

Chapter 8 – Alcohol policy in Europe

In contrast to most of the 20th century, countries no longer make their national alcohol policies in an international vacuum. Instead, policies dealing with alcohol must take into account three different aspects of the international arena – (i) international and European legal obligations; (ii) other policies dealing with alcohol as an economic commodity; and (iii) international actions to reduce the harm done by alcohol.

The most prominent international legal obligations are the General Agreement on Tariffs and Trade (GATT) dealing with goods, and the General Agreement on Trade in Services (GATS). Past cases on these have shown that the World Trade Organization (WTO) will prioritize health over trade in some circumstances (for example, a ban on asbestos imports), although policies must pass a series of strict tests in order to be maintained. Future developments should be monitored to ensure that trade negotiators are aware of the health implications of both current and future agreements,

However, by far the greater effect on alcohol policy in practice has come from the trade law of the European Union (EU). Most of the cases relating to alcohol stem from the 'national treatment' rule on taxation, which means that states are forbidden from discriminating – either directly or indirectly – in favour of domestic goods against those from elsewhere in the EU. No exceptions can be made to this on health grounds, with the result that countries face certain restrictions in the design of their tax policy. Other rules on monopolies have also led to much of the Nordic alcohol monopolies being removed, although the off-premise retail monopolies have been upheld by the European Court of Justice (ECJ). In contrast, the increasingly influential ECJ has unambiguously supported advertising bans in Catalonia and France, accepting that "it is in fact undeniable that advertising acts as an encouragement to consumption".

Alcoholic drinks are also dealt with as economic commodities through agriculture and taxation policy at the European level. Standardized excise duties are a longstanding goal of the EU in order to reduce market distortions, where large differences in tax rates between nearby countries lead to large amounts of shopping abroad. This leads to lost revenue for the high-tax government, as well as creating pressure to lower taxation rates, as has occurred in some of the Nordic countries.

The production of alcoholic drinks in the form of wine receives €1.5 billion worth of support each year through the Common Agricultural Policy (CAP). For some time there has been an imbalance in the CAP, with increasing consumption, a more recent fall in demand and greater international competition leading to a considerable surplus of European wines. The economic and political importance of these subsidies, and in particular the problems of wine producers, makes it hard to progress from a public health perspective.

The international body most active on alcohol has been the World Health Organization (WHO), whose European office has undertaken several initiatives to reduce alcohol-related harm in its 52 Member States. These include the European Alcohol Action Plan, the European Charter on Alcohol and two ministerial conferences, which confirmed the need for alcohol policy (and public health more broadly) to be developed without any interference from commercial or economic interests.

Although the EU itself cannot pass laws simply to protect human health (Member States have not conferred this power on the European institutions), some policies dealing with the internal market can incorporate substantial health

concerns, such as the alcohol advertising clause within the Television Without Frontiers Directive. Otherwise, the EU's action on alcohol has come through 'soft law', in the form of non-binding resolutions and recommendations urging Member States to act in a certain way, such as the 2001 Commission Recommendation on the maximum permitted blood alcohol content for drivers of motorized vehicles. Partly driven by the sudden growth of alcopops from 1995, alcohol policy has become more politically prominent in recent years, leading to a 2001 Council resolution on the Europe-wide problem of drinking by young people, in particular children and adolescents, and the Council's invitation to the Commission to produce a strategy on alcohol-related harm in Europe, which, as of early 2006, is currently being drafted.

WORLD TRADE LAW AND ALCOHOL

Why is trade law relevant for alcohol policy?

As with any other economic commodity, policies dealing with alcohol must fit with the legal obligations made by states to each other within a body of international treaties that have built up since the end of the Second World War. These commitments reduce the scope for states to enact protectionist policies, but what this means for public health policy has generally been interpreted in two ways. Some commentators – in particular those from health or social issue backgrounds – have expressed concerns about how trade rules (particularly on a global level) may constrain health or social policy within a trading system that prioritizes commercial goals above health. Others – mainly from business, governmental or economic spheres – have responded with confidence that governments are safe to pursue health aims as long as they follow the rules when doing so. The reality, inevitably, is more complicated than either view. As a World Health Organization (WHO) paper notes in the context of just one provision, the rules are so complex that states “should view simplistic assertions about [them] with scepticism” (Fidler and Drager 2003:10).

The easiest way to understand the health impact of the two levels of trade agreements (European and global) is to work down from the highest level, with the World Trade Organization (WTO; see Box 8.1). This includes a variety of commitments built up over several treaties, in particular the General Agreement on Tariffs and Trade (GATT) dealing with goods, and the General Agreement on Trade in Services (GATS) that focuses on services (see Box 8.2). The GATS in particular has aroused much debate due to its potential scope, as it defines ‘services’ in a way that incorporates most types of human activity. For example, although alcohol is a good and covered by GATT, alcohol policy could be far more affected by service commitments that cover the production, wholesale, distribution, retail and advertising of alcohol.

BOX 8.1 – THE WORLD TRADE ORGANIZATION (WTO)

- *History:* The main international agreements today can be traced back to the General Agreement on Tariffs and Trade (GATT), which was one of the 'Bretton Woods Institutions' set up to help the world economy recover from the Second World War. Countries since then have negotiated progressively wider-ranging agreements with the goal of further liberalizing world trade and increasing standards of living, counteracting the tendency of states to put up trade barriers to protect domestic vested interests.
- *Process:* Within each trade round, member countries make *offers* (to liberalize their domestic markets) and *requests* (asking other countries to liberalize in certain sectors) until agreement can be reached by all. From a European perspective, it is important to note that the European Commission (EC) negotiates on behalf of all Member States – so whatever the ambivalences within the European Union (EU), this becomes a single position at the WTO negotiating table (Alavaikko 2002).
- *The Uruguay Round:* The trade round process was formalized at the end of the eighth round (known as the 'Uruguay Round') of negotiations in 1995 with the creation of the World Trade Organisation (WTO) to coordinate negotiating rounds – a moment that also considerably expanded the reach of the agreements into new areas such as intellectual property (the TRIPS agreement) and services (the General Agreement on Trade and Services – GATS).
- *Dispute Settlement:* The Uruguay Round also contained new powers to settle trade disputes between countries, allowing the WTO to put its blessing on retaliatory sanctions against the offending country. The case is initially passed on to a Panel appointed by the WTO Director-General, but following this either party can appeal on points of law to the WTO Appellate Body. The process itself is very slow, and at each stage the WTO only acts if the countries cannot negotiate an agreement between themselves. Together with Trade Policy Reviews undertaken by the WTO Secretariat – that “pose questions on member nations’ trade policies and create pressure for the homogenisation of these policies” (Alavaikko 2002:71) – this gives the WTO substantial power to discipline countries in accordance with their commitments.

Some observers have argued that for legal psychoactive substances such as alcohol, the objectives of the WTO are at odds with public health – “the promise of trade liberalization under the WTO is to reduce costs, increase choice, and expand the availability of consumer products in its 143 member countries. However, to varying extents members also pursue policies to restrict choice, reduce the availability, and increase the price of alcohol, with a view to reducing consumption—particularly among young people” (Gould and Schacter 2002). In practice, this could be interpreted that alcohol monopolies, certain tax structures, advertising bans, and controls over imports will all be ruled counter to world trade law. Even from an optimistic viewpoint, “*the best outcome that can be hoped for when any regulation becomes the subject of a trade complaint is that it will not be struck down*” (Gould 2005:360).

The health defence

To what extent this is true depends almost entirely on the interpretation of one part of the treaties – GATT Article XX and GATS Article XIV. These state that nothing in

either agreement “shall be construed to prevent the adoption or enforcement by any contracting party of measures...necessary to protect...human health,” as long as these measures are not a “disguised restriction on trade” or “unjustifiable discrimination.” It is up to the country defending a health policy to show that there is no 'less trade restrictive' alternative that would have the same effect, and that the policy is being used in good faith – although the value of a goal like human life is unquestioned (WTO Committee on Trade and Environment 2002).

Where a measure is very important for an aim such as health, it will be maintained by the WTO even if it is severely disruptive to trade (WHO and WTO 2002; WTO Committee on Trade and Environment 2002). However, where the measure is less than indispensable, the burdens of this ‘necessity test’ are ‘substantial and difficult’ – which could mean that the defence is not enough to protect health policies in practice (Fidler and Drager 2003).

