EUROPE

The European Commission's Communication on alcohol, and the WHO framework for alcohol policy – Analysis to guide development of national alcohol action plans

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ABSTRACT

This public health analysis examines the supporting documentation for the formulation and implementation of the European Commission's 2006 Communication on a strategy to reduce alcohol-based harm (the Communication) and the framework for alcohol policy in the WHO European Region (the framework), in order to provide guidance for the development of country-based action plans on alcohol. This report also examines relevant findings from projects co-financed by the Commission. The analysed materials call for strong, coordinated action across all relevant policy domains to reduce alcohol-related harm, supported by national action plans and backed by the European Union (EU). The Communication, an action-oriented instrument, focuses on mapping present actions and sharing experiences, whereas the framework, a process-oriented instrument, calls for national infrastructure to implement effective action. In implementing the Communication, the Commission has focused on education, young people's drinking and industry self-regulation. Actions in other EU policy domains have not yet contributed to reducing the health and economic burden of alcohol use. National action plans should complement implementation of the Communication and the framework by emphasizing actions that regulate alcohol price, availability and marketing, which will have an immediate impact on reducing alcohol's burden.

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Abbreviations

BAC	blood alcohol concentration
DG SANCO	Directorate-General of Health and Consumer Safety (European Commission)
EAIS	European Alcohol Information System
EU	European Union
EU10	the 10 countries that joined the EU in 2004 and 2007 (Bulgaria, the Czech Republic, Estonia, Hungary, Latvia, Lithuania, Poland, Romania, Slovakia and Slovenia)
EU15	the 15 countries that were members of the EU prior to May 2004 (Austria, Belgium, Denmark, Finland, France, Germany, Greece, Ireland, Italy, Luxembourg, the Netherlands, Portugal, Spain, Sweden and the United Kingdom)
NGO	nongovernmental organization
YLL	years of life lost

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Foreword

In the last few years, state interventions on alcohol consumption control have proved to be essential in many countries, but we have also learnt that efforts must be focused and sustained, while the policy tools constantly evaluated and updated. Clear results are starting to show but perhaps not at the speed that one would have liked to see.

Sadly, alcohol consumption rates and the related disease burden are still twice the world average in the WHO European Region. Alcohol is the second-largest risk factor for death and disability and the largest risk factor for young people. Alcohol abuse has led to significant health inequalities across the Region.

The WHO Regional Office for Europe has been supporting its 53 Member States in alcohol-related health promotion, disease prevention, evaluation and surveillance activities in line with the aims of the framework for alcohol policy in the WHO European Region (2006).

As part of this process, WHO and the European Commission jointly developed this volume – bringing together a series of scientific background documents to inform and support national policy-making processes. The studies have followed the direction set out in WHO's framework for alcohol policy in the WHO European Region (2005) and the European Commission's EU strategy to support Member States in reducing alcohol-related harm (2006).

These landmark instruments called for strong and coordinated action across all relevant policy domains to reduce alcohol-related harm, as well as the development of national action plans, supported and backed by the strategy of the European Union. The European Commission's strategy, an action-oriented instrument, focused on mapping existing tools and sharing experiences, whereas the WHO framework, a process-oriented instrument, called on governments to implement effective action.

The present volume seeks to analyse the similarities and differences between these strategies, analysing the impact of measures targeting the availability, marketing and pricing of alcohol, as well as the importance of counter-measures to fight drink–driving. The volume also covers interventions used for individuals at risk from hazardous or harmful alcohol consumption. The background papers provide evidence on the argument that existing educational tools and approaches are less effective.

This book is designed primarily for those who work in the area of alcohol policy in ministries of health but also targets stakeholders working in other government sectors on licensing, commercial communication and taxation policies.

The WHO Regional Office for Europe looks forward to future collaboration with all partners on alcohol-related diseases, in the hope that we can jointly improve the overall health of citizens in this diverse Region.

Zsuzsanna Jakab
WHO Regional Director for Europe

Summary

This report uses a public health framework to analyse the European Commission's 2006 Communication on a strategy to reduce alcohol-related harm and the same year's framework for alcohol policy in the WHO European Region (European Commission, 2006a; WHO Regional Office for Europe, 2006). The purpose of this analysis is to inform the development of guidelines for national action plans on alcohol throughout the European Region. In addition to the Communication and the framework themselves, the report also examines background documents that contributed to the formulation of these two instruments, documents and procedures that support their implementation, and Commission-co-financed projects in the field of alcohol.

The background documents confirm the heavy burden that alcohol inflicts on Europeans and European society, noting that Europe bears the world's highest health and economic burden due to alcohol use, and that alcohol use contributes to gross health inequalities across Europe. The documentation also shows that the greater an individual's alcohol consumption, the greater the risk of death from an alcohol-related cause, and the greater the societal consumption, the greater the burden on society. The background documents also outline the evidence for effective policy, which has remained consistent over time, describing the potential of measures that address the availability, marketing and pricing of alcohol to avert alcohol-related harm, as well as the importance of drink–driving countermeasures and individually directed interventions for those at risk from hazardous or harmful[1] alcohol consumption. In addition, the background scientific documents note the evidence for the lack of effectiveness in educational approaches. The background documents all call for strong, coordinated action across all relevant policy domains to reduce alcohol-related harm, supported by national action plans and backed up by the European Union (EU).

The Communication and the framework differ greatly from each other in mandate and approach, and their content reflects these differences. The Communication is an action-oriented instrument, as articulated in its main aim, "to address the adverse health effects related to harmful and hazardous alcohol consumption, as well as the related social and economic consequences" (European Commission, 2006a). The framework, on the other hand, is a process instrument, as shown in its main aim, "to link ways, means and ends of an effective alcohol policy" (WHO Regional Office for Europe, 2006). The differing mandates also lead to differences in the strategic methods and main policy tools that each instrument describes, with the Communication focusing on mapping present actions and sharing experiences, and the framework calling for the establishment of national infrastructure to implement effective action.

Both instruments underline clear areas of evidence-based action, including action in health care settings, in the community and in workplaces; actions that address drinking and driving; and actions that concern drinking environments. Among the other major evidence-based policy areas that both instruments mention are alcohol marketing and price measures, with the Communication placing great emphasis on the self-regulation of marketing practices within the alcohol industry. When it comes to education and information, the two instruments diverge, with the Communication stressing education and information, while the framework

[1] *Hazardous use* refers to patterns of alcohol consumption that increase the risk of harm to the user, while *harmful* use refers to patterns that are actually damaging the user's physical health (e.g. through cirrhosis of the liver) or mental health (e.g. through depressive episodes).

expresses considerable caution about action in this area, reflecting the evidence base. Both documents emphasize the importance of monitoring and evaluation, including research, and the need to coordinate alcohol policy internationally.

The Communication and the framework also differ considerably when it comes to implementation. The framework was formulated without any specific implementation measures. The WHO Expert Committee on Problems Related to Alcohol Consumption addressed this lack by issuing a report that provides clear guidance on national implementation, stressing the need for well-financed infrastructure to implement alcohol policy and for extensive monitoring, evaluation and research (WHO Expert Committee on Problems Related to Alcohol Consumption, 2007).

Although the Communication has led to action, the Commission processes have focused on a few select areas, including education, young people's drinking and industry self-regulation. However, two scientific documents that were recently prepared for Commission bodies have presented clear evidence that can facilitate stronger policy-making. First, a review by the Science Group of the European Alcohol and Health Forum found consistent evidence to demonstrate the impact of alcohol advertising on the uptake of drinking among non-drinking young people, and on increased consumption among their drinking peers (2009a). Second, a report by RAND Europe found a strong relationship between the increasing affordability of alcohol consumption throughout the EU and an increase in alcohol consumption (Rabinovich et al., 2009). It also found that open borders within the EU have led to greater decrease in taxes than would have otherwise occurred, which together with cross-border price differentials have led to increased consumption and increased alcohol-related harm in countries where alcohol prices have fallen.

The Committee on Data Collection, Indicators and Definitions, which is part of the Commission's Directorate-General for Health and Consumers (DG SANCO), agreed on several clear indicators for monitoring alcohol consumption and alcohol-related harm (2008). Actions in other EU policy domains have taken place (for example, taxation, agriculture, audiovisual and media, and consumers), although their impact on alcohol's health and economic burden in the EU is not known.

One of the most important tools that the Commission has employed in supporting national action on alcohol policy is co-financing. Over the years, it has co-financed a wide range of projects covering many aspects of alcohol policy. While the breadth and depth of this support has been commendable, there have been no systematic evaluations of the coordination and complementarity of the projects, the extent to which their findings are disseminated in European and national institutions, or the extent to which these findings affect alcohol policy and programme development. It is important that the results of co-financed projects be well integrated into guidelines for national action plans.

While the documentation analysed in this report provides a solid basis for developing such guidelines, three points should be kept in mind.

1. The guidelines for national action plans should underscore the importance of actions that regulate the price, availability and marketing of alcohol, actions that can have immediate impact on the health and economic burden of alcohol. The Communication and framework do not emphasize such actions as strongly as some of their supporting materials.

2. The guidelines should include a discussion of alcohol policy action in the workplace since both the Communication and the framework feature workplace efforts prominently, although the background materials make little mention of them and the evidence base for their effectiveness is relatively weak.
3. The guidelines should make clear reference to the findings of projects co-financed by the Commission, since it is not known how well the outcomes of these projects are known at the country level.

1. Background

The WHO European Region comprises 53 Member States, including all of the Member States of the European Union (EU). In 2007 it had a population of just under 900 million (WHO Regional Office for Europe, 2009c). The European Region has the highest level of alcohol-related burden in the world (Rehm, Mathers & Popova, 2009). Within the Region, 6.5% of all deaths (11% of male deaths and 1.8% of female deaths) and 11.6% of all disability-adjusted life-years (17.3% for men and 4.4% for women) are due to alcohol, while the one-year prevalence rate for alcohol-use disorders in the population aged 15–64 years is 5.5% (9.1% of men and 2.0% of women have an alcohol disorder during the course of a year). There are enormous health disparities across the Region. In the Russian Federation in the year 2000, for example, the probability of a 15-year-old male dying before the age of 35 was 10% (versus 2% for western Europe), and the probability that a 35-year-old man would die before age 55 was 27% (versus 6% for western Europe). Alcohol is a fundamental cause of these health inequalities, being responsible for more than half (52%) of all the deaths among Russians aged 15–54 years (59% of male deaths and 33% of female deaths) (Zaridze et al., 2009).

The EU consists of 27 Member States, with a population of a little under 500 million. At present there are also three candidates for membership, Croatia, the former Yugoslav Republic of Macedonia, and Turkey (European Commission, 2009b). Alcohol is the third most significant risk factor for ill health and premature death in the EU, behind tobacco and high blood pressure (Anderson & Baumberg, 2006). The social cost of alcohol use is estimated to be €125 billion per year. As in the European Region as a whole, the EU is marked by enormous health disparities (Zatonski et al., 2008). For example, in 2002, the difference in male life expectancy at age 20 between the 15 countries that had been members before 2004 (the EU15: Austria, Belgium, Denmark, Finland, France, Germany, Greece, Ireland, Italy, Luxembourg, the Netherlands, Portugal, Spain, Sweden and the United Kingdom) and the Baltic states (Estonia, Latvia and Lithuania) was 9.8 years. For men aged 20–64, about 25% of the difference in life expectancy between the EU15 and 10 countries that would subsequently join the EU (the EU10: Bulgaria, the Czech Republic, Estonia, Hungary, Latvia, Lithuania, Poland, Romania, Slovakia and Slovenia)[2] was attributable to alcohol, largely as a result of differences in patterns of heavy episodic drinking (Zatonski et al., 2008).

The WHO Regional Office for Europe has a long history of action on alcohol, being the first regional office to address the problem. A starting point could be said to be 1975 with the scientific publication *Alcohol control policies in a public health perspective* (Bruun et al., 1975). It was followed with two further scientific publications, by Edwards et al. (1994) and Babor et al. (2003). At a political level, action culminated in the European Alcohol Action Plan, first endorsed by the Member States in 1992, complemented by the European Charter on Alcohol in 1995 and updated in 2000 (WHO Regional Office for Europe, 1992, 1995, 2000). In 2006, the Member States endorsed the framework, which provides a frame for implementing the European Alcohol Action Plan (WHO Regional Office for Europe, 2006). Over the years, the Regional Office has also published a wide-ranging series of technical support documents on the subject (for a list, see Anderson & Baumberg, 2006, p. 364).

In contrast, the European Commission did not address alcohol until some time later. Although European internal market policy has affected alcohol policy issues throughout the history of

[2] The two other recent members of the EU are Cyprus and Malta.

the European Community and Union (for a review, see Anderson & Baumberg 2006, pp. 348–360), specific action on alcohol can be said to start in 2001, with a Council conclusion inviting the Commission to produce a strategy on alcohol-related harm in Europe, a request repeated in 2004 (European Council, 2001a, 2004), and a Council resolution on the alcohol problems of young people across the EU, particularly children and adolescents (European Council, 2001b). At about the same time, the Parliament and Council adopted a public health programme of EU action in the field of public health (2003–2008), with co-financing arrangements for alcohol projects, a provision that was later renewed in a second programme (2008–2013) (European Parliament & European Council, 2002, 2007a). EU action on alcohol culminated in 2006, when the Commission issued the Communication (European Commission, 2006a).

The 2006 adoption of both the framework and the Communication inspired closer collaboration between officials of the two sponsoring organizations, the Regional Office and the Commission, on supporting action on alcohol in European countries. This collaboration culminated later in the same year in a co-financed project to facilitate coordinated implementation of the framework and the Communication, a project to which the present analysis contributes.

The aim of this analysis is to inform both the implementation of national action on alcohol and the preparation of a handbook on such action (WHO Regional Office for Europe, 2009e). A companion document reviews evidence of the effectiveness and cost–effectiveness of reducing alcohol-related harm (WHO Regional Office for Europe, 2009d).

The analysis has been carried out within a public health framework that recognizes public health and social well-being as two of the main goals of effective alcohol policy (Anderson, Chisholm & Fuhr, 2009). Other goals of alcohol policy include addressing some of the consequences of market failures by seeking to deter children from using alcohol, protecting people who are not drinking from the harm caused by alcohol use and providing consumers with information about the effects of alcohol. In addition, alcohol policy should reflect the concept of stewardship, the liberal state's commitment to look after the basic needs of its people, both individually and collectively. Stewardship implies the obligation of the state to provide conditions that enable people to be healthy, particularly an obligation to take steps to reduce health inequities. The state that is guided by the ideal of stewardship recognizes that the health of the people is one of its primary assets, and that better health is associated with greater overall well-being and productivity.

2. Methods

In preparing this report, four groups of documents and procedures were identified and analysed:

1. background documents that contributed to the drafting of the Communication and the framework;
2. the Communication and the framework themselves;
3. documents and procedures involved in the implementation of the Communication and the framework; and
4. alcohol projects co-financed by the European Commission.

The background materials (see Table 1) were identified by searching the European Commission web site devoted to alcohol as a health determinant (DG SANCO, 2009), the Regional Office web site on alcohol consumption (2009a), the Communication and framework themselves and the Commission-financed report *Alcohol in Europe* (Anderson & Baumberg, 2006).

The implementation documents and procedures were also identified by searching the two web sites just mentioned. In addition, for the 32 areas of EU activity that the Commission lists (2009a), a search on "alcohol" was performed for the following areas: agriculture; audiovisual and media; consumers; culture; customs; education, training, youth; employment and social affairs; enterprise; fight against fraud; food safety; information society; internal market; public health; taxation; and transport.

Relevant documents published 2007 or later were identified in just four areas: agriculture, audiovisual and media, consumers and taxation (see Table 5, Sources I-9 through I-12). While there did exist alcohol policy documents in other areas, e.g. fraud and transport policy, they predate the Communication.

Co-financed projects were identified by searching the list of funded projects 2003–2008 on the web site of the Executive Agency for Health and Consumers (EAHC) (2009). The individual project web sites were identified either by searching the EAHC database, or searching for the project name using Google's search engine. Similarly, research projects were identified through searches of cordis.europa.eu, the web site of the EU research and development programme, including its Seventh Framework Programme (FP7) (CORDIS, 2009).

The four sets of documents and procedures were then analysed for policy recommendations on the following 15 topics:

1. review of the problem status
2. review of the response status
3. raising awareness: information and education
4. raising awareness: political commitment
5. health sector response
6. community action

7. drink–driving
8. availability
9. marketing
10. pricing
11. drinking environments
12. illegally and informally produced alcohol
13. implementation
14. monitoring and evaluation, including research
15. international issues.

Topics 3–12 were taken from the policy target areas in a report by the WHO secretariat to the 2008 World Health Assembly on reducing harmful alcohol use (WHO, 2008b).

Finally, the Communication and the framework themselves were analysed for their strategic directions, including their main aims, specific objectives, strategic outcomes, strategic methods, guiding principles, main policy tools and main sponsoring body actions (see Table 3).

3. Results

Background documents

Ten background documents for the Communication and five for the framework were analysed. Of the background documents for the Communication (Table 1, Documents B1–B10), four are from the European Council, one is from the European Parliament, two are Communication annexes (a report on the implementation of the 2001 Council recommendation on drinking and young people, and an impact assessment of the Communication), one is a Eurobarometer report and two are commissioned scientific documents. All five background documents for the framework (Table 1, Documents B11–B15) are official publications or copublications of the WHO Regional Office, including a database and a scientific publication.

Table 2 summarizes the contents of these background documents by topic.

