Chapter 10: Conclusions and recommendations

INTRODUCTION

At the level of the European Union, there is, as yet, no comprehensive alcohol policy document or strategy. Current Union wide actions on alcohol are based on two Council initiatives adopted in June 2001, the Council Recommendation on the drinking of alcohol by young people, in particular children and adolescents[1] and the Council Conclusions on a Community strategy to reduce alcohol-related harm[2], with the request for a comprehensive alcohol strategy repeated by the Council in June 2004[3].

There are both community and cross border aspects related to alcohol. Union policies influence alcohol production, marketing, trade, consumption and the reduction of harm. Union policy provides subsidies for wine production; policy on television without frontiers regulates alcohol advertising; consumer policy regulates labelling and claims; internal market and taxation policy influence the price structure and therefore consumption; and transport policy influences the law on blood alcohol levels and driving.

The ability of Member States to frame effective alcohol policy can be restrained due, for example, to differences in excise duties on alcoholic beverages, young peoples' changing drinking habits, and cross border marketing. Thus, a comprehensive strategy at the level of the European Union would also support Member States, as well as regions and municipalities in the strengthening and implementation of their own policies.

This final chapter draws together a number of conclusions and recommendations to inform the development and implementation of alcohol policy at the European, Member State and regional and municipal levels. The conclusions and recommendations, which are drawn from the previous chapters, as well as from the Health for All principles of the World Health Organization[4], are focussed to support the objective of the European Commission's proposals for a comprehensive alcohol strategy to reduce the health and social harm done by alcohol, and thus contribute to higher productivity and a sustainable economic development in the Union in line with the objectives set out in the Lisbon Strategy[5].

CONCLUSIONS

Fifteen public health conclusions are drawn, stressing that alcohol policy does not need to affect the role that alcohol plays in the economy of Europe; the importance of alcohol as an economic burden to European society and an impediment to the objectives of the Lisbon Strategy; the similarities and differences in drinking across Europe; the importance of alcohol as a health determinant leading to harm to others

[1] http://europa.eu.int/eur-lex/pri/en/oj/dat/2001/l_161/l_16120010616en00380041.pdf.

[2] http://europa.eu.int/eur-lex/pri/en/oj/dat/2001/c_175/c_17520010620en00010002.pdf.

[3] http://ue.eu.int/ueDocs/cms_Data/docs/pressData/en/lsa/80729.pdf.

[4] World Health Organization (1998). Health 21 – The Health For All Policy For The WHO European Region.

[5] Lisbon strategy: http://europa.eu.int/comm/lisbon_strategy/index_en.html.

and health inequalities; the responsibilities and benefits of governments in implementing alcohol policy; and the policy differences across Europe which can impair the ability of countries to set their own alcohol policies.

Alcohol and the Economy of Europe

Conclusion 1 Europe plays a central role in the **global alcohol market**, acting as the source of a quarter of the world's alcohol and over half of the world's wine production. **Trade** is even more centred on Europe, with 70% of alcohol exports and just under half of the world's imports involving the European Union, with the majority of this trade being between Union countries.

Conclusion 1	Evidence (ch: pp)[6]
The trade in alcohol contributes around €9billion to the **goods account balance** for the European Union as a whole, with such trade not necessarily affected by European and domestic policy to reduce the harm done by alcohol.	3: 48-52

Conclusion 2 Alcohol excise duties amounted to €25 billion in the older EU15 countries in 2001, excluding sales taxes and other taxes paid within the supply chain – although €1.5 billion is given back to the supply chain through the Common Agricultural Policy. Due to the relative inelasticity of the demand for alcohol, the average tax rates are a much better predictor of a government's **tax revenue** than the level of consumption in a country.

Conclusion 2	Evidence (ch: pp)
Alcohol tax revenues, an important source of government revenue (€25bn in 2001 in the older EU15 countries), are more closely related to tax rates than to the overall level of alcohol consumption.	3: 54-55

Conclusion 3 Alcohol is also associated with a **number of jobs**, including over an estimated three-quarters of a million in drinks production (mainly wine). Additional jobs are related to alcohol elsewhere in the supply chain, e.g. in pubs or shops. However, the size of the industry is not necessarily a good guide to the economic impact of alcohol policies – for example, trends in alcohol consumption show no crude correlation with trends in the number of jobs in associated areas such as the hotels, restaurants, and catering sector, suggesting that the effect of changes in consumption may be relatively weak. A reduction in spending on alcohol would also be expected to free consumer funds to be spent on other areas, with the economic impact depending on exactly what this new expenditure is. Current evidence from alcohol and other sectors suggests that declining consumption does not necessarily lead to job losses in the economy as a whole.

[6] ch=chapter; pp=page number

Conclusion 3	Evidence (ch: pp)
Declining consumption will not necessarily lead to **job losses** in the economy as a whole, and may not even lead to large changes in employment in some **sectors linked to alcohol** such as restaurants and bars.	3: 57-58

The social costs of alcohol

Conclusion 4 Alcohol-attributable disease, injury and violence is an **economic burden to society** in the health, welfare, employment and criminal justice sectors, with a total calculated tangible cost of €125bn ((and a range of €79-220bn) in 2003, equivalent to 1.3% of GDP. €59bn of these tangible costs due to alcohol result from **lost production** (absenteeism, unemployment and lost working years through premature mortality), and can be an impediment to the competitiveness of Europe as envisaged by the Lisbon strategy.

