European Alcohol Policy Alliance's Response to House of Lords Inquiry into the EU Alcohol Strategy

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The European Alcohol Policy Alliance (EUROCARE)

The European Alcohol Policy Alliance (EUROCARE) is an alliance of non-governmental and public health organisations with 57 member organisations across 25 European countries advocating the prevention and reduction of alcohol related harm in Europe. Member organisations are involved in advocacy and research, as well as in the provision of information to the public; education and training; the provision of workplace programmes; counselling services and residential support.

The mission of Eurocare is to promote policies to prevent and reduce alcohol related harm, through advocacy in Europe. The message, in regard to alcohol consumption is "less is better".

Eurocare has prepared this consultation response in close collaboration with our UK members Institute of Alcohol Studies (IAS) and Scottish Health Action on Alcohol Problems (SHAAP).

Response to call for evidence

Q 1. Should there be another EU Alcohol Strategy? If so, bearing in mind the wide social and health implications of alcohol consumption, what should the content, focus and purpose of the next Strategy be, with reference to the previous strategy and evaluations thereof?

Eurocare is a strong supporter of effective alcohol policy in Europe and has been calling for a renewed EU Alcohol Strategy since 2010, when the previous Strategy was approaching its expiration date. Eurocare has coordinated the European work on the advocacy for a new EU Alcohol Strategy, and among those activities are an event in the European Parliament (June 2012)[1] and preparing the Eurocare Recommendations for a future EU Alcohol Strategy (June 2012)[2], as well as gathering more than 90 signatures from public health organisations across Europe calling for a new Alcohol Strategy (November 2011)[3]. Eurocare sees the failure to establish a renewed Strategy in 2012 as a significant setback for achieving progress on reducing alcohol harm in Europe. Eurocare has expressed concerns about the limitations of the interim EU Alcohol Action Plan, which seeks to address a much narrower element of alcohol harm, covering young people and heavy episodic (binge) drinking, and has made repeated calls for a new comprehensive strategy that would take a whole population based approach

[1] http://eurocare.org/media_centre/previous_eurocare_events/eurocare_eu_alcohol_strategy
[2] http://eurocare.org/resources/policy_issues/eu_alcohol_strategy/eurocare_papers/eurocare_recommendations_for_a_future_eu_alcohol_strategy_2013_2020_june_2012
[3] http://eurocare.org/resources/policy_issues/eu_alcohol_strategy/eurocare_papers/ngos_call_for_a_new_eu_alcohol_strategy_november_2011

and thus include policies that would impact all Europeans affected by alcohol problems, including adults of working age and those affected by third party harms (e.g. victims of drink drive accidents and domestic abuse).

We believe the next EU Strategy should be based on the evidence-based framework for effective alcohol policies outlined in the World Health Organisation (WHO) Global Strategy to reduce harmful use of alcohol (2010) and, more specifically, the WHO European Action Plan to reduce the harmful use of alcohol 2012-2020 (2011). Both of these strategies have received unanimous endorsement by all EU Member States and are based on the best available scientific evidence of policy effectiveness. The ten policy areas for action outlined in these two strategies are:

1. Leadership, awareness and commitment
2. Health services' response
3. Community action
4. Drink-driving policies and countermeasures
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 alcohol and informally produced alcohol
10. Monitoring and surveillance

Item 5, 6 and 7 denotes a "best buy" policy identified by the WHO. The WHO has identified, in line with the international evidence, the three "best buy" policy interventions that are most cost-effective in reducing harmful consumption of alcohol are controls on price, availability and promotion of alcoholic beverages.

Eurocare acknowledges that the responsibility for delivering public health policy lies primarily with individual member states. Each country in the EU has different requirements and cultural backgrounds and there is no one-size-fits-all strategy that can be applied. The EU Alcohol Strategy should therefore seek to support and complement comprehensive national alcohol strategies by focusing on policy areas where the EU mandate can add value, for example in relation to trade and cross border issues. It should also provide Member States with the freedom to implement national policies that prioritise the health and wellbeing of their citizens. An EU Alcohol Strategy could therefore address the following policy areas:

