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Science and alcohol policy: a case study of the EU Strategy on Alcohol

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ABSTRACT

Aims To describe the extent to which the content of the European Commission's Communication on alcohol reflects public health-based scientific evidence. **Design** Document retrieval and content analysis. **Setting** European Union. **Participants** Background documents leading up to the European Commission's Communication on alcohol, the Communication itself and implementation actions following the Communication. **Measurements** Documents were read and analyzed for evidence-based alcohol policy content. **Findings** Although the Communication acknowledges and supports existing interventions which have high evidence for effectiveness, such as enforcing blood alcohol concentration (BAC) limits for drivers, it extensively promotes other interventions which have been shown to be ineffective; for example, recommending education and persuasion strategies as a measure across all its five priority areas. Measures to influence price are mentioned only once in relation to sales in drinking venues limiting two-for-one drinks offers. Measures to control physical availability are mentioned infrequently. **Conclusions** The Communication reflects the science, in that it acknowledges the significance of alcohol as a social and health determinant in Europe. However, it places more emphasis on policy actions with less evidence for effectiveness than on those with strong evidence. It also focuses its efforts more on mapping member state actions and coordinating knowledge exchange than on providing concrete recommendations for action or developing Europe-wide policy measures. This may be a compromise between the rights of Member States to develop national policy and legislation and the obligation of the European Union as a collaborative body to protect health. Furthermore, it has been suggested that the European Union's roots as a trading block emphasizes collaboration with industry stakeholders and this influences the ability to prioritize health over trade considerations.

Keywords Alcohol policy, European Commission, evidence.

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INTRODUCTION

The European Union (EU) comprises 27 Member States, with a population of a little over 500 million people. Alcohol is the third most significant risk factor for ill health and premature death in the EU, behind tobacco and high blood pressure [1].The social cost of alcohol use is estimated to be €125 billion per year [1]. The EU is marked by enormous health disparities [2]. In many new Member States rapid social change, combined with increases in alcohol affordability and availability of unrecorded alcohol, has contributed to higher levels of consumption and subsequent increases in alcohol related harm, damaging health and slowing economic and social development in many of these countries. For example, in 2002, the difference in male life expectancy at age 20 years 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 years, about 25% of the difference in life expectancy between the EU15 and the 10 mainly eastern countries that would subsequently join the EU (the EU10) (Bulgaria, the Czech Republic, Estonia, Hungary, Latvia, Lithuania, Poland, Romania, Slovakia and Slovenia; the two other recent members of the EU are Cyprus and Malta) was attributable to alcohol [2].

Recognizing the importance of alcohol as a health determinant, the Council of the European Union, in its *Council Conclusions of 5 June 2001 on a Community*

Strategy to Reduce Alcohol-Related Harm [3] invited the European Commission to put forward proposals for a comprehensive Community strategy aimed at reducing alcohol-related harm to complement national policies. In the same year, the *Council Recommendation of 5 June 2001 on the Drinking of Alcohol by Young People, in Particular Children and Adolescents* [4] also invited a strategy to reduce alcohol-related harm with particular reference to young people. The invitation of the 2001 Conclusions was reiterated by *Council Conclusions* of June 2004 [5]. These documents acknowledge that harmful alcohol consumption is damaging to European health, economy and society. They state the need for a cross-sectoral approach undertaken within the cultural, social and economic differences which exist within and between Member States, as well as a need for ongoing research and knowledge exchange within Europe.

The documents led to the 2006 Communication: *An EU Strategy to Support Member States in Reducing Alcohol Related Harm* [6]. This response was developed within the context of a substantial body of research evaluating the effectiveness of various policy measures in reducing consumption and therefore alcohol-related harm. Some of this research already existed or was under way at the time of the 2001 invitation and some was subsequently commissioned by the European Commission to inform the development of its strategy. Following the 2006 Communication, a number of implementation activities were established by the Commission aimed at addressing the Communication's priorities.

Noting that policy is not developed and implemented based solely on evidence and that numerous factors influence alcohol policy [7], this paper reviews the extent to which the content of the Communication and subsequent implementation activities reflected public health-based scientific evidence. The analysis does not deny the impact that the Communication has had in increasing the visibility of alcohol-related harm and alcohol policy issues on European and member state level agendas.

METHODS

To prepare this paper, a number of documents and actions were identified and analysed. These were grouped into the following.

Background documents

1. Those which 'set the scene', outlining the situation in Europe with regard to alcohol-related harm and the case for Community level action, but which do not themselves propose specific policy measures.
2. Scientific documents and reports which were either available at the time or which were produced to inform the Communication. These provide and analyse evidence for the effectiveness of different actions to reduce alcohol-related harm. These documents include recommendations for action based on the evidence.
3. Commission documents which informed the Communication and evaluated its probable impact on alcohol-related harm.

