World Health Organization

Addressing alcohol consumption and socioeconomic inequalities:

how a health promotion approach can help

Snapshot series on alcohol control policies and practice

Brief 1, 4 June 2021

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Brief at-a-glance

The problem

Evidence consistently finds that people with lower socioeconomic status are disproportionately or disparately affected by alcohol-related harms. Alcohol consumption – especially heavy episodic drinking – explains 27% of the socioeconomic inequalities in mortality. As countries progress in their development, alcohol consumption may exacerbate disparities in the burden of disease attributable to alcohol.

The evidence

Alcohol consumption accounts for about 5% of the global burden of disease but is unequally distributed across socioeconomic groups. Socioeconomic status has repeatedly been shown to be associated with an elevated risk of mortality. For alcohol consumption, the inequalities in morbidity and mortality are especially stark. The availability of alcohol in communities with fewer resources reinforces and exacerbates these differences. Places that have higher alcohol outlet density tend to have more road crashes, hospital admissions, suicide, alcohol use disorders, child abuse and neglect, violence, underage drinking and sexually transmitted infections. Nevertheless, substantial evidence indicates that alcohol control policies can play an important role in reducing socioeconomic inequalities.

The know-how

Experiences describing how alcohol drives inequalities can inform future policy decisions. Four experiences with these inequalities and the steps taken to reduce gaps in health are described. These experiences describe efforts to reduce the acceptability, availability and affordability of alcohol across different settings.

The next steps

Policy-makers could pursue evidence-informed alcohol control policies working in collaboration with other countries to develop multinational responses. Civil society, community-based organizations, researchers and research institutions could continue to document the experiences of countries implementing policies to reduce alcohol consumption and develop innovative research methods that can be applied in low- and middle-income countries to fill the existing gaps in the knowledge base

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Related resources

Webinar recording | Event description | Programme

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About the series

This Snapshot is part of a series of briefs tackling critical issues related to the determinants driving the acceptability, availability and affordability of alcohol consumption and how it affects people and their communities. The series aims to facilitate evidence and experience-informed conversations on key topics relevant to achieving the Sustainable Development Goals and the noncommunicable diseases targets in the context of the WHO Global Strategy for reducing the harmful use of alcohol and its global action plan. Each brief is the result of a global, multistakeholder conversation convened by the Less Alcohol Unit, part of the WHO Department of Health Promotion. The topics of the series emerged in response to blind spots in the current policy conversations. The approach and length of the Snapshots do not fully describe the complexities of each topic nor do the illustrative country experiences. The series is a conversation-starter rather than normative guidance. Relevant WHO resources are provided to explore the subject in more depth.

The series is intended for a wide audience, including professionals working in public health and local and national alcohol policy focal points, policy-makers, government officials, researchers, civil society groups, consumer associations, the mass media and people new to alcohol research or practice.

What is a health promotion approach to reducing alcohol consumption?

Drinking has multidimensional connotations. Robust and growing evidence demonstrates that cultural, social and religious norms influence alcohol consumption – acceptability, ease of purchase (availability) and price (affordability). Addressing this multidimensional causality chain requires a portfolio of health promotion interventions to moderate the determinants driving alcohol consumption and, in turn, enable populations to increase control over and improve their health to realize their full potential.

Determinants driving the consumption of alcohol

	Acceptability	Availability	Affordability
Public health objectives	Protect consumers	Promote healthier settings	Build resilient societies
Health promotion interventions	Raising awareness, e.g. labelling	Mediating licensing, e.g. outlet density and location, online sales	Increasing prices, excise taxes and moderating other fiscal measures, reducing and ending financial incentives and subsidies
	Banning or comprehensively restricting alcohol marketing, advertising, sponsorships and promotion	Promoting healthy settings and pro-health environment, e.g. schools, stadiums	Tackling unrecorded alcohol
	Adressing commercial determinants and conflict of interests		

How are the briefs developed?

The briefs result from a quick scanning of the recent evidence on the topic, insights from leading experts, consultation with selected countries and discussions that took place during webinars convened to create a platform to match evidence, practice and policies. Each webinar, attended by more than 100 participants, took place over 1.5 hours in English, Russian and Spanish. Between 8 and 10 speakers were invited to participate in each webinar, engaging global experts, officials from governments, academia, civil society and other United Nations agencies. Participants also engaged in the webinar by posting questions, sharing experiences and resources. The snapshot has been reviewed by the respective speakers – the contributors to each brief – to confirm the completeness and accuracy of the synthesis prepared.

