Chapter 1: Introduction

At the time that the European Commission has been preparing its own strategy on alcohol to cover the full range of activity that takes place at a European level, it has called for an analysis of the health, social and economic impact of alcohol in Europe. This is the present report, which is an expert synthesis of published reviews, systematic reviews, meta-analyses and individual papers, as well as an analysis of data made available by the European Commission and the World Health Organization. The report views alcohol policy as "serving the interests of public health and social well-being through its impact on health and social determinants." This is embedded in a public health framework, a process to "mobilize local, state, national and international resources to ensure the conditions in which people can be healthy". A standardized terminology has been proposed throughout the report based on that of the World Health Organization, the specialized United Nations agency on health matters. This has led to avoiding terms such as "alcohol misuse" and "alcohol abuse" which can be both ill-defined and misleading.

INTRODUCTION

Although alcohol consumption levels have been falling (see Chapter 4), the European Union remains the part of the world with the highest proportion of drinkers and with the highest levels of alcohol consumption per population (World Health Organization 2005a), Figure 1.1. Although parts of Europe are described as having drinking patterns that are less risky to health, alcohol remains one of the most important risk factors for ill-health and premature death (see Chapter 6). Alcohol is the third largest risk factor for ill-health (after smoking and raised blood pressure), being more important than high cholesterol levels and overweight (World Health Organization 2002).

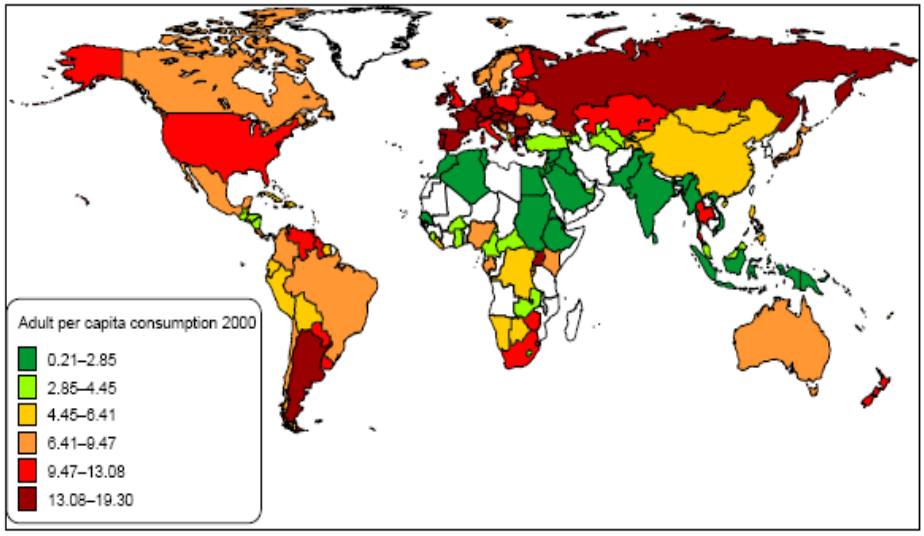

Figure 1.1 Adult per capita alcohol consumption in the world measured in pure alcohol per person per year (estimates include unrecorded consumption). Source: World Health Organization (2005a).

Since the 1970s and the growing process of European integration, there has been a rising and coordinated response to the problems caused by alcohol, at the level of science, policy and civil society:

1. At the scientific level, three major publications co-sponsored by the European Region of the World Health Organization (WHO) have presented the scientific foundation for alcohol policy (Bruun *et al.* 1975; Edwards *et al.* 1994; Babor *et al.* 2003), supplemented by a wide range of background technical documents. As described in detail in Chapter 8, the WHO has also contributed substantially to the political process through two ministerial conferences (Anderson 1996; World Health Organization 2001), the European Charter on Alcohol (World Health Organization 1995), two European Alcohol Action Plans (World Health Organization 1992a; 2000) and a new Framework for Alcohol Policy in the European Region (World Health Organization 2005b).

2. The civil society response in Europe to the harm done by alcohol was given a boost in 1990, with the creation of Eurocare,[1] a European non-governmental organization drawing together networks and organizations throughout Europe. Eurocare represents a diversity of views and cultural attitudes, and is dedicated to the prevention of the harm done by alcohol, focusing in particular on the impact of the European Union on alcohol policy in Member States.

3. The European Union itself has supported the process of alcohol policy through its Council Recommendation of 5 June 2001 on the drinking of alcohol by young people, in particular children and adolescents,[2] and its Council Conclusions of 5 June 2001 on a Community strategy to reduce alcohol-related harm (see also Chapter 8).[3] During June 2004, the Council reiterated the importance of its 2001 Recommendation and Conclusions and recalled its invitation to the Commission to develop a strategy,[4] which, as of the beginning of 2006, is under preparation.

In 2003, the European Commission called for a report and analysis of the health, social and economic impact of alcohol (SANCO/G/3/2003/06), in particular to summarize the available information on alcohol at the country and European levels (economic factors, health and social problems, health promotion, prevention and treatment, alcohol policies) and describe options for action at the country and European levels. The present report is the response to the European Commission's call.

This chapter will describe how the report has been prepared, will outline the public health basis of the report, will discuss issues of terminology, and will introduce the readers to the remaining chapters.