We have accepted the findings and recommendations of the scientific documents as the best available evidence at the time. Within this paper, these are summarized into a set of policy measures identified as having strong or weak evidence for effectiveness.

The Communication itself

The Communication itself outlines the EU Strategy to support Member States in reducing alcohol-related harm. Using the summary of evidence-based recommendations from the scientific documents the Communication was analysed to assess the extent to which its content reflects the scientific evidence.

Implementation actions

Following the Communication, implementation actions were then analysed for their purpose, action taken, outcomes and relation to the science, as follows.

1. Committee on National Alcohol Policy and Action.
2. European Alcohol and Health Forum.
3. Committee on Data Collection, Indicators and Definitions.
4. Other activities, such as co-financed projects.

FINDINGS

Background documents

Those which 'set the scene'

(i) Council conclusions of 5 June 2001 on a Community strategy to reduce alcohol-related harm [3].
(ii) Council recommendation of 5 June 2001 on the drinking of alcohol by young people, in particular children and adolescents [4].
(iii) Council conclusions on alcohol and young people of June 2004 [5].

These documents acknowledge alcohol as a health and social determinant in Europe as shown by research undertaken by Member States and by international bodies. They recognize that cultural, social and economic differences exist between Member States and that individual Member States have undertaken action to reduce alcohol-related harm within their own socio-economic infrastructures.

Within this context they invite the Commission to put forward a comprehensive Community strategy to reduce

alcohol-related harm which would complement national policies and set a timetable for action. They also note the need for coordinated action in all policy areas, increased research and knowledge exchange and emphasize the need to give special attention to young people.

Scientific documents and reports

Two core documents were indentified (i) *Alcohol: No Ordinary Commodity* [8] and (ii) *Alcohol in Europe*, a report for European Commission [1].

Both documents review extensively and provide the evidence base for effective policy, summarized in Table 1, and confirmed in more recent publications [9–11]. They put forward a substantial evidence base of systematic reviews and meta-analyses. The evidence shows that policies that are most effective in reducing alcohol-related harm are those which:

- regulate the marketing and sale of alcohol (particularly its price and availability), through measures such as taxation and licensing;
- enforce legislative measures to reduce drinking and driving; and
- individually directed interventions to already at-risk drinkers.

School-based education was found not to reduce alcohol-related harm, although public information and education programmes contribute to broader strategies by providing information, increasing attention on the political and public agendas and increasing acceptance of measures to reduce alcohol consumption.

Commission documents

Two core documents were identified: (i) an *ex-ante* assessment of the economic impacts of EU alcohol policies undertaken by RAND Europe for the European Commission [12]; and (ii) the Impact Assessment annexed to the Communication [13]. Both documents examined four policy options, as follows.

1. No change.
2. Coordination of activities at EU level; encouraging stakeholders throughout the EU to undertake similar activities (e.g. self-regulation, common codes of conduct on commercial communication, exchange of best practice on interventions) and to hold Member States to their Treaty obligations.
3. A comprehensive strategy; application of a wide variety of policy instruments (legislation, self-regulation, information and education campaigns, exchange of best practice, stakeholder involvement) across all relevant policy domains (internal market, taxation, transport, education, research and consumer policy). Focusing on: drink-driving, coordinated campaigns, protection of third parties, commercial communication, consumer information, availability and prices.
4. A purely regulatory approach [12,13].

The RAND report found that option 3 offered the best outcomes by targeting the behavioural foundations of harmful drinking and reinforcing this with cost-effective strategies.The report recommends application of a wide variety of policy instruments, e.g. legislation,

Table 1 Summary of the evidence of the effectiveness of alcohol policies.

Degree of evidence	*Evidence of action that reduces alcohol-related harm*	*Evidence of action that does not reduce alcohol-related harm*
Convincing	Alcohol taxes	School-based education and information
	Government monopolies for retail sale	
	Restrictions on outlet density	
	Restrictions on days and hours of sale	
	Minimum purchase age	
	Lower legal BAC levels for driving	
	Random breath-testing	
	Brief advice programmes	
	Treatment for alcohol use disorders	
Probable	Restrictions on the volume of commercial communications	Training of alcohol servers
		Designated driver campaigns
	Enforcement of restrictions of sales to intoxicated and underage people	Consumer labelling and warning messages
		Public education campaigns
Limited-suggestive	Suspension of driving licences	Campaigns funded by the alcohol industry
	Alcohol locks	
	Work-place programmes	
	Community-based programmes	

BAC: blood alcohol concentration; EU: European Union; MS: .

self-regulation, education campaigns, exchange of best practice, across all relevant policy domains with a focus on drink driving, coordinated campaigns, protection of third parties, commercial communication, consumer information and availability and prices.

