

Fact sheet:

Monitoring the harm that alcohol does to Europe

December 2012



The harm done by alcohol

Alcohol is a risk factor for disease and social harm. As the Europe drinks at a level of alcohol consumption which ranks among the highest globally, the countries of the European Union show a high level of alcohol-attributable harm. In the EU, in 2004, almost 95,000 men and more than 25,000 women between 15 and 64 years of age were estimated to have died prematurely of alcohol-attributable causes. This means that 1 in 7 male and 1 in 13 female premature deaths were caused by alcohol. These are net numbers, already taken into consideration the protective effect of alcohol on ischemic disease and diabetes. Moreover, as alcohol consumption contributes substantially to morbidity and disability as well, the overall alcohol-attributable burden of disease is high. In 2004, over 4 million disability-adjusted life years (DALYs), i.e., years of life lost either due to premature mortality or due to disability, were estimated to be caused by alcohol consumption, corresponding to 15% of all DALYs in men and 4% of all DALYs in women. Most of the health harms related to alcohol are caused by heavy drinking. The high toll of alcohol-attributable burden requires alcohol policy countermeasures including a monitoring system that is capable of evaluating change. While the tools for such a monitoring system exist, it is not possible to implement fully, as almost all countries lack comparable routine data on burden of disease such as DALYs.

Monitoring the harm done by alcohol

Epidemiology can help guide alcohol policy. However, what is necessary are relevant and timely data on a regular basis, i.e., a comprehensive monitoring and surveillance system, which can serve multiple purposes: as an early warning system, as a resource to monitor change and to evaluate the impact of policy, and as a comparator to benchmark against other countries. While in principle the elements to create such a monitoring system are in place, in practice meaningful monitoring and surveillance for alcohol-attributable harm is hindered by the data situation.

Consider the following situation: at the media launch of the WHO European Region on alcohol, harm and policy in March 2012, data from 2004 were launched as the most recent data on alcohol-attributable burden of disease. Such a time lag is unacceptable if monitoring and surveillance are to have real impact on policy making. The reason for this time lag is clear: conceptually, public health wants to move away from mortality as the main indicator and incorporate disability and quality of life into a summary measure of health.

This goal is laudable as it reflects preferences of modern societies and individuals not only to increase life expectancy but also to maximize disability-free life expectancy. However, while the goal is laudable, the implementation does not follow suit, and studies measuring burden of disease or other summary measures of health are rare. Thus, after the publication of the last Global Burden of Disease 2000 Study, there has de facto been a 10 year gap before new data on burden of disease were presented (in August 2012), with one non-empirical based update for the year 2004 in-between in 2008. During this time, few countries have conducted their own burden of disease study, so monitoring of alcohol-attributable burden of disease on a continuous basis has been absent.

In consequence, in order to make monitoring relevant, measures will have to be developed which are based on routinely collected statistics (e.g. hospitalization which could be comparable for a region like the EU – for the use of hospitalizations as a tool to quantify alcohol-attributable harm) and which can be reported within one or two years after the event. Only if we achieve monitoring and surveillance to give timely updates, can these data be really used as policy tools. Otherwise, the recent developments in alcohol epidemiology will remain academic successes without any impact on policy making.

Take home messages

1. The countries of the European Union have a high level of alcohol consumption, more than twice the global average.
2. Consequently, alcohol-attributable harm is also at high levels, with almost 12% of all premature deaths and more than 10% of all premature burden of disease as measured in DALYs being caused by alcohol. In other words, 1 in every 7 premature deaths before age 65 in men, and 1 in every 13 premature deaths in women is estimated to be caused by alcohol.
3. Given the high level of alcohol-attributable health harm, new forms of alcohol policy, including monitoring and surveillance systems to evaluate effectiveness, should be implemented.
4. While all the elements of such monitoring and surveillance systems have been developed, the underlying data currently limit them to indicators based solely on mortality. This does not correspond to the focus in most societies on increasing healthy life expectancy rather than just prolonging life. There is an urgent need for developing a monitoring and surveillance system for alcohol, which includes non-fatal health outcomes.
5. With respect to social harm, some progress has been made, but further developments to derive comparable and comprehensive indicators are still necessary.

This fact sheet was based information in the [AMPHORA ebook](#) produced as part of the AMPHORA project (www.amphoraproject.net), funded by the European Commission under the 7th Framework Programme for research. Grant Agreement No. 223059

