

The burden of alcohol use: better data and strong policies towards a sustainable development



Alcohol is a psychoactive substance with toxic and dependence-producing properties, which is consumed worldwide. More than 2 billion people, or about three of ten individuals, are current drinkers globally.¹ The prevalence of current drinking differs widely by location and, in many societies, alcohol consumption is strongly embedded in cultural norms and traditions leading to its health and social damages being often overlooked.

Using a comparative risk assessment approach, the study by Kevin Shield and colleagues² in *The Lancet Public Health* confirms that alcohol use is a major contributor to injuries, mortality, and the burden of disease. According to the authors, 3 million alcohol-attributable deaths occurred and 131.6 million disability-adjusted life-years (DALYs) were lost in 2016. They also conclude that the alcohol-attributable burden disproportionately affects young people and those living in countries with a lower human development index. This finding is further highlighted in the Global Burden of Disease 2017 study,³ which shows that alcohol use is the leading global risk factor for both premature death and disease burden among people aged 15–49 years, a position that has remained unchanged since 1990.

The inclusion of a health target to strengthen the prevention and treatment of substance use disorders in the Sustainable Development Goals 2030 (SDG 2030) agenda is a powerful recognition of these negative effects of alcohol use. Therefore, scientific evidence is central in identifying ways to work towards meeting the 2030 goals, and the work by Shield and colleagues² contributes to that. Still, many efforts aiming to measure the health loss associated with alcohol are commonly hindered by scarce and low-quality underlying data. According to the Global Health Data Exchange repository, the amount of general data available for tobacco, another dependence-producing substance that poses a major threat to population health, is almost twice as high as what's available for alcohol. An accurate assessment of the amounts and distributions of alcohol consumption in the general population is key for estimating the extent of alcohol's harm and for providing accurate advice about health risks to the public. However, as one example

of the limitations of measuring patterns of alcohol consumption, the measurement of illicit production or unrecorded consumption continues to be a significant challenge and has been limited by the use of non-systematic methods and the adoption of numbers produced via expert judgement.^{4,5} Given that the size of unrecorded alcohol consumption is not negligible—it can make up to 70.5% of total alcohol consumption in the Eastern Mediterranean region, according to WHO's Global status report on alcohol and health⁶—priorities should be given to risk factor surveillance systems that measure unrecorded alcohol use in particular.

Despite the recognition of the harms associated with alcohol use, the history of alcohol control lags substantially behind tobacco control efforts, especially after the ratification of the Framework Convention on Tobacco Control in response to the globalisation of the tobacco epidemic.⁷ With the absence of an international-level legally binding regulatory framework, WHO's Global strategy to reduce the harmful use of alcohol⁸ continues to be the most comprehensive international policy document providing guidance on reducing alcohol use at all levels. Regrettably, national policies addressing the availability, marketing, and price and taxation of alcoholic beverages, as well as drunk driving, are being implemented at a very slow pace. By 2016, less than half of the countries reported having written alcohol legislation.⁶ Enacting and maintaining strong alcohol control policies are vital to reducing population-level consumption and improving population health, and positive results have already been observed in some locations.⁹ After decades of unclear messages, policies and health programmes should be dictated by scientific evidence and recommendations for abstaining from alcohol should be prioritised, because there is an increasing amount of evidence that the healthiest amount of alcohol to consume is zero.^{1,10}

The study by Shield and colleagues² adds to the growing recognition that alcohol consumption is a marked contributor to the loss of healthy life and that alcohol requires amplified attention from the public health community. As efforts towards achieving the SDG 2030 goals become intensified, appropriately protecting the population from alcohol-related harm is a priority.

See [Articles](#) page e51

For the SDG 2030 agenda see <https://sustainabledevelopment.un.org/content/documents/21252030%20Agenda%20for%20Sustainable%20Development%20web.pdf>

For the Global Health Data Exchange see <http://ghdx.healthdata.org/>

A commitment to timely monitoring of alcohol use and to a package of policies that address, among others, taxation, access to alcohol, and the availability of treatment of alcohol use disorders, are likely to achieve success in reducing the health and negative social effects of alcohol use.

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