



European Alcohol Policy Alliance

EUROCARE RECOMMENDATIONS FOR A FUTURE EU ALCOHOL STRATEGY

November 2014

REGULATION OF
 MARKETING,
 PRICE AND
 AVAILABILITY
 INFORMATION
 TO CONSUMER
 LABELLING
 PREVENTION
 ALCOHOL
 RELATED HARM
 PROTECTION OF
 YOUNG PEOPLE
 DRUNK DRIVING
 ROAD SAFETY
 EARLY
 INTERVENTIONS
 TREATMENT
 BETTER
 MONITORING
 EVIDENCE
 BASED POLICY
 DATA
 COLLECTION
 REDUCTION IN
 TOTAL ALCOHOL
 CONSUMPTION HEALTH
 RISK SAFER DRINKING
 ENVIRONMENTS ALCOHOL RELATED
 HARM REGULATED ADVERTISING
 CARCINOGENIC INCREASE IN EXCISE
 DUTIES ALCOHOL AND PREGNANCY LIVER
 CIRRHOSIS LESS IS BETTER TAXES ALCOHOL
 RELATED HARM CONSUMER PROTECTION
 EQUALITY IN HEALTH REGULATION OF
 MARKETING, PRICE AND AVAILABILITY
 INFORMATION TO CONSUMER LABELLING
 PREVENTION ALCOHOL RELATED HARM
 PROTECTION OF YOUNG PEOPLE DRUNK
 DRIVING ROAD SAFETY EARLY INTERVENTIONS
 TREATMENT BETTER MONITORING EVIDENCE
 BASED POLICY DATA COLLECTION REDUCTION
 IN TOTAL ALCOHOL CONSUMPTION HEALTH
 RISK SAFER DRINKING ENVIRONMENTS

The European Alcohol Policy Alliance (EUROCARE)

The European Alcohol Policy Alliance (EUROCARE) is an alliance of non-governmental and public health organisations with around 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 and training on alcohol issues and the service for people whose lives are affected by alcohol problems.

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

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Contents

Foreword by President Tiziana Codenotti.....	4
Summary.....	5
Introduction.....	6
Alcohol – a cause for action.....	7
Main policy areas.....	8
2.1 Alcohol Pricing Policies.....	8
2.2 Marketing of Alcohol Beverages.....	10
2.3 Availability of alcohol.....	11
2.4 Consumer Information – Product labelling.....	12
2.5 Drink-driving policies and countermeasures.....	12
2.6 Health sector responses for early detection, brief interventions and treatment.....	13
2.7 Strategies that alter drinking contexts, backed up by community based prevention actions.....	14
2.8 Evidence-based public awareness communication and school-based education to help reduce risks and harm from alcohol.....	14
2.9 Raised awareness of dangers from drinking alcohol during pregnancy.....	15
2.10 Protection of family and children.....	16
2.11 Prevention with special focus on the workplace.....	16
2.12 Alcohol Research, data collection and Monitoring programmes.....	17
Way forward: how to address alcohol related harm?.....	18

Foreword by President Tiziana Codenotti

Europe's newly elected European Parliament and the College of Commissioners are taking their seats for the next five years. Now is the moment to update the European Union Strategy to support Member States in reducing alcohol related harm building on recommendations from the World Health Organisation. The European Alcohol Policy Alliance wishes to present its view and recommendations for of a comprehensive alcohol policy in the European Union (EU) 2016 - 2025.

The European Alcohol Policy Alliance (Eurocare) was created in 1990, as concerns grew over the impact of the single market on national alcohol policies. The recognition of the importance of health issues has since moved forward on the European political agenda. Progress has been achieved, from the first mention in the 1986 Council Resolution, through 2006 EU Alcohol Strategy, to 2010 adoption of WHO Global Alcohol Strategy and the European Action Plan 2014 - 2016. However, Europe is still the heaviest drinking region in the world and harm caused by alcohol to the individual and society is too high.

In the current political context with financial cuts in the health sector, keeping the focus on public health and prevention is crucial. Eurocare would like to emphasise the need to place the health and social well being of European citizens above purely economic interests. The Member States and European Commission should commit to prioritising cost-effective measures in order to reduce rates of alcohol-related harm.

We hope that the European Commission and decision makers at both national and European level will find this document a valuable source of inspiration.

Tiziana Codenotti,
Eurocare President



Summary

The European Alcohol Policy Alliance strongly supports a continuation of efforts at the EU level to address alcohol related harm. An up-to-date EU Alcohol Strategy 2016 - 2025 based on latest evidence and abreast with societal change (for example move of alcohol advertising from traditional to new media) is needed to lay out a longer term framework for sustainable action at the EU level.

A healthy workforce and inclusive growth is a priority for the EU. Alcohol is the world's number one risk factor for ill-health and premature death among the 25-59 year age group, the core of the working age population¹. Alcohol is also a significant risk factor for absenteeism and poor quality work. This loss of productivity needs to be addressed in order for EU to reach its full economic potential.

