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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

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1. INTRODUCTION

This Communication addresses the adverse health effects related to harmful and hazardous alcohol consumption[1], as well as the related social and economic consequences, and answers to Council requests for the Commission to follow-up, assess and monitor developments and the measures taken in this field and to report back on the need for further actions. It focuses on preventing and cutting back heavy and extreme drinking patterns, as well as under-age drinking, and some of their most harmful consequences such as alcohol-related road accidents and Foetal Alcohol Syndrome. The Communication therefore is not a reflection on alcohol use as such, but on misuse and its harmful consequences. The Communication recognises that there are different cultural habits related to alcohol consumption in the various Member States. There is no intention to substitute Community action to national policies, which have already been put in place in most of the Member States and relate to national competences in accordance with the principle of subsidiarity and Article 152 of the EC Treaty. In particular, the Commission does not intend as a consequence of this Communication to propose the development of harmonised legislation in the field of the prevention of alcohol-related harm.

The Communication aims at mapping actions which have already been put in place by the Commission and Member States, and identifies on the one hand good practices which have led to positive results, and on the other hand, areas of socio-economic importance and Community relevance where further progress could be made.

The Communication also explains how the Commission can further support and complement national public health policies implemented by Member States in cooperation with stakeholders[2], taking into account that drinking patterns and cultures vary across the EU. This commitment from the Commission to further pursue and develop actions under its competences together with a list of good practices which have been implemented in different Member States, and the establishment of an Alcohol and Health Forum which will help their dissemination, will constitute the backbone of a comprehensive strategy to reduce alcohol-related harm in Europe.

2. MANDATE FOR ACTION

The European Union has competence and responsibility to address public health problems such as harmful and hazardous alcohol use by complementing national actions in this field, as stated in Article 152 of the EC Treaty.

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1 Hazardous alcohol consumption has been defined as a level of consumption or pattern of drinking that is likely to result in harm should present drinking habits persist (Babor, T., Campbell, R., Room, R. & Saunders, J., (1994) Lexicon of Alcohol and Drug Terms, World Health Organization, Geneva); however, there is no standardised agreement on the level of alcohol consumption that should be regarded as hazardous drinking. Harmful drinking is defined as 'a pattern of drinking that causes damage to health, either physical (such as liver cirrhosis) or mental (such as depression secondary to alcohol consumption)' (The ICD-10 Classification of Mental and Behavioural Disorders: Clinical Descriptions and Diagnostic Guidelines. Geneva: World Health Organisation 1992).

2 These include actors as varied as health and consumer NGOs, self-help groups, producers and retailers of alcoholic beverages, the hospitality sector, schools, employers and trade unions, the advertising industry, the media…

The European Court of Justice has repeatedly confirmed that combating alcohol-related harm is an important and valid public health goal[3].

In 2001 the Council adopted a Recommendation on the drinking of alcohol by young people, in particular children and adolescents[4], which invites the Commission to follow-up, assess and monitor developments and the measures taken, and to report back on the need for further actions[5].

In its Conclusions of 5 June 2001 the Council invited the Commission to put forward proposals for a comprehensive Community strategy aimed at reducing alcohol-related harm to complement national policies. The Council Conclusions on Alcohol and young people of June 2004 reiterated this invitation[6].

Most Member States have taken actions to reduce alcohol-related harm, and many of them have extensive policies in this field. Despite the implementation of health policies at both Community and national level, the level of harm, especially among young people, on roads and at workplaces is still unacceptably high in all Member States. Moreover, studies carried out at national and EU level[7] show that in some cases, where there is a cross border element, better coordination at, and synergies established with, the EU level might be needed. Examples include cross-border sales promotion of alcohol which could attract young drinkers, or cross-border TV advertising of alcoholic beverages which could conflict with national restrictions.

This tends to show that some problems are shared by all Member States (i.e. underage drinking or alcohol-related road accidents), that the policies which have been led to tackle them have not been fully successful since the problems either remain or in certain cases have worsened, and that some issues are of Community relevance because of a cross-border element. This highlights the need for further actions and cooperation at EU and national level. This Communication sets out a European Union approach to support and underpin a coordinated strategy to reduce alcohol-related harm, which will rely on commitments from the Commission to further pursue and develop actions under its competences and dissemination of good practices which have been implemented in different Member States.