The impact assessment proposed developing a comprehensive EU-wide strategy to reduce alcohol-related harm (option 3) that would incorporate coordination of activities at EU level (option 2). Under this proposed strategy, EU institutions and bodies would encourage Member States and stakeholders to undertake coordinated activities. Analysis of all relevant policy domains in the EU and Member States would identify common aims and targeted actions. To improve coordination at the EU level and facilitate knowledge exchange, a platform based on common objectives and an agreed framework involving all stakeholders [non-governmental organizations (NGOs and industry] would be created.

What can we learn from the background documents?

The background documents emphasize the need for a comprehensive strategy which includes a range of policy actions across all relevant sectors. Key areas for action identified in the documents which are supported by evidence are:

- pricing and taxation (identified in the scientific documents);
- controlling physical availability (identified in the scientific documents);
- drink-driving countermeasures (identified in the scientific and Commission documents);
- regulating commercial communications (identified in the scientific documents);
- treatment and early intervention intervention in health care settings (identified in the scientific documents);
- increasing research and knowledge exchange (identified in the scientific and Commission documents); and
- education and persuasion strategies for raising awareness and support for action within a comprehensive strategy.

The documents note that all legislative measures must include adequate enforcement.

Reflecting the evidence base, the Council conclusions, the impact assessment annexed to the communication and the RAND report all call for comprehensive action. They note that action should be supported by country-based action plans, and backed up by coordinated activities across relevant policy domains of the European Union.

The Communication itself (summarized in Table 2)

The Communication on an EU strategy to reduce alcohol-related harm was launched at the end of 2006. It states that 'Member states have the main responsibility for national alcohol policy' and identifies the main role of the Commission as:

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'.
3. 'To support and help coordinate national actions, in particular by identifying and disseminating good practice across the EU' [6].

It describes as the 'backbone of a comprehensive strategy to reduce alcohol-related harm in Europe' a commitment to further pursue and develop actions under its competencies together with a list of good practices already implemented in Member States and the establishment of an Alcohol and Health Forum to aid in their dissemination.

The Council conclusion which supported its launch [14] invited the Commission to 'continue its systematic and sustainable approach to tackling alcohol-related harm at European level', including:

- the use of health impact assessment of Community actions;
- continuing support for member states' efforts to sustain, strengthen or develop national policies to reduce alcohol-related harm;
- to consider and apply coherently the Treaty provisions concerning the protection of public health and the Internal Market;
- to ensure balanced representation for the various stakeholders when setting up the Alcohol and Health Forum;
- to develop measurable core indicators for monitoring progress; and
- to report regularly on the progress of Commission activities to implement the EU alcohol strategy.

The Communication identifies five priority themes each with a set of aims, rationale for action and an overview of best practice.

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

Although the Communication covers a broad range of policy issues, it is lacking in support for actions shown to be most effective. In terms of regulating pricing and

Table 2 Content of commission communication.