[1] http://www.eurocare.org.
[2] http://europa.eu.int/eur-lex/pri/en/oj/dat/2001/l_161/l_16120010616en00380041.pdf .
[3] http://europa.eu.int/eur-lex/pri/en/oj/dat/2001/c_175/c_17520010620en00010002.pdf.
[4] http://ue.eu.int/ueDocs/cms_Data/docs/pressData/en/lsa/80729.pdf.

METHODS, STRUCTURE AND TERMINOLOGY OF THIS REPORT

Method of preparing the report

Source materials The report is not meant to be a series of new meta-analyses or systematic reviews, but rather an expert synthesis of published reviews, systematic reviews, meta-analyses and individual papers. It is this review of reviews, supplemented by information from additional individual papers that forms the primary evidence base for the report. Summaries of this evidence are presented in the report, citing some of the better known and more substantial work in the field, although readers should consult the literature reviews themselves if more detail is required.

To begin with, source materials were identified through the references of key texts (including Norström 2001; Heather, Peters, and Stockwell 2001; Babor *et al.* 2003; Rehm *et al.* 2004; Loxley *et al.* 2004), hand searches of the journals Addiction, Drug and Alcohol Review, Alcohol Research and Health, and Nordic Studies on Alcohol and Drugs, and the websites of the European Commission, the National Institute on Alcohol Abuse and Alcoholism, and the World Health Organization. From these initial source materials, topics were identified for inclusion, and additional source material to update the evidence base was identified through literature searches using PubMed,[5] MEDLINE,[6] and PsychINFO.[7]

The report has followed the definitions of evidence-based medicine modified for the purpose of alcohol policy. This can be defined as 'the conscientious, explicit and judicious use of current best evidence in informing decisions about alcohol policy' through an approach that 'promotes the collection, interpretation, and integration of valid, important and applicable research-derived evidence that can support alcohol policy' (adapted from Sackett *et al.* 2000). In adopting an evidence-based approach, it is relevant to note the importance of doing this pragmatically and realistically. As Gray (Gray 2001) states, *'The absence of excellent evidence does not make evidence-based decision making impossible; what is required is the best evidence available, not the best evidence possible'.* A substantial body of rigorous data was used in preparing the report, although there are many areas where additional research is required (see Chapter 10 for research recommendations).

Where possible, the report has drawn on publications and data available directly from the European Commission as well as European Commission (co-)financed projects, as well as publications produced, supported or co-sponsored by the World Health Organization, see Table 1.1. The report has further given preferential treatment to publications of official bodies or governmental organizations from both within and without Europe. For example, it has drawn heavily on the publications of the National Institute on Alcohol Abuse and Alcoholism of the United States, and the Interim Analysis produced for the national strategy on alcohol in England and Wales.

Data The literature review has been supplemented with data obtained from many different sources (referred to in the chapters). Key data sources include the alcohol policy summaries and the alcohol profiles of the World Health Organization (World

[5] http://www.pubmedcentral.nih.gov/.
[6] http://medline.cos.com/.
[7] http://www.psycinfo.com/.

Health Organization 2004a; World Health Organization 2004b). These profiles were checked and updated by members of the Alcohol Policy Network, a network co-financed by the European Commission.[8] Additional data were obtained from Eurostat,[9] with the support of the Public Health and Risk Assessment's Health Information Unit of the General Directorate of Health and Consumer Protection (SANCO).[10] A hierarchy of data sources has been adopted, such that data from Eurostat has been given preference to data from the Health for All database of the European Region of the World Health Organization,[11] which has been given preference to data from the WHO Global Alcohol Database.

New work Some additional work was undertaken specifically for this project in estimating the social cost of alcohol to Europe (Baumberg & Anderson, submitted).

Limits of the report While randomised controlled trials are considered to be the 'gold standard' of evidence, they are often neither feasible nor possible for many public health interventions, and there is currently no agreed grading for levels of evidence that are specific and appropriate to this area. Similarly, both logistical and ethical barriers often prevent the use of randomised controlled trials to assess alcohol toxicity. Valid conclusions on the consequences of alcohol consumption can nevertheless be drawn from well designed and conducted observational studies.

In addition, the conclusions of the report can be limited in the extent to which they can make allowances for individual country and cultural variation (as discussed in Chapters 2 and 3), and this needs to be considered in implementing alcohol policy. Finally, the report is based on the best evidence available at the time of writing. Its conclusions may be subject to different interpretation as the body of research builds in various areas.

The report is also dependent on the available published literature, which is not always representative of all countries, cultures and population groups. Although the literature base is growing throughout Europe (Sanchez-Carbonell *et al.* 2005), it is still heavily dominated by North American, and northern and central European literature, although with a growing literature from southern Europe. Where caution in interpreting the literature base is warranted, we have exercised this throughout the report. It should be emphasized, however, that large parts of the report (and in particular, much of Chapters 3, 4, 6, and 9) are based on data from all of the European Union Member States.

[8] http://www.eurocare.org/btg/countryreports/index.html.
[9] http://epp.eurostat.cec.eu.int/portal/Page?_pageid=1090,30070682,1090_33076576&_dad=portal&_schema=PORTAL.
[10] http://europa.eu.int/comm/health/ph_information/information_en.htm.
[11] http://www.who.dk/hfadb.

