



# Alcohol and inequities

Guidance for addressing inequities  
in alcohol-related harm







# Alcohol and inequities

Guidance for addressing inequities  
in alcohol-related harm

Written by: Belinda Loring

## Abstract

This policy guidance aims to support European policy-makers to improve the design and implementation of policies to reduce inequities in alcohol-related harm. The WHO European Region has the highest level of alcohol consumption and alcohol-related harm in the world. Within European countries, the burden of alcohol-related harm falls more heavily upon certain groups. Reducing health inequities is a key strategic objective of Health 2020 – the European policy framework for health and well-being endorsed by the 53 Member States of the WHO European Region in 2012. This guide seeks to assist European policy-makers in contributing to achieving the objectives of Health 2020 in a practical way. It draws on key evidence, including from the WHO Regional Office for Europe's *Review of social determinants and the health divide in the WHO European Region*. It sets out practical options to reduce the level and unequal distribution of alcohol-related harm in Europe, through approaches that address the social determinants of alcohol misuse and the related health, social and economic consequences.

## Keywords

ALCOHOL ABUSE

ALCOHOL-INDUCED DISORDERS

HEALTH POLICY

SOCIAL DETERMINANTS OF HEALTH

SOCIOECONOMIC FACTORS

Address requests about publications of the WHO Regional Office for Europe to:

Publications

WHO Regional Office for Europe

UN City, Marmorvej 51

DK-2100 Copenhagen Ø, Denmark

Alternatively, complete an online request form for documentation, health information, or for permission to quote or translate, on the Regional Office website (<http://www.euro.who.int/pubrequest>).

**ISBN 978 92 890 5046 3**

© **World Health Organization 2014**

All rights reserved. The Regional Office for Europe of the World Health Organization welcomes requests for permission to reproduce or translate its publications, in part or in full.

The designations employed and the presentation of the material in this publication do not imply the expression of any opinion whatsoever on the part of the World Health Organization concerning the legal status of any country, territory, city or area or of its authorities, or concerning the delimitation of its frontiers or boundaries. Dotted lines on maps represent approximate border lines for which there may not yet be full agreement.

The mention of specific companies or of certain manufacturers' products does not imply that they are endorsed or recommended by the World Health Organization in preference to others of a similar nature that are not mentioned. Errors and omissions excepted, the names of proprietary products are distinguished by initial capital letters.

All reasonable precautions have been taken by the World Health Organization to verify the information contained in this publication. However, the published material is being distributed without warranty of any kind, either express or implied. The responsibility for the interpretation and use of the material lies with the reader. In no event shall the World Health Organization be liable for damages arising from its use. The views expressed by authors, editors, or expert groups do not necessarily represent the decisions or the stated policy of the World Health Organization.

Edited by Nicole Satterley

Book design by Marta Pasqualato

Printed by AREAGRAPHICA SNC DI TREVISAN GIANCARLO & FIGLI

Cover: © iStockphoto

# Contents

<b>Acknowledgements and contributions</b>	<b>iv</b>
<b>Foreword</b>	<b>v</b>
<b>Introduction</b>	<b>1</b>
Purpose of this guidance	1
Using this guide	1
Relevance to other key goals	2
<b>Inequities in alcohol-related harm in Europe</b>	<b>3</b>
<b>What can be done?</b>	<b>7</b>
Step-wise approach	7
“First do no harm”	8
Policy interventions at different levels	9
Socioeconomic context and position	12
Differential exposures	13
Differential vulnerabilities	15
Differential health outcomes	16
Differential consequences	18
<b>Where to find out more</b>	<b>21</b>
Alcohol consumption in Europe	21
Alcohol policy options	21
Actions to reduce health inequities through action on SDH	21
Policy equity assessment tools	22
Data disaggregation and tools	22
<b>References</b>	<b>23</b>

## Acknowledgements and contributions

This document was written by Belinda Loring, WHO European Office for Investment for Health and Development, Venice, Italy.

The following people provided helpful comments and expert technical review:

- Mark Bellis, WHO Collaborating Centre for Violence Prevention, Liverpool John Moores University, Liverpool, United Kingdom
- Lesley Graham, NHS National Services Scotland, Edinburgh, Scotland
- Margaret Whitehead, WHO Collaborating Centre for Policy Research on Social Determinants of Health, University of Liverpool, Liverpool, United Kingdom
- Sue Povall, WHO Collaborating Centre for Policy Research on Social Determinants of Health, University of Liverpool, Liverpool, United Kingdom
- Chris Brookes, UK Health Forum, London, United Kingdom
- Charles Price, European Commission Directorate-General for Health & Consumers, Brussels, Belgium
- Nabil Safrany, European Commission Executive Agency for Health and Consumers, Luxembourg
- Chris Brown, Lars Møller, Åsa Nihlén, Francesco Zambon, Erio Ziglio and Sara Barragán Montes, WHO Regional Office for Europe.

Further comments were also provided by the European Commission Directorate-General for Health & Consumers, the Executive Agency for Health and Consumers and the European Union Expert Group on Health Inequalities.

This document has been produced with the financial assistance of the European Union. The views expressed herein can in no way be taken to reflect the official opinion of the European Union.

The WHO European Office for Investment for Health and Development of the WHO Regional Office for Europe also wishes to thank the Italian Ministry of Health, the Veneto Region and the Tuscany Region for their long-standing support to the work of the office as well as the financial support for this publication.

## Foreword

Overall population health indicators have improved across Europe over recent decades, yet that improvement has not been experienced equally everywhere, or by all. There are widespread inequities in health between and within societies, reflecting the different conditions in which people live. These health inequities offend against the human right to health and are unnecessary and unjust.

Health 2020 is a new value- and evidence-based health policy framework for Europe, supporting action across government and society to promote health and well-being, the reduction of health inequities and the pursuit of people-centred health systems. It was adopted at the 62nd session of the Regional Committee held in Malta in September 2012. Its commitment is to health and well-being as a vital human right, essential to human, social and economic development and a sustainable and equitable Europe. Health is a fundamental resource for the lives of people, families and communities.

To make this vision a reality we need to tackle the root causes of health inequities within and between countries. We know more about these now from the 2013 report of the European review of social determinants of health and the health divide, led by Professor Sir Michael Marmot and his team at the University College London Institute of Health Equity. Yet opportunities to be healthy are far from being equally distributed in our countries, and are closely linked to good upbringing and education, decent work, housing and income support throughout our life course. Today's disease burden is rooted in how we address these social factors that shape current patterns of ill health and lifestyles, and in the way our resources are distributed and utilized.

For these reasons I welcome the publication of this series of policy briefs, which describe practical actions to address health inequities, especially in relation to priority public health challenges facing Europe: tobacco, alcohol, obesity and injury. I hope this series will offer policy-makers and public health professionals the tools and guidance they need to implement the Health 2020 vision and the recommendations of the social determinants review. The policy briefs were prepared in collaboration with the European Union and I would like to express my gratitude for this support and for the recognition that the European Union and WHO both share this common commitment to addressing equity.

Achieving the promise of Health 2020 will depend on successful implementation of the relevant policies within countries. We can and must seize new opportunities to enhance the health and well-being of all. We have an opportunity to promote effective practices and policy innovations among those working to improve health outcomes. The present (often extreme) health inequities across our Region must be tackled and the health gap among and within our European Member States reduced.

**Zsuzsanna Jakab** WHO Regional Director for Europe





# Introduction

## Purpose of this guidance

This policy guidance aims to support European policy-makers to improve the design and implementation of policies to reduce inequities in alcohol-related harm.

The WHO European Region has the highest level of alcohol consumption and alcohol-related harm in the world. The serious consequences of harmful alcohol consumption are a major policy concern across Europe. Harmful use of alcohol accounts for nearly 6.5% of all deaths in Europe, but the burden is much higher in certain countries and for certain groups within countries. When developing alcohol control policies at European, national and local levels, it is essential to consider the equity implications with the best available evidence. This is important to ensure that policy choices (i) do not make inequities worse, and (ii) reduce inequities in harm.

Addressing the social determinants of health (SDH) and health inequities are essential requirements for successfully combating alcohol-related harm. This guide draws on key evidence, including from the WHO Regional Office for Europe's *Review of social determinants and the health divide in the WHO European Region (1)*. It sets out practical options to reduce the level and unequal distribution of alcohol-related harm in Europe, through approaches which address the social determinants of alcohol misuse and the related health, social and economic consequences.

