm et al., 2010b) and pancreatitis (both acute and chronic; Irving et al., 2009) are causally related to alcohol consumption. Higher levels of alcohol consumption create an exponential increase in risk. The impact of alcohol is so important that for both disease categories there are subcategories which are labelled as "alcoholic" or "alcohol-induced" in the ICD.

**Cancers:** alcohol consumption has been identified as carcinogenic for the following cancer categories (International Agency for Research on Cancer, 2012) cancer of the mouth, nasopharynx, other pharynx and oropharynx, laryngeal cancer, oesophageal cancer, colon and rectum cancer, liver cancer and female breast cancer. In addition, alcohol consumption is likely to cause pancreatic cancer. The higher the consumption, the greater the risk for these cancers, with consumption as low as one drink per day causing significantly increased risk for some cancers, such as female breast cancer (Seitz et al., 2012; Rehm & Shield, 2013; Nelson et al., 2013).

**Intentional injuries:** alcohol consumption, especially heavy drinking, has been causally linked to suicide and violence (Cherpitel, 2013; Macdonald et al., 2013).

**Unintentional injuries:** almost all categories of unintentional injuries are impacted by alcohol consumption. The effect is strongly linked to the alcohol concentration in the blood and the resulting effects on psychomotor abilities. Higher levels of alcohol consumption create an exponential increase in risk (Taylor et al., 2010).

**Cardiovascular diseases (CVD):** the relationship between alcohol consumption and cardiovascular diseases is complex. The beneficial cardioprotective effect of relatively low levels of drinking for ischaemic heart disease and ischaemic stroke disappears with heavy drinking occasions. Moreover, alcohol consumption has detrimental effects on hypertension, atrial fibrillation and haemorrhagic stroke, regardless of the drinking pattern (Roerecke & Rehm, 2012).

**Fetal alcohol syndrome (FAS) and preterm birth complications:** alcohol consumption by an expectant mother may cause these conditions that are detrimental to the health of a newborn infant (Foltran et al., 2011).

**Diabetes mellitus:** a dual relationship exists, whereby a low-risk pattern of drinking may be beneficial while heavy drinking is detrimental (Baliunas et al., 2009).

**Infectious diseases:** harmful use of alcohol weakens the immune system thus enabling development of pneumonia and tuberculosis. This effect is markedly more pronounced when associated with heavy drinking, and there may be a threshold effect, meaning that disease symptoms manifest mainly if a person drinks above a certain level of heavy drinking (Lönnerth et al., 2008).

In addition to the causal relationships between alcohol consumption and disease and injury categories described in Box 3, a strong association exists between alcohol consumption and HIV infection and sexually transmitted diseases (Baliunas et al., 2010; Hahn et al., 2011). This in itself is no proof of a causal relationship, as it may be that a common third cause, such as having generally risky behaviour impacts on both alcohol consumption and risky sexual behaviour leading to infection. However, experimental research, where alcohol consumption was manipulated, showed that it was clearly related to the increased risk of unsafe sex (Rehm et al., 2012). If one assumes a causal relationship between intention and (risky sexual) behaviour, which research has demonstrated to be the case (Sheeran et al., 1998; 1999), the result is acceptance of a causal relationship between alcohol consumption and HIV incidence. In addition, there is a clear causal effect of alcohol consumption on HIV/AIDS patients' adherence to antiretroviral treatment, which can be quantified (Hendershot et al., 2009; Azar et al., 2010; Gmel et al., 2011), as well as on the course of HIV/AIDS among patients who are not yet on antiretroviral therapy (Pol et al., 1996; Liu et al., 2003; Chander et al., 2006; Azar et al., 2010; Baum et al., 2010; Hahn & Samet, 2010).

Of the more than 200 ICD-10 disease and injury codes for which alcohol consumption is a component cause, more than 30 include alcohol in their name or definition. This indicates that these disease conditions would not exist at all in the absence of alcohol consumption. Of these 30, AUDs, (see Box 4) are the most significant.

#### **Box 4. Alcohol use disorders (AUDs)**

**Harmful use of alcohol** is defined as a pattern of alcohol use that is causing damage to health, and the damage may be physical (as in cases of liver cirrhosis) or mental (as in cases of depressive episodes secondary to heavy consumption of alcohol) (see ICD-10; WHO, 1992).

**Alcohol dependence** (also known as alcoholism or alcohol dependence syndrome) is defined as a cluster of behavioural, cognitive, and physiological phenomena that develop after repeated alcohol use and that typically include a strong desire to consume alcohol, difficulties in controlling its use, persisting in its use despite harmful consequences, a higher priority given to alcohol use than to other activities and obligations, increased tolerance, and sometimes a physiological withdrawal state (see ICD-10; WHO, 1992).

