COMMISSION OF THE EUROPEAN COMMUNITIES

Brussels, xxx
SEC (2006) 1360/2

COMMISSION STAFF WORKING DOCUMENT

Document accompanying the

COMMUNICATION FROM THE COMMISSION TO THE COUNCIL, THE EUROPEAN PARLIAMENT, THE EUROPEAN ECONOMIC AND SOCIAL COMMITTEE AND THE COMMITTEE OF THE REGIONS

An EU strategy to support Member States in reducing alcohol related harm

{COM(2006) 625 final}

Summary
of the IMPACT ASSESSMENT

SUMMARY OF THE IMPACT ASSESSMENT[1] [i] ON A COMMISSION COMMUNICATION ON - AN EU STRATEGY TO SUPPORT MEMBER STATES IN REDUCING ALCOHOL RELATED HARM

NOTE:
Given the requirements in terms of number of pages, this summary is limited to the main findings of the impact assessment, which is available only in English.

1. BACKGROUND

In 2001 the Council adopted a Recommendation on the drinking of alcohol by young people, in particular children and adolescents[2], 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[3].

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[4].

Since 2004 the Commission services have held extensive consultations with Member States experts, international organisations, researchers and stakeholders (wider alcohol industry and consumer and health NGOs), which have led to the identification of the options analysed in the present Impact Assessment (IA). As part of the IA process the Commission contracted an ex ante assessment of the economic impact of alcohol policies[5]. This assessment, hereinafter referred to as the 'IA Background Report', can be consulted at the Commission's public health web site *http://ec.europa.eu/health/index_en.htm.*

2. THE COMMISSION'S "ROAD MAP"

The Commission's "Road Map" published in 2005[6] identified four options for a future policy to reduce alcohol-related harm. As these four options are valid for structuring an assessment of the impact of Community action, or lack of such action, in this area, they were maintained for the impact assessment process. These four options are:

(1) **No change**: In this option, policy decisions and initiatives would be left largely to Member States and stakeholders, without coordination at European level. The EU would limit its role to financing a limited number of projects within the Public Health Programme, facilitating the exchange of best practice, and collecting and disseminating information on alcohol consumption and harm. This option would neither involve coordination of activities across policy domains, nor any comprehensive strategy.

(2) **Coordination of activities at EU level:** Under this option the EU institutions and bodies would encourage Member States and stakeholders throughout the European Union to undertake coordinated activities to reduce alcohol-related harm (e.g. encourage representatives of the wider alcohol industry to better implement and monitor their own activities related to self-regulation and to common codes of conduct on commercial communication; encourage the exchange of best practice on interventions between Member States). There would be no agreed coherent and

[i] References are grouped in Annex 1 at the end of this document

comprehensive EU-wide strategy with specified objectives and implementation tools that could serve as the basis for orienting such coordination, and for underpinning approaches that would cut across other policies. Moreover, this option would not provide opportunities for supporting multi-stakeholder action and public-private partnerships on the basis of a solid strategic approach.

(3) **A comprehensive EU-wide strategy**: In addition to option 2, all relevant policy domains of the EU and of Member States (public health, internal market, employment, social, taxation, transport, education, agriculture, research, youth and consumer policy etc) would be analysed to develop and implement a coherent EU-wide strategy with common aims and targeted actions to tackle alcohol related harm. A platform based on common objectives and an agreed framework, and involving all stakeholders (NGO and industry) would be created in order to improve coordination at the EU level and facilitate exchange of evidence based activities. While this strategy will not intend to substitute Community action to national policies, which are in place in most of the Member States and relate to national competences, the work would involve all relevant EU institutions and Member States and would be supported by a wide variety of policy instruments.

(4) **Purely regulatory approach**: Focus only on far-reaching stricter regulation at EU and national level, and on stronger enforcement to achieve a decline in the harmful effects of alcohol use, without any further support to Member States or any additional activities at the EU level.

3. THE ROLE OF THE ALCOHOL INDUSTRY

The IA Background report estimated the total size of the alcohol industry at roughly €45 billion (23% of the food industry and 0.4% of EU25 GDP)[7].

In 2004, European breweries directly employed a total of 164,000 workers and were indirectly responsible for 342,000 jobs in supplying industries; 147,000 of these 342,000 jobs were in agriculture[8]. Spirits producers account for 50,000 workers in the industry itself, and for a further 250,000 in supplying industries (ICAP 2006). In the IA Background Report the number of workers in the wine sector is estimated at 385,000. In the impact assessment conducted by the Commission services on the wine reform it was estimated at 1, 5 million AWU (annual work unit)[9].

Households in the EU annually spend about €95 billion on alcoholic beverages per year, equal to 13.9% of total expenditure on foodstuffs, and to 1.6% of total consumer expenditure[10].

Harmful and hazardous alcohol consumption affects productivity mainly in three ways[11]:

1. It inflicts physical damage on drinkers, and poor health has an adverse effect on productivity (when the employee still works), output (when the employee is absent or becomes unemployed) or on the “entering” into workforce (youth drinking negatively influences educational attainment).

2. It alters the behaviour of drinkers, diminishes their capacity to perform complex tasks and can lead to mistakes and accidents that cause damage or otherwise disrupt the production process.

3. It can have an impact on third parties, such as co-workers, and can be detrimental to social capital, as it undermines trust.

4. THE IMPACT OF HARMFUL AND HAZARDOUS ALCOHOL CONSUMPTION ON HEALTH

In general, for adult people with no chronic diseases, a moderate consumption of alcohol does not appear to create health risks in general. Moderate alcohol consumption appears to offer some protection against coronary heart disease in older people (45 and above depending on gender and individual differences)[12]. According to WHO and most researchers harmful and hazardous consumption may cause 60 different types of diseases and conditions[13], including injuries, occupational diseases, mental and behavioural disorders, gastrointestinal conditions, cancers, cardiovascular diseases, immunological disorders, lung diseases, skeletal and