

Alcohol policy as a public health issue. Reconsidering an old concept and its relevance for mental health

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INTRODUCTION

Alcohol problems have been experienced by individuals and peoples since those pre-historic times when a man invented alcoholic beverages. Nevertheless, throughout millennia and centuries drinking used to be a part of human history bringing not only harm but also numerous benefits to drinkers and their communities. In a long social history of alcohol, its position in cultures, perceptions of associated problems as well as public responses changed considerably and ranged from strictly prohibitive to fully permissive ones (for review see Barrows *et al.*, 1987). Also drinking patterns and consumption levels greatly varied constituting long waves of alcohol consumption (Room, 1991). Those waves, however, not always corresponded with fluctuations in public response or public policy on alcohol (Moskalewicz, 1999, Moskalewicz & Simpura, 2000).

Last fifty years witnessed a high tide of alcohol consumption in majority of industrialised countries that cumulated around the late 1970s and has been followed by levelling-off or declining trends in 1980s. The transition period, instead of further homogenisation, produced divergent patterns: further decline Western Europe and rapid growth in its Eastern parts.

Those significant changes in alcohol consumption were accompanied by changing prevalence of problems associated with drinking. Public policy on alcohol also underwent substantial variations adopting different concepts and interpretations of a nature and source of alcohol problems. In the following sections of this paper an attempt will be made to trace pre-dominant

conceptions of alcohol problems that prevailed in industrialised countries and their impact on policy and eventually on amount of alcohol-related problems in the post-war Europe.

ERA OF DISEASE CONCEPT OF ALCOHOLISM

Repeal of American prohibition reflected weakening political influence of old, puritan middle classes and implied also shrinking public support for any restrictions with regard to alcohol availability (Gusfield, 1963). In a climate of post-prohibitionist disillusionment with moral crusade against alcohol, a disease concept of alcoholism formulated by Jellinek in the late 1940s (Jellinek, 1960) offered apparently new, rational solution to an old problem. According to the disease concept a source of all evils and problems could be reduced to alcoholism or otherwise to yet-unidentified factor that makes some people particularly vulnerable to alcohol. Cultural message of the disease concept led to dramatic re-definition of alcohol problems. Blame for their endurance was shifted from alcohol to an individual, moral sin was replaced by physical defect, social problem was reduced to medical complication. In result, social response had to be substantially re-formulated. Medical treatment was to replace control of alcohol supply and prosecution of an individual drunkard.

Appearance of the disease concept, its scientific legitimisation and international recognition by the World Health Organization had long lasting effects that surpassed by far its original medical field. Since medicine claimed responsibility for the problem, a status of alcohol evolved: from special product that required particular attention to a normal commodity whose production and distribution had to be regulated by market forces rather than any other considerations. In majority of industrialised countries alcohol supply had not been restricted and its availability remarkably

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increased. During three post-war decades alcohol production and consumption tended to follow or even surpass rate of growth of economy and of production of other goods. Rapid growth of alcohol consumption, however, may not be attributed to economic factors only. Its consumption has been subordinated to a more general process of cultural homogenisation including patterns of consumption of different goods and services. Huge variation in amount of drinking and beverage preferences that distinguished different European countries just after the World War Two tended to vanish. Countries having relatively low initial consumption increased their levels of drinking much faster than other cultures more saturated with alcohol. (table I). Traditional wine cultures increased their consumption of beer and spirits, often at the expense of wine drinking. Societies where white spirits were considered beverage of choice increased their beer and wine consumption while beer cultures adopted manners of wine drinking. In result, drinking levels have come closer to each other and beverage preferences diversified within countries (Sulkunen, 1976).

All in all, in majority of industrialised countries alcohol consumption increased two-three times within less than 30 years, with exception of a few Mediterranean countries that had already had per capita consumption exceeding dozen litres of pure ethanol. Political barriers occurred to be too weak to prevent diffusion of drinking patterns and the cultural homogenisation covered countries on both sides of the Iron Curtain (Hannibal *et al.*, 1995). Long high tide of

alcohol had been associated by another long wave of problems associated with drinking, which were expected to be absorbed by medicine.