### 1.6.2 SOCIOECONOMIC CONSEQUENCES FOR DRINKERS

In addition to harm to the physical (e.g., liver disease) and/or mental health (e.g., episodes of depressive disorder) of the drinkers, alcohol consumption is often associated with socioeconomic consequences, as shown in Figure 1. These socioeconomic consequences are tied up with the responses of other people. Where use of alcohol is forbidden for religious or cultural reasons, drinking at all will be negatively judged by others. Also in societies where drinking is thoroughly integrated into daily life, there are boundaries of acceptable drinking behaviour, whether in terms of a specific drinking event or a specific pattern of drinking (Bennett et al., 1993). When an individual crosses culture-specific boundaries, he or she may experience socioeconomic consequences such as loss of earnings, unemployment or family problems, stigma and barriers to accessing health care. These four consequences are discussed in more detail below.

Alcohol is typically a valued commodity, which means that drinking usually uses resources which would otherwise be available for other purposes. Where earnings are low, heavy drinking may further impoverish the drinker, the drinker's family, or a whole community, thus increasing health or social harm (Schmidt et al., 2010; De Silva et al., 2011).

Intoxication, dependence or alcohol withdrawal states can result in poor performance in major social roles – in functioning at work, in parenting, in relationship and friendship roles. Both the drinker and others may be affected by the consequences, such as job or productivity loss, break-up and dysfunction in family life, including domestic violence. This in turn can result in harm to physical or mental health, caused by the role functioning impairment itself, others' reactions to the impairment, or both (Schmidt et al., 2010).

The reputational drinking history of an individual, i.e., how the pattern of drinking is interpreted by others, is crucial in social judgements, both those made in the moment and in the longer term. There is a clear tendency in many cultures to marginalize and socially exclude habitually intoxicated persons and their families, even more so than "dirty or unkempt" persons (Room et al., 2001).

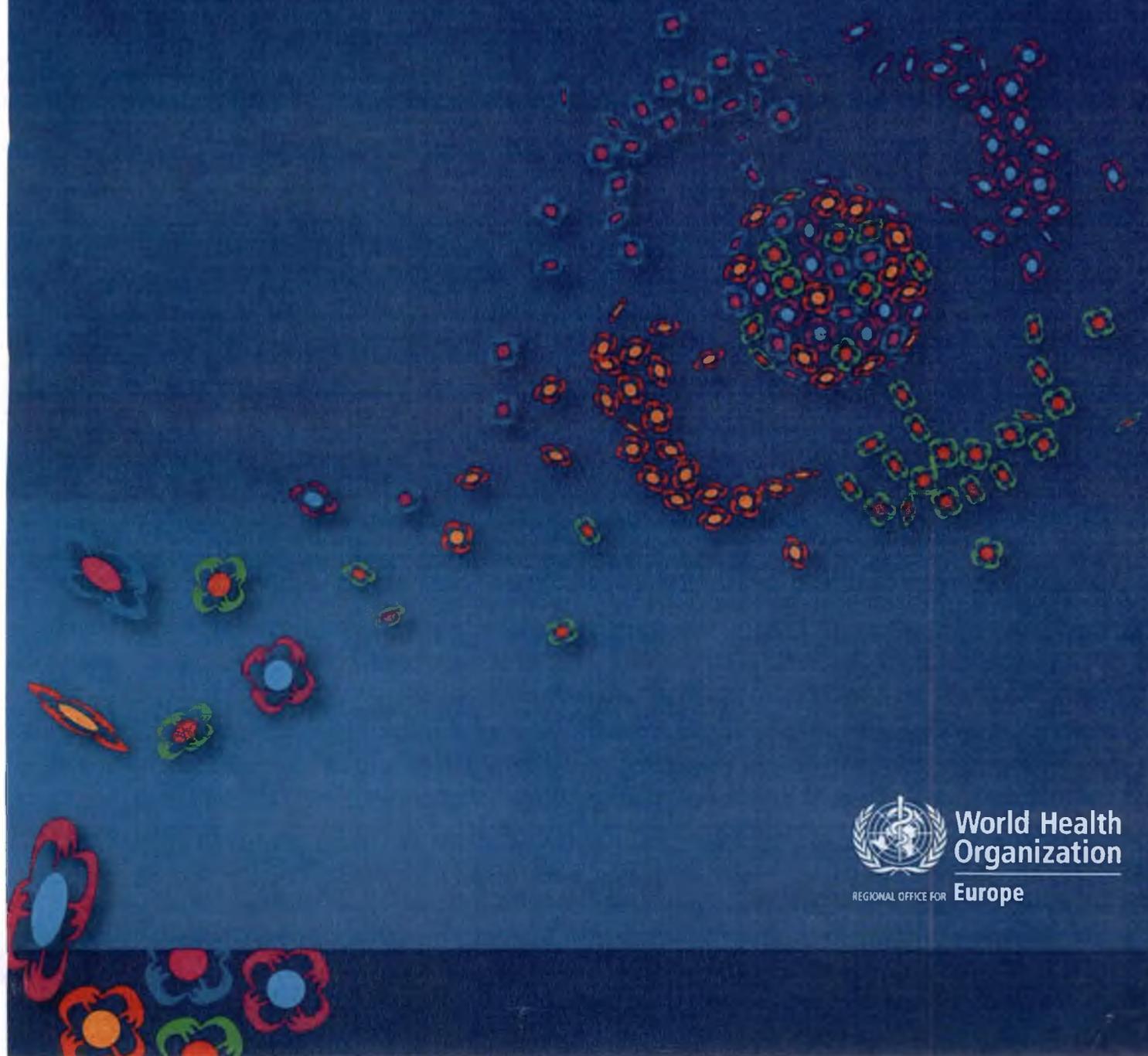
One direct path by which marginalization can affect health status is through diminished access to good health care. In several surveys around the world, respondents felt that heavy alcohol users should receive less priority in health care. Often the justification given is the belief that the users' behaviour contributed to their own illness (Olsen et al., 2003). More worryingly, studies on health services show that the care given is likely to be inferior, or the access to health care worsened, if the patient is seen as a run-down drinker or a similarly degraded status (e.g., Sudnow, 1967; Strong, 1980; Santana 2002; Mitchell et al., 2009). Given that access to good health care is expected to affect health status, this is a major concern both at the individual and at the societal level.

