Summary

Background to the report

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 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.

Alcohol and Europe

Alcohol has been produced and drunk in Europe for thousands of years, usually made out of whatever materials were locally available. Alcoholic drinks were often also used as a medicine, a practice that continued until the early twentieth century and the advent of modern medicine. Laws on alcohol did exist, but normally for reasons of public order or to regulate the market rather than for public health. However, this picture changed with a series of developments in medieval and early modern Europe, including industrialization, improved communication links, and the discovery of stronger, distilled beverages. Large 'temperance' movements spread across much of Europe in the nineteenth and early twentieth centuries, driven by concerns over spirits before often moving on to an opposition to all alcoholic drinks. In most, but not all, countries the temperance movement has since faded, to a position of little significance by the end of the twentieth century.

The idea of 'alcoholism' as a disease also grew during the nineteenth century, with many European countries developing homes or asylums to treat 'alcoholics'. In recent years, the 'new public health movement' has become the dominant paradigm for discussing alcohol-related problems, allowing a broader discussion than a focus on a small subset of 'alcoholics'. Today's Europe includes a wide range of uses and meanings of alcohol, ranging from an accompaniment to family meals to a major part of rites of passage. Drinking behaviour is often used to communicate the formality of an event or the division between work and leisure. Drunkenness is equally symbolic, with 'drunken comportment' – how people act under the influence of alcohol – varying across Europe.

Alcohol and the economy of Europe

Europe plays a central role in the global alcohol market, acting as the source of a quarter of the world's alcohol and over half of the world's wine production. Trade is even more centred on Europe, with 70% of alcohol exports and just under half of the

world's imports involving the European Union (EU). Although the majority of this trade is between EU countries, the trade in alcohol contributes around €9billion to the goods account balance for the EU as a whole.

It is hard to place a value on the amount of **smuggling** in the EU, although the European High Level Group on Fraud estimated that €1.5bn was lost to alcohol fraud in 1996. Price differences play more of a role in the level of legitimate **cross-border shopping**, where individuals legally bring back alcohol with them from cheaper countries. At least 1 in 6 tourists returns from trips abroad with alcoholic drinks, carrying an average of over 2 litres of pure alcohol per person in several countries.

The **economic role of the alcoholic drinks industry** is considerable in many European countries. Alcohol excise duties in the EU15[1] countries amounted to €25 billion in 2001, excluding sales taxes and other taxes paid within the supply chain – although €1.5 billion is given back to the supply chain through the Common Agricultural Policy. Due to the relative inelasticity of the demand for alcohol, the average tax rates are a much better predictor of a government's tax revenue than the level of consumption in a country.

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

Based on a review of existing studies, the **total tangible cost of alcohol** to EU society in 2003 was estimated to be €125bn (€79bn-€220bn), equivalent to 1.3% GDP, which is roughly the same value as that found recently for tobacco. The **intangible costs** show the value people place on pain, suffering and lost life that occurs due to the criminal, social and health harms caused by alcohol. In 2003 these were estimated to be €270bn, with other ways of valuing the same harms producing estimates between €150bn and €760bn. While these estimates consider a number of different areas of human life where alcohol has an impact, there are several further areas where no estimate has been made as it was impossible to obtain data. Similarly, while the estimates take into account the benefits of alcohol to health systems and loss of life (valued intangibly), there is no research that would enable the other social benefits to be evaluated.

The use of alcohol in Europe

The EU is the **heaviest drinking region** of the world, although the 11 litres of pure alcohol drunk per adult each year is still a substantial fall from a recent peak of 15 litres in the mid-1970s. The last 40 years has also seen a harmonization in

[1] Austria, Belgium, Denmark, France, Finland, Germany, Greece, Ireland, Italy, Luxembourg, Netherlands, Portugal, Spain, Sweden, and the United Kingdom.

consumption levels in the EU15, with rises in central and northern Europe between 1960 and 1980, met by a consistent fall in southern Europe. Average consumption in the EU10[2] is also closer to the EU15 than ever before, although substantial variation remains within the EU10. Most Europeans drink alcohol, but 55 million adults (15%) abstain; taking this and unrecorded consumption into account, the consumption per drinker reaches 15 litres per year.