Table 1.1 Key primary source materials in drawing up report

Source Body	Materials[1]	Chapters supported
European Commission	Updated country profiles provided by the members of the Alcohol Policy Network (APN), co-financed by the European Commission (www.eurocare.org/btg)	4,6,9
	Eurostat NewCRONOS database	3,4,6,9
	Eurobarometer surveys	4
Commission-funded projects	European Comparative Alcohol Study (ECAS) reports (2001-2)	All
World Health Organization (WHO)	Comparative Risk Assessment Study, carried out within the Global Burden of Disease (GBD) project	4,6
	CHOosing Interventions that are Cost-Effective project (CHOICE)	7
	Global Status Report on Alcohol	4,6
	Global Status Report on Alcohol Policies	9
	WHO-EURO Health for All Database	4,6
	WHO-EURO Alcohol Control Database	9
	WHO Global Alcohol Database	4
International comparative surveys	European Schools Project on Alcohol and Other Drugs (ESPAD; part-financed by Council of Europe)	4
	Health Behaviour in School-aged Children (HBSC; WHO-EURO)	4
Food and Agriculture Organization	Statistical division (FAOSTAT) database	3
OECD	OECD Statistics Portal	6
United Kingdom Government	*Prime Minister's Strategy Unit*: Alcohol Harm Reduction project: Interim Analytical Report	6,7
United States Government	*National Institute of Alcohol and Alcohol Abuse (NIAAA):* 10th Special report to the US Congress on Alcohol and Health	5
	National Institute on Alcohol Abuse and Alcoholism (NIAAA): Alcohol Research & Health [Journal]	5,7
Australian Government	*Ministerial Council on Drug Strategy:* The prevention of substance use, risk and harm in Australia	5,7
Scientific texts	Alcohol: No Ordinary Commodity (2003), and the two preceding volumes Alcohol Policy and the Public Good (1994) and Alcohol Control Policies in Public Health Perspective (1975) (Co-sponsored by WHO-EURO)	4,7
	International Handbook of Alcohol Problems and Dependence	All

[1] For references, see individual chapters.

A public health approach to alcohol policy

The frame of reference for this report is public health, defined as "*the science and art of preventing disease, prolonging life and promoting health through the organized efforts of society*" (International Epidemiological Association, (Last 2001, derived from Acheson 1988), or similarly "*the process of mobilizing local, state, national and international resources to ensure the conditions in which people can be healthy*" (Oxford Textbook of Public Health (Detels *et al.* 2002)). These definitions are consistent with the 1998 World Health Declaration (World Health Organization 1988) which states that *"the enjoyment of the highest attainable standard of health (defined as a state of complete physical, mental and social wellbeing and not merely the absence of disease or infirmity), is one of the fundamental rights of every human being."*

From the perspective of the individual, health promotion can be seen as "*the process of enabling people to increase control over, and to improve, their health*" through building healthy public policy, creating supportive environments, strengthening community actions, developing personal skills, and reorienting health services (Ottawa Charter for Health Promotion; World Health Organization 1986). Similarly, the UK government's basis for public health policy is that "*People need to be supported more actively to make better decisions about their own health and welfare because there are widespread, systematic failures that influence the decisions individuals currently make. These failures include a lack of full information, the difficulty individuals have in considering fully the wider social costs of particular behaviours, engrained social attitudes not conducive to individuals pursuing healthy lifestyles, and addictions. These failures can be tackled not only by individuals but by wide ranging action by health and care services, government – national and local, media, businesses, society at large, families and the voluntary and community sector. The main levers for Government Action include taxes, subsidies, service provision, regulation and information*" (Wanless 2004).

What do we mean by alcohol policy?

The third in the series of WHO co-sponsored publications on alcohol policy set out what is meant by alcohol policy (Babor *et al.* 2003). The authors noted that "*the first book in the series defined alcohol control policies as all relevant strategies employed by governments to influence alcohol availability, leaving health education, attitude change and informal social control as beyond the scope of a public health approach*" (Bruun *et al.* 1975), whereas the second book in the series "*provided a broader view of alcohol policy, considering it as a public health response dictated in part by national and historical concerns. Though there was not an explicit definition of the nature of alcohol policy, its meaning could be inferred from the wealth of policy responses that were considered: alcohol taxation, legislative controls on alcohol availability, age restrictions on alcohol purchasing, media information campaigns and school-based education, to name a few*" (Edwards *et al.* 1994). The third book expanded the concept in keeping with evolving views of public health both nationally and internationally. The authors described public policies as *"authoritative decisions that are made by governments through laws, rules and regulations (Longest 1998). The word authoritative indicates that the decisions come from the legitimate purview of legislators and other public interest group officials, not from private industry or related advocacy groups".* Thus, they noted that *"when public policies pertain to the relation between alcohol, health, and social welfare, they are considered alcohol policies. Thus, drinking-driving laws designed to prevent alcohol-related accidents,*

rather than those merely intended to punish offenders, are considered alcohol policies."

In the context of public health policy (above), this means that the central purpose of alcohol policies here "*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*" (Babor *et al.* 2003).

What do we mean by Europe?

Europe can mean different things to different people. In this report Europe means the 25 countries of the European Union (EU25), Figure 1.2. We sometimes break this down into the **EU15** (Austria, Belgium, Denmark, France, Finland, Germany, Greece, Ireland, Italy, Luxembourg, Netherlands, Portugal, Spain, Sweden, United Kingdom) and the **EU10**, the ten Member States which joined the Union in 2004 (Cyprus, the Czech Republic, Estonia, Hungary, Latvia, Lithuania, Malta, Poland, Slovakia and Slovenia), simply to explain the differences (which can be quite substantial in the evolving Europe).