Conclusion 4	Evidence (ch: pp)
The tangible **costs of alcohol** to the European Union were estimated to be €125bn in 2003, including €59bn worth of **lost productivity** through absenteeism, unemployment and lost working years through premature death.	3: 59-69 6: 197-204

Conclusion 5 The **intangible costs** show the value people place on pain, suffering and lost life that occurs due to the criminal, social and health harms caused by alcohol. In 2003 these were estimated to be €270bn, with other ways of valuing the same harms producing estimates between €150bn and €760bn.

Conclusion 5	Evidence (ch: pp)
The intangible **costs of alcohol** (which describe the value people place on suffering and lost life) to the European Union were estimated to be €270bn in 2003.	3: 65-68 6: 197-204

The use of alcohol in Europe

Conclusion 6 Although many differences between countries remain, there have been several examples of convergence in drinking across Europe, in terms of the amount drunk, drinking patterns and styles, and beverage choices (sometimes within the whole EU and sometimes between different regions). North-south gradients can still be seen for many aspects of drinking, such as more binge drinking in the north and more drinking with meals in the south, but these are less apparent than previously described and obscure increasing exceptions to this general pattern. Most countries have seen a rise in binge-drinking for both boys and girls in the 1990s followed by mixed trends since, resulting in a narrower gap in binge drinking between the newer EU10 countries and the older EU15 countries.

Conclusion 6	Evidence (ch: pp)
While **differences** between countries in the levels and patterns of drinking are still evident, they are smaller than they were 40 years ago, and many aspects of drinking are much more similar across Europe than commonly believed. **Adolescent binge drinking** has increased in most countries in the 1990s, followed by mixed trends in the past few years.	4: 83-85 4: 108-110

Conclusion 7 Although the prevalence of drunkenness and its consequences differs across Europe, problems arising from intoxication (such as intentional and unintentional injuries) are also important in southern Europe. Some of the perceived differences arise because some Europeans believe more in a link between alcohol and violent injuries than other Europeans, although this appears to show no clear pattern across Europe. The reality is that, for example, changes in alcohol consumption have a significant effect on male homicide rates in all regions of Europe, with some estimates even suggesting that the role of alcohol as a cause of homicides may be similar in southern Europe (61% of all homicides) and northern Europe (50% of all homicides).

Conclusion 7	Evidence (ch: pp)
Drunkenness is an important cause of **injuries** – including violent injuries – across all of Europe, including in southern Europe.	6: 196-205 6: 210-213

Conclusion 8 Hippocrates, writing 2500 years ago, advised anyone coming to a new city to enquire whether it was likely to be a healthy or unhealthy place to live, depending on its geography and the behaviour of its inhabitants ("whether they are fond of excessive drinking"). This is equally true today. Although there has been a convergence in drinking behaviour and drinking styles, a European citizen is more likely to have a problem from alcohol **if they live** in a country, region or municipality with a higher relative alcohol consumption or a more detrimental pattern of drinking.

Conclusion 8	Evidence (ch: pp)
Where you live in Europe remains a major determinant of the harm done by alcohol.	6: 211-230

Alcohol and Health

Conclusion 9 Alcohol is a key **health determinant**, being a cause of some 60 diseases and conditions. Alcohol is responsible for 7.4% of all ill-health and premature death in the European Union, being the third leading risk factor after high blood pressure and tobacco, and a cause of over 25% of male deaths in the age group 15-29 years. Both the overall amount of alcohol consumed and the amount consumed on any one drinking occasion are important determinants of health and social harm. Fifty-five million adults drink to hazardous levels and some 100 million Europeans binge-drink at least once a month. Although in low doses, alcohol reduces the risk of coronary heart disease, the current estimate of 160,000 deaths delayed in old age is likely to be an overestimate.

Conclusion 9	Evidence (ch: pp)
Alcohol is a health determinant, responsible for 7.4% of all disability and premature death in the European Union.	5: 141-165 6: 205-219

Conclusion 10 Alcohol is a key cause of harm to **people other than the drinker** including, crime, violence and injuries, and harm to the unborn child.

Conclusion 10	Evidence (ch: pp)
Alcohol is a cause of harm to **others than the drinker**, including some 60,000 underweight births, 5-9 million children living in families adversely affected by alcohol and 10,000 traffic deaths to people other than the driver in the European Union each year.	5: 136-141 6: 222-223

Conclusion 11 Alcohol contributes to **health inequalities** between and within Member States. The alcohol disease burden is highest in some of the new Member States, and alcohol related harm is one factor behind the difference in life expectancy between the older EU15 countries and the newer EU10 countries. In England, men aged 25–69 years in the lowest socio-economic status category have a 15-fold higher risk of alcohol-related mortality than professionals in the highest category.

Conclusion 11	Evidence (ch: pp)
Alcohol is a cause of **health inequalities** both between and within Member States, causing an estimated 90 extra deaths per 100,000 men and 60 extra deaths per 100,000 women in the newer EU10 countries, compared to the older EU15 countries.	6: 220-222

Alcohol and government policy

Conclusion 12 Governments have a **responsibility** for alcohol policy, and government action, which includes taxes, service provision, regulation and information, also brings in **benefits**, including reduced costs and increased income due to taxes.

Conclusion 12	Evidence (ch: pp)
Governments have a **responsibility** to intervene in the market, and **benefit** from doing so, with, for example, a 10% increase in the price of alcohol across the older EU15 Member States estimated to bring in approximately €13bn in extra alcohol taxes in the first year.	7: 262-263

Conclusion 13 The most robust evidence for effectiveness in reducing the harm done by alcohol results from those measures that regulate the marketing of alcohol, including price and taxation, managing the availability of alcohol and regulating commercial communications. Educational type preventive interventions show little evidence of effectiveness across authoritative reviews and are not an alternative to regulating the marketing of alcohol.