Box 8.2 – Principles of world trade	
<i>Principle</i>	<i>What it means</i>
<p>Most Favoured Nation GATT Article I GATS Article II</p>	<p>The best treatment for one foreign trader must be extended to all the others, in effect making all WTO countries equally ‘most favoured nations’.</p> <p>This applies to all WTO members for everything except (i) regional free trade agreements (ii) to give preferential access to developing countries; (iii) in response to products seen to be traded unfairly; and (iv) for some services.</p>
<p>National Treatment GATT Article III GATS Article XVII</p>	<p>The best treatment for <i>domestic</i> traders is extended to treaty partners. Sometimes called ‘the golden rule of international trade law’ as it ensures <i>substantive</i> equality of treatment – this can mean that even formal equality is not enough.</p> <p>Under GATT, national treatment only applies when a product has entered a market; this allows differential treatment before entering a market (e.g. tariff barriers). This does not apply under GATS, making the commitment more powerful – as a result, it is a ‘positive listing’ article that countries can choose to sign up to in each area (exemptions are listed in the country schedules).</p>
<p>Market Access GATT Article XI GATS Article XVI</p>	<p>Broadly speaking, ‘market access’ simply means committing to open up a market in a given sector. As with the national treatment commitment, governments choose to offer market access in different sectors and can specify any limitations in each area.</p> <p>For goods, market access tends to refer to import quotas and is, therefore, a reduction/abolition of a numerical limit. In GATS, however, market access is defined as the absence of limits on (i) numbers of suppliers; (ii) value of transactions; (iii) output; (iv) employment; (v) the types of legal entity; and (vi) participation of foreign capital. In all cases, both numerical limits (including bans, seen as ‘a limit of zero’) and ‘economic needs tests’ are outlawed where commitments are made.</p>
<p>Monopolies GATT Article VIII GATS Article XVI</p>	<p>Monopolies must be carefully crafted to minimize the trade disruption they cause. Mainly this means they must trade in line with commercial considerations, not discriminate on any goods that affect private traders, and limit ‘mark-ups’ on imports.</p> <p>It should also be noted that monopolies would evidently break Market Access commitments, so must be written into the country’s schedule as an exemption (if relevant).</p>

Past cases can be a useful guide to how far health policies can be defended at the WTO. Few of the cases have been directly for alcohol, and most of those that do

exist are about tax systems seemingly designed to favour the locally produced drink.¹ Three other cases under GATT pre-date the WTO, with the US and Canada exchanging complaints in the late 1980s and early 1990s as regards their minimum pricing, taxation and marketing policies – but again, the GATT panel did not have to decide between trade and health interests in any of the cases, even if some of the policies concerned could be argued to be relevant to public health (documents L/6304, DS17/R, and DS23/R; see also Ferris, Room, and Giesbrecht 1993; Vingilis, Lote, and Seeley 1998; Room and West 1998).

Other areas of public health offer more insight into whether the health defence will be enough to defend discriminatory alcohol policies, such as the 1990 Thai Cigarettes case (DS10/R). Here a ban on tobacco imports was struck down on the basis of Market Access after the Thai government failed to demonstrate the laws were necessary for health, despite a WHO intervention during the panel to point out that “multinational tobacco companies had routinely circumvented national restrictions on advertising through indirect advertising and a variety of other techniques” (cited in Howse 2004). However, the panel’s reasoning explicitly allowed a number of other less trade-restrictive tobacco control policies to achieve the same objectives, including an advertising ban, labelling requirements, bans on harmful additives, and a tobacco retail monopoly. Following this ruling, and combined with domestic support, the Thai parliament passed two tobacco control acts in 1992 that reversed the rise in the prevalence of smoking (Bettcher and Shapiro 2001; WHO and WTO 2002:77).

This confirms the implications of the discussion above – it is not enough for a health policy to be defended simply because it works; it must also work in a way to disrupt trade as little as possible. For example, foreign exchange fees and locally supervised tax stamps may have ‘secured compliance with laws or regulations’ against cigarette smuggling in line with Article XX, but the Dominican Republic lost its case as it failed to explain why other GATT-consistent measures could not perform the same role (DS302/5, Nov 2004). Most recently of all, the WTO Appellate Panel ruled that the ‘public morals’ defence under Article XX was not enough to justify the US remote gambling laws, again on the grounds that the laws were not applied equally to domestic and foreign firms (DS285, in 2005). While some non-governmental organizations (NGOs) argued this would have serious ramifications for US gambling policy, the US government itself claimed this as a victory because it would be easily able to adjust its laws to fit the ruling.²

The first policy measure to be successfully defended in full at the WTO based on Article XX came in 2001, with the EC-Asbestos case (DS135). The EC successfully maintained a French ban on asbestos against Canada’s protests, with the WTO panel and appellate bodies both finding that the measure was justified to protect human health. Furthermore, the (more senior) appellate body also said that health effects may determine if one product is ‘like’ another if it affects their competitive relationship in the marketplace (WTO Committee on Trade and Environment 2002;

¹ For example, Chile’s tax went up steeply between an alcoholic strength of 35% (the level of Chilean pisco) and 40% (that of foreign spirits). In the Chilean as well as similar Korean and Japanese cases the WTO ruled against the tax policy, although none of these were being defended substantially on the basis of Article XX.

² This was only decided on appeal, as the original dispute resolution panel believed that bilateral talks between the US and Antigua were a less-trade distorting alternative. This was thrown out by the Appellate Body, as “consultations are by definition a process, the results of which are uncertain and therefore not capable of comparison with the measures at issue in this case.” See Bridges Trade Digest, 17 Nov 2004 and 13 Apr 2005, available from www.ictsd.org/weekly/archive.htm and the Public Citizen press release <http://www.citizen.org/pressroom/release.cfm?ID=1915>.

Slotboom 2003). Taken together, these cases show that the WTO – in certain conditions – is prepared to prioritize health over trade interests. However, there are other outstanding concerns relating to alcohol and WTO law, to which this chapter will return after examining how alcohol is affected by trade law at the European level.

THE ALCOHOL TRADE IN THE EUROPEAN INTERNAL MARKET

Although the binding global commitments of the WTO are potentially important for health policy, by far the greater effect in practice has come from the trade law of the EU (see Box 8.3 and Figure 8.1).³ In 1986, EC Member States signed the Single European Act as a commitment to completing a single internal market in Europe by 1993. This internal market would be a place ‘without internal frontiers’ where goods, people, services and capital could move freely, thereby enhancing competition and consumer choice (see also COM (1999) 624). One part of this is the common definition of an alcoholic drink for tax purposes (in 92/83/EC), which include a minimum strength of 0.5% alcohol by volume for beer, 1.2% for wine and intermediate products and 22% for spirits (there are also thresholds for lowered tax rates for ‘low alcohol’ types set at 2.8% for beer and 8.5% for wine and intermediate products).

BOX 8.3 – THE EUROPEAN UNION (EU)

- **History:** The EU is the end result of a sequence of treaties between growing numbers of European States, dating back to the creation of the European Coal and Steel Community in 1951. The most recent of these agreements is the Treaty of Nice in 2000, which paved the way for the EU to take in 10 new Member States largely from eastern Europe.
- **Powers:** In these treaties, Member States have given the European Community a legal status and conferred powers on the EU that allow it to make binding legislation – although only in certain areas. All action must stay within this legal base (sometimes known as the principle of *conferral*), and meet two further tests to avoid being ruled *ultra vires* (beyond its power):
 - **Subsidiarity** – the EU should only act if its aims can be better achieved (due to either scale or effect) on a European level rather than local or national one. Another way of seeing this is that all action should take place on the lowest level that it can work successfully.
 - **Proportionality** – each action must be ‘proportionate’ to its aims, i.e. ensure that the means employed are suitable, and they do not go beyond what is necessary to achieve the aim
- **Non-legislative actions:** Where these tests are not met, there is sometimes the possibility for the EU to adopt non-binding positions known as ‘soft law’. These are often in the form of *Recommendations* for Member States to act in a certain way, or expressing *Opinions* that may pave the way for later legislation.

³ Although not members of the EU, Iceland and Norway (together with Lichtenstein) are members of the European Economic Area (EEA). This enables them to participate in the Internal Market, but they do not have a voice in decision-making. These three countries plus Switzerland are also members of the European Free Trade Association (EFTA), which conducts trade negotiations on behalf of its members.