That is why the three post-war decades saw yet another increasing wave, wave of alcoholism treatment that expanded every year to catch up with the growing numbers of clients. In the US, overall expenditures on alcohol treatment increased twenty fold between 1950 and 1975 (Wiener, 1981) without much evidence of treatment efficiency (Armor *et al.*, 1975) and with growing numbers of alcoholics. In Poland, specialised system of treatment was established in the mid-1950s. New legislation of that time decriminalised public drunkenness and introduced compulsory treatment for those who due to alcoholism breakdown family ties, demoralise minors or violate public peace and order. Rationale for involuntary admissions was that ill individuals who suffer from alcoholism should rather be treated than prosecuted (Wald & Moskalewicz, 1987). In less than 20 years the number of residential admissions in Poland increased four times from less than 5 thousand in 1960 to more than 20 thousands in 1979 while the number of out-patient clients approached 100 thousands (Morawski, 1983). In Russia, specialised narcological services were established in the early 1970s and soon increased their capacity from 80 thousands in 1965 to close to half a million in an eve of Gorbatschov's anti-alcohol crusade. In Holland, where real consumption growth was initiated not earlier than in the 1960s, number of residential admissions due to alcoholism quadrupled in 10 years only between 1969 and 1979 (de Lint, 1981).

Table I. - Three decades of increasing alcohol consumption 1950-1980.

Countries	1950 Consumption in litres of 100% alcohol	1980 Consumption in litres of 100% alcohol	1951-1980 Annual rate of growth in percent
German Democratic Republic	1.2	10.1	7.2
Netherlands	2.1	8.8	4.8
Federal Republic of Germany	3.1	11.4	4.8
Finland	2.1	6.4	3.8
Poland	3.0	8.4	3.5
Denmark	3.4	9.1	3.4
Hungary	4.9	11.8	2.9
Austria	4.9	11.0	2.7
Czechoslovakia	4.9	9.6	2.3
New Zealand	5.7	9.6	1.8
Australia	5.9	9.6	1.7
United States	5.2	8.2	1.7
Switzerland	6.8	10.8	1.5
Italy	9.2	13.0	1.2
France	17.2	14.9	-0.5

Sources: Litmanowicz M., Moskalewicz J. (1986). Wielkosc i struktura spozycia alkoholu w róznych krajach. In *Alkohol oraz zwiazane z nim problemy spoleczne i zdrowotne* (ed. I.Wald). PWN: Warszawa, p.68.

By the mid-1970s it became obvious that medical approach is not sufficient to respond satisfactory to growing wave of alcohol-related problems. Further strengthening of alcoholism treatment would have required multiplication of funds, which appeared to be less accessible due to symptoms of crisis of the welfare state including weakening economic growth and less public support for welfare ideologies.

PUBLIC HEALTH ERA IN ALCOHOL POLICY

Failure of alcohol treatment to absorb and solve increasing wave of problems related to drinking as much as shrinking resources reduced legitimacy of disease concept of alcoholism and paved way to new interpretations of its sources and to new recommendations. A hallmark to those new ideas was given by the publication of so called *Purple Book* that summarised a work done by an international group of researchers headed by the Finnish scientist Kettil Bruun (Bruun *et al.*, 1975). In their review of the post-war trends, a strong relationship was found between per capita alcohol consumption and severe physical complications, first of all mortality due to liver cirrhosis. It was therefore recommended that the mean alcohol consumption should become an important public health issue. Limitation of mean consumption level appeared to be the cost-efficient and non-discriminating approach to reduce amount of alcohol related harm.

The *Purple Book* had a profound impact on public perception of alcohol problems and public policy in that field. In effect, the *World Health Organisation Strategy Health for All* in 2000 included target 17, which postulated significant reduction in mean alcohol consumption in the Member States before the end of the century as a major measure to reduce harm associated with drinking (World Health Organization, 1993).