Conclusion 13	Evidence (ch: pp)
Educational interventions, which show little effectiveness in reducing the harm done by alcohol, are not an alternative to **measures that regulate the alcohol market**, which have the greatest impact in reducing harm, including amongst heavier and younger drinkers.	7: 251-258 7: 258-287

Alcohol and European policy

Conclusion 14 Although alcohol polices have converged in Europe over the last 50 years, substantial differences in alcohol taxes that result in cross-border shopping impede the ability of many countries to implement effective policies.

Conclusion 14	Evidence (ch: pp)
Continuing differences in alcohol policy across Europe, such as tax rates, impair the ability of countries to implement effective policies.	8: 349-359

Conclusion 15 Despite the differences in policies between Member States, the European Court of Justice has increasingly ruled in favour of different alcohol policies for **health reasons**. An example of this is when the French Government was taken to the European Court, alleging that its Loi Evin, by prohibiting alcohol advertising on hoardings visible during the retransmission of bi-national sporting events on TV, entailed restrictions on the freedom to provide advertising services and television broadcasting services. The Court ruled in favour of the Loi Evin by stating: it is in fact undeniable that advertising acts as an encouragement to consumption; the French rules on television advertising are appropriate to ensure their aim of protecting public health; they do not go beyond what is necessary to achieve such an objective.

Conclusion 15	Evidence (ch: pp)
Different policies between Member States are sometimes ruled as legitimate to **protect public health**, such as the European Court's 2004 ruling in favour of the French advertising law.	8: 351-352

RECOMMENDATIONS

In this section, 18 general recommendations are made for supporting alcohol policy based on previous chapters as well as on the Health for All policy principles of the World Health Organization[7], in the four areas of: (i) defining an alcoholic beverage; (ii) creating the evidence base; (iii) preparing and implementing resourced strategies and plans; and (iv) assessing the impact of other policy areas and increasing cross border support.

These general recommendations are followed by 34 specific alcohol policy recommendations in six areas derived from Chapter 7: (v) policies that reduce drinking and driving; (vi) policies that support education, communication, training and public awareness; (vii) policies that provide consumer information; (viii) policies that regulate the alcohol market; (ix) policies that support the reduction of harm in drinking and surrounding environments; and (x) policies that support interventions for individuals.

General Recommendations

I. Defining an alcoholic beverage

Although the EU has a definition of alcohol for tax purposes (0.5% alcohol concentration for beer and 1.2% alcohol concentration for all other drinks), considerable differences remain across countries in the definition of an alcoholic beverage for public policy purposes (see Chapter 9). This is compounded by the difficulty of classifying many mixed drinks that have been produced in recent years (see Chapter 3, 4 and 7), and the varied definitions of 'low alcohol' beverages that are subject to fewer restrictions (e.g. only beer below 4.2% alcohol concentration can be sold on trains in the Czech Republic).

Defining an alcoholic beverage	Relevant actor	Evidence (ch:pp)
I.1. Public policies need to define alcoholic beverages in a uniform way across the European Union. A starting point could be the lowest definition for tax purposes (0.5% alcohol by volume).	(I) European institutions	9: 377

II. Creating the evidence base

Research A firm research base is a pre-requisite for alcohol policies and actions. A clear finding of this report is that Europe, and particularly southern and eastern Europe, lag behind other parts of the world in undertaking and publishing research on alcohol and alcohol policy. The scientific community should be involved in developing scientifically sound, socially relevant and feasible bases for alcohol policy decisions. Research is not value-free, in the sense that the framing and choice of topics

[7] World Health Organization (1998). Health 21 – The Health For All Policy For The WHO European Region.

inevitably reflects judgments and choices between competing priorities. The duty of the scientific community is to be faithful to the research evidence, which means that the findings of research may contradict current policies and programmes. There is good reason, then, for there to be some distance between the public health scientific community and both governments and the beverage alcohol industry.

However, there must be a much better match between the needs for alcohol policy research as perceived by decision-makers and planners on the one hand, and the research priorities set by the research community on the other. And to be useful, research evidence has to be communicated simply and given meaning by making it relevant to current issues. Such sustained contributions may only be possible in the context of a long-term, publicly-funded research programme designed to engage members of the scientific community in each country in the collection, evaluation, and interpretation of research data that is relevant to a country's alcohol policy needs.
Research and development efforts cannot be implemented without building the appropriate capacity. 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.

Responsibility for translating scientific research into effective policy is distributed across a wide variety of government agencies and public interest groups. In addition, there need to be systematic mechanisms for ensuring that new evidence from research is actually introduced into policy and programme practice. If all existing knowledge about which alcohol policy approaches work and which do not were fully applied, this could have a major impact in improving public health.

Recommendations for research	Relevant actor	Evidence (ch:pp)
II.1. European infrastructures should be established and financed to undertake collaborative cross country alcohol research (see Box 10.1).	(I) European institutions (II) Member States and regions	All report
II.2. European infrastructures should be created and financed to review and disseminate all major research outcomes in alcohol policy through, for example, registries and databases; the evidence base should be translated into easily understood policies and practices through practical toolkits and guidelines	(I) European institutions (II) Member States and regions	All report
II.3. Long-term publicly-funded alcohol research programmes should be established and financed (see Box 10.1).	(I) European institutions (II) Member States and regions	All report
II.4. Research capacity in alcohol policy should be developed through professional development programmes.	(I) European institutions (II) Member States and regions	All report

Information systems are a key component in making knowledge more widely available. Intelligence is broader than information. It implies identifying and interpreting essential knowledge for making decisions from a range of formal and informal sources. Intelligence should include: current and future trends and system performance (e.g. levels, trends and inequalities in areas of alcohol consumption and alcohol-related harm); risk factors for harm; vulnerable groups; organizational or institutional challenges in implementing policy; governance; important contextual factors and actors (the political, economic and institutional context); the roles and motivation of different actors; user and consumer preferences; opportunities and constraints for change; and events and reforms in other sectors with implications for alcohol policy. This information should be available on electronic media and be published regularly in a publicly accessible form, so as to promote an informed and open debate among politicians, professionals and the public concerning outcomes and determinants, and future priorities for action and investment.