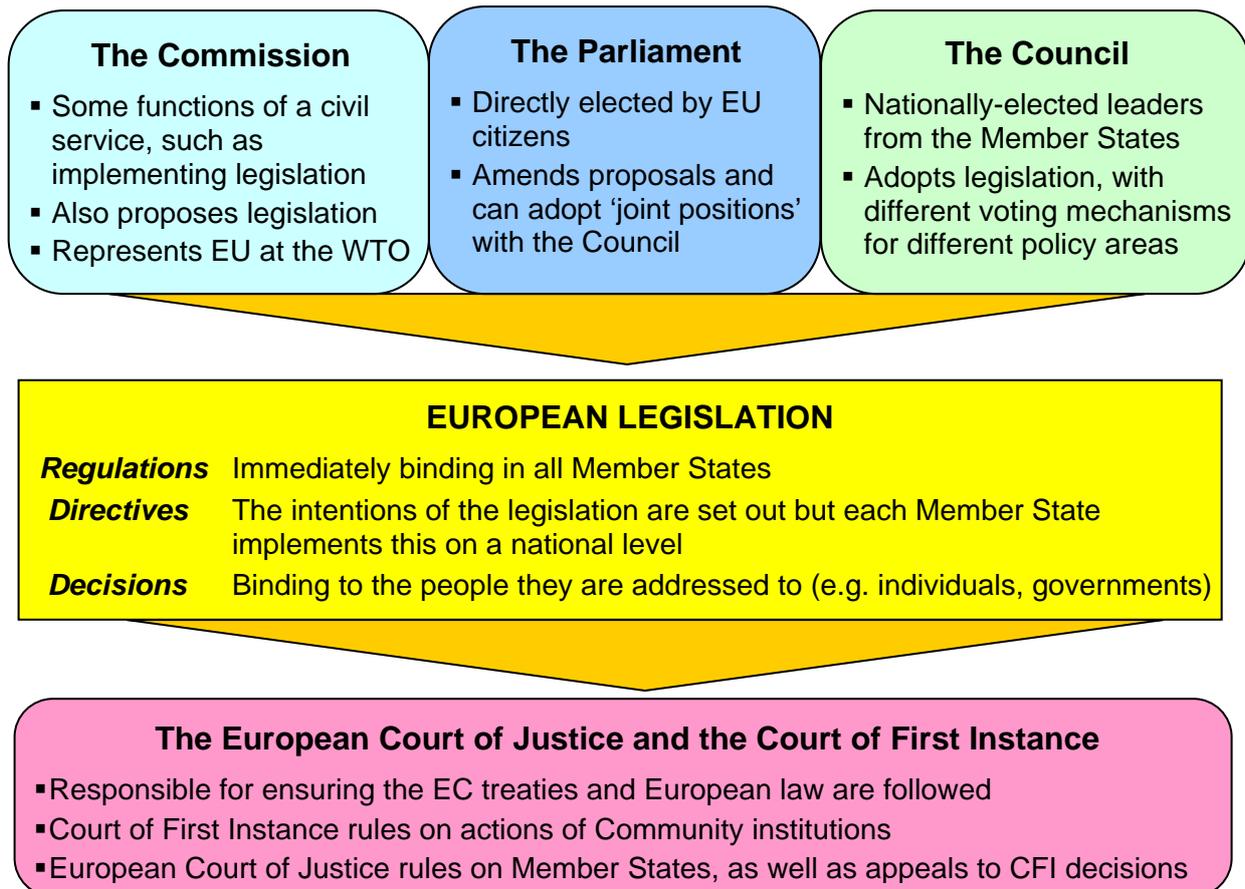


Figure 8.1 The key institutions of the EU

This market is certainly not yet complete, however, and discussions are ongoing to deepen and broaden it, such as in the proposed Services Directive.⁴ As on the global level, this introduces the question of how far public health policies can be maintained if they discriminate against other countries' trade interests. Contrary to the global level though, there is no one article that provides an overarching defence for health-motivated policies, which makes it important to look at the European trade rules commitment-by-commitment.

Tax and pricing policy

Most of the cases relating to alcohol stem from the 'national treatment' rule on taxation (article 90 ex 95)⁵, which allows no exceptions to be made on health grounds. This means that states are forbidden from discriminating in favour of domestic goods at the expense of those from elsewhere in the EU – which at its

⁴ Services are currently covered in analogous fashion to goods (articles 49, 46), but the Framework Directive on Services (COM (2004) 2) would go beyond this to remove many existing barriers to free trade. However, it has so far proved difficult to overcome the substantial differences between Member States on this policy.

⁵ These articles refer to the consolidated version of the European Community Treaty, available from http://europa.eu.int/abc/treaties_en.htm.

simplest, has meant that French and Italian taxes favouring cognac over whisky were ruled illegal some time ago (C-168/78; C-169/78 & C-216/81).

Complications arise when there is uncertainty over whether drinks are 'similar', or whether dissimilar drinks types are nevertheless in competition with each other. On similarity, the courts have made clear that fruit and grape wines are similar, while champagne and fruit wines are less clear.⁶ Whisky and fruit wines have been found to be dissimilar though, due to a combination of objective criteria (e.g. raw materials, production processes, alcoholic strength) and whether they "*are capable of meeting the same needs from the point of view of consumers*" [C-243/84; "Johnny Walker"]

Perhaps the most famous case interpreting whether products were in competition comes from an examination of wine and beer in the UK in the 1980s. Here the court ruled that "*the tax policy of a Member State must not crystallize existing consumer habits so as to be biased in favour of the competing national industries,*" (the tax policy was also found to be disproportionate to any available criteria). Similarly, the 'cultural use' of a particular drink – in this case, drinking Danish aquavit with meals – has also been decided to be irrelevant for the *potential* competition of this drink with others [C-171/78 & C-68/79].⁷ Even for drinks in competition though, the Johnny Walker case found that there is no protectionist effect "*if a significant proportion of domestic production of alcoholic beverages falls within each of the relevant tax categories.*"⁸

Taken together, these cases suggest that Member States do have flexibility in setting the relative taxes on drinks but not to the extent that they can attach a greater tax to drinks only produced abroad. This means that a beer-producing country that taxes wine more than beer will have to be mindful of the relevant case law when setting tax rates, while it is perfectly free to tax beer more than wine (Elinder *et al.* 2003). A further judgement on valid criteria for taxation is likely to arrive with a pending case, where the Commission argues that the greater tax on wine over beer of identical alcohol content in Sweden is discriminatory (see IP/04/1280).

A similar conclusion has been reached on the legality of minimum pricing agreements, which may be ruled illegal where they stop low-price competition from abroad (as occurred for gin in the Netherlands in the 1970s; C-82/77). There have also been some discussions (particularly in the UK) on whether fixed minimum prices contravene European competition legislation on cartels. Legal opinions suggest that industry voluntary agreements may be illegal, but that statutory benchmarks within the marketplace are permissible, although further clarification has been requested (Baylis 2005; House of Commons Home Affairs Committee 2005).

Alcohol monopolies

EU attempts to reconcile monopolies and non-discrimination date back to the Treaty of Rome, and even by the 1970s, the European Court of Justice (ECJ) had shown

⁶ The champagne case was referred back to a national court to decide; see C-106/84; C-386/93 to C-377/93.

⁷ This has been clarified when a higher VAT on wine in Belgium was upheld: due to the high pre-tax price differential between beer and cheap wines, no practical effect of the tax could be observed, hence the drinks were not in potential competition [C-356/85].

⁸ An earlier case concerning France is also relevant here, finding that European law "does not prohibit the imposition on national products of internal taxation in excess of that on imported products" [C-86/78].

that while monopolies are allowable (e.g. case 91/78), exclusive import rights are not ('Manghera', C-59/75). Alcohol monopolies did not form part of the main agenda during the European Economic Area (EEA) accession negotiations, although the eventual 1994 agreement included a note where the countries stressed the importance of their monopoly systems. However, this was a statement of opinion rather than a legal agreement, and soon afterwards a European court ruled against the import rights of the Finnish monopoly in a landmark case (see Box 8.4; Österberg 1993; Lubkin 1996; Holder *et al.* 1998; Alavaikko and Österberg 2000).

Large parts of the alcohol monopolies in Finland, Norway and Sweden were, therefore, removed, leaving only the off-premise retail monopolies. While this was acceptable to the Commission, it took three further cases to establish that monopolies were legally valid as long as they fulfilled all Treaty requirements "save, however, for restrictions on trade which are inherent in the existence of the monopolies in question" (see Box 8.4).

Following these rulings the basis of the monopolies was unchallenged for several years, although practical details of the Swedish monopoly were sometimes questioned by the Commission (see Kühlhorn and Trolldall 2000) while the EFTA Court ruled against the Norwegian monopoly on alcopops.⁹ However, in 2004 the Commission started proceedings against Sweden, arguing that the ban on consumers using private intermediaries to import alcohol is a disproportionate obstacle to the free movement of goods. Sweden maintains this is an integral and non-discriminatory part of the alcohol monopoly. It is currently unknown whether the court will accept the Commission's contentions that the restriction is not integral to the monopoly, and that public health can be protected by less trade-restrictive measures.

Box 8.4: KEY MONOPOLY CASES

Four case histories from the mid-1990s show the conditions under which alcohol monopolies can be maintained:

- **Restamark (E-194)** – the Finnish 'Restamark' company attempted to import alcoholic beverages against the Finnish law. The European Free Trade Association (EFTA) Court found that the import monopoly contravened the EEA agreement, a decision that helped unravel the Nordic import, export and wholesale monopolies.
- **Wilhelmson (E-6/96)** – the Norwegian shopkeeper Tore Wilhelmson appealed to the EFTA Court after being turned down for a beer licence by the state monopoly. The EFTA Court supported the retail monopoly.
- **Gunderson (E-1/97)** – again in Norway, Fritjof Gunderson asked the EFTA Court to allow him to sell wine in his store given that he could sell beer. Again, the EFTA Court defended the Norwegian policy
- **Franzén (C-189/95)** – in the only case to be brought under EU (rather than EEC) law, Harry Franzén deliberately broke the Swedish retail monopoly by selling wine in his shop. The ECJ ruled that the monopoly was non-discriminatory and therefore legal under EC commitments, and also decided that trade restrictions could be maintained if they were 'inherent to the existence of the monopoly'.