Just under half of this alcohol is consumed in the form of **beer** (44%), with the rest divided between **wine** (34%) and **spirits** (23%). Within the EU15, northern and central parts drink mainly beer, while those in southern Europe drink mainly wine (although Spain may be an exception). This is a relatively new phenomenon, with a harmonization visible over the past 40 years in the EU15. Around 40% of **drinking occasions** in most of the EU15 involve consuming alcohol with the afternoon/evening **meal**, although those in southern Europe are much more likely to drink with lunch than elsewhere. While the level of **daily drinking** also shows a north—south gradient, non-daily **frequent consumption** (i.e. drinking several times a week but not every day) seems to be more common in central Europe, and there is evidence for a recent harmonization within the EU15.

Drinking to drunkenness varies across Europe, with fewer southern Europeans than others reporting getting drunk each month. This pattern is attenuated when 'binge-drinking', a measure of drinking beyond a certain number of drinks in a single occasion, is instead investigated, suggesting that there are systematic differences in people's willingness to report being intoxicated or the length of a 'single occasion'. The studies of binge-drinking also show occasional exceptions to the north-south pattern, in particular suggesting that Sweden has one of the lowest rates of binge-drinking in the EU15. Summing up across the EU15, adults report getting drunk 5 times per year on average but binge-drink (5+ drinks on a single occasion)17 times. This is equivalent to 40m EU15 citizens 'drinking too much' monthly and 100m (1 in 3) binge-drinking at least once per month. Much fewer data are available for the EU10, but that which exists suggests that some of the wine-drinking is replaced by spirits, the frequency of drinking is lower, and the frequency of binge-drinking higher than in the EU15.

While 266 million adults drink alcohol up to 20g (women) or 40g (men) per day, over 58 million adults (15%) consume above this level, with 20 million of these (6%) drinking at over 40g (women) or 60g per day (men). Looking at addiction rather than drinking levels, we can also estimate that 23 million Europeans (5% of men, 1% of women) are **dependent on alcohol** in any one year.

In every culture ever studied, **men are more likely than women** to drink at all and to drink more when they do, with the gap greater for riskier behaviour. Although many women give up alcohol when pregnant, a significant number (25%-50%) continue to drink, and some continue to drink to harmful levels. Patterns in drinking behaviour can also be seen for **socio-economic status** (SES), where those with low SES are less likely to drink alcohol at all. Despite a complex picture for some aspects of drinking (with some measures showing opposite trends for men and women), getting drunk and becoming dependent on alcohol are both more likely among drinkers of lower SES.

[2] Cyprus, the Czech Republic, Estonia, Hungary, Latvia, Lithuania, Malta, Poland, Slovakia and Slovenia.

Nearly all **15-16 year old students** (>90%) have drunk alcohol at some point in their life, on average beginning to drink at 12½ years of age, and getting drunk for the first time at 14 years. The average amount drunk on a single occasion by 15-16 year olds is over 60g of alcohol, and reaches nearly 40g in the south of Europe. Over 1 in 8 (13%) of 15-16 year olds have been drunk more than 20 times in their life, and more than 1 in 6 (18%) have 'binged' (5+ drinks on a single occasion) three or more times in the last month. Although two countries saw more drunkenness on some measures in girls than boys for the first time in 2003, boys continue to drink more and get drunk more often than girls, with little reduction in the absolute gap between them. Most countries show a rise in binge-drinking for boys from 1995/9 to 2003, and nearly all countries show this for girls (similar results are found for non-ESPAD countries using other data). Behind this overall trend we can see a rise in binge-drinking and drunkenness across most of the EU 1995-9, followed by a much more ambivalent trend since (1999-2003).