We also refer to three of the four candidate countries (Bulgaria, Romania and Turkey) (the fourth being Croatia) as well as three (Iceland, Norway and Switzerland) of the countries of the European Free Trade Association (EFTA)[12] (the other country being Liechtenstein). Norway and Iceland (along with Liechtenstein) are also members of the European Economic Area (EEA),[13] allowing them to participate in the European Union's (EU) Internal Market, while not assuming the full responsibilities of EU membership. The European Union is different from the European Region of the World Health Organization, which comprises 52 Member States.[14]

Throughout the report, we often describe the countries in various groupings, some more definitive than others. Three of these stem from the European Comparative Alcohol Study (ECAS) that divided the EU15 (plus Norway) into three groups:[15]

Central This refers to countries between north and south rather than between east and west, i.e. Austria, Belgium, Denmark, Germany, Ireland, the Netherlands and the UK. Unlike ECAS, 'central Europe' in this report also refers to Luxembourg and Switzerland (which were not included within the ECAS project).

Northern This refers to Finland, Norway, Sweden, and Iceland, i.e. all countries north of the Baltic Sea. This, therefore, does not include Denmark, which is classified here as a central European country (see also the term 'Nordic countries' below).

Southern This refers to France, Greece, Italy, Portugal, and Spain. Sometimes these are also described as the **'Mediterranean'** countries. If this is used in contrast

[12] http://www.efta.int/.
[13] http://europa.eu.int/comm/external_relations/eea/.
[14] http://www.euro.who.int/AboutWHO/About/MH.
[15] Within the original ECAS project these were defined as 'high-consuming, 'medium-consuming' and 'low-consuming' countries, but – as discussed in chapter 4 – these categorizations are becoming more problematic and hence the grouping has been re-titled.

to ‘eastern Europe’ then it will also include Cyprus and Malta (while this will not be true when opposed to ‘the EU10’).

Throughout the report these groupings are adapted to particular questions, and will often explicitly include or exclude nearby countries outside of these definitions (e.g. “central Europe, including the Czech Republic”).

Three additional terms have also been used in the report:

Baltic This refers to Estonia, Latvia, and Lithuania. Some results refer to the ‘Baltic region’, which includes other countries bordering the Baltic (usually only Finland).

Eastern This is generally shorthand referring to the EU10 countries plus Bulgaria and Romania but minus Cyprus and Malta.

Nordic This refers to Denmark plus the northern European countries (Finland, Iceland, Norway, and Sweden).

Figure 1.2 Countries of the European Union (in yellow) as of 2005 (using country names in the original language, as provided by the European Commission). Source: http://europa.eu.int/abc/maps/index_en.htm.

Some notes on terminology [16]

There are many different terms used when talking about alcohol, many lacking definition, some confusing, and some even pejorative. The World Health Organization (as the specialized United Nations agency on health matters) provides a standardized nomenclature through its ICD-10 classification of mental and behavioural disorders (World Health Organization 1992b) and its lexicon of alcohol and drug terms.[17] We have adopted these terms throughout the report, including:

Alcohol Clearly, the report concerns *ethyl alcohol*, also known as *ethanol*, the type of alcohol found in drinks intended for human consumption.

Levels and categories of drinking Wherever possible, the report defines levels of drinking precisely, using grammes of alcohol, where, due to its specific gravity, one ml of alcohol contains 0.785g of alcohol. Where descriptive terms such as 'light' or 'heavy', are used, some quantitative descriptors are included where possible. The report has avoided the use of the term *'standard drink'*, because these differ from country to country and change over time; they also vary considerably, depending on the amount of drink poured or served. It is nevertheless helpful to have some understanding of how much alcohol is in a drink:

- one pint (UK) of beer of average strength (around 5% alcohol concentration) contains about 23g of alcohol;
- assuming a 750ml bottle of wine serves six glasses of wine, then a glass of wine at 13% alcohol concentration contains about 13g of alcohol;
- a 50ml serving of vodka containing 40% alcohol concentration contains 16g of alcohol.

When describing the results of the epidemiological data, we have sometimes used **categories of drinking**, the preferred descriptive grouping of the World Health Organization (e.g., see Rehm *et al.* 2004).

Category	Definition (g alcohol/day)	
	Men	***Women***
Abstinent	0	0
Level I	>0-40g	>0-20g
Level II	>40-60g	>20-40g
Level III	>60g	>40g

Hazardous alcohol consumption Hazardous alcohol consumption has been defined as a level of consumption or pattern of drinking that is likely to result in harm

[16] We have also provided a glossary of terms at the end of the report, derived from glossaries provided by the World Health Organization, the European Commission and the International Epidemiological Association.

[17] http://www.who.int/substance_abuse/terminology/who_lexicon/en/.

should present drinking habits persist (Babor *et al.* 1994). There is no standardized agreement for the level of alcohol consumption that should be taken for hazardous drinking, and, as shown for many conditions in Chapter 5, any level of alcohol consumption can carry risk.