Interested in other topics?

Visit the *Less Alcohol webpage* for other briefs in this series and forthcoming webinars. During 2021, topics including alcohol consumption and socioeconomic inequalities, unrecorded alcohol, conflicts of interest, labelling, digital marketing and per capita alcohol consumption have been explored. If you have a suggestion for a topic that has yet to be explored, contact our team at *lessalcohol@who.int.*

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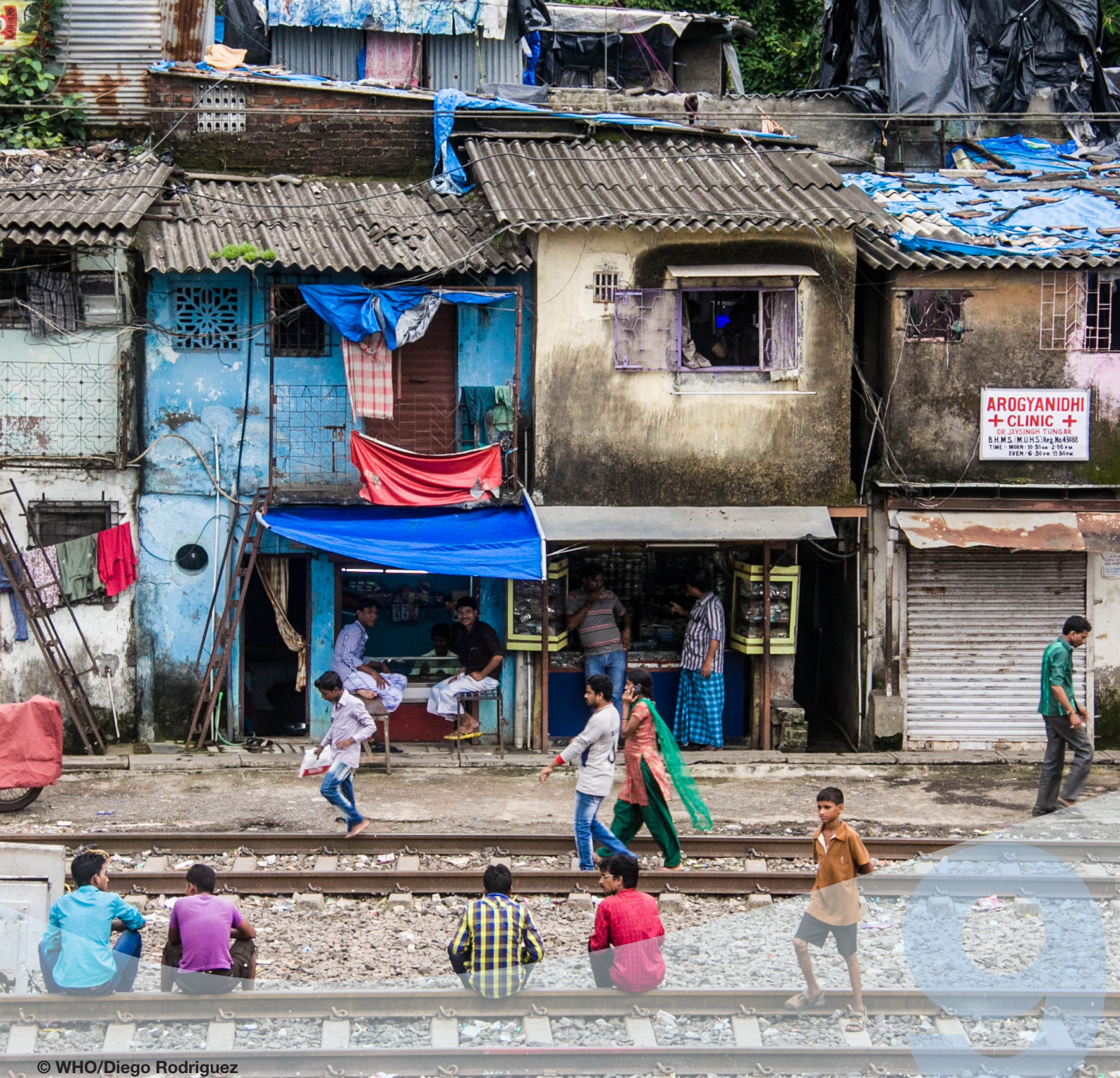