Hazardous and harmful alcohol consumption

There are two related axes of hazardous and harmful alcohol consumption: the lifetime volume of consumption and the frequency and volume of heavy episodic drinking. The Alcohol in Europe report (Anderson & Baumberg, 2006) and the Eurobarometer report (TNS Opinion and Social, 2007) provide data on the extent of hazardous and harmful alcohol consumption. Fifteen percent of the adult population in the EU in 2001 consumed on average more than 40 g alcohol/day (among the men) or 20 g/day (among women (Anderson & Baumberg, 2006), levels that carry a lifetime risk of an alcohol-related death of respectively 4 per 100 and 1 per 100 (National Health and Medical Research Council, 2009). Some 80 million EU residents age 15 or older, more than one fifth of the adult population, reported a heavy drinking episode (defined as at least five drinks or 50 g alcohol on a single occasion) at least once a week in 2006. This proportion has increased since 2003, at least for the EU15 (TNS Opinion and Social, 2007). Some 25 million residents age 15 or older (one fifteenth of the adult population) reported that heavy episodic drinking was their usual pattern of consumption during the previous month. Whereas 24% of those aged 15–24 years reported heavy episodic drinking at least once a week in 2006, it was also common among those 55 and older, with 18% of them reporting heavy drinking episodes at least once a week. The project called GENACIS (Gender, Alcohol and Culture – an International Study) has also found high levels of risky drinking among those who are middle-aged (Wilsnack et al., in press). The average amount of alcohol consumed by EU residents who were 15–16 years old on their last drinking occasion was six drinks, or 60 g alcohol (2003 data) (see Anderson & Baumberg, 2006). More than one in six (18%) of EU residents aged 15 or 16 reported heavy episodic drinking three times or more in the last month (2003 data). In general, heavy episodic drinking has increased across Europe among 15- and 16-year-olds since 1995, although less so in recent years.

The harm done by alcohol

The *Alcohol in Europe* report (Anderson & Baumberg, 2006) summarizes the harm done by alcohol to individuals and to European society as a whole, findings confirmed by more recent publications (Anderson, Chisholm & Fuhr, 2009; Rehm et al., 2009). Alcohol is an intoxicant affecting a wide range of structures and processes in the central nervous system, and by interacting with personality characteristics, associated behaviours and sociocultural expectations, drinking is a causal factor in intentional and unintentional injuries and harm to

self and others, including reduced job performance and absenteeism, family deprivation, interpersonal violence, suicide, homicide, crime, and drink–driving fatalities. It is also a contributory factor in risky sexual behaviour, sexually transmitted diseases and HIV infection. In addition, alcohol is a potent teratogen with a range of negative outcomes for the fetus, including low birth weight, cognitive deficiencies and fetal alcohol disorders. Alcohol is neurotoxic to brain development, leading to structural hippocampal changes among adolescents and reduced brain volume among middle-aged adults. Moreover, alcohol is a dependence-producing drug, like other substances under international control, through its reinforcing properties and neuro-adaptation in the user's brain. Alcohol is also an immunosuppressant, increasing the risk of communicable diseases, including tuberculosis. Alcoholic beverages are classified as carcinogenic by the International Agency for Research on Cancer, increasing the risk of cancers of the oral cavity and pharynx, oesophagus, stomach, colon, rectum and breast in a linear dose–response relationship, with acetaldehyde as a potential pathway. Alcohol's relation to coronary heart disease is more mixed. In low and apparently regular doses (as little as 10 g every other day), alcohol is cardio-protective, although doubt remains about the impact of confounding factors, while at high doses, particularly when consumed irregularly, it is cardio-toxic. Finally, consumption of surrogate or illegal alcohol can bear an extra health risk from high ethanol levels and toxic contaminants, compounded by the social marginalization associated with their consumption.

At the individual level, the lifetime risk of a death attributable to a condition related to chronic alcohol consumption increases linearly with the volume of alcohol consumed from zero consumption in a dose–response manner. Similarly, the risk of death from an acute alcohol-related condition increases from zero consumption in a dose–response relationship with frequency of drinking, and it increases exponentially with the amount drunk on a given occasion. For both men and women, consumption of more than 20 g alcohol/day increases the lifetime risk of an alcohol-related death to more than 1 in 100, and at 60 g alcohol/day the risk rises to nearly 1 in 10 (National Health and Medical Research Council, 2009).

At the societal level, there is a very close relationship between a country's total alcohol consumption per capita and the prevalence of both alcohol-related harm and alcohol dependence, implying that when alcohol consumption increases, so does alcohol-related harm and the proportion of people with alcohol dependence, and vice versa. Heavy episodic drinking is more common among poorer than among richer drinking populations, a pattern that is largely responsible for alcohol's contribution to the differences in life expectancy between eastern and western Europe.

The total economic cost of alcohol to the EU was estimated to be €125 billion in 2003, equivalent to 1.3% of the EU's overall gross domestic product (Anderson & Baumberg, 2006). Actual spending on alcohol-related problems including health care costs (€22 billion) and crime (€44 billion) accounts for €66 billion of this figure, while unrealized productivity due to absenteeism, unemployment and premature mortality accounts for the remaining €59 billion.

Policy responses

Both *Alcohol: no ordinary commodity* (Babor et al., 2003) and *Alcohol in Europe* (Anderson & Baumberg, 2006) comprehensively review the evidence base for effective policy, and their review findings are confirmed in current publications (WHO Regional Office for Europe, 2009d; Anderson, Chisholm & Fuhr, 2009). Essentially, both books find a substantial

evidence base of systematic reviews and meta-analyses showing that policies regulating the alcohol marketing environment, particularly its price and availability, are effective in reducing alcohol-related harm. Enforced legislative measures to reduce drinking and driving and individually-directed interventions to already at-risk drinkers are also effective. However, school-based education has not been found to reduce alcohol-related harm, although public informational and educational programmes play important roles in providing information and in increasing support for putting alcohol control high on the political and public agendas. Making alcohol more expensive and less available are highly cost-effective strategies to reduce harm. Banning alcohol advertising, drink–driving counter measures and individually directed interventions to drinkers who are already at risk are also cost-effective.

Public support for policy measures

The Eurobarometer report (TNS Opinion and Social, 2007) documents public support for alcohol policy measures. At the end of 2006, 87% of EU citizens stated that they agree that selling and serving alcohol to people younger than 18 should be banned. Three quarters would approve a prohibition on alcohol advertising that targets young people, and the addition of consumer warning labels to alcoholic beverage containers. Almost three quarters would agree to a lower blood alcohol concentration (BAC) limit of 0.2 g/l for young and novice drivers, and 80% believed that random police alcohol checks would reduce people's alcohol consumption before driving. On the other hand, despite evidence to the contrary, two thirds believe that higher prices for alcohol would not discourage young people and heavy drinkers from drinking, suggesting that policy-makers should include this topic in future public education campaigns in order to seek stronger support for higher alcohol taxes.

Policy recommendations

The European Council responded to the Communication with a set of conclusions that asked the Commission to:

- continue its systematic, sustainable approach to tackling alcohol-related harm at the European level, including the use of health impact assessments for EU actions with an evident health dimension;
- provide continuing strong support for Member States' efforts to sustain, strengthen and develop national alcohol policies to reduce alcohol-related harm;
- consider and coherently apply the Treaty on European Union provisions concerning the protection of public health and the EU internal market;
- ensure in setting up the Alcohol and Health Forum proposed in the Communication the balanced representation of various stakeholders, including the public health community, nongovernmental organizations (NGOs) and the alcoholic beverage production, retailing and hospitality sectors;
- develop measurable core indicators so that progress in reducing alcohol-related harm at EU level can be monitored, especially for areas of priority action; and
- report regularly, starting in 2008, on the progress of Commission activities to implement the EU alcohol strategy and on activities reported by Member States, as well as their impact at the EU level and within Member States, including assessment of the response from different stakeholders (European Council, 2006).

In addition, the Council called upon EU Member States to:

- foster a multisectoral approach towards preventing alcohol-related harm, in order to ensure the contribution of all areas of public government at all national levels;
- strengthen or (if they are not already in place) develop coordinated national strategies or action plans for reducing alcohol-related harm that include effective enforcement provisions, and support national action and measures tailored to domestic circumstances;
- emphasize specifically the enforcement of national legislation that contributes to reducing alcohol-related harm, such as legislation on drink–driving and on selling and serving alcoholic beverages;
- collect relevant and comparable information on alcohol consumption and alcohol-related harm; and
- provide full support for the strategy set out by the Commission and facilitate its implementation at both the national and EU levels (European Council, 2006).

The impact assessment annexed to the Communication proposed that EU institutions and bodies encourage Member States to undertake coordinated activities to reduce alcohol-related harm, and that the institutions analyse all the relevant policy domains of the EU and its Member States – public health, the EU internal market, employment and social affairs, taxation, transport, education, agriculture, research, youth and consumer policy, etc. – to develop and implement a coherent EU wide-strategy with common aims and targeted actions to tackle alcohol-related harm, supported by a platform based on common objectives and an agreed framework, to create improved coordination at the EU level and to facilitate exchange of evidence-based activities (European Commission, 2006b).

An ex ante assessment of the economic impacts of EU alcohol policies made by RAND Europe in 2006 recommended the implementation of a comprehensive strategy by undertaking a wide variety of policy activities (legislation, self-regulation, information and education campaigns, exchange of best practice and stakeholder involvement) across all relevant policy domains (internal market, taxation, transport, education, research and consumer policy) (Horlings & Scoggins, 2006). The strategy would focus on drink–driving, coordinated campaigns, protection of third parties, commercial communications, consumer information and alcohol availability and pricing.

The European Alcohol Action Plan 2000–2005 (WHO Regional Office for Europe, 2000) called for action in all evidence-based policy domains. It also called for the development of a European Region country programme that would contain an alcohol action plan with clear targets, and for the establishment of a body to coordinate the country programme, with adequate funding for such coordination and a specific timetable to ensure implementation and monitoring of the national action plans.

Lessons from the background documents

The scientific documents confirm the heavy burden that alcohol inflicts on individuals and societies, as well on Europe as a whole. The greater an individual's consumption is, the greater the individual's risk of death from an alcohol-related cause, and the greater a society's consumption, the greater the economic and health burden it must bear. In addition, the scientific documents outline the evidence for effective policy, evidence that has remained consistent over time, and they note the effectiveness of measures addressing the availability, marketing and pricing of alcohol in reducing alcohol-related harm, as well as the importance

of drink–driving countermeasures and individual interventions for those already at risk from hazardous or harmful alcohol consumption. The scientific documents also note the evidence for a lack of effectiveness from educational approaches. Reflecting the evidence base, the 2006 Council conclusions, the Communication impact assessment, the RAND report and the European Alcohol Action Plan all call for strong, coordinated action across all relevant policy domains to reduce alcohol-related harm. Such action should be supported by national action plans and reinforced by coordinated activities across relevant EU and European Region policy domains.

The Communication and the framework

Table 3 summarizes the strategic directions present in the Communication and the framework, and Table 4 the actions they recommend.

Strategic directions

The Communication and the framework differ markedly in their mandate and approach, and the differences are reflected in their content. The Communication is an action-oriented document, as indicated by its main aim, "to address the adverse health effects related to harmful and hazardous alcohol consumption, as well as the related social and economic consequences" (European Commission, 2006a). The framework on the other hand is a process document, as indicated by its main aim, "to link ways, means and ends of an effective alcohol policy" (WHO Regional Office for Europe, 2006).

The different mandates of the two instruments lead to differences in the strategic methods and main policy tools they describe. The strategic methods of the Communication are:

> … to map actions which have already been put in place by the Commission and [EU] Member States, and to identify good practices which have led to positive results, and areas of socioeconomic importance and Community relevance where further progress could be made (European Commission, 2006a).

By contrast, the framework states that its strategic method is "to facilitate the development and implementation of global, regional, national and local community policies and actions to prevent or reduce the harm caused by alcohol" (WHO Regional Office for Europe, 2006).

For policy tools, the Communication proposes:

> … to highlight what the Commission and Member States have already done, and further action or continuation of existing actions by the Commission … [and to present] good practices implemented in Member States … which could inspire similar actions and synergies at national level (European Commission, 2006a).

The framework states that its policy tools are:

> … to establish a national alcohol strategy and an action plan at the national and/or appropriate level within each Member State, with the infrastructure and capacity required to implement effective and cost-effective measures, as well as to monitor and follow up the action plan (WHO Regional Office for Europe, 2006).

In short, the Communication focuses on mapping present actions and sharing experiences, while the framework calls for establishing national infrastructure to implement effective action.

Recommended actions

Problem status

Both documents highlight the health and societal burden that alcohol places on the EU and the European Region.

Response status

Both documents summarize current initiatives. The Communication emphasizes the fact that the policies that have been implemented to tackle alcohol-related problems have not been fully successful since the problems remain and in certain instances have gotten worse.

Information and education

The two documents differ strongly in their approach to informational and educational activities. The Communication places considerable stress on them, including the involvement of economic operators.[3] On the other hand, the framework (WHO Regional Office for Europe, 2006) notes that "appealing solely to the individual to drink responsibly lacks contextual meaning, disregards the fact that decisions often have to be made when the individual is already intoxicated, and rarely yields a significant behavioural response", and adds:

> Involvement of the drinks industry and associated businesses and organizations in youth education or youth activities is subject to question because their support, direct or indirect, could be seen as an attempt to gain credibility with a youth audience.

Political commitment

The framework lays great emphasis on the need to gain political commitment for action, whereas the Communication barely mentions it.

Health sector response

Both documents stress the need for the health sector to address the issue, providing primary care resources to identify alcohol problems and offer limited advice, and specialized treatment services for more serious problems.

Community action

Both documents stress the importance of community action, placing particular emphasis on workplace activities.

Drink–driving policies and countermeasures

Both documents stress the need for lower BAC levels and better enforcement of drink–driving laws.

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[3] *Economic operators* include producers, distributors and retailers of alcoholic beverages; those responsible for commercial communications for alcoholic beverages; and organizations such as those funded by the alcohol industry to address issues of corporate social responsibility.

Addressing the availability of alcohol

The two documents differ greatly on restricting alcohol availability, with the Communication merely emphasizing the need to enforce existing restrictions, while the framework calls for limits on the geographic density of alcohol sale outlets and on the days and hours of sale.

Addressing the marketing of alcoholic beverages

Both documents are relatively weak on the topic of alcohol marketing measures. The Communication stresses self-regulation, and the framework just calls for alcohol marketing to be prohibited at sports and leisure events.

Pricing policies

Both documents are also relatively weak in their treatment of pricing policies. The Communication only mentions taxes on products deemed to be particularly attractive to underage drinkers, and the framework simply calls for an effective taxation policy.

Drinking environments

Both documents call for strengthened server training and enforcement of laws concerning sales to underage and intoxicated customers.
Reducing the public health impact of illegally and informally produced alcohol
The Communication does not mention the subject. The framework calls for better measurement of unrecorded alcohol consumption.

Implementation

The Communication refers to its own implementation only through the creation of the European Alcohol and Health Forum. The framework calls for the development of effective implementation infrastructure, the creation of national action plans and the strong involvement of civil society.

Monitoring and evaluation

Both documents stress the need for research, surveillance, monitoring and reporting, and for using the monitoring to re-evaluate strategies and adapt them as appropriate.

International responsibilities and issues

Both documents note that there are key international issues that clearly require common approaches and discussion of the legal and administrative frameworks needed to implement these approaches. These issues include commercial communications, cross-border trade, smuggling, transport and the impact of trade decisions.

Lessons from the Communication and framework documents

There are areas of action that both documents emphasize, where the policy responses are based on evidence and reflect the findings in the background documents. These areas include action in health care settings, the community and workplaces; action on drinking and driving; and action on drinking environments. On the other hand, several major policy areas receive only brief mention in both documents, including alcohol marketing and pricing, with the Communication placing great emphasis on self-regulation of marketing practices. When it comes to educational and informational efforts, the two instruments diverge, with the Communication stressing their importance but the framework expressing considerable caution in accordance with the weak evidence for their efficacy. Both documents emphasize the

importance of monitoring and evaluation, including research, and the need to coordinate alcohol policies internationally. When it comes to implementation and support of national efforts, the documents again diverge, with the Communication promoting exchange of experiences and the framework promoting the need for effective infrastructure.

Viewed from a larger public health perspective, the two documents are complementary, though they should perhaps be considered with a proviso: the public health evidence, as presented in the background documentation, calls for increasing efforts to manage the environment in which alcohol is marketed (price and availability), and for making educational and self-regulatory efforts less of a priority.

Implementation materials

Eight sources were analysed relating to the Communication, another four relating to other EU activities and four relating to the framework. Of the Communication materials, four of the sources originated with the European Alcohol and Health Forum, including its task forces and science group; two came from Commission committees; and two were commissioned scientific documents. The other EU materials are four documents taken from the agriculture, audiovisual and media, consumer, and taxation areas. The framework materials include two WHO publications, an information system and a scientific publication. The implementation materials are listed in Table 5 and their relevant contents summarized in Table 6.

The Communication and the framework differ considerably when it comes to implementation. The framework and its supporting materials do not explicitly specify any action to support its implementation. (For implicit implementation, see the end of this section). In contrast, the Communication specifies a variety of activities, though they are largely focused on internal Commission processes, and it only considers a narrow range of policy options. It introduces no specific new actions in the areas of health sector response, community efforts, drink–driving, alcohol availability, drinking environments or illegally/informally produced alcohol. Nor does it list any specific actions for implementing international policy.

Much of the work the Communication describes involves the European Alcohol and Health Forum and its related youth and marketing task forces. One of the Forum's key tasks has been to obtain commitments from economic operators and NGOs to take action to reduce alcohol-related harm. Of the 108 commitments the Forum received through 23 April 2009, some three quarters were proposed by economic operators, including one quarter for educational programmes and another quarter for self-regulatory activities (European Alcohol and Health Forum, 2009a). The Forum's youth task force concluded its activities with a proposal to establish a clearing house that would facilitate the collection and sharing of information on alcohol and youth health activities (European Alcohol and Health Forum, 2009c). The marketing task force continues to map the regulation and self-regulation of alcohol marketing, map industry procedures to ensure that alcohol marketing does not target minors, and map social marketing activities (European Alcohol and Health Forum, 2009b).