Recommendations for information	Relevant actor	Evidence (ch:pp)
II.5. A European Alcohol Monitoring Centre (EAMC), with country based counterparts, should be established and financed.	(I) European institutions (II) Member States and regions	All report
II.6. The importance of including alcohol-related indicators dealing with consumption, harm and policy and programme responses within the European Community Health Indicators short-list should be stressed to the EU Working Party on Health Indicators.	(I) European institutions	All report
II.7. Alcohol surveillance programmes should be established so that data are comparable and analysable across Europe (see Box 10.1).	(I) European institutions (II) Member States and regions	All report
II.8. A European database of laws and regulations and of effective polices and programmes at European, Member State and municipal level should be established and maintained.	(I) European institutions (II) Member States and regions (III) Municipal	9: 376-394

Box 10.1 – Improving Information and research on Alcohol

Throughout this report, there have been areas of public health relevance where there was insufficient comparative information to make robust conclusions. Although a detailed list of research recommendations is beyond the scope of this report (see instead the ECAS II study), the following areas strike the present authors as key gaps to be addressed:

Making data comparable

1. Given substantial problems in the comparability and robustness of certain data, a new European Alcohol Monitoring Centre (EAMC; see Recommendation II.6) should be a source of best practice for Member States and others. This should include expertise in the interpretation and context of questions on drinking, and how these vary across Europe. It could also act as a repository for datasets.
2. This infrastructure should provide a set of flexible but standardised definitions for alcohol data. These should cover both the use of alcohol (e.g. cut-off levels for episodic heavy drinking and binge-drinking) and alcohol-related harm (e.g. definitions of a 'drink-driving death').

Economic evaluations

3. The social and external cost of alcohol should be assessed using a standardised methodology in all Member States.
4. While the WHO's CHOICE project represents an important first step in cost-benefit analyses of alcohol policies, there is a need for further European research to estimate the costs and benefits of potential policy options and to evaluate the economic impact of policies that have recently been adopted.
5. Robust, transparent economic evaluation should also be conducted on (i) the number of jobs linked to alcohol; (ii) what happens to consumer spending if less money is spent on alcohol; and the effect of changing alcohol consumption on (iii) areas of the economy closely linked to alcohol and (iv) the wider economy.

Use of alcohol

6. Further repeated and comparative surveys are required – particularly in the EU10 – for abstention, heavy drinking, episodic heavy drinking (binge-drinking), drunkenness, context of drinking (with meals, in public), alcohol dependence, and unrecorded consumption (smuggling, cross-border shopping). While these areas (apart from unrecorded consumption) were mentioned within the European Community Health Indicators (ECHI) project,[1] they were not selected for the short-list and represent potential areas of future research only. Their importance should therefore be stressed to the EU Working Party on Health Indicators.
7. Measures of binge-drinking and drunkenness (and their link to outcomes) should be investigated further to determine their cross-cultural validity, and also to provide robust information on 'drunken comportment' within Europe. Policymakers should also consider whether 'heavy episodic drinking' is a sufficiently meaningful term to replace the more stigmatizing 'binge-drinking' within public debate.
8. A more detailed investigation of young people's drinking would be valuable for understanding contemporary trends, in particular including research on why young people drink as they do, e.g. motivations for drinking (and how they link to outcomes) and the wider risk factors for youth drinking. This could also include an analysis of the developmentally important 18-25 age group, as well as the more conventional focus on younger ages.

Social harms

9. There is a clear need for greater research in nearly all aspects of the social harms related to alcohol, including within the family, at the workplace, criminal behaviour, sexual behaviour and less serious but more common harms.

[1] *See points 2.3.5, 2.3.17, 3.1.2, 3.2.2 in the original (Feb 2004) ECHI long list, available from http://europa.eu.int/comm/health/ph_information/indicators/docs/longlist_en.pdf*

Box 10.1 – Improving Information and research on Alcohol [Con.]

Social harms (con.)

10. New research should focus, in particular, on the harm to others from a person's drinking, as well as:
    i. Crime: both aggregate- and individual-level methods are needed to allow a comparison of the crime caused by alcohol across Europe.
    ii. Workplace: the possibility of attaching questions on alcohol and the workplace to the existing Labour Force Survey should be investigated.
11. The methodology underlying research on social harms also needs attention, in particular, relating to the validity of the survey measures used. Further work should be undertaken on how problems are attributed to alcohol, including the extent to which this varies across Europe. For example, surveys could ask about non-alcohol-attributed levels of harm before asking about attributions to alcohol, so that risk ratios and varying attributions can be identified.

Health harms

12. While the WHO's Global Burden of Disease study is a major advance on previous work, it would be useful if future versions could also:
    - Investigate a further counterfactual scenario (i.e. the total burden of disease compared to light (or lowest-risk) drinking).
    - Provide a mechanism by which the impact of changes in drinking levels/patterns could be estimated and linked to cost-benefit analyses.
13. The EU institutions should also consider funding an in-depth analysis of the role of alcohol in the health gap between the EU10 and the EU15.

