

For more information please email Helena.Conibear@aim-digest.com or Alison.rees@aim-digest.com

Alcohol - one perspective on Europe

The Institute of Alcohol Studies has published a report, funded by the European Commission entitled 'Alcohol in Europe: a public health perspective'. The Report contends that it is a Government's duty to intervene in the alcoholic drinks market to reduce alcohol related harm. The authors lists 52 recommendations for the Commission aimed to increase joint working and intelligence sharing and to reduce alcohol related harm across the EU25 .

The recommendations from 'Alcohol in Europe' are aimed to contribute to the European Communication on Alcohol and Health expected later this year along with other reports instigated by the Commission including the 'Round table' work of the European Policy Centre and the report on the economic aspects of alcohol in Europe. Although these reports will feed into the development of a European alcohol policy, the findings, conclusions and recommendations are not binding on the Commission.

The essence of the report's findings is that 'The top 10% of drinkers account for one third to one half of the total consumption in most countries'. Governments, SAO's, industry, health care providers and the public would agree that this is the sector of the populations across Europe that should be focused on in efforts to reduce harmful or hazardous drinking and associated issues.

There is an important divide to be drawn between this 10% and the majority of European adult consumers who drink moderately, however, which is not recognised in the reports findings or recommendations.

Consumption has declined rapidly between 1980 and 2003 (source: World Drink Trends 2005), in many of the EU15 including France (-37%), Italy (-46%), Spain (-27%) and Germany (-11%). Ironically it is the Northern EU countries on average, where alcohol control policies are higher, that consumption has increased within the same period, including the UK (+31%), Ireland (+47%) and Finland (+25%). The overwhelming statistics are of European adults drinking within the WHO sensible drinking guidelines (no European standard exists) - with 266 million adults drinking alcohol up to 20g a day (women) and 40g a day (men) according to the IAS study - 6% exceed the WHO recommendations for hazardous drinking of 40g for women per day and 60g for men. 1% of women and 5% of men are estimated to be dependent on alcohol according to the report.

The report begins by recognising the role that alcohol plays in European society, accepting that it is integral to the social fabric over 1000's of years, playing a medicinal and religious role as well as being a social lubricant 'probably the main benefit of alcohol derives from the pleasure that

the people get from drinking it' state the authors. Regulation came with industrialisation and the consumption of more potent distilled spirits. Hence the growth of temperance movement sin the C19th and C20th centuries and the categorisation of alcoholism as a 'disease'.

'Today, 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 industry,' states the report.

The IAS study sees Europe playing a central role on the global alcohol market, accounting for half of the worlds wine production and quarter of all alcohol produced. 70% of the all exports and half of all imports involve the EU, contributing 9 billion Euros to the goods account balance of the EU.

The report discusses the problem of smuggling alcohol within the EU, but recognising that legitimate cross border shopping is a much bigger issue between Demark and Sweden for example or the UK and France. Hence the report calls for more equality of taxes across Europe.

The economic contribution of excise duties from the EU15 member states is stated to be 25 billion Euros a year, and 850,000 are employed in drinks production (excluding retail, on trade, shippers, marketers etc - a total of 2 and a half million according to TAG) - but the report then states 'that trends in alcohol consumption show no crude



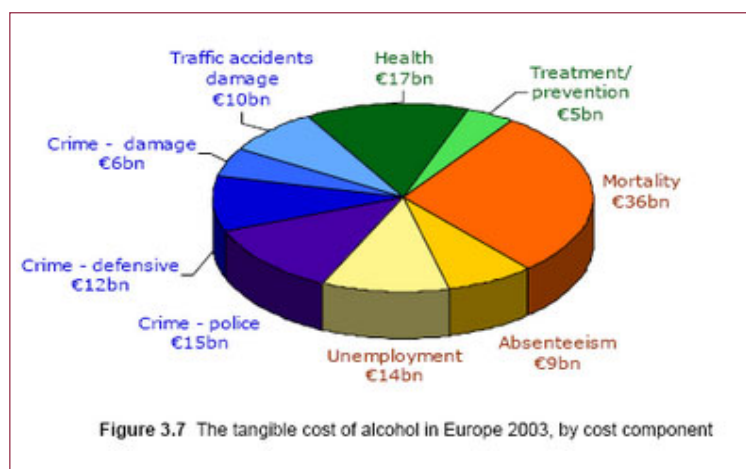
Figure 4.4 Total alcohol consumption per drinker in Europe in 2002