DG SANCO commissioned RAND Europe to prepare a report on the relationship between alcohol affordability and consumption in the EU, the relationship between consumption and harm, and the possible impact of cross-border trade on alcohol consumption and related harm in recipient countries (countries whose residents buy alcohol abroad). Alcohol affordability is a composite measure that expresses the net effect of price and income. The report found that

affordability of alcoholic beverages has increased between 1996 and 2004 in every one of the 20 countries examined except Italy (Rabinovich et al., 2009). Affordability of alcohol increased by 50% or more in 8 of these countries – in order of decreasing affordability, Lithuania, Estonia, Latvia, the United Kingdom, the Czech Republic, Finland, Slovakia and Ireland. Across the EU, 84% of the increase in alcohol affordability is due to increases in income, and only 16% to changes in alcohol prices. The increased affordability is primarily due to incomes' having risen considerably while the price of alcoholic beverages remained relatively stable, or rose at a lower rate than income. There is a statistically significant positive relationship between alcohol affordability and consumption across the EU, with a short-term elasticity of 0.22 and long-term elasticity of 0.32 (meaning that long-term consumption increases 0.32% for each 1.00% increase in affordability).

The RAND report described how in Sweden, total alcohol consumption (both recorded and unrecorded) rose from 1989 through 2004, after which there was a slight drop in annual consumption to an estimated 9.7 litres of pure alcohol per person aged 15 or older in 2007 (Rabinovich et al., 2009). In that year, cross-border purchases of alcoholic beverages were the source of almost a fifth of the country's alcohol consumption. Starting from an alcohol consumption rate that was slightly below the national average, consumption in the southern Swedish counties increased substantially until around 2003, while the northern counties experienced only a slight increase. In the southern counties, both the increase through 2004 and the slump in consumption the next year were largely due to changes in cross-border purchasing (and smuggling) of alcohol from Denmark and Germany. It appears that the increased consumption of imported alcoholic beverages has also resulted in increased alcohol-related morbidity and mortality. In addition, the closer a Swedish hospital lies to the Danish border, the higher the treatment costs for inpatients with alcohol-related diagnoses.

On the other hand Finland, which joined the EU in 1995, was allowed to continue restricting alcohol imports until 2003 (Rabinovich et al., 2009). Alcohol imports were then expected to increase heavily, not only because of the opening of EU borders generally, but also because neighbouring Estonia, well-known for its low alcohol prices, was scheduled to join the EU in 2004. The Finnish government therefore decided to lower its alcohol taxes, and on 1 March 2004, it dropped the alcohol excise duty by an average of 33% to prevent excessive imports and thereby too much lost tax revenue. The tax decrease was greatest for distilled spirits (44%) and more modest for wine (10%) and beer (32%). In 2004, both the importation of alcohol from Estonia and retail sales of alcohol in Finland increased. The total consumption of alcohol per capita increased by 10%, from 9.4 litres in 2003 to 10.3 litres in 2004, with recorded consumption increasing by 6.5%, from 7.7 to 8.2 litres per capita, and unrecorded (and thus untaxed) consumption by an estimated 25%, from 1.7 to 2.1 litres per capita. The recorded consumption of spirits increased by 18%, though the increase in sales did not fully offset the effects of the tax cuts on tax revenues. While the health impact associated with Estonia's accession to the EU was not statistically significant for Finland, the impact of the alcohol tax cuts in March 2004 was, resulting in an estimated eight additional alcohol-related deaths per week, a 17% increase over the weekly average in 2003. Overall alcohol-related mortality increased by 16% among men and 31% among women; 82% of the increase was due to chronic causes, particularly liver disease. The increase in absolute terms was largest among men aged 55–59 years and women aged 50–54 years. Among people aged 30–59, it increased most among the unemployed, early-age pensioners and those with less education, a low social class or low income. Employed people and people younger than 35 did not experience increased alcohol-related mortality during the two years after the change. In

response to the worsening situation, Finland raised alcohol taxes in the beginning of 2008 by an average of 11.5%.

The European Alcohol and Health Forum also requested advice from its scientific advisory group on the impact of marketing communication on alcohol consumption patterns, especially among young people. In its response, the Science Group noted that marketing communications are just one aspect of the determinants for alcohol consumption and alcohol-related harm, and that it can be difficult to isolate the impact of one aspect from another (Science Group, 2009a). Its opinion also noted that a total marketing strategy includes not only marketing communication and promotional activities but also product development, pricing, physical availability, and market segmentation and targeting, factors that the available published studies do not consider. Based on the consistency of findings across the studies the Science Group reviewed, the confounders controlled for, the dose–response relationships and the theoretical plausibility of the findings, the Group concluded that alcohol marketing increases the likelihood that adolescents will start to use alcohol, and to drink more if they are already using alcohol.

The Committee on Data Collection, Indicators and Definitions met once and recommended three key indicators for monitoring alcohol consumption and alcohol-related health harm (2008), to measure:

- volume of consumption (total recorded and unrecorded per capita consumption of pure alcohol in litres by adults (15 years and older), with subindicators for beer, wine, and spirits);
- consumption pattern (intake of at least 60 g alcohol on a single occasion at least once per month during the previous 12 months); and
- alcohol-related health harm (years of life lost (YLL) attributable to alcohol, with subindicators for alcohol-attributable YLL from chronic disease and from injury).

In addition, the Committee on National Policy and Action on Alcohol has met five times and shared experiences (2009).

Other branches of the Commission have also instituted policies that concern alcohol. However, their impact on public health is unknown. Stipulations that taxation on alcohol in the Member State of acquisition shall also apply to alcohol products dispatched by one private individual to another without any additional payment, direct or indirect may impact on cross-border alcohol purchases (European Commission, 2008a). The regulations on commercial audiovisual communications for alcoholic beverages have been revised, with stipulations in force being that alcohol communications should not specifically target minors or encourage immoderate consumption (European Parliament & European Council, 2007b). Proposals for labelling have included the voluntary listing of relevant ingredients on alcoholic beverage containers (European Commission, 2008b). In the field of agriculture, reform of the common wine market has established lower limits for added sugar and grape must (with exceptions for particularly unfavourable climatic conditions), limits that in principle could lead to lower alcohol concentration in EU wines (European Council, 2008).

As mentioned above, the framework specified no implementation procedures. However, about the same time that the framework was approved, the WHO Expert Committee on Problems Related to Alcohol Consumption produced its second report (2007). The following

recommendations from the report could be interpreted as guidance for the implementation of the framework:

2. Within the context of a public health approach to alcohol-related problems, the Committee recommends that WHO support governmental bodies at national and subnational levels, and in particular in low- and middle-income countries:
    - to give high priority to the prevention of harmful use of alcohol, with an increased investment in the implementation of policies known to be effective;
    - to continue to review the nature and extent of the problems caused by the harmful use of alcohol in their populations, the resources and infrastructures already available for reducing the incidence, prevalence and impact of these problems, and the possible constraints in establishing new policies and programmes;
    - to formulate, develop and implement adequately financed action plans on alcohol with clear objectives, strategies and targets;
    - to establish or reinforce mechanisms and focal points to coordinate the work of public health stakeholders;
    - to implement and evaluate evidence-based policies and programmes, using existing structures where feasible.
3. Based on the substantive evidence base for the effectiveness and cost– effectiveness of alcohol policies and programmes in reducing the negative consequences of harmful use of alcohol, the Committee recommends that WHO support and assist governments, upon request:
    - to regulate the availability of alcohol, including minimum ages for purchasing alcohol, hours of sale and density of outlets;
    - to implement appropriate drink–driving policies based on low legal BAC limits that are strongly enforced;
    - to reduce the demand for alcohol through taxation and pricing mechanisms;
    - to raise awareness and support for effective policies. (In this regard, it is stressed that many commonly-used education and persuasion measures, for example school education programmes, mass media campaigns and warning labels, show little evidence of effectiveness in reducing alcohol-related harm, and therefore should not be implemented in isolation as alcohol policies.)
4. Considering the detrimental effects of alcohol marketing measures on young people, the Committee recommends that WHO support and assist governments:
    - to effectively regulate the marketing of alcoholic beverages, including effective regulation or banning of advertising and of sponsorship of cultural and sports events, in particular those that have an impact on younger people;
    - to designate statutory agencies to be responsible for monitoring and enforcement of marketing regulations;
    - to work together to explore establishing a mechanism to regulate the marketing of alcoholic beverages, including effective regulation or banning of advertising and sponsorship, at the global level.
5. The Committee recommends that WHO support and assist governments:
    - to ensure that all people with alcohol problems in need of treatment have access to non-stigmatized and confidential evidence-based treatments and community services;

- to increase investments in the widespread implementation of early identification and brief intervention programmes for hazardous and harmful alcohol use in a wide variety of settings, including primary care, social welfare, accident and emergency departments, workplaces, and educational institutions;
- to expand capacity by educating and training professionals in health care, social service, and criminal justice settings, in implementing identification and intervention programmes;
- to give greater attention in treatment policies to the organization, integration and delivery of treatment services at the local, municipal and national levels.

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8. Recognizing the role that nongovernmental organizations can play in supporting alcohol policy, the Committee recommends that WHO strengthen its processes of consultation and collaboration with nongovernmental organizations which are free of potential conflict of interest with the public health interest.
9. The Committee recommends that WHO continue its practice of no collaboration with the various sectors of the alcohol industry. Any interaction should be confined to discussion of the contribution the alcohol industry can make to the reduction of alcohol-related harm only in the context of their roles as producers, distributors and marketers of alcohol, and not in terms of alcohol policy development or health promotion.
10. Recognizing that alcohol is a special commodity in terms of its toxic and dependence-producing properties, with serious implications for public health, and that mechanisms should be developed to protect the public health interest concerning alcohol in trade, industrial and agricultural decisions, the Committee recommends that WHO:
    - stimulate a dialogue concerning those international aspects of the alcohol market which impinge on the ability of countries to combat alcohol-related problems within their borders, analysing the feasibility of international mechanisms, including legally binding agreements between countries, to support the implementation of alcohol policies and programmes;
    - seek opportunities to provide an active and continuing presence in trade negotiations and dispute adjudications to represent the public health interest in alcohol trade matters;
    - develop guidance that can be used by policy-makers and advisers at all levels of government to monitor and reduce the risks to alcohol policy that might be inherent in the process of trade liberalization.

Lessons from the implementation documents

The documents directly supporting the Communication have focused on only a few select areas, including education, young people's drinking and industry self-regulation. However, two scientific documents requested by the European Alcohol and Health Forum present clear evidence that may facilitate strengthened policy-making in other areas. The Science Group found consistent evidence demonstrating the impact of alcohol advertising on the uptake of drinking by non-drinking young people, and on increased consumption by their drinking peers (2009a). And the RAND report found a strong relationship between the increasing affordability of alcohol consumption throughout the EU and an increase in alcohol consumption (Rabinovich et al., 2009). Contributing to greater affordability, open borders within the EU have led to greater decreases in alcohol taxes than would have otherwise

occurred, which, together with cross-border price differences, has led to increased consumption and alcohol-related harm in the recipient countries.

Elsewhere within DG SANCO, the Committee on Data Collection, Indicators and Definitions agreed upon key indicators to monitor alcohol consumption and alcohol-related harm. Relevant actions in other EU areas of activity cannot be described as helping reduce the health and economic burden of alcohol consumption.

Although the framework came with no specific provisions for implementation, a report by the WHO Expert Committee on Problems Related to Alcohol Consumption contained clear guidance for national implementation, stressing the need for well-financed infrastructure and extensive monitoring, evaluation and research (2007).

Co-financed projects

Twelve alcohol projects co-financed by the European Commission were identified in preparing this report (see Table 7). With the exceptions of raising awareness for political commitment and of international issues, they address the full range of alcohol policy actions, including new initiatives on workplace policies and on the chemical composition of illegally and informally produced alcoholic beverages (see Table 8). The Health Evolution Monitoring (HEM) project on health differentials is bringing to light shocking health inequalities between different parts of the EU, and alcohol's role in them. As mentioned in the Background section above, the 2002 difference in male life expectancy at age 20 between the 15 original Member States and the 3 Baltic states was nearly 10 years. For men aged 20–64, about 25% of the difference in life expectancy between eastern and western Europe can be attributed to alcohol, largely as a result of differences in patterns of heavy episodic drinking (Zatonski et al., 2008).

Lessons from the projects

Co-financing is one of the Commission's most important tools in supporting country-based action on alcohol policy. Over the years, the Commission has co-financed a wide range of projects covering many aspects of alcohol policy. While the breadth and depth of these efforts is a good thing, there have been no systematic evaluations of the coordination and complementarity of these projects, the extent to which their findings have been disseminated in regional and national institutions, or the degree to which these findings have affected alcohol policy and programme development. It is important that the findings be well integrated into the development of guidelines for national action plans.

4. Discussion and conclusions

The European Region is in the unusual position of being the WHO region with the highest levels of alcohol consumption and related harm. In many European countries, there was once a strong tradition of government regulating the sale of alcohol, and for many countries, adopting evidence-based alcohol policies could be seen as a matter of recovering a lost policy tradition abandoned during the deregulatory phase of the past three decades or so.

At the European level, there has been strong leadership in developing and implementing evidence-based alcohol policies, from the WHO Regional Office for Europe since the early 1990s and more recently from the European Commission with the launch of the Communication in 2006.

There is extensive documentation on the harm that European citizens and societies have suffered from alcohol, and a strong evidence base to inform effective alcohol policy. The policy documents leading up to the Communication and the framework argue strongly for a coordinated approach across a wide range of alcohol policy domains, including the regulation of price, availability and commercial communications.

While the Communication and the framework cover many different policy issues in detail, it can be argued that they are relatively weak in their calls for intensifying the regulation of alcohol price, availability and marketing. Both instruments stress the need for awareness-raising, health sector action, drink–driving policies, harm reduction in drinking environments and international and cross-border actions. Both documents emphasize workplace policies more than the background documents do. They make little mention of the potential health impact of illegally and informally produced alcohol.

Fortunately, two other areas of relative weakness in the Communication and framework have been balanced by documents involved in implementing the Communication. A report by RAND Europe stresses the importance of price and cross-border trade (Rabinovich et al., 2009), while a review requested by the European Alcohol and Health Forum underscores the importance of commercial communications (Science Group, 2009a). These issues were also taken up by a report of the WHO Expert Committee on Problems Related to Alcohol Consumption (2007).

The Commission's co-financed projects play a strong supportive role with respect to the Communication by providing evidence and experience across a wide range of alcohol policy issues. Yet how much this knowledge is disseminated at the country level is unknown, as is the extent to which it affects alcohol policy development and implementation.

The documentation analysed in this report provides a firm basis for the development of guidelines for national action plans on alcohol, with the possible addition of three issues.

1. Recognizing the need for immediate impact, such guidelines should strongly emphasize the importance of regulating the price, availability and marketing of alcohol, since these issues are underemphasized in the Communication and the framework.
2. The guidelines should include a discussion of workplace initiatives since both the Communication and the framework give the subject prominence, and despite the fact that the background materials make little mention of the topic, and that the evidence for the effectiveness of workplace efforts is weak.

3. Finally, the guidelines should highlight the findings of alcohol projects co-financed by the Commission, since it is not clear how well the outcomes of these projects are known at the country level.

5. References

Anderson P, Baumberg B (2006). *Alcohol in Europe.* London, Institute of Alcohol Studies (http://ec.europa.eu/health/ph_determinants/life_style/alcohol/documents/alcohol_europe.pdf, accessed 10 July 2009).

Anderson P, Chisholm D, Fuhr DC (2009). Effectiveness and cost–effectiveness of policies and programmes to reduce the harm caused by alcohol. *The Lancet*, 373:2234–2246.

Babor TF et al. (2003). *Alcohol: no ordinary commodity: research and public policy.* Oxford, Oxford University Press.

Bruun K et al. (1975). *Alcohol control policies in public health perspective.* Helsinki, Finnish Foundation for Alcohol Studies.

Committee on Data Collection, Indicators and Definitions (2008). *1st meeting: Luxembourg, 4 December 2008: summary report.* Luxembourg, European Communities (http://ec.europa.eu/health/ph_determinants/life_style/alcohol/Forum/docs/ev_20081204_mi_en.pdf, accessed 12 July 2009).

Committee on National Policy and Action on Alcohol (2009). Committee on National Policy and Action on Alcohol [web page]. Luxembourg, European Communities (http://ec.europa.eu/health/ph_determinants/life_style/alcohol/alcohol_policyaction_en.htm, accessed 19 July 2009).

Community Research and Development Information Service (CORDIS) (2009). CORDIS: Community Research & Development Information Service [web site]. Luxembourg, European Communities (http://cordis.europa.eu, accessed 10 July 2009).

Directorate-General for Health and Consumers (DG SANCO) (2009). Alcohol [web page]. Luxembourg, European Communities (http://ec.europa.eu/health/ph_determinants/life_style/alcohol/alcohol_en.htm, accessed 10 July 2009).

Edwards G et al. (1994). *Alcohol policy and the public good.* New York, Oxford University Press.

European Alcohol and Health Forum (2009a). *Commitments made by members of the European Alcohol and Health Forum: summary report (updated 20/04/2009).* Luxembourg, European Communities (http://ec.europa.eu/health/ph_determinants/life_style/alcohol/Forum/docs/report_commitments_en.pdf, accessed 18 July 2009).

European Alcohol and Health Forum (2009b). Task Force Marketing Communication [web page]. Luxembourg, European Communities (http://ec.europa.eu/health/ph_determinants/life_style/alcohol/Forum/alcohol_forum_en.htm, accessed 18 July 2009).

European Alcohol and Health Forum (2009c). Task Force on Youth-Specific Aspects of Alcohol [web page section]. Luxembourg, European Communities (http://ec.europa.eu/health/ph_determinants/life_style/alcohol/Forum/alcohol_forum_en.htm#taskforce, accessed 18 July 2009).

European Commission (2006a). *Communication from the Commission to the Council, the European Parliament, the European Economic and Social Committee and the Committee of the Regions: an EU strategy to support member states in reducing alcohol related harm.* Luxembourg, European Communities (COM(2006) 625 final; http://eur-lex.europa.eu/LexUriServ/LexUriServ.do?uri=COM:2006:0625:FIN:EN:PDF, accessed 10 July 2009).