Parallel, a number of research initiatives received international support and recognition. A project called *International Study of Alcohol Control Experiences* run in seven jurisdictions brought further evidence of the mutual interplay between consumption of alcohol, control of its availability and prevalence of problems. Publication from that study (Makela *et al.*, 1981) showed that also social problems are strongly related to mean consumption level in addition to health complications. Another WHO-sponsored study worthwhile mentioning here was *Community response study* initiated by Geneva Headquarters in Mexico, Scotland and Zambia (Ritson, 1985) and then continued within European Region by

sixteen other countries (Hannibal *et al.*, 1995; Anderson, 1993). The latter study, which stressed significance of local specificity and community mobilisation in solving alcohol-related problems contributed in a significant way to increased concern and reformulation of alcohol policy in a number of countries, particularly in Mediterranean region.

In the beginning of the 1980s, Parliaments of the Nordic countries and Holland adopted the 25% decline in alcohol consumption as their national targets while Poland included it into its National Health Programme. In the same time, political tensions led to further elevation of concern, in addition to existing health and social considerations.

In Poland, a flag with alcohol question was raised as early as in the beginning of the historical strikes in the Summer time in 1980, which eventually resulted in establishment of "Solidarity". Introduction of alcohol prohibition during those strikes symbolised intentions of non-violent, peaceful solution to that social conflict (Bielewicz & Moskalewicz, 1982). Later on, in its struggle for moral superiority, "Solidarity" blamed the government for pushing alcohol not only in order to maximise its budget revenues but also to manipulate "drunken society". To respond the blame, the government imposed severe restrictions on alcohol supply and its availability, which finally forced introduction of rationing system (Moskalewicz, 1981). Due to those measures, per capita consumption declined from 8.4 litres to 6.4 and then 6.2, which is by more than 25% in two years only. Consequently, rapid decrease was observed in a number of acute psychiatric complications including 40% drop in first admissions due to alcoholic psychosis as well as in variety of social problems, e.g. in public drunkenness, traffic crashes and alike (Morawski, 1983). The latter statistics, however, could be also be affected by other factors like enforcement practices and shortage of fuel.

Even more dramatic interplay between alcohol and political developments took place in the Soviet Union in the mid-1980. From its very beginning a policy of *perestrojka* was associated with alcohol reform. Drastic reduction in alcohol production and supply, disrooting old vineyards, limiting hours of sale and number of alcohol outlets reduced alcohol intake in the Soviet Union from about 14 to 10 litres per capita within one-two years only. In spite of eruption of illegal distilling, positive health effects were paramount. Rapid improvement was noted not only in health problems directly associated with drinking but also in more general health indicators including life expectancy.

Especially visible changes were observed among men, which suggests important alcohol attribution as men in the Soviet Union used to drink five-six times more than female (Partanen, 1993; Simpura & Levin, 1997; Sholnikov & Nemtsov, 1997).

Polish and Soviet natural experiments with alcohol control constitute extreme examples of an overall trend that swept over all industrialised world. In the decade of the 1980s, alcohol consumption decreased by more than 11%, in which by 27.5% in Eastern Europe, 8.5% in North America and 7.7% in Western Europe. In Latin America and in “rest of the world” consumption increased by 8.4% and 16.5% respectively (figure 1).