The impact of alcohol on individuals

Although the use of alcohol brings with it a number of pleasures, alcohol increases the risk of a wide range of **social harms**, generally in a dose dependent manner - i.e. the higher the alcohol consumption, the greater the risk. Harms done by **someone else's drinking** range from social nuisances such as being kept awake at night through more serious consequences such as marital harm, child abuse, crime, violence and homicide. Generally the higher the level of alcohol consumption, the more serious is the crime or injury. The volume of alcohol consumption, the frequency of drinking and the frequency and volume of episodic heavy drinking all independently increase the risk of violence, with often, but not always, episodic heavy drinking mediating the impact of volume of consumption on harm.

Apart from being a drug of dependence, alcohol is a cause of some 60 different types of diseases and conditions, including injuries, mental and behavioural disorders, gastrointestinal conditions, cancers, cardiovascular diseases, immunological disorders, lung diseases, skeletal and muscular diseases, reproductive disorders and pre-natal harm, including an increased risk of prematurity and low birth weight. For most conditions, alcohol increases the risk in a dose dependent manner, with the higher the alcohol consumption, the greater the risk. For some conditions, such as cardiomyopathy, acute respiratory distress syndrome and muscle damage, harm appears only to result from a sustained level of high alcohol consumption, but even at high levels, alcohol increases the risk and severity of these conditions in a dose dependent manner. The frequency and volume of episodic heavy drinking are of particular importance for increasing the risk of injuries and certain cardiovascular diseases (coronary heart disease and stroke).

A small dose of alcohol consumption reduces the risk of **coronary heart disease**, although the exact size of the reduction in risk and the level of alcohol consumption at which the greatest reduction occurs are still debated. Better quality studies that account for other influences find less of a reduced risk than poorer quality studies and find that the reduced risk occurs at a lower level of alcohol consumption. Most of the reduction in risk can be achieved by an average of 10g of alcohol (one drink) every other day. Beyond 20g of alcohol (two drinks) a day - the level of alcohol consumption with the lowest risk - the risk of coronary heart disease increases. In very old age, the reduction in risk is less. It is alcohol that mainly reduces the risk of heart disease rather than any specific beverage type. There is evidence that alcohol

in low doses might reduce the risk of vascular-caused dementia, gall stones and diabetes, although these findings are not consistent across all studies.

The **risk of death** from alcohol is a balance between the risk of diseases and injuries that alcohol increases and the risk of heart disease (which mostly occurs at older age) which, in small amounts, alcohol decreases. This balance shows that, at least in the United Kingdom, the level of alcohol consumption with the lowest risk of death is zero or near zero for women under the age of 65 years, and less than 5g of alcohol a day for women aged 65 years or older. For men, the level of alcohol consumption with the lowest risk of death is zero under 35 years of age, about 5g a day in middle age, and less than 10g a day when aged 65 years or older, (and probably returning towards zero in very old age).

There are health benefits to the heavier drinker from reducing or stopping alcohol consumption. Even for chronic diseases, such as liver cirrhosis and depression, reducing or stopping alcohol consumption is associated with rapid improvements in health.

The impact of alcohol on Europe

Alcohol places a significant burden on several aspects of human life in Europe, which can broadly be described as 'health harms' and 'social harms'. Seven million adults report being in **fights when drinking** over the past year and (based on a review of a small number of national costing studies) the economic cost of alcohol-attributable crime has been estimated to be €33bn in the EU for 2003. This cost is split between police, courts and prisons (€15bn), crime prevention expenditure and insurance administration (€12bn) and property damage (€6bn). Property damage due to drink-driving has also been estimated at €10bn, while the intangible cost of the physical and psychological effects of crime has been valued at €9bn-€37bn.

An estimated 23 million Europeans are dependent on alcohol in any one year, with the pain and suffering this causes for family members leading to an estimated intangible impact of €68bn. Estimates of the scale of harm in the workplace are more difficult, although nearly 5% of drinking men and 2% of drinking women in the EU15 report a negative impact of alcohol on their work or studies. Based on a review of national costing studies, lost productivity due to alcohol-attributable absenteeism and unemployment has been estimated to cost €9bn-€19bn and €6bn-€23bn respectively.