Alcohol is the third biggest risk factor in Europe for non-communicable diseases, ill health and premature death². For the EU to achieve its ambition to increase average healthy life years by two by 2020, prevention through the life cycle, and especially in early years, is crucial. Eurocare supports efforts to invest in the healthy life years, from focusing on the unborn baby, young people who can be affected by their own or other people's drinking, people in the workforce and finally the dangers of drinking alcohol in old age.

Europe is the heaviest drinking region of the world. Consumption levels in some countries are around twice the global average³. Due to the size of the problem and the universal impact, alcohol requires a focused approach and commitment for action from policy and decisions makers at the European and national levels.

An EU Alcohol Strategy to support Member States in reducing alcohol related harm must:

- Be based on the best available scientific evidence
- Be informed and underpinned by a coherent policy framework
- Address the full spectrum of alcohol problems and the need for whole population-level responses
- Include an approach to all EU policy-making which supports reduction of alcohol harms
- Set clear targets and objectives and be externally monitored and evaluated
- Pay attention to the need to reduce health inequalities across the EU and within Member States.

The EU Strategy should address the following areas:

- Alcohol pricing policies
- Marketing of alcoholic beverages
- Availability of alcohol
- Consumer information – product labelling
- Drink driving policies and countermeasures
- Health sector responses for early detection, brief interventions and treatment
- Strategies that alter drinking contexts, backed up by community-based prevention action

¹ World Health Organisation Europe (2012). Alcohol in the European Union: Consumption, harm and policy approaches. (http://www.euro.who.int/__data/assets/pdf_file/0003/160680/e96457.pdf, accessed 24 September 2014)

² Ibid

³ WHO Status Report on Alcohol and Health in 35 European Countries 2013

- Evidence-based public awareness communication and school-based education to help reduce risks and harm from alcohol
- Raised awareness of dangers from drinking alcohol during pregnancy
- Protection of family and children
- Prevention with special focus on the workplace
- Alcohol research, data collection and monitoring programmes

There is a mass of evidence that the levels of alcohol related harm in any population are correlated with the overall level of alcohol consumption: higher per capita consumption tends to be associated with higher levels of harm and lower consumption with lower levels of harm⁴.

Eurocare recommends that the target for the EU should be a minimum 10% reduction of total alcohol consumption in Europe by 2025.

Introduction

The European Alcohol Policy Alliance has a vision of Europe where alcohol related harm is no longer one of the leading risk factors for ill-health and pre-mature death. Children, young people, family members and work colleagues no longer suffer from the drinking of others and where the European Union and its Member States recognize the harm done by alcohol and apply effective and comprehensive policies to tackle it.

The following recommendations are based on "Eurocare Overview and Recommendations for a Sustainable EU alcohol Strategy" September 2009, Eurocare recommendations for a future EU Alcohol Strategy, June 2012, Eurocare – Initial NGO recommendations for the new EU Action Plan on Alcohol November 2013. During this period Eurocare has consulted its member organizations, the Alcohol Policy Network (APN), the European Public Health Alliance (EPHA) alcohol working group and other relevant European umbrella organisations on ways forward and progress so far with the EU Alcohol Strategy.

Throughout the 1990s Eurocare published reports outlining the negative impact of alcohol consumption in Europe, but otherwise played a relatively limited advocacy role. At the time, health policy was not in the remit of the European Union, even though Community regulations such as those governing the internal market, trade, competition and agriculture in practice have an enormous impact on national and local health policies. The history of the EU's engagement with alcohol policy reflects the inherent difficulty of tackling an issue in which very strong vested interests are present; interests opposed to the formulation of any recognisable public health strategy on alcohol. It is worth recalling that the EU's early initiatives in this area were not auspicious. In 1993 the European Commission contributed €70,000 to the alcoholic drinks industry's Amsterdam Group to publish *Alcoholic Beverages and European Society*. This report was described in its introduction as a comprehensive review of the role of alcoholic beverages in European society, and as a reliable source on information that needed to be taken into account in devising "balanced and socially responsible alcohol policies." The Amsterdam Group report suggested that the EU dialogue on alcohol should exclude scientific researchers and all civil society organisations, including medical bodies. It was this report that prompted Eurocare, without any financial support from the EU, to produce "Counterbalancing the Drinks Industry: A Report to the European Union on Alcohol Policy". This report pointed out the self-serving, anti-scientific nature of the alcohol industry's stance on alcohol policy and attempt to

⁴ Ibid

summarise the scientific consensus. A civil society voice is needed for the EU Institutions to understand alternative positions on alcohol, even if the level of resources never will be equal to those of economic agents.