[Sources: primarily from WHO data (Global Status Report on Alcohol 2004, HFA Database and GBD project); see above for detail]

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 in other areas' claim the authors.

The statistical analysis leading to 'the tangible cost of alcohol to society' at 125 billion Euros in 2003 is less clear - 'equivalent to 1.3% GDP, which is roughly the same as tobacco'. E59 billion is accounted for by lost productivity and working years. The authors calculate that alcohol is responsible for 7.4% of ill health and early death in the EU, behind only tobacco and high blood pressure.

The report recognises, however, that although Europe is still the heaviest drinking region of the world, consumption has fallen from a peak of 15 litres in mid 1970's to 11 litres at present within the EU15. The IAS study estimates there are 55 million abstainers in the EU15 - 15% of adults. Half of the alcohol consumed is beer (44%), wine 34% and spirits 23%). The disease burden due to alcohol within the new EU10, predominantly from Eastern Europe is discussed to some degree with an estimate of extra deaths, but more research and action is needed here. Interestingly, lower



socio-economic classes are more likely to be teetotal, but also more likely to become dependent on alcohol.

Drinking to drunkenness varies across Europe, hardly existing in Italy for example, or amongst French women, but the EU average for getting drunk, according to the authors is five times a year. The report calls for a more uniform definition of binge drinking so that effective comparisons can be made between member states - calling for a well-funded coordinating body at EU level.

Across Europe, 90% of 15 and 16 year olds have tried alcohol, with the average age of a first drink being 12.5 years, an important point to take on board for school curriculum. The average age for 'getting drunk' according to the report is just 14 - an important area to be addressed. In general boys get drunk more often and drink more than girls, although in Ireland and the UK girls are drinking

more and getting drunk more often. Recent trends 'are more ambivalent' according to IAS, and signs are beginning to show slight reductions. The report calls for a minimum drinking age across Europe of 18 and restrictions on alcohol advertising as they 'glamorise' alcoholic drinks. It also calls for a European curriculum on alcohol education.

The impact of alcohol on individuals

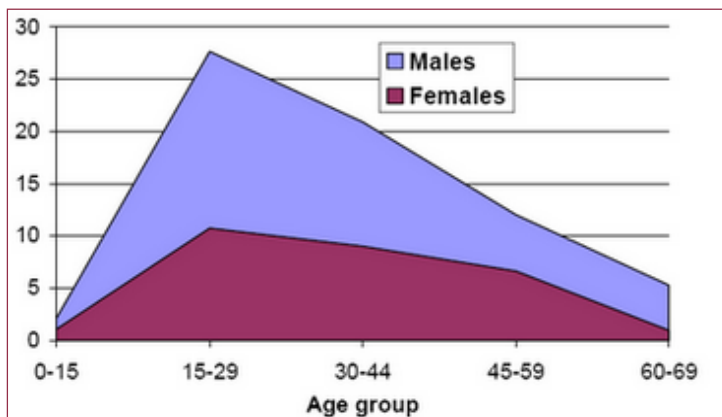
The report largely agrees that moderate alcohol consumption brings benefit (as well as enjoyment) to consumers, taking two 10g drinks a day as 'the lowest risk'

The report states: '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, the higher the alcohol consumption, the greater the risk. A small dose of alcohol consumption reduces the risk of coronary heart disease. Most of the reduction in risk can be achieved by an average of 10g of alcohol every other day. Beyond 20g of alcohol a day - the level of consumption with the lowest risk - the risk of coronary disease increases. It is alcohol that mainly reduces the risk of heart disease rather than specific beverage type. Alcohol in low doses might reduce the risk of vascular caused dementia, gallstones and diabetes. There are health benefits for 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'.