Looking from a **health perspective**, alcohol is responsible for about 195,000 deaths each year in the EU, although it is also estimated to delay 160,000 deaths in older people, mainly through its cardioprotective effect for women who die after the age of 70 years (although due to methodological problems, this is likely to be an over-estimate of the number of deaths delayed). A more accurate estimate is likely to be the 115,000 net deaths caused in people up to the age of 70, which avoids most of the likely overestimate of alcohol's preventive effect. These figures are also relative to a situation of no alcohol use, and the net effect would be much greater, looking at the lowest-risk level of drinking. Measuring the impact of alcohol through Disability-Adjusted Life Years (DALYs) lessens this problem, and shows that alcohol is responsible for 12% of male and 2% of female premature death and disability, after accounting for health benefits. This makes alcohol the third highest of twenty-six risk factors for ill-health in the EU, ahead of overweight/obesity and behind only tobacco and high blood pressure.

This health impact is seen across a wide range of conditions, including 17,000 deaths per year due to road traffic accidents (1 in 3 of all road traffic fatalities), 27,000 accidental deaths, 2,000 homicides (4 in 10 of all murders and manslaughters), 10,000 suicides (1 in 6 of all suicides), 45,000 deaths from liver cirrhosis, 50,000 cancer deaths, of which 11,000 are female breast cancer deaths, and 17,000 deaths due to neuropsychiatric conditions as well as 200,000 episodes of depression (which also account for 2.5 million DALYs). The cost of treating this ill-health is estimated to be €17bn, together with €5bn spent on treatment and prevention of harmful alcohol use and alcohol dependence. Lost life can either be valued as lost productive potential (€36bn excluding health benefits), or in terms of the intangible value of life itself (€145bn-€712bn after accounting for health benefits).

Young people shoulder a disproportionate amount of this burden, with over 10% of youth female mortality and around 25% of youth male mortality being due to alcohol. Little information exists on the extent of social harm in young people, although 6% of 15-16 year old students in the EU report fights and 4% report unprotected sex due to their own drinking.

Between countries, alcohol plays a considerable role in the lowered life expectancy in the EU10 compared to the EU15, with the alcohol-attributable gap in crude death rates estimated at 90 (men) and 60 (women) per 100,000 population. **Within countries**, many of the conditions underlying health inequalities are associated with alcohol, although the exact condition may vary (e.g. cirrhosis in France, violent deaths in Finland). Worse health in deprived areas also appears to be linked to alcohol, with research suggesting that directly alcohol-attributable mortality is higher in deprived areas beyond that which can be explained by individual-level inequalities.

Many of the harms caused by alcohol are borne by **people other than the drinker**. This includes 60,000 underweight births, as well as 16% of child abuse and neglect, and 5-9 million children in families adversely affected by alcohol. Alcohol also affects other adults, including an estimated 10,000 deaths in drink-driving accidents for people other than the drink-driver, with a substantial share of alcohol-attributable crime also likely to occur to others. Parts of the economic cost are also paid by other people or institutions, including much of the estimated €33bn due to crime, €17bn for healthcare systems, and €9bn-€19bn of absenteeism.

Natural experiments and time-series analyses both show that the health burden from alcohol is related to **changes in consumption**. These changes reflect the behaviour of the heaviest drinkers more than lighter drinkers (given that e.g. the top 10% of drinkers account for one-third to one-half of total consumption in most countries), but also tap into the wider tendency for populations to change their levels of consumption collectively. Across the whole population, the impact of a one-litre change in consumption on levels of harm is highest in the low-consuming countries of the EU15 (northern Europe), but still significant for cirrhosis, homicide (men only), accidents, and overall mortality (men only) in southern Europe. While some have argued that the greater change in northern Europe reflects the ‘explosive’ drinking culture there, this may also reflect the greater proportional size of a one-litre change in the low-consuming northern European countries. Overall, it has been estimated that a one litre decrease in consumption would decrease total mortality in men by 1% in southern and central Europe, and 3% in northern Europe.