European Commission (2006b). *Impact assessment report (long version, available in English only): annexed to the Communication from the Commission to the Council, the European Parliament, the European Economic and Social Committee and the Committee of the Regions: an EU strategy to support member states in reducing alcohol related harm.* Luxembourg, European Communities (http://ec.europa.eu/health/ph_determinants /life_style/alcohol/documents/alcohol_com_625_a2_en.pdf, accessed 12 July 2009).

European Commission (2006c). *Report on the implementation of the Council recommendation of 5 June 2001 on the drinking of alcohol by young people, in particular children and adolescents: annexed to the Communication from the Commission to the Council, the European Parliament, the European Economic and Social Committee and the Committee of the Regions on alcohol and health: an EU strategy to support member states in reducing alcohol related harm.* Luxembourg, European Communities (http://ec.europa.eu/health/ph_determinants/life_style/alcohol/documents/alcohol_com_625_a3_en.pdf, accessed 12 July 2009).

European Commission (2008a). Proposal for a Council directive concerning the general arrangements for excise duty (presented by the Commission): Brussels, 14.2.2008: COM(2008) 78 final/3: 2008/0051 (CNS). Luxembourg, European Communities (http://eur-lex.europa.eu/LexUriServ/LexUriServ.do?uri=COM:2008:0078:FIN:EN:PDF, accessed 19 July 2009).

European Commission (2008b). *Proposal for a regulation of the European Parliament and of the Council on the provision of food information to consumers: Brussels, 30.1.2008: COM(2008) 40 final, 2008/0028 (COD).* Luxembourg, European Communities (http://eur-lex.europa.eu/LexUriServ/LexUriServ.do?uri=COM:2008:0040:FIN:EN:PDF, accessed 19 July 2009).

European Commission (2009a). Activities of the European Union [web page]. Luxembourg, European Communities (http://europa.eu/pol, accessed 10 July 2009).

European Commission (2009b). The EU at a glance [web page]. Luxembourg, European Communities (http://europa.eu/abc, accessed 10 July 2009).

European Council (2001a). Council conclusions of 5 June 2001 on a Community strategy to reduce alcohol-related harm (2001/C 175/01). *Official Journal of the European Communities*, 44(C 175):1–2 (http://eur-lex.europa.eu/LexUriServ/LexUriServ. do?uri=OJ:C:2001:175:0001:0002:EN:PDF, accessed 10 July 2009).

European Council (2001b). Council recommendation of 5 June 2001 on the drinking of alcohol by young people, in particular children and adolescents (2001/458/EC). *Official Journal of the European Communities*, 44(L 161):38–41 (http://eur-lex.europa.eu/ LexUriServ/LexUriServ.do?uri=OJ:L:2001:161:0038:0041:EN:PDF, accessed 10 July 2009).

European Council (2004). Alcohol and young people: Council conclusions. In: *Press release: 2586th Council meeting: employment, social policy, health and consumer affairs: Luxembourg, 1–2 June 2004.* Luxembourg, European Council:40–41 (http://www.consilium.europa.eu/ueDocs/cms_Data/docs/pressdata/en/lsa/80729.pdf, accessed 10 July 2009).

European Council (2006). *Council conclusions on EU strategy to reduce alcohol-related harm.* Luxembourg, European Council (http://www.consilium.europa.eu/ueDocs/cms_Data/docs/pressData/en/lsa/91933.pdf, accessed 12 July 2009).

European Council (2008). Council regulation (EC) No 479/2008 of 29 April 2008 on the common organisation of the market in wine, amending regulations (EC) No 1493/1999, (EC) No 1782/2003, (EC) No 1290/2005, (EC) No 3/2008 and repealing Regulations (EEC) No 2392/86 and(EC) No 1493/1999. *Official Journal of the European Union*, 51(L 148) (http://eur-lex.europa.eu/LexUriServ/LexUriServ.do?uri=OJ:L:2008:148:0001:0061:EN:PDF, accessed 19 July 2009).

European Parliament, European Council (2002). Decision No 1786/2002/EC of the European Parliament and of the Council of 23 September 2002 adopting a programme of Community action in the field of public health (2003–2008). *Official Journal of the European Communities*, 49(L 271):1–11 (http://eur-lex.europa.eu/LexUriServ/LexUriServ.do?uri=OJ:L:2002:271:0001:0011:EN:PDF, accessed 10 July 2009).

European Parliament, European Council (2007a). Decision No 1350/2007/EC of the European Parliament and of the Council of 23 October 2007 establishing a second programme of Community action in the field of health (2008–13). *Official Journal of the European Communities*, 50(L 301):3–13 (http://eur-lex.europa.eu/LexUriServ/LexUriServ.do?uri=OJ:L:2007:301:0003:0013:EN:PDF, accessed 10 July 2009).

European Parliament, European Council (2007b). Directive 2007/65/EC of the European Parliament and of the Council of 11 December 2007 amending Council Directive 89/552/EEC on the coordination of certain provisions laid down by law, regulation or administrative action in Member States concerning the pursuit of television broadcasting activities (text with EEA relevance). *Official Journal of the European Communities*, 50(L 332):27–45 (http://eur-lex.europa.eu/LexUriServ/LexUriServ.do?uri=OJ:L:2007:332:0027:0045:EN:PDF, accessed 19 July 2009).

Executive Agency for Health and Consumers (EAHC) (2009). Projects [web page]. Luxembourg, European Communities (http://ec.europa.eu/eahc/projects/projects.html, accessed 10 July 2009).

Foglietta A (2007). *Reducing alcohol-related harm: European Parliament resolution of 5 September 2007 on an European Union strategy to support member states in reducing alcohol-related harm (2007/2005(INI)).* Luxembourg, European Communities (http://www.europarl.europa.eu/oeil/DownloadSP.do?id=13936&num_rep=6808&language=en, accessed 12 July 2009).

Horlings E, Scoggins A (2006). *An ex ante assessment of the economic impacts of EU alcohol policies.* Cambridge, United Kingdom, RAND Corporation (http://www.rand.org/pubs/technical_reports/2006/RAND_TR412.pdf, accessed 12 July 2009).

National Health and Medical Research Council (2009). *Australian guidelines to reduce health risks from consuming alcohol.* Canberra, Commonwealth of Australia (http://www.nhmrc.gov.au/publications/synopses/ds10syn.htm, accessed 10 July 2009).

Rabinovich L et al. (2009). *The affordability of alcoholic beverages in the European Union: understanding the link between alcohol affordability, consumption and harms.* Cambridge, United Kingdom, RAND Corporation (http://www.rand.org/pubs/technical_reports/TR689, accessed 12 July 2009).

Rehm J et al. (2009). Global burden of disease and injury and economic cost attributable to alcohol use and alcohol-use disorders. *The Lancet*, 373:2223–2233.

Science Group of the European Alcohol and Health Forum (2009a). *Does marketing communication impact on the volume and patterns of consumption of alcoholic beverages, especially by young people? A review of longitudinal studies.* Luxembourg, European Communities (http://ec.europa.eu/health/ph_determinants/life_style/alcohol/Forum/docs/science_o01_en.pdf, accessed 12 July 2009).

Science Group of the European Alcohol and Health Forum (2009b). Science Group of the European Alcohol and Health Forum [web page]. Luxembourg, European Communities (http://ec.europa.eu/health/ph_determinants/life_style/alcohol/Forum/alcohol_science_group_en.htm, accessed 19 July 2009).

TNS Opinion and Social (2007). *Attitudes towards alcohol.* Luxembourg, European Commission (Special Eurobarometer 272b; http://ec.europa.eu/health/ph_determinants/life_style/alcohol/documents/ebs272_en.pdf, accessed 10 July 2009).

WHO (2007). Global Information System on Alcohol and Health (GISAH) [online database]. Geneva, WHO (http://who.int/globalatlas, accessed 19 July 2009).

WHO (2008a). *Resolution WHA61.4: strategies to reduce the harmful use of alcohol.* Adopted 24 May 2008. Geneva, WHO (http://who.int/gb/ebwha/pdf_files/A61/A61_R4-en.pdf, accessed 19 July 2009).

WHO (2008b). *Strategies to reduce the harmful use of alcohol: report by the Secretariat.* Geneva, World Health Organization (http://who.int/gb/ebwha/pdf_files/A61/A61_13-en.pdf, accessed 10 July 2009).

WHO European Ministerial Conference on Young People and Alcohol (2001). *Declaration on Young People and Alcohol.* Copenhagen, WHO Regional Office for Europe (http://www.euro.who.int/AboutWHO/Policy/20030204_1, accessed 12 July 2009).

WHO Expert Committee on Problems Related to Alcohol Consumption (2007). *WHO Expert Committee on Problems Related to Alcohol Consumption: second report.* Geneva, World Health Organization (WHO Technical Report Series 944; http://who.int/substance_abuse/expert_committee_alcohol, accessed 12 July 2009).

WHO Regional Office for Europe (1992). *European Alcohol Action Plan 1992–1999*. Copenhagen, WHO Regional Office for Europe.

WHO Regional Office for Europe (1995). *European Charter on Alcohol adopted at the European Conference on Health, Society and Alcohol, Paris, 12–14 December 1995*. Copenhagen, WHO Regional Office for Europe (http://www.euro.who.int/Document/EUR_ICP_ALDT_94_03_CN01.pdf, accessed 10 July 2009).

WHO Regional Office for Europe (2000). *European Alcohol Action Plan 2000–2005*. Copenhagen, WHO Regional Office for Europe (http://www.euro.who.int/document/E67946.pdf, accessed 10 July 2009).

WHO Regional Office for Europe (2006). *Framework for alcohol policy in the WHO European Region.* Copenhagen, WHO Regional Office for Europe (http://www.euro.who.int/document/e88335.pdf, accessed 10 July 2009).

WHO Regional Office for Europe (2009a). Alcohol drinking [web page]. Copenhagen, WHO Regional Office for Europe (http://www.euro.who.int/healthtopics/HT2ndLvlPage?HTCode=alcohol_drinking, accessed 10 July 2009).

WHO Regional Office for Europe (2009b). European Alcohol Information System [online database]. Copenhagen, WHO Regional Office for Europe (http://data.euro.who.int/alcohol, accessed 12 July 2009).

WHO Regional Office for Europe (2009c). European Health for All database (HFA-DB) [online database]. Copenhagen, WHO Regional Office for Europe (http://www.euro.who.int/hfadb, accessed 9 July 2009).

WHO Regional Office for Europe (2009d). *Evidence for the effectiveness and cost–effectiveness of interventions to reduce alcohol-related harm.* Copenhagen, WHO Regional Office for Europe (http://www.euro.who.int/InformationSources/Publications/Catalogue/20090918_2, accessed 9 July 2009).

WHO Regional Office for Europe (2009e). *Handbook for action to reduce alcohol-related harm.* Copenhagen, WHO Regional Office for Europe (http://www.euro.who.int/Information Sources/Publications/Catalogue/20090918_1, accessed 9 July 2009).

Wilsnack RW et al. (2009). Gender and alcohol consumption: patterns from the multinational GENACIS project. *Addiction*, 104:1487-1500.

Zaridze D et al. (2009). Alcohol and cause-specific mortality in Russia: a retrospective case–control study of 48 557 adult deaths. *The Lancet*, 373:2201–2214.

Zatonski W et al., eds. (2008). Closing the health gap in European Union. Warsaw, Health Evolution Monitoring (HEM) Project Team (http://www.hem.home.pl/index.php?idm=87,139&cmd=1, accessed 10 July 2009).

6. Tables

Table 1. List of background documents

Document	Content
Background documents for the Communication *(B1–B10, in date order)*	
B1. European Council (2001a). Council conclusions of 5 June 2001 on a Community strategy to reduce alcohol-related harm (2001/C 175/01). *Official Journal of the European Communities*, 44(C 175):1–2 (eur-lex.europa.eu/LexUriServ/LexUriServ.do?uri=OJ:C:2001:175:0001:0002:EN:PDF).	Invites the Commission to put forward proposals for a comprehensive EU strategy to reduce alcohol-related harm. The strategy proposals should complement national policies and set out a timetable for its various actions.
B2. European Council (2001b). Council recommendation of 5 June 2001 on the drinking of alcohol by young people, in particular children and adolescents (2001/458/EC). *Official Journal of the European Communities*, 44(L 161):38–41 (eur-lex.europa.eu/LexUriServ/LexUriServ.do?uri=OJ:L:2001:161:0038:0041:EN:PDF).	Recommends multisectoral education and a more robust enforcement of underage drinking laws, and asks the alcohol industry not to target young people in its advertising.
B3. European Council (2004). Alcohol and young people: Council conclusions. In: *Press release: 2586th Council meeting: employment, social policy, health and consumer affairs: Luxembourg, 1–2 June 2004.* Luxembourg, European Council:40–41 (www.consilium.europa.eu/ueDocs/cms_Data/docs/pressdata/en/lsa/80729.pdf).	Re-emphasizes Council conclusions of 5 June 2001.
B4. European Council (2006). *Council conclusions on EU strategy to reduce alcohol-related harm.* Luxembourg, European Council (www.consilium.europa.eu/ueDocs/cms_Data/docs/pressData/en/lsa/91933.pdf).	Welcomes the Communication as a major step towards a comprehensive and coherent EU approach to tackling the adverse impact of excessive alcohol consumption on health and well-being in Europe.
B5. European Commission (2006c). *Report on the implementation of the Council recommendation of 5 June 2001 on the drinking of alcohol by young people, in particular children and adolescents: annexed to the Communication from the Commission to the Council, the European Parliament, the European Economic and Social Committee and the Committee of the Regions on alcohol and health: an EU strategy to support member states in reducing alcohol related harm.* Luxembourg, European Communities (ec.europa.eu/health/ph_determinants/life_style/alcohol/documents/alcohol_com_625_a3_en.pdf).	Reviews progress on the implementation of the Council recommendation of 5 June 2001 on the drinking of alcohol by young people, in particular children and adolescents.

Document	Content
B6. European Commission (2006b). *Impact assessment report (long version, available in English only): annexed to the Communication from the Commission to the Council, the European Parliament, the European Economic and Social Committee and the Committee of the Regions: an EU strategy to support Member States in reducing alcohol related harm.* Luxembourg, European Communities (ec.europa.eu/health/ph_determinants/life_style/alcohol/documents/alcohol_com_625_a2_en.pdf).	Concludes, in line with the findings of the reports that provided input for this impact assessment and based on the consultations held in connection with it, that the preferred approach from both a public health and an economic point of view would be to develop an EU-wide strategy that seeks to reduce alcohol-related harm and coordinates activities at the EU level.
B7. Anderson P, Baumberg B (2006). *Alcohol in Europe.* London, Institute of Alcohol Studies (ec.europa.eu/health/ph_determinants/life_style/alcohol/documents/alcohol_europe.pdf).	Reviews the harms of alcohol consumption and effective policy responses. A comprehensive, 400-page, peer-reviewed report prepared for the European Commission.
B8. Horlings E, Scoggins A (2006). *An ex ante assessment of the economic impacts of EU alcohol policies.* Cambridge, United Kingdom, RAND Europe (www.rand.org/pubs/technical_reports/2006/RAND_TR412.pdf).	Assesses and analyses different alcohol policy options in the EU; prepared for the Commission.
B9. Foglietta A (2007). *Reducing alcohol-related harm: European Parliament resolution of 5 September 2007 on an European Union strategy to support Member States in reducing alcohol-related harm (2007/2005(INI)).* Luxembourg, European Communities (www.europarl.europa.eu/oeil/DownloadSP.do?id=13936&num_rep=6808&language=en).	Sees the Commission's primary roles as stimulating Member State and stakeholder action and setting ambitious and concrete objectives, which Member States should then address using appropriate means and on which they should report progress regularly. Moreover, underlines the Commission's supporting role in the achievement of European alcohol objectives by helping members exchange knowledge and best practices and carry out research.
B10. TNS Opinion and Social (2007). *Attitudes towards alcohol.* Luxembourg, European Commission (Special Eurobarometer 272b; ec.europa.eu/health/ph_determinants/life_style/alcohol/documents/ebs272_en.pdf).	Summarizes drinking behaviours and attitudes to alcohol and alcohol policy for each EU country.
Background documents for the framework *(B11–B15, in date order)*	
B11. WHO Regional Office for Europe (1995). *European Charter on Alcohol adopted at the European Conference on Health, Society and Alcohol, Paris, 12–14 December 1995*. Copenhagen, WHO Regional Office for Europe (www.euro.who.int/Document/EUR_ICP_ALDT_94_03_CN01.pdf).	Outlines 5 ethical principles and 10 action strategies for reducing the harm done by alcohol.

Table 1. List of background documents

Document	Content
B12. WHO Regional Office for Europe (2000). *European Alcohol Action Plan 2000–2005.* Copenhagen, WHO Regional Office for Europe (www.euro.who.int/document/E67946.pdf).	Summarizes outcomes to be achieved and lists effective actions that can be implemented to reduce the harm done by alcohol.
B13. WHO European Ministerial Conference on Young People and Alcohol (2001). *Declaration on Young People and Alcohol.* Copenhagen, WHO Regional Office for Europe (www.euro.who.int/AboutWHO/Policy/20030204_1).	Stresses that public health policies concerning alcohol need to be formulated by public health interests without interference from commercial interests.
B14. WHO Regional Office for Europe (2002–2009). European Alcohol Information System (EAIS) [online database]. Copenhagen, WHO Regional Office for Europe (data.euro.who.int/alcohol).	Will be replaced with a new system, provisionally called the European Information System on Alcohol and Health (EISAH), by the end of 2009, in partnership with the European Commission.
B15. Babor TF et al. (2003) *Alcohol: no ordinary commodity: research and public policy.* Oxford, Oxford University Press.	A systematic review, copublished by the Regional Office, of the evidence for effective alcohol policy.