'Alcohol is responsible for about 195,000 deaths each year in the EU, although it is also estimated to delay 160,00 deaths in older people'. However, the IAS then appears to undermine this analysis by measuring the impact of alcohol through disability adjusted life years (DALY's) suggesting that alcohol 'is responsible' for 12% of male and 2% of female premature death and disability, after accounting for health benefits'. This calculation is then used to rank alcohol as the third highest (after tobacco and high blood pressure) of twenty six factors for ill health in the EU - ahead of obesity. The health impact is across a wide range of conditions including road traffic deaths, accidental deaths, murders and manslaughter, suicides, cirrhosis, depression and cancer. It is unclear whether alcohol is considered as a contributing factor or as fully accountable for these deaths.

It is clear that young people shoulder a disproportionate amount of the premature death linked to alcohol, with it implication in accidental death and driving fatalities, especially among young men. The report suggests a lower BAC level for young drivers.

Encouragingly low percentages of students report 'social harm' due to drinking according to the report at EU level, with 6% of 15 -16 year olds reporting fights and 4% unprotected sex due to their drinking.



The share of deaths attributable to alcohol in EU citizens younger than age 70 years (year 2000). Source: GBD data (Rehm 2005).

The harms associated with excess alcohol consumption are then discussed, including alcohol related crime, injury, missed working days, drink driving and dependency. The report claims alcohol is linked to 7 million fights a year and crime costs 33 billion (including the cost of police, courts and prisons). It also discusses the harm done to people other than the drinker, including underweight births (rather than fetal alcohol syndrome) and an estimated 16% of child abuse and neglect.

The report contains 52 recommendations on issues that it believes will impact on reducing alcohol consumption across Europe, including recommendations to restrict availability of alcohol, the advertising of alcohol and a firm recommendation to raise a 10% tax in order to fund alcohol treatment programmes. Further more it is recommended that the EU should have a harmonised BAC level of .5g/l – in spite of the UK having the lowest drink drive fatalities in Europe with a BAC level of .8g/l

The key issue that the report raises in its recommendations for more control policies, is should the EU be aiming to reduce overall consumption in terms of litres of pure alcohol consumed per capita, or address the agreed areas of necessary action, which include drink drive, better recognition and treatment of dependency at primary care level, preventing underage purchase and reducing the crime and disorder associated with drunkenness for example?

This report estimates 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. The report fails to draw on the evidence in countries such as Italy and France where per capita consumption has dropped significantly (by 30-40 percent) since the 1980's to substantiate this claim. The report does call for more consistency of methodology of research in Europe and for a EU level alcohol research and statistical collecting body. The report fails to call for a 'standard drink' within Europe, however, although 10g is referred to, neither is there a EU level 'daily drinking guideline' proposal although countries such as Ireland do not have government guidelines. The report calls for health warnings on back labels however although admitting that consumers pay little attention to them.

Drink drive recommendations

The report endorses random breath testing and lower BAC levels for young drivers, yet dismisses effective designated driver initiatives. 'The limited evidence does not find an impact from designated driver and safe driver programmes'. Yet US evidence, suggests that designated driver programmes have helped lower drink driving fatalities by 41% since 1982 (US Department of Transportation) with 112 Million Americans have been a designated driver or have been driven by one.

Regulating the alcohol market

It is stated as fact, that if alcohol taxes were raised by 10% in the EU15, then over 9000 deaths would be prevented during the following year'. A detailed analysis of EU members with higher taxation levels, such as Ireland and the UK is not assessed however, who have some of the highest levels of binge drinking amongst young populations in Europe, suggesting price is not a determining factor in levels of drinking.