⁹ The case ruled against a restriction on (foreign-produced) alcopops being sold outside monopoly stores when (domestically-produced) beer of the same strength can be bought from grocery stores (E-9/00).

The health defence and advertising

For several EU Treaty commitments, restrictions of free trade can be defended on health grounds on similar terms to the WTO articles above. This includes quantitative restrictions (article 30, and has been broadly interpreted cf. C-8/74), the right of establishment (article 46), and services (article 55). As before though, these restrictions must be determined to be proportionate responses; that is, they cannot go beyond what is necessary to fulfil their aim.

This is particularly important for advertising regulations, which have been seen to reduce the ability of foreign firms to successfully enter a market compared to established ones, sometimes to a protectionist effect. Yet, despite the acceptance that advertising restrictions may discriminate against trade, only once has an advertising ban been struck down by the courts, and this was for a clearly discriminatory ban on certain drinks advertising (C-152/78, in parallel to C-168/78). Even here though, the court accepted that *“it is in fact undeniable that advertising acts as an encouragement to consumption”* (a verdict repeated in each of the more recent cases).

Box 8.5: THE LOI EVIN

The ban in France on alcohol advertising in ‘bi-national’ broadcasts¹ was upheld by the European Court of Justice in 2004. The court stated:

- *“It is for the Member States to decide on the degree of protection which they wish to afford to public health and on the way in which that protection is to be achieved”*
- *The law “[reduces] the occasions on which television viewers might be encouraged to consume alcoholic beverages”*
- *“The French rules on television advertising are appropriate to ensure their aim of protecting public health”*
- *The laws “do not go beyond what is necessary to achieve such an objective”*

¹ *Bi-national broadcasts are those to be broadcast in two countries only*

Source: C-262/02 and C-429/02

On only one other occasion has the court not fully confirmed the legality of an advertising restriction, when discussing a complete ban on alcohol advertising in print media in Sweden. As before though, previous points of law were confirmed, but the issue of whether a complete ban was proportionate was passed back to the Swedish national court – and it was they who ruled against the policy (the Gourmet Foods case, C-405/98).¹⁰

In the three other cases though, the courts have unambiguously supported advertising bans. First, a ban in Catalonia on advertising drinks over 23% absolute volume in public places was upheld with the comment that *“in principle, the [23%] criterion does not appear to be manifestly unreasonable as part of a campaign against alcoholism”* (C-190 and C-176/90). Second, in a celebrated recent case, a French ban on alcohol advertising in ‘bi-national broadcasts’ was upheld (the loi Evin; see Box 8.5 above). Most recently of all, the EFTA court affirmed the previous

¹⁰ The Swedish Market Court ultimately decided that the public health benefits of a print media ban were *not* proportionate to the restrictions on trade. Certain aspects of the situation did not help the case, such as the existence of ‘editorial advertising’ that tends to favour domestic goods, and the proliferation of internet advertising. In response, new legislation was passed outlawing print advertising for products over 16% alcohol volume, followed in January 2005 by compulsory warning labels on all print advertisements.

reasoning but left the advertising restrictions with no case to answer on a technicality (E-4/04).

Although yet another case is pending,¹¹ the basic opinion of the courts is clear: advertising restrictions may infringe trade commitments, but (if proportionate) they are justified by the aim of protecting health, since advertising acts as an encouragement to consumption.

Conclusions on trade law

In conclusion, it is inaccurate to suggest that the WTO or European courts have been entirely oblivious to health concerns when it comes to alcohol. Nevertheless, the lack of public health representation within trade negotiations (Room and West 1998:85) means that a number of risks should be monitored at the EU level, and, particularly, at the WTO:

- *Trade creep*: within the WTO, the most severe clauses are all voluntarily signed but then effectively locked-in, due to the cost of negotiating compensatory payments to other countries (Sinclair and Grieshaber-Otto 2002). This occurs in a context of ongoing pressure from commercial, trade and economic sectors to make further commitments and also pressure other countries to do so (Gould 2004). Perhaps of even more concern is the potential for WTO panels to interpret agreements more broadly than originally intended – even the US has made commitments on gambling that it has shown it never intended to make (see also Wallach 2005).¹² Furthermore, the ongoing process of negotiations may lead to new trade agreements with further implications for health policy, such as the ‘expropriation of investment’ agreements within the North American Free Trade Association (NAFTA; Gould 2005).

In light of these concerns, some WTO members (including Bulgaria, Poland, Slovenia, and Switzerland, but not the EU)¹³ have already attempted to exempt alcohol restrictions from advertising commitments under GATS (Gould 2005). In similar fashion, health stakeholders should, therefore, work with national and international trade representatives to make sure that the ‘health policy space’ for future generations is fully considered when making WTO trade commitments at the present time.

- *Domestic Regulation*: this clause in GATS (Article VI) commits states to negotiations aimed at ensuring that qualification, licensing and technical standards are “*not more burdensome than necessary to ensure the quality of the service*” (Honeck 2004). How to turn this broad commitment into a clearly defined regulation is currently under negotiation (Mamdouh 2004), with some expressing concern that it will become a necessity test for non-discriminatory policy (Sinclair 2000), making the vast majority of national

¹¹ On this occasion, a request from Norway for an EFTA opinion on the proportionality of an advertising ban within a specialty wine publication; E-4/04.

¹² The panel remarked, “the US may well have inadvertently undertaken specific commitments on gambling and betting services. However, it is not for the Panel to second-guess the intentions of the US at the time the commitment was scheduled. Rather, our role is to interpret and apply the GATS in light of the facts and evidence before us.” The panel’s verdict in this area was upheld in an appeal. See Bridges Trade Digest, 17 Nov 2004 and 13 Apr 2005, available from www.ictsd.org/weekly/archive.htm.

¹³ Before the accession of the new Member States in May 2004, Poland and Slovenia were represented separately from the EU at the WTO, and hence have made different commitments in certain areas.

policy potentially dependent on WTO Panel decisions (Wallach 2005). The WTO's working group on this has noted that a necessity test must "[demonstrate] credibly that such a test can be applied in a way that does not threaten legitimate regulatory autonomy" (Mattoo 2004), but even so some commentators have advised that the clause should be monitored in relation to health policy (Fidler and Drager 2003; Gould 2005).

- *The health defence*: article XIV within GATS has never been tested, and it has been suggested that there may be future challenges to labelling standards (violating trademark rights), ingredient disclosure rules (violating trade secrets); local monopolies, and advertising bans (favouring domestic producers) (Callard, Chitanhondh, and Weissman 2001; Grieshaber-Otto and Schacter 2002; Secretariat of the Pacific Community 2005). Similarly, there have been suggestions that other trade agreements – such as Technical Barriers to Trade (see e.g. WHO and WTO 2002), or the Trade-Related Aspects of Intellectual Property Rights (which has no overriding health defence) – may produce challenges to ingredient restrictions or compulsory health warnings (Secretariat of the Pacific Community 2005). In this context, research demonstrating the effectiveness of policy options (including mixes of policies) may well play an important role in future WTO cases.

Given these concerns, some commentators have stated that alcohol should be viewed as no ordinary commodity and that alcohol control policies should take precedence over trade negotiations (Grieshaber-Otto, Sinclair, and Schacter 2000; Jernigan *et al.* 2000). However, others have argued that such an approach would protect discriminatory control policies that might invite retaliatory measures (Chaloupka/Laixuthai 1996), making alcohol a potential bargaining tool in trade negotiations (Grieshaber-Otto and Schacter 2002). Moreover, there may not be the political will to achieve this in a WTO that is "*already staggering under the weight of the current trade agenda*" (Bettcher and Shapiro 2001:67). Nevertheless, the assembly of the World Medical Association has recently recommended that "measures affecting the supply, distribution, sale, advertising, promotion or investment in alcoholic beverages be excluded from international trade agreements" (World Medical Association 2005), while health ministers in the Pacific Region have agreed to work towards removing alcohol and tobacco from the Pacific Island Countries Trade Agreement (PICTA) in 2005.

Irrespective of this debate, it seems essential to improve the coordination between policymakers in the trade and health sectors to ensure any tensions between the sectors are minimized. A 2005 paper presented to the Executive Board of the World Health Organization made similar suggestions, arguing that health policymakers need to become more trade-aware, and that they also should help trade negotiators become more health-conscious (WHO 2005). It also noted that this "*requires rigorous research on the potential implications of trade agreements on health and of trade liberalization in health-related sectors on health-sector performance and health outcomes.*" The first half of this chapter suggests that these general health actions are as applicable in the alcohol policy sphere as when discussing health systems.

ALCOHOL AS AN ECONOMIC COMMODITY

International policies that deal with alcohol as an economic commodity can have important consequences for public health policy on alcohol. One positive example is that of the World Bank (the body providing loans and technical assistance to low and middle income countries in order to reduce poverty). In 2000, the Bank recognized that investment in alcoholic beverages was sensitive, and mandated all its employees to be ‘highly selective’ in only supporting projects “*with strong developmental impacts which are consistent with public health issues and social policy concerns*” (World Bank Group 2000).¹⁴

Of more importance in a European context is the position of health within economic decision-making within the EU. When taking actions to improve the workings of the European internal market, the EU institutions are legally obliged to ensure “a high level of human health protection” (see Box 8.6). Given that the EU has no legal powers to pass legislation specifically oriented to health (see below), this means that the only possibility of legislating for health on the European level is in the context of internal market reforms (as has been found for the legislation on tobacco advertising; see The ASPECT Consortium 2004).