Alcohol policy

14. Collaborative comparative studies should be undertaken to look into the impact of different alcohol policy options within Europe. They should also investigate what happens when alcohol policies change in Member States.
15. A review should be undertaken of evidence of the effect of general risk-reduction programmes (rather than alcohol-specific ones) to impact on patterns of use and harm.
16. Analyses should be undertaken of the price and income elasticities of alcoholic beverages in the different Member States, including cross-product elasticities, the impact of tax changes on different age and socio-economic groups, and estimates of government revenue from different alcohol tax regimes.
17. Analyses should be undertaken of the impact of differential taxes on alcoholic beverages and liberalised personal allowances on cross border purchases.
18. Public attitudes to alcohol policy across Europe should be investigated, looking at the differences between groups within countries as well as across EU Member States. This research should take account of the need for informed decision-making (which, in a situation of low knowledge, may include methodologies such as deliberative workshops).

III. Preparing and implementing resourced strategies and plans

Alcohol policy is shaped by strategies and action plans that are developed at the European, country and regional and municipal levels. At the European level, the Commission is preparing a comprehensive strategy to support Member States to reduce the health and social harm done by alcohol, and thus contribute to higher productivity and a sustainable economic development in the Union in line with the

objectives set out in the Lisbon Strategy. The World Health Organization has also provided a framework for action for European Member States[8].

At the country level, it is ultimately a government's responsibility to define and be accountable for a clear alcohol policy for the whole country and region within a country. Many different decision-making authorities are involved in the formulation and implementation of alcohol policy, such as the health ministry, the transportation authority or the taxation agency. Governments need to establish effective and permanent coordination machinery, such as a national alcohol council, comprising senior representatives of many ministries and other partners, to ensure that a coherent approach is taken to alcohol policies and that policy objectives are properly balanced in both political and technical forms.

Targets make policy objectives more specific, allow progress towards them to be monitored and inspire many partners actively to support alcohol policy developments. Targets require an assessment of the present situation and help to determine priorities; they can focus discussion on what it had been hoped to achieve and why, and whether or not this was successful, and why; they provide a powerful communication tool, taking policy-making out of bureaucratic confines and making it a clearly understood public issue; they give all partners a clearer understanding of the scope of the policy; they strengthen accountability for health; and they motivate people for action.

Accountability for the health impact of alcohol policies and programmes rests with all sectors of society, as well as government officials who create policy, allocate resources and initiate legislation. Mechanisms such as alcohol policy audits, litigation for health damages and public access to reports on impact assessments can ensure that both the public sector and private industry are publicly accountable for the health effects of their alcohol policies and actions. Accountability can be achieved through mechanisms for coordinating, monitoring and evaluating progress in policy implementation and through procedures for reporting to elected bodies, as well as through the mass media.

One method of financing programmes to reduce the harm done by alcohol is an earmarked alcohol tax. This means that a proportion of tax revenue collected from alcohol is devoted to a specific activity, such as policy implementation or healthcare.

Many alcohol policies and programmes are devolved to jurisdictions within countries, including local government authorities and municipalities. Within a framework of such devolvement, it is vital that country or regional-based legislation enables rather than restricts the ability of local government authorities and municipalities to act.

[8] http://www.euro.who.int/Governance/RC/RC55/20050920_1.

Recommendations for strategies and action plans	Relevant actor	Evidence (ch:pp)
III.1. A European mechanism and focal point for alcohol policy should be strengthened within the European Commission with adequate staff and financial resources to oversee the development of European alcohol policy and the implementation of the Commission's strategy on alcohol.	(I) European institutions	8: 365-367
III.2. Coordinating mechanisms and focal points for alcohol policy should be established or reinforced at all levels of action and adequately financed.	(I) European institutions (II) Member States and regions (III) Municipal	9: 377
III.3. Action plans on alcohol with clear objectives, strategies and targets should be formulated and implemented.	(I) European institutions (II) Member States and regions (III) Municipal	9: 377
III.4. A predictable funding system should be set in place for organizations, programmes and human resources involved in reducing the harm done by alcohol. Analyses should be undertaken of the practicality and desirability of earmarking a proportion of alcohol taxes (hypothecated tax) to fund these.	(I) European institutions (II) Member States and regions (III) Municipal	9: 377
III.5. Support for alcohol policy measures amongst civil and political society should be promoted through awareness-raising campaigns and initiatives.	(I) European institutions (II) Member States and regions (III) Municipal	7: 252
III.6. Regular reports on alcohol should be prepared and made accessible to a wide public audience.	(I) European institutions (II) Member States and regions (III) Municipal	All report

IV. Other policies and actions and cross border support

Alcohol consumption, the harm done by alcohol policy, and alcohol policy itself are influenced to a great extent by **other sectors and other Directorates-General**, including the trade law of the European Union (EU). Where a product like alcohol is both traded and relevant for health then it becomes important to recognise the Treaty's obligation that "a high level of human health protection shall be ensured in the definition and implementation of all Community policies and activities." This means there is substantial scope for health concerns to be incorporated within

policies of other Directorates-General and within actions to improve the single market.

Global and European trade law can constrain alcohol policies, despite the existence of certain exemptions on public health grounds. This is particularly true when legislation treats alcohol only as an economic commodity, without considering the substantial health impact of many of these laws. Given that the European Union has a legal commitment to consider health in all its activities, there is a potential to close this gap at the European level. **Governments** should be mindful of when alcohol policy is best implemented at the local and municipal level, when respect of the laws of different countries in relation to alcohol policy should be upheld (comity), and when collective action at both the European and global level is more appropriate.