Table 2. Topical breakdown of background documents

Topic	Communication background materials	Framework background materials
Review of the problem status	B6 summarizes the data from B7 and B8. B7 provides an extensive overview of harmful alcohol use and the health, social and economic harm that alcohol use does to individuals, Member States and the EU as a whole. It emphasizes that the harm increases for individuals and society as alcohol consumption increases, that alcohol is the third leading risk factor for ill health and premature death in the EU and that the social costs of alcohol to the EU total some €125 billion/year. B8 largely summarizes the data from B7. B10 provides data on alcohol use and drinking patterns for each EU Member State, stressing that harmful alcohol use affects all age and socioeconomic groups.	B15 reviews the data on alcohol consumption and drinking patterns and reviews the evidence of alcohol's impact on a wide range of health and social harms at the individual and societal level, finding that harm increases for individuals and societies as alcohol consumption does.
Review of the response status	B5 describes changes in several policy areas that affected the drinking of young people between 2001 and 2005, noting strengthened enforcement of underage drinking and increased educational activities that target young people. B6 advocates coordination of activities at the EU level, in which EU institutions and bodies would encourage Member States and other stakeholders to act to reduce alcohol-related harm, e.g. by encouraging representatives of the alcohol industry to better implement and monitor their self-regulatory efforts, including common codes of conduct for commercial communication, and by encouraging the exchange of best practice on interventions among Member States. B6 also suggests analysing all relevant policy domains of the EU and its Member States – public health, the internal market, employment and social affairs, taxation, transport, education, agriculture, research, youth and consumer policy, etc. – to develop and implement a coherent EU-wide strategy with common aims and	—

Table 2. Topical breakdown of background documents

Topic	Communication background materials	Framework background materials
	targeted actions to tackle alcohol-related harm, supported by a platform based on common objectives and an agreed framework, and involving all stakeholders (including NGOs and industry) to create improved coordination at the EU level and to facilitate exchange of evidence-based activities. B7 provides an extensive review of the effectiveness and cost–effectiveness of policies and programmes to reduce the harm done by alcohol use, stressing the cost–effectiveness of policies that manage the price, availability and marketing of alcohol; drink–driving policies; and brief advice programmes in primary care settings for hazardous and harmful alcohol consumption. The review stresses the evidence that demonstrates a lack of effectiveness for a range of educational and informational programmes. B8 recommends the implementation of a comprehensive strategy through the application of a wide variety of policy activities (legislation, self-regulation, information and education campaigns, exchange of best practice and stakeholder involvement) across all relevant EU policy domains (internal market, taxation, transport, education, research and consumer policy). The strategy would focus on drink–driving, coordinated campaigns, protection of third parties, commercial communication, consumer information and alcohol availability and pricing. B10 describes public support of alcohol policy initiatives to regulate the availability and marketing of alcohols and to strengthen drink–driving policies. It also describes public scepticism of the effectiveness of price measures.	
Raising awareness: information and education	B7 reviews the scientific literature and finds considerable evidence that educational initiatives do not diminish the harm caused by alcohol. It stresses that such initiatives should not be implemented as the sole alcohol policy measures, and that they should strive to mobilize public support for alcohol policies.	B12 calls for action to use public education or the mass media to provide the population with information about the harm that alcohol can inflict on the health and well-being of individuals, families and communities. It recommends mounting mass media

Table 2. Topical breakdown of background documents

Topic	Communication background materials	Framework background materials
	B8 recommends focusing on consumer information.	campaigns to promote public support for policies that combat alcohol-related harm; providing all young people with skill-based learning through an integrated, holistic health education programme committed to a safe, health-enhancing social and physical environment; and ensuring that school-based alcohol education, from preschool upwards, is integrated into the concept of the health-promoting school and into local community prevention coalitions. B15 notes that the expected impact of alcohol education and public service messages about drinking is low.
Raising awareness: political commitment	B4 is a political document. It invites the Commission to: • continue its systematic, sustainable approach to tackling alcohol-related harm at the European level, including the use of health impact assessments for EU actions with an evident health dimension; • provide continuing strong support for Member States' efforts to sustain, strengthen and develop national alcohol policies to reduce alcohol-related harm; • consider and coherently apply the Treaty of European Union provisions concerning the protection of public health and the EU internal market; • ensure balanced stakeholder representation in setting up the European Alcohol and Health Forum proposed in the Communication, including representatives from the public health community, NGOs and the alcoholic beverage production, retail and hospitality sectors; • develop measurable core indicators so that progress in reducing alcohol-related harm at the EU level can be monitored, especially for areas of priority action; and	—

Table 2. Topical breakdown of background documents

Topic	Communication background materials	Framework background materials
	• report regularly, starting in 2008, on the progress of Commission activities to implement the EU alcohol strategy and on activities reported by Member States, as well as their impact at the EU level and within Member States, including assessment of the response from different stakeholders. In addition, B4 calls upon the EU Member States to: • foster a multisectoral approach towards preventing alcohol-related harm, in order to ensure the contribution of all areas of public government at all national levels; • strengthen or (if they are not already in place) develop coordinated national strategies or action plans for reducing alcohol-related harm that include effective enforcement provisions, and support national action and measures tailored to domestic circumstances; • emphasize specifically the enforcement of national legislation that contributes to reducing alcohol-related harm, such as legislation on drink–driving and on selling and serving alcoholic beverages; • collect relevant and comparable information on alcohol consumption and alcohol-related harm; and • provide full support for the strategy set out by the Commission and facilitate its implementation at both national and EU levels.	
Health sector response	B7 summarizes the extensive evidence that demonstrates the effectiveness and cost–effectiveness of early identification and brief intervention programmes based in primary care settings.	B12 calls for action to: • build a comprehensive treatment system based on needs assessment that is accessible, effective, flexible and accountable; • ensure a coordinated approach that involves the social services, criminal justice bodies and self-help groups as well as health services;

Table 2. Topical breakdown of background documents

Topic	Communication background materials	Framework background materials
		• ensure that treatment is evidence-based, effective and flexible enough to respond to developments in scientific knowledge and treatment technology; • ensure that alcohol treatment services cater for the complete range of problems and provide for detoxification, assessment, treatment matching, relapse prevention and after-care; • provide for the training of primary health care professionals in identifying hazardous and harmful alcohol consumption and intervening appropriately; • allocate sufficient funds and adopt contractual strategies that will ensure the broad availability, accessibility and affordability of interventions based on primary care; and • provide long-term treatment alternatives to custodial sentences for offenders who have chronic alcohol problems and who cooperate with a therapeutic programme. B15 notes that treatment and early intervention strategies are at best moderately effective.
Community action	B7 summarizes the evidence demonstrating the potential of community-based programmes and community mobilization to reduce alcohol-related harm, particularly in the areas of drink–driving and the enforcement of safer drinking environments.	—
Drink–driving	B4 calls for enforcement of national legislation on drink–driving. B7 reviews the extensive evidence showing the particular effectiveness of introducing or reducing legal BAC limits for drivers, and of enforcing such measures through random breath testing and sobriety checkpoints.	B12 calls for action to: • ensure high enforcement levels for current drink–driving legislation; • promote high-visibility random breath testing; and • review current BAC limits and consider enacting

Table 2. Topical breakdown of background documents

Topic	Communication background materials	Framework background materials
	B8 recommends a focus on drink–driving.	legislation to adopt limits of 0.5 g/l or lower, and of close to zero for novice drivers and professional transport drivers. B15 notes that most drink–driving countermeasures have been shown to be highly effective, particularly random breath testing, lowered BAC limits, administrative licence suspension and "zero tolerance" for youth drivers.
Availability	B4 calls for enforcement of national legislation on selling and serving alcoholic beverages. B7 reviews the extensive evidence demonstrating the effectiveness of several measures to reduce alcohol-related harm, including reducing the geographic density of alcohol sales outlets and the days and hours of sale, and increasing the minimum age for purchasing alcoholic beverages. B8 recommends focusing on availability.	B12 calls for action to use licensing laws to control the availability of alcohol by restricting the number of outlets where alcohol is sold, limiting the number of alcohol licences and restricting the hours or days of sale. It also urges that countries control underage drinking by setting a minimum age requirement, usually 18, for the purchase and public consumption of alcohol. B15 notes that regulating the physical availability of alcohol is highly effective.
Marketing	B7 reviews the extensive evidence demonstrating that both the content and volume of commercial communications can increase the risk of drinking for young people, and the lack of evidence demonstrating any effectiveness in the alcohol industry's self-regulation of commercial communications. B8 recommends a focus on commercial communications.	B12 calls for action to: • restrict alcohol advertising to product information and, where a more comprehensive ban is not in force, limit such advertising to adult print media; • develop an advertising code, for areas where alcohol advertising is permitted, that forbids glorifying the effects of alcohol and using young people in alcohol advertisements; • develop a code of practice to prevent alcohol product promotion and advertising that might appeal particularly to children or young people; • prohibit the alcoholic beverage industry from

Table 2. Topical breakdown of background documents

Topic	Communication background materials	Framework background materials
		sponsoring young people's leisure activities; • place restrictions on sponsorship of sports by the alcoholic beverage industry; and • provide for strict regulation of events designed to promote alcohol consumption, such as alcohol festivals and beer-drinking competitions.
Price	B4 calls for enforcement of national legislation on the selling and serving of alcoholic beverages. B7 reviews the extensive evidence that demonstrates the effectiveness of price increases in reducing alcohol-related harm, including harm among younger and heavier drinkers. B8 recommends that alcohol policy focus on prices.	B12 calls for action to: • develop a taxation policy that ensures a high net price for alcohol, tax rates based on alcohol volume, and lower prices for non-alcoholic beverages; and • use alcohol taxes to fund alcohol control activities, including health education, research into alcohol policy, and support for local and national health services. B15 notes that alcohol taxes are highly effective.
Drinking environments	B4 calls for enforcement of national legislation on the selling and serving of alcoholic beverages. B7 reviews evidence demonstrating the limited effectiveness of interventions based in drinking environments unless backed up by enforcement.	B15 notes that research on the effects of altering the drinking context is relatively sparse but suggests it is likely that such strategies would have some impact.
Illegally and informally produced alcohol	B7 notes that information on the size of the illegally and informally produced alcohol market is limited and rather outdated.	B12 calls for the establishment of instruments such as duty stamps on alcohol products to combat alcohol smuggling and ensure the implementation of effective price policies and the collection of all taxes.
Implementation	B4 invites the European Commission to provide continuing strong support for EU Member State efforts to sustain, strengthen and develop national policies to reduce alcohol-related harm. It also calls upon the Member States to:	B12 calls for action to: • develop a country programme containing an alcohol action plan with clear targets;

Table 2. Topical breakdown of background documents

Topic	Communication background materials	Framework background materials
	• foster a multisectoral approach towards preventing alcohol-related harm to ensure the contribution of all areas of government; and • strengthen or develop coordinated national strategies and action plans to reduce alcohol-related harm, providing support for action at all national levels and for measures tailored to domestic circumstances, and including provisions for effective enforcement. B7 stresses the importance of action plans with clear objectives, strategies and targets, and of well-funded infrastructure to support implementation of policy. B8 recommends the implementation of a comprehensive strategy with application of a wide variety of policy tools (including legislation, self-regulation, information and education campaigns, the exchange of best practices, and stakeholder involvement) across all relevant EU policy domains, including the internal market, taxation, transport, education, research and consumer policy.	• establish a body to coordinate the country programme, and provide adequate funding for such coordination, with a specific timetable to ensure implementation and monitoring of national action plans; • provide education and training in alcohol policy to professionals in sectors such as education, social welfare and jurisprudence in order to ensure an effective multisectoral approach; • support programmes that strengthen community mobilization, development and leadership for the prevention of alcohol-related problems; • establish at least one coordinated, sustainable community demonstration project for the prevention of alcohol-related problems; and • ensure that a municipal alcohol policy is developed and implemented in every city participating in the WHO Healthy Cities project.
Monitoring and evaluation, including research	B4 invites the Commission to: • use health impact assessments for EU actions with an evident health dimension; • develop measurable core indicators so that progress on the reduction of alcohol-related harm at the EU level can be monitored, especially for priority action areas; and • report regularly, starting in 2008, on the progress and impact of Commission and Member State activities in implementing the EU alcohol strategy. B4 also calls upon Member States to collect relevant and comparable information on alcohol consumption and alcohol-related harm. B7 stresses the need for effective research and information	B12 calls for the establishment of an effective framework to monitor and evaluate alcohol consumption, and to track indicators of the harm caused by alcohol and of the effectiveness of alcohol control efforts. It notes that such a framework may require the development of appropriate research tools. B15 notes that the responsibility for translating scientific research into effective policy is borne by a wide variety of government agencies and public interest groups. If the public's health is to be served, it will be necessary to strengthen the links between science and policy with an innovative strategy that identifies, synthesizes and effectively communicates promising research findings to policy-makers and the

Table 2. Topical breakdown of background documents

Topic	Communication background materials	Framework background materials
	infrastructure and for regular reporting on alcohol consumption, alcohol-related harm and policy responses.	general public.
International issues	B4 invites the Commission to consider and coherently apply Treaty of European Union provisions concerning the protection of public health and the EU internal market to the strategy to reduce alcohol-related harm. It calls on Member States to provide their full support for the strategy set out by the Commission and to facilitate its national and EU implementation. B7 recommends that health policy-makers and advisers monitor the risks inherent in the process of trade liberalization and ensure that health concerns are recognized in European and global trade negotiations. They also need to make sure that analytical and feasibility studies are undertaken to determine when collective action on alcohol policy is more appropriate to undertake at the European or global level, and how the comity of nations can be strengthened with respect to alcohol policy.	—

Table 3. Strategic directions in the Communication and the framework

	Communication (European Commission, 2006a)	**Framework** **(**WHO Regional Office for Europe, 2006)
Purpose	To address the adverse health effects related to harmful or hazardous alcohol consumption, as well as related social and economic consequences. ["Introduction", p. 4]	To link the ways, means and ends of an effective alcohol policy. ["Goals and objectives of framework", p. 3]
Specific objectives	1. To protect young people, children and foetuses; 2. to reduce injury and death from alcohol-related road accidents; 3. to prevent alcohol-related harm among adults and reduce alcohol's negative impact on the workplace; 4. to inform, educate and raise awareness about the impact of harmful and hazardous alcohol consumption, and about appropriate consumption patterns; and 5. to develop and maintain a common EU evidence base. ["Case for action", p. 7]	1. To provide a broad vision for the development of alcohol policy in the European Region and demonstrate an understanding for the need to prevent and reduce alcohol-related harm; 2. to formulate guiding principles and policy goals, and to provide clarity with respect to objectives, roles and responsibilities; 3. to reaffirm, create continuity with and develop a common platform for existing instruments: the European Charter on Alcohol, the European Alcohol Action Plan and the Declaration on Young People and Alcohol, the principal documents for alcohol policy development in the Region; 4. to facilitate consolidation and synergetic interaction with other international, national and local public health initiatives; and 5. to provide a rationale and guidance for the continuing process of reviewing and realigning policies and programmes at the local, national and international level. ["Goals and objectives of framework", p. 3]
Strategic outcome	To prevent and reduce the occurrence of heavy and extreme drinking, underage drinking and their most harmful consequences, such as alcohol-related road accidents and foetal alcohol syndrome. ["Introduction", p. 4]	To respond to the magnitude of the problem and to put new knowledge on effective strategy into practice. ["Need for a framework in the Region", p. 2]

Table 3. Strategic directions in the Communication and the framework

	Communication (European Commission, 2006a)	**Framework** **(**WHO Regional Office for Europe, 2006)
Strategic methods	Mapping actions that the Commission and EU Member States have already put in place, identifying good practices that have led to positive results and identifying areas of socioeconomic importance and EU relevance where further progress can be made. ["Introduction", p. 4]	Facilitating the development and implementation of global, regional, national and local community policies and actions to prevent and reduce the harm caused by alcohol. ["Need for a framework in the Region", p. 2]
Guiding principles	Some problems are shared by all EU Member States (e.g. underage drinking and alcohol-related road accidents), but the policies that have been used to tackle them have not been fully successful, since the problems remain and in certain cases have gotten worse. Some issues are of EU relevance due to a cross-border element. An EU approach underpinning a coordinated strategy to reduce alcohol-related harm can use commitments from the Commission to further pursue and develop actions, and can disseminate good practices that different Member States have implemented. EU action to reduce alcohol-related harm should support the implementation of other relevant policy objectives already agreed upon at the EU level, e.g. on road safety, health and safety at work and the Convention on the Rights of the Child. ["Case for action", pp. 5–6]	Each Member State of the European Region has not only the right but also the obligation to provide a high level of protection to its citizens from alcohol-related harm, particularly with regard to harm from others' drinking and harm to vulnerable groups such as children. The choice of alcohol policies and actions should be based on the best scientific evidence about their effectiveness and cost–effectiveness, and should be sensitive to cultural diversity. Where the science is uncertain, the precautionary principle should be applied. In the face of increasing levels of cross-border trade and price differences, regional and global solutions to the problem of reducing alcohol-related harm should be explored. While the diverse, multisectoral nature of alcohol problems requires dialogue with and appropriate involvement of a wide variety of governmental, private sector and civil society actors, public health approaches to alcohol problems need to be formulated by public health interests without any formal or informal veto from other actors. ["Guiding principles for the framework", p. 4]
Main policy tools	Highlighting what the Commission and EU Member States have already done, continuing existing actions by the Commission and presenting good practices implemented in Member States that can inspire similar actions and national synergies. ["Case for action", p. 7]	Establishing within each Member State of the Region a national alcohol strategy and an action plan at the national or other appropriate level, with the infrastructure and capacity required to implement effective and cost-effective measures; and monitoring and following up on this action plan. ["Core areas and instruments for national action", p. 12]

Table 3. Strategic directions in the Communication and the framework

	Communication (European Commission, 2006a)	**Framework** (WHO Regional Office for Europe, 2006)
Main actions of sponsoring body	1. To inform and raise awareness on major public health concerns at both the EU and the Member State level, and to cooperate with Member States in addressing them; 2. to initiate action at the EU level that relates to its field of competence, in particular through sectoral programs; and 3. to support and help coordinate national actions, in particular by identifying and disseminating good practice across the EU. ["Three levels of action", p. 12] Using the EU Platform for Action on Diet, Physical Activity and Health as a model, the Commission plans to set up by June 2007 an alcohol and health forum that will bring together experts from various stakeholder organizations and representatives from Member States and from other EU institutions and agencies. The overall objective of the forum will be to support, provide input to and monitor the implementation of the strategy outlined in the Communication. ["Coordination of actions at EU level", p. 16].	1. To review current research and policy implementation and to advise on future development needs; 2. to improve the surveillance and monitoring of alcohol-related problems in the European Region by systematically collecting, collating and analysing available data; by developing and improving the necessary indicators; and by disseminating relevant information in a timely fashion to Member States; 3. to ensure that the European Alcohol Information System (EAIS) becomes the main clearing house for timely, relevant, objective information about alcohol policy research, formulation and implementation in the Region; 4. to assist Member States in developing training systems, building national coalitions and improving the dissemination of effective and cost-effective interventions to prevent or reduce alcohol-related harm; and 5. to support advocacy, networking and policy development at the regional level. ["Key tools for international cooperation", pp. 17–19]