EU action to reduce alcohol-related harm will support the implementation of other relevant policy objectives already agreed at EU level, e.g. on Road Safety[8], Health and Safety at work[9], and the Convention on the Rights of the Child[10].

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3 Franzen case (C-189/95), Heinonen case (C-394/97), Gourmet case (C-405/98), Catalonia (C-190 and C-179/90), Loi Evin (C-262/02 and C-429/02)

4 Council Recommendation 2001/458/EC – OJ L 161/38 of 16/06/2001 http://eur-lex.europa.eu/pri/en/oj/dat/2001/l_161/l_16120010616en00380041.pdf

5 Full report published at http://ec.europa.eu/comm/health

6 Council Conclusions of 5 June 2001 on a Community strategy to reduce alcohol-related harm (2001/C 175/01 - http://eur-lex.europa.eu/pri/en/oj/dat/2001/c_175/c_17520010620en00010002.pdf), Council Conclusions on Alcohol and Young people of 1-2 June 2004 (http://ue.eu.int/ueDocs/cms_Data/docs/pressData/en/lsa/80729.pdf)

7 e. g.: What are the most effective and cost-effective interventions in alcohol?, WHO Regional Office for Europe's Health Evidence Network (HEN) 2004; Alcohol Policy and the Public Good, Griffith Edwards 1994, Cochrane Library; EconLit and the Alcohol and Alcohol Problems Science Database (ETOH), National Institute on Alcohol Abuse and Alcoholism (NIAA).

8 Commission Recommendation 2004/345/EC of 6 April 2004 on enforcement in the field of road safety, OJ L 111, 17/04/2004, Commission Recommendation 2001/116/EC of 17 January 2001 on the

3. CASE FOR ACTION

Harmful and hazardous alcohol consumption has a major impact on public health and also generates costs related to health care, health insurance, law enforcement and public order, and workplaces, and thus has a negative impact on economic development and on society as a whole. Harmful and hazardous alcohol consumption is a key health determinant and one of the main causes of premature death and avoidable disease. It is a net cause of 7.4 %[11] of all ill-health and early death in the EU, and has a negative impact on labour and productivity. Policies aimed at the prevention and treatment of harmful and hazardous consumption as well as appropriate information on responsible patterns of consumption have important benefits for individuals and families, but also address social costs and the labour market, and will contribute to fostering competitiveness in line with the Lisbon objectives, and with the objective of more Healthy Life Years for all. Workplace-based initiatives should therefore be fostered. The relevant stakeholders (business organisations, trade unions) have a particular responsibility in this regard.

Young people in the EU are particularly at risk, as over 10% of female mortality and around 25% of male mortality in the 15–29 age group is related to hazardous alcohol consumption[12]. The harmful and hazardous consumption of alcohol has effects not only on those who drink, but also on others and on society. Harmful effects of alcohol tend to be greater in less advantaged social groups, and therefore contribute to inequalities in health.

While average alcohol consumption has been decreasing in the EU, the proportion of youth and young adults with harmful and hazardous consumption patterns has increased in many Member States over the last ten years[13]. Drinking patterns in many parts of the EU, and particularly the reported increasing trends in under-age "binge-drinking"[14] and high frequency under-age drinking in many European countries[15], may have long-term adverse health effects and increase the risk of social harm.

Traffic accidents related to alcohol consumption are also a major cause for concern. About one accident in four can be linked to alcohol consumption, and at least 10,000 people are killed in alcohol-related road accidents in the EU each year. The EU has the goal of halving the number of people killed on European roads from 50,000 in the year 2000 to 25,000 by 2010[16], and efforts to curb drink-driving can make a substantial contribution to achieving this objective.

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maximum permitted blood alcohol content (BAC) for drivers of motorised vehicles, OJ L 43, 14/02/2001, Communication of the Commission, OJ C 48, 14/02/2004

9 Community strategy on health and safety at work 2002-2006/* COM/2002/0118 final

10 UN resolution 44/25 of 20 November 1989

11 The WHO's Global Burden of Disease Study (Rehm et al 2003a and b, Rehm et al 2004 and Rehm 2005)

12 Alcohol in Europe A public health perspective, P Anderson and B Baumberg, Institute of Alcohol Studies, UK 2006 http://ec.europa.eu/health-eu/news_alcoholineurope_en.htm (based on The WHO's Global Burden of Disease Study, Rehm et al 2003a and b, Rehm et al 2004 and Rehm 2005)

13 Increasing trends are mostly reported among young adults (above legal drinking ages). Binge-drinking among under aged drinkers has levelled out in EU-15 but increased in EU-10.