Recommendations for impact assessment and collective action	Relevant actor	Evidence (ch: pp)
IV.1. Health policy-makers and advisers should monitor the risks inherent in the process of trade liberalization and should ensure that health concerns are accounted for in trade negotiations at both the global and European levels.	(I) European institutions (II) Member States and regions	8: 344-359
IV.2. Analytical and feasibility studies should be undertaken to determine when collective action on alcohol policy at both the European and global level is more appropriate and how comity of countries in relation to alcohol policy can be strengthened	(I) European institutions (II) Member States and regions	8: 348-362
IV.3. Increased resources should be provided to undertake thorough assessments of the impact of European community policies and activities (including agricultural policy) on the harms and costs associated with alcohol.	(I) European institutions	8: 348-360

Specific alcohol policy recommendations

Chapter 1 suggested that the central purpose of alcohol policies is to serve the interests of public health and social well-being through their impact on health and social determinants, such as drinking patterns, the drinking environment, and the health services available to treat problem drinkers. There is a wealth of evidence to advise which alcohol policies and programmes work and which do not work in protecting young people, protecting third parties, and in reducing the harm done by alcohol to adults. Although a large part of the scientific evidence originates outside Europe, its robustness is strengthened by a consistency of evidence over time and in different jurisdictions, countries and cultures.

The most robust evidence for effectiveness in reducing the harm done by alcohol results from (i) drink-driving countermeasures; (ii) pricing and taxation; (iii) restrictions on the availability of alcohol, including a minimum purchasing age; (iv) restrictions on commercial communications; (v) managing drinking environments; and (vi) providing brief interventions and treatment in primary health care and accident and emergency departments.

Education type programmes and policies, such as educational programmes to promote designated drivers and school-based educational programmes are the least effective. On the other hand, mass media programmes have a particular role to play in reinforcing community awareness of the problems created by alcohol use and to prepare the ground for specific interventions.

What is also clear is that both enforcement and comprehensive approaches are important. For example, the impact of responsible beverage service is much enhanced when there is active enforcement and the support of community based prevention programmes. Such policies should also be supported by improved awareness and information of the risks connected to the consumption of alcoholic beverages, and by campaigns among citizens on the implementation of policy initiatives.

Non-governmental organizations are essential partners for all elements of alcohol policy. They are a vital component of a modern civil society, raising people's awareness of issues and their concerns, advocating change and creating a dialogue on policy. Of particular importance are those organizations which deal with families, civil, cultural, economic, political, and social rights, including those that deal with the rights of children and young people. Their role in alcohol policy should be strengthened to include (i) monitoring implementation of existing laws, codes and practices of the public and private sectors; (ii) translating the evidence base into easily understood policies and practices to reduce the harm done by alcohol; (iii) safeguarding and representing civil society in the implementation of such policies and practices; and (iv) collecting and disseminating information and knowledge to mobilize civil society to support the implementation of evidence-based policy.

The beverage alcohol and related industries have a particular role to play in the implementation of alcohol policies and programmes. This can include (i) providing server training and monitoring to all involved in the alcohol sales chain to ensure responsibility in adhering to the law, and in reducing the risk of subsequent harmful consequences of intoxication, harmful patterns of drinking and the risk of drinking and driving; (ii) ensuring that the full marketing process (product development, pricing, market segmentation and targeting, advertising and promotion campaigns, and physical availability) does not promote an alcoholic product by any means that directly appeals to minors; (iii) undertaking impact assessments on the health and social environment of their actions; and (iv) providing public statements and reports on how all of the above have been implemented.

V. Reducing drinking and driving

The European Union itself has set a target of halving the number of people killed annually in road traffic accidents between 2000 and 2010 through harmonization of penalties, and the promotion of new technologies to improve road safety. The drinking-driving policies that are highly effective include lowered blood alcohol concentration (BAC) levels, unrestricted (random) breath testing, administrative license suspension, and lower BAC levels and graduated licenses for young drivers. Whilst alcolocks can be used as a preventive measure, their use for drink driving offenders lasts for only as long as the device is fitted. There is no evidence for an effective impact from designated driver and safe drive programmes or from school based education courses. To be effective drink driving laws must be publicized; if the public is unaware of a change in the law or an increase in its enforcement, it is unlikely that it will affect their drinking and driving. When incorporated as part of

community programmes, drink-driving measures appear to have increased effectiveness.

Recommendations for drinking and driving	Relevant actor	Evidence (ch: pp)
V.1. A maximum blood alcohol concentration limit of 0.5g/L should be introduced throughout Europe; countries with existing lower levels should not increase them.	(I) European institutions (II) Member States and regions	7: 243
V.2. A lower limit of 0.2g/L should be introduced for young drivers and drivers of public service and heavy goods vehicles; countries with existing lower levels should not increase them.	(I) European institutions (II) Member States and regions	7: 246
V.3. Unrestricted powers to breath test, using breathalysers of equivalent and agreed standard, should be implemented throughout Europe.	(I) European institutions (II) Member States and regions	7: 244
V.4. Common penalties with clarity and swiftness of punishment, with penalties graded depending at least on the BAC level should be implemented throughout Europe.	(I) European institutions (II) Member States and regions	7: 244-245
V.5. Driver education, rehabilitation and treatment schemes, linked to penalties, and based on agreed evidence-based guidelines and protocols should be implemented throughout Europe.	(I) European institutions (II) Member States and regions	7: 244-245
V.6. Action to reduce drinking and driving should be supported by a Europe-wide campaign.	(I) European institutions	7: 250
V.7. Existing designated driver campaigns should be evaluated for their impact in reducing drink-driving accidents and fatalities before financing and implementing any new campaigns.	(I) European institutions (II) Member States and regions	7: 247-248
V.8. Effective and appropriate training for the hospitality industry and servers of alcohol should be implemented to reduce the risk of drinking and driving.	(III) Municipal	7: 246-247
V.9. Comprehensive community-based educational and mobilization programmes, including urban planning and public transport initiatives, should be implemented to reduce drinking and driving.	(III) Municipal	7: 249