FREE MARKET REPLACING PUBLIC POLICY IN EASTERN EUROPEAN TRANSITIONS

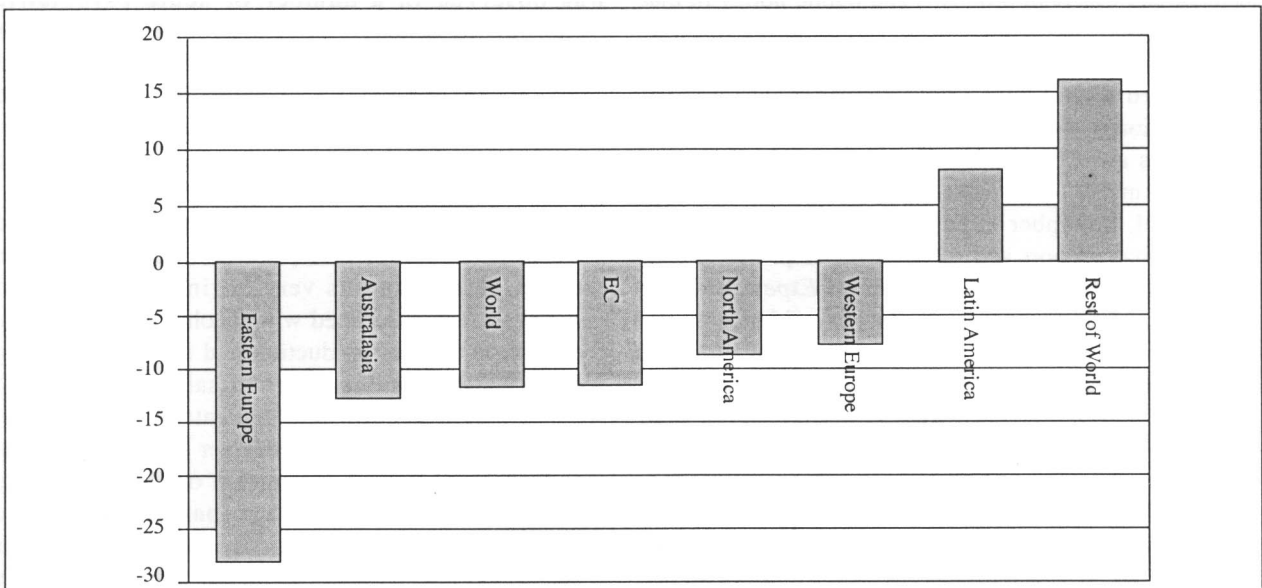
The 1990s witnessed further stabilisation or decline in Western Europe and rapid growth in Eastern Europe. According to the estimations provided for European Office of the World Health Organisation, consumption of alcohol declined or levelled off in 12 out of 17 from its Member States from Western Europe while increased in majority of countries from Eastern Europe (Harkin *et al.*, 1995). Illegal or other unrecorded channels constituted major source of that growth. Privatisation of alcohol distribution and trade and then of production in many countries resulted in domination of market

interests in alcohol policy (Lehto & Moskalewicz, 1994). Number of outlets multiplied as much as wholesale system. Existing restrictions with regard to alcohol availability were lifted and alcoholic beverages could be sold virtually every corner and every hour of the day and night. Neither fiscal apparatus nor statistical systems were able to control this expanded network having only experience with monopolistic markets (Moskalewicz & Swiatkiewicz, 2000).

Alcohol has become an ordinary commodity that does not require any special regulations. Former efforts at reducing access to alcohol were presented as remnants of ancient regime. Responsibility for problems related to drinking was reduced to individual level again. Social solidarity disappeared and apparently nobody would agree to devote his or her individual freedom of unrestricted access to a drink in order to prevent alcohol problems among others. Public health interests lost their impact on alcohol policy and health care system was expected to offer treatment rather than to be involved in policy-making. If any preventive policy is applied, its focus is on under-aged young people and alcoholics (Moskalewicz & Simpura, 2000a). Majority of drinkers may enjoy a drink without any restrictions.