## Using this guide

The pattern of alcohol-related inequities varies significantly between countries in Europe. It is therefore not possible or desirable to make specific policy recommendations that will work in every country in Europe. This guide provides a framework that policy-makers at national, regional and local levels can apply to their own unique context, in order to consider the processes by which inequities might occur, and to suggest policy interventions that may be helpful in addressing each of these factors. Additional resources are listed at the end of the guide to direct policy-makers to further evidence, promising practices and tools to support policy formulation and evaluation.

Not all European countries have data on alcohol consumption that can be disaggregated by socioeconomic factors beyond age and sex. There are very few published studies of interventions to reduce alcohol-related harm which focus on equity or the distribution of impacts within the population. Efforts to improve data collection and its disaggregation will enhance capacity to monitor the differential impacts of policies and interventions on social groups, and increase knowledge about how best to reduce inequities in alcohol-related harm.

### Relevance to other key goals

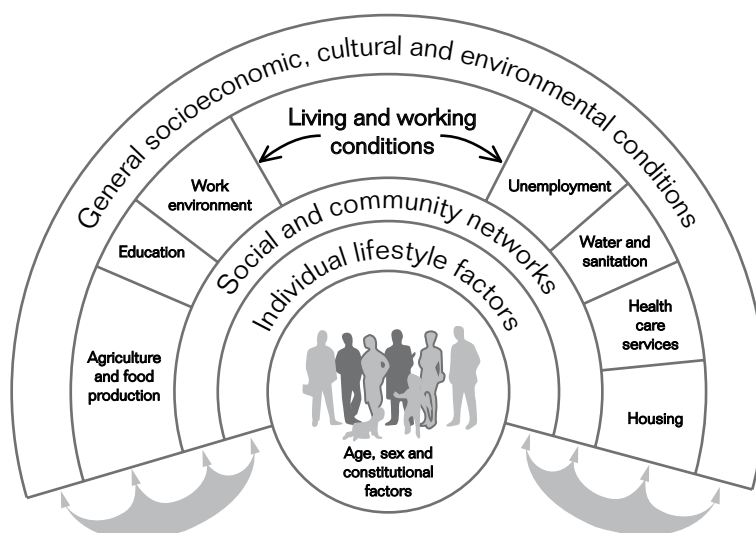
Reducing health inequities is a key strategic objective of Health 2020 – the European policy framework for health and well-being endorsed by the 53 Member States of the WHO European Region in 2012. Tackling the major challenge posed by noncommunicable diseases, such as alcohol-related harm, is one of Health 2020's policy priorities. To achieve these objectives, Health 2020 strongly emphasizes the need to strengthen population-based prevention, and accelerate action on the SDH across government. This guide seeks to assist European policy-makers in contributing towards achieving the objectives of Health 2020 in a practical way.

*The European action plan to reduce harmful use of alcohol 2012–2020 (2)* was endorsed by all 53 Member States in 2011. This plan acknowledges that countries that take stronger action on reducing harmful alcohol use will reap considerable gains in terms of population health, economic productivity, equity, and greater social cohesion and inclusion.

## Inequities in alcohol-related harm in Europe

Health inequities are defined as systematic differences in health that can be avoided by appropriate policy intervention and that are therefore deemed to be unfair and unjust. To be able to devise effective action, it is necessary first to understand the causes of these inequities in health. Health inequities are not solely related to access to health care services; there are many other determinants related to living and working conditions, as well as the overall macro-policies prevailing in a country or region (Fig. 1). Inequities in health are caused by the unequal distribution of these determinants of health, including power, income, goods and services, poor and unequal living conditions, and the differences in health-damaging behaviours that these wider determinants produce.

**Fig. 1. The main determinants of health**



Source: Dahlgren & Whitehead (3).

Europe has the highest per capita consumption of any region in the world. On average Europeans consume 12.45 litres (L) of pure alcohol per year (over twice the global average) (4). Alcohol consumption varies hugely between European countries. In the Czech Republic and Romania, average per capita alcohol consumption is over 16 L per year, whereas in Malta it is 8 L. In eastern Europe, alcohol use is the leading risk factor contributing to the overall burden of disease, accounting for almost a quarter of the disease burden (5). In central Asian and central European countries, alcohol use is the second most important risk factor, and across western European countries it is the fourth leading risk factor for the overall disease burden.

Within European countries, the burden of alcohol-related harm falls more heavily upon certain groups. A range of inequities have been observed – including inequities based on socioeconomic status, education level, sex, ethnicity, and place of residence. The relationship between alcohol and socioeconomic status is complex. It does not always

follow the gradient typically observed for many other risk factors, whereby harm increases with decreasing socioeconomic status. In understanding how to reduce inequities, it is necessary to consider differences in (i) the frequency of binge drinking, (ii) the type of alcohol consumed, and (iii) vulnerabilities and exposures to positive and negative factors.

In most European countries, inequities in alcohol-related deaths and health problems are more pronounced than the differences in alcohol consumption across the social gradient (6). In general, lower socioeconomic groups consume less alcohol overall and are more likely to be abstainers, but they experience higher levels of alcohol-related harm than wealthier groups with the same level of consumption. Variations in the pattern of alcohol consumption, especially binge drinking, can have a stronger bearing on alcohol-related harm than overall alcohol consumption. For example, drinkers in low socioeconomic groups are more likely to binge drink (7).

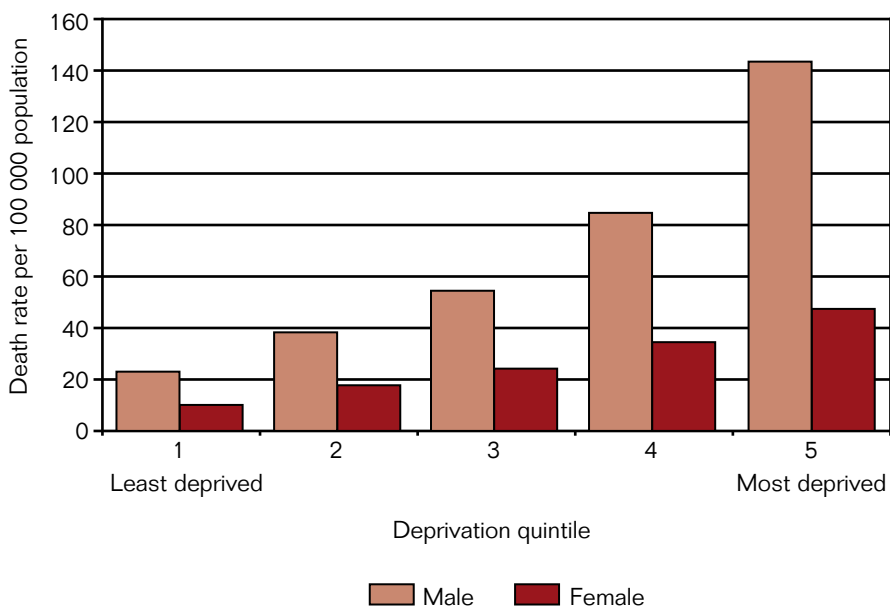
Inequities in alcohol-related harm need to be examined from a national perspective. For example, in the United Kingdom, alcohol-related deaths increase with decreasing socioeconomic status, producing a social gradient. This gradient is steeper for men (8), particularly in Scotland (Fig. 2). In Sweden, manual workers are 2–3 times more likely to experience alcohol-related harm than civil servants, even when alcohol consumption levels were similar (9). In many countries in central and eastern Europe and in the newly independent states, harmful drinking is more common in lower socioeconomic groups (10). In the Russian Federation, the poorest 40% of the population consume spirits more frequently than the rest of the population. However, there is no difference between the top three socioeconomic quintiles, producing a distinct gap in harmful drinking linked to levels of poverty (10). In Austria, France, Germany, the Netherlands and Switzerland, women with higher levels of education are more likely to drink heavily than women with fewer years in formal education, while among men, early school leaving age increases the risk of harmful drinking in Austria, the Czech Republic, Hungary, Israel, Italy, Norway and Switzerland (11). Inequities in other areas of life produce a compound effect in contributing to inequities in alcohol-related harm. For example, in Finland, personal income, educational level, occupational level, household income and housing tenure all independently contribute to higher rates of alcohol-related deaths (12).

Economic and educational factors partly explain inequities in alcohol-related harm. However, other factors also contribute. In France, children of farmers have the highest level of consumption and the highest level of binge drinking, even when compared to young people with unemployed parents, indicating that culture and place of residence are also important (13). In contrast, binge drinking is more common in urban than rural areas in Finland (14).