Table 4. Actions recommended in the Communication and the framework

Topic	Communication recommendations	Framework recommendations
Review of the problem status	Considerable information is given throughout the document. Much of the text draws on the *Alcohol in Europe* report. ["Case for action", pp. 6–7; "Five priority themes and relevant good practices", pp. 8–12]	Chapter 4 summarizes the problem, based on a report. ["The situation regarding alcohol in the Region", pp. 5-6]
Review of the response status	A review of the response tends to show that the policies that have been used to tackle the problems that all Member States share (e.g. underage drinking and alcohol-related road accidents) have not been fully successful, since the problems remain and in certain cases have gotten worse. ["Case for action", p. 5]	Chapter 5 describes international efforts extensively. ["Existing international alcohol policy initiatives", pp. 7–8]
Raising awareness: information and education	Interventions and educational programmes have been proven to increase the ability of young people, and their parents, to tackle alcohol problems and risky behaviour. Such interventions can target both risk and protective factors, with the aim of promoting effective behavioural change among children and adolescents, and can be carried out in schools and other appropriate settings. Active learning methods can be used to discourage adolescents from experimenting with harmful alcohol consumption. ["Subsidiarity: mapping of actions implemented by Member States", p. 15]	It is important to empower individuals to make significant lifestyle changes, but all choices are made and created in a cultural and situational context, and behaviour with respect to alcohol is no different. Appealing solely to the individual to drink responsibly lacks contextual meaning, disregards the fact that decisions often have to be made when the individual is already intoxicated and rarely yields a significant behavioural response. ["Key players and their role", p. 10]
	Broad, carefully implemented health and life-skills education programmes, beginning in early childhood and ideally continued throughout adolescence, can raise awareness and have an impact on risk behaviour. Such interventions should address on the one hand risk factors such as alcohol and periods of risk such as adolescence, and on the other hand protective factors, i.e. certain lifestyle and behaviour changes. Media campaigns – such as the EU-	Involvement in youth education or youth activities by the alcoholic beverage industry and associated businesses and organizations is subject to question, because its support, direct or indirect, may be an attempt to gain credibility with a youth audience. ["Key players and their role", p. 10]

Table 4. Actions recommended in the Communication and the framework

Topic	Communication recommendations	Framework recommendations
	funded Euro-Bob campaign aimed at preventing drink–driving – can be used to inform and raise awareness among citizens and support policy interventions. ["Inform, educate and raise awareness on the impact of harmful and hazardous alcohol consumption, and on appropriate consumption patterns: good practice", p. 11]	
	Broad community-based action, involving teachers, parents, stakeholders and young people and supported by media messages and life-skills training programmes, can help prevent alcohol-related harm and risky behaviour. ["Protect young people, children and the unborn child: good practice", p. 9]	Education and information should be combined with other measures in a comprehensive strategy. The education of minors is best implemented by state agencies and other independent educational organizations that have the necessary professional expertise and can focus their activities on a healthy young generation. While research on the long-term effectiveness of school-based information on behaviour has been disappointing, parental programmes appear more promising. These programmes, addressing risk and protective factors, underline the importance of parental support for children, as well as the need to set limits and the importance of delaying the onset of drinking. ["Core areas and instruments for national action", p. 13]
	The Commission should explore, in cooperation with EU Member States and business organizations, the possibility of developing specific informational and educational campaigns or similar initiatives to tackle alcohol-related harm in the workplace. ["Action by the European Commission", p. 13]	Governments have differed on the advisability of low-risk drinking guidelines for the general population. Research has shown that they can be difficult to interpret and may be perceived as a "safe" baseline from which to range upward in setting personal limits. Specific drinking guidelines for the entire Region are not advisable, and WHO continues to promote the message that "less is better". ["Core areas and instruments for national action", p. 15]
	The Commission should explore, in cooperation with EU Member States and other stakeholders, the usefulness of developing efficient common approaches throughout the EU to provide warning labels with adequate consumer information. ["Action by the European Commission", p. 13]	

Table 4. Actions recommended in the Communication and the framework

Topic	Communication recommendations	Framework recommendations
	The Commission should support Member States and other stakeholders in their efforts to develop informational and educational programmes addressing responsible patterns of consumption and the effects of harmful drinking. ["Action by the European Commission", p. 13]	
Raising awareness: political commitment	Educational and informational activities and campaigns promoting moderate consumption, or addressing topics such as drink–driving, alcohol during pregnancy and underage drinking, can be used to mobilize public support for interventions. ["Prevent alcohol-related harm among adults and reduce the negative impact on the workplace: good practice", p. 11]	One possibility for raising awareness about the negative health and societal consequences of alcohol is to initiate a national focus day for preventing or reducing alcohol-related problems. In combination with longer term measures, such a focus day could be an important instrument in increasing knowledge of the magnitude of alcohol-related problems and thus stimulate support for effective alcohol policy options. ["Core areas and instruments for national action", p. 15]
		Effective public health advocacy must be evidence-based, ethical and credible. It must be able to package accurate, relevant and impartial information in ways that inform and ignite healthy personal and political action. Unfortunately, public health advocates often underutilize or ignore the possibilities of communication, particularly popular communication. ["Key tools for international cooperation", p. 19]
		There is also a clear need to disseminate understandable research results about effective and cost-effective measures to civil society actors to gain public support for alcohol policy interventions. ["Key players and their role", p. 10]

Table 4. Actions recommended in the Communication and the framework

Topic	Communication recommendations	Framework recommendations
Health sector response	The provision of advice and treatment by primary care doctors or nurses to adults at risk for alcohol-related harm appears to be effective in preventing it and reducing its negative impact on the workplace. Allocation of the necessary primary care resources is thus needed to provide such advice and treatment and to provide appropriate training for health care professionals. In addition, it is important to prioritize alcohol prevention in the workplace, provide counselling for children in families with alcohol problems and promote education and awareness-raising actions to protect fetuses. ["Prevent alcohol-related harm among adults and reduce the negative impact on the workplace: good practice", pp. 10–11; "Subsidiarity: mapping of action implemented by Member States", p. 15]	Health care professionals and public health facilities are crucial resources for providing health care services, including treatment and brief interventions, to problem drinkers and their families. In addition, they are natural allies in helping tackle alcohol-related harm, given their respected roles in society. A better understanding among health care professionals about the scope and extent of alcohol problems and about the effective policy responses needed would help to mobilize support for appropriate reform. ["Key players and their role", p. 10]
		Primary health care is an important part of local communities. The efficacy of screening and brief interventions for hazardous drinking is supported by a large body of international research literature. To implement such programmes, the health professions need to play an active role and obtain support from health authorities. For the care of severe alcohol-related disorders, specialist services are needed and should be linked to other professional and non-professional approaches. ["Core areas and instruments for national action", p. 13]
		In the absence of demonstrated safe limits, abstinence from alcohol during pregnancy is recommended and should be encouraged. ["Core areas and instruments for national action", p. 15]

Table 4. Actions recommended in the Communication and the framework

Topic	Communication recommendations	Framework recommendations
Community action	Broad community-based action, involving teachers, parents, stakeholders and young people themselves and supported by media messages and life-skills training programmes, can help prevent alcohol-related harm and risky behaviour. ["Protect young people, children and the unborn child: good practice", p. 9]	Local community involvement is crucial in preventing and reducing alcohol-related harm. To empower local communities to take effective action, local needs, interests, resources and abilities should all be addressed, as should the evidence for interventions. The active involvement of local decision-makers, including elected officials and senior administrators, is vital to improving public health. ["Key players and their role", p. 10]
	Explore, in cooperation with EU Member States and business organizations, the possibility of developing specific information and education campaigns or similar initiatives to tackle alcohol-related harm in the workplace. Pursue the exchange of specific best practices for workplace interventions, possibly in conjunction with other Commission-led initiatives such as those on corporate social responsibility. Support the involvement of relevant organizations competent in the field of workplace health, e.g. the European Agency for Safety and Health at Work, especially given the relevance of its initiatives like the Healthy Workplace Initiative, which aims to provide both employers and employees with easy access to information about how to improve their business environment by becoming healthier and more productive. ["Action by the European Commission", p. 13]	Many hazardous drinkers are employed and may thus be reached through workplace interventions. To achieve systematic activity in this field, it is necessary to adopt alcohol policies in the workplace. Such policies should set rules for alcohol consumption during and prior to working hours. They should also include guidelines for management of hazardous drinking and alcohol problems. Schools similarly need to adopt alcohol policies that acknowledge their responsibility for providing knowledge about alcohol, to improve the psychosocial climate in school and to provide health services that address alcohol drinking and other risky behaviours. ["Core areas and instruments for national action", p. 13]
		Most workplaces clearly depend on employees' exercise of judgement and skill. Many workers interact with the public, making alcohol-impaired employees a health hazard to others. This observation is particularly true for the transport sector, but many sectors place high demands on their employees. From a public health point of view, alcohol should not be a part of working life. ["Core areas and instruments for national action", p. 14]
		To successfully reduce alcohol-related harm, national alcohol action plans need to support local communities in developing and implementing effective measures. Local communities need to adopt

Table 4. Actions recommended in the Communication and the framework

Topic	Communication recommendations	Framework recommendations
		policies that set targets, identify responsible agencies and establish accountability, and adequately involve NGOs. As serious public health threats, alcohol-related problems should be properly addressed in the health care system. Several community sectors should be empowered and coordinated to enhance the effectiveness of action to reduce alcohol-related problems. Advocacy is also needed to raise public awareness of the extent of alcohol-related harm in the community and to gain public acceptance for effective policy measures. ["Core areas and instruments for national action", p. 12].
Drink–driving	An enforced maximum BAC limit of 0.5 g/l or less is desirable for drivers, with zero BAC levels for novice drivers, public transport drivers and commercial vehicle drivers. ["Reduce injuries and deaths from alcohol-related road traffic accidents: good practice", p. 10]	Alcohol impairs psychomotor performance, as well as judgement. There is no safe lower limit; driving skills are affected at even very low levels of consumption. Research around the world has demonstrated large reductions in traffic crashes and fatalities when legal blood-alcohol levels have been reduced. The effectiveness of legislation on blood-alcohol levels depends to a large extent on active enforcement, in particular on random breath testing. ["Core areas and instruments for national action", p. 14]
	Effective national policies require the introduction and enforcement of frequent, systematic random breath testing, supported by education and awareness campaigns that involve all stakeholders. ["Reduce injuries and deaths from alcohol-related road traffic accidents: good practice", p. 10]	Drink–driving accidents, violence and public disturbances are common alcohol-related occurrences in many local communities, requiring community agencies to respond. Local regulation and enforcement can effectively reduce rates of such alcohol-related problems. Although legal BAC levels for drivers are usually decided at the national level, enforcement is to a large extent a local responsibility, and it is important that police authorities prioritize it. ["Core areas and instruments for national action", p. 13]

Table 4. Actions recommended in the Communication and the framework

Topic	Communication recommendations	Framework recommendations
	The Commission recommends that countries develop a framework to enable unrestricted random breath testing for all drivers, enforcement of drink–driving countermeasures and application of dissuasive sanctions for anyone found driving over the BAC limit, particularly repeat offenders. ["Subsidiarity: mapping of action implemented by Member States", p. 15]	
	In order to better coordinate activities to reduce alcohol-related road accidents and combat drink–driving, the Commission will improve coordination between drink–driving and road safety efforts, including those supported by its Public Health Programme and the Action Plan on Road Safety. These efforts will particularly address the issue of novice and young drivers. ["Coordination of actions at EU level", p. 16]	
Availability	The Commission urges enforcement of restrictions on alcohol sales and availability. ["Protect young people, children and the unborn child: good practice", p. 9]	Controls on the supply and availability of alcohol have proved to be among the most effective and cost-effective approaches to limiting the harm done by alcohol. ["Recent and re-emerging challenges", p. 9]
	The Commission urges countries to enforce alcohol licensing laws. ["Prevent alcohol-related harm among adults and reduce the negative impact on the workplace: good practice", p. 10]	A strong case can be made for restricting the availability of alcohol by limiting the number of outlets permitted to sell it and by limiting the hours of sale. ["Core areas and instruments for national action", p. 12]
	The Commission encourages countries to enforce age limits for selling and serving alcohol, and to re-examine minimum	Availability plays a particularly important role in limiting youth drinking, where the enforcement of age
	age requirements for selling and serving alcoholic beverages, particularly where the minimum age is below 18 years. ["Subsidiarity: mapping of action implemented by Member States", pp. 14–15]	limits on alcohol sales has proven to be an effective tool in reducing drinking. Sometimes underage access to alcohol is social rather than commercial, however, with youth obtaining alcohol from parents or older friends, a situation that calls for the broader community to address it. ["Core areas and instruments for national action", p. 13]

Table 4. Actions recommended in the Communication and the framework

Topic	Communication recommendations	Framework recommendations
	The Commission encourages countries to introduce and enforce rules against serving alcohol to intoxicated people. ["Subsidiarity: mapping of action implemented by Member States", p. 15]	
Marketing	Suggested policy actions include enforcing restrictions on alcohol marketing, and exchanges of good practice on how to address irresponsible marketing and the image of excessive alcohol use conveyed by the media and by role models. ["Protect young people, children and the unborn child: good practice", p. 9; "Action by the European Commission", p. 13]	Pressures on young people to drink have increased, while at the same time protective factors have somewhat declined in force. Extensive marketing has strongly linked sports and leisure environments, which form a central part of young people's social space, to drinking, resulting in unintentional injuries and violence. Establishing youth sport and leisure environments that are free from alcohol and alcohol marketing can help reduce the pressure on young people to drink, and provide them with a safer social environment. ["Core areas and instruments for national action", p. 14]
	The Commission services will work with stakeholders to create sustained momentum for cooperating on responsible commercial communication and sales, including presentation of a model of responsible alcohol consumption. The main aim will be to support EU, national and local government actions that prevent irresponsible marketing of alcoholic beverages, and to regularly examine advertising trends and areas of concern. One aim of this joint effort will be to reach an agreement with representatives from a range of industries (hospitality, retail, production, media and advertising) on a code of commercial communication at both the national and the EU level. Benchmarks could be agreed upon for national codes and strategies. As part of this approach, industry compliance with self-regulatory codes and the impact of such codes on young people's drinking will be monitored. Independent parties will be invited to verify the performance and outcomes of self-regulatory codes with respect to the benchmarks agreed upon, thus allowing socially responsible organizations to adjust their objectives accordingly. ["Coordination of actions at EU level", p. 16]	

Table 4. Actions recommended in the Communication and the framework

Topic	Communication recommendations	Framework recommendations
Price	Some EU Member States have increased taxes on products which they perceive to be particularly attractive to underage drinkers. ["Protect young people, children and the unborn child: rationale for action", p. 8]	A strong case can be made for restricting availability through an effective taxation policy. ["Core areas and instruments for national action", p. 12]
	Pricing policy is another area of good practice (e.g. reducing "two drinks for the price of one" offers). ["Prevent alcohol-related harm among adults and reduce the negative impact on the workplace: good practice", p. 10]	
Drinking environments	Effective interventions include server training, coordination of public transport and closing times, the introduction and enforcement of rules against serving alcohol to intoxicated people, as well as effective licensing systems for the sale and responsible serving of alcoholic products in accordance with their particular context and national laws. ["Prevent alcohol-related harm among adults and reduce the negative impact on the workplace: good practice", p. 10; "Subsidiarity: mapping of action implemented by Member States", p. 15]	Programmes for responsible beverage service can also effectively reduce problems, if they are combined with active enforcement by police and licensing authorities. ["Core areas and instruments for national action", p. 13]
Illegally and informally produced alcohol	—	Better means of measuring unrecorded alcohol consumption, including flows between countries, should be developed and implemented on a regular basis. ["Key tools for international cooperation", p. 17]
Implementation	Using the EU Platform for Action on Diet, Physical Activity and Health as a model, the Commission will set up an alcohol and health forum by June 2007 that will bring together experts from different stakeholder organizations and representatives from Member States and from other EU bodies. The overall objective of this forum will be to support, provide input to and monitor the implementation of the strategy outlined in the Communication. ["Coordination of actions at EU level", p. 16]	The participation of family, peers and civil-society groups (including self-help movements and advocacy groups) is essential in preventing, treating and reducing alcohol-related problems. Civil-society groups (NGOs) can play an essential advocacy role in ensuring that the Member States of the European Region develop and implement effective alcohol policies. They also provide vital checks and balances by highlighting how the practices and policies of vested interests can act as barriers to efforts to reduce alcohol-related problems in society.