- Price
    - Acknowledgement and acceptance of the evidence to support price controls in order to reduce the affordability of alcohol as one of the most cost effective interventions to tackle alcohol harm
    - Enabling and encouraging Member States to regulate domestic alcohol prices through taxation, minimum unit pricing and other fiscal measures where appropriate
    - Reviewing the EU directive on alcohol taxation to allow Member States to implement pricing policies that incentivize the production and consumption of lower strength alcoholic beverages (especially for wine products)
- Marketing
    - Review the EU Audio Visual Media Services Directive to establish a framework for regulating exposure of children to alcohol marketing activities in digital media. This would apply across the EU and therefore prevent cross-border discrepancies that can undermine national policies in Member States
    - Enabling and encouraging Member States to adopt statutory and co-regulatory frameworks for marketing and advertising, and discouraging self-regulatory frameworks that have been shown to fail to protect children from exposure to alcohol marketing
- Availability
    - An EU directive could establish a common minimum purchase age for alcohol, set at 18 years
    - The EU Services Directive should be reviewed to enable licensing authorities to fully recover the costs associated with enforcing licensing regulations through license fees
- Labelling
    - Establish an EU-wide requirement for all alcoholic beverages to list their ingredients, allergen and calorie information, in line with EU current regulations on the Provision of Food Information to Consumers
    - Establish an EU-wide requirement for all alcoholic beverages to carry independent health information for consumers, for example in relation to drinking during pregnancy, drink driving and risk of dependency, liver disease and cancer
- Drink Driving
    - A harmonised Blood Alcohol Content legal limit across the EU would prevent cross-border discrepancies for drink driving incidents, as would a harmonised penalty system
- Workplace policies

  - Encourage a uniform approach to alcohol policies in the workplace across the EU, combining legislation, alcohol-free workplaces, and interventions aimed at those employees whose drinking patterns have an impact on performance at work
- Inequalities
  - Alcohol related harm hits harder in lower economic groups, despite higher consumption levels in higher economic groups. Alcohol must be included in the work on health inequalities being one of the top risk factors for ill health and premature death.
- Monitoring and Surveillance
  - Greater resources could be dedicated to data collection throughout the EU relating to alcohol consumption and related harms, including third party harms such as drink driving accidents, alcohol-related assaults, injuries, domestic abuse and sexual assaults. Better data on the impacts of alcohol will enable policymakers to identify policy needs and monitor and evaluate policy effectiveness.
  - Common measurement standards could be agreed across the EU in order to monitor and evaluate alcohol harm and interventions to reduce harm and help to prevent cross-border discrepancies. For example, a common unit of alcohol or standard drink would harmonise consumption trend data across the region and also allow for common EU consumer information such as low risk drinking guidelines and health information on labels (see above)

A primary aim of an EU Alcohol Strategy must be to ensure that a Health in All Policies approach is taken with decisions at the EU level, and that the health and wellbeing of EU citizens is prioritized over trade and economic operator interests. An important objective within this aim must be to address the health inequalities, both within and between Member States, which are exacerbated by harmful alcohol use.

Q 2. Are the EU's alcohol policies underpinned by a sound scientific base?

There are many elements of the previous EU Alcohol Strategy that were underpinned by a strong evidence base of effectiveness. The comprehensive framework of policies outlined acknowledged the breadth of scope required in order to reduce alcohol harm across the EU population. Similarly, funding streams were established to advance the work of alcohol researchers and develop the evidence base for effective policies, through projects such as AMPHORA and ALICE RAP. Funding was also allocated to NGOs in order to build capacity amongst civil society actors, thus following an evidence-based approach of good governance in policymaking.

However, the previous EU Alcohol Strategy could have been more ambitious in its objectives to be more in line with evidence of effectiveness, and its expiration in 2012 presents a real threat that EU alcohol policies are not currently being prioritised according to the scientific evidence of the burden of disease in the region. The EU is the heaviest drinking region in the world and a significant proportion of alcohol harm is experienced by adults of working age through chronic health conditions including liver cirrhosis, cancer, stroke, heart disease and also mental illness and dependency (WHO EU Alcohol Action Plan, 2011). The focus of the current EU Alcohol Action Plan is on young people and binge drinking, and whilst the latter will capture the adult population to some extent, the Plan does not include recommendations for interventions aimed at reducing health problems caused by regular heavy consumption amongst middle-aged adults, who have the absolute highest rates of disability and premature death due to alcohol. For example, the recommendations for alcohol workplace policies refer only to those targeting young people, and lower blood alcohol content levels are recommended for young drivers and professional drivers of public transport services for children. Therefore it could be argued that the current EU alcohol policy is not underpinned by the scientific evidence relating to the health needs of all EU citizens, or the most cost-effective approach to tackling alcohol harm.