There are also ethnic differences in patterns and the type of alcohol consumption in Europe. These need to be better understood – especially how ethnic inequities interact with gender and other socioeconomic differences. In Spain, for example, Roma women consume alcohol less frequently than women in the general population, but young Roma men are more likely to drink alcohol than other young men (15). In Slovakia, Roma adolescents reported being drunk less frequently than non-Roma individuals, partly explained by higher levels of parental monitoring among Roma and lower levels of peer

influence (16). Educational inequities (that is, difference in number of years of education) in the context of heavy alcohol consumption are much larger for male migrants in Switzerland than for men born there (17). There are many factors leading to inequity in alcohol-related harm in Europe, and the combined effect of several factors amplifies the differences in risks and consequences.

**Fig. 2. Alcohol-related death rate by Scottish Index of Multiple Deprivation, 2005**



Source: The Scottish Government (18).

**Key messages**

- Social inequities in alcohol-related harm in Europe do not follow a consistent pattern, and vary from country to country.
- Inequities in alcohol-related harm in Europe exist based on factors including economic status, education, gender, ethnicity and place of residence.
- In general, lower socioeconomic groups experience higher levels of alcohol-related harm than wealthier groups with the same level of alcohol consumption.
- Experiencing multiple aspects of socioeconomic disadvantage amplifies inequities in alcohol-related harm.



## What can be done?

There is good evidence for policies to reduce the harmful use of alcohol. Three of the ten best-buys (the most cost-effective and feasible interventions) for noncommunicable disease prevention and control relate to alcohol: (1) raising alcohol prices, (2) restricting access to retailed alcohol, and (3) bans on alcohol advertising (19). The *European action plan to reduce the harmful use of alcohol 2012–2020* outlines 10 action areas (2).

1. Leadership, awareness and commitment
2. Health services' response
3. Community action
4. Policies and counter-measures on drink–driving
5. Availability of alcohol
6. Marketing of alcoholic beverages
7. Pricing policies
8. Reducing the negative consequences of drinking and alcohol intoxication
9. Reducing the public health impact of illicit and informally produced alcohol
10. Monitoring and surveillance

For each of these action areas, it is necessary to consider the equity implications – which groups are most affected, and which groups are most likely to benefit from a proposed effort? How can policies be crafted so that the benefits are shared fairly across the population, especially for those with the greatest need? Addressing inequities is important for reducing overall alcohol-related harm. If most of the harmful drinkers are in socially disadvantaged groups, yet the policy interventions selected are most effective in advantaged groups, then there will be less impact overall in reducing alcohol-related harm.

The following section sets out the key considerations to assist policy-makers to better analyse and respond to the alcohol-related inequities in their specific context. It includes guidance on how to analyse the processes by which inequities might occur, and suggests evidence-informed policy interventions that have the best potential to address each of these factors and reduce inequities.

### Step-wise approach

Countries in Europe have very different experiences and capacities to address health inequities; however, no matter what the starting point, something can be done. An incremental approach can be taken to reducing inequalities wherever one begins (Fig. 3).

**Fig. 3. Incremental approach to reducing inequities**



It is not only the most disadvantaged who suffer a disproportionate burden of alcohol-related harm. A social gradient exists, whereby each lower socioeconomic group suffers more alcohol-related harm than the group above them in the social spectrum. Addressing gaps between groups and the social gradient requires universal policies together with additional measures depending on different levels of need.

### **“First do no harm”**

Some public health interventions inadvertently make inequities worse. There is often a mismatch between intended goals and actual policy results. Unless equity is explicitly taken into consideration, the business-as-usual approach tends to create policies, programmes and services that have a social gradient in their effect. Unfortunately, although this is not the policy-makers’ intent, it means that the most disadvantaged groups receive the least benefit from the policy, even though they have the most to gain, and inequities worsen rather than improving.

This seems to be especially true for broad public education campaigns and individual health promotion interventions, which often have the most impact on people who are better off (20, 21). This does not have to be the case, however. Education and persuasion should not be relied upon as the only strategies to reduce the harmful use of alcohol. Not only are they less effective than other interventions (such as increasing prices and restricting availability), they are strategies which have a high potential to increase inequities. Where these strategies are used, specific efforts are needed to ensure the messages and methods are designed with and for the most disadvantaged groups.

Even highly effective alcohol control strategies have not been evaluated for their effectiveness in different socioeconomic groups. It cannot be assumed that these measures will have the same effects across society. A number of tools are available for



assessing the equity impact of policies and interventions (see the section on where to find out more at the end of this policy brief).

Policy coherence is also crucial. An intervention to reduce inequities in alcohol-related harm may be undermined on a much larger scale by a policy in another area (for example, a trade policy that reduces the price of alcohol), resulting in a net worsening of inequities.

### Key messages

- Well-intentioned public health interventions often make health inequities worse – equity needs to be explicitly considered in the design of all policies and programmes to address alcohol-related harm.
- Education and persuasion alone do not work to reduce alcohol-related harm, and are likely to make inequities worse.
- Policy coherence is important, to ensure efforts to reduce inequities are not undermined by other policies.
- Do not assume that what works on the population average will work for everyone – investigate the effect of interventions on different socioeconomic groups.
- All policies need to be monitored to ensure they work effectively in practice to deliver the intended equity results.

### Policy interventions at different levels

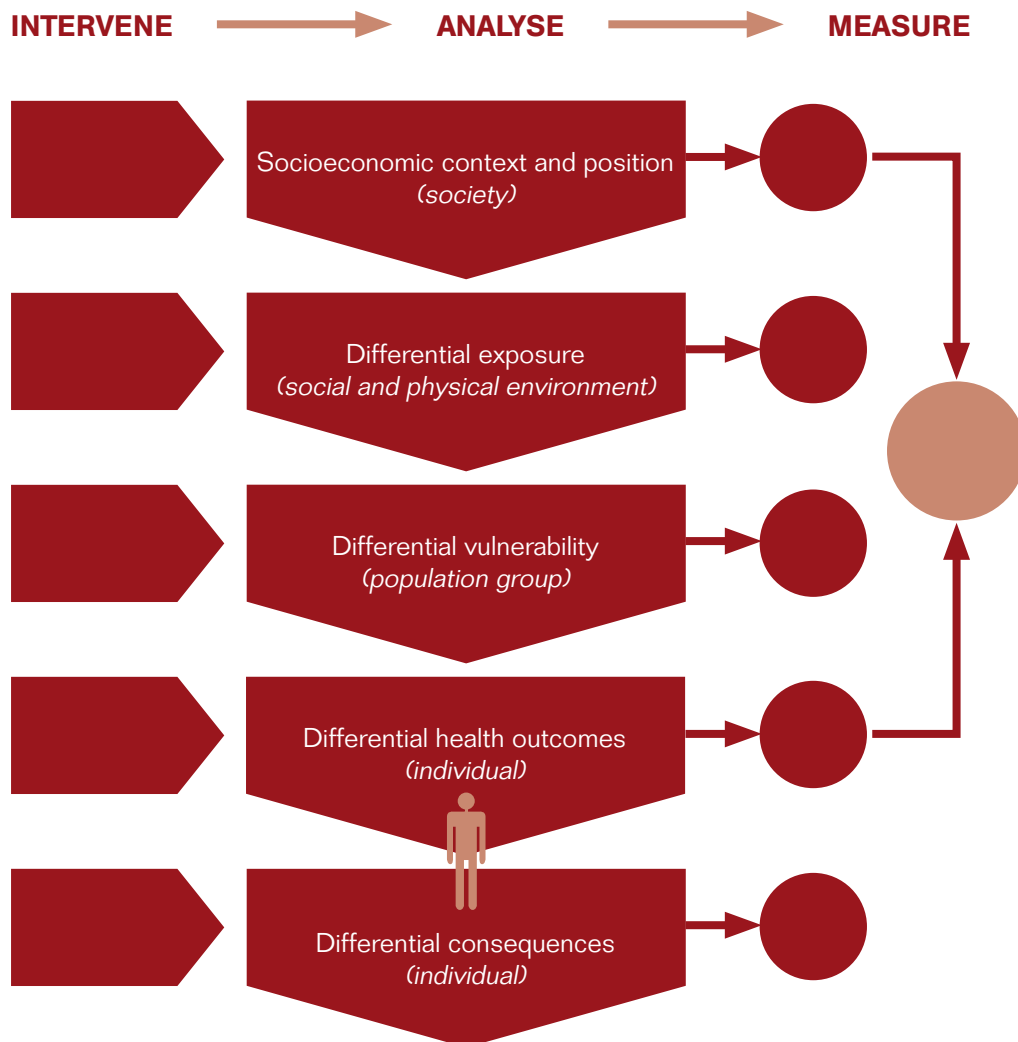
Inequities in alcohol-related harm can arise from factors at many levels. This includes factors in the broader socioeconomic context, different exposures, different vulnerabilities, different experience within the health system, and different consequences from alcohol use. For the most disadvantaged in society, inequities exist at all of these levels, leading to compounding disadvantage (Fig. 4).