Addressing the issue of alcohol related harm through cost effective policies will offer measurable health system savings and enhance the growth and productivity agenda for Europe 2020. Eurocare would emphasise that the updated EU Alcohol Strategy needs to complement the WHO European Action Plan to Reduce the Harmful Use of Alcohol, 2012-2020 and to recognise the evidence base to support effective alcohol policies in Europe, as presented by Alcohol in the European Union (WHO, 2012). An EU Alcohol Strategy would lay out a longer-term context to support the continuation of efforts at the EU level to address alcohol related harm. In line with several Member States, we are disappointed that this to date has not been forthcoming.

Alcohol – a cause for action

Europe is the heaviest drinking region of the world even with a decrease of recorded alcohol consumption of 12,4% between 1990 – 2010⁵. Europe is still drinking alcohol more than twice world average and drinking patterns vary considerably across the region⁶. Heavy drinking, consuming at least 60 grams of alcohol in a day on average for men and at least 40 grams in a day for women, causes the overwhelming majority of the alcohol-attributable health burden. In 2005 (the latest year for which data are available) an estimated 5,4% of all men and 1,5% of all women aged 18 – 64 years in the EU suffered from alcohol dependence. This represents nearly 11 million people. In the EU, one in 7 men and one in 13 women, aged between 15 and 64 years, die of alcohol-attributable causes⁷.

Alcohol is a major threat to the public health, safety and economic prosperity of EU citizens and is the 3rd main contributory factor to Non Communicable Diseases (NCDs). Alcohol causes some 60 different types of diseases, including cancers, liver disease, cardiovascular diseases, many gastrointestinal conditions, immunological disorders, lung diseases, skeletal and muscular diseases, reproductive disorders and pre-natal harm, including increased risks of prematurity and low birth. Alcohol has been classified by the WHO's International Agency for Research on Cancer as a category one carcinogen, defining it as a determinant of many types of cancer - 10% cancers in men and 3% of total cancers in women are directly attributable to alcohol⁸. The World Economic Forum and Harvard School of Public Health estimate that NCDs will cause a €25 trillion global economic output loss over the period 2005-2030. Beyond its health consequences, the harmful use of alcohol inflicts significant social and economic losses on individuals and society at large.

The societal costs of alcohol in the EU for 2010 were an estimated €155.8 billion⁹. Alcohol is the world's number one risk factor for ill health and premature death among 25- 59 year olds, the core of the working age population¹⁰. Harmful alcohol use affects work performance, drains healthcare systems and is a contributory factor in crime, accidents and injuries.

⁵ WHO Status Report on Alcohol and Health in 35 European Countries 2013

⁶ British Medical Journal (2011) Alcohol attributable burden of incidence of cancer in eighth European countries based on results from prospective cohort study

⁷ Rehm, J, Shield K Interventions for alcohol dependence in Europe: a missed opportunity to improve public health, 2012

⁸ British Medical Journal (2011) Alcohol attributable burden of incidence of cancer in eighth European countries based on results from prospective cohort study

⁹ Rehm, J. et all (2012) Interventions for alcohol dependence in Europe: A missed opportunity to improve public health

¹⁰ Scientific Opinion of the Science Group of the European Alcohol and Health Forum (2011) Alcohol, Work and Productivity

Alcohol harm is disproportionately high among young people (115 000 deaths per year). Alarmingly 43% of male and 38% of female young European students (15-16 year old) reported heavy binge drinking during the past 30 days. Alcohol is the single biggest cause of death among young men of age 16 to 24¹¹.

Evidence demonstrates that the harm caused by alcohol is related to overall drinking levels, as well as drinking patterns. A comprehensive Strategy needs to incorporate both types of intervention to reduce alcohol-related harm, not just for problem drinkers but also for other people, such as children, families and communities, who are negatively affected by their drinking behaviours. The harms from alcohol are therefore multidimensional and require a range of policies to contribute towards having a healthy population and reduce costs for health care services, in line with the strategic aims of the Europe 2020 Strategy.

The European Commission is well placed to enhance actions and deliver measureable achievements to form a coherent approach to reducing alcohol related harm in EU. This document aims to contribute to a constructive and action oriented discussion on the updated EU Alcohol Strategy for (2016-2025). It will focus on the main policy areas accompanied with Eurocare recommendations and followed by suggestions on the methods of implementation.

With this in mind Eurocare calls on the Member States and the European Institutions to support the development of an updated comprehensive EU Alcohol Strategy with clear and targeted measures.