VI. Supporting education, communication, training and public awareness

Public service announcements, public education campaigns, and particularly those that focus on low risk drinking guidelines have limited evidence for effectiveness, although media advocacy approaches are important to gain public support for policy changes. Although there are individual examples of the beneficial impact of school-based education, systematic reviews and meta-analyses find that the majority of well-evaluated studies show no impact even in the short-term. There is considerable experience of what might be best practice in school-based education programmes, but currently unconvincing evidence for their effectiveness. This is not to imply that education programmes should not be delivered, since all people do need to be informed about the use of alcohol and the harm done by it, but school-based education should not be seen as the answer to reduce the harm done by alcohol, and is not an alternative to more effective alcohol policy measures.

Recommendations for education and public awareness	Relevant actor	Evidence (ch: pp)
VI.1. Educational programmes should not be implemented in isolation as an alcohol policy measure, or with the sole purpose of reducing the harm done by alcohol, but rather as a measure to reinforce awareness of the problems created by alcohol and to prepare the ground for specific interventions and policy changes.	(II) Member States and regions (III) Municipal	7: 253-258
VI.2. Funding should be provided to evaluate the design and impact of individual-based programmes that may show some promise.	(II) Member States and regions (III) Municipal	7: 253-259
VI.3. Broad educational programmes, beginning in early childhood, should be implemented to inform young people of the consequences of alcohol consumption on health, family and society and of the effective measures that can be taken to prevent or minimize harm.	(II) Member States and regions (III) Municipal	7: 253-258
VI.4. Educational-type programmes imported from another country or culture should first be evaluated in the new setting before being widely implemented.	(II) Member States and regions (III) Municipal	7: 253-258
VI.5. Media campaigns should be used to inform and raise awareness among citizens on implementation of policy initiatives.	(I) European Institutions (II) Member States and regions (III) Municipal	7: 251-252

VII. Consumer labelling

Although there is limited evidence for the impact of warning labels on alcoholic products in reducing the harm done by alcohol, European consumers can benefit from receiving accurate and consistent information on alcohol in order to help them make informed choices. Packaging and labelling should not be misleading to consumers, nor designed for direct appeal to children and adolescents.

Recommendations on labelling	Relevant actor	Evidence (ch: pp)
VII.1. Containers of alcoholic products should carry warnings determined by health bodies, describing the harmful effects of alcohol when driving or operating machinery, and during pregnancy, or other messages as appropriate.	(I) European institutions (II) Member States and regions	7: 252-253
VII.2. Alcohol product packaging and labelling should not promote an alcoholic product by any means that are likely to create an erroneous impression about its characteristics or health effects, or that directly or indirectly appeals to minors.	(I) European institutions (II) Member States and regions	7: 252-253

VIII. Policies that regulate the alcohol market

Price and tax measures Taxes are an effective policy option in reducing the harm done by alcohol, with a greater impact on younger and heavier drinkers and a particular impact in reducing the harm done by alcohol to people other than the drinker. Alcohol taxes generate direct revenue for governments, and – due to the relative inelasticity of the demand for alcohol – are generally much more closely related to average tax rates than levels of consumption, thus allowing considerable scope in most countries for raising taxes before the maximum revenue is achieved.

There is an enormous discrepancy in the current tax rates between countries, even when adjusting for purchasing power, and one half of countries still have no tax on wine. Standardized excise duties are a longstanding goal of the European Union mainly because the combination of a single market, together with wide excise variations, leads to serious market distortions and lost tax revenue. Further, there is a continued need to increase the minimum rates in line with inflation (24%) so that taxes do not become meaningless.

The consequences of differential taxes between countries are compounded by the high and increasingly liberal limits of the amount of alcohol that individuals can transfer between countries.

Recommendations for tax, cross border purchases and smuggling	Relevant actor	Evidence (ch: pp)
VIII.1. Minimum tax rates for all alcoholic beverages should be increased in line with inflation; should be at least proportional to the alcoholic content of all beverages that contain alcohol; and should at least cover the external costs of alcohol as determined by an agreed and standardized methodology.	(I) European institutions (II) Member States and regions	7: 258-263
VIII.2. Member States should retain the flexibility to use taxes to deal with specific problems that may arise with specific alcoholic beverages, such as those that prove to be appealing to young people.	(II) Member States and regions	9: 386-388
VIII.3. Alcoholic products should be marked to determine their origin and movement in trade, to enable estimates to be made of the value of the amount of alcohol smuggling into and within the EU.	(I) European institutions (II) Member States and regions	3: 52-53
VIII.4. Member States should have the flexibility to limit individual cross-border purchases so as not to diminish the impact of their current tax policies.	(I) European institutions (II) Member States and regions	3: 53-54

Restrictions on the availability of alcohol There is very strong evidence for the effectiveness of policies that manage the physical availability of alcohol (raising the minimum purchase age and managing days and hours of sale). The evidence shows that, if opening hours for the sale of alcohol are extended, then more violent harm is likely to result. Policies that manage the availability of alcohol are largely devolved to the municipal level. They can only be effective if any national and regional legislation is enabling rather than restrictive, and if the policies are adequately enforced.