For example, poor, socially excluded groups are more likely to have increased exposure to life stressors; have fewer buffering and coping resources; live in neighbourhoods with a higher density of alcohol sales outlets; have reduced access to affordable and appropriate support; experience greater adverse consequences for their household budget from alcohol consumption; live with or near people who also drink excessively; and are more likely to suffer co-morbidities such as mental health problems and other substance abuse disorders (Fig. 5).

Thinking about the ways in which inequities in alcohol-related harm may arise can be a helpful way to identify points at which to intervene.

A comprehensive approach to reducing inequities in alcohol-related harm involves a combination of policies that address inequities in the root social determinants, as well as policies that treat the symptoms or attempt to compensate for inequities in the SDH. This requires a mix of interventions that have short-term actions but a long-term focus, as well as both simple and complex interventions (Fig. 6).

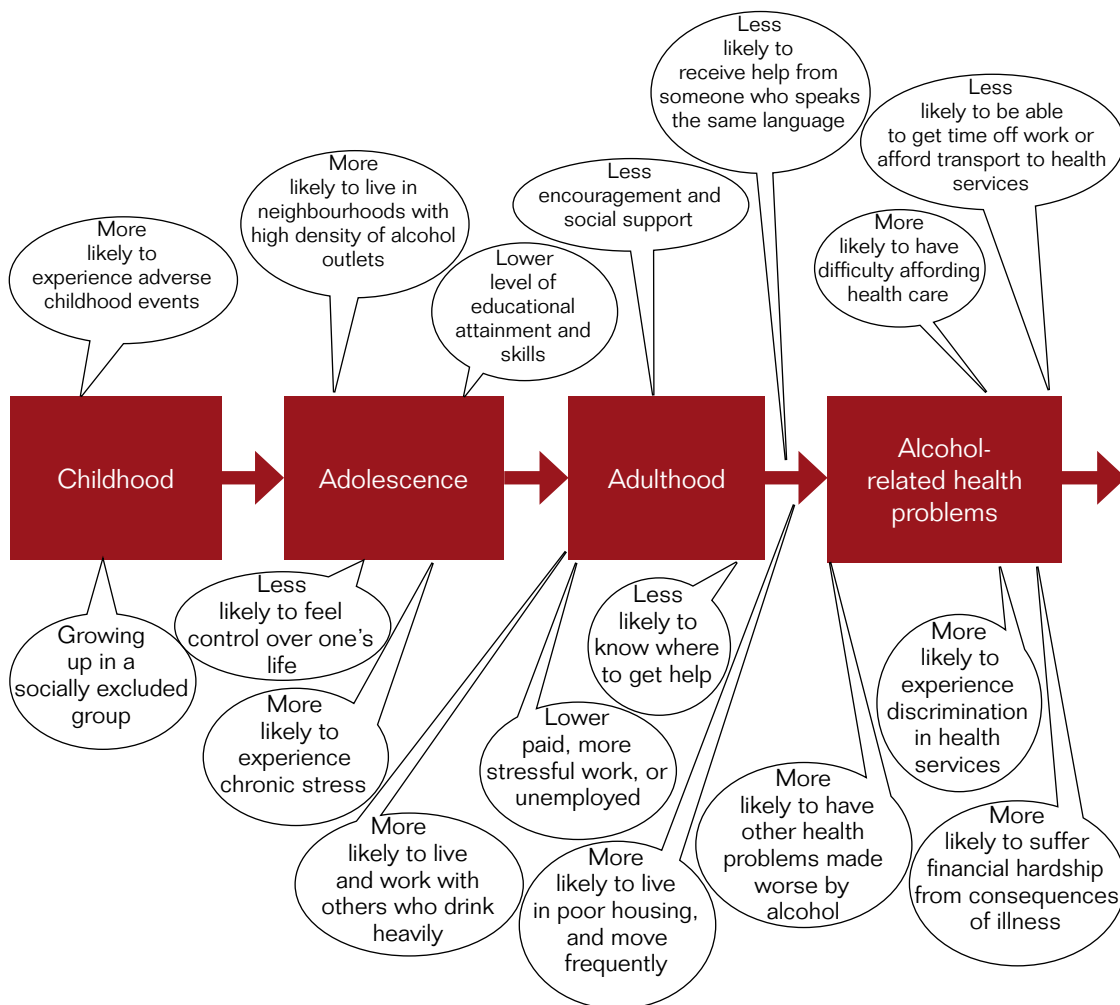
Fig. 4. Levels at which health inequities can arise and be addressed



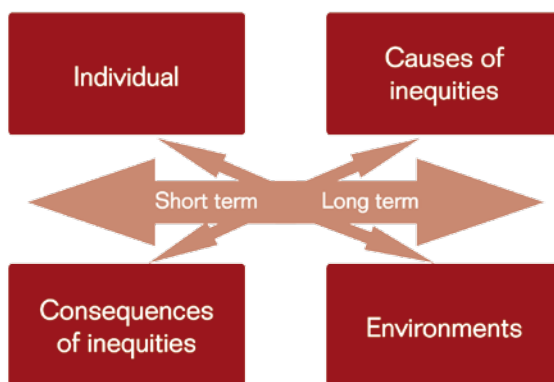
Source: Blas & Kurup (7).

For example, in addition to health service interventions to improve access for low-income groups to brief alcohol interventions, there is a need for policies to change the intermediate environmental factors (such as making alcohol more expensive and less accessible), as well as shifting macro-level policies to a longer-term focus to reduce poverty and promote resilience (including social protection, raising levels of education and skills, and reducing social exclusion). While it can be tempting to prefer interventions which act quickly and are directed to cause and effect, relying solely on these interventions will not solve the underlying causes that give rise to the alcohol-related inequities in the first place.

**Fig. 5. How inequities in alcohol-related harm compound over the life course**



**Fig. 6. Addressing inequities requires a combination of policies**



Many of the interventions to address inequities in alcohol-related harm offer broader benefits for other health and social inequities. For example, active workforce programmes to improve employment may not only reduce alcohol-related harm, but also improve mental health, reduce household poverty, and reduce food insecurity and childhood obesity. Improving access to primary health care not only improves access to brief alcohol interventions, but also to drinking cessation support, screening and treatment for other physical and mental health issues, as well as assisting with links to other social services.

### **Socioeconomic context and position**

Factors in the global, European or national socioeconomic contexts can influence how the SDH are distributed. This includes factors in the socioeconomic context which influence how risk is produced, distributed and played out in European societies. These factors can influence which groups are most at risk of alcohol-related harm, and they may be modifiable or able to be compensated for (Table 1).

The most promising set of interventions so far to reduce inequities in alcohol-related harm is raising the price (22, 23). People in lower socioeconomic groups with harmful levels of drinking are likely to benefit more from measures to increase the price of retailed alcohol. Poorer people, young people and the heaviest drinkers are most likely to reduce their consumption with increases in price (24). Thus, the health benefit will be greatest in poorer groups, yet the economic burden will be greater in wealthier groups, who are more likely to continue drinking when the price is raised.

**Table 1. Factors in the socioeconomic context that shape inequities and interventions to consider**

Sources/drivers for inequities	Interventions to consider
Levels and distribution of poverty	<ul style="list-style-type: none"> <li>• Social protection – increased spending on social welfare policies can mitigate the impacts of economic recession and unemployment on increased alcohol-related harm.</li> <li>• Early childhood investment – ensure every child gets the best start (high-quality early childhood education, parenting support, generous social protection).</li> </ul>
Availability and affordability of alcohol	<ul style="list-style-type: none"> <li>• Introduce pricing policies to raise price of alcohol, for example setting a minimum price per unit of alcohol (23) (Box 1).</li> <li>• Restrict new licences in areas of high licence density.</li> </ul>
Effects of economic crisis and unemployment	<ul style="list-style-type: none"> <li>• Set up active workforce programmes and promotion of lifelong opportunities for education and skills training.</li> </ul>

**Table 1. contd**

Sources/drivers for inequities	Interventions to consider
<p>Drinking culture and gender norms</p> <p><i>E.g. compared to women, men in Europe are likely to abstain, but they drink more frequently and in larger quantities and they experience more alcohol-related harm</i></p>	<ul style="list-style-type: none"> <li>• Introduce measures to change harmful drinking cultures among certain groups (e.g. men, young people).</li> <li>• Build on strengths (e.g. evidence from Roma populations suggests that higher levels of parental monitoring in a minority population living in high-poverty neighbourhoods can lead to less substance use).</li> </ul>
<p>Social exclusion/marginalization</p>	<ul style="list-style-type: none"> <li>• Implement community empowerment and skill development programmes to address broader issues of hopelessness and exclusion affecting groups with higher prevalence of harmful alcohol use.</li> <li>• Involve people from excluded groups in development and implementation of policies that allow them to fulfil their rights (e.g. to education, health, housing).</li> </ul>