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The problem

This section provides a brief overview of why this issue matters to the health of populations and why it is worth further examining within global alcohol policy

Alcohol use is connected to inequalities through several pathways. Evidence consistently finds that people with lower socioeconomic status are disproportionately or disparately affected by alcohol-related harms *(1,2)*. Alcohol consumption – especially heavy episodic drinking – explains 27% of the socioeconomic inequalities in mortality *(3)*. As countries progress in their development, alcohol consumption may exacerbate disparities in the burden of disease attributable to alcohol *(4)*. Although the relationship between alcohol and inequities has been known for some time, many policymakers, government officials, and health specialists are not aware of the details or depths of the association.

Alcohol consumption is a major risk factor for several disease and negative health and social outcomes, including a greater co-occurrence of obesity, smoking, lack of exercise, mental health problems, communicable diseases such as tuberculosis and HIV, increased exposure to life stressors and reduced access to and use of health services and social support (5–7). An uneven distribution in morbidity and mortality is consistently observed for these outcomes wherein greater socioeconomic deprivation is associated with greater likelihood of harms related to alcohol consumption. This phenomenon is referred to as the alcohol-harm paradox (*8)*, whereby those experiencing lower socioeconomic conditions experience harm related to alcohol consumption at disproportionately greater rates than those that experience less socioeconomically deprived conditions even when the amount of alcohol is the same or less.

The easy availability of alcohol through higher density of alcohol outlets in disadvantaged neighbourhoods *(9,10),* its increasing affordability when produced with local crops *(11)* and its cultural and social acceptability perpetuated through marketing and advertisements *(12,13)*, are documented drivers that are increasing the divide across population groups. However, there have been policy efforts put in place to combat these inequities including the use of taxation and

minimum unit pricing, changes to zoning laws, and downstream interventions to tackle heavy-episodic drinking.

Models of policy interventions have shown that increasing alcohol taxes in New York City would proportionally benefit more lowest income groups by reducing consumption and related violence *(14)*. New zoning in Baltimore would reduce spaces available to alcohol outlets by 27.2%, mainly in high poverty areas *(15)*. Moreover, reducing the number of alcohol outlets by one quintile would potentially result in fewer homicides and disability-adjusted life years *(16)*. In Scotland, the introduction of minimum unit price resulted in less alcohol purchased by lower-income households *(17)*. In England, brief interventions tackling to reduce risky drinking were delivered in primary care more often to economically disadvantaged groups, potentially contributing to a reduction in socioeconomic inequalities in health *(18)*.

What does this snapshot aim to achieve?

This snapshot aims to closely examine the relationship between alcohol and health inequities; learn from approaches seeking to reduce the gaps in health and well-being caused by alcohol availability; and outline possible next steps for government decision-makers, civil society and researchers to move the conversation beyond this brief.

What is the alcohol-harm paradox?

Individuals experiencing lower socioeconomic conditions experience harm related to alcohol consumption at disproportionately greater than those that experience less socioeconomically deprived conditions even when the amount of alcohol is the same or less *(19)*

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The evidence

This section provides a summary of what is known about the issue, implementation considerations for different settings, and any gaps in the existing knowledge base

Alcohol consumption drives socioeconomic inequalities

Alcohol use accounts for about 5% of the global burden of disease but is unequally distributed across socioeconomic groups. Socioeconomic status has repeatedly been shown to be associated with an elevated risk of mortality. For alcohol consumption, the inequalities in morbidity and mortality are especially stark. For example, one systematic review and meta-analysis found that the relative socioeconomic inequalities in mortality were 1.5 to 2 times higher for mortality attributable to alcohol than for socioeconomic inequalities in all-cause mortality (*20*). In addition, although significant differences between the two ends of the socioeconomic spectrum have been known for some time, findings from a recent systematic review show that individuals across the entire continuum of socioeconomic status are exposed to increased mortality attributable to alcohol (*21*). The relative inequalities attributable to alcohol are broader and wider than for all-cause mortality, suggesting that they also contribute to socioeconomic inequalities overall.