14 "Binge-drinking" is normally considered to be the drinking over 5 units of alcohol on one single occasion.

15 The ESPAD Report 2003, Alcohol and Other Drug Use Among Students in 35 European Countries, Björn Hibell et al, Stockholm 2004 http://www.espad.org/reports.asp.

16 COM(2001)370 final: "European transport policy for 2010: time to decide".

Exposure to alcohol during pregnancy can impair brain development of the foetus and is associated with intellectual deficits that become apparent later in childhood[17]. As high-risk consumption is increasing among young women in most Member States and as alcohol consumption impacts on the foetus already at the start of the pregnancy, awareness raising interventions on this issue are of key importance.

In order to address the above concerns, and based on the outcomes of the impact assessment process, the Commission has identified the following five priority themes, which are relevant in all Member States and for which Community action in complement to national policies and coordination of national actions has an added value:

- Protect young people, children and the unborn child;
- Reduce injuries and death from alcohol-related road accidents;
- Prevent alcohol-related harm among adults and reduce the negative impact on the workplace;
- Inform, educate and raise awareness on the impact of harmful and hazardous alcohol consumption, and on appropriate consumption patterns;
- Develop and maintain a common evidence base at EU level.

These themes cut across EU, national and local level, and call for multi-stakeholder and multi-sector action. The present strategy therefore proposes to highlight what the Commission and Member States have already done, and further action or continuation of existing actions by the Commission. It also presents good practices implemented in Member States, and which could inspire similar actions and synergies at national level.

4. THE CONSULTATION AND IMPACT ASSESSMENT PROCESS

Since 2004 the Commission services have held extensive consultations with Member State experts, international organisations, researchers and stakeholders[18]. In addition, the Commission has participated in round table talks organised with selected key stakeholders under the auspices of the European Policy Centre (EPC)[19].

Through an open call for tender the Commission contracted an expert public health report from the Institute of Alcohol Studies[20].

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17 In France for example, more than 700 children were born with Foetal Alcohol Syndrome in 2001, and more than 60,000 persons are estimated to be living with this condition (data calculated by the INSERM - "Expertise collective" in September 2001 - after two epidemiological studies made in the North of France and La Réunion.

18 Including Non-Governmental Organisations (health and consumer NGOs, self-help groups…) and organisations representing producers of alcoholic drinks.

19 The EPC report on the alcohol round table is published on www.theepc.be

20 Published on the EU Health portal and web site alongside a report on the peer review meeting, comments from the peer review panel, stakeholders' views on alcohol policy and on the implementation of the Council Recommendation (http://ec.europa.eu/health-eu/news_alcoholineurope_en.htm).

To analyse the health, social, economic and environmental problems related to alcohol and the different policy options the Commission conducted an Impact Assessment[21].

Furthermore, stakeholders had an opportunity to comment on an open consultation on the labelling of food and drinks launched by the Commission[22].

5. FIVE PRIORITY THEMES AND RELEVANT GOOD PRACTIVES

5.1. Protect young people, children and the unborn child

Aims:

Aim 1: To curb under-age drinking, reduce hazardous and harmful drinking among young people, in cooperation with all stakeholders.

Aim 2: To reduce the harm suffered by children in families with alcohol problems.

Aim 3: To reduce exposure to alcohol during pregnancy, thereby reducing the number of children born with Foetal Alcohol Disorders.

5.1.1. Rationale for action

Young people are often unfairly depicted as the perpetrators of alcohol problems rather than the victims. Alcohol is estimated to be a causal factor in 16% of cases of child abuse and neglect[23].

Harmful alcohol consumption among young people has been shown to have a negative impact not only on health and social wellbeing, but also on educational attainment[24]. There is an increasing trend of "binge drinking" by young people in many parts of the EU. This is exacerbated by the continued availability of alcoholic beverages to under-age consumers. There is therefore a need to consider further actions to curb under-age drinking and harmful drinking patterns among youth.