**Box 1. Scotland: minimum unit price**

In 2012 Scotland passed legislation to set a minimum price below which a unit of alcohol cannot be sold. This was in response to high alcohol consumption and rising levels of alcohol-related harm, especially in the most deprived social groups. Increasing affordability of alcohol over time – especially in off-licence trade – was considered an important factor. Statistical modelling demonstrated that hazardous and harmful drinkers would be most affected by the minimum price policy, with those drinking within healthy levels being minimally impacted. The distribution of alcohol consumption across social groups was examined in the Scottish Health Survey from 2010 (25), which found that those in the highest income groups are more likely to exceed guideline limits. Therefore, the economic impact of the policy would be borne more by groups with higher socioeconomic status and, importantly, by those drinking at harmful levels (26). There is still debate about whether families of low-income harmful drinkers might be disadvantaged if consumption is maintained despite higher prices, emphasizing the need for pricing policies to be supported by adequate social protection and alcohol support services.

**Differential exposures**

Certain groups may have increased exposure to factors that mean they are more likely to consume excess alcohol or experience alcohol-related harm. This includes both push and pull factors for excessive alcohol consumption, such as exposure to discrimination and chronic stress, and increased exposure to alcohol promotion (Table 2). Adverse childhood experiences contribute a range of poorer health and social outcomes over the life course, and this effect is transmitted to future generations – those who

experience adverse events in childhood are more likely to expose their own children to similar adverse events (27). A recent European review of alcohol-related harm stated that “alcohol may be one of the major conduits through which psychosocial stress is translated into poorer health and higher mortality” (10). People in lower socioeconomic groups engaging in harmful levels of drinking can disproportionately benefit from population-based measures, such as restricting trading hours and alcohol availability.

**Table 2. How differential exposures could occur and interventions to consider**

Sources/drivers for inequities	Interventions to consider
<p>Differential exposure to chronic life stressors</p> <p><i>E.g. people living in poverty, socially excluded groups, people in insecure and low-income employment, and migrants experience more stress and discrimination</i></p>	<ul style="list-style-type: none"> <li>• Enable social protection and cash transfers, especially for families comprising children and unemployed people.</li> <li>• Introduce parenting support programmes and investment in high-quality early childhood education and childcare.</li> <li>• Improve psychosocial conditions in workplaces, especially for low-income workers.</li> </ul>
<p>Differential exposure to alcohol advertising and availability</p> <p><i>E.g. increased density of alcohol outlets in poor neighbourhoods – higher densities of alcohol outlets are associated with increased alcohol-related harm</i></p>	<ul style="list-style-type: none"> <li>• Ensure that population-based measures to reduce availability of alcohol equitably benefit those groups with excess exposure to alcohol.</li> <li>• Introduce zoning restrictions to reduce disproportionate density of alcohol outlets in low-income or other areas with a high burden of alcohol-related harm, and reduce alcohol outlets near schools and youth venues (Box 2).</li> <li>• Ensure enforcement of age limits for alcohol purchase and enforce drink–driving measures, especially in disadvantaged areas.</li> <li>• Restrict alcohol marketing, advertising and promotion.</li> </ul>
<p>Neighbourhood factors</p> <p><i>E.g. people living in deprived neighbourhoods may be more likely to be living with or near other people who drink heavily</i></p>	<ul style="list-style-type: none"> <li>• Implement measures to reduce household overcrowding.</li> <li>• Introduce local measures, based on success in communities with excess burden of alcohol-related harm. In indigenous Australian communities, for example, a tailored combination of measures to reduce availability of alcohol has proved to be effective at reducing harmful alcohol consumption, crime and alcohol-related hospitalizations (28).</li> </ul>

**Box 2. Poland: local councils taking action to limit exposure to alcohol outlets**

In Poland, local councils are responsible for limiting alcohol availability in terms of the number of outlets and hours of operation. Local authorities have a perverse incentive to issue alcohol licences because the licence fees generate income for the council (29). However, some councils are beginning to use their powers to address the rising level of alcohol-related harm in their communities (30). One local council has adopted a resolution to diminish the number of alcohol outlets. Other councils have designated places (such as schools, churches, sports facilities and bus/train stations) that must not have alcohol outlets within a minimum distance. A large number of councils have also introduced bans on drinking in public places.

**Differential vulnerabilities**

Certain factors make groups more vulnerable than others to excess alcohol consumption or alcohol-related harm, even if their exposures are the same. Exposure to stressful situations can lead to alcohol abuse more commonly for poor people than for the wealthier individuals (15). For example, having a stressful job is bad, but having a low-paid stressful job is worse. Vulnerabilities that contribute to inequities in alcohol-related harm can be social in nature (such as lower levels of resilience or social support) or biological (for example, women and children are vulnerable to increased harm from a given level of alcohol consumption). Co-morbidities (such as obesity) can increase people’s vulnerability to developing health consequences from alcohol use. Individuals in the most deprived social groups are more likely to be in poorer general health, and to experience multiple co-morbidities.

Many of the interventions outlined in Table 1 to address social exclusion, poverty and chronic stress, such as investing in early childhood, improving living conditions, increasing skills and training, and building on community strengths will help to reduce many of these biological and social vulnerabilities. Table 3 suggests interventions to combat the inequities that arise.

**Table 3. How differential vulnerabilities could occur and interventions to consider**

Sources/drivers for inequities	Interventions to consider
<p>Less resilience/support to cope with stressors</p> <p><i>E.g. poor people, socially excluded groups and people who are homeless have fewer coping mechanisms</i></p>	<ul style="list-style-type: none"> <li>Review how vulnerable groups are identified for brief alcohol interventions in the health care system. Ensure that those groups with excess vulnerability to alcohol-related harm are offered interventions (even if they are not in the groups with the highest levels of alcohol consumption).</li> </ul>
<p>Biological vulnerabilities</p> <p><i>E.g. women are at greater risk of harm from the same level of consumption</i></p>	

Table 3. contd

Sources/drivers for inequities	Interventions to consider
<p>Higher rates of co-morbidities can contribute to inequities in alcohol-related harm (obesity, substance abuse, mental health problems, life stressors)</p> <p><i>E.g. obesity and alcohol use in combination cause a much higher risk of liver disease than either risk factor alone (31)</i></p>	<ul style="list-style-type: none"> <li>• Implement policies to address multiple risk factors (especially poor nutrition and smoking) collectively (32) (Box 3).</li> </ul>

**Box 3. Romania: building family assets to reduce vulnerability**

Romania’s family training project to build education skills for alcohol and tobacco abuse prevention (33) was a national initiative aiming to develop protection factors for 1000 parents with low levels of education and family management skills, or with children at risk (adjustment problems, low school participation levels, early or persisting behavioural problems, or coming from families with conflicts or minimal education levels). The project was implemented by 68 school counsellors (education specialists) in education resource and assistance centres in three counties (Bihor, Iași and Ilfov). They implemented interactive activities, with the parents participating in the programme based on a methodological guideline and training manual formulated by specialists of the National Anti-drug Agency and the Ministry of Education, Research, Youth and Sport.

**Differential health outcomes**

In addition to differential exposures and vulnerabilities that put groups at greater risk of alcohol-related harm, various health system factors can also cause certain groups to experience poorer health outcomes from alcohol-related conditions. Inequities exist in access to health care services and treatment for alcohol problems, which can also help to explain why certain groups fare less well, even though their levels of harmful alcohol consumption may be similar to others. Differences have also been observed in Europe in the treatment received within health systems, based on socioeconomic factors, and this can also contribute to inequities in health outcomes. Table 4 shows ways in which differential health outcomes occur and interventions that should be considered to tackle the resulting inequities.