The density of alcohol outlets in communities with fewer resources reinforces and exacerbates inequalities

Alcohol consumption drives socioeconomic inequalities, but the availability of alcohol in communities also reinforces and exacerbates these differences. Alcohol outlet density refers to the number of stores in an area that sell alcohol, increasing the availability of alcoholic beverages. When more stores sell alcohol, it is more convenient for consumers to purchase. Places that have higher alcohol outlet density tend to have more road crashes (*22,23*), hospital admissions (*24,25*), suicide (*26*), alcohol use disorders (*27*), child abuse and neglect (*28,29*), violence (*30,31*), underage drinking (*32*) and sexually transmitted infections (*33*). These findings have been documented in high-, middle- and low-income settings. Further, the same amount of alcohol in a community with fewer resources will do more damage than in one with more resources because the

protective factors may be absent. Despite this reality, alcohol outlets tend to cluster more in disadvantaged neighbourhoods even though, on average, the populations drink less than their more advantaged counterparts. For example, a study conducted in Scotland found that deprived areas had 40% more alcohol outlets than areas with more resources *(34)*.

Alcohol control policies may be effective at reducing socio-economic inequalities

Substantial evidence indicates that alcohol control policies can play an important role in reducing socioeconomic inequalities: for example, a policy setting a minimum sale price per unit of alcohol. The idea underpinning this policy is that it raises the floor price of alcohol, reducing consumption. Recent evidence shows that the outcomes of these policies favour lower-income communities rather than placing additional burdens on people with low socioeconomic status and exacerbating inequalities. For example, in Scotland, introducing a minimum unit price of £0.50 per unit of alcohol resulted in a reduction in weekly purchases of alcohol per adult per household and a non-statistically significant increase in weekly expenditure on alcohol per household, indicating a change in consumption patterns (17). The reduction in grams of alcohol purchased was greater in lower-income households and in the households that purchased the most alcohol (17). In certain parts of the world,

including countries of the former Soviet Union, the use of minimum unit pricing has become standard practice. This includes countries such as Armenia, Belarus, Kazakhstan, Moldova, Russian Federation, Ukraine and Uzbekistan. In many other countries, however, particularly low- and middle-income countries, additional research should be conducted to examine the policies effectiveness prior to implementation.

Alcohol control policies should be combined with upstream policies to address the root causes of health inequalities

Alcohol control policies may be one tool to help address inequalities. However, they should be combined with additional policies that address the root causes of inequalities. This includes policies that improve the conditions in which people are born, live, work and age. A health in all policies approach should be taken such that policy decisions beyond the health system consider the effects on health and health inequalities. Research related to alcohol and economic inequalities has shown that policy decisions related to urban planning, housing, transport and economic development all affect how communities develop. This, in part, determine the health outcomes of the people who reside there. For example, the introduction of new zoning laws in Baltimore would reduce spaces available to alcohol outlets by 27.2%, mainly in high poverty areas (*15*). In addition, these upstream approaches should also be combined with downstream care. In England, brief interventions to reduce risky drinking were delivered in primary care more often to economically disadvantaged groups, potentially contributing to a reduction in socioeconomic inequalities in health (*18*). As is clear through these examples, alcohol control policies are just one tool in a much larger toolbox that must be used to reduce social and health inequalities.

There remains a gap in knowledge and practice of what works in settings with fewer resources

Substantial research has examined the relationship between alcohol and socioeconomic status, mostly in high-income countries and/or settings with more resources. This largely results from the data available since formal markets regulate alcohol more and have a greater share of total alcohol purchases. This leaves a significant gap in understanding how alcohol affects socioeconomic inequalities and the effectiveness of alcohol control policies. Recently, innovative research methods have been used to begin to document both. Additional research should be undertaken to ensure that alcohol control policies do not have knock-on effects and end up increasing inequalities in these settings. One method to mitigate these effects may be to involve members of affected communities throughout the policy development process.