Actors in the alcohol beverage chain have been actively engaged in most Member States in enforcement of national regulations, and have declared their willingness to become more pro-active in enforcing regulatory and self-regulatory measures.

Some Member States have increased taxes on products which they perceive to be particularly attractive to under age drinkers[25].

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21 Furthermore, a more detailed economic analysis of the impact of alcohol on the economic development of the EU has been conducted as part of the impact assessment procedure by an external contractor: "RAND Report", published on http://ec.europa.eu/comm/health

22 The background paper used for the consultation is available on the Internet at http://ec.europa.eu/food/food/labellingnutrition/betterregulation/index_en.htm.

23 English et al. 1995, Single et al, 1999, Ridolfo and Stevenson 2001, taken from Alcohol in Europe – a public health perspective, http://ec.europa.eu/health-eu/news_alcoholineurope_en.htm

24 RAND: An economic analysis of the impact of alcohol on the economic development in EU (Horlings, Scoggins 2006)

25 This has been addressed by imposing a special tax or compulsory labelling for products such as "alcopops" (Denmark, France, Germany, Ireland and Luxembourg)

5.1.2. Good practice

Worrying drinking trends among young people can be effectively addressed through public policy. The 2001 Council Recommendation has contributed to developing such policies. Examples of effective measures implemented by Member States are: enforcement of restrictions on sales, on availability and on marketing likely to influence young people, broad community-based action to prevent harm and risky behaviour, involving teachers, parents, stakeholders and young people themselves[26], and supported by media messages and life-skills training programmes. The alcohol beverage industry and retailers can play an important role to ensure that alcohol is consumed responsibly.

5.2. Reduce injuries and deaths from alcohol-related road traffic accidents[27]

Aims:

Aim 4: To contribute to reducing alcohol-related road fatalities and injuries.

5.2.1. Rationale for action

Approximately one accident in four can be linked to alcohol consumption, and at least 10,000 people are killed in alcohol-related road accidents in the EU each year. Young people aged 18 to 24 are particularly in danger of having an accident. 35% to 45% of fatalities of this age group are due to traffic accidents. For young people, traffic accidents are the most common cause of death (47% according to several sources). For drink-driving accidents, two thirds of the people involved were between 15 and 34 years, and 96% were male.

5.2.2. Good practice

Numerous studies have found that the risk of alcohol-related road traffic accidents increases with the blood alcohol concentration (BAC) of the driver. All Member States have taken measures to introduce BAC limits. Studies tend to show that an enforced maximum limit of 0.5 mg/ml or less would be desirable[28]. Effective enforcement of drink-driving countermeasures could substantially reduce traffic deaths (by up to 25% in the case of men, and up to 10% in the case of women), injuries and disability. Example of efficient national policies rely on the introduction and enforcement of frequent and systematic random breath testing, supported by education and awareness campaigns involving all stakeholders. A combination of strict enforcement and active awareness raising is a key to success. Young and

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[26] The Commission has involved young people in the consultation process of this Communication, in projects co-financed trough the Public Health Programme. The European Youth Forum has set up a working group to contribute to the ongoing work.

[27] Apart from road traffic, and in line with the general concerns regarding alcohol at the workplace as described in section 5.3, there is obviously also a need to check alcohol consumption in other transport sectors, such as sea, rail and air transport. These are however not addressed specifically by the present Communication.

[28] A review of 112 studies provided strong evidence that impairment in driving skills begins with a departure from a zero blood alcohol concentration level (Moskowitz and Fiorentino 2000). A study that compared the blood alcohol concentrations (BACs) of drivers in accidents with the BACs of drivers not involved in accidents found that male and female drivers at all ages who had BACs between 0.2 g/l and 0.49 g/l had at least a three times greater risk of dying in a single vehicle crash. The risk increased to at least 6 times with a BAC between 0.5 g/l and 0.79 g/l and to 11 times with a BAC between 0.8 g/l and 0.99 g/l (Zador et al 2000) All studies confirm that the positive effect of new legislation to lower BAC limits is higher if it is followed by public discussions, media campaigns and enforcement of the new laws.

novice drivers are more involved in alcohol-related road accidents. Another example of efficient policy is the introduction of a lower or zero BAC limit for these drivers and, for safety reasons, also for public transport drivers as well as for drivers of commercial vehicles, in particular those transporting dangerous goods.