Table 4. How differential health outcomes could occur and interventions to consider

Sources/drivers for inequities	Interventions to consider
<p>Cost of access to care</p>	<ul style="list-style-type: none"> <li>• Provide universal health services.</li> <li>• Remove financial barriers for those who cannot pay (user charges, transport costs).</li> </ul>



**Table 4. contd**

Sources/drivers for inequities	Interventions to consider
<p>Non-financial barriers to accessing care</p> <p><i>E.g. the United Kingdom National Institute for Health and Clinical Excellence (NICE) guideline on alcohol use disorders identifies a number of specific groups that require special consideration because their needs are not well met by mainstream services (e.g. young people, homeless people, ethnic minorities)</i></p>	<ul style="list-style-type: none"> <li>• Simplify eligibility requirements and support provided to those without documentation.</li> <li>• Improve acceptability of services for high-risk groups (staff training, recruitment policies, gender and cultural sensitivity, opening hours, location of services).</li> <li>• Review the continuum of care pathway to ensure better links between health and social services for people at risk of poorer outcomes upon discharge from health care (e.g. homeless people; see for example Box 4).</li> <li>• Provide supported housing to people discharged from care.</li> </ul>
<p>Different treatment within the health care system</p> <p><i>E.g. females with hazardous drinking patterns in Sweden are less likely than male drinkers with similar drinking patterns to be asked about alcohol use by their physician (34)</i></p>	<ul style="list-style-type: none"> <li>• Train health professionals to ask more frequently about alcohol use and provide screening, early identification and brief advice interventions in primary care, including to groups with excess exposure or vulnerability. Review the equity in provision of this advice.</li> <li>• Change attitudes of staff, and create greater awareness of the distribution of alcohol-related harm according to socioeconomic factors.</li> <li>• Accompany this with targeted measures to ensure that groups of the population are reached that would ordinarily be less likely to access primary care (e.g. homeless people, individuals without a general practitioner, and prisoners).</li> </ul>

**Box 4. Latvia: improving access to health and social services in Karosta**

Karosta is a former closed military port area near the city of Liepāja. Many of the residents have limited access to medical and prevention services. In addition, many have been unemployed and homeless for years and do not have the appropriate documents and Latvian language skills to be registered at family doctors' offices or to receive social benefits or unemployment services. Hopelessness and alcohol abuse are common. The NGO Vienība, together with the Karosta Housing enterprise and Liepāja City Council provide coaching and psychological support, subsidized employment, creative workshops, and health and prevention services for homeless inhabitants of the city. They provide social and legal assistance to those who do not have proper documents, and social rehabilitation and health improvement programmes for those that are long-term unemployed and homeless. They directly improve access to primary health care services for the most disadvantaged groups of the population by providing a medical room staffed by general practitioner volunteers (35).

**Differential consequences**

For certain groups, harmful alcohol consumption can have more severe consequences than for other groups, in addition to poorer health outcomes. This is partly because wealthier drinkers have a wider social buffer to protect them from harm as a result of alcohol consumption (9). These consequences can include imprisonment, unsafe sexual behaviour, job loss, household impoverishment, further social exclusion, violence, injury and crime. It is possible that disadvantaged groups do more of their drinking in public places, where they are more likely to be arrested or injured when intoxicated. Table 5 details the drivers for inequities and the interventions to be considered in order to combat them.

**Table 5. How differential consequences could occur and interventions to consider**

Sources/drivers for inequities	Interventions to consider
Homeless and marginalized groups are more likely to be imprisoned for being drunk and disorderly, or to suffer injury/violence	<ul style="list-style-type: none"> <li>• Provide sobering up facilities for homeless people, or people without a safe place to be when intoxicated. Effective harm reduction measures have included community-run patrols, and sobering-up shelters. These approaches have the added benefit of being community-led and building upon community strengths.</li> <li>• Provide wet hostels for homeless people where drinking is permitted, to reduce harm from drinking in public spaces (Box 5).</li> </ul>
Impoverishment for lower income drinkers and families – including “crowding out” of household expenditure on health care, food, education and clothing	<ul style="list-style-type: none"> <li>• Implement adequate social protection policies for children, including universal provision of high-quality early childhood education, free universal education and health care.</li> </ul>
Young adults are more likely to be injured or killed when consuming alcohol than older adults, probably due to differences in risk-taking behaviour	<ul style="list-style-type: none"> <li>• Raise the price of alcohol to induce a disproportionate effect on younger drinkers.</li> </ul>
Stigma <i>E.g. social stigma of alcohol problems can compound existing marginalization of vulnerable groups, leading to further social exclusion</i>	<ul style="list-style-type: none"> <li>• Avoid implementing alcohol control policies that exacerbate stigma and marginalization.</li> </ul>

### **Box 5. Germany: Kiel safe drinking room**

The local government in Kiel established Germany's first drinking room for unemployed alcoholics (36). The centre accommodates approximately 70 regular visitors between the ages of 18 and 70 years, most of whom have long-standing alcohol addiction problems. Clients are allowed to bring their own beer or sangria, and can purchase soft drinks or coffee. The initiative has proven to be such a success that other local authorities in Germany are keen to replicate it. The centre has been seen as a win-win for the visitors and the local community. Visitors to the centre have a warmer and safer place to drink compared to the street and other public spaces, directly reducing their risk of harm, and residents of the city are enjoying cleaner streets and safer public parks.

However, the benefits also extend to a range of upstream SDH. The centre provides a way for services to contact a vulnerable group, and it is managed by a team of social workers offering assistance and guidance to help the centre's visitors take control of their lives. They help with a range of problems, including communicating with landlords and utility companies, and navigating government bureaucracy. They offer advice about addiction counselling and rehabilitation programmes, and regular visitors can also obtain "one-euro" jobs, working at the counter in soup-kitchens or distributing newspapers.

### **Key policy recommendations**

- A comprehensive approach to reducing inequities in alcohol-related harm requires action that includes mix of long- and short-term impacts, addressing the consequences and the root causes of inequities, and acting on both individuals and environments.
- Increasing the price of alcohol is the most promising policy intervention to reduce social inequities in alcohol-related harm.
- Local measures to reduce the availability of alcohol can reduce the excess burden of alcohol-related harm in high-risk communities. This includes restricting times, locations and quantities of alcohol purchases. Zoning and licensing measures can be more fully utilized to ensure that disadvantaged areas are not exposed to a higher density of alcohol outlets.
- Income, employment and education are all factors that protect against alcohol-related harm – social protection policies can protect against the adverse impact of economic shocks and unemployment.
- Differential access to and treatment within the health system contribute to inequities in alcohol-related harm. Actions to address this include:
  - reducing financial, geographical and cultural barriers to accessing primary care and alcohol treatment services for groups experiencing disproportionate alcohol-related harm;
  - ensuring that people from groups vulnerable to alcohol-related harm are identified and offered brief advice interventions in primary care settings;
  - boosting social support and post-discharge care for people engaging in harmful alcohol consumption who are also experiencing other social disadvantages.
- Consequences of harmful alcohol use are more severe for those already experiencing social exclusion. Harm reduction measures, such as safe places to sober up and community patrols can reduce inequitable consequences.

### Checklist: are you on track?

1. Do you routinely measure alcohol consumption and alcohol-related harm by socioeconomic group (e.g. gender, ethnicity, education level)?
2. Have you identified which groups experience most harm (health and/or social) from alcohol, and are they clearly prioritized in your strategies and plans?
3. Do you routinely assess the equity impact of alcohol control policies and plans before they are implemented?
4. Can the most marginalized groups in society meaningfully participate in decision-making processes about alcohol control policies?
5. Do you have robust policies in place with the following specific goals?
  - a. To increase the price of alcohol.
  - b. To reduce availability of alcohol, especially in disadvantaged areas.
  - c. To improve access to primary care, alcohol services, and social support.
  - d. To reduce the harmful consequences of alcohol in vulnerable groups (places to sober up, community patrols, and so on).
6. Do you have effective policies in place to address the root social determinants of inequities in alcohol-related harm? Such measures should include:
  - a. social protection, especially for families with children and the unemployed;
  - b. high-quality early childhood education and parenting support;
  - c. active labour force programmes for unemployed people, including skills development;
  - d. policies to reduce social exclusion;
  - e. policies to reduce household overcrowding;
  - f. improving psychosocial working conditions for low-income workers.
7. Do you evaluate the impact of all alcohol control interventions on different social groups?
8. Have you set targets for reducing alcohol-related harm in different social groups?
9. Is there clear accountability and leadership for reducing inequities in alcohol-related harm?

## Where to find out more

### Alcohol consumption in Europe

- **European Information System on Alcohol and Health (EISAH).** European-specific data from the WHO Global Information System on Alcohol and Health (37).
- **Status report on alcohol and health in 35 European countries 2013** (38).
- **European status report on alcohol and health 2010** (39).
- **Alcohol in the European Union: consumption, harm and policy approaches** (4).

### Alcohol policy options

- **European action plan to reduce the harmful use of alcohol 2012–2020** (2).
- **Global strategy to reduce the harmful use of alcohol** (40).
- **Alcohol problems in the criminal justice system: an opportunity for intervention** (41).
- **Action plan for implementation of the European Strategy for the Prevention and Control of Noncommunicable Diseases 2012–2016** (42).