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The know-how

This section provides examples of country experiences that can be used as evidence and inspiration as to what policy approaches may be possible in different settings

Tackling alcohol availability in Australia

The Northern Territory has a higher rate of alcohol-related harm than other parts of Australia. For example, two thirds of family violence in the Northern Territory involves alcohol. Given these risks, efforts to improve the health and well-being of the community in such areas as Bagot have made the decision to become dry, alcohol-free areas. This has been supported by the Government of the Northern Territory, which has imposed a moratorium on any new liquor licences in the Northern Territory. Nevertheless, Woolworths, the largest distributor of alcohol in Australia, wanted to use an existing licence to build one of the biggest bottle shops in the country near the dry community of Bagot. This bottle shop was 43 times larger than the shop it was replacing and would significantly increase the availability of alcohol in the community. Despite significant efforts from Woolworths to advance the store's development, which included both lobbying and public relations efforts, the Bagot community came together to stop its development. Their efforts included developing a petition to the government, elevating the voices of community members who spoke about the risks this development had for their communities and timing communication against the store's development to interfere most strongly with Woolworth's business, including around annual general meetings and any important news releases. This effort demonstrates the work that community members can do to reduce health inequalities caused by alcohol and their effectiveness when supported by existing government efforts *(35).*

Smart alcohol affordability: the case of Ceará, Maranhão and Pernambuco, Brazil

Brazil provides an important example of how inequalities from alcohol can manifest themselves. Five men in Brazil have the same wealth as the lowest 50% of the population. Three of these men work for large alcoholic beverage companies. These inequalities have only worsened during the pandemic, as the availability of alcohol has increased. The alcohol industry has recently pursued a strategy called "smart affordability", which intends to make beer more acceptable, available and affordable. Numerous policies in the country support this approach including tax shelters in select regions, tax rebates for using local agriculture and advertising and marketing alcohol in vulnerable regions of Brazil perpetuate these inequalities and enable industry to benefit. Further, as ingredients for alcohol production are purchased inexpensively from local farmers. The use of local produce creates economic opportunities for small farmers giving the impression that the company is socially responsible. Despite the positive economic view, the alcohol-related harms still fall disproportionately on the same community. Further, the alcohol industry has been attaching emotional marketing and rhetoric to appeal the countries most disadvantaged. The rhetoric promotes the inexpensive beer created with local ingredients such as cassava and connects it with central features of the local culture such as celebrations and food, as well as producing advertisements in local dialects. These approaches have largely undermined any government measures to reduce alcohol consumptions and alcohol-related harms.

Although relatively little has been done to deal with these inequalities, parliamentarians' opinions on the alcohol industry are beginning to change, with 69% displaying strong support for higher taxation on unhealthy products and for prohibiting subsidies for unhealthy products. A window of opportunity may be opening in Brazil to begin addressing some of the systemic issues perpetuating these inequalities *(36)*.

Tackling alcohol acceptability in Sri Lanka

In Sri Lanka, about 22% of the population consume alcohol. This percentage has decreased since 2018 across all age groups, but especially among people 15–24 years old. Alcohol control policies were initially put in place through the National Authority on Tobacco and Alcohol, which prohibited selling alcohol to people younger than 21 years, banned print and electronic media promotions, free offers and vending machines and sponsorship for cultural, educational and sport events. These policies have been complemented with community-based interventions led by the Alcohol and Drug Information Centre

“The pressure was felt so deeply by the company that they put together an independent review of the proposed store which was so damning that it forced them to pull out and will likely” have implications for liquor license into the future”

Caterina Giorgi, Foundation for Alcohol Research and Education, at the webinar Addressing alcohol consumption and socioeconomic inequalities: how a health promotion approach can help