5.3. Prevent alcohol-related harm among adults and reduce the negative impact on the workplace

Aims:

Aim 5: To decrease alcohol-related chronic physical and mental disorders.

Aim 6: To decrease the number of alcohol related deaths.

Aim 7: To provide information to consumers to make informed choices.

Aim 8: To contribute to the reduction of alcohol-related harm at the workplace, and promote workplace related actions.

5.3.1. Rationale for action

Although 85% of adult individuals consume alcohol in a moderate and responsible manner most of the time, harmful and hazardous alcohol consumption is one of the main causes of premature death and avoidable disease and furthermore has a negative impact on working capacity[29]. Alcohol-related absenteeism or drinking during working hours have a negative impact on work performance, and therefore on competitiveness and productivity[30]. While 266 million adults drink alcohol up to 20g (women) or 40g (men) per day, over 58 million adults (15%) consume above this level, with 20 million of these (6%) drinking at over 40g (women) or 60g per day (men). Looking at addiction rather than drinking levels, it is also estimated that 23 million Europeans (5% of men, 1% of women) are dependent on alcohol in any one year.

5.3.2. Good practice

Experience gained in Member States tends to show that improved enforcement of current regulations, codes and standards, is essential to reduce the negative impact of harmful and hazardous alcohol consumption. Licence enforcement, server training, community- and workplace-based interventions, pricing policy (e.g. reducing “two-drinks-for-one” offers), coordination of public transport and closing times, advice by doctors or nurses in primary health care to people at risk, and treatment, are interventions that appear effective to prevent alcohol-related harm among adults and reduce the negative impact on the workplace. Education, information activities and campaigns promoting moderate consumption, or addressing drink-driving, alcohol during pregnancy and under-age drinking, can be used to mobilise public support for interventions.

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[29] Alcohol in Europe A public health perspective, P Anderson and B Baumberg, Institute of Alcohol Studies, UK 2006 http://ec.europa.eu/health-eu/news_alcoholineurope_en.htm

[30] RAND: An economic analysis of the impact of alcohol on the economic development in EU (Horlings, Scoggins 2006).

5.4. Inform, educate and raise awareness on the impact of harmful and hazardous alcohol consumption, and on appropriate consumption patterns

Aims:

Aim 9: To increase EU citizens' awareness of the impact of harmful and hazardous alcohol consumption on health, especially the impact of alcohol on the foetus, on under-age drinkers, on working and on driving performance.

5.4.1. Rationale for action

Citizens have the right to obtain relevant information on the health impact, and in particular on the risks and consequences related to harmful and hazardous consumption of alcohol, and to obtain more detailed information on added ingredients that may be harmful to the health of certain groups of consumers. Moderate alcohol consumption appears to offer some protection against coronary heart disease in older people (45 and above depending on gender and individual differences).

5.4.2. Good practice

Lifestyle choices at a young age pre-determine health as an adult. This makes children and young people – as well as their parents – an important target group for health education and awareness raising interventions. Broad and 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 both risk factors such as alcohol and periods of risk, such as adolescence, and protective factors, i.e. changes in lifestyles and behaviours.

Media campaigns – such as the Community-funded "Euro-Bob" campaign aimed at preventing drink-driving – can be used to inform and raise awareness among citizens and support policy interventions.

5.5. Develop, support and maintain a common evidence base

Aims:

Aim 10: To obtain comparable information on alcohol consumption, especially on young people; definitions on harmful and hazardous consumption, on drinking patterns, on the social and health effects of alcohol; and information on the impact of alcohol policy measures and of alcohol consumption on productivity and economic development.

Aim 11: To evaluate the impact of initiatives taken on the basis of this Communication.

5.5.1. Rationale for action

Research and information systems are crucial for the development and implementation of effective actions at EU, national and local level to be able to prevent harmful and hazardous consumption as well as to better assess the effects of moderate alcohol consumption. There is also a strong need for common definitions of binge-drinking, harmful and hazardous consumption, in particular to follow trends in young peoples' drinking habits.