Table 4. Actions recommended in the Communication and the framework

Topic	Communication recommendations	Framework recommendations
		["Key players and their role", p. 10]
		While alcohol policy initiatives can be carried out at various levels, the need for coordinated, strategic national efforts is clear. It is important to establish a national alcohol strategy and a national action plan in every Member State. In addition, there must be in place the infrastructure and capacity required to implement effective and cost-effective measures and to monitor and follow up on the action plan. Member States are called upon to develop or review their national strategies and action plans, taking into consideration the framework goal and objectives. ["Core areas and instruments for national action", p. 12]
		The 10 areas for action and their identified outcomes in the European Alcohol Action Plan (WHO Regional Office for Europe, 2000) continue to be of central importance for the implementation of national alcohol policies and should be seen as an integral part of the framework. These areas are information and education; public, private and working environments; drink–driving; availability of alcohol products; promotion of alcohol products; treatment; responsibilities of the alcoholic beverage industry and hospitality sector; society's capacity to respond to alcohol-related harm; NGOs; and policy formulation, implementation and monitoring. ["Core areas and instruments for national action", p. 12]
Monitoring and evaluation, including research	The Commission has identified the need to create a system for flexible but standardized definitions of alcohol data; to conduct repeated and comparative surveys on alcohol consumption, making particular use of the European Health Interview Survey and complementary surveys; to develop health indicators to monitor and assess changes; to research the costs and benefits of various policy options; to assess differences in drinking patterns by country, age and gender; and to fill research gaps on alcohol-related health and social harm, on the causes of harmful alcohol consumption and on its role in widening the health gaps between socioeconomic groups. The Commission also calls for further studies to evaluate the effectiveness of the actions and interventions	Policies to prevent or reduce alcohol-related harm should be evidence-based. This requirement imposes strict demands on the research community's independence from commercial interests and other vested interests. In addition to the ethical obligations of scientific inquiry, researchers also have a public responsibility to bring the findings that emerge from the research literature on alcohol and public health into public discussion and policy debate. ["Key players and their role", p. 10]

Table 4. Actions recommended in the Communication and the framework

Topic	Communication recommendations	Framework recommendations
	proposed in this Communication. ["Develop, support and maintain a common evidence base: what is needed", p. 12; "Action by the European Commission", pp. 12–13]	
	Based on information from EU Member States, the Commission will report on the implementation of Communication measures to tackle harmful and hazardous alcohol consumption and on the impact of the EU strategy the Communication sets out. ["Action by the European Commission", pp. 13–14]	The Regional Office will continue to improve the surveillance and monitoring of alcohol-related problems in the Region by systematically collecting, collating and analysing available data; by developing and improving the necessary indicators; and by disseminating relevant information in a timely fashion to Member States. ["Key tools for international cooperation", p. 18]
	Through the proposed Seventh Framework Programme (2007–2013), the Commission will support research on young people's drinking habits (trends and determinants); on the links between harmful alcohol consumption and drinking patterns and other health, social and economic harm; and on other factors relating to alcohol's impact on society. ["Action by the European Commission", pp. 12–13]	The literature on the impact of alcohol policy interventions requires further development, including studies conducted in a wider variety of societies and improved capacity for integrated health impact assessments. ["Key tools for international cooperation", p. 17]
	Some EU countries have established publicly funded alcohol research and monitoring programmes. ["Subsidiarity: mapping of action implemented by Member States", p. 15]	In future studies, attention should be paid to the differential costs of implementing new measures, in order to provide a basis for cost–effectiveness studies. ["Key tools for international cooperation", p. 17]
		There is an urgent need to harmonize measurements of alcohol consumption and related risk, to implement a common alcohol monitoring system and to measure the social problems that drinking creates for others beside the drinker. Such measurements will improve estimations of the social costs of alcohol consumption. ["Key tools for international cooperation", p. 18]
		The European Alcohol Information System (EAIS), established in 2002, is a web-based portal that collects, analyses and disseminates information on alcohol policy formulation and implementation in the European Region (WHO Regional Office for

Table 4. Actions recommended in the Communication and the framework

Topic	Communication recommendations	Framework recommendations
		Europe, 2009b). It is a key instrument for monitoring implementation of the framework nationally and regionally. EAIS needs to expand to include a systematic regional overview of alcohol legislation and marketing practices. It should become the Region's main clearing house for timely, relevant, objective information about alcohol policy research, formulation and implementation. ["Key tools for international cooperation", p. 18]
		A progress report on the framework should be produced every third year. The report should not only assess the framework's implementation and success, but also alert Member States to emerging public health challenges and threats and identify any need to adjust the framework. This progress report should be produced in close collaboration with the network of national alcohol policy counterparts and relevant collaborating centres. ["The follow-up process", p. 20]
		The Regional Office should organize a special high-level forum on alcohol every third year. The purpose of such a forum would be to discuss the outcomes and recommendations of the progress report and to deliberate critical or challenging alcohol policy issues, focusing particularly on issues with cross-border implications and other issues that a single Member State would find difficult to address alone. ["The follow-up process", p. 20]
International issues	National and EU studies show that where there is a cross-border factor, better EU coordination may be needed. Examples include cross-border sales promotion of alcohol that appeals to young drinkers, and cross-border TV advertising of alcoholic beverages that conflicts with national restrictions. However, the Commission will not use the Communication to propose harmonized legislation for the prevention of alcohol-related harm. ["Mandate for action", p. 5; "Introduction", p. 4]	Within the EU, very large travellers' allowances for personal use of alcohol have restricted the ability of some national governments to control sales to residents and have forced down alcohol tax rates. ["Recent and re-emerging challenges", p. 9]

Table 4. Actions recommended in the Communication and the framework

Topic	Communication recommendations	Framework recommendations
	Explore, in cooperation with Member States and stakeholders, the usefulness of developing efficient common approaches throughout the EU to provide adequate consumer information on warning labels. ["Action by the European Commission", p. 13]	The alcoholic beverage industry's extensive regional marketing strategies, many of which appeal to young people, demonstrate the transnational nature of modern marketing. ["Recent and re-emerging challenges", p. 9]
	To better coordinate activities to reduce alcohol-related road accidents, and with a particular view to combating drink–driving, the Commission will improve coordination between drink–driving and road safety actions, including those supported by its Public Health Programme and the Action Plan on Road Safety. These efforts will particularly address the issue of novice and young drivers. ["Coordination of actions at EU level", p. 16]	The growth of trade agreements and common markets, and more generally the process of globalization, has substantially weakened governments' ability to use some of their most effective tools to prevent and reduce alcohol-related problems in their own cultures. ["Recent and re-emerging challenges", p. 9]
	The Commission will work with stakeholders to build support for cooperating on responsible commercial communication and sales, including presentation of a model for responsible alcohol consumption. The Commission's main goals will be to support EU, national and local government efforts to prevent irresponsible marketing of alcoholic beverages, and to regularly examine trends in alcohol advertising and related areas. One aim of this joint effort will be to reach an agreement with representatives from a range of sectors (hospitality, retail, production, media and advertising) on a code of commercial communication to implement at the national and EU levels. Benchmarks for national codes and strategies may be adopted. As part of this approach, the impact of self-regulatory codes on young people's drinking and industry compliance with such codes will also be monitored. Independent parties will be invited to verify the performance and outcomes of self-regulatory codes against the benchmarks, thus allowing socially responsible organizations to adjust their objectives accordingly. ["Coordination of actions at EU level", p. 16]	

Table 5. List of implementation materials

Source	Description
Commission materials relevant to the implementation of the Communication *(I-1 through I-8)*	
I-1. European Alcohol and Health Forum (2009a). European Alcohol and Health Forum [web page]. Luxembourg, European Communities (ec.europa.eu/health/ph_determinants/life_style/alcohol/Forum/alcohol_forum_en.htm).	The overall objective of the Forum is to provide a common platform at the EU level for all interested stakeholders who pledge to step up activity to reduce alcohol-related harm, notably in the following areas: strategies aimed at curbing underage drinking; informational and educational programmes on the effects of harmful drinking and on responsible consumption patterns; development of common, efficient EU-wide efforts to provide consumers with adequate information on alcohol products; better enforcement of age limits for selling and serving alcohol; interventions promoting effective behavioural change among children and adolescents; and coordinated promotion of responsible commercial communication and sales.
I-2. European Alcohol and Health Forum (2009b). Task Force Marketing Communication [web page section]. Luxembourg, European Communities (ec.europa.eu/health/ph_determinants/life_style/alcohol/Forum/alcohol_forum_en.htm).	The main objectives of the Forum's marketing task force are to examine best practices that promote responsible marketing and prevent irresponsible marketing; to examine and build upon the DG SANCO report on the Advertising Round Table; to examine trends in alcohol product development, product placement, promotions, advertising, sponsorship and other forms of marketing; and to make appropriate recommendations to the Forum.
I-3. European Alcohol and Health Forum (2009c). Task Force on Youth-Specific Aspects of Alcohol [web page section]. Luxembourg, European Communities (ec.europa.eu/health/ph_determinants/life_style/alcohol/Forum/alcohol_forum_en.htm#taskforce).	The Forum's youth task force focuses on identifying actions which have a potential to curb underage drinking, curb drink–driving by young people, promote responsible selling and serving of alcohol to young people and protect young people from the consequences of others' misuse of alcohol.
I-4. Science Group of the European Alcohol and Health Forum (2009b). Science Group of the European Alcohol and Health Forum [web page]. Luxembourg, European Communities (ec.europa.eu/health/ph_determinants/life_style/alcohol/Forum/alcohol_science_group_en.htm).	The Science Group is tasked with providing scientific guidance to other members of the Forum; offering guidance on monitoring and evaluation; using monitoring output to identify the areas of action where Forum members may be able to reduce alcohol-related harm, and the forms such action should take; and providing in-depth analyses of key issues identified by the Forum.

Table 5. List of implementation materials

Source	Description
I-5. Committee on National Policy and Action on Alcohol (2009). Committee on National Policy and Action on Alcohol [web page]. Luxembourg, European Communities (ec.europa.eu/health/ph_determinants/life_style/alcohol/alcohol_policyaction_en.htm). The Committee has also produced an overview of the various EU Member State policies to reduce alcohol-related harm (ec.europa.eu/health/ph_determinants/life_style/alcohol/overviewms_alcohol_en.htm).	The main objective of this Committee is to help coordinate national and local government policies to reduce alcohol-related harm, building upon inter alia the examples of good practice identified in the Communication. To further this objective, Committee members will be able to report regularly on alcohol policy developments in their home countries and present national alcohol policy action plans and strategies. These reports will be followed by discussions in order to clarify the positions of other EU Member States vis-à-vis these developments and strategies, with the goal of developing coordinated policy approaches. The Committee will also organize in-depth discussions of topical or controversial issues in order to clarify the direction that Member States are moving on such issues, again with the objective of achieving the broadest possible consensus and convergence of policy within the EU.
I-6. Committee on Data Collection, Indicators and Definitions (2008). *1st meeting: Luxembourg, 4 December 2008: summary report.* Luxembourg, European Communities (ec.europa.eu/health/ph_determinants/life_style/alcohol/alcohol_data_en.htm).	The report describes the Committee meeting to outline and discuss the collection of alcohol data, indicators and definitions, with special emphasis on comparability of data at the EU level, and to discuss the way forward.
I-7. Rabinovich L et al. (2009). *The affordability of alcoholic beverages in the European Union: understanding the link between alcohol affordability, consumption and harms.* Cambridge, United Kingdom, RAND Corporation (www.rand.org/pubs/technical_reports/TR689).	This report examines the relationship between the affordability of alcohol and alcohol consumption in the EU, and the relationship between consumption and harm. It also describes the possible impact of cross-border trade on alcohol consumption and related harm in recipient countries.
I-8. Science Group of the European Alcohol and Health Forum (2009a). *Does marketing communication impact on the volume and patterns of consumption of alcoholic beverages, especially by young people? A review of longitudinal studies.* Luxembourg, European Communities (ec.europa.eu/health/ph_determinants/life_style/alcohol/Forum/docs/science_o01_en.pdf).	This report presents the opinion of the Science Group (see I-4 above) about the impact of marketing communication on young people's drinking.

Table 5. List of implementation materials

Source	Description
Communication implementation documents from other areas of Commission activity *(I-9 through I-12)*	
I-9. [Taxation] European Commission (2008a). Proposal for a Council directive concerning the general arrangements for excise duty (presented by the Commission): Brussels, 14.2.2008: COM(2008) 78 final/3: 2008/0051 (CNS). Luxembourg, European Communities (eur-lex.europa.eu/LexUriServ/LexUriServ.do?uri=COM:2008:0078:FIN:EN:PDF).	According to Article 30 of the proposed directive, taxation in the EU Member State of acquisition shall also apply to excise goods dispatched by one private individual to another without any payment, direct or indirect.
I-10. [Agriculture] European Council (2008). Council regulation (EC) No 479/2008 of 29 April 2008 on the common organisation of the market in wine, amending regulations (EC) No 1493/1999, (EC) No 1782/2003, (EC) No 1290/2005, (EC) No 3/2008 and repealing Regulations (EEC) No 2392/86 and(EC) No 1493/1999. *Official Journal of the European Union*, 51(L 148) (eur-lex.europa.eu/LexUriServ/LexUriServ.do?uri=OJ:L:2008:148:0001:0061:EN:PDF).	This regulation addresses the phasing-out of distillation schemes, and lowering the permitted amounts of sugar and grape must used in making wine (which increase alcohol content), except for particularly unfavourable climatic conditions.
I-11. [Audiovisual and media] European Parliament & European Council (2007b). Directive 2007/65/EC of the European Parliament and of the Council of 11 December 2007 amending Council Directive 89/552/EEC on the coordination of certain provisions laid down by law, regulation or administrative action in Member States concerning the pursuit of television broadcasting activities (text with EEA relevance). *Official Journal of the European Communities*, 50(L 332):27–45 (eur-lex.europa.eu/LexUriServ/LexUriServ.do?uri=OJ:L:2007:332:0027:0045:EN:PDF).	Article 3e 1 (e) of this directive specifies that audiovisual commercial communications for alcoholic beverages shall not be aimed specifically at minors and shall not encourage immoderate consumption of such beverages.

Table 5. List of implementation materials

Source	Description
I-12. [Consumers] European Commission (2008b). *Proposal for a regulation of the European Parliament and of the Council on the provision of food information to consumers: Brussels, 30.1.2008: COM(2008) 40 final, 2008/0028 (COD).* Luxembourg, European Communities (eur-lex.europa.eu/LexUriServ/LexUriServ.do?uri=COM:2008:0040:FIN:EN:PDF).	The proposed regulation would require that beverages containing more than 1.2% alcohol by volume would have to list their actual alcoholic strength by volume. Member States would, pending the adoption of the EU provisions referred to in Article 20(e) of the regulation, be able to maintain national rules concerning the listing of ingredients for such beverages (e.g. they can choose to *not* require a list of ingredients).
Documents from WHO headquarters that inform implementation of the framework *(I-13 through I-16)*	
I-13. WHO (2008a). *Resolution WHA61.4: strategies to reduce the harmful use of alcohol.* Adopted 24 May 2008. Geneva, WHO (who.int/gb/ebwha/pdf_files/A61/A61_R4-en.pdf).	In this resolution, the Sixty-first World Health Assembly calls for the development of a global strategy to reduce the harmful use of alcohol, with a draft to be presented to the Sixty-third Assembly in 2010.
I-14. WHO (2008b). *Strategies to reduce the harmful use of alcohol: report by the Secretariat.* Geneva, WHO (Sixty-first World Health Assembly Provisional Agenda Item A61/13; who.int/gb/ebwha/pdf_files/A61/A61_13-en.pdf).	This report by the WHO Secretariat proposes nine target areas for alcohol policy: education and information, health sector response, community action, drink–driving policies, alcohol availability, the marketing of alcoholic beverages, pricing policies, harm reduction and reducing the public health impact of illegally and informally produced alcohol.
I-15. WHO Expert Committee on Problems Related to Alcohol Consumption (2007). *WHO Expert Committee on Problems Related to Alcohol Consumption: second report.* Geneva, WHO (WHO Technical Report Series 944; who.int/substance_abuse/expert_committee_alcohol).	This report provides an expert overview of problems related to alcohol consumption and policy approaches to reduce them.
I-16. WHO (2007). Global Information System on Alcohol and Health (GISAH) [online database]. Geneva, WHO (who.int/globalatlas).	This system, based on the Global Survey on Alcohol and Health, will be updated by the end of 2009.

Table 6. Topical breakdown of implementation materials

Topic	Communication implementation materials	Framework implementation materials
Review of the problem status	See "Monitoring and evaluation" in Table 8 below and its reference to the updating of the EAIS.	I-15 recommends reviewing the nature and extent of the problems that the harmful use of alcohol causes to populations; the resources and infrastructure available for reducing the incidence, prevalence and impact of these problems; and possible constraints on establishing new policies and programmes. I-16 provides extensive country-based information on alcohol consumption and alcohol-related harm.
Review of the response status	I-5 provides an overview for each EU Member State on current policy approaches to the first four themes in the Communication: protecting young people, children and foetuses; reducing injury and death from alcohol-related road accidents; preventing alcohol-related harm among adults and reducing alcohol's negative impact on the workplace; and informing, educating and raising awareness about the impact of harmful and hazardous alcohol consumption, and about appropriate consumption patterns. See also "Monitoring and evaluation" in Table 8 and its reference to the updating of the EAIS.	I-16 provides extensive country-based information on alcohol policies and programmes to reduce alcohol consumption and alcohol-related harm.
Raising awareness: information and education	I-1 lists 108 commitments that the European Alcohol and Health Forum has received from economic actors and NGOs to reduce alcohol-related harm. Economic operators have proposed about three quarters of these commitments, including one quarter that are for educational programmes.	I-15 recommends raising awareness and building support for effective alcohol policies. It stresses however that many commonly used approaches to educate people about alcohol and persuade them to change their behaviour, for example school education programmes, mass media campaigns and warning labels, show little evidence of effectiveness in reducing alcohol-related harm and therefore should not be implemented in isolation as alcohol policies.