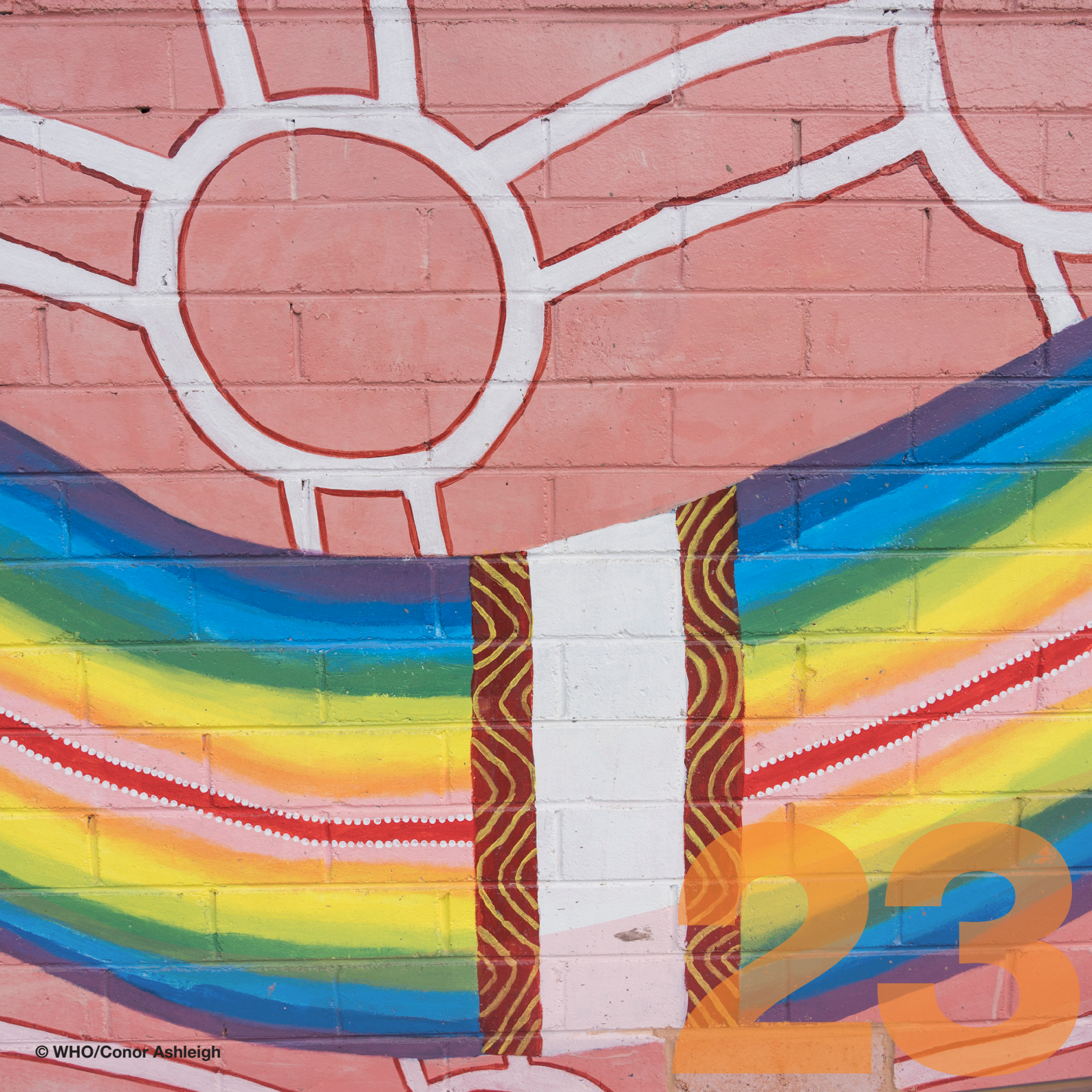
and other stakeholders. As a result, alcohol consumption among people younger than 21 years have decreased. The approach used a health promotion lens and engaged young adults to be champions for reducing alcohol consumption among their peers. Tactics used by young people include counteracting industry promotion by questioning the advertisements, busting myths about alcohol, confronting industry agents, using celebrities and media to reinforce messaging around consumption of alcohol as an impediment to happiness and pressuring politicians and policy-makers by exposing those who supported the industry *(37).*

The case in sub-Saharan Africa: the case for stronger national and regional responses

Sub-Saharan Africa countries became a target for market expansion by global alcohol producers as considered to have a minority of heavy episodic drinkers, a large proportion of abstainers and relatively weak alcohol control policies. The alcohol market has changed significantly in recent years, including changes in the industry's advertising and marketing activities and the introduction of new products such as small sachets of spirits and beer containers more than 750 ml. Consumption of commercially produced alcoholic beverages has increased in sub-Saharan Africa.