This section looks in detail at four European policy areas that deal with the trade aspect of alcohol, and summarizes the significant implications of these for public health policy.

European alcohol taxes

Standardized excise duties are a longstanding goal of the EU, (see COM (72) 225 in the early 1970s), mainly because the combination of a single market together with wide excise variations leads to serious market distortions and lost tax revenue (see Chapter 3). Tax harmonization became a priority again in the 1980s with the extension of the internal market in the Single European Act, and a number of proposals for harmonized and target rates were put forward.

However, as fiscal policy requires unanimous agreement, the EU alcohol tax regime agreed in 1992 fell a long way short of full harmonization. The first of the two Directives – known as the Structures Directive (92/83/EEC) – detailed the method of calculating duty, the definitions of different products, and some of the derogations (exceptions). The excise rates themselves are detailed in the Approximating Directive (92/84/EEC), but are minimum rates only, with the target rates reduced to a (non-binding) note in the minutes. Wine was subject to no tax at all, leaving this beverage type as effectively un-harmonized.

One way of interpreting this is to see it as an attempt to let the market lead tax harmonization, with private individuals personally bringing back alcohol from abroad to avoid domestic duties (Holder *et al.* 1998). Large differences in tax rates between nearby countries, therefore, lead to large amounts of shopping abroad and lost revenue for high-tax governments, which will face pressure to lower their taxation rates (see also Chapter 3). Such chain reactions have occurred at several points

¹⁴ The Group has also published a report on gender inequalities in alcohol consumption and harms in Latin America and the Caribbean (Pyne, Claeson, and Correia 2002).

over the past 10 years, e.g. loosened import restrictions and the continuing tax differential between Denmark and Germany being followed by tax cuts in Denmark and then Sweden, and recent duty reductions in Denmark and Finland following the accession of Estonia to the EU. Private transfers may also rise in the near future, with the UK being challenged by the Commission through the ECJ for excessive penalties against small-scale smuggling by individuals in single vehicles, and also given recently expired derogations in Finland, Sweden and Denmark that previously allowed limits on private transfers within the EU.¹⁵

Box 8.6 The EU's legal commitment to health	
<i>Subject, and article in current Treaty</i>	<i>Description</i>
Activities of the EC <i>Article 3</i>	"The activities of the Community shall include...a contribution to the attainment of a high level of health protection"
Laws on the internal market <i>Article 95 (3)</i>	"The Commission, in its proposals... concerning health, safety, environmental protection and consumer protection, will take as a base a high level of protection, taking account in particular of any new development based on scientific facts." "Within their respective powers, the European Parliament and the Council will also seek to achieve this objective."
Public health in the EC <i>Article 152</i>	"A high level of human health protection shall be ensured in the definition and implementation of all Community policies and activities." "Community action, which shall complement national policies, shall be directed towards improving public health, preventing human illness and diseases, and obviating sources of danger to human health."
Other mentions <i>Articles 153, 175, 137</i>	Consumer protection: "In order to promote the interests of consumers and to ensure a high level of consumer protection, the Community shall contribute to protecting the health, safety and economic interests of consumers" Health and environment: "Community policy on the environment shall contribute to...protecting human health..." Workers' safety: "the Community shall support and complement the activities of the Member States in... improvement in particular of the working environment to protect workers' health and safety"
The health defence	Available to justify policies contrary to obligations on quantitative restrictions (article 30), free movement of workers (article 39 (3)), and on the right of establishment (article 46).

These likely increases in private transfers arise at the same time as a Commission-launched debate on alcohol excise duty rates, which is trying to find some way of reducing competition distortions, or at least to increase the minimum rates in line with inflation (24%) so that they do not become meaningless (COM (2004) 223). However, the EU Member States are still a long way from unanimous agreement on this issue. Many wine-producing countries see a zero tax on wine as essential for the functioning of the Common Agricultural Policy (CAP), especially given endemic problems in the European wine sector in recent years (see below). The higher-tax countries conversely feel that any move – even up-rating the minimum duties – should be conditional on introducing a positive duty for wine. Given the difficulties in

¹⁵ Norway has been able to retain border controls given that it lies outside the EU.

satisfying both these views simultaneously, it may be difficult for this long-running problem to be resolved within the current debate.

Aside from this relatively old problem for public health policy on alcohol, a new problem may arise from another Commission proposal from 2004, which suggested a further liberalization of intra-EU alcohol transfers (COM (2004) 227). The Directive would allow consumers buying non-commercially at distance – such as over the internet – to pay the tax level of the product's country of origin, even if they do not accompany it over the border themselves. It also proposed that the burden of proof over the indicative limits is changed from the individual (to show the goods are for private use) to the state (in showing that the goods are for commercial use). Industry groups have predicted that this would lead to 'agency traffic' where one person buys for many others on a non-commercial basis, and would make the commercial clause itself very difficult to police. More importantly in the present context, this would be likely to increase the scale of cross-border shopping and would thereby severely reduce Member States' control of their alcohol taxation policy. This is despite tobacco being exempted from the Directive on the grounds that "if applied to these products, the above principle would *inter alia* contradict the health policy advocated in Article 152 of the Treaty in particular (COM (2004) 227)."

Nevertheless, the Commission's proposal was supported by the European Economic and Social Council and the European Parliament, with the latter noting that "it is obvious that the amendments as formulated will mainly affect alcoholic beverages. Although no impact assessment has been carried out into the economic implications of such liberalisation, the Commission is not expecting any explosive increase in the type of transaction concerned." However, the proposal is far from a *fait accompli* at the time of writing (November 2005) – currently the Commission has rejected European Parliament amendments relating to the nature of 'personal use', and the Council has yet to issue its formal position on the draft.

Labelling and packaging

Wines and spirits traded within the EU internal market have to conform to a number of technical regulations, relating to both their labels and their packaging more generally. While these are based on trade and consumer concerns rather than health, it is worth being aware of this body of legislation as a context for potential future health-focused recommendations in this area (see Chapters 7 and 10).

Probably the greatest amount of regulation on labelling is dedicated to protecting producers' rights to use certain names when describing their drinks, a concern that also links to the TRIPS agreement in the WTO (see above). The key legislation for spirits in this regard is a 1989 Regulation on the definition, description and presentations of spirits (EEC 1576/89), which sets out the conditions necessary for a drink to be described as 'whisky', 'rum' etc. This includes a *minimum* alcoholic strength for each type of drink, generally set at 37.5% alcohol concentration (although there is some variation; whisky, for example, must be 40% concentration or greater), and also specifies the size that this is displayed on the label.

Legislation for wine is both more complicated and more controversial, with Regulation 753/2002 subject to considerable US pressure over protection for geographical indicators, resulting in the more recent Regulation 316/2004. Wine labels must include a set of compulsory information within a single field of vision (i.e. visible without turning the bottle), including alcoholic strength (with a specified

minimum text size, as for spirits), country of origin (for imports), production lot and other details.

More generally, all alcoholic drinks over 1.2% volume are required to state their alcohol content on their label (Directive 2000/13/EC Article 3.10). Amendments to the same Directive also require all products containing certain allergens to list these on the label (Directive 2003/89/EC). In addition, wine and spirits must indicate “contain sulphites” since November 2004. Directive 2005/26/EC allows further research to see if some other ingredients are (or are not) to be considered allergenic. Further requirements relating to ingredients listing may also be impending, following a recommendation from the Evaluation of EU Labelling Legislation that the feasibility of mandatory listing of ingredients on alcoholic beverages should be investigated.¹⁶ This was based on ‘strong convergence’ among stakeholders that this is desirable, and DG SANCO expect to propose legislation on labelling in response to the study in 2006.

Beyond labelling, EU law specifies common sizes for pre-packaged alcoholic drinks, which must be accepted for intra-Community trade by all EU countries (Directive 75/106/EEC). The specified sizes are the only allowable ones for wine and spirits, but Member States are allowed to use other sizes within their national markets for beer.¹⁷ Originally the harmonization was motivated by consumer protection, but more recent legislation on unit pricing, misleading advertising and labelling requirements have made this redundant. Nevertheless, a Commission proposal to replace this legislation (COM (2004) 708 final) recommended keeping similar fixed sizes for wine and spirits to help smaller producers given the power of buyers and sluggish growth.¹⁸ The Commission proposed that these fixed sizes should only be kept for 20 years to allow smaller producers time to adapt, after which the wine and spirits market would revert to free sizes.