Action	*Appears in the communication*
Information and education	Priority area 5.2. Reduce injuries and deaths from alcohol-related road traffic accidents
Number of times words mentioned in document	• To support random breath testing
Education (education programmes not educational attainment) 12	Priority area 5.3. Prevent alcohol-related harm among adults and reduce the negative impact on the work-place
	• To mobilize public support for interventions on drinking in pregnancy, underage drinking, drink driving
Information 14	• To target young people and their parents
	EU action
Awareness 10	• Could support MS in developing information and education programmes on harmful drinking and responsible consumption
	Mapping of member state actions
Health sector response	Priority area 5.3. Prevent alcohol-related harm among adults and reduce the negative impact on the work-place
	• Advice by doctors or nurses in primary health care to people at risk, and treatment listed as good practice
Number of times words mentioned in document	Mapping of member state actions
Health care 2	• Resource allocation for advice and treatment in primary care and for training of health professionals
Community action	Priority area 5.1. Protect young people, children and the unborn child
Number of times words mentioned in document:	
Community 4	• Listed as good practice to prevent harm and risky behaviour, involving teachers, parents, stakeholders and young people themselves, and supported by media messages and life-skills training programmes
(excludes community as in European Community)	
Work-place	Priority area 5.3. Prevent alcohol-related harm among adults and reduce the negative impact on the work-place
	• Work-place interventions listed as good practice
Number of times words mentioned in document	EU action
Work-place 13	• Explore, with MS and business organizations, developing information and education campaigns or similar initiatives. Exchange of specific best practice possibly with other Commission-led initiatives
Drink driving	Priority area 5.2. Reduce injuries and deaths from alcohol-related road traffic accidents
	• Enforcement of counter measures listed under good practice
	Priority area 5.3. Prevent alcohol-related harm among adults and reduce the negative impact on the work-place
	• Education campaigns targeting drink-driving listed under good practice
Number of times words mentioned in document	Priority area 5.4. Inform, educate and raise awareness on the impact of harmful and hazardous alcohol consumption, and on appropriate consumption patterns
	• Media campaigns to inform and raise awareness listed under good practice
	Mapping of MS action
	• Development of a framework to enable unrestricted (random) breath testing for all drivers
Drink driving 10	• 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
	Coordination of actions at EU level
	• To better coordinate activities to reduce alcohol-related road accidents, improve coordination between drink-driving and road safety actions
Availability	Priority area 5.1. Protect young people, children and the unborn child
Number of times words mentioned in document:	• Enforcement of restrictions on sales, and on availability listed under good practice
Availability 2	Priority area 5.3. Prevent alcohol-related harm among adults and reduce the negative impact on the work-place
	• Licence enforcement, server training, education campaigns on underage drinking listed as good practice
Sales 3	Mapping of MS action
	• Action to improve consumer information at point of sale
Serving 5	• Introduction, review and enforcement of rules on serving intoxicated and underage people and effective licensing systems for sale and service
	• Review of current age limits for serving/selling alcohol
Under age 6	Coordination of actions at EU level
	• Work with stakeholders on responsible commercial communication and sales
Marketing	Priority area 5.1. Protect young people, children and the unborn child
	• Enforcement of marketing restrictions listed under good practice
Number of times words mentioned in document	EU action
	• Exchanges of good practice to address irresponsible marketing, and the image of excessive alcohol use conveyed through the media and by role models
Marketing 3	Coordination at EU level
	• Work with stakeholders on cooperation on responsible commercial communication and sales, including the presentation of a model of responsible consumption. To support EU and national/local governments to prevent irresponsible marketing and to regularly examine trends in advertising and issues of concern
Self-regulatory 4	• To reach an agreement with representatives from a range of sectors on a code of commercial communication implemented at national and EU level. Monitoring of the impact of self-regulatory codes on young people's drinking and industry compliance with such codes. Independent parties invited to verify the performance and outcomes of self-regulatory codes against agreed benchmarks, thus allowing Social Responsibility Organizations to adjust objectives accordingly
Price	Priority area 5.1. Protect young people, children and the unborn child
	• Some MS increased taxes on products they perceive to be particularly attractive to underage drinkers
Number of times words mentioned in document	Priority area 5.3. Prevent alcohol-related harm among adults and reduce the negative impact on the work-place
Price 0	• Some Member States have increased taxes on products which they perceive to be particularly attractive to underage drinkers
Pricing 1	• Pricing policy (e.g. reducing 'two-drinks-for-one' offers) is listed as appearing to be an effective intervention under good practice
Tax 1	Mapping of MS action
Taxation 1	• Setting levels of alcohol taxation
Drinking environments	Priority area 5.3. Prevent alcohol-related harm among adults and reduce the negative impact on the work-place
	• Listed as appearing to be effective under good practice
Number of times words mentioned in document	Mapping of MS actions
Server training 1	• 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

BAC: blood alcohol concentration; EU: European Union; MS: Member States.

taxation, the most cost-effective of all alcohol policy options to reduce alcohol-related harm, there is little call for strengthened action. The word 'price' is not mentioned in the document at all, with 'pricing' once, 'tax' once and 'taxation' once.

The impact of price on consumption was established further in a 2009 report by RAND Europe for the Commission on affordability and alcohol consumption in the European Union. The report found a statistically significant positive relationship between alcohol affordability and consumption across the EU, suggesting a total increase in consumption of 0.32% following a 1% increase in affordability [15].

Measures to control physical availability are barely mentioned, other than to say that effective measures have been taken in Member States related to enforcement of restrictions on sales (to young people or the intoxicated), effective licensing systems and responsible service. Early and brief interventions/advice in health-care settings are mentioned only twice, once in relation to reducing harm in the work-place and once as an example of measures currently implemented in Member States.

Conversely, the document is extensive in its call for more information and education, the least effective of all alcohol policy options. The word 'education' is mentioned 12 times, 'information' (excluding information as in data sources or monitoring) 14 times and 'awareness' 10 times. Although health care (as in advice or treatment) is mentioned only twice, work-place interventions (providing support), for which evidence for effectiveness is weak, is mentioned 13 times.

While there is an emphasis on mapping and exchange of best practices, and the Council's invitation calls for monitoring and reporting on progress, there are no recommendations regarding the evaluation of existing or proposed actions. The document also provides little guidance on how to develop, introduce or enforce those actions found to be effective. However, the Communication does state that an action for the Commission is prioritizing support for the development of standard definitions and indicators through the Public Health Programme and other structures.

