WHO's Hijacking Responsible Drinking?

report by Helena Conibear

WHO Recommendations

'With the wealth of scientific evidence currently available, decision-makers are now better placed to make informed public policy choices. The following basic conclusions can be drawn from a review of the research (Klingemann, Holder & Gutzwiller, 1993, Holder & Edwards, 1995, Babor, 2002, Ludbrook et al., 2002): alcohol problems are highly correlated with per capita consumption and reductions in per capita consumption produce decreases in alcohol problems;

- the greatest amount of evidence with regard to public policy has been accumulated on the price-sensitivity of alcoholic beverage sales, suggesting that alcoholic beverage demand is responsive to price movements, so that as price increases, demand declines and vice versa;

- Heavy drinkers have been shown to be affected by policy measures, including price, availability and alcohol regulation;

- Alcohol policies that affect drinking patterns by limiting access and discouraging drinking under the legal purchasing age are likely to reduce the harm linked to specific drinking patterns;

- Individual approaches to prevention (e.g. school-based prevention programs) are shown to have a much smaller effect on drinking patterns and problems than do population-based approaches that affect the drinking environment and the availability of alcoholic beverages;

- Legislative interventions to reduce permitted blood alcohol levels for drivers, to raise the legal drinking age and to control outlet density have been effective in lowering alcohol-related problems.

Overall, one could suggest several components to a comprehensive licensing system, such as the requirement of a substantial fee to be paid (which could be used to fund treatment, prevention or policy activities), that licences are not granted automatically, that licences are effectively enforced, that sanctions can be used for violations such as selling alcoholic beverages to underage or clearly intoxicated people, and also that the licensing system is used for limiting the density of licensed outlets.'
Global Report on Alcohol

The Global Status Report on Alcohol Policy published by WHO earlier this year offers 217 pages of statistics and research on alcohol and society as well as recommendations for policy implementation by the 51 countries who have signed the charter.

WHO has reaffirmed its policy of seeking to reduce overall consumption of alcohol by individuals throughout the world in adherance to the so called Ledermann theory, whereby if you reduce overall consumption, the misuse of alcohol will automatically be reduced. This is in contrast to the focus by most working in alcohol affairs who seek to address misuse by targeting the well known problem areas such as drink driving, under age-drinking and binge drinking together with its anti-social 'side effects' of violence and disorder, not to mention the long term health consequences.

The justification by WHO in targeting alcohol consumption per se is that it has estimated that there are about 2 billion people worldwide consuming alcoholic beverages and 76.3 million with diagnosed alcohol use disorders.

It claims that globally, alcohol consumption causes 3.2% of deaths (1.8 million) and states that there are causal relationships between alcohol consumption and more than 60 types of disease and injury. It cites alcohol consumption as the leading risk factor for disease burden in low mortality developing countries, and the third largest risk factor in developed countries . WHO's figures cite that in Europe alone, alcohol consumption was responsible for over 55 000 deaths among young people aged 15 to 29 years in 1999 (Rehm & Gmel, 2002).

Worryingly, WHO takes its arguments for per capita reduction in consumption further, arguing, in fact, that responsible drinking does not exist.

'Light and moderate drinkers, i.e. the majority of the population in many countries, who occasionally drink at high risk levels, while being individually responsible for fewer harms than heavy drinkers, are collectively responsible, due to their greater numbers, for the largest share of alcohol's burden on society'

WHO categorically states as an aim that ' by 2015 ' per capita consumption should not increase or exceed 6 litres per annum (this requires Britain, Ireland, France and Germany to cut their consumption by approximately half). France's Health Ministry has already committed itself to reducing per capita consumption by 20% by 2008 with a 500 million Euro budget granted to MILDT to help effect this. More recently, the Strategic Task Force on Alcohol Report for the Repulblic of Ireland, driven by the Department of Health and Children, and drawing largely on the WHO report, has called for a reduction in outlets, a rise in taxes as well as a lowering of BAC levels as measures to tackle misuse.

Eurocare reinforces WHO's findings stating that ' There is a direct link between per capita consumption levels and alcohol related harm'. The suggested means of reducing consumption by both WHO and EUROCARE include the following:

· The use of road blocks and random breath testing

· Higher taxes on alcohol ..' taxes on alcoholic beverages should be placed high on a list of possible policy measures as they are effective, cost-effective, easy to implement, and can generate government revenue and reduce both consumption and harm... Ideally, countries should implement a tax and price level which is high enough to reduce consumption and harm while not being so high as to increase illegal production, smuggling and cross-border trade'.