Main policy areas

Eurocare supports a combination of policy tools and interventions that are needed to prevent and reduce alcohol related harm. According to WHO¹² more than 90% of alcohol-attributable net deaths (the number of deaths after adjusting for the potential beneficial effects of moderate alcohol consumption) are due to three major causes: cancers, liver cirrhosis and injuries. The separation of causes of death is important, as there are differences in the preventive measures which should be implemented. For cancers, overall tissue exposure to alcohol is important, such that even one drink per day has shown to be associated with an increased risk of cancer. Consequently, the main emphasis of preventive measures should be on an overall reduction in the volume of drinking. For liver cirrhosis, the risk curve is more exponentially shaped. From a prevention standpoint, measures should be aimed at an overall reduction of volume of consumption, with a special emphasis on chronic heavy drinkers. Finally, for injuries, the blood alcohol content (BAC) at the time of the injury is the determining variable, which implies that preventive measures should be aimed at risky single occasion drinking. This needs to be solved by a comprehensive strategy employing a number of policy options, some of which are presented below.

2.1 Alcohol Pricing Policies

There is strong and consistent evidence that increasing the price of alcohol reduces immediate and chronic harm related to drinking among people of all ages. All consumers, including heavy and problematic drinkers, respond to changes in alcohol prices¹³. The affordability of alcoholic

¹¹ ESPAD (2011) ESPAD Report: Substance Use Among Students in 36 European Countries

¹² World Health Organisation: Status Report on Alcohol and Health in 35 European Countries , 2013

¹³ Babor TF et al (2010) Alcohol: no ordinary commodity. Research and public policy, 2nd ed. Oxford, Oxford University Press.

beverages has increased in Europe over the last 12 years. The real value of excise duty rates for most alcoholic beverages has gone down since 1996 and consequently alcohol has been much more affordable, particularly in the Baltic States, Eastern Europe and the UK. Relative prices have been stable in Southern Europe. There has been a decline in the EU minimum excise duty rate in real terms for alcoholic beverages since 1992 as they have not been adjusted for inflation.

The EU needs to change the structure of excise duties in the EU directive to ensure that all types of alcohol beverage can be taxed in relation to the volume of alcohol they contain. Current excise duties vary for different alcoholic products; this means duty does not always relate directly to the amount of alcohol in the product; in addition an increase in the duty levied does not necessarily translate into a price increase- retailer or producers may absorb the cost. There is a trend towards more off-trade alcohol consumption, which tends to be cheaper than alcohol sold on-trade¹⁴. Therefore the structure of excise tax should also allow a higher rate of excise duty to be applied to alcohol sold in the off-trade and encourage a shift in consumption of lower strength products.

At Member State level, alcohol should be made less affordable by increasing alcohol taxes in line with inflation and income changes, banning discounting and promotions, such as “two for one” and “happy hour” .

Different countries operate different alcohol policies. In 2011 the alcohol related death rate in Scotland was almost twice that of 1982. Hospital admissions for alcoholic liver disease have more than quadrupled in the past 30 years and Scotland now has one of the highest cirrhosis mortality rates in Western Europe. Minimum Unit Pricing (MUP) is a policy that sets a floor price below which alcohol cannot be sold, based on the amount of alcohol contained in the product. MUP is particularly effective at reducing the amount of alcohol drunk by harmful drinkers as they tend to buy most of the cheap alcohol. Harmful drinkers on low incomes will benefit most in terms of improved health and wellbeing. MUP has been adopted in Scotland without opposition, however is delayed by a legal challenge by trade bodies representing international alcohol producers. The case has now been referred to the European Court of Justice to ask for its opinion. Eurocare is calling for the importance that Member States and regions can implement without legal challenges the public health policies that are found most suitable.

Pricing and other economic measures would be an important part of an effective policy mix to tackle harmful and hazardous alcohol consumption. Eurocare acknowledges the difficulties in tackling this issue on the European level, however believes that a European strategy should encourage Member States to introduce policy options like minimum pricing and increased taxes.

EUROCARE RECOMMENDATIONS

- Excise duty on all alcohol beverages should rise in line with inflation.
- EU Recommendation of “zero” for excise duty on wine should be brought to an end.
- Member States should have the flexibility to limit individual cross-border purchases so as not to diminish the impact of their current tax policies
- Member States should have the flexibility to set minimum unit prices based on alcohol content in products

¹⁴ RAND (2009) The affordability of alcoholic beverages in the European Union, Understanding the link between alcohol affordability, consumption and harms. Cambridge

2.2 Marketing of Alcohol Beverages

Despite being a key health determinant alcohol is still heavily marketed with young people as an important target group¹⁵. Consumers (and non-consumers) are exposed to sophisticated marketing aimed at creating positive expectations and beliefs not just about the product itself but how it will make them feel and be perceived by others. Alcohol marketing techniques range from mass media advertising to sponsorship of events, product placement, internet and social media campaigns, merchandise and usage of other products connected with alcohol brands. In 2009, the Science Group of the European Alcohol and Health Forum reviewed evidence¹⁶ looking at the impact of marketing on the volume and patterns of drinking alcohol. It concluded that alcohol marketing increases the likelihood that young people will start to drink alcohol and that if they are already drinking, they will drink more in terms of amount and frequency.