Harmful drinking Harmful drinking is defined as 'a pattern of drinking that causes damage to health, either physical (such as liver cirrhosis) or mental (such as depression secondary to alcohol consumption)' (World Health Organization 1992b).

Intoxication is a condition that follows the use of alcohol resulting in disturbances in level of consciousness, cognition, perception, affect or behaviour, or other psycho-physiological functions and responses (World Health Organization 1992b). The disturbances are directly related to the acute pharmacological effects of alcohol and are mostly dose-related, involving multiple body functions. Intoxication can lead to unintentional injuries and acute social consequences such as violence and crime, and can also lead to long term social consequences – for example when an intoxicated person causes an intentional injury to another person, leading to a prison sentence. Intoxication's equivalent in everyday speech is '**drunkenness**', which is manifested by such signs as facial flushing, slurred speech, unsteady gait, euphoria, increased activity, volubility, disorderly conduct, slowed reactions, impaired judgement and motor incoordination, insensibility, or stupefaction.

Episodic heavy drinking A drinking occasion that includes consumption of at least 60g of alcohol can be defined as episodic heavy drinking (World Health Organization 2004a), although other definitions (such as 5 or more 'standard drinks') have also been used (see Chapter 4). In common terms this is frequently called '**binge drinking**',[18] which is the term we have used in Chapter 4, when describing alcohol use and drinking patterns in Europe. In Chapter 5, we have used the term episodic heavy drinking, since this is now becoming a common term when describing the relationship between patterns of alcohol use and harm in epidemiological studies based on individuals.

Alcohol dependence The World Health Organization's International Classification of Mental and Behavioural Disorders (1992b) (ICD-10) defines alcohol dependence as a cluster of physiological, behavioural, and cognitive phenomena in which the use of alcohol takes on a much higher priority for a given individual than other behaviours that once had greater value. A central characteristic is the desire (often strong, sometimes perceived as overpowering) to drink alcohol. Return to drinking after a period of abstinence is often associated with rapid reappearance of the features of the syndrome.

Ill-defined terms not recommended for use As the World Health Organization's lexicon of alcohol and drug terms notes, there are a number of ill-defined terms that the report does not use, including:

- **moderate drinking** The report has avoided the use of the word 'moderate', since it is an inexact term for a pattern of drinking that is by implication contrasted with heavy drinking. Although it commonly denotes drinking that

[18] Binge drinking is defined by the WHO as "A pattern of heavy drinking that occurs in an extended period set aside for the purpose. In population surveys, the period is usually defined as more than one day of drinking at a time. The terms "bout drinking" and "spree drinking" are also used for the activity, and "drinking bout" for the occasion. A binge drinker or bout drinker is one who drinks predominantly in this fashion, often with intervening periods of abstinence". See http://www.who.int/substance_abuse/terminology/who_lexicon/en/.

does not cause problems (and thus is not drinking to 'excess'), it is difficult to define. A better description might be *lower-risk drinking*.

- **sensible drinking**, **responsible drinking** and **social drinking**, all of which are impossible to define and depend on social, cultural and ethical values which can differ widely from country to country, from culture to culture, and from time to time.

- **excessive drinking** is currently a non-preferred term for a pattern of drinking considered to exceed some standard of light drinking. *Hazardous use* is the preferred term in current use.

- **alcoholism** is a term of long-standing use and variable meaning, generally taken to refer to chronic continual drinking or periodic consumption of alcohol which is characterized by impaired control over drinking, frequent episodes of intoxication, and preoccupation with alcohol and the use of alcohol despite adverse consequences. The inexactness of the term led a WHO Expert Committee to disfavour it, preferring the narrower formulation of alcohol dependence syndrome as one among a wide range of alcohol-related problems (Edwards and Gross 1976; World Health Organization 1980), and it is not included as a diagnostic entity in ICD-I0. The preferred term is *alcohol dependence*.

- **alcohol abuse** a term in wide use but of varying meaning. Although it is used in the DSM (Diagnostic and Statistical Manual of Mental Disorders) classification (American Psychiatric Association 1994), it should be regarded as a residual category, with dependence taking precedence when applicable. The term is sometimes used disapprovingly to refer to any use at all, particularly of illicit drugs. Because of its ambiguity, the term is not used in the ICD-I0 classification. *Harmful use* and *hazardous use* are the equivalent terms;

- **alcohol misuse** is a term that describes the use of alcohol for a purpose not consistent with legal or medical guidelines, as in the non-medical use of prescription medications. Although misuse is preferred by some to abuse in the belief that it is less judgmental, it is also ambiguous. *Hazardous use* is the equivalent term.

The terms "misuse" and "abuse" are sometimes used to convey the idea that alcohol problems represent a marginal phenomenon, or that there is a straightforward dichotomy between "use" and "misuse". However, as will be apparent from the data presented throughout this report, the harm done by alcohol is not a marginal phenomenon, and the risk curves describing the relationship between alcohol use and harm do not find simple dichotomies between misuse and risk-free use (see also McNeill 2004). Thus, this report refers to "the harm done by alcohol use" rather than "misuse" or "abuse" (see World Health Organization 1992a).

The review process

The Public Health reports of the European Commission[19] (in which the present report is framed) are not normally subject to a review process. However, we have subjected the report to an extensive review process. During the preparation of the report, drafts have been reviewed by the scientific advisers of the Institute of Alcohol Studies, and by three external reviewers. The report was also reviewed by four external reviewers chosen by the European Commission. (See acknowledgements for the names of the reviewers).

