Commentary: Alcohol use disorder: as usual, prevention is better than cure

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In a very comprehensive review in this issue of the International Journal of Epidemiology, Roerecke and Rehm show a very high cause-specific mortality among alcohol use disorder (AUD) patients, especially regarding liver cirrhosis, mental disorders and injury.1 Several mortality estimates presented were higher than those previously found, and it appears that the newer (and better?) studies demonstrate higher risk estimates. In addition to the well-known consequences of a high alcohol intake (cirrhosis, mental disorders and some cancers), this study also reported a higher risk for heart disease in this population. This is in line with data from Russia, that show a strong relationship between high alcohol intake and high all-cause mortality, together with a high risk for cardiovascular disease (CVD) in heavy drinkers.2,3

It is, however, in contrast to many studies of general populations suggesting that a light to moderate intake of alcohol has a beneficial effect on coronary heart disease (CHD); the study does suggest that there is an upper limit for the beneficial effect of alcohol intake on coronary heart disease. In fact, this work by Roerecke and Rehm is so convincing that one might question the need stated in their own conclusion, that ‘there is a lack of research’. From my point of view, we need no further evidence before action is taken. We already have evidence from many large studies: from ecological studies in countries with high alcohol intakes and high frequency of cirrhosis, cancer, etc.; from case-control studies of the effect of alcohol on rare cancers; from large cohort studies of samples of the general population showing consequences of a heavy intake on a number of health outcomes; and now from this very thorough review—all pointing to the fact that alcohol in high doses is one of the largest killers in the Western world.

Thus, if more research is needed, it is not research documenting the harms done by alcohol, but research into the interventions that may reduce the harm, or even better the interventions that may prevent us from beginning to drink hazardously, since prevention is always better than cure.

All the studies included in the present review were cohorts of AUD patients. Although most of these presumably have had some treatment, many died too early compared with the background population. In this commentary it is not my aim to point out inadequate or insufficient methods of treatment, but rather to conclude that in these populations it was somehow too late. Of course, any treatment given may have been of some help: we may have observed more than 6420 deaths in this population of 28 087 patients, had they not been treated, but had they been included in the treatment earlier, or even better had their alcohol use disorder never developed, the numbers could have been lower.

With regard to prevention, what measures could be taken? There are, of course, many reasons for people to drink heavily, but one of them is the easy availability of alcohol. Availability is a contributory cause for drinking too much, rather than a necessary cause. In some countries, such as the UK and Denmark, young people start to drink at a very early age. This has been shown to imply a higher intake later in life.4 In some countries, such as my own (Denmark), restrictions for selling alcohol to youth are not completely clear. A uniform age limit of, for example, 18
years for purchase of all types of alcohol in all of Europe would have an effect on heavy drinking among youngsters.

Another structural measure is the price of alcohol. In 1917 Denmark experienced a very dramatic decrease in alcohol intake in the whole population after the introduction of a very high tax on alcohol. A dramatic decrease in alcohol use disorders was seen a few months after introducing an increase in price for a bottle of Schnaps from 1 D.kr to 10 D.kr. This is, to my knowledge, one of the greatest single changes in price of alcohol in the western world, and had a very dramatic effect. President Gorbatjov introduced similar, although less dramatic adjustments in the Soviet Union in the 1980s, with a similar positive effect on alcohol-related morbidity.

In most Western countries, too many people have an alcohol intake above the sensible drinking limits, and are thereby at risk of alcohol use disorders, but at the same time a large proportion of the populations drink sensibly. For instance, in Denmark, 70–75% of adults have a light to moderate intake which may be considered to be healthy. So how do we use the price weapon as a target against those with the high alcohol intake? One way would be, as recently suggested by the Scottish Government, to introduce a minimum price per unit of alcohol. A suggestion could be to set in Europe a minimum price for beer of 75 cents, for a bottle of wine (6 units) of 4.5 euro, etc. This is likely to result in a decline in binge drinking, without seriously interfering with sensible drinking limits, resulting in a healthier society.

While we wait for studies on preventive measures, we, the experts, could add our voice to the lobbyists. There is certainly a need for lobbying at national as well as international level in order to convince, for example, the European Parliament to heed the mass of evidence already reported and to incorporate it into planning stronger action on the consequences of AUD.

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References