According to the WHO European Charter on Alcohol 1995, "All children and adolescents have the right to grow up in an environment protected from the negative consequences of alcohol consumption and, to the extent possible, from the promotion of alcoholic beverages".

Reducing exposure to alcohol marketing by young people should be a key objective of an updated EU Alcohol Strategy. The existing French 'Loi Evin'¹⁷ provides an approach to the regulation of alcohol marketing that should be adopted as the minimum standard across the EU. A statutory regulatory framework should control the volume and content of marketing, online marketing, sponsorship and product placement. Crucially, in light of technological advances and the increased role of social media in society today, particular focus needs to be placed on regulation of the alcohol marketing in the online and mobile environments.

Eurocare calls for a level playing field for commercial communications that should be implemented across Europe, building on existing regulations in Member States, with an incremental long-term development.

¹⁵ Eurocare defines marketing as a mix of sophisticated, integrated strategies, grouped around four main elements: the product, its price, its place (distribution) and its promotion.

¹⁶ Science Group of the Alcohol and Health Forum (2009) Does marketing communication impact on the volume and patterns of consumption of alcoholic beverages, especially by young people? Retrieved from: http://ec.europa.eu/health/ph_determinants/life_style/alcohol/Forum/docs/science_o01_en.pdf

¹⁷ Included in the French Act of Public health

EUROCARE RECOMMENDATIONS

- No alcohol advertising on television or in cinemas.
- No alcohol advertising on the internet except at points of sale.
- No alcohol sponsorship of cultural or sport events.
- No alcohol advertising outdoors and in public premises (i.e. athletes' shirts, bus stops, lorries etc)
- No sales promotions such as Happy Hours and Open Bars/Girls Night etc.
- No intrusive¹⁸ and interstitial¹⁹ marketing tools such as: social media, apps on mobile phones.
- Young people should not be exposed to alcohol marketing. Strict regulations should be in place to restrict product placement of alcohol products in films and programs portraying drinking classified as for 18 certificate.
- Alcohol advertising should only be permitted under precise conditions defined by statutory regulation. It should neither be mentioned nor linked to sexual, social and sports related images, nor imply benefits related to these areas that are accrued from consumption of alcoholic products.
- A health message must be included on each advertisement, drawing attention to specific risks associated with alcohol consumption.

2.3 Availability of alcohol

Availability of alcohol refers to the ease and convenience with which alcohol can be obtained. Greater access to alcohol through more outlets and longer trading hours influences a range of alcohol-related harms, and levels and patterns of consumption. A large number of research studies from different countries have shown links between the number of alcohol outlets and opening hours and levels of violence, alcohol-related traffic accidents, self-reported injuries and suicide, sexually-transmitted disease and child abuse or neglect.

In many EU countries, liberalisation and globalisation of trade over the past few decades has resulted in increased availability of alcohol. More alcohol sold in a wider range of retail premises and for longer trading hours has enhanced access, visibility and promotion of alcohol, decreasing the perception that it is not an ordinary commodity. Greater availability and affordability of alcohol have been associated with a rise in alcohol consumption and related problems in many countries.

Regulating the availability of alcohol and placing restrictions on the eligibility to sell and purchase alcohol is an important mechanism for controlling and reducing alcohol-related harm in the EU.

EUROCARE RECOMMENDATIONS

- Any retailer selling alcohol should require a licence to operate. A licensing system should regulate the overall number, type, trading hours and operating conditions of all premises licensed to sell alcohol.
- The sale of alcohol in shops should be restricted to specific days, times of the day and designated areas.
- Legislation should be enacted to monitor and control all sales, including the location of

¹⁸ Intrusive here defined as behaviour ad that targets your habits and based on your profile using social net, your own emails, cookies, localisation etc, or brings you to change web page by replacing ads by others.

¹⁹ Interstitial here defined as movable ads that appears between two web pages in a plain screen or when you start apps on your smartphone

sale, dispatch and delivery. This would include ensuring that online retailers comply with local regulations on the availability of alcohol.

- All EU countries should restrict alcohol sales to young people. Legal age restrictions on the purchase of alcohol should be rigorously enforced.
- The EU and Member States should support initiatives to provide alcohol-free leisure environments for adults and young people.

2.4 Consumer Information – Product labelling

Product labels can serve a number of purposes, providing information about the product to the consumer, enticing the consumer to buy the product and informing consumers of dangers and health risks from the product. Listing the ingredients contained in a particular beverage alerts the consumer to the presence of any potentially harmful or problematic substances. Providing information about the ingredients and energy content enables the consumer to monitor their diets better and supports them in maintaining a healthy lifestyle.

Labelling on alcohol products should provide information not only on ingredients, but also about the risks associated with alcohol consumption: damages to health (liver cirrhosis, certain kinds of cancers (such as breast, oesophageal and oral cancer), risks of dependence, dangers associated with drinking alcohol during pregnancy, when driving, operating machinery and when taking certain medication.