Evaluating alcohol policy options

The **drinking-driving policies** that are highly effective include unrestricted (random) breath testing, lowered blood alcohol concentration (BAC) levels, license suspension, and lower BAC levels for young drivers. The limited evidence does not find an impact from designated driver and safe drive programmes. Alcohol locks can be effective as a preventive measure, but as a measure with drink driving offenders, only work as long as they are fitted to a vehicle. The World Health Organization has modelled the impact and cost of unrestricted breath testing compared with no testing; applying this to the Union finds an estimated 111,000 years of disability and premature death avoided at an estimated cost of €233 million each year.

The impact of policies that support **education, communication, training and public awareness** is low. Although the reach of school-based educational programs can be high because of the availability of captive audiences in schools, the population impact of these programs is small due to their current limited or lack of effectiveness. Recommendations exist as to how the effectiveness of school-based programmes might be improved. On the other hand, mass media programmes have a particular role to play in reinforcing community awareness of the problems created by alcohol use and to prepare the ground for specific interventions.

There is very strong evidence for the effectiveness of policies that **regulate the alcohol market** in reducing the harm done by alcohol. Alcohol taxes are particularly important in targeting young people and the harms done by alcohol in all countries. If alcohol taxes were used to raise the price of alcohol in the EU15 by 10%, over 9,000 deaths would be prevented during the following year and an estimate suggests that approximately €13bn of additional excise duty revenues would also be gained. The evidence shows that if opening hours for the sale of alcohol are extended, then more violent harm results. The World Health Organization has modelled the impact of alcohol being less available from retail outlets by a 24 hour period each week; applying this to the Union finds an estimated 123,000 years of disability and premature death avoided at an estimated implementation cost of €98 million each year.

Restricting the volume and content of **commercial communications** of alcohol products is likely to reduce harm. Advertisements have a particular impact in promoting a more positive attitude to drinking amongst young people. Self-regulation of commercial communications by the beverage alcohol industry does not have a good track record for being effective. The World Health Organization has modelled the impact of an advertising ban; applying this to the Union finds an estimated 202,000 years of disability and premature death avoided, at an estimated implementation cost of €95 million each year.

There is growing evidence for the impact of strategies that alter the **drinking context** in reducing the harm done by alcohol. However, these strategies are primarily applicable to drinking in bars and restaurants, and their effectiveness relies on adequate enforcement. Passing a minimum drinking age law, for instance, will have little effect if it is not backed up with a credible threat to remove the licenses of outlets that repeatedly sell to the under-aged. Such strategies are also more effective when backed up by community based prevention programmes.

There is extensive evidence for the impact of **brief advice**, particularly in primary care settings, in reducing harmful alcohol consumption. The World Health Organization has modelled the impact and cost of providing primary care-based brief

advice to 25% of the at-risk population; applying this to the Union finds an estimated 408,000 years of disability and premature death avoided at an estimated cost of €740 million each year.

Using the World Health Organization's models, and compared to no policies at all, a **comprehensive European Union wide package** of effective policies and programmes that included random breath testing, taxation, restricted access, an advertising ban and brief physician advice, is estimated to cost European governments €1.3billion to implement. This is about 1% of the total tangible costs of alcohol to society and only about 10% of the estimated income gained from a 10% rise in the price of alcohol due to taxes in the EU15 countries. It is estimated that such a package can avoid 1.4 million years of disability and premature death a year, approximately 2% of all disability and premature death facing the European Union.

European and global alcohol policy

The most prominent **international legal obligations** that affect alcohol policy 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.

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. In contrast, the increasingly influential **European Court of Justice** (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".

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). 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 Framework for Alcohol Policy in the European Region, the European Charter on Alcohol and two ministerial conferences, which confirmed the need for alcohol policy (and public health policy 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.