Other EU internal market legislation

The most important other piece of internal market legislation involving alcohol is within audiovisual policy. Here the Television Without Frontiers (TVWF) Directive contains a specific clause on alcohol advertising (see Box 8.7) as well as a more general requirement that minors should be protected from programmes that may inhibit their physical, mental or moral development. The alcohol clause was included when freedom of movement of television programmes was introduced, so that the country of origin principle (where a programme legal in its home broadcasting country can be shown anywhere in the EU) can coexist with a ‘high level of health protection’. Current discussions on revising the legislative framework for audiovisual services include considerations of new media and below-the-line¹⁹ advertising (as outlined in

¹⁶ pp14, http://europa.eu.int/comm/food/food/labellingnutrition/foodlabelling/effl_conclu.pdf.

¹⁷ For example, all spirits must come in containers of size 20-30-40-50-200-350-500-700-1000-1500-2000-2500-3000-4500ml. Sizes of 100-1125-5000-10000ml are also allowed for trade use only. For full details on the common sizes in wine and beer, see http://europa.eu.int/eur-lex/en/consleg/main/1975/en_1975L0106_index.html; for details on the newly proposed sizes see COM (2004) 708 final.

¹⁸ See also “Pack sizes in the EU: Report on the extended impact assessment of sectors asking for fixed sizes” available from http://europa.eu.int/comm/enterprise/prepack/packsizes/packsiz_en.htm.

¹⁹ Below the line is an advertising technique which uses less conventional methods of advertising, typically focusing on direct means of communication, most commonly direct mail and e-mail, and often using highly targeted lists of names to maximize response rates. This differs from above the line advertising which makes use of traditional media such as newspapers, magazines, radio and television.

Chapter 7), and there have been suggestions that product placement may be legalised for certain types of programmes (see The Economist “Lights, cameras, brands,” Oct 27 2005).

Several other proposals affecting alcohol are also under discussion at the present time, although their final form is uncertain. The most advanced of these is the Commission’s draft Health Claims Regulation (COM (2003) 424), which aims to better inform consumers and aid harmonisation of the market. In keeping with article 95, the draft regulation would only allow health claims if the product truly contributes to a healthy diet – and as such would exclude all alcoholic drinks over 1.2% alcohol by volume. At the time of this report (November 2005), this particular proposal (included in article 4) had been rejected by the European Parliament, although the Council had re-stated their determination to include the article in the final piece of legislation.

Other ongoing discussions relate to ingredients labelling for alcoholic drinks (discussed above) and the draft Sales Promotions Regulation. The most recent draft at the time of writing (November 2005) would place alcoholic beverages outside the scope of the legislation, although as this draft was rejected by Member States in late 2004 there is uncertainty as to the future of the whole regulation.

BOX 8.7: THE TELEVISION WITHOUT FRONTIERS DIRECTIVE (TVWF)

Article 15 of the TVWF requires that Member States must ensure *as a bare minimum* that alcohol advertising does not:

- “aim specifically at minors” (especially showing them drinking);
- link consumption to driving or “enhanced physical performance” (not including sport);
- suggest that alcohol “contributes towards social or sexual success”;
- “claim that alcohol has therapeutic qualities or that it is a stimulant, a sedative or a means of resolving personal conflicts”;
- “encourage immoderate consumption of alcohol or present abstinence or moderation in a negative light”;
- “place emphasis on high alcoholic content” as a plus point”.

Source: 89/552/EEC, amended by 97/36/EC

The Common Agricultural Policy

In the year 2002, €1.5 billion was spent by the European Union in the EU15 supporting the production of wine through the Common Agricultural Policy (CAP) – equivalent to 30 times the entire annual public health budget. The CAP was originally set up in the 1960s to ensure a fair standard of living for farmers and to secure the survival of small farms, although as the nature of the business has changed the objectives have shifted towards environmental and social concerns. Since the enlargement of the EU in 2004, six of the new Member States have also started to receive funds for restructuring vineyards, although the €20m they receive is only a small fraction of the total €450m restructuring budget.²⁰ As shown in Chapter 3, the production of wine is an important part of many regional economies in southern Europe, and it has been suggested that the value of wine output may be over 20% of the total value of agricultural output in some regions (Österberg and Karlsson 2002).

²⁰ The countries receiving money (in descending order of money given) are Hungary, Slovenia, the Slovak Republic, Cyprus, the Czech Republic and Malta). The relatively small amount of the budget they receive is mainly due to the much smaller total area of vineyards involved; see IP/04/1193.

Wine under the CAP has been experiencing problems since the 1970s, with expanding production (and later falling demand) leading to large wine surpluses. Wine policy has, therefore, involved bans on planting vines and distillation measures, with the result that wine production has fallen from an average of around 210m hectolitres to 180m since the early 1980s.²¹ The 'Agenda 2000' proposals included incentives to produce quality rather than table wine, and for a short period of time co-financed some sales promotion campaigns for the "health benefits of moderate wine consumption" (Regulations 2702/1999 and 2826/2000) (see also Lock and McKee 2005:20). However, after 2002, the Commission Regulations laying down detailed rules for applying Council Regulation (EC) No 2826/2000 on information and promotion actions for agricultural products on the internal market no longer include any message on health benefits as regards wine (see, for example Commission Regulation 1071/2005).

Nevertheless, a combination of intensified international competition (including cuts in export subsidies and tariffs due to GATS), a strong Euro, and recent high yields have led to a European surplus that stood at 35.5m hectolitres in 1999-2000 (Elinder *et al.* 2003; Furlani and *et al.* 2003), in parallel to a global surplus estimated at 57m hectolitres for 2004 (World Drinks Report, 28 April 2005).²² As an emergency measure, the Commission has agreed to pay €145m for crisis distillation in France and Spain, in return for digging up vines and curbing plantings (Bloomberg 29/4/05). This can be considered as a withdrawal of alcohol from the market, since the alcohol resulting from crises distillation can be used as fuel.

The CAP subsidies (including the indirect subsidy of crisis distillation) are likely to have distorted the market in wine, although quantifying this effect has proved difficult (Furlani and *et al.* 2003). The Commission has also admitted that the most recent CAP wine measures have not had the desired effect, and plans to launch a new strategy in Spring 2006 to try and rectify the structural imbalance (Just Drinks 15/3/05).

Absent from the CAP is any mention of articles 152 and 153 (see box 8.9) emphasizing the role of the Community to have a high level of human health protection in all its work (see also Lock and McKee 2005).²³ This is particularly striking given that the imbalance in the wine sector has hindered negotiations on tax harmonization, with some arguing that CAP wine reform is vital to move forward on tax (Elinder *et al.* 2003). Yet in parallel fashion to tobacco leaves – where the CAP subsidy has been described by the European Court of Auditors as "a misuse of public funds" – the economic and political importance of the subsidies makes it hard to progress from a public health perspective (Hämäläinen, Koivusalo, and Ollila 2004).

ALCOHOL POLICY ACROSS BORDERS

The international level also offers the opportunity for countries to come together in reducing the harm done by alcohol, with such action growing alongside trade-

²¹ European Commission official statistics obtained from http://europa.eu.int/comm/agriculture/markets/wine/facts/index_en.htm.

²² Current negotiations at the WTO may also be relevant, with proposals to reduce allowable levels of trade-distorting support and possibly caps on all production and tariff supports in food and drink (Aroq Ltd. 2004).

²³ Although, under the new CAP system, farmers who receive direct income payments will have to respect, among others, environmental, health and safety standards.

oriented debates during the 20th century. One of the oldest of these agreements is the founding statement of the International Labour Organisation (ILO) dating from 1949, which forbids the payment of wages *'in the form of liquor of high alcoholic content'* or in taverns (except for the tavern's employees). Since then, the ILO has been active in trying to reduce workplace substance abuse around the world, including the publication of a 1995 Code of Practice on managing workplace alcohol-and-other-drug issues (ILO 1996).

A much more general agreement with some relevance for alcohol comes from the Council of Europe, who created the Convention for the Protection of Human Rights and Fundamental Freedoms in 1953. This Convention – separate from the EU institutions, but including all the EU states among its 46 members – is governed by the European Court of Human Rights, although cases rarely impact on alcohol policy. However, the Valencia authority lost a recent case for not securing the right to respect of the home, in this case from noise caused by local bars and clubs (application 4143/02).

The World Health Organization

Unsurprisingly, the international body most active on alcohol has been the World Health Organization (WHO), which has passed more than 10 alcohol-related resolutions at its governing World Health Assembly. In 1979, the Assembly noted that *"problems related to alcohol, and particularly to its excessive consumption, rank among the world's major public health problems."*

A similar sentiment was repeated over 25 years later in 2005, when the Assembly recognized that *"harmful drinking is among the foremost underlying causes of disease, injury, violence – especially domestic violence against women and children – disability, social problems and premature deaths, is associated with mental ill-health, has a serious impact on human welfare affecting individuals, families, communities and society as a whole, and contributes to social and health inequalities"* (see Box 8.8).