In addition, during the preparation of the document, five hearings were convened: with stakeholders (that includes the beverage alcohol and related industries), 20 January 2005,[20] 30 August 2005,[21] and 26 September 2005;[22] with members of the Commission's Alcohol and Health Working Group, 8 March 2005;[23] and with non-governmental organizations, 19 May 2005.[24]

Database of country profiles

As part of the background to the report, a database of country profiles on alcohol and alcohol policy was prepared, with ongoing development.[25] The database comprises four elements: the alcohol profiles of the World Health Organization (2004a), checked and updated; the alcohol policy summaries of the World Health Organization (2004b), checked and updated; a revision (or preparation where not previously available) of the country reports of the ECAS project (Österberg and Karlsson 2002); and a list of infrastructures available for alcohol policy,[26] all of these undertaken by members of the Alcohol Policy Network of the Bridging the Gap project.[27] A key finding of this activity is that it is never easy to reach complete agreement at the country level on the data used, a problem complicated by the differing jurisdictional responsibilities (for example regions and municipalities) within countries. At the time of publication, there still remained differences between the data used by the World Health Organization, and that available within countries which could not be resolved.[28]

---

[19] http://europa.eu.int/comm/health/ph_information/reporting/full_listing_reporting_en.htm.
[20] http://europa.eu.int/comm/health/ph_determinants/life_style/alcohol/ev_20050120_en.htm.
[21] http://europa.eu.int/comm/health/ph_information/dissemination/ev_20050830_en.htm.
[22] http://europa.eu.int/comm/health/ph_determinants/life_style/alcohol/ev_20050926_en.htm.
[23] http://europa.eu.int/comm/health/ph_determinants/life_style/alcohol/ev_20050307_en.htm
[24] http://www.eurocare.org/btg/apn/minutes0505.html.
[25] http://www.eurocare.org/btg/countryreports/index.html.
[26] http://www.hp-source.net/dataoutput.html?module=btg.
[27] http://www.eurocare.org/btg.
[28] For example, at the time of printing, the Estonian Institute of Economic Research provided data on recorded and unrecorded consumption, adjusted for tourism purchases, which differed from the Estonian data used in Figure 4.2 and for this report.

Stakeholders' views of alcohol policy

At the same time as the preparation of the report, a questionnaire survey was completed by stakeholders (country counterparts of the European Commission's Alcohol and Health Working Group (mostly government officials), country and European non-governmental organizations that have a remit on alcohol policy, and representative bodies of the beverage alcohol industry, who are stakeholders of the European Commission's Alcohol and Health Working group) (Anderson and Baumberg 2005). The questionnaire ascertained views of the impact and importance of a range of alcohol policy measures, implementation estimates of the WHO European Alcohol Action Plan (2000-2005) and of the 2001 Council Recommendation on the drinking of alcohol by young people, and perceived advances and barriers for alcohol policy at the country and European levels.

Representatives of the alcohol industry (AIs) tended to hold different views from representatives of governmental (GOs) and non-governmental organizations (NGOs), who were more similar in their views. The AIs viewed regulatory measures (such as tax and price measures, and restrictions on the availability and advertising of alcoholic beverages) as of low impact and policy importance, Table 1.2, whereas they were more favourable to educational measures. All three groups were similar and positive in their views of the impact and importance of implementation measures and of interventions for hazardous and harmful alcohol consumption.

In general, AIs were more positive in their views of successful implementation of both the WHO European Alcohol Action Plan and the Council Recommendation on the dinking of alcohol by young people (mean score 6.1 and 5.9 respectively on an 11 point scale from 0 (not at all) to 10 (fully)) than GOs (mean score 5.0 and 4.6 respectively) who were more favourable than NGOs (mean score 3.7 and 3.3 respectively), but this was largely due to the AIs giving very high implementation scores for items that were their responsibility.

Table 1.2 Results for three factors (mean (standard error of the mean)) for views of the policy impact and of the policy importance in reducing the harm done by alcohol on a scale ranging from 0 (no impact or not important at all) to 10 (very high impact and very important). *Main values refer to the mean; values in brackets show the standard error of the mean.*

	Policy impact				Policy importance			
	NGO[1]	GO[2]	AI[3]	Anova[4]	NGO[1]	GO[2]	AI[3]	Anova[4]
Factor 1 (regulations)	7.4 (0.31)	7.3 (0.30)	1.4 (0.31)	0.000	8.2 (0.93)	8.2 (0.72)	1.6 (1.0)	0.000
Factor 2 (education)	4.8 (0.31)	6.0 (0.48)	8.7 (0.23)	0.000	6.3 (0.28)	6.7 (0.46)	8.7 (0.23)	0.000
Factor 3 (implementation and interventions)	8.3 (0.28)	8.3 (0.21)	9.5 (0.21)	0.000	9.1 (0.18)	8.8 (0.18)	9.5 (0.20)	0.072

[1]Non-governmental organization
[2]Governmental organization
[3]Alcohol industry
[4]Anova, p value.

The structure of the report

Chapter 2 of the report will provide a very brief history of alcohol in Europe, describing the long history (several thousands of years) of the use of alcohol in everyday life, the changes that occurred in mediæeval Europe and during the industrial revolution, the rise of mass movements beginning particularly in the 19th century, and finishing with a discussion of the rise of the concept of addiction and the modern public health movement.