· Lower BAC levels (.5 or below)

· A higher minimum drinking age

· Increased restriction on alcohol sales

· Reduced number of outlets of sale

· Restrcitions on advertising

WHO accept that much of the research on the impact of alcohol advertising is not conclusive, but claims that increasing evidence can be found that exposure shapes positive perceptions of drinking and can increase heavier drinking. *'Therefore, it seems that restrictions on advertising and sponsorship should be part of a comprehensive alcohol policy, especially*

when it is targeted at young people'.

The National Academy of Sciences in the US echoes calls for the above measures in the US, plus an independent fund to be financed by a contribution of 0.5% of gross revenue by beverage alcohol companies ($250 -$500 million according to the ABI).

The Drink Drive Debate

The record on drink driving

The blanket approach on drink driving, whereby a policy is suggested by WHO and EUROCARE that a global BAC level should be established of .5mg.ml (Eurocare recommend .2mg/ml) does not take account of existing example and experience:

The US and UK could well claim to be victims of their own success. After two decades of reducing drink drive crashes and fatalities, figures have stabilized and increased by a few percent over the last two years (the US fatailty ratehas stagnated for several years before its slight drop in 2003. The UK collison figures are now down again by 4.17%). The UK with a relatively high BAC level of .8mg/ml has the best record amongst the OECD countries (see table) per billion km travelled, whereas France with a BAC level of .5 has one of the worst.

The decline in drink drive fatalities are not solely due to a change in attitude to drink driving, although this is significant, but are also partly due to investments and improvements in road safety measures. In the words of the Vermont Alcohol Research Center, 'Investment and improvements are widely understood to have contributed significantly in the past several decades to the decline in the number of fatal and serious injury crashes involving impaired driving among developed countries.' The center found that these measures include seat belt legislation, better-engineered roadways, installation of air bags in new motor vehicles, and strong enforcement of driving laws. The Centre also finds a lack of comprehensive and consistent data collection between countries hinders their research efforts. They state 'Despite the fact that only 10% of the world's road fatalities occur in high-income countries, there appear to be compelling disparities in road fatality rates within these developed countries. Of all the factors influencing the probability of a road crash, exposure to risk is most dependent on a country 's general economic status and its ability to afford safety measures. Crash occurrence, another factor, is tied to excessive speed, drinking and driving, unsafe vehicles, poor road design, and lack of effective law enforcement and / or traffic regulations. Understanding the quantity and the character of the problem is critical for policymakers in identifying, implementing, and evaluating effective intervention efforts, and yet it is in exactly this arena of data collection that the disparities among developed countries exist.'

The National Highway Traffic Safety Administration (NHTSA) in the US has found that 65% of all alcohol-related highway deaths involve drivers with a BAC of .15 or higher and that nearly one-third of drivers arrested or convicted of drunk driving each year are repeat offenders, and as many as 75% of those who lose their license for driving drunk continue to drive on a suspended license. These repeat offences of the hard core drink drivers are echoed in the UK and Canada.

It is argued, in the words of Dr. Jeffrey Runge, Administrator of NHTSA "that the educable have been educated, and that's why we saw the rapid drop off in the numbers. What we're dealing with now is a very different population of impaired drivers... by far and away, the larger majority of (these) drivers are those who have alcohol use disorders." This is re-enforced by Herb Simpson, President and CEO of the Traffic Injury Research Foundation who states: "I think we've been very effective in convincing the average citizen, the more socially responsible individual, that this [drunk driving] is unacceptable behaviour, and I think that's reflected in the statistics. What we're left with, more and more, is

Table 1 Adjusted capita GDP,compared to road fatality rates

Comparative ranking in per capita GDP (out of 24)	Per capita GDP/PPP in US$	Country	Killed per 1 billion vehicle-kilometers, all roads
1	36,300	USA	9.4 (2001)
2	31,800	Norway	8.3 (2001)
3	31,700	Switzerland	8.4 (2002)
4	29,400	Canada	9.0 (2001)
5	29,000	Denmark	9.2(2001)
	29,000	Belgium	16.3 (2001)
7	28,500	Ireland	10.9 (2001)
8	28,000	Japan	12.7 (2001)
9	27,700	Austria	12.3 (2002)
10	27,100	Iceland	16.0 (2000)
11	27,000	Australia	9.0 (2002)
12	26,900	Netherlands	8.5 (2002)
13	26,600	Germany	11.1 (2002)
14	26,200	Finland	8.5 (2000)
15	25,700	France	13.6 (2002)
16	25,400	Sweden	8.3 (1999)
17	25,300	UK	7.5 (1998)
18	19,500	New Zealand	12.4 (2000)
19	19,400	Republic of Korea	22.8 (2002)
20	19,000	Greece	26.7 (1998)
21	18,000	Slovenia	21.7 (2002)
22	15,300	Czech Republic	33.1 (2002)
23	12,200	Slovak Republic	46.9 (2000)
24	7,000	Turkey	73.0 (2001)

a group of individuals who don't give a tinker's damn about those messages."