Implementation

Implementation of the strategy is based on four pillars, as follows.

1. Strengthened coordination and policy development between Member States and the European Union level, through the Committee on National Alcohol Policy and Action.
2. Stimulation of concrete stakeholder-driven action on the ground, through the European Alcohol and Health Forum.
3. Development of reliable, comparable and regularly updated data on alcohol consumption, drinking patterns and alcohol-related harm, as well as on common indicators and definitions, through the Committee on Data Collection, Indicators and Definitions.
4. Mainstreaming the reduction of alcohol-related harm into other Community policies [16].

Committee on National Alcohol Policy and Action

The Committee on National Alcohol Policy and Action is composed of Member State representatives and experts, and observers from the European Free Trade Association (EFTA) and EU candidate countries, and includes the WHO. Its main objective is 'to further coordinate government-driven policies aimed at reducing alcohol-related harm at national and local level, building *inter alia* upon the examples of good practice identified in the European Strategy' [17].

Until December 2009, the Committee had met five times. Member State representatives have shared knowledge and presented policy in their countries at Committee meetings and EC initiatives and other European research have been presented and discussed. The Committee has undertaken a one-off policy mapping exercise to identify policies in Member States in the first four priority areas of the Communication [18].

The European Alcohol and Health Forum

The purpose of the European Alcohol and Health Forum [19] is to provide a common platform at the EU level for stakeholders to collaborate and commit to action to reduce alcohol-related harm. Forum members include European and national industry associations, civil society organizations, research institutes/alliances, associations of health professionals and marketing and advertising associations. It is supported by a Science Group, which contributes scientific research and opinion and has Task Forces on Youth-Specific Aspects of Alcohol and on Marketing Communications.

The seven priority areas of the Forum are as follows.

1. Better cooperation/actions on responsible commercial communications and sales.
2. Develop efficient common approaches to provide adequate consumer information.
3. Develop information and education programmes on the effect of harmful drinking.
4. Develop information and education programmes on responsible patterns of consumption.
5. Enforce age limits for selling and serving alcoholic beverages.
6. Develop a strategy aimed at curbing underage drinking.

7. Promote effective behavioural change among children and adolescents.

The Forum invites members to make commitments to action to reduce alcohol-related harm under the priority areas. In April 2009, 108 commitments had been received [20]. Of these, close to half (46%) related to education and persuasion activities, among the interventions with the lowest evidence for effectiveness. Only 6% of commitments were in the area 'behavioural change among children and adolescents'. Protecting young people is a priority theme in the Communication. Commitments to 'responsible communication and sales' accounted for 22% of commitments, most of which focused primarily on self-regulation activities, also shown to have little evidence for effectiveness. Alcoholic beverage producers proposed 58% of the commitments. This reflects the make-up of the Forum, with production and sales groups representing 22 of the 43 members. The specific proposed actions indicated few evidence-based approaches or methods/plans for evaluating/monitoring effectiveness [21].

Members are required to provide monitoring reports on their stated commitments in a standardized format. These reports are to include objectives, outputs, outcomes and impacts and proposed dissemination activities. In January 2010, RAND Europe published the first monitoring progress report, a quality assessment of the information in these monitoring reports [22]. The majority (69%) of the reports included in the RAND report were submitted by members classified as 'production and sales organisations' with the largest number of these (21) relating to the priority 'Better cooperation/action on responsible commercial communications and sales'. Further analysis of these 21 reports by RAND found that almost all of them were self-regulation activities [22].

The most common target group of the commitments reported on was 'policy makers and professionals' (33%), with very few targeting young people. This suggests that the focus of the Forum members overall is more about influencing policy than about undertaking direct public health actions themselves. This would also suggest that the over-representation of the number of commitments made by production and sales organizations is unlikely to be due to the fact that such organizations tend to have more resources than other members of the Forum. The report found significant variation in the quality of the reports with some members appearing to struggle with their monitoring commitments and having 'difficulty in communicating how they relate to the aims of the Forum or what they have produced in terms of outputs' [22].

The Task Force on Youth. The Task Force on Youth proposed the establishment of a clearing-house that would enable the collection and sharing of information on alcohol and health activities that target youth.

The Task Force on Marketing. The Task Force on Marketing has undertaken a mapping exercise and produced reports on targeting youth which notes the evidence of a link between advertising and youth alcohol consumption, social marketing and self-regulation which maps statutory and self-regulation in Europe and provides a summary of best practices [23].

The Science Group. The Science Group produced a report in 2009: *Does Marketing Communication Impact on the Volume and Patterns of Consumption of Alcoholic Beverages, Especially by Young People? A review of longitudinal studies*. This report found consistent evidence for an impact of alcohol advertising on the uptake of drinking among non-drinking young people and increased consumption among those who already drank, consistent with previous research [24].