Member State alcohol policy

Every country in the European Union (EU) has a number of laws and other policies that set alcohol apart from other goods traded in its territory, often for reasons of public health. Despite the ubiquity of alcohol policies, just under half the EU countries still do not have an **action plan or coordinating body for alcohol**. Even so, most countries have programmes for one aspect of alcohol policy, of which **school-based education** programmes are the most common throughout Europe. All countries also have some form of **drink-driving restrictions**, with everywhere except the UK, Ireland and Luxembourg having a maximum blood alcohol limit for drivers at the level recommended by the European Commission (0.5g/L). However, many European drivers believe that there is only a slim chance of being detected - a third overall believe they will never be breathalysed, although this is lower in countries with random breath testing.

Sales of alcohol are generally subject to restrictions in most EU countries, in a few cases through retail monopolies but more often through licences, while the places that alcohol can be sold are frequently restricted. Over one-third of countries (and some regions) also limit the **hours of sale**, while restrictions on the days of sale or the density of off-premise retailers exist in a small number of countries. All countries prohibit the **sale of alcohol to young people** beneath a certain age in bars and pubs, although four countries have no policy on the sale of alcohol to children in shops. The cut-off point for allowing sales to young people also varies across Europe, tending to be 18 years in northern Europe and 16 years in southern Europe.

Alcohol marketing is controlled to different degrees depending on the type of marketing activity. Television beer adverts are subject to legal restrictions (beyond content restrictions) in over half of Europe, including complete bans in five countries; this rises to 14 countries for bans on spirits adverts. Billboards and print media are subject to less regulation though, with one in three countries (mainly in the EU10) having no controls. **Sports sponsorship** is subject to the weakest restrictions, with only seven countries having any legal restrictions at all.

The **taxation** of alcoholic beverages is another consistent feature of European countries, although the rates themselves vary considerably between countries. This can be seen clearly for wine, where nearly half the countries have no tax at all, but one in five countries has a tax rate above €1,000, adjusted for purchasing power. In general, the average effective tax rate is highest in northern Europe, and weakest in southern and parts of central and eastern Europe. Four countries have also introduced a targeted **tax on alcopops** since 2004, which appears to have reduced alcopops consumption since.

When the different policy areas are combined into a **single scale**, the overall strictness of alcohol policy ranges from 5.5 (Greece) to 17.7 (Norway) out of a possible maximum of 20, with an average of 10.8. The least strict policies are in

southern and parts of central and eastern Europe, and the highest in northern Europe – but the scores do not all decrease from north to south, as seen in the high score in France. This picture of alcohol policy is very different from the one visible fifty years ago, with the overall levels of policy now much closer together, largely due to the increased level of policy in many countries, particular in the area of drink-driving where all countries have a legal limit. Marketing controls, minimum ages to buy alcohol, and public policy structures to deliver alcohol policy are also much more common in 2005 than in 1950.

CONCLUSIONS

Alcohol and the Economy of Europe

Conclusion 1

The trade in alcohol contributes around €9billion to the **goods account balance** for the European Union as a whole, with such trade not necessarily affected by European and domestic policy to reduce the harm done by alcohol.

Conclusion 2

Alcohol tax revenues, an important source of government revenue (€25bn in 2001 in the older EU15 countries), are more closely related to tax rates than to the overall level of alcohol consumption.

Conclusion 3

Declining consumption will not necessarily lead to **job losses** in the economy as a whole, and may not even lead to large changes in employment in some **sectors linked to alcohol** such as restaurants and bars.

The social costs of alcohol

Conclusion 4

The tangible **costs of alcohol** to the European Union were estimated to be €125bn in 2003, including €59bn worth of **lost productivity** through absenteeism, unemployment and lost working years through premature death.

Conclusion 5

The intangible **costs of alcohol** (which describe the value people place on suffering and lost life) to the European Union were estimated to be €270bn in 2003.