Box 8.8: "PUBLIC HEALTH PROBLEMS CAUSED BY HARMFUL USE OF ALCOHOL"

Resolution 58.26, which was passed at the World Health Assembly in May 2005, requested the WHO to:

- Strengthen the WHO Secretariat's capacity to support states and reinforce the evidence on which policies work
- Draw up recommendations for effective policies and interventions
- Report to the 2007 Assembly on evidence-based strategies to reduce alcohol-related harm, including a comprehensive assessment of all alcohol-related public health problems
- Strengthen global & regional information systems
- Promote effective policies in health-care settings
- Collaborate with governments, health professionals, NGOs and others
- Consult with industry representatives
- Report to the 2007 Assembly on the progress made on this resolution

The WHO has also brokered the first ever global public health treaty, the Framework Convention on Tobacco Control (FCTC), which entered into force on 28 February 2005. The FCTC was agreed by all 192 Member States of the WHO in 2003 but only applies to those countries that have ratified it – at the beginning of November 2005,

this stood at the Union as a whole and 19 individual Member States, but states are freely able to join the convention at a later date.²⁴ Parties to the FCTC commit to minimum levels of tobacco control, including comprehensive bans on tobacco advertising; health warnings on tobacco packaging covering 30+% of the display areas; protection of citizens from tobacco smoke in workplaces, public transport, and indoor public places; and increased, harmonized tobacco taxes.

Drawing on the experience of the framework convention on tobacco control, Room (2006) has identified several justifications for an international legally binding agreement. These are (i) to protect consumers from the harm done by alcohol; (ii) the scope of the damage; (iii) substantial harm in most regions of the world; (iv) harm done by alcohol transcending national borders; (v) difficulty of dealing with the harm done by alcohol by countries in isolation; and (vi) lack of any suitable pre-existing convention or other international agreement.

Room noted that it would be technically possible to manage alcohol through an international agreement by adding it to the lists of substances covered by one or more of the three existing Conventions controlling drugs. For example, he reported that a “*psychotropic substance*” may be scheduled under the 1971 Convention “*if the World Health Organization finds that the substance has the capacity to produce a state of dependence, and central nervous system stimulation or depression, resulting in hallucinations or disturbance in motor function or thinking or behaviour or perception or mood, and that there is sufficient evidence that the substance is likely to be abused so as to constitute a public health and social problem warranting the placing of the substance under international control*” (United Nations 1976). He notes that, although the framers of the 1971 Convention had not intended alcohol to be included, it certainly qualifies according to the Convention’s Schedule II: “*substances whose liability to abuse constitutes a substantial risk to public health and which have little to moderate therapeutic usefulness*”.

Since adding alcohol to the 1971 Convention is unlikely to receive political support, an alternative option is to consider a Framework Convention on Alcohol Policy, similar to the FCTC. It has been suggested that such a convention should start from the basis of the very substantial health and social problems from alcohol, which make it “no ordinary commodity” to be dealt with like bread or orange juice in the marketplace. It has further been suggested that such a convention could then identify policy areas for collective action (including marketing restrictions and tackling the illicit trade in alcohol) as well as urging countries to implement effective and evidence-based policies within their national boundaries (Anderson 2004). This process could help to: mobilize national and global technical and financial support for alcohol policy; raise awareness across different government ministries (and other health bodies) on alcohol policy; strengthen national legislation and action; and mobilize NGOs and other members of civil society in support of alcohol policy.

The World Health Organization in Europe

The European Office of the WHO (WHO-EURO) has undertaken several initiatives to reduce alcohol-related harm in its Member States, of which there are currently 52, including all the states of the EU. The European Commission itself has long-standing

²⁴ <http://www.who.int/tobacco/framework/>, 7 November 2005.

Box 8.9: THE EUROPEAN CHARTER ON ALCOHOL

Adopted at the WHO Ministerial Conference in Paris in 1995, the Charter promoted five ethical principles:

1. All people have the right to a **family, community and working life** protected from accidents, violence and other negative consequences of alcohol consumption.
2. All people have the right to valid **impartial information and education**, starting early in life, on the consequences of alcohol consumption on health, the family and society.
3. All children and adolescents have the right to **grow up in an environment protected** from the negative consequences of alcohol consumption and, to the extent possible, from the promotion of alcoholic beverages.
4. All people with hazardous or harmful alcohol consumption and members of their families have the right to **accessible treatment and care**.
5. All people who do not wish to consume alcohol, or who cannot do so for health or other reasons, have the right to be safeguarded from **pressures to drink** and be supported in their non-drinking behaviour.

bilateral relations with WHO-EURO, although cooperation has been less structured for alcohol than in other fields such as obesity or mental health.

The first global Health for All targets in 1991 included a target to reduce the 'health-damaging consumption' of alcohol, and more specifically "to reduce alcohol consumption by 25% with particular attention to harmful alcohol use" (Harkin, Anderson, and Lehto 1995; Solco *et al.* 2003). In 1992, the WHO-EURO Member States adopted the European Alcohol Action Plan (EAAP) from 1993-2000 (World Health

Organization 1992), aiming to reduce overall consumption as well as using measures to combat high-risk drinking behaviours. This was followed three years later by a WHO Ministerial Conference, held in 1995 in Paris, The European Charter on Alcohol was agreed at this conference, setting out five ethical principles to underpin alcohol policy (see Box 8.9; World Health Organization 1995).

Evaluating the EAAP in 1998, WHO-EURO noted that over half of the countries had developed a country alcohol action plan and had a coordinating body responsible for its implementation (see WHO-EURO 1999; Rehn, Room, and Edwards 2001). Of those countries where data were available at the time of the review, 11 had seen a decrease in per capita consumption and 3 (Italy, Poland, Spain) had achieved the European target of the health for all (HFA) policy of a 25% reduction, but 11 countries had experienced an increase in consumption since 1992. The alcohol and hospitality industry were also considered to play an insufficient role in preventing alcohol-related harm.

The original Health for All target and the EAAP have both been superseded by more recent versions. The new target set from 2000 aims that "by the year 2015, the adverse health effects from the consumption of addictive substances such as tobacco, alcohol and psychoactive drugs should have been significantly reduced in all Member States." The new EAAP 2000-5 was adopted by WHO-EURO a year later in 1999 (World Health Organization 2000), and emphasized country-based planning and monitoring (see Box 8.8).

A second WHO ministerial conference was held in Stockholm in February 2001, addressing in particular the issue of young people and alcohol. The resulting 'Stockholm Declaration' not only reinforced the earlier European Charter on Alcohol, but also set a number of targets including:

- Reduced numbers of drinkers, levels of high-risk drinking, pressures (including marketing) and alcohol-related harm (especially for young people);
- Delayed onset of drinking in young people; and
- More alternatives to drinking, more young people's involvement in health-policy (including alcohol policy), and more education.

Furthermore, it confirmed the need for public health and alcohol policy to be developed without any interference from commercial or economic interests.

Action in several related areas has also referred to alcohol, including the 2005 WHO Ministerial Conference on Mental Health that committed Member States to address the causes of harmful alcohol use disorders, and to support NGOs that are active in this area. Similarly, the draft European Strategy for Child and Adolescent Health and Development (Feb 2005) mentions alcohol in the context of harm to unborn children, reducing exposure of late childhood to risky behaviours like alcohol, and prevention of risky behaviours of adolescents with respect to alcohol. The Regional Committee's discussions on the upcoming strategy on non-communicable diseases also noted that they were "conscious that the most prominent noncommunicable diseases are linked to common preventable risk factors such as tobacco, alcohol, overweight and physical inactivity" (EUR/RC54/REC/1).

Throughout this recent period, a key role of WHO-EURO (sometimes in conjunction with the WHO head office) has been to set out the scientific basis for alcohol policy. The most prominent of these publications have been three major books co-sponsored by WHO-EURO over the past 30 years, representing collaborative efforts to set out the current 'state of the knowledge' at the time of publication (Bruun *et al.* 1975; Edwards *et al.* 1994; Babor *et al.* 2003). This has been supplemented by a series of wide-ranging background documents on particular technical aspects of alcohol and alcohol policy (Walsh 1982; Grant 1985; Partanen and Montonen 1988; Plant 1989; Anderson 1991; Anderson 1993; Hannibal *et al.* 1994; Harkin, Anderson, and Lehto 1995; Anderson and Lehto 1995; Anderson 1995; Heather 1995; Ritson 1995; Anderson and Lopez 1995; Lehto 1995a; Lehto 1995b; Anderson 1996; Henderson, Hutcheson, and Davies 1996; Montonen 1996; Harkin, Anderson, and Goos 1997; Rehn, Room, and Edwards 2001; Klingemann and Gmel 2001; WHO-EURO 2005).

Following on from the second EAAP that finishes in 2005, the Regional Committee of WHO-EURO has recently endorsed a new Framework on Alcohol Policy. The core principles of the EAAP have been maintained – including the importance of Member States' obligations to their citizens, the precautionary principle and the need to formulate public health approaches by public health interests – but places more emphasis on strategic guidance and different policy options as well as international collaboration.²⁵

²⁵ The Resolution, Framework and background papers are available from http://www.euro.who.int/Governance/RC/RC55/20050920_1.