5.5.2. What is needed

In addition to the ongoing work on European Community Health Indicators, the Commission services have identified the need to develop a standardised definition for data on alcohol use and alcohol-related harm; to initiate research to estimate the cost and benefits of policy options; to carry out regular and comparative European surveys; and to fill research gaps on alcohol-related health and social harm, on the causes of harmful and hazardous alcohol consumption, and on its role in widening the health gap between socio-economic groups. Furthermore, there is a need for assessing the differentiation of drinking patterns by country, age and gender.

Moreover, there is a need for further studies to evaluate the effectiveness of actions and interventions, as proposed in this Communication.

6. THREE LEVELS OF ACTIONS

Member States have the main responsibility for national alcohol policy. In addition, the Community encourages cooperation and coordination between the Member States and lends support to their action. As a complement to these national initiatives, the Commission implements policies in the field of alcohol related harm, in particular through the Public Health Programme and the Research Framework Programme. There are thus three levels of actions, the national level, the coordination of national policies at Community level and actions by the Commission on the basis of its prerogatives. In this context, the main role of the Commission is: (1) to inform and raise awareness on major public health concerns at EU and Member State level, and to cooperate with Member States in addressing these; (2) to initiate action at EU level when this 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.

6.1. Action by the European Commission

The Community role in public health is to complement Member State efforts, to add value to their actions and, in particular, to deal with issues that Member States cannot effectively handle on their own. The Commission will in particular prioritise actions to:

- Support, through the Public Health Programme, projects that contribute towards reducing alcohol-related harm in the EU, especially the harm suffered by children and young people, and monitor and evaluate the effectiveness of interventions. *(refers to aims 1-11 in section 5)*

- Support, through the Public Health Programme and other existing structures, the creation of a system for flexible but standardised definitions for alcohol data, the conducting of repeated and comparative surveys on alcohol consumption, in particular via the European Health Interview Survey and complementary surveys (to be developed in the framework of the European Health Survey System and the European Statistical System), and the development of health indicators to monitor and assess developments. Comparable information on alcohol will be made available on the Europa web site linked to the Health Portal. *(aims 9-11)*

- Support the monitoring of young people's drinking habits, and of the harm they suffer, with a particular focus on the increased alcohol consumption among girls and the increase in "binge-drinking". *(aims 1, 3, 4, 6, 7, 9)*

- Develop, in cooperation with Member States and stakeholders, strategies aimed at curbing under-age drinking. This would take the form of exchanges of good practice to address issues such as selling and serving, irresponsible marketing, and the image of excessive alcohol use conveyed through the media and by role models, and could possibly be taken forward within the Alcohol and Health Forum referred to in section 6.3.1. and in the implementation of the European Youth Pact[31] *(aims 1, 2, 4, 5, 6, 7, 8)*

- Support Member States and stakeholders in their efforts to develop information and education programmes on the effect of harmful drinking and on responsible patterns of consumption. *(aims 1- 9)*

- Explore, in cooperation with Member States and business organisations, the possibility of developing specific information and education campaigns or similar initiatives to tackle alcohol-related harm at the workplace. In this context, exchange of specific best practice should be pursued, possibly together with other Commission led initiatives such as those on e.g. Corporate Social Responsibility. *(aims 1-9)*

- Support the involvement of relevant organisations competent in the field of workplace health, e.g. the European Agency for Safety and Health at Work given the relevance of some of its initiatives such as the '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. *(aims 1-9)*

- Explore, in cooperation with Member States and stakeholders, the usefulness of developing efficient common approaches throughout the Community to provide adequate consumer information. Such reflections are particularly important as some Member States are planning to introduce warning labels (e. g. on alcohol and pregnancy), and as more generally there is an ongoing discussion about best practice in consumer education. *(aims 1, 3, 4, 6, 7, 9)*

- To report on the implementation of measures to tackle harmful and hazardous alcohol consumption, as described in this Communication, based also on the information from Member States, and on the impact of the EU strategy set out in this Communication. *(aim 11)*

Moreover, through the proposed 7th Research Framework Programme (2007-2013), in particular under the Health Theme of the proposed Specific Programme "Co-operation", there will be opportunities to examine how research at the European level brings value to an EU strategy to support Member States to reduce alcohol related harm. In order to provide

[31] In its Communication on "European policies concerning youth: Addressing the concerns of young people in Europe – implementing the European Youth Pact and promoting active citizenship" of 30 May 2005 the Commission confirms the importance of paying attention to the health of young people. One of the areas for action is the use of alcohol by young people.

evidence for the best public health measures and to guide integrated policy making for prevention of alcohol abuse, areas for research could include:

- work on young people's drinking habits (trends, determinants);
- the link between harmful alcohol consumption/drinking patterns and related health, social and economic harm (refers to aims 1-10 in section 5);
- other factors relating to impact on society (refers to aims 1-10 in section 5).