Within the narrow scope of the EU Action Plan on Youth and Heavy Episodic Drinking, there are several recommended policies that are based on good scientific evidence of effectiveness. These include supporting the implementation of fiscal and pricing policies to discourage heavy episodic drinking, promoting and ensuring the implementation of screening, early identification and brief advice in relevant subgroups and settings, use of effective enforcement measures to reduce availability of alcohol to underage people, use of legislation and co-regulation to reduce the exposure of young people to alcohol advertising and the establishment and enforcement of lower blood alcohol content levels for young and professional drivers. There are also several recommendations for improved and harmonised data collection, monitoring and surveillance of alcohol harm and interventions, which will help to improve the evidence base for effective EU policies in the future.

The Science Group of the EU Alcohol and Health Forum was established in 2008 to provide scientific guidance to the Forum. Since its inception the Group has produced two reports, relating to adolescent exposure to alcohol marketing and alcohol policies in the workplace. However, as outlined below, the function and role of the Science Group could be improved upon in order to ensure that EU alcohol policies are underpinned by an up to date evidence base of effectiveness moving forward, and that the evidence advising such policies is independently verified and free from commercial vested interests.

Q 3. Are the EU's alcohol policies in line with existing international frameworks to tackle alcohol misuse, for example the World Health Organisation (WHO)?

The absence of a current EU Alcohol Strategy means that there is no comprehensive policy framework in existence at the EU level that can be compared to the WHO Global Alcohol Strategy or WHO EU Alcohol Action Plan. The interim EU Action Plan on Youth Drinking and Heavy Episodic Drinking has a narrower scope, however, as stated previously, there are operational objectives within this that adhere to WHO recommendations based on the best available scientific evidence. These include:

- Encourage health related information including alcohol related risks on alcoholic beverages to help consumers make informed choices. Also, ensure that containers of alcoholic products carry a warning message determined by public health bodies describing the harmful effects of drinking during conception and pregnancy
- Support and implement fiscal and pricing policies to discourage heavy episodic drinking
- Promote and ensure the implementation of Screening, Early Identification and Brief Intervention in all relevant subgroups and settings
- Promote, ensure and enforce adequate level of controls in on- and off-premises relating to underage sales
- Use existing legislation and co-regulation to reduce young people's exposure to alcohol advertising
- Reduce alcohol related traffic accidents by establishing lower BAC levels (for young drivers and profession drivers for public transport services for children)
- Make data on alcohol related harm available as a basis for policy making

Policies outlined in the previous EU Alcohol Strategy that were in alignment with WHO frameworks, but are absent from the Action Plan on Young People and Binge Drinking include:

- Recommendations for a drink driving legal blood alcohol content (BAC) limit of 0.5mg or less for all adults, combined with the enforcement of frequent and systematic random breath testing, supported by education and awareness campaigns involving all stakeholders
- Setting a minimum purchase age of 18 years for all alcoholic beverages, including beer and wine

A key omission from the EU alcohol policies at present is a set of specific, measurable and timely targets or indicators, outlining the EU ambitions for reducing alcohol harm. This is in contrast to current WHO strategies that include the following goals:

- To achieve a 10% relative reduction in the harmful use of alcohol, as appropriate in the national context, by 2025 (WHO Global Action Plan for Prevention and Control of Non Communicable Diseases 2013-2020 – baseline data from 2010)
- Offer brief advice programmes to 30% of the population at risk of hazardous or harmful alcohol consumption; or offering early identification and brief advice to 60% of the population at risk (WHO European Alcohol Action Plan)
- To achieve a 25% global reduction in premature mortality from non-communicable diseases (NCDs) by 2025 (World Health Assembly Political Declaration, May 2012)

Eurocare believes that a new EU Alcohol Strategy should compliment existing WHO strategies by including targets and indicators that have been endorsed by Member States.