Recommendations for minimum purchase age and availability	Relevant actor	Evidence (ch: pp)
VIII.5. A minimum system of licensing for the sale of alcoholic products should be implemented throughout Europe, respecting existing licensing systems, where these are stronger.	(I) European institutions (II) Member States and regions (III) Municipal	7: 265
VIII.6. The sales of alcoholic products to persons under the age set by domestic law, national law or eighteen years, whichever is the higher, should be prohibited and enforced.	(II) Member States and regions	7: 264-265

VIII.7. Jurisdictions that manage outlets through number and density, location and hours and days of sale should consider not relaxing their regulations; jurisdictions without such regulations or with very limited regulations should analyze the impact of introducing or strengthening them.	(II) Member States and regions (III) Municipal	7: 266-269
VIII.8. A range of increasingly severe penalties against sellers and distributors, such as withdrawal of license or temporary and permanent closures, should be implemented in order to ensure compliance with relevant measures.	(III) Municipal	7: 287-291

Alcohol advertising, promotion and sponsorship There is evidence that the new products developed by the alcoholic drinks industry are attractive to and readily consumed by underage drinkers. Price promotions increase binge drinking and exposure to point of purchase advertising predicts onset of youth drinking. There is evidence for targeting of alcohol advertisements to underage drinkers, and consistent evidence that exposure to television, music videos and sponsorship which contain alcohol advertisements predicts onset of youth drinking and increased drinking. Consumer studies have shown that alcohol advertisements lead to positive expectancies and attitudes about alcohol. Consumer studies also show that exposure to tobacco advertising increases smoking initiation amongst young people, exposure to food advertising changes children's food consumption behaviour, and there is increasing evidence that exposure to alcohol advertisements increase initiation of alcohol use amongst adolescents. Despite the difficulties of population-based studies, there is a range of evidence with some econometric studies finding a relationship between the volume of advertising and drinking behaviour and outcomes, and others not. Since advertisements have a particular impact in promoting a more positive attitude to drinking amongst young people it is likely that restricting the content of advertisements will reduce harm, although this has not been specifically evaluated. To date, self-regulation of commercial communications by the beverage alcohol industry does not have a consistent record for being effective.

Recommendations for commercial communications	Relevant actor	Evidence (ch: pp)
VIII.9. A level playing field for commercial communications should be implemented across Europe, building on existing regulations in Member States, with an incremental long-term development of no advertising on TV and cinema, no sponsorship, and limitation of messages and images only referring to the quality of the product.	(I) European institutions (II) Member States and regions	7: 276-283
VIII.10. Article 15 of the Television Without Frontiers Directive should be strengthened in terms of both content and volume, and an analysis of its adherence across Member States should be commissioned.	(I) European institutions (II) Member States and regions	7: 272-275 8: 358-359

VIII.11. Where self-regulatory approaches adopted by the beverage alcohol industry or marketing industry are in place, they should be monitored by a body that is independent of the alcohol and marketing industries.	(I) European institutions (II) Member States and regions	7: 283-286

IX Reducing harm in drinking and surrounding environments

Strategies that alter the drinking context have the potential to reduce the harm done by alcohol, being primarily applicable to drinking in bars and restaurants, with effectiveness relying on adequate enforcement. Such strategies are also more effective when backed up by municipal and community-based prevention programmes.

Recommendations for drinking and surrounding environments	Relevant actor	Evidence (ch: pp)
IX.1. Urban planning, community strategies, licensing regulations and restrictions, transport policies and management of the drinking and surrounding environments should work to minimize the negative effects that result from alcohol intoxication, particularly for local residents.	(III) Municipal	7: 287-293
IX.2. Effective and appropriate training should be implemented for the hospitality industry and servers of alcohol to reduce the harmful consequences of intoxication and harmful patterns of drinking.	Alcohol industry	7: 287-290
IX.3. Adequate policing and enforcement of alcohol sales and licensing laws should be implemented, targeted at premises associated with a higher level of harm.	(III) Municipal	7: 288-289
IX.4. Well-resourced community mobilization and intervention projects, involving different sectors and partners, should be implemented to create safer drinking environments and to reduce the harm done by alcohol.	(III) Municipal	7: 291-294

X. Advice for hazardous and harmful alcohol consumption and alcohol dependence

There is extensive evidence for the impact and cost-effectiveness of brief advice, delivered through a number of different settings, in reducing harmful alcohol consumption. They are not only an efficient use of scarce resources, but, if implemented widely, can have a large population impact in reducing the harm done by alcohol. There is further evidence that primary care providers can be engaged in delivering early identification and brief advice programmes.

Recommendations for advice	Relevant actor	Evidence (ch: pp)
X.1. Integrated evidence-based guidelines for brief advice for hazardous and harmful alcohol consumption should be developed and implemented in different settings upwardly to harmonize the quality and accessibility of care.	(II) Member States and regions (III) Municipal	7: 295-298
X.2. Training and support programmes to deliver brief advice for hazardous and harmful alcohol consumption should be developed and implemented in different settings upwardly to harmonize the skills of primary care providers.	(II) Member States and regions (III) Municipal	7: 295-298
X.3. Resources should be made available to ensure the widespread availability and accessibility of identification and advice programmes for hazardous and harmful alcohol consumption and alcohol dependence.	(II) Member States and regions (III) Municipal	7: 295-298