### Actions to reduce health inequities through action on SDH

- **Equity, social determinants and public health programmes** (7).
- **Review of social determinants and the health divide in the WHO European Region: final report** (1).
- **Strategic review of health inequalities in England post-2010 (Marmot Review). Task group 8: priority public health conditions. Final report** (43).
- **Resource of health system actions on socially determined health inequalities.** WHO Regional Office for Europe online database (44).
- **Action:SDH.** A global electronic discussion platform and clearing house of actions to improve health equity through addressing the SDH (45).
- **European Portal for Action on Health Inequalities.** An Equity Action partnership information resource on health equity and SDH in Europe, including a database of policy initiatives (46).

### Policy equity assessment tools

- **Health inequalities impact assessment. An approach to fair and effective policy making. Guidance, tools and templates (47).**
- **Methodological guide to integrate equity into health strategies, programmes and activities (48).**
- **Tools and approaches for assessing and supporting public health action on the social determinants of health and health equity (49).**

### Data disaggregation and tools

- **Equity in Health project interactive atlases. WHO Regional Office for Europe online resource (50).**
- **Handbook on health inequality monitoring with a special focus on low- and middle-income countries (51).**

## References

1. Review of social determinants and the health divide in the WHO European Region: final report. Copenhagen: WHO Regional Office Europe; 2013 ([http://www.euro.who.int/\\_\\_data/assets/pdf\\_file/0006/215196/Review-of-social-determinants-and-the-health-divide-in-the-WHO-European-Region-final-report-Eng.pdf](http://www.euro.who.int/__data/assets/pdf_file/0006/215196/Review-of-social-determinants-and-the-health-divide-in-the-WHO-European-Region-final-report-Eng.pdf), accessed 4 December 2013).
2. European action plan to reduce the harmful use of alcohol 2012–2020. Copenhagen: WHO Regional Office for Europe; 2012 ([http://www.euro.who.int/\\_\\_data/assets/pdf\\_file/0008/178163/E96726.pdf](http://www.euro.who.int/__data/assets/pdf_file/0008/178163/E96726.pdf), accessed 4 December 2013).
3. Dahlgren G, Whitehead M. European strategies for tackling social inequities in health: levelling up part 2. Copenhagen: WHO Regional Office Europe; 2007 ([http://www.euro.who.int/\\_\\_data/assets/pdf\\_file/0018/103824/E89384.pdf](http://www.euro.who.int/__data/assets/pdf_file/0018/103824/E89384.pdf), accessed 4 December 2013).
4. Anderson P, Moller L, Galea G, editors. Alcohol in the European Union: consumption, harm and policy approaches. Copenhagen: WHO Regional Office for Europe; 2012 ([http://www.euro.who.int/\\_\\_data/assets/pdf\\_file/0003/160680/e96457.pdf](http://www.euro.who.int/__data/assets/pdf_file/0003/160680/e96457.pdf), accessed 4 December 2013).
5. Lim SS, Vos T, Flaxman AD, Danaei G, Shibuya K, Adair-Rohani H et al. A comparative risk assessment of burden of disease and injury attributable to 67 risk factors and risk factor clusters in 21 regions, 1990–2010: a systematic analysis for the Global Burden of Disease Study 2010. *Lancet* 2012 Dec 15;380(9859):2224–2260.
6. Schmidt LA, Mäkelä P, Rehm J, Room R. Alcohol and social determinants of health. In: Blas E, Sivasankara Kurup A, editors. Priority public health conditions: from learning to action on social determinants of health. Geneva: World Health Organization; 2009.
7. Blas E, Kurup A, editors. Equity, social determinants and public health programmes. Geneva: World Health Organization; 2010 ([http://whqlibdoc.who.int/publications/2010/9789241563970\\_eng.pdf](http://whqlibdoc.who.int/publications/2010/9789241563970_eng.pdf), accessed 4 December 2013).
8. Siegler V, Al-Hamad A, Johnson B, Wells C, Sheron N. Social inequalities in alcohol-related adult mortality by National Statistics Socio-economic Classification, England and Wales, 2001–03. *Health Stat Q*. 2011;Summer(50):1–36.
9. Hemmingsson T, Lundberg I, Diderichsen F, Allebeck P. Explanations of social class differences in alcoholism among young men. *Soc Sci Med*. 1998 Nov;47(10):1399–1405.
10. Walters S, Suhrcke M. Socioeconomic inequalities in health and health care access in central and eastern Europe and the CIS: a review of the recent literature. Working paper 2005/1. Copenhagen: WHO Regional Office for Europe; 2005.
11. Bloomfield K, Grittner U, Kramer S, Gmel G. Social inequalities in alcohol consumption and alcohol-related problems in the study countries of the EU concerted action 'Gender, Culture and Alcohol Problems: a Multi-national Study'. *Alcohol Alcohol Suppl*. 2006 Nov;41(1):i26–36.
12. Mäkelä P. Alcohol-related mortality as a function of socio-economic status. *Addiction* 1999 Jun;94(6):867–886.
13. Legleye S, Janssen E, Spilka S, Le Nézet O, Chau N, Beck F. Opposite social gradient for alcohol use and misuse among French adolescents. *Int J Drug Policy* 2013 Jul;24(4):359–366.

14. Helasoja V, Lahelma E, Prättälä R, Petkeviciene J, Pudule I, Tekkel M. The sociodemographic patterning of drinking and binge drinking in Estonia, Latvia, Lithuania and Finland, 1994–2002. *BMC Public Health* 2007;7:241.
15. Towards equity in health: comparative study of national health surveys in Roma population and general population in Spain, 2006. Madrid: Spanish Ministry of Health and Social Policy; 2009.
16. Bobakova D, Kolarcik P, Geckova AM, Klein D, Reijneveld SA, van Dijk JP. Does the influence of peers and parents on adolescents' drunkenness differ between Roma and non-Roma adolescents in Slovakia? *Ethn Health* 2012 Oct;17(5):531–541.
17. Stringhini S, Spencer B, Marques-Vidal P, Waeber G, Vollenweider P, Paccaud F et al. Age and gender differences in the social patterning of cardiovascular risk factors in Switzerland: the CoLaus Study. *PLoS One* [Internet] 2012 Nov 13 [cited 2013 Mar 6];7(11) (<http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3496703/>, accessed 4 December 2013).
18. Equally well: report of the ministerial task force on health inequalities – volume 2 [Internet]. Edinburgh: The Scottish Government; 2008 (<http://www.scotland.gov.uk/Publications/2008/06/09160103/0>, accessed 4 December 2013).
19. Global status report on noncommunicable diseases 2010. Geneva: World Health Organization; 2011 ([http://www.who.int/nmh/publications/ncd\\_report\\_full\\_en.pdf](http://www.who.int/nmh/publications/ncd_report_full_en.pdf), accessed 4 December 2013).
20. O'Dowd A. Fight to tackle unhealthy lifestyles has widened gap in health inequalities. *BMJ*. 2012;345:e5707–e5707.
21. White M, Adams J, Heywood P. How and why do interventions that increase health overall widen inequalities within populations? In: Babones S, editor. *Social inequality and public health*. Bristol: The Policy Press; 2009:65–82.
22. Rombouts T, Mantingh F, Galea G, editors. *Resource package on fiscal policy*. Copenhagen: WHO Regional Office Europe; 2013.
23. Meng Y, Brennan A, Holmes J, Hill-McManus D, Angus C, Purshouse R et al. Modelled income group-specific impacts of alcohol minimum unit pricing in England 2014/15: policy appraisals using new developments to the Sheffield Alcohol Policy Model (v2.5). Sheffield: SchARR, University of Sheffield; 2013 ([http://www.sheffield.ac.uk/polopoly\\_fs/1.291621!/file/julyreport.pdf](http://www.sheffield.ac.uk/polopoly_fs/1.291621!/file/julyreport.pdf), accessed 4 December 2013).
24. Meier P, Brennan A, Purshouse R, Taylor K, Rafia R, Booth A et al. Independent review of the effects of alcohol pricing and promotion: part B. Modelling the potential impact of pricing and promotion policies for alcohol in England: results from the Sheffield Alcohol Policy Version 2008 (1-1). London: Department of Health; 2008.
25. Bromley C, Corbett J, Day J, Doig M, Gharib W, Given L et al. The Scottish health survey: volume 1: main report. Edinburgh: The Scottish Government; 2010 (<http://www.scotland.gov.uk/Publications/2011/09/27084018/0>, accessed 4 December 2013).
26. Robson K. SPICe Briefing: Alcohol (Minimum Pricing) (Scotland) Bill. Edinburgh: The Scottish Parliament; 2012 ([http://www.scottish.parliament.uk/ResearchBriefingsAndFactsheets/S4/SB\\_12-01.pdf](http://www.scottish.parliament.uk/ResearchBriefingsAndFactsheets/S4/SB_12-01.pdf), accessed 4 December 2013).
27. Bellis MA, Lowey H, Leckenby N, Hughes K, Harrison D. Adverse childhood experiences: retrospective study to determine their impact on adult health behaviours and health outcomes in a UK population. *J Public Health (Oxf)*. 2014 Mar; 36(1):81–91.