Q 4. Are the mechanisms created in the last strategy for facilitating discussion, cooperation and the exchange of good practice between Member States, industry, civil society organisations and EU institutions, for example, the EU Alcohol and Health Forum (EAHF) and the Committee on National Alcohol Policy and Action (CNAPA), still appropriate?

Eurocare believes that the mechanisms created in the previous EU Alcohol Strategy still have an important role to play in working to reduce alcohol harm in Europe, however the roles of the Committee on National Alcohol Policy and Action (CNAPA) and the EU Alcohol and Health Forum (EUAHF) need to revised to reflect the requirements of a new, more ambitious strategy that puts Health in All Policies at the heart of it focus. In addition, Eurocare advocates for a framework for a civil society dialogue process which does not include economic operators.

As CNAPA is the body representing Member States, it is essential that its role be strengthened to reflect its position as the driving force for the design and implementation of a new EU Alcohol Strategy. One way of doing this could be to make CNAPA as a working group within the structures of the Council of the EU. This group can build on the experiences from the Horizontal Working Party on Drugs (HDG), which is the coordination body meeting on a monthly basis to discuss drug-related issues. The HDG prepares all relevant legislation and political documents adopted by the Council, such as the EU drugs strategies and action plans.

It could be argued that to date CNAPA's view has not been awarded sufficient attention, with several calls for a renewed EU Strategy since 2010 failing to result in action from the European Commission. CNAPA has recently been tasked with drafting a scoping paper, outlining the principals required for a new EU Alcohol Strategy. This will be presented to the new Commissioner following their appointment. It is essential that the views and priorities of CNAPA are given active consideration in developing and implementing European alcohol policy.

Conversely, the EUAHF has been awarded greater priority in the EU alcohol policy process that its remit requires. Despite the EUAHF having no official role in policy development, views of forum members were sought throughout the development of the EU Alcohol Action Plan, and objections from economic operators to scientific reports produced on behalf of the Forum have been upheld. Eurocare is a member of the EUAHF and sees value in maintaining a mechanism whereby NGOs and public health bodies can discuss with the European Commission how economic operators can contribute to actions that will reduce alcohol harm. However, we believe that the role and function of the EUAHF should be guided by the WHO guidance, which states alcohol industry activities should be restricted to their core roles as developers, producers, distributors, marketers and sellers of alcoholic beverages and that they should have no role in the formulation of alcohol policies, which must be protected from distortion by commercial or vested interests.

We therefore believe the EUAHF should become a more focussed body, with an agreed workplan that is aligned to a set of core objectives laid down by CNAPA. Economic operators can commit to take action that will achieve measurable objectives, in line with such a workplan. NGOs and public health bodies can support this process by ensuring that commitments are based on evidence of effectiveness and are subject to robust monitoring and evaluation processes, and that there is transparency in all Forum activities.

The function of the Science Group of the EUAHF would be better placed if it reported directly to CNAPA. This would enable policy discussions on the evidence to support interventions to reduce alcohol harm to be free from commercial conflicts of interest. It is not appropriate that economic operators with pecuniary interests in policy areas such as price and marketing should be involved in the presentation of scientific evidence to policy makers. The Science Group of the EUAHF should therefore be re-established as an independent expert group, free from membership from economic operators.

In addition to the existing structure of CNAPA and EUAHF, Eurocare advocates for the establishment of a framework for a civil society dialogue on alcohol related issues. There are several options on how

to structure this dialogue, and one of them could be to extend the scope of the existing EU Health Policy Forum and include the process within this forum.

Q 5. Is the EU funding allocated to alcohol-related research and harm reduction programmes sufficient to achieve the stated aims?

The previous strategy established funding streams for alcohol research, including the Alice Rap and AMPHORA projects, however the absence of an EU Alcohol Strategy presents the threat that research grants will not be made available to investigate alcohol harm.

Whilst there are funding streams available within EU programmes for alcohol research, there is an urgent need for better data on alcohol in Europe and coordination of alcohol research, both of which should be addressed in a new EU Alcohol Strategy. The European Commission's evaluation of the Alcohol Strategy to 2012 highlighted that less than 3% of the total budget of the Health Programme for 2008-2013 and less than 1% of the budget for health under the Seventh Research Programme were allocated to alcohol. This is not sufficient given the harm cause by alcohol.

