HealthInvest

Position Statement

Alcohol

Summary

Alcohol is a dependence-producing substance associated with significant adverse health impacts. Harmful alcohol use can undermine progress towards Sustainable Development Goal 3: Good Health and Well-being. For this reason, we apply exclusion criteria for alcohol.

This document maps alcohol to SDG 3 and explains why we apply exclusion criteria for alcohol.

Our position

Alcohol consumption is associated with significant adverse health impacts and can contribute to disease, injury and other harms to individuals and society. Given these adverse impacts and their relevance to HealthInvest's focus on health and well-being, we apply exclusion criteria for alcohol.

Connection to sustainability

Harmful alcohol use is a causal factor for more than 200 disease and injury conditions, and contributes to an estimated 3 million deaths per year (Griswold et al. 2018; Rehm et al. 2009; Shield et al. 2020). At the population level, the volume of alcohol consumed per person is closely linked to the level of alcohol-related harm in society (Norström and Mäkelä 2019; Norström and Ramstedt 2018). This impact of alcohol consumption on SDG 3 is so strong that the United Nations uses alcohol consumption per capita as one of the quantitative indicators for measuring good health and well-being (SDG 3.5.2).

Mapping alcohol to SDG 3

SDG Target	SDG Indicator	Comment
3.3 End the epidemics of AIDS, tuberculosis, malaria and neglected tropical diseases and combat hepatitis, waterborne diseases and other communicable diseases	3.3.2 Tuberculosis incidence per 100,000 population	Alcohol consumption is a major risk factor for contracting infectious diseases including tuberculosis (Griswold et al. 2018).
3.4 Reduce by one third premature mortality from non-communicable diseases through prevention and treatment and promote mental health and well-being	3.4.1 Mortality rate attributed to cardiovascular disease, cancer, diabetes or chronic respiratory disease	Alcohol use is a leading risk factor for NCDs, especially cardiovascular disease (Griswold et al. 2018).
	3.4.2 Suicide mortality rate	Alcohol use leads to impulsive behavior that is linked to suicide (Breet et al. 2018; Griswold et al. 2018; Sher 2006).
3.6 Halve the number of global deaths and injuries from road traffic accidents	3.6.1 Death rate due to road traffic injuries	Alcohol impairs judgment, increases reaction time, and decreases vigilance and visual acuity. Alcohol use is associated with a significant proportion of traffic accident injuries and deaths. The number of road deaths due to alcohol consumption increased between 2000 and 2016 (Griswold et al. 2018; Shield et al. 2020).
3.8 Achieve universal health coverage, including financial risk protection, access to quality essential health-care services and access to safe, effective, quality and affordable essential medicines and vaccines for all	3.8.1 Coverage of essential health services	A substantial portion of hospital visits is tied to alcohol use. This is thought to place a large burden on the attention and resources of healthcare providers, sometimes resulting in insufficient supply of healthcare services, for example during the COVID-19 pandemic (Myran et al. 2024; Parry 2021; Stockwell et al. 2021).

References

Breet, E. et al. (2018). Substance use and suicidal ideation and behaviour in low- and middle-income countries: a systematic review. *BMC Public Health* 18, 549.

Burd, L. et al. (2004). Increased sibling mortality in children with fetal alcohol syndrome. *Addiction Biology* 9, 179–186.

Griswold, M. G. et al. (2018). Alcohol use and burden for 195 countries and territories, 1990–2016: a systematic analysis for the Global Burden of Disease Study 2016. *The Lancet* 392, 1015–1035.

Hill, H. H. (1987). A functional taxonomy of normative conflict. *Law and Philosophy* 6, 227–247.

Mandelbaum, D. (1965). Alcohol and Culture. *Current Anthropology* 6, 281–293.

Myran, D. T. et al. (2024). The association between alcohol retail access and health care visits attributable to alcohol for individuals with and without a history of alcohol-related health-care use. *Addiction* 119, 1554–1563.

Norström, T. and P. Mäkelä (2019). The connection between per capita alcohol consumption and alcohol-specific mortality accounting for unrecorded alcohol consumption: The case of Finland 1975–2015. *Drug and Alcohol Review* 38, 731–736.

Norström, T. and M. Ramstedt (2018). The Link Between Per Capita Alcohol Consumption and Alcohol-Related Harm in Sweden, 1987–2015. *Journal of Studies on Alcohol and Drugs* 79, 578–584.

Parry, C. D. H. (2021). A timely piece that resonates with the South African experience: Commentary on Stockwell et al. *Drug and Alcohol Review* 40, 8–9.

Rehm, J. et al. (2009). Global burden of disease and injury and economic cost attributable to alcohol use and alcohol-use disorders. *The Lancet* 373, 2223–2233.

Sher, L. (2006). Alcohol consumption and suicide. *QJM: An International Journal of Medicine* 99, 57–61.

Shield, K. et al. (2020). National, regional, and global burdens of disease from 2000 to 2016 attributable to alcohol use: a comparative risk assessment study. *The Lancet Public Health* 5, e51–e61.

Stockwell, T. et al. (2021). The burden of alcohol on health care during COVID-19. *Drug and Alcohol Review* 40, 3–7.

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