Table 6. Topical breakdown of implementation materials

Topic	Communication implementation materials	Framework implementation materials
	I-3 proposes the establishment of a clearing house that would enable the collection and sharing of information on alcohol and health activities that target youth. I-12 requires beverages containing more than 1.2% alcohol by volume to list the actual alcoholic strength by volume, though it does not stipulate ingredient labelling.	
Raising awareness: political commitment	—	I-14 notes that the actions needed to reduce harmful use of alcohol call for sustained, determined efforts by all relevant partners. Written alcohol policies and strategies can facilitate and clarify the division of responsibilities among partners involved at different levels. An action plan with clear objectives, strategies and targets is required at the national level, and when appropriate, at subnational and municipal levels too. Regular reports on the harmful use of alcohol at international, national, regional and local levels need to be made broadly available to policy-makers, the general public and other stakeholders. Building a strong base of public awareness and support can also help secure the continuity and sustainability that effective alcohol policies require.
Health sector response	—	I-14 notes that health sector measures to prevent hazardous and harmful alcohol consumption, such as screening and brief interventions, have proven to be effective and cost-effective in reducing alcohol consumption and alcohol-related harm. Early identification and effective treatment in health-care settings of alcohol-use disorders, including cases with comorbid conditions, can reduce associated morbidity and mortality and improve the well-being of affected individuals and their families. Treatment is most effective when supported by sound policies and health systems and integrated into a broader preventive strategy. Health care providers should concentrate on client health improvement and satisfaction through the use of evidence-based, cost-effective interventions. Governments seeking to improve their health systems should consider services for alcohol-use disorders and interventions for hazardous and harmful use of alcohol. As the main providers of health care, the world's millions of health workers can

Table 6. Topical breakdown of implementation materials

Topic	Communication implementation materials	Framework implementation materials
		contribute substantially to reducing and preventing the harmful use of alcohol. I-15 recommends: • ensuring that everyone with an alcohol problem that requires treatment have access to non-stigmatized, confidential, evidence-based treatments and community services; • increasing investments in the widespread implementation of early identification and brief intervention programmes for hazardous and harmful alcohol use in a wide variety of settings, including primary care, social welfare offices, accident and emergency departments, workplaces and educational institutions; • expanding capacity by educating and training professionals in health care, social service and criminal justice settings to implement programmes for alcohol problem identification and intervention; and • paying greater attention in alcohol treatment policies to the organization, integration and delivery of treatment services at the local, municipal and national levels.
Community action	I-3 proposes the establishment of a clearing house that would enable the collection and sharing of information about projects addressing alcohol and youth health.	I-14 notes that community-based action, with the appropriate engagement of various stakeholders, can effectively reduce the harmful use of alcohol. Community action is particularly important in settings where unrecorded alcohol consumption is high, or where negative social consequences of alcohol use – such as public drunkenness, mistreatment of children or violence against sexual partners – are prevalent. Community efforts can increase community recognition of alcohol-related harm, make public drunkenness less acceptable, bolster other alcohol initiatives at the community level, enhance partnerships and networks among community groups and NGOs, provide care and support for affected individuals and their families and mobilize community members in opposing the sale and consumption of illicit and potentially contaminated alcohol.

Table 6. Topical breakdown of implementation materials

Topic	Communication implementation materials	Framework implementation materials
Drink–driving	—	I-14 notes that strategies aiming to reduce the harm associated with drink–driving can be broadly classified as follows: deterrence, or measures that seek to reduce the incidence of drink–driving directly; measures that aim to reduce the incidence of drink–driving indirectly by reducing alcohol consumption; and measures that create a safer driving environment in order to reduce the consequences and level of severity associated with impaired driving. A substantial body of research evidence exists that introducing a low BAC limit reduces the harm. Young drivers are at particular risk for death from alcohol-related traffic crashes, and many countries have lowered the limit for new and/or young drivers. The success of deterrent legislation in reducing the incidence of drink–driving depends largely on enforcement and the severity of the penalties. Consistent enforcement by police departments using random, targeted or selective breath-testing is essential and should be supported by sustained publicity and awareness campaigns. I-15 recommends implementing appropriate drink–driving policies based on strict enforcement of low BAC limits.
Availability	The Commission materials mention do not mention any specific actions. However, the chaptalization regulations described in I-10 may lead to EU wines with lower alcohol content.	I-14 notes that regulating the production and distribution of alcoholic beverages is an effective strategy for reducing the harmful use of alcohol, particularly by young people and other vulnerable groups. All countries have some restrictions on the sale of alcohol, addressing e.g. the age of consumers, the type of retail establishments that can sell alcoholic beverages, licensing requirements for serving establishments, the hours and days of sale and the geographic density of sales outlets. I-15 recommends regulating the availability of alcohol, including efforts to establish minimum ages for purchasing alcohol, restrict the hours of sale and limit the geographic density of sales outlets.
Marketing	I-1 lists 108 commitments that the European Alcohol and Health Forum has received from economic operators and NGOs to reduce alcohol-related harm. The economic operators have proposed about three quarters of these commitments, including one quarter that are for educational programmes.	I-14 notes that young people who have chosen to drink alcoholic beverages and who drink regularly are an important market segment for alcohol producers. It is very difficult to target young adult consumers without exposing cohorts of adolescents under the legal drinking age to the same marketing practices. Research has shown that controls or partial bans on volume, placement and content of alcohol advertising are important parts of an effective strategy to protect adolescents from the pressure to start

Table 6. Topical breakdown of implementation materials

Topic	Communication implementation materials	Framework implementation materials
	I-2 describes efforts to map various alcohol marketing policies in the EU, including regulation and self-regulation, industry procedures to ensure the non-targeting of minors, and social marketing activities. I-8 reviews studies on the impact of alcohol advertising, concluding that: Despite … methodological concerns and despite the fact that not all studies found an impact for all the individual marketing exposures studied, nevertheless, the overall description of the studies found consistent evidence to demonstrate an impact of alcohol advertising on the uptake of drinking among non-drinking young people, and increased consumption among their drinking peers. This finding is all the more striking, given that only a small part of a total marketing strategy has been studied, and is corroborated by the results of the other methodologies, including qualitative, econometric, cross-sectional and experimental studies. It should be stressed that the studies come from countries with a long history of advertising and with relatively high levels of alcohol consumption, and it is difficult to speculate [on] the size of the impact of marketing in cultures with either a short history of advertising or low alcohol consumption (Science Group, 2009a). I-12 proposes that audiovisual commercial communications promoting alcoholic beverages be prohibited from specifically targeting minors or encouraging immoderate consumption.	drinking. Marketing practices that appeal to children and adolescents are important policy concerns. I-15 recommends: • regulating the marketing of alcoholic beverages, including regulating or banning advertising and sponsorship of cultural and sports events, in particular those that appeal to younger people; • designating statutory agencies that will be responsible for monitoring and enforcing alcohol marketing regulations; and • working together globally to explore establishment of a mechanism to regulate the marketing of alcoholic beverages, including regulation or banning of advertising and sponsorship.

Table 6. Topical breakdown of implementation materials

Topic	Communication implementation materials	Framework implementation materials
Price	I-7 is a review of the impact of the affordability of alcohol on its consumption, commissioned by the European Alcohol and Health Forum from RAND Europe. The review found that alcohol has become more affordable across the EU since 1996, and that there is a positive relationship between alcohol affordability and alcohol consumption in the EU, such that a 1.00% increase in affordability leads to a long-term 0.32% increase in consumption. The review also analysed cross-border trade from France to the United Kingdom, from Estonia to Finland and from Denmark and Germany to Sweden. In each case there are significant differences in alcohol taxes and prices between the individual countries, and these differences, in combination with reduced restrictions on the importation of alcohol for personal use, have led to increases in cross-border alcohol consumption. There is evidence that the increased cross-border purchase of alcohol has led to an increase in consumption in the recipient countries, especially Finland and Sweden. There is also evidence of a relationship between the reduction of import controls for personal use and increases in alcohol-related harm in the countries examined, being strong in Finland, suggestive in Sweden and inconclusive in the United Kingdom. I-9 states that taxation in an EU Member State of acquisition shall also apply to excise goods dispatched by one private individual to another without any payment, direct or indirect.	I-14 notes that price is an important determinant of alcohol consumption and, in many contexts, of the extent of alcohol-related problems. Considerable evidence has accumulated to support the use of taxes to influence price. It is also worth keeping in mind that taxes are only one component of alcoholic beverage prices, and that tax changes are not always reflected in retail price changes. Moreover, vendors or manufacturers may attempt to encourage demand by price promotions. I-15 recommends reducing the demand for alcohol through taxation and pricing mechanisms.
Drinking environments	—	I-14 notes that directly focusing on reducing the negative consequences of drinking and alcohol intoxication can be an effective strategy in specific contexts. A range of interventions have been developed to reduce alcohol-related harm in and around licensed serving establishments. Interventions that focus on changing the night life environment can reduce the harmful consequences of drinking in and around these settings, without necessarily

Table 6. Topical breakdown of implementation materials

Topic	Communication implementation materials	Framework implementation materials
		altering overall consumption levels. The impact of these measures is greatly enhanced when there is active, continual enforcement of laws prohibiting sale of alcohol to intoxicated individuals and when the streets are regularly policed at night. The evidence base for such harm-reduction approaches, however, is not yet as well established as that for regulating alcohol availability and demand.
Illegally and informally produced alcohol	—	I-14 notes that illegally or informally produced alcoholic beverages can lead to additional negative health effects if they contain methanol or other contaminants, or if production and distribution of such beverages are less carefully controlled than legally produced and sold alcohol. Evidence for the effectiveness of measures to counteract the negative health consequences of consuming illegally produced alcohol is weak, but it suggests that community mobilization and the enforcement of relevant regulations may reduce such problems. The feasibility and effectiveness of these countermeasures will depend in part on the fact that those who buy informally produced alcohol often have very little purchasing power.
Implementation	—	I-14 recommends formulating, developing and implementing adequately financed alcohol action plans with clear objectives, strategies and targets; establishing (or reinforcing) mechanisms and focal points that coordinate the work of public health stakeholders; and implementing and evaluating evidence-based policies and programmes, using existing structures where feasible.
Monitoring and evaluation, including research	I-6 recommends three indicators, to measure: • volume of consumption (total recorded and unrecorded per capita consumption of pure alcohol in litres for adults (people older than 15), with subindicators for beer, wine, and spirits); • consumption pattern (intake of at least 60 grams alcohol on a single occasion at least once per month during the past 12 months); and • alcohol-related health harm (years of life lost	I-15 recommends that WHO establish a global information system on alcohol based on the current WHO Global Alcohol Database, with national counterparts, to: • bring together and analyse alcohol monitoring and surveillance information based on comparable data and common definitions; • integrate policies, laws and regulations, as well as data on the effectiveness of policies and programmes, into the information system to help identify best practices and support countries in shaping effective programmes; and

Table 6. Topical breakdown of implementation materials

Topic	Communication implementation materials	Framework implementation materials
	(YLL) attributable to alcohol, with subindicators for alcohol-attributable YLL from chronic disease and from injury).	• fully continue its comparative risk assessment of alcohol-attributable problems as part of its global burden-of-disease estimates.
International issues	—	I-15 recommends: • stimulating a dialogue about the international aspects of the alcohol market that impinge on the ability of countries to combat alcohol-related problems within their borders;
		• analysing the feasibility of international mechanisms, including legally binding agreements between countries, to support the implementation of national alcohol policies and programmes; • seeking opportunities to provide an active, continuing presence in trade negotiations and dispute adjudications to represent the public health interest in alcohol trade matters; and • developing guidance for policy-makers and advisers at all levels of government in monitoring and reducing the risks to effective alcohol policy that might arise in the process of trade liberalization.

Table 7. List of alcohol-related projects co-financed by the European Commission

Project	Activities
C1. Building Capacity Project (www.ias.org.uk/buildingcapacity/index.html)	• Is undertaking a cost–effectiveness analysis of alcohol policies in all EU Member States. • Produces guidance on regional alcohol policy. • Produces guidance on municipal alcohol policy. • Produces guidance on prevention of alcohol-related injuries. • Is creating a database on laws and regulations.
C2. Enforcement of National Laws and Self-Regulation on Advertising and Marketing of Alcohol (ELSA) (stap.nl/elsa/elsa_project)	• Has described regulations on alcohol marketing in EU Member States. • Has provided guidance on monitoring commercial communications. • Has reviewed evidence of the impact of commercial communications.
C3. Pathways for Health Project (PHP) (dhs.de/web/dhs_international/pathways.php)	• Has produced guidance on the prevention of drink–driving. • Has produced guidance on consumer labelling. • Has produced guidance on the prevention of binge drinking.
C4. Primary Health Care European Project on Alcohol (PHEPA) (gencat.net/salut/phepa/units/phepa/html/en/Du9/index.html)	• Has produced clinical guidelines for brief advice programmes. • Has produced a training manual for brief advice programmes. • Has produced a tool to assess delivery of brief advice programmes.
C5. Focus on Alcohol-Safe Environments (FASE)	• Produces guidance on workplace actions. • Produces guidance on safer drinking environments. • Produces guidance on regulating commercial communications.
C6. Standardizing Measurement of Alcohol-Related Troubles (SMART) (www.ipin.edu.pl/alcsmart)	• Produces guidance on survey methodology for heavy drinking. • Produces guidance on cost–benefit analyses.

Table 7. List of alcohol-related projects co-financed by the European Commission

Project	Activities
C7. Alcohol Measures for Public Health Research Alliance (AMPHORA) (amphoraproject.net)	• Produces guidance on evaluating policy interventions. • Studies the impact of planned and unplanned social determinants on alcohol consumption. • Studies the impact of commercial communications. • Studies the impact of policy changes in the areas of price and availability. • Studies the impact of brief advice and treatment programmes. • Studies the impact of drinking environments. • Analyses the chemical composition of illicit alcohols. • Measures and ranks existing alcohol policies. • Analyses public perceptions of drinking problems. • Documents laws and regulations.
C8. Health Evolution Monitoring (HEM) (hem.home.pl)	• Has analysed alcohol's contribution to health inequalities in different EU countries.
C9. Good Health into Older Age (VINTAGE)	• Provides guidance on reducing the harm alcohol has done to older people.
C10. Alcohol Labelling Policies to Protect Young People (PROTECT)	• Provides guidance on the labelling of alcoholic products.
C11. Monitoring Alcohol Commercial Communications in Europe (AMMIE)	• Provides guidance on monitoring alcohol marketing.

Table 7. List of alcohol-related projects co-financed by the European Commission

Project	Activities
C12. WHO Project to Support Coordinated Implementation of the framework for alcohol policy in the WHO European Region and the Commission Communication on an EU Strategy to Support Member States in Reducing Alcohol-Related Harm (www.euro.who.int/partnerships/partners/20070326_1)	• Is updating the European Alcohol Information System (EAIS) and ensuring compatibility with the Commission database on alcohol. • Is reviewing social cost studies on alcohol. • Has analysed the Commission Communication and the WHO framework (the present document). • Is reviewing the evidence for the effectiveness and cost–effectiveness of alcohol policy options. • Has developed a handbook for country-based action (WHO Regional Office for Europe, 2009e).

Table 8. Topical breakdown of co-financed project activities

Topic	Activities
Review of the problem status	C8 found that about 25% of the difference between the EU10 and the EU15 life expectancy for men aged 20–64 in 2002 was due to alcohol (Zatonski et al., 2008). C12 is updating the EAIS and reviewing studies on the social costs of alcohol use.
Review of the response status	C1 is analysing the cost–effectiveness of alcohol policies for all EU Member States. C6 will provide guidance on cost–benefit analyses. C7 will analyse the relative contribution of unplanned determinants (urbanization, employment, etc.) and planned determinants (alcohol policies) to alcohol consumption across the EU. C7 will measure and rank alcohol policies in each EU Member State. C12 is updating the EAIS and reviewing the evidence for the effectiveness and cost–effectiveness of different alcohol policy options.
Raising awareness: information and education	C3 reviewed the evidence for consumer labelling on alcoholic beverage containers and recommended that it be introduced. C10 will provide concrete advice on the introduction of consumer labelling. C7 will provide information on public perceptions of what comprises an alcohol problem.
Raising awareness: political commitment	—
Health sector response	C4 provided clinical guidelines and a training manual for brief advice programmes in primary care, developed an assessment tool and analysed the delivery of primary care services for hazardous and harmful alcohol consumption in the EU. C7 will analyse the gap between treatment need and treatment uptake for alcohol use disorders, and the corresponding utilization gap for brief advice on hazardous/harmful alcohol consumption.

Table 8. Topical breakdown of co-financed project activities

Topic	Activities
Community action	C5 will provide information on the evidence and experience of work-based alcohol policies and programmes to reduce alcohol-related harm. C9 will review the evidence of the harm done by alcohol to older people, and the evidence for (and experiences with) effective policies and programmes to reduce such harm. C1 will provide guidance on regional, local and municipal action to reduce the harm done by alcohol.
Drink–driving	C3 reviewed the evidence and provided recommendations for effective drink–driving policies and programmes.
Availability	C7 will review the impact of "natural" experiments (changes in regulations in EU countries) on consumption and harm.
Marketing	C2 reviewed regulations of alcohol marketing across the EU and the impact of marketing on alcohol consumption and related harm. C11 will monitor alcohol marketing across the EU. C5 will review the evidence for implementing effective regulatory systems. C7 will conduct longitudinal studies in four EU countries to evaluate the impact of alcohol marketing.
Price	C7 will review the impact of natural experiments – specifically, changes in alcohol taxes in EU countries – on consumption and harm.
Drinking environments	C3 reviewed the evidence for the effectiveness of policies and programmes to reduce heavy episodic drinking, and used it to provide recommendations. C5 will review the evidence for the effectiveness of interventions in drinking environments. C7 will study drinking environments in four EU countries to investigate the impact of the drinking environment on alcohol-related harm. C1 will review the evidence for effective policies and programmes to reduce alcohol-related accidents and injuries.
Illegally and informally produced alcohol	C7 will test the chemical composition of samples of illegally and informally produced alcohol in every EU Member State.

Table 8. Topical breakdown of co-financed project activities

Topic	Activities
Implementation	C7 will review evidence for the influence of infrastructure on the implementation of effective alcohol policy and build a database of existing laws and regulations. C12 has developed a handbook for country-based action (WHO Regional Office for Europe, 2009e).
Monitoring and evaluation, including research	C6 will propose standard survey indicators for harmful alcohol consumption and heavy episodic drinking. C7 will propose standard indicators to evaluate the effectiveness and cost–effectiveness of alcohol policies. C12 is updating the EAIS.
International issues	—

The WHO Regional Office for Europe

The World Health Organization (WHO) is a specialized agency of the United Nations created in 1948 with the primary responsibility for international health matters and public health. The WHO Regional Office for Europe is one of six regional offices throughout the world, each with its own programme geared to the particular health conditions of the countries it serves.

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