The use of alcohol in Europe

Conclusion 6

While **differences** between countries in the levels and patterns of drinking are still evident, they are smaller than they were 40 years ago, and many aspects of drinking are much more similar across Europe than commonly believed. **Adolescent binge drinking** has increased in most countries in the 1990s, followed by mixed trends in the past few years.

Conclusion 7

Drunkenness is an important cause of **injuries** – including violent injuries – across all of Europe, including in southern Europe.

Conclusion 8

Where you live in Europe remains a major determinant of the harm done by alcohol.

Alcohol and Health

Conclusion 9

Alcohol is a health determinant, responsible for 7.4% of all disability and premature death in the European Union.

Conclusion 10

Alcohol is a cause of harm to **others than the drinker**, including some 60,000 underweight births, 5-9 million children living in families adversely affected by alcohol and 10,000 traffic

deaths to people other than the driver in the European Union each year.

Conclusion 11

Alcohol is a cause of **health inequalities** both between and within Member States, causing an estimated 90 extra deaths per 100,000 men and 60 extra deaths per 100,000 women in the newer EU10 countries, compared to the older EU15 countries.

Alcohol and government policy

Conclusion 12

Governments have a **responsibility** to intervene in the market, and **benefit** from doing so. For example, a 10% increase in the price of alcohol across the older EU15 Member States estimated to bring in approximately €13bn in extra alcohol taxes in the first year.

Conclusion 13

Educational interventions, which show little effectiveness in reducing the harm done by alcohol, are not an alternative to **measures that regulate the alcohol market**, which have the greatest impact in reducing harm, including amongst heavier and younger drinkers.

Alcohol and European policy

Conclusion 14

Continuing differences in alcohol policy across Europe, such as tax rates, impair the ability of countries to implement effective policies.

Conclusion 15

Different policies between Member States are sometimes ruled as legitimate to **protect public health**, such as the European Court's 2004 ruling in favour of the French advertising law.

RECOMMENDATIONS

I. Defining an alcoholic beverage

Defining an alcoholic beverage	Relevant actor
I.1. Public policies need to define alcoholic beverages in a uniform way across the European Union. A starting point could be the lowest definition for tax purposes (0.5% alcohol by volume).	(I) Eur. Inst.[3]

II. Creating the evidence base

Recommendations for research	Relevant actor
II.1. European infrastructures should be established and financed to undertake collaborative cross country alcohol research.	(I) Eur. Inst. (II) MS/region[4]
II.2. European infrastructures should be created and financed to review and disseminate all major research outcomes in alcohol policy through, for example, registries and databases; the evidence base should be translated into easily understood policies and practices through practical toolkits and guidelines.	(I) Eur. Inst. (II) MS/region
II.3. Long-term publicly funded alcohol research programmes should be established and financed.	(I) Eur. Inst. (II) MS/region
II.4. Research capacity in alcohol policy should be developed through professional development programmes.	(I) Eur. Inst. (II) MS/region
Recommendations for information	**Relevant actor**
II.5. A European Alcohol Monitoring Centre (EAMC), with country based counterparts, should be established and financed.	(I) Eur. Inst. (II) MS/region
II.6. The importance of including alcohol-related indicators dealing with consumption, harm and policy and programme responses within the European Community Health Indicators short-list should be stressed to the EU Working Party on Health Indicators.	(I) Eur. Inst.
II.7. Alcohol surveillance programmes should be established so that data are comparable and analysable across Europe.	(I) Eur. Inst. (II) MS/region
II.8. A European database of laws and regulations and of effective polices and programmes at European, Member State and municipal level should be established and maintained.	(I) Eur. Inst. (II) MS/region (III) Municipal[5]

[3] European Institutions.
[4] Member States and regions within Member States.
[5] Municipalities.