### 1.6.3 HARMS TO OTHER INDIVIDUALS

The harms done by people's drinking to others involve both socioeconomic consequences and substantial health problems, such as alcohol-related injuries, mental health impacts and FASD (see Box 5 for examples; Navarro et al., 2011). As stated in the WHO Global strategy to reduce the harmful use of alcohol (WHO, 2010a), "special attention needs to be given to reducing harm to people other than the drinker". The individual(s) affected may be a spouse or partner, child, relative, friend, neighbour, co-worker, person living in the same household, or a stranger, as is particularly common in the case of traffic crashes.



# Action Plan for implementation of the European Strategy for the Prevention and Control of Noncommunicable Diseases 2012–2016



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## **Mental disorders**

There is a strong connection between mental and physical health: for instance, harmful stress is associated with cardiovascular diseases, and cerebrovascular disease is a cause of dementia. Although “neuropsychiatric disorders” are the second leading cause of NCD burden in the European Region, it would be erroneous to subordinate a mental health strategy within an NCD action plan. Mental health and NCDs require distinct strategies and action plans arising out of a specific evidence base and unique technical requirements. The Regional Office is currently revisiting the Mental Health Action Plan in consultation with Member States and stakeholders, with a view to proposing a new mental health strategy to the Regional Committee in 2012.

## **Violence and injury**

Violence and injuries have much in common with NCDs. Real or perceived risks of injuries are cited as the greatest barrier to cycling and walking. Furthermore, over-reliance on car transportation causes physical inactivity, noise and air pollution, which are also linked to NCDs. Violence and injuries have some risk factors in common with NCDs, such as deprivation and socioeconomic inequality, and are often mediated through harmful use of alcohol. Adverse childhood experiences are not only linked to an increased propensity towards violent behaviour in later life, but are also related to high-risk behaviours such as harmful alcohol use.

## **Infectious diseases**

Despite the label “noncommunicable”, many NCDs have a strong link with infectious diseases. For example, cervical and liver cancers are linked with the human papilloma and hepatitis viruses, respectively, with unsafe sex and needle-sharing by intravenous drug users increasing risk; the chronic and palliative care of people living with HIV is often integrated with services for other chronic diseases. NCD risk factors (such as tobacco smoking, or the harmful use of alcohol) are associated with the majority of new cases of tuberculosis (TB) in the world’s highest TB burden countries; an effective TB programme in Europe must address these common risk factors. The links between NCDs, and with HIV/AIDS and TB, as well as with maternal and child health, have implications for attainment of the Millennium Development Goals (MDGs): promoting synergies between programmes could be an efficient and effective way of using limited resources.