Similarly, it is stated as fact that if the opening hours for the sale of alcohol are extended, the more violent harm results. The limited evidence available from the UK recently extended opening hours shows evidence contrary to this statement, suggesting that effective enforcement of laws aimed at preventing anti social behaviour and punishing irresponsible premises are far more effective at reducing alcohol related crime, underage sales, violence and accidents than a restrictive trading environment.

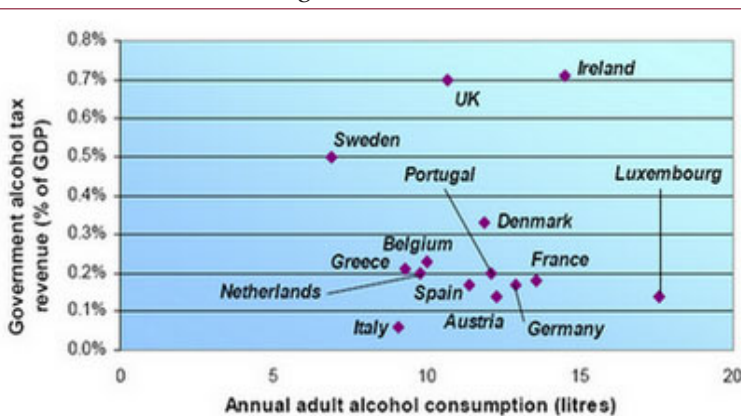


Figure 3.3 Alcohol consumption and alcohol tax revenue in the EU15. Source: Eurostat, cited by COM (2004) 223.

Advertising

The report suggests self-regulation by the industry is ineffective and that the restriction of the volume and content of alcoholic products is likely to reduce the positive image of alcohol amongst young people. The report in its 'comprehensive European wide package of effective programmes' says an 'advertising ban' is desirable with 'an incremental long term development of no advertising on TV and cinema, no sponsorship and limitation of messages and images only referring to the quality of the product'.

The overall strictness of alcohol policy ranges from 5.5 in Greece, to 17.7 in Norway 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, with a high score in France. The correlation of strictness of policy and alcohol related harm could be assessed further – as in some instances the stricter policy does not equate to reduced levels of harm, whereas effective enforcement of existing policy can an example is Britain’s drink drive record in comparison with France.

Brief advice is recommended for primary care settings and is to be commended.

The report draws attention to the important issues that just under half the EU countries do not have an alcohol action plan or coordinating body for alcohol but all countries have some form of drink driving framework.

An important statement in the report is as follows

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

Much of the report is sound with some sensible recommendations, however some speculative figures are presented as ‘fact’, just as other research and programmes are dismissed. Some of the solutions at European level, such as a blanket 10% tax to fund a reduction in alcohol related harm and a desired advertising ban makes the report controversial reading for many.

The European Federation of responsible drinking, speaking on behalf of its industry members comments : ‘EFRD does not believe that restrictions on alcohol advertising, as called for in the report, are an effective way to reduce harmful drinking behaviour. Nevertheless, the drinks industry is since long committed to Responsible Marketing through codes of conducts that sets out clear, independently monitored guidelines on alcohol marketing. This report is only one contribution in the consultation process. As a stakeholder of the Commission in its dialogue on alcohol policy, EFRD believes any successful public policy on alcohol needs to reflect the fact that a majority of adults, who choose to drink, do so responsibly. Any proposed solutions must target harm and not alcohol per se’.

¹EU25:- all countries in EU10 and EU15

²EU15: Austria, Belgium, Denmark, France, Finland, Germany, Greece, Ireland, Italy, Luxembourg, Netherlands, Portugal, Spain, Sweden, United Kingdom.

³EU10: Cyprus, the Czech Republic, Estonia, Hungary, Latvia, Lithuania, Malta, Poland, Slovakia and Slovenia.

The full report can be found at: http://ec.europa.eu/health-eu/news_alcoholineurope_en.htm

The comments of the Peer review Group, on the accuracy of research and important omissions can be read via: http://ec.europa.eu/health-eu/news_alcoholineurope_en.htm

For more information contact Helena Conibear via Helena.Conibear@aim-digest.com

The 52 main recommendations include:

Alcohol Information

> A uniform EU definition of alcohol beverages should be reached.