Committee on Data Collection, Indicators and Definitions

The Committee on Data Collection, Indicators and Definitions is composed of representatives from the Commission, the WHO, the European School Survey Project on Alcohol and Other Drugs (ESPAD), the European Monitoring Centre for Drugs and Drug Addiction (EMCDDA) and other partners [25].

Goal 5 of the 2006 Communication is to 'develop, support and maintain a common evidence base' including comparable information, definitions and information on the impact of policies and of alcohol consumption on productivity and economic development, and to evaluate the impact of initiatives taken on the basis of the Communication. The Communication notes development of health indicators to monitor and assess developments as an action by the European Commission [6].

At its first meeting in December 2008 the Committee agreed on three key indicators: volume of consumption; pattern of consumption; and alcohol-related health harm. At the second meeting in September 2009 indicators aligned with the priority themes of the Communication were proposed [25]. It is not the purpose of the Committee to collect data based on the indicators.

Other Commission activities

Activities within other branches of the Commission can impact on alcohol-related harm. Cross-border shopping has been encouraged by 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 payment, direct or indirect [26]. The Audiovisual Media Services Directive (2007/

65/EC) includes guidance on the advertising of alcoholic beverages and young people; however, it has weakened over time, with the text in force stating only that alcohol communications shall not be aimed specifically at minors and shall not encourage immoderate alcohol consumption, whereas the original text provided clear guidelines describing the types of images and advertising which appeal to young people and were to be avoided [27]. Proposals for labelling have failed to include a mandatory placement of warning labels or the listing of relevant ingredients on alcoholic beverage containers [28]. In the field of agriculture, reform of the common wine market has set lower limits for added sugar (with exceptions for particularly unfavourable climatic conditions) and which, in principle, could lead to lower alcohol concentration in European wines and thus less negative impact on health [29].

Co-financed projects (summarized in Table 3)

A number of alcohol-related projects have received EC funding under the Public Health Programme and the Research Framework Programme (for overview, see [30]). These projects provide significant evidence and policy recommendations and guidelines and add value to work undertaken by other bodies, including the World Health Organization, national ministries and civil society organizations in areas such as: brief interventions; the impact of marketing communications on young people; effectiveness and cost-effectiveness of interventions; price and affordability; cultural and social aspects of alcohol consumption and their impact on the effectiveness of policy measures; and data collection methods.

Although the breadth and depth of co-financed projects is apparent, there have been no systematic evaluations of the coordination and complementarity of the projects, the extent to which their findings are well disseminated throughout European and national institutions or the extent to which their findings impact on alcohol policy and programme development.

DISCUSSION

Europe is in the unusual position of being the region in the world with the highest levels of alcohol consumption and alcohol-related harm [1]. In many European countries there has been a strong tradition of government regulation of the sale of alcohol. For these countries, adoption of evidence-based alcohol policies could be seen as a matter of recovering a lost policy tradition abandoned in the face of a period of deregulation over the past three or so decades.

The debate on science and alcohol policy has existed for many years. While research may provide evidence of the social, health and economic impacts of various actions or of inaction, political decision makers do not develop and implement policy based solely on research evidence. Many other factors influence policy. These may include issues around tariffs and trade, input from multiple stakeholders, including non-governmental organizations, corporate social responsibility organizations and industry, policies in other sectors such as agriculture and media and the findings of impact assessment in areas such as the environment. In particular, the EU's beginnings as a trading bloc with its roots originally in trade may have led to an emphasis on collaboration with industry and to policies which protect open trade but do not traditionally prioritize health, although the introduction of health impact assessments aims to address this.

Furthermore, scientific evidence can become blurred and conflicts of interest arise, such as with industry involvement, especially in supporting research and public health campaigns. In policy making in all sectors, evidence is often incomplete, may be ambiguous and is frequently contested [31]. In the case of alcohol, the vigorous participation of the alcohol industry in the policy debate and the promotion of a common market are significant factors [32–36]. The policy options contested by the alcohol industry also happen to be those that are effective in reducing alcohol-related harm, such as regulation of price and availability, measures given scant mention in the Communication.

The very nature of the EU itself gives rise to complex issues around roles, obligations and rights. The structure of the EU as a union of Member States with a diverse mix of cultural, social, political and economic structures poses difficulties in the form of conflict between the role and right of individual Member States to develop and implement national policies and legislation, their obligations under various Treaties and the role of the EU as an overarching cooperative body. All these factors add another level of complexity to the already difficult process of translating research to policy and effective action.