Box 8.10 Framework for Alcohol Policy in the European Region	
Area	<i>Aims and objectives</i>
<i>Strategies and action plans</i>	There is a need for an action plan at the appropriate level as well as a national alcohol strategy, with the capacity to both implement measures and monitor and follow-up the plan. Local communities, multiple community sectors, tax/availability restrictions, parental programmes, drink-driving enforcement, brief interventions, and workplace interventions should all be considered within such a strategy.
<i>Alcohol-free situations</i>	A number of groups and situations should be kept alcohol free, including: (1) Young People, (2) Young People's Environment; (3) Road Safety; (4) the Workplace; and (5) Pregnancy.
<i>Drinking guidelines</i>	Many people have found a difficulty in interpreting guidelines, which can be treated as a baseline to range upward from. The WHO continues to have the message that 'Less Is Better'. Individual drinking guidelines for problem drinkers should be delivered in a healthcare setting.
<i>Preventing problems</i>	A national focus day to raise awareness of preventing alcohol-related problems could be an effective way of generating support for other policies.
<i>Further research needs</i>	While there is enough evidence to implement policies, further research should fill gaps in: (i) epidemiological studies in different societies; (ii) measuring unrecorded consumption; (iii) alcohol policy interventions' effects on different target groups in a wider variety of societies; (iv) cost-effectiveness. Additionally, an Expert Group on Alcohol Policy should be established.
<i>Surveillance and monitoring</i>	While WHO-EURO will continue to collect and analyse data, there is a need for harmonized measures of consumption and risk within a common monitoring system. This should contain measures of social problems experienced by others as well as the drinker. The European Alcohol Information System should be expanded to include information on legislation and marketing practices and to meet these other needs.
<i>Training and capacity-building</i>	This is an important aspect of building a multi-sectoral approach to tackle harm, and WHO-EURO will continue to assist Member States in this. Biennial Collaborative Agreements – providing a platform for national initiatives to support (sub-)regional actions – could be a key tool in implementing this.
<i>Advocacy, networking and policy development</i>	Popular communication is often a weakness for public health advocates, and WHO-EURO will try to strengthen links to improve communication through training and networking activities. The national counterparts for alcohol are expected to build up capacity at the national level, while WHO-EURO will create a European Coalition on Alcohol Policy Development formed of Member States and international organizations / institutions.

The Resolution endorsing the Framework in September 2005 (EUR/RC55/R1) also:

- *Urged Member States:* to (re)formulate national policies and action plans and strengthen international collaboration;
- *Urged International organizations and NGOs:* to work jointly with Member States and WHO-EURO to maximise the impact of the Framework; and
- *Requested the Regional Director:* to mobilize resources and other international organizations in support of the Framework; to assist Member States in their efforts; to revise and improve the European Alcohol Information System; and to organize a report on status and progress every three years.

This triennial report will be accompanied by a triennial high-level forum on alcohol policy within the Region to discuss the outcomes of the report. This will deliberate crucial and challenging issues, and consider cross-border and other issues that are beyond the scope of response of individual Member States.

The European Union and alcohol policy

With a few exceptions,²⁶ the EU cannot pass laws simply to protect human health as Member States have not conferred this power on the European institutions. Much of the EU's action on alcohol has, therefore, come through 'soft law', in the form of non-binding resolutions and recommendations urging Member States to act in a certain way, as well as research and information functions. Nevertheless, it is worth reiterating that there is substantial scope for health concerns to be incorporated within actions to improve the single market (see discussion above).

Non-legislative action on public health is grounded in the second Community public health programme 2003-8, which calls for strategies and measures on lifestyle-related health determinants including alcohol (1786/2002/EC). This may change, however, – the Commission has proposed that the health and consumer protection funding streams are merged from 2007, although the 2007-13 Financial Perspectives (of which this is a part) have not at the end of 2005 been confirmed by the Council and Parliament (COM (2005) 115). For both programmes, the Commission states that the subsidiarity test (see Box 8.3) is met due to the 'transnational character' of these health determinants, while the Council also stressed the need to reduce health differentials between Member States (COM (2000) 285, 2000/C 218/03).

As in the WHO, alcohol is sometimes mentioned in the context of wider health issues, such as in the recent Green Paper on a European Mental Health Strategy (COM (2005) 484). The current proposal aims to create a framework for cooperation, increase the coherence of actions and open up a platform for stakeholders (including civil society), and would focus on preventive efforts, quality of life and the creation of an information system. The Green Paper is currently out for consultation until May 2006, after which the Commission will analyse the responses and (depending on the result) propose a strategy in late 2006.²⁷

²⁶ These exceptions are for blood products, organs, and in the veterinary and phytosanitary fields.

²⁷ http://europa.eu.int/comm/health/ph_determinants/life_style/mental/green_paper/consultation_en.htm.

Alcohol itself was first mentioned as a public health and social problem by the Council in 1986 (Official Journal C 184/02), and over the next 10 years was gradually legitimized through work in related areas, such as traffic safety, the Television Without Frontiers Directive (discussed above) and the Europe against Cancer programme. Following the Maastricht Treaty, €1.5m was given to health promotion projects in the alcohol field, although much of the effort of Directorate General (DG) V (and also now the Directorate General for Health and Consumer Protection (DG SANCO)) since has concentrated on building European opinion, developing interest groups, and ensuring a high degree of practical competence.

EU road safety policies have also often dealt with alcohol-related driving accidents, in particular the 'Commission Recommendation on the maximum permitted blood alcohol content (BAC) for drivers of motorized vehicles' in Jan 2001 (2001/115/EC).²⁸ This called for all Member States to adopt a BAC of 0.5g/L lowered to 0.2g/L for inexperienced, two-wheel, large vehicle or dangerous goods drivers, and random breath testing so that everyone is checked every 3 years on average. Take-up of the recommendation has since been encouraged by the European Road Safety Action Programme (COM (2003) 311), while the Commission has said that it will propose a Directive if insufficient progress is made towards a 50% reduction in road deaths by 2010 (2004/345/EC). Several other recent moves include efforts to tackle drink-driving, including harmonized penalties and the exchange of best practice (COM (2001) 370; 2004/345/EC).

Increasing action

Although there has been a rising and coordinated response to alcohol since the 1970s, alcohol policy has become more politically prominent in recent years partly driven by the sudden growth of alcopops from 1995. A working group on alcopops was established to move forward at a European level, which – together with the Stockholm Ministerial Conference (see above), a European Parliament declaration and several draft resolutions – led to a broader Council resolution of 5 June 2001 on the Europe-wide problem of drinking by young people, in particular children and adolescents (2001/458/EC).²⁹ This recommended multi-sectoral education and a more robust enforcement of underage drinking laws, as well as asking the alcohol industry not to target young people with their advertising. This view of the industry as a voluntary partner in the solution goes alongside confirmation from the Ministerial Conference that public health policy should be developed without any interference from commercial or economic interests (Sutton and Nylander 1999).

On the same day as the resolution on youth drinking, the Council invited the Commission to produce a strategy on alcohol-related harm in Europe.³⁰ This invitation was repeated in June 2004 when the Council adopted a follow-up conclusion on Alcohol and Young People, with the Council underlining that special attention should be paid to young people within the strategy.³¹ The strategy is currently being drafted and is expected to be published during 2006.

²⁸ The explanatory memorandum to the recommendation notes that although the Commission would ideally propose a directive to harmonize BAC limits, it realizes that there are longstanding objections on grounds on subsidiarity to such a move (dating from when it was previously attempted in 1988).

²⁹ http://europa.eu.int/eur-lex/pri/en/oj/dat/2001/l_161/l_16120010616en00380041.pdf.

³⁰ http://europa.eu.int/eur-lex/pri/en/oj/dat/2001/c_175/c_17520010620en00010002.pdf.

³¹ http://ue.eu.int/ueDocs/cms_Data/docs/pressData/en/lsa/80729.pdf.

For the years 2004-2006, the Commission has also co-financed an Alcohol Policy Network with representation in all Member States, applicant countries, Norway and Switzerland to inform the Commission in its alcohol related work.³² This is being coordinated by Eurocare,³³ a European non-governmental organization drawing together networks and organizations throughout Europe dedicated to the prevention of the harm done by alcohol since 1990.

CONCLUSION

The European and global dimensions of policy-making are increasingly important for public health policy on alcohol, and those making national health policies should consider three key messages. First, alcohol policies are subject to global and European trade law, which means that policies such as alcohol monopolies or certain tax systems can be ruled illegal. It is not fair to say that health considerations are ignored in this process, given a number of global and particular European cases establishing the primacy of health over trade interests. Nevertheless, health policy-makers should ensure that health policies interfere with trade as little as possible, and should monitor the risks inherent in the process of trade liberalization, especially at the global level.

Second, health concerns can be lost where policies consider alcohol as an economic commodity, despite the substantial health impact of many of these actions. 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.

Finally, it should be remembered throughout that the international level offers opportunities as well as risks for health policy. The World Health Organization and the European Union have made substantial contributions to greater awareness and action on alcohol in Europe in recent years, and, with a suitable level of commitment, there is no reason why international actions cannot make even greater strides towards reducing the harm done by alcohol in the future.

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³² <http://www.eurocare.org/btg/index.html>.

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