6.2. Subsidiarity: Mapping of actions implemented by Member States

6.2.1. National action

Most Member States have put in place legislation and policy related to harmful and hazardous alcoholic beverages. Moreover, in 2005 fifteen Member States reported that they had adopted national action plans, or had coordinating bodies for alcohol policy in place. The range of measures implemented by Member States is very large and includes issues such as education, consumer information, and enforcement of traffic controls or of selling licences for alcoholic beverage as well as setting the levels of alcohol taxation[32].

Specific measures adopted by Member States to reduce alcohol-related harm with a view to protecting public health are based on their particular cultural contexts. The mapping of certain actions taken within the framework of national policies can facilitate the dissemination of good practices. Every measure has to be considered on a case-by-case basis; in all cases, they should be evidence-based, proportionate and implemented on a non-discriminatory basis. Examples of national measures currently implemented in Member States are the following:

- Action to improve consumer information, at point of sale or on products, on the impact of alcohol abuse on health and work performance. As part of consumer information, some Member States have introduced, or are considering introducing labelling to protect pregnant women and the unborn child. Other actions aim at providing easily understandable information on alcohol content and moderate drinking. *(aims 1-9)*
- Action to better enforce age limits for selling and serving alcohol. Such actions appear to be more efficient if they involve all stakeholders, parents, and young people. As alcohol is poorly metabolised at a young age, the re-examination of minimum age requirements for selling and serving all alcoholic beverages, in particular where the minimum age is currently below 18 years, also appears to be considered by some Member States as an option. *(aims 1, 4, 6, 7, 8)*
- Interventions and educational programmes are proven to increase the ability of young people, and their parents, to tackle alcohol problems and risky behaviour. These interventions could target both risk and protective factors, with the aim of promoting effective behavioural change among children and adolescents, and could be carried out in

[32] Minimum rates for excise duties are laid down in Council Directive 92/84/EEC of 19 October 1992 on the approximation of the rates of excise duty on alcohol and alcoholic beverages. Above these minima Member States are free to set their national rates at levels they consider appropriate and which may incorporate other policies such as health.

schools and other appropriate settings. To increase efficiency, this should actively involve young people and all other relevant stakeholders. *(aims 1, 2, 4, 6-9)*

- Introduction and enforcement of rules against serving alcohol to intoxicated persons, as well as effective licensing systems for the sale and responsible serving of alcoholic products, in accordance with their particular contexts and national legal order. *(aims 1-7, 9)*

- Introduction of a zero BAC limit for young or inexperienced drivers, and for public transport drivers as well as drivers of commercial vehicles, in particular those transporting dangerous goods. *(aims 4-6)*

- Development of a framework to enable unrestricted (random) breath testing for all drivers, enforcement of drink-driving countermeasures and application of dissuasive sanctions against all who are found to be driving over the BAC limit, and in particular for repeated drink drivers. *(aims 4-7, 9)*

- Specific actions aimed at addressing the problems posed by alcohol consumption at and around the workplace. *(aims 2-6)*

- Allocation of the necessary resources in primary health care, to advice and treatment regarding hazardous and harmful alcohol consumption, to provide training for health care professionals and to prioritise alcohol prevention at workplaces, counselling for children in families with alcohol problems and education and awareness-raising actions to protect the unborn child. *(aims 2-9)*

- Establishment of publicly funded alcohol research and monitoring programmes. *(aims 7-11)*

6.2.2. Local action

National strategies could be more effective if they are supported by local and community based activities. Moreover, local multi-stakeholder action appears to be essential to underpin the strategy set out in this Communication. For example:

- Active learning methods could be used to discourage adolescents to start experimenting with harmful alcohol consumption. *(aims 1, 6, 7, 9)*