In the Communication, there are fewer recommendations for concrete actions than might be expected considering the burden of alcohol-related harm in Europe, which had already been acknowledged widely as in need of addressing. Furthermore, the Communication does not respond fully to the Council's invitation to 'put forward proposals for a comprehensive strategy aimed at reducing alcohol related harm which shall complement national policies and set out a timetable for the different actions' presented in the 2001 and 2004 Conclusions. Instead, it emphasizes mapping existing interventions and identifying best practice rather than outlining a concrete strategy with measurable indicators, ongoing monitoring and evaluation or timetable for action. Although it prioritizes supporting the development of common

Table 3 Alcohol policy-related projects co-financed by the European Commission.

Project	*Activities*	*Outcome/s*
Building capacity project (http://www.ias.org.uk/buildingcapacity/index.html)	• 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 • Creating database on laws and regulations	• Series of country reports • Series of 'fact sheets' relating to alcohol policy, evidence and options • Set of cost-effectiveness briefing notes
Enforcement of National Laws and Self-Regulation on Advertising and Marketing of Alcohol (ELSA) (http://stap.nl/elsa/elsa_project)	• Reviewed alcohol marketing regulations across the EU and the impact of marketing on alcohol consumption and related harm	• Mapping and description of regulations on alcohol marketing in EU Member States • Guidance on monitoring commercial communications • Reviewed evidence of the impact of commercial communications
Pathways for Health Project (PHP) (http://dhs.de/web/dhs_international/pathways.php)	• Reviewed evidence and make recommendations on: consumer labelling of alcoholic beverage containers; effective drink–driving policies and programmes; the effectiveness of policies and programmes to reduce heavy episodic drinking	• Guidance on prevention of drink–driving • Guidance on consumer labelling • Guidance on prevention of binge drinking
Primary Health Care European Project on Alcohol (PHEPA) (http://gencat.net/salut/phepa/units/phepa/html/en/Du9/index.html)	• Development of clinical guidelines and a training manual for brief advice programmes • Analysis of the delivery of primary care services for hazardous and harmful alcohol consumption in the EU with development of a tool to assess programmes	• Clinical guidelines for brief advice programmes • Training manual for brief advice programmes • Tool to assess delivery of brief advice programmes
Focus on Alcohol-Safe Environments (FASE) (http://www.faseproject.eu/wwwfaseprojecteu/about-fase/project-description.html)	• Produces guidance on: work-place actions; safer drinking environments; regulating commercial communications • Reviews of international and European literature to identify evidence based interventions and policies • Collation of examples of best practice laws and infrastructure in Europe • Recommendations based on the findings of the reviews and best practice examples	• Ongoing
Standardizing Measurement of Alcohol-Related Troubles (SMART) (http://www.ipin.edu.pl/alcsmart)	• Development of standard survey methodologies on heavy drinking, binge drinking drunkenness, context of drinking, alcohol dependence and unrecorded consumption, as well as public support for alcohol policy measures • Development of standardized methodology for cost–benefit analyses of alcohol policies to evaluate the economic impact of existing alcohol policies in the EU • Propose standard survey indicators for harmful alcohol consumption and heavy episodic drinking	• Ongoing
Alcohol Measures for Public Health Research Alliance (AMPHORA) (http://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	• Ongoing
Health Evolution Monitoring (HEM) (http://hem.home.pl)	• Analysis of alcohol's contribution to health inequalities in different EU countries	• Data included in a set of Country Profiles and Reports describing alcohol's contribution to health inequalities
Good Health into Older Age (VINTAGE) (http://www.epicentro.iss.it/vintage/project.asp)	• Provides guidance on reducing alcohol-related harm among older people • Systematic reviews of international literature with the aim of documenting the extent and characteristics of harmful alcohol use among older people, including alcohol-related disorders and conditions, and identifying evidence-based interventions and policies to reduce such harm • Collection of examples of best practice and related laws and infrastructures to reduce alcohol-related harm among older people gathered from partner agencies in European and international networks	• Ongoing
Alcohol Labelling Policies to Protect Young People (PROTECT)	• Provides guidance on the labelling of alcoholic products	• Ongoing
Monitoring Alcohol Commercial Communications in Europe (AMMIE)	• Provides guidance on monitoring alcohol marketing	• Ongoing
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 (http://www.euro.who.int/partnerships/partners/20070326_1)	• Updating the European Alcohol Information System (EAIS) and ensuring compatibility with the Commission database on alcohol • Reviewing social cost studies on alcohol • Reviewing the evidence for the effectiveness and cost-effectiveness of alcohol policy options	• Analysed the Commission Communication and the WHO Framework • Developed a handbook for country-based action

EU: European Union; WHO: World Health Organization.

indicators and definitions, it offers little guidance in evaluating the effectiveness of existing or proposed actions.