Chapter 3 will describe the economic impact of alcohol. It will describe the global and European production and trade in alcohol. It will briefly describe smuggling and lost taxes from alcohol due to cross border trade. It will summarize how much Europeans spend on alcohol and outline the relationship between alcohol consumption and both government revenue from alcohol taxes, and employment in the alcohol sector from production to retailing. It will provide estimates of the tangible and intangible costs of alcohol to European society and note opportunities and limitations of using such data as an aid to policy making.

Chapter 4 will describe the use of alcohol in Europe and how this has changed over time. It will describe population levels of drinking based on both recorded and unrecorded consumption, and will provide estimates of the numbers of abstainers, and the number of people with hazardous and harmful alcohol consumption and with alcohol dependence. It will describe ways and patterns of drinking, including drinks of choice, drinking context (for example drinking with meals and public drinking). It will provide estimates of drinking frequency, and intoxication and binge drinking, and describe different drinking patterns across Europe. It will discuss how drinking varies by gender and socio-economic grouping and will describe in detail the patterns, changes, and determinants of young people's drinking. Finally, it will stand back from the detail and consider the broad cultural and social influences on European drinking.

Chapter 5 will describe the impact of alcohol on individuals. It will begin with some general observations on the measurement of alcohol consumption, patterns of drinking and issues of causality and attribution. It will then describe alcohol's impact on social well-being, both positive and negative, and, in particular, consider alcohol's role in violence and crime. It will then discuss alcohol's role as a cause or contributor (both positive and negative) to a wide range of conditions, grouped under the headings of intentional and unintentional injuries, neuropsychiatric conditions, gastrointestinal conditions, endocrine and metabolic conditions, cancers, cardiovascular conditions, the immune system, lung diseases, post-operative complications, skeletal conditions, and reproductive and pre-natal conditions. It will discuss in some length the robustness of the data and some concerns about alcohol's role in reducing the risk of coronary heart disease. It will summarize the overall risk to individuals, discuss some of the determinants of risk, and conclude by describing the evidence of the relationship between reductions in harmful alcohol consumption and risk of harm.

Chapter 6 will describe alcohol's impact on European health, summarizing the numbers of people affected by different alcohol-related conditions. Referring back to the impact of alcohol on the individual discussed in Chapter 5, and the costs of alcohol presented in Chapter 3, it will describe alcohol's role in social harms at the European level, including social nuisances, crime and violence, and harm to the family and at work. It will then consider health harms, with overall estimates of the

numbers of deaths caused and delayed at the European level, and the overall contribution of alcohol to disability and premature death in the Union. It will outline some of the difficulties and cautions in these estimates, in particular, the possible overestimates of the numbers of deaths delayed. It will continue by providing estimates of the numbers of Europeans affected by the different disease headings presented in Chapter 5. It will describe the overall harms to young people, harms to people other than the drinker, and the socio-economic differences due to alcohol between and within countries. It will finish with an extensive discussion of how alcohol-related harms change when population levels of alcohol consumption change.

Chapter 7 will describe at some length what works in alcohol policy (and what does not work). Detailed evidence will be provided for the following policy options, (i) policies that reduce drinking and driving; (ii) policies that support education, communication, training and public awareness; (iii) policies that regulate the alcohol market (price and tax, availability and commercial communications); (iv) policies that support the reduction of harm in drinking and surrounding environments; and (v) policies that support advice and treatment for individuals.

Chapter 8 will describe how global and European factors impinge on alcohol policy. It will begin with a discussion of why trade law is relevant for alcohol policy, discussing both the General Agreement on Tariffs and Trade (GATT) and the General Agreement on Trade in Services (GATS). It will continue with a discussion of trade law in the European internal market and how this can affect Member State alcohol policy, in the areas of tax, monopolies and advertising, noting both positive and negative effects. It will discuss alcohol as an economic commodity and how this is influenced in more detail by European policy on taxes, labelling and packaging, other internal market legislation, and the Common Agricultural Policy. Finally it will describe the role of the World Health Organization and the European Commission in influencing alcohol policy.

Chapter 9 will summarize existing alcohol policy within the Member States, under the headings of drinking and driving, workplace, market restrictions, controlling sales to young people, and tax and price. It will compare European countries in relation to the rest of the world and over time.

Chapter 10, taking stock of all of the material presented so far, will bring the report together in some brief conclusions and recommendations as to what further could be done to improve the health of European citizens and of the European Union as a whole.

REFERENCES

Acheson, D. (1988). Public Health in England. The report of the Committee of Inquiry into the future development of the public health function. Cmnd 289. London: HMSO.

American Psychiatric Association (1994) Diagnostic and Statistical Manual of mental Disorders. 4th edn. Washington DC: American Psychiatric Association

Anderson, P. (1996) Alcohol - less is better. Report of the WHO European Conference, Health, society and alcohol, Paris 12-14 December 1995. WHO Regional Publications, European Series, No 70. Copenhagen, WHO Regional Office for Europe.

Anderson, P. & Baumberg, B. (2005) Stakeholders' views of alcohol policy. London: Institute of Alcohol Studies

Babor TF, Caetano R, Casswell S, Edwards G, Giesbrecht N, Graham K, Grube JW, Gruenewald PJ, Hill L, Holder HD, Homel R, Österberg E, Rehm J, Room R & Rossow I (2003). Alcohol: No Ordinary Commodity. Research and Public Policy. Oxford, Oxford Medical Publication, Oxford University Press.