## **Environment and health**

Environmental and occupational exposures account for a significant part of the NCD burden. Physical activity is influenced by urban environments and transport policies, which can promote cycling and walking for transport by developing safe infrastructure, as well as fostering the establishment of accessible green spaces for leisure-time physical activity and encouraging behaviour modification. Occupational health and safety programmes can also be advocates for workplace wellness interventions. On a larger scale, lessons learned from the climate change and sustainable development movements serve as a model for developing advocacy for NCDs and development. There are deep connections with the causes of air and noise pollution and with efforts to control them. Sound and sustainable policies relating to the

- Increased health care surveillance, with measurement of the impact of health interventions, including how satisfied patients/families are and what patients feel about their health.
- Aspects of health promotion and disease prevention included in the curricula of health professionals and primary care providers, in particular, empowered to become agents of change in “advertising” NCD risk reduction strategies to their target population and more aware of how people’s social and economic circumstances affect their opportunities to make healthy choices, while the content of public health operations in countries is harmonized with the scope and content of individual health promotion and disease prevention.
- Public health capacities and services strengthened at all levels and close links with health care ensured in implementing the framework for action on strengthening public health capacities and services in Europe.

## Priority interventions

The priority interventions for the next five years have been selected because they are evidence-based, cost-effective measures that are feasible, financially and politically, for implementation and scale-up in a range of country contexts. The evidence base behind these priority interventions has been summarized and many of them are included as “best buys” in the WHO Global status report on NCDs (2010), which characterizes them as “actions that should be undertaken immediately to produce accelerated results in terms of lives saved, diseases prevented and heavy costs avoided”. These actions are also consistent with a consensus listing of priority actions on the prevention and control of NCDs (19).

The intention is that these priority interventions take place within the framework of a more comprehensive and integrated approach, and against a backdrop of efforts outlined in the preceding section of this document on priority action areas. It is *not* the intention that only these interventions and nothing else are achieved in the next five years. But it is the intention that at least the results listed here are achieved.

By the end of 2012, a detailed project plan will have been developed for each priority intervention, and there will be a monitoring and evaluation framework in place that will report in 2017 not only on impact but also on the distribution of that impact across the population.

## Promoting healthy consumption via fiscal and marketing policies

### Goal

To use fiscal policies and marketing controls to full effect to influence demand for tobacco, alcohol and foods high in saturated fats, *trans* fats, salt and sugar.

### Outcome measures

- Reduction of tobacco prevalence – both in terms of the population average and at a faster rate among groups in the population with the highest levels;
- reduction of harmful use of alcohol – both in terms of the population average and at a faster rate among groups in the population with the highest levels;
- reduced obesity.

### ***Process measures***

- Restrictions of exposure to direct and second-hand smoking via increases in tobacco prices, health warnings, smoke-free environments, and a complete ban on all forms of tobacco promotion;
- reduction in the harmful use of alcohol via increases in alcohol taxes, enforcing advertising bans and restricted access to retailed alcohol;
- promotion of healthier diets via food pricing, labelling and marketing controls.

### ***Rationale***

Marketing of processed food, with its “hidden” sugars, salt and excessive saturated fats, especially to children, and their increased availability are contributing to the alarming increase in the prevalence of overweight and obesity among children and adults reported in Europe, particularly for those with a lower socioeconomic status. Alcohol is a risk factor for NCDs, but it is also an important, independent cause of mortality and morbidity through alcohol dependence, violence and injury, and other alcohol-related disorders. Too high a proportion of the population is not yet covered by the cost-effective interventions outlined in the FCTC, either because their country has not ratified it or because the translation of commitment to action (for example in legislating for smoke-free environments) has been weak. A package of interventions on the pricing and marketing of tobacco and alcohol and the control of marketing of foods to children are both mandated by global and regional strategies and resolutions, as well as being part of the package of ‘best buys’ identified.

### ***Actions***

- Build the case for fiscal mechanisms to support healthy choices and explore the use of revenues from these taxes to funding sustainable structures for health promotion;
- ban the marketing of tobacco products (not limited to cigarettes), progressively reduce children’s and young people’s exposure to the full range of alcohol marketing, and limit their exposure to the marketing of foods high in salt, fat and sugar, and sugar-sweetened beverages.

## **Replacement of *trans* fats in food with polyunsaturated fats**

### ***Goal***

To eliminate *trans* fatty acids from processed foods and replace them with polyunsaturated fats.

### ***Outcome measures***

- *Trans* fats eliminated in processed foods in the majority of Member States.

### ***Process measures***

- National and international agreements reached and implemented on the elimination and appropriate replacement of *trans* fats in processed foods intended for the European market.