As stated earlier, the Communication is weak in its support for proven actions and favours less effective measures such as education and self-regulatory approaches. Taxation (strong evidence for effectiveness) is not mentioned, other than to state that the EU sets a minimum excise and Member States impose their own taxes on top of this as they deem necessary. Cross-border trade and its relation to taxation is also not addressed in the Communication. Taxation and cross-border trade are areas which can and need to be addressed at Community level, and the statement 'some issues are of Community relevance because of a cross-border element' might have raised the expectation that this would have been addressed.

In terms of increasing the knowledge base, the Commission's co-financed projects take on a strong supportive role to the Communication by providing evidence and experience across a wide range of alcohol policy domains and issues. However, the extent to which this knowledge is received at the country level and the extent to which it impacts on alcohol policy development and implementation is unknown.

It has been argued frequently (for example, see [37]) that one of the reasons for the lack of evidence in driving the Communication results from the European Union's roots in trade, placing priority on a collaborative relationship with, in this case, alcohol-industry interests. Consensus-building among stakeholders, one of the implicit assumptions of the Communication, while admirable, seems fraught with difficulty when, with regard to pricing policy, the alcohol industry has stated frequently that they 'Objected to the statement that there is "strong evidence" that increasing the level of excise duties is an effective means of reducing alcohol-related harm. This assertion was based on a selective and tendentious reading of the available "evidence" and a comprehensive and balanced reading does not support this conclusion' (see [31,38]).

In alcohol policy, factors impeding progress include a failure of political will, unhelpful participation of the alcohol industry in the policy process, with surprising similarities between alcohol and tobacco companies in their approaches to evidence and counter-arguments to public health measures [39], and increasing difficulty in free-trade environments to respond adequately at a national level [37]. In tobacco policy, however, failure of political will has not been the case, despite the presence of stiff opposition by the tobacco industry [40], described as merchants of doubt [41]. Most European countries have effective tobacco control policies, and the European Commission has been active in cross-border issues, with legislative measures, including advertising bans and highly visible and common health warning labels, being the backbone of its present and future tobacco control activities [42]. Globally, alcohol is the third most important risk factor for ill health and premature death after childhood underweight and unsafe sex, and more important than tobacco (although in high-income countries, tobacco remains the most important risk factor ahead of alcohol, in second place) [43]. Increasingly, these data are spurring new action, as evidenced by the WHO global strategy on reducing harmful alcohol use [44], which may provide the incentive for increased political will at the European and Member State level.

CONCLUSIONS

In 2002, the European Commission introduced an integrated impact assessment (IA) procedure to inform all policy making. The process was to be undertaken for all major initiatives and includes a requirement to consult with a wide range of stakeholders [45]. This was introduced within the context of the Lisbon Agenda and its purpose is to assess 'the potential economic, social and environmental consequences that they [proposed policies] may have. . . . It is a process that prepares evidence for political decision-makers on the advantages and disadvantages of possible policy options by assessing their potential impact' (http://ec.europa.eu/governance/impact/index_en.htm). There is, however, concern that this important policy tool does not fully consider alcohol-related health and, rather, favours corporate interests [45].

The European Union has a strong legal commitment to health. For example, its article 152 states: 'A high level of human health protection shall be ensured in the definition and implementation of all Community policies and activities', and 'Community action, which shall complement national policies, shall be directed towards improving public health, preventing human illness and diseases, and obviating sources of danger to human health'. Notwithstanding favourable European court cases on alcohol policy [46], the evidence presented in this paper and elsewhere [1] would suggest that current actions in sectors other than health, with the exception of transport policy, are unlikely to contribute in any significant way in reducing the harm caused by alcohol.

The Communication makes important commitments to taking action to improve the evidence base, and a number of co-financed projects have contributed significantly to this objective. However, more could be done in terms of evaluating the impact of these projects and supporting effective monitoring and evaluation of all implementation activities in general.

The Communication on an EU Strategy to support Member States in reducing alcohol-related harm

acknowledges the science in terms of recognizing the importance of alcohol as a health and social determinant in Europe, but does not propose actions which address adequately the size of the problem which it describes. The strategy places more emphasis on actions known to be less effective, such as education, persuasion and self-regulation activities, than on those with strong evidence for effectiveness, such as measures to control availability through taxation and pricing.

With regard to reducing the harm caused by alcohol, there is an asynchronization with regard to alcohol policy governance and implementation. On one hand, poor health and premature death (of which some 8% is due to alcohol) present a high threat to European wellbeing and development. On the other hand, strong European cooperation seems to be lacking for different sectors to work together for reductions in the harm caused by alcohol when, under the concept of 'stewardship', governance systems are considered to have an obligation to provide conditions that enable people to be healthy.

Declarations of interest

None.

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