- For all workplaces, there could be a policy to prevent alcohol-related harm, including information and/or education campaigns, and to provide help and specialised care for employees with alcohol-related problems. *(aims 5 -9)*

- Youth and civil society organisations should reflect on how they can contribute to reducing alcohol-related harm. *(aims 1-9)*

- Local communities could contribute to prevent and promote strategies to protect citizens from alcohol-related harm. *(aims 1-9)*

6.3. Coordination of actions at EU level

EU competence in health is not confined to specific public health actions. Where possible, the Commission will seek to improve the coherence between policies that have an impact on

alcohol-related harm. A number of mechanisms are currently in place to ensure that health is taken into consideration in other Community policy areas, in accordance with Article 152 (1) of the EC Treaty.

6.3.1. Alcohol and Health Forum

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, which will put together experts from different stakeholder organisations and representatives from Member States, other EU institutions and agencies. The overall objective of this Forum will be to support, provide input for and monitor the implementation of the strategy outlined in this Communication. The Alcohol and Health Forum could, when appropriate, set up sub-groups on special topics such as research, information and data collection, and education. *(aims 1-11)*

6.3.2. Drink-driving

In order to better coordinate the 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 the Public Health Programme and the Action Plan on Road Safety. This will address in particular the issue of novice and young drivers. *(aims 4, 6, 7)*

6.3.3. Commercial communication

Community law already regulates certain aspects of commercial communication, and some instruments are currently being reviewed and updated. In addition, there is increasing clarity regarding the kinds of self-regulatory best practices that will help create effective parameters of behaviour for advertisers, and thus align advertising practice with social expectations[33]. The Commission services will work with stakeholders to create sustained momentum for cooperation on responsible commercial communication and sales, including the presentation of a model of responsible consumption of alcohol. The main aim will be to support EU and national/local Government actions to prevent irresponsible marketing of alcoholic beverages, and to regularly examine trends in advertising and issues of concern relating to advertising, for example on alcohol.

One aim of this joint effort will be to reach an agreement with representatives from a range of sectors (hospitality, retail, producers, media/advertising) on a code of commercial communication implemented at national and EU level. Benchmarks for codes/strategies at national level could be agreed.

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[33] As far as television advertising for alcoholic beverages is concerned, the Television without Frontiers Directive regulates such (Council Directive 89/552/EEC of 3 October 1989 on the coordination of certain provisions laid down by Law, Regulation or Administrative Action in Member States concerning the pursuit of television broadcasting activities; OJ L 298, 17.10.1989, p. 23–30). Directive 2005/29/EC of the European Parliament and of the Council of 11 May 2005 concerning unfair business-to-consumer commercial practices addresses misleading and aggressive practices, and practices which use coercion as a means of selling (OJ L 149/22 of 11 June 2005). As far as self-regulation approaches are concerned, the multi-stakeholder and multi-sector Advertising Round Table established by the Commission services has identified some key elements for effective self-regulation, which are presented in the report available at: http://ec.europa.eu/consumers/overview/report_advertising_en.pdf.

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 agreed benchmarks, thus allowing Social Responsibility Organisations to adjust objectives accordingly. *(aims 1-9)*

7. CONCLUSIONS

With this Communication, the Commission, in response to the Council's invitation in 2001, presents a comprehensive strategy to reduce alcohol-related harm in Europe until the end of 2012, and explains what has already been done at national and Community level, what are the priority areas which deserve further action and how the Commission can further contribute to address this major public health concern. The Commission proposes that Member States and stakeholders should take this Communication as a basis to work forward, in particular within the framework of the Alcohol and Health Forum.

The Commission considers that its main contribution to the strategy should be based on the existing approach of complementing national policies and strategies in this area and therefore, does not intend to implement the strategy through specific new legislative proposals. The Commission will report regularly on the implementation of measures to tackle harmful and hazardous alcohol consumption, as described in this Communication, as well as on the impact of the EU strategy set out in this Communication; this will be based on regular reporting from the Member States on the implementation of the relevant measures.

Certain existing Member States actions are to be considered as examples of good practice and have proven their effects. In respect of the principles of subsidiarity and better regulation, these actions need to be strengthened in order to achieve the goal of this strategy. The Commission will contribute through its role of complementing Member States efforts, by adding value to their actions and dealing with issues that Member States cannot effectively handle on their own.