28. Gray D, Siggers S, Atkinson D, Sputore B, Bourbon D. Beating the grog: an evaluation of the Tennant Creek liquor licensing restrictions. *Aust N Z J Public Health* 2000 Feb;24(1):39–44.
29. Moskalewicz J, Pisarska A. Alcohol and substance use among adults and juveniles in Poland: facts, policy and attitudes. Warsaw: AAA PREVENT Project (Workpackage 4); 2011 April (<http://www.aaaprevent.eu/doc/PolandNP.pdf>, accessed 4 December 2013).
30. Moskalewicz J, Zielinski A. Forgotten or neglected experiences with community action on alcohol. *Nordic Study Alcohol Drugs [English Suppl.]* 2003;20:5–12.
31. Hart CL, Morrison DS, Batty GD, Mitchell RJ, Davey Smith G. Effect of body mass index and alcohol consumption on liver disease: analysis of data from two prospective cohort studies. *BMJ*. 2010;340:c1240.
32. Hart CL, Davey Smith G, Gruer L, Watt GCM. The combined effect of smoking tobacco and drinking alcohol on cause-specific mortality: a 30-year cohort study. *BMC Public Health* 2010;10:789.
33. Ministry of Administration and Interior, National Anti-Drug Agency, Romanian Monitoring Centre for Drugs and Drug Addiction. Romania: new developments, trends and in-depth information on selected issues. 2011 national report (2010 data) to the EMCDDA by the Reitox national focal point. Bucharest: National Anti-Drug Agency; 2011.
34. Engdahl B, Nilssen P. Receiving an alcohol enquiry from a physician in routine health care in Sweden: a population-based study of gender differences and predictors. *Int J Environ Res Public Health* 2011 May;8(5):1296–1307.
35. Bezpajumtnieku un ilgstošo bezdarbnieku integrācija [Integration of homeless and long-term unemployed] [Internet]. Brussels: EuroHealthNet European Portal for Action on Health Inequalities Good Practice Database; 2008 [cited 2013 Aug 28] ([http://www.health-inequalities.eu/HEALTHYQUITY/EN/good\\_practice\\_database/](http://www.health-inequalities.eu/HEALTHYQUITY/EN/good_practice_database/), accessed 4 December 2013).
36. Kleinhubbert G. Fixerstube light. *Der Spiegel* 2010 Apr 19;16:50.
37. European Information System on Alcohol and Health (EISAH) [website]. Geneva: World Health Organization; 2013 (<http://apps.who.int/gho/data/view.main-euro?showonly=GISAH>, accessed 4 December 2013).
38. Status report on alcohol and health in 35 European countries 2013. Copenhagen: WHO Regional Office for Europe; 2013 ([http://www.euro.who.int/\\_\\_data/assets/pdf\\_file/0017/190430/Status-Report-on-Alcohol-and-Health-in-35-European-Countries.pdf](http://www.euro.who.int/__data/assets/pdf_file/0017/190430/Status-Report-on-Alcohol-and-Health-in-35-European-Countries.pdf), accessed 4 December 2013).
39. European status report on alcohol and health 2010. Copenhagen: WHO Regional Office for Europe; 2010 ([http://www.euro.who.int/\\_\\_data/assets/pdf\\_file/0004/128065/e94533.pdf](http://www.euro.who.int/__data/assets/pdf_file/0004/128065/e94533.pdf), accessed 4 December 2013).
40. Global strategy to reduce the harmful use of alcohol. Geneva: World Health Organization; 2010 ([http://www.who.int/substance\\_abuse/alcstratenglishfinal.pdf](http://www.who.int/substance_abuse/alcstratenglishfinal.pdf), accessed 4 December 2013).
41. Graham L, Parkes T, McAuley A, Doi L. Alcohol problems in the criminal justice system: an opportunity for intervention. Copenhagen: WHO Regional Office for Europe; 2012 ([http://www.euro.who.int/\\_\\_data/assets/pdf\\_file/0006/181068/e96751-ver-2.pdf](http://www.euro.who.int/__data/assets/pdf_file/0006/181068/e96751-ver-2.pdf), accessed 4 December 2013).
42. Action plan for implementation of the European Strategy for the Prevention and Control of

- Noncommunicable Diseases 2012–2016. Copenhagen: WHO Regional Office for Europe; 2012 ([http://www.euro.who.int/\\_\\_data/assets/pdf\\_file/0019/170155/e96638.pdf](http://www.euro.who.int/__data/assets/pdf_file/0019/170155/e96638.pdf), accessed 4 December 2013).
43. Bamba C, Joyce K, Maryon-Davis A. Strategic review of health inequalities in England post-2010 (Marmot Review). Task group 8: priority public health conditions. Final report. London: University College London; 2009 (<http://www.instituteofhealthequity.org/projects/priority-public-health-conditions-task-group-report>, accessed 4 December 2013).
  44. Resource of health system actions on socially determined health inequalities [online database]. Copenhagen: WHO Regional Office for Europe; 2013 (<http://data.euro.who.int/equity/hidb/Resources/List.aspx>, accessed 4 December 2013).
  45. Action:SDH [website]. Geneva: World Health Organization; 2010 (<http://www.actionsdh.org/>, accessed 4 December 2013).
  46. European portal for action on health inequalities [website]. Brussels: EuroHealthNet and Equity Action; 2013 (<http://www.health-inequalities.eu/HEALTHEQUITY/EN/home/>, accessed 2013).
  47. Health inequalities impact assessment. An approach to fair and effective policy making. Guidance, tools and templates. Edinburgh: NHS Health Scotland; 2011 (<http://www.healthscotland.com/uploads/documents/17227-0%20HIIA%20-%20GUIDANCE.pdf>, accessed 4 December 2013).
  48. Methodological guide to integrate equity into health strategies, programmes and activities. Version 1. Madrid: Ministry of Health, Social Services and Equality; 2012 ([http://www.msssi.gob.es/profesionales/saludPublica/prevPromocion/promocion/desigualdadSalud/jornadaPresent\\_Guia2012/docs/Methodological\\_Guide\\_Equity\\_SPAs.pdf](http://www.msssi.gob.es/profesionales/saludPublica/prevPromocion/promocion/desigualdadSalud/jornadaPresent_Guia2012/docs/Methodological_Guide_Equity_SPAs.pdf), accessed 4 December 2013).
  49. Mendell A, Dyck L, Ndumbe-Eyoh S, Morrison V. Tools and approaches for assessing and supporting public health action on the social determinants of health and health equity. Montréal: National Collaborating Centre for Determinants of Health (NCCDH) and National Collaborating Centre for Healthy Public Policy (NCCHPP); 2012 ([www.ncchpp.ca/docs/Equity\\_Tools\\_NCCDH-NCCHPP.pdf](http://www.ncchpp.ca/docs/Equity_Tools_NCCDH-NCCHPP.pdf), accessed 4 December 2013).
  50. Interactive atlases [website]. Copenhagen: WHO Regional Office for Europe; 2012 (<http://www.euro.who.int/en/what-we-do/data-and-evidence/equity-in-health/interactive-atlases>, accessed 4 December 2013).
  51. Handbook on health inequality monitoring with a special focus on low- and middle-income countries. Geneva: World Health Organization; 2013 ([http://apps.who.int/iris/bitstream/10665/85345/1/9789241548632\\_eng.pdf](http://apps.who.int/iris/bitstream/10665/85345/1/9789241548632_eng.pdf), accessed 4 December 2013).



---

**World Health Organization**  
**Regional Office for Europe**

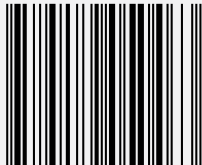
UN City, Marmorvej 51, DK-2100 Copenhagen Ø, Denmark

Tel.: +45 45 33 70 00 Fax: +45 45 33 70 01

Email: [contact@euro.who.int](mailto:contact@euro.who.int)

Website: [www.euro.who.int](http://www.euro.who.int)

ISBN 978-9-289-05046-3



9 789289 050463 >