Ironically, the National Highway Traffic Safety Administration (NHTSA) and groups such as Mothers Against Drunk Driving (MADD) have used an increase in drunk driving fatalities by repeat offenders as a justification for a major campaign against responsible adults and on-premise consumption. They have increased their calls for zero-tolerance laws and roadblocks which target responsible social drinkers, hoping to scare people into not driving after drinking- even when they are well within the legal limits. However,when national BAC limits are considered, no clear relationship between them and road fatality rates is found (Table 2). The lack of a clear relationship between road fatalities and BAC limits shown in Table 2 is further reinforced by the data for countries with the highest reported rates of road fatalities (Table 3). Some of these countries even have zero tolerance laws for alcohol in drivers, and yet suffer high fatality rates. It is unfortunate that comparison data in these countries with the higher fatality rates are not available on the types of roadways, enforcement rate of their driving laws, their traffic mix (numbers of cars, trucks, bicycles, etc.), and their fatality mix (numbers of drivers, passengers, pedestrians, bicyclists, etc.).

The recent reduction in the US from .10% to .08% BAC-has not reduced drunk driving deaths as envisaged.

Various sources are quoted below listing the effect of the .08 law in the US:

"primarily limited to individuals who generally restrict their alcohol consumption before driving anyway." California Department of Motor Vehicles

"None of the fatal accident series produced any evidence of a decrease associated with the 0.08% legislation." California Department of Motor Vehicles

Table 2 Lowest rate of road fatalities, in rank order, among selected OECD countries (20-day period), with corresponding BAC limits

Rank	Country	Killed per 1 billion vehicle –kilometers, all roads	BAC limit (grams. DL)
1	UK	7.5 (1998)	0.08
2	Norway	8.3 (2001)	0.02
	Sweden	8.3 (1999)	0.02
3	Switzerland	8.4 (2002)	0.08
4	Finland	8.5 (2002)	0.05
	Netherlands	8.5 (2000)	0.05
5	Canada	9.0 (2001)	0.08
	Australia	9.0 (2002)	0.05

Table 3 Highest rate of road fatalities, in rank order, among selecte OECD countries (20-day period), with corresponding BAC limits

Rank	Country	Killed per 1 billion vehicle –kilometers, all roads	BAC limit (grams. DL)
24	Turkey	73.0 (2001)	0.05
23	Slovak Republic	46.9 (2000)	0.00
22	Czech Republic	33.1 (2002)	0.00
21	Greece	26.7 (1998)	0.05
20	Reoublic of Korea	22.8 (2002)	0.05

"The conclusion that 500 to 600 fewer fatal crashes would occur annually if all states had .08 BAC laws is unfounded." United States General Accounting Office

The .08 mandate has split the highway traffic safety community and others committed to reducing the drunk driving problem. This rift widened when NHTSA (perhaps in reaction to the dismal results generated by .08) sought further sanctions against responsible adults in the form of nationwide roadblock campaigns-campaigns that they acknowledge are specifically designed to frighten responsible adults, not to catch drunk drivers.

"While a lot of attention is paid to the serious problems of repeat offenders, we don't want to overlook the casual drinker. If you choose to drink you should never drive. We will not tolerate drinking and driving-period." Karolyn Nunnallee, former president of MADD

"Saturation patrols maximize the efficiency and effectiveness of routine patrols as a means of identifying impaired drivers by having a number of patrol units concentrate their impaired driving enforcement efforts in a specific geographic area. Saturation patrols might also be viewed as a roving, mobile spot check. These roving patrols are difficult to avoid, and the drivers arrested are most likely to be those at highest risk of crash involvement. Saturation patrols combine the desirable features of spot checks and routine patrols to create an efficient means of identifying the highest risk group of impaired drivers - DWI repeat offenders." Health Canada, "DWI Repeat Offenders: A Review and Synthesis of the Literature"

"The number of DWI arrests made by the roving patrol program was nearly three times the average number of DWIs made by the checkpoint programs." NHTSA, "Experimental Evaluation of Sobriety Checkpoints"

As with targetting misuse of the consumption of alcohol (binge drinking, underage drinking and dependence), the most important debate and policy focus re drink driving should centre more on how to deal with persistent drink drivers, as well as effective enforcement of existing laws if today's drunk driving problems are to be reduced in developed countries.