> A European infrastructure should be established and financed to undertake collaborative cross-country alcohol research, and to review and disseminate all major alcohol research.

> A European database of alcohol-related laws, regulations and policies should be established.

> A European Alcohol Monitoring Centre should be established and financed.

Strategies and Action Plans

> An adequately staffed European ‘mechanism’ within the Commission to oversee alcohol policy.

> Action plans on alcohol with clear objectives, strategies and targets

> A ‘predictable’ funding system with resources to reduce alcohol related harm. The desirability of a hypothecated alcohol tax should be considered.

> There should be awareness-raising campaigns and initiatives, including regular reports on alcohol for a wide public audience.

Drinking and driving recommendations

> A maximum blood alcohol concentration (BAC) limit of 0.5g/L throughout Europe, and a lower limit of 0.2g/L for young drivers and drivers of public service and heavy goods vehicles.

> Unrestricted powers to breath test using standardised equipment.

> EU wide penalties, graded according to BAC level.

> Driver education, rehabilitation and treatment schemes throughout Europe

> A Europe-wide campaign to reduce drinking and driving

> Training for the hospitality industry and services of alcohol to reduce the risk of drinking and driving

> Comprehensive community-based programmes, including urban planning and public transport initiatives to reduce drinking and driving

Education and public awareness

> Educational programmes should not be used in isolation, but to reinforce awareness and prepare the ground for specific interventions and policy changes.

> Broad educational programmes should be used to inform young people of the consequences of alcohol consumption.

> Media campaigns should be used to inform and raise awareness of policy initiatives.

Consumer labelling

> Containers of alcoholic product 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.

> Alcohol 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.

Regulation of the alcohol market

“Standardised excise duties are a longstanding goal of the EU.”

> Minimum tax rates for all alcoholic beverages (from 0.05%) should be set and increased in line with inflation and proportional to the alcoholic content A 10% increase in the price of alcohol across the EU15 Member States is estimated to bring in approximately E13 billion in extra alcohol taxes in the first year.

> Member states should retain the flexibility to use taxes to deal with specific problems that may arise, such as “those products that prove to be appealing to young people”.

> Alcohol products should be marked to estimate the value of the amount of alcohol smuggled into and within the EU.

> Member States should have the flexibility to limit individual cross-border purchases so as not to diminish the impact of the current tax policies.

Restrictions on the availability of alcohol

> Licensing standards covering the number, density, location and permitted hours of alcohol outlets should be implemented throughout Europe.

> There should be a minimum purchase age set at 18, unless national law sets it higher.

> A range of increasingly severe penalties against sellers and distributors, including licence revocation, should be implemented in order to ensure compliance.

Drinking environments

> Policies on planning, transport, licensing etc should be considered to minimise negative effects of alcohol consumption on residents in the vicinity of outlets.

> Effective server training

> Effective Policing and enforcement

> Stakeholder projects should be encouraged to help create safe drinking environments and to reduce the harm done by alcohol.

Brief interventions to reduce hazardous consumption

> Integrated evidence-based guidelines for brief advice for hazardous and harmful alcohol consumption should be developed and implemented in different settings upwardly to harmonise the quality and accessibility care.

Training and support programmes to deliver brief advice for hazardous and harmful alcohol consumption should be developed and implemented in different settings upwardly to harmonise the skills of primary care providers.

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.

Industry role

> providing server training to ensure responsibility in adhering to the law, and in reducing the risk of subsequent harmful consequences of intoxication, harmful patterns of drinking and the risk of drinking and driving;

> ensuring that the full marketing process (product development, pricing, market segmentation and targeting, advertising and promotion campaigns, and physical availability) does not promote an alcohol product by any means that directly appeals to minors;

> undertaking assessments on the impact of their actions on health and the social environment; and

> providing public statements and reports on how all of the above have been implemented.