III. Preparing and implementing resourced strategies and plans

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

IV. Other policies and actions and cross border support

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

V. Reducing drinking and driving

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

VI. Supporting education, communication, training and public awareness

Recommendations for education and public awareness	Relevant actor
VI.1. Educational programmes should not be implemented in isolation as an alcohol policy measure, or with the sole purpose of reducing the harm done by alcohol, but rather as a measure to reinforce awareness of the problems created by alcohol and to prepare the ground for specific interventions and policy changes.	(II) MS/region (III) Municipal
VI.2. Funding should be provided to evaluate the design and impact of individual-based programmes that may show some promise.	(II) MS/region (III) Municipal

VI.3. Broad educational programmes, beginning in early childhood, should be implemented to inform young people of the consequences of alcohol consumption on health, family and society and of the effective measures that can be taken to prevent or minimize harm.	(II) MS/region (III) Municipal
VI.4. Educational type programmes imported from another country or culture should first be evaluated in the new setting before being widely implemented.	(II) MS/region (III) Municipal
VI.5. Media campaigns should be used to inform and raise awareness among citizens on implementation of policy initiatives.	(I) Eur. Inst. (II) MS/region (III) Municipal

VII. Consumer labelling

Recommendations on labelling	Relevant actor
VII.1. Containers of alcoholic products should carry warnings determined by health bodies, describing the harmful effects of alcohol when driving or operating machinery, and during pregnancy, or other messages as appropriate.	(I) Eur. Inst. (II) MS/region
VII.2. Alcohol product packaging and labelling should not promote an alcoholic product by any means that are likely to create an erroneous impression about its characteristics or health effects, or that directly or indirectly appeals to minors.	(I) Eur. Inst. (II) MS/region

VIII. Policies that regulate the alcohol market

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

Recommendations for minimum purchase age and availability	Relevant actor
VIII.5. A minimum system of licensing for the sale of alcoholic products should be implemented throughout Europe, respecting existing licensing systems, where these are stronger.	(I) Eur. Inst. (II) MS/region (III) Municipal
VIII.6. The sales of alcoholic products to persons under the age set by domestic law, national law or eighteen years, whichever is the higher, should be prohibited and enforced.	(II) MS/region
VIII.7. Jurisdictions that manage outlets through number and density, location and hours and days of sale should consider not relaxing their regulations; jurisdictions without such regulations or with very limited regulations should analyze the impact of introducing or strengthening them.	(II) MS/region (III) Municipal
VIII.8. A range of increasingly severe penalties against sellers and distributors, such as withdrawal of license or temporary and permanent closures, should be implemented in order to ensure compliance with relevant measures.	(III) Municipal

Recommendations for commercial communications	Relevant actor
VIII.9. A level playing field for commercial communications should be implemented across Europe, building on existing regulations in Member States, with an incremental long-term development of no advertising on TV and cinema, no sponsorship, and limitation of messages and images only to those that refer to the quality of the product.	(I) Eur. Inst. (II) MS/region
VIII.10. Article 15 of the Television Without Frontiers Directive should be strengthened in terms of both content and volume, and an analysis of its adherence across MS should be commissioned.	(I) Eur. Inst. (II) MS/region
VIII.11. Where self-regulatory approaches adopted by the beverage alcohol industry or marketing industry are in place, they should be monitored and adjudicated by a body that is independent of the alcohol and marketing industries.	(I) Eur. Inst. (II) MS/region

IX Reducing harm in drinking and surrounding environments

Recommendations for drinking and surrounding environments	Relevant actor
IX.1. Urban planning, community strategies, licensing regulations and restrictions, transport policies and management of the drinking and surrounding environments should work to minimize the negative effects that result from alcohol intoxication, particularly for local residents.	(III) Municipal

IX.2. Effective and appropriate training should be implemented for the hospitality industry and servers of alcohol to reduce the harmful consequences of intoxication and harmful patterns of drinking.	(IV) Alcohol industry
IX.3. Adequate policing and enforcement of alcohol sales and licensing laws should be implemented, targeted at premises associated with a higher level of harm.	(III) Municipal
IX.4. Well-resourced community mobilization and intervention projects, involving different sectors and partners should be implemented to create safer drinking environments and to reduce the harm done by alcohol.	(III) Municipal

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

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