In response, some control mechanisms have been implemented in efforts to reduce alcohol-related harm. Despite the intention of many of these policies, the region has seen uneven implementation of alcohol control policies. Most countries in sub-Saharan Africa have adopted taxation and pricing policies with respect to all main types of commercially available beverages. However, the policies least likely to have been implemented are those restricting the sale of alcohol for off-premises consumption, countermeasures for drinking and driving, access to screening, brief interventions and treatment and restrictions on alcohol advertising, sponsorship and promotion. In addition, some countries have implemented multisectoral policy frameworks to reform harmful drinking, but others have no clear national policy. These policies have been branded paternalistic, exploitive or regressive *(38)*.

In addition to facilitating alcohol policy development and reporting and building institutional capacity to support the implementation of alcohol control measures, these countries can benefit from developing multinational responses and sharing experiences about what works to reduce alcohol consumption and tackling industry interference *(38).*



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Next steps

This section provides directions to explore to ensure the conversation continues beyond this brief

Tackling the challenges laid out in this brief undoubtedly requires a multi-stakeholder approach with each partner playing to their comparative advantage. Some examples of this are provided below for each researchers and research organizations and for government policy- and decision-makers. However, those best suited to move forward these next steps will be specific to each setting and may differ by country.

Policy- and decision-makers

Government policy- and decision-makers can learn from the experience of reducing health inequities related to other unhealthy products such as tobacco and food. This could include:

- pursuing evidence-informed policies to curb the acceptability, availability and affordability driving alcohol consumption, also learning from other unhealthy commodities such as tobacco;
- using zoning and land-use policies to reduce the overall availability of alcoholic beverages and prevent the uneven distribution of alcohol outlets across communities;
- working in collaboration to develop multinational responses to issues that affect individual countries' ability to implement effective control measures, especially in such areas as international trade policies and cross-border and digital marketing;

- applying a life-course and health in all policies approach when developing and implementing upstream policies to address alcohol-related inequalities; and
- magnifying and elevating the voices of community members who can speak about how alcohol policies affect the health and well-being of their communities, including empowering community members to hold seats at decision-making tables.

Civil society, community-based organisations, researchers and research institutions

However, policy- and decision-makers are restricted by gaps in applied evidence and information. Civil society, community-based organizations, researchers and research institutions have a critical role to play in advancing the understanding those gaps and propose mechanisms that can reduce inequalities associated with alcohol consumption, these include:

- documenting the experiences of countries implementing policies to reduce harm from other unhealthy commodities and considering how similar initiatives could be used with the alcohol industry;
- documenting and evaluating policies aimed at reducing alcohol-related inequalities, especially in low- and middle-income countries;
- developing innovative research methods that can be used in low- and middle-income countries to understand how alcohol affects socioeconomic inequalities and the effectiveness of alcohol control policies;
- supporting capacity building and knowledge translation activities with policy- and decision-makers to enable evidence-informed approaches that reduce alcohol-related inequalities;
- advocating for protecting consumer's right to informed decisions and for addressing inequalities;
- eliciting conflict of interests related to research; and
- undertaking qualitative research aimed at documenting alcohol-related health inequalities in severely affected communities.

Takeaway messages

1. Alcohol consumption may exacerbate disparities as countries progress in their economic development.
2. The availability and affordability of alcohol in lower resourced settings reinforce and exacerbate inequalities.
3. Society responses to men and women's drinking reflect broader gender norms. Women are judged more harshly on their behaviour and appearance while men's behaviour is more likely to be excused.
4. People from lower socioeconomic groups drink more heavily on drinking occasions, engage in other health risk behaviours, have lower access to health services.
5. Drinking patterns and health behaviours explain some, but not all, of the outcomes experienced by those with fewer resources.
6. There remains a gap in knowledge and practice of what works in settings with fewer resources and how alcohol policies affect men and women.
7. Alcohol control policies effectively reduce socioeconomic inequalities and should be combined with upstream interventions to address the root causes of inequalities.

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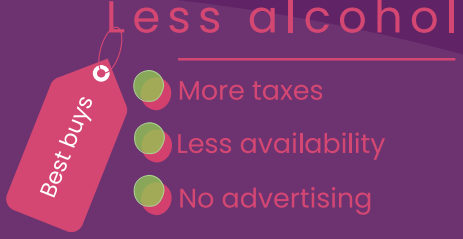

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