Babor, T., Campbell, R., Room, R. & Saunders, J., (1994) Lexicon of Alcohol and Drug Terms, World Health Organization, Geneva.

Baumberg, B. & Anderson P. (2005). The social cost of alcohol to Europe. Submitted for publication.
Bruun, K., Edwards, G., Lumio, M., Mäkelä, K., Pan, L., Popham, R.E., Room, R., Schmidt, W., Skog, O-J., Sulkunen, P. & Österberg, E. (1975) Alcohol Control Policies in Public Health Perspective. Helsinki: Finnish Foundation for Alcohol Studies.

Department of Health (2004). Choosing Health. Making healthy choices easier. London: HMSO.

Detels, R., McEwen, J., Beaglehole, R. & Tanaka, H. Eds. (2002). Oxford Textbook of Public Health. Oxford: Oxford University Press.

Edwards G, Anderson P, Babor TF, Casswell S, Ferrence R, Giesbrecht N, Godfrey C, Holder HD, Lemmens PH, Mäkelä K, Midanik LT, Norström T, Österberg E, Romelsjö A, Room R, Simpura J & Skog O-J (1994). Alcohol Policy and the Public Good. New York, Oxford University Press.

Edwards, G. & Gross, M.M. (1976) Alcohol dependence: provisional description of a clinical syndrome. British Medical Journal 1, 1058-1061.

Gray, J.A.M. (2001). Evidence-based Health Care. London: Churchill Livingstone.

Heather, N., Peters, T.J. & Stockwell, T. (2001) (Eds.), *International Handbook of Alcohol Problems and Dependence.* West Sussex, U.K: John Wiley & Sons, Ltd.

Last, J. (2001). A dictionary of epidemiology. (Fourth edition ed.) Oxford: Oxford University Press.

Longest B.B. (1998) Health policymaking in the United States. Chicago, IL: Health Administration Press.

Loxley, W., Toumbourou, J.W., Stockwell, T., Haines, B., Scott, K., Godfrey, C., Waters, E., Patton, G., Fordham, R., Gray, D., Marshall, J., Ryder, D., Saggers, S., Sanci, L & Williams, J. (2004). The prevention of substance use, risk and harm in Australia. Canberra: National Drug Research Institute and Centre for Adolescent Health.

McNeill, A. (2004). Alcohol Harm Reduction Strategy for England. Response by the Institute of Alcohol Studies. http://www.ias.org.uk/iaspapers/ahrs_july04.pdf.

Norström, T. (2001) Ed. *Alcohol in postwar Europe: Consumption, drinking patterns, consequences and policy responses in 15 European countries*, Stockholm: National Institute of Public Health, European Commission.

Österberg, E. and Karlsson, T. 2002. *Alcohol Policies in EU Member States and Norway: a Collection of Country Reports*. Helsinki: STAKES.

Rehm J, Room R, Monteiro M, Gmel G, Graham K, Rehn T, Sempos CT, Frick U, Jernigan D. (2004). Alcohol. In: WHO (ed), *Comparative quantification of health risks: Global and regional burden of disease due to selected major risk factors*. Geneva: WHO.

Sanchez-Carbonell, X., Guardiola, E., Belles, A. & Beranuy, M. (2005). European Union scientific production on alcohol and drug misuse (1976-2000). Addiction 100 1166-1174.

Wanless, D (2004). Securing Good Health for the Whole Population. London: HMSO.

World Health Organization (1980) Problems related to alcohol consumption. Report of a WHO Expert Committee. Geneva. World Health Organization, 1980 (WHO Technical Report Series, No.650).

World Health Organization (1986). Ottawa Charter for Health promotion. Geneva, World Health Organization.

World Health Organization (1992a). European Alcohol Action Plan 1992-1999. Copenhagen: World Health Organization Regional Office for Europe.

World Health Organization (1992b) The ICD-10 Classification of Mental and Behavioural Disorders: Clinical Descriptions and Diagnostic Guidelines. Geneva: World Health Organization.

World Health Organization (1995). European Charter on Alcohol. Copenhagen: World Health Organization Regional Office for Europe.

World Health Organization (1998). Health 21 – health for all in the 21st century. Copenhagen: World Health Organization Regional Office for Europe.

World Health Organization (2000). European Alcohol Action Plan 2000-2005. Copenhagen: World Health Organization Regional Office for Europe.

World Health Organization (2001). Stockholm Declaration on Alcohol and Young people Copenhagen: World Health Organization Regional Office for Europe.

World Health Organization (2002). The World Health Report 2002 - Reducing Risks, Promoting Healthy Life. Geneva, World Health Organization.

World Health Organization (2004a). Global Status Report on Alcohol 2004. Geneva, World Health Organization.

World Health Organization (2004b). Global Status Report on Alcohol Policy. Geneva, World Health Organization.

World Health Organization (2005a) Alcohol policy in the WHO European Region: current status and the way forward. Copenhagen, World Health Organization Regional Office for Europe.

World Health Organization (2005b). Framework for Alcohol Policy in the European Region. Copenhagen: World Health Organization Regional Office for Europe.