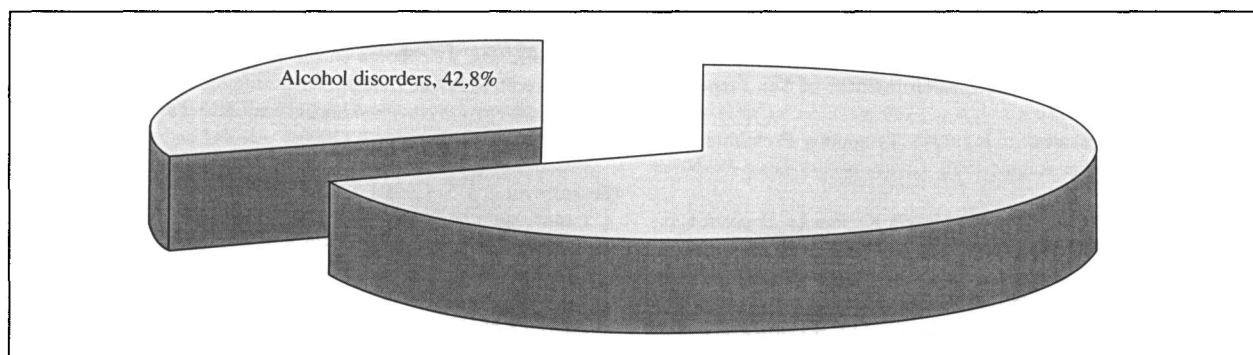
This *laisse-faire* approach in alcohol policy as much as neglecting public health interests in social and economic policy in general, has had a far-reaching health consequences. Especially Russia, Ukraine, Lithuania, Latvia and Estonia suffered dramatic

Figura 1. - Change in recorded alcohol consumption by world region (% change 1980-1989).



Source: World drink trends, 1991 edition, NTC publications limited.

Figura 2. - Share of male patients with alcohol disorders among all in-patients in mental health services in Poland, 1998.



mortality crisis, which killed 1.5 million people more than expected in 1990-1996 period. Unlike any other health crisis, this particular crisis affected mostly middle-aged men who are also the biggest consumers of alcohol (Cornia & Panicia, 2000). It is estimated that between 30 and 50 percent of that increase in number of death can be attributed to alcohol. Very illustrative indeed is mortality due to causes directly attributable to alcohol, which cover alcohol dependence, alcohol psychosis and alcohol poisoning. In 1989-1995 period, in Russia and Lithuania respective standardised death rates increased approximately four-fold from about 20 to almost 80 per 100 000 men. In Poland, where mortality crisis was less pronounced and lasted shorter an increase was two fold only from about 10 to 20 per 100 000 men in the period 1989-1992 (Moskalewicz *et al.*, 2000). Other data source confirm trends in the above countries and in addition shows similar growth of death rates due to alcohol dependence in Hungary and Romania and a bit lower but significant in Bulgaria and Slovenia (World Health Organization, 1999a). Indicative for combined effect of drinking and transitional stress are also suicidal deaths, which doubled on averaged in Estonia, Latvia, Lithuania and Russia to approximately 90 deaths per 100 000 men (Moskalewicz *et al.*, 2000). Relatively high suicide rates are also observed in Hungary (World Health Organization, 1999b).

Despite high mortality levels, which should have reduced a number of alcoholics searching care in alcohol treatment, clients with alcohol-related disorders still constitute a heavy burden for mental health services that include often alcoholism services e.g. in Poland „alcohol” male patients represent almost 43% of all men admitted to residential psychiatric facilities and 27% of those in out-patient sector (figure 2).

CONCLUSIONS

As it has been argued in the previous sections, prevailing conceptions of alcoholism and alcohol-related problems may change over time in response to more general social, cultural and economic shifts. Apparently scientific definitions based on available evidence attract public attention if fit well into dominant ideological climate and do not contradict powerful political and economic interests.

Existing evidence cumulated over last 30 years suggests that aggregate or mean alcohol consumption affects population health including mental health. Mental health services have no capacity and resources any longer to absorb health problems related to alcohol consumption, especially during current transitions in Eastern Europe and economic rationalisation of mental health services throughout the world.

Moreover, experiences of a number of countries show that public health policy aiming at reduction alcohol consumption is possible and feasible and probably constitutes the most cost-efficient way to reduce large segments of mental health problems of the population. Renewal of population-based strategies aimed at all drinkers as well as popularisation of individual advise to persons that ask for assistance due to alcohol-problems, especially in basic public services including primary health care, social welfare agencies and law enforcement should be recommended unless psychiatric services are totally overburdened with alcohol-related interventions.

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