The European Commission is well positioned to coordinate efforts to protect consumers from side effects of products which are sold in the internal market of the EU. Labelling should be part of a comprehensive strategy to secure information and educate consumers about alcohol.

EUROCARE RECOMMENDATIONS

- There should be compulsory EU wide introduction of health information labels on containers of alcoholic beverages.
- Containers of alcoholic products should be required to provide the following information about the product to consumers:
 - Country of production
 - Ingredients
 - Substances with allergenic effect
 - Relevant nutrition information (energy value kcal)
 - Alcoholic strength
 - Include health information, always including a specific warning about the dangers of drinking alcohol in pregnancy

2.5 Drink-driving policies and countermeasures

Traffic accidents related to alcohol consumption are a major cause for concern in the EU. Around one accident in four can be linked to alcohol consumption, and at least 6.500 people are killed in alcohol-related road accidents in the EU each year. Drink driving remains the second biggest killer on EU roads. The fatality risk increases exponentially with the blood alcohol content (BAC) level of the driver. The risk for drivers with low BAC levels (0.1 tot 0.5 g/L) is 1 to 3 times the risk of sober drivers. For drivers with a BAC level of 0.5 to 0.8 g/L it is already up to 20 times higher, increasing to 5-30 times for drivers with BAC levels of 0.8 to 1.2

g/L. For high BAC offenders the risk is 20-200 times higher than that of sober drivers²⁰.

Effective methods to tackle drink driving include reducing the legally permitted BAC, effective enforcement and the use of alcohol interlock devices. In addition there needs to be greater attention paid to the risks of alcohol for pedestrian road users.

EUROCARE RECOMMENDATIONS

- The principle of zero tolerance for drink driving should inform policy. To achieve this, a common upper limit, based on research evidence, should be applied²¹.
- Adequate enforcement is needed within Member States, who should rigorously enforce drink driving laws, using evidence-based measures such as random checks and breath testing.
- A harmonised penalty system with license suspension should be implemented across the EU
- Information on drink driving, the harm which results from drinking and driving and the penalties should be included in driving lessons, driving tests and in published driving codes
- Ban on sale of alcoholic beverages at petrol stations and motorway service stations
- Alcohol interlocks should be made compulsory for all professional drivers and for people who have been convicted of two or more drink driving offences.
- All alcohol beverages should carry labels informing about the dangers of drink driving and the legal penalties associated with it.

2.6 Health sector responses for early detection, brief interventions and treatment

Treatment and early interventions is a vital component of the total response to alcohol problems, and must be included in a comprehensive approach to alcohol policy. As some studies indicate in primary health care settings, commonly less than 10% of the population at risk of becoming hazardous and harmful drinkers are identified and less than 5% of those who could benefit are offered brief interventions²². There is consistent evidence that early interventions reduce alcohol related harm and are cost effective. The introduction of these programmes requires strong leadership and detailed planning in health and related services. Care and treatment for people with alcohol problem, including dependence is effective and highly cost effective²³.

EUROCARE RECOMMENDATIONS

- Support given to Member States to implement programmes of brief interventions and a full range of care and treatment for those with alcohol problems.
- Recognition and support for mutual help groups

²⁰ Study on the prevention of drink driving by the use of alcohol interlocks devices - Report for the European Commission DG Mobility and Transport by ECORYS and COWI 2014

²¹ A technical enforcement tolerance level could be set at 0,1 or 0,2 g/l BAC but the message to drivers should always be clear: no drink and drive

²² WHO Europe (2012) Alcohol in the European Union

²³ NICE guidelines on Alcohol Dependence

2.7 Strategies that alter drinking contexts, backed up by community based prevention actions

Harm done by alcohol to third parties is a significant burden on society. It causes a number of deaths. Accidents harm individuals, families, communities and society at large. There is a strong link between alcohol and violence (e.g. 80% of violent crimes committed by adolescents in Estonia are associated with alcohol use). Alcohol is an attributable factor in 40% of all homicides throughout the EU²⁴. Effort should be made to create an environment that supports lower-risk drinking. Drinking settings such as pubs, bars, nightclubs are key areas for interventions to improve the way alcohol is served and consumed. Key features of dangerous venues include a permissive atmosphere, crowding, low levels of comfort, inadequately trained staff, and cheap drinks promotions²⁵. Thoroughly implemented interventions can enhance prevention of risky behaviour, protect the health of individuals and care for broader impact of hazardous alcohol consumption on communities (i.e. vandalism).

EUROCARE RECOMMENDATIONS

- Minimum legal age for purchasing 18 years (while respecting MS with higher minimum age of purchase and stricter implementation policy)
- Stricter opening hours for commerce selling alcohol (with special emphasis on night shops)
- Reduced density of alcohol outlets, especially around areas where young people are more likely to be present e.g. schools, sport centres, cultural centres, stadiums, play grounds etc.
- Professional training for employees handling alcohol (serving, selling)

2.8 Evidence-based public awareness communication and school-based education to help reduce risks and harm from alcohol

Effective alcohol policy needs competent and well-informed personnel working in settings aimed to support their efforts. Therefore, investments must be made in both institutional and human capacity research development. Engaging stakeholders who are directly affected by the situation allows for more effective decision-making. Organisational capacity building focuses on developing the capacities of organizations so they are better equipped to accomplish the missions they have set out to fulfil. Capacity building in NGOs often involves building up skills and abilities, such as decision making, policy-formulation, appraisal, and learning. For organizations, capacity building may relate to almost any aspect of its work: improved governance, leadership, mission and strategy, administration (including human resources, financial management, and legal matters), program development and implementation, fund-raising and income generation, diversity, partnerships and collaboration.

Actions on preventing alcohol related harm takes place at local, national, European and global level, and there is a lot of good practice, experience and knowledge already available. To better enable cooperation and efficiency on actions that work, investment in capacity, network building and learning exchange is needed. This should include funds to support the work of researchers, professionals in medical and social issues, and civil society.

Social inclusion is important both as prevention and as rehabilitation. In order to keep people in the workforce and out of treatment, care and social support, programs to socially integrate

²⁴ WHO Europe (2012) Alcohol in the European Union

²⁵ Hughes et al (2011) Environmental factors in drinking venues and alcohol-related harm: the evidence base for European intervention *Addiction* 106(S1):36-46

and rehabilitate people with alcohol problem are a priority. It would benefit the individual, its family and community and the economy as well as reducing inequalities in health. This could be achieved by integration of alcohol harm related dimension in programs aiming at reducing inequalities in health and social exclusion. Furthermore, effective programs should be supported, such as self- help groups and early intervention programs as well as effective treatment.

The adverse effects of alcohol are exacerbated among those from lower socioeconomic groups; this is especially the case for dependency, which is often accompanied by poor diet and general lack of money. People in lower socioeconomic groups who drink heavily cannot protect themselves as well as those in more affluent groups, who can purchase social and spatial buffering of their behaviour. Low socioeconomic status renders a pattern of drinking more visible and makes the drinker more vulnerable to marginalisation and stigma.

EUROCARE RECOMMENDATIONS

- Grants should be made available for capacity and network building for researchers, professionals in medical and social issues, and civil society to facilitate exchange of knowledge and plans based on evidence from across the EU.
- Implementation of health objectives in all policies

2.9 Raised awareness of dangers from drinking alcohol during pregnancy

Drinking alcohol during pregnancy can lead to birth defects and developmental disorders. It may cause the unborn child physical, behavioural and learning disabilities. Alcohol can damage the baby throughout the entire pregnancy. During the first trimester of pregnancy, when pregnancy may not be recognised, exposure to alcohol can cause abnormalities in the physical structure of the foetus. During the third trimester, the baby's length and weight increase dramatically and exposure to alcohol can impair the growth. The brain develops and is vulnerable to damage during the entire pregnancy. The damage to the brain, which may result in behaviour problems and cognitive deficits, is the most debilitating of the effects of prenatal alcohol exposure. FASD is an umbrella term describing the range of effect that can occur in person whose mother drank during pregnancy. It affects nearly 5 million people and is 100% preventable. Although many women give up alcohol when pregnant there are a substantial number of women in all the EU Member States who continue to drink.

Early years are a vital stage of child development and alcohol problems within the family can have a significant effect on infant attachment and neurodevelopment and action on drinking in pregnancy should be linked to actions to protect families and children.

EUROCARE RECOMMENDATIONS

- Containers of alcoholic products should carry a health information message determined by public health bodies describing the harmful effects of drinking alcohol during pregnancy
- Introduction of comprehensive and permanent awareness-raising campaigns and educational programmes for the public at large
- Programmes to enhance knowledge of health care professionals
- Provision of services for diagnosis and treatment for children with foetal alcohol syndrome (FAS/FASD)
- Implementation of modules promoting health prevention and awareness-rising as compulsory modules in the curriculum for medical degrees
- Strategies to reduce rates of heavy drinking by all women of child-bearing age with an inclusion of FASD diagnosis by social and judicial services

2.10 Protection of family and children

Whilst millions of families within the EU are affected by alcohol problems it is difficult to find an accurate assessment of its size. Perceptions on alcohol problems vary from culture to culture and, among those affected, it can often take the 'character of a shameful secret'. It is being estimated that 11 million people in the EU are dependent on alcohol, which consequently results in 9 million children and young people in the EU living with at least one parent addicted to alcohol²⁶. Many of these children are raised in families with alcohol addiction and are exposed to risk behaviour of their parents. Two thirds of the reported victims of domestic violence had been attacked by a person using alcohol, and 16% of cases of child abuse and neglect involve alcohol²⁷. Children living with families affected by alcohol related harm tend to have lower school attendance and worse health.

EUROCARE RECOMMENDATIONS

- Increase support for children affected by harmful parental drinking.
- Awareness raising campaigns on protection of children from alcohol related harm.

2.11 Prevention with special focus on the workplace

Prevention cannot remain a responsibility of the Member States alone, Europe, as a market place, a cultural space and communication area must address prevention. Equally the local level is where people conduct their daily lives. Therefore, prevention should span across the European and local level. Community based prevention must be supported by a European wide program in a comprehensive, coordinated, long- term manner. Harmful and hazardous alcohol consumption is one of the main causes of premature death and avoidable disease and furthermore has a negative impact on working capacity. Alcohol-related absenteeism or drinking during working hours has a negative impact on work performance, competitiveness and productivity. Often forgotten is the impact of drinkers on the productivity of people other than the drinker. Moreover, about 20 to 25% of all accidents at work involve intoxicated people injuring themselves and other victims, including co-workers²⁸.

²⁶ Anderson P, Baumberg B (2006) Alcohol in Europe: a public health perspective. London Institute of Alcohol Studies

²⁷ Ibid

²⁸ Science Group of the Alcohol and Health Forum (2011) Alcohol, Work and Productivity: Scientific Opinion of the Science Group of the European Alcohol and Health Forum Retrieved from: http://ec.europa.eu/health/alcohol/docs/science_02_en.pdf

EUROCARE RECOMMENDATIONS

- Implementation of health promotion policies and campaigns within the workplace with focus on alcohol
- More comprehensive data collection on impact of alcohol related problems on economy and within the workplace
- Enforcement and where not existent introduction of zero tolerance policies for BAC levels in industries where alcohol increases the danger of accidents and injuries

2.12 Alcohol Research, data collection and Monitoring programmes

It is crucial to appropriately monitor alcohol policy developments in the EU, with a set of common indicators and definitions, in order to ensure that comparable data across EU is available. Consequently, this consistency will provide tools to assess the policy actions undertaken. There is a need for better data on alcohol in Europe. The European Commission and Member States should regularly obtain comparable information on alcohol consumption, on drinking patterns, on the social and health effects of alcohol; and information on the impact of alcohol policy measures and of alcohol consumption on productivity and economic development. The European Commission should monitor and follow the developments in Member States to see if targets are reached.

EUROCARE RECOMMENDATIONS

- A European Alcohol Monitoring centre with country based counterparts, should be established and financed. It should draw on the best scientific advice and engage with national and international NGOs to set priorities, assess evidence, monitor trends and improve data accessibility.
- When new legislation is adopted at regional, national and the European level standardised evaluation should be performed.
- Alcohol related targets should be included in European Commission work on prevention of chronic disease
- EU-wide policy guidance and standards should be provided on prevention, brief interventions and treatment of alcohol related health disorders.
- The European Commission should define and track a common set of indicators, policy responses and interventions in close collaboration with Member States.
- Increased funding should be made available for European research on alcohol, both as health and as a social issue.
- Additional coordination should be promoted among European and national research organisations in alcohol research and other areas.
- A European working group should be created with members from the European Commission, Member States and experts in the field to discuss the main research challenge in the alcohol field.

Way forward: how to address alcohol related harm?

Compared to the current EU alcohol strategy there is a strong need for future policies to have specific and clear targets, whilst also working harder at promoting a coherent approach through health in other policies. European Union regulations, such as those governing the internal market, trade, competition and agriculture, have in practice an enormous impact on national and local health policies.

Eurocare is concerned that alcohol related harm does not seem to be taken into account when issues like cross border trade, taxes and agricultural support are discussed and regulated by Directorates of the Commission which are not directly working on health. The efforts of the health community and all stakeholders involved could be counterproductive if the issue is not being addressed. This has been recognised over the years by the EU legislature and as mentioned in Art. 168(5) TFEU, it (...) may adopt incentives measure designed to protect and improve human health (...) and measures which have as their direct objective the protection of public health regarding tobacco and the abuse of alcohol.

One way forward to provide a more structured approach would be for the updated EU Alcohol Strategy to include:

- Fixing guidelines and timetables for achieving short, medium and long-term goals
- Establishing quantitative and qualitative indicators and benchmarks, tailored to the needs of Member States and sectors involved, as a means of comparing best practices
- Translating European guidelines into national and regional policies, by setting specific measures and targets
- Periodic monitoring and evaluation of the progress achieved in order to put in place mutual learning processes between Member States

Eurocare suggests having a 3 step period; 2016 – 2018, 2019- 2021, 2022-2025 that would be expected to produce the following outcomes:

- Enhanced mutual learning and peer review
- Identification of good practices and of their conditions for transferability
- Development of joint policy initiatives among several Member States and regions
- Identification of areas where Community initiatives could reinforce actions at Member State level.