The European Commission's Committee on Alcohol Data Collection, Indicators and Definitions outlines three key indicators for monitoring changes in alcohol consumption and alcohol-related harm. These indicators measure:

- Volume of consumption (total recorded and unrecorded per capita consumption of pure alcohol in litres by adults (15 years and older), with sub-indicators for beer, wine, and spirits);
- Harmful consumption pattern (intake of at least 60 g of alcohol on a single occasion at least once per month during the previous 12 months); and
- Health harm (years of life lost – YLL) attributable to alcohol, with sub-indicators for alcohol-attributable YLL from chronic disease and injury).

The WHO European Alcohol Action Plan recommends that regular reports on alcohol are prepared covering the following five topics:

- Drinking among adults, including trends in alcohol consumption, types of alcohol consumed, socioeconomic variables, demographic characteristics, drinking and pregnancy, adults' drinking behaviour and knowledge of alcohol, and geographical patterns of alcohol consumption;
- Underage drinking, including trends in alcohol consumption, types of alcohol consumed, socioeconomic variables and drinking among different ethnic groups, associations with other substance use, and drinking behaviour and knowledge of alcohol;

- Drinking-related ill health, including hazardous, harmful and dependent drinking, consultations about drinking with health professionals, alcohol-related hospital admissions and alcohol-related mortality;
- Availability and affordability of alcohol;
- Costs to society, including expenditure on alcohol-related harm, alcohol-related crime and alcohol-related traffic accidents; and
- Policy responses, including all the policy outcomes of [the WHO] Action Plan relevant to a country related to leadership, awareness and commitment, health services' response, community and workplace action, drink–driving, availability, marketing, pricing, reducing intoxication, and reducing the impact of illicit and informally produced alcohol.

At present several Member States collect relevant data on alcohol harm and consumption, however there are many countries where sufficient data is not routinely available. We recommend that an EU Alcohol Strategy includes funding mechanisms for data collection for the above indicators, so that alcohol harm and policy progress can be monitored and evaluated across the EU.

Q 6. Do EU policies on the taxation of alcohol and the rulings of the Court of Justice of the European Union (CJEU) balance successfully the aims of the single market with the wishes of the individual EU Member States to promote public health within their borders, for example through minimum pricing?

Tensions exists between the promotion of free trade (under Article 34 of the EU Treaty) and the conditions upon which Member States can restrict free trade, including the protection of public health (outlined in Article 36), through fiscal measures for alcohol within the EU. Current EU regulations have the ability to undermine Member States' efforts to implement pricing policies designed to protect public health. The abolition of the duty paid allowance system effectively undermined countries with higher taxation rates for alcohol, and Scotland's plans to introduce minimum unit pricing for alcohol could potentially be thwarted by a legal decision made in the European Court of Justice.

In 2012, the legal challenge to Scotland's plans to introduce minimum unit pricing, launched by the Scotch Whisky Association and Spirits Europe, generated an unfavourable and ill-informed opinion from the European Commission. This did not correctly differentiate between the roles of minimum unit pricing and taxation, and recommended that taxation alone could achieve the same objective of reducing consumption of cheap, strong alcohol amongst harmful drinkers. However, the EU Directive on alcohol taxation actually prohibits the implementation of a taxation system for all beverages based on their alcoholic strength. Indeed, this is one of the many reasons why the Scottish

Government turned to minimum unit pricing as a policy solution to the problems caused by cheap, strong drink in Scotland. Minimum pricing and taxation are complimentary policies and are not mutually exclusive.

Questions have been referred to the European Court of Justice (CJEU) for clarification by the Scottish Courts in the legal challenge. If the CJEU responds unfavourably against minimum pricing, which has been ruled by Scottish Court of Session as a proportionate response to a public health need, this will raise a key issue regarding the role of the European Courts in re-assessing evidence considered by elected legislatures within Member States. This would raise questions about subsidiarity and the margin of appreciation between Member States and the EU and could potentially have adverse consequences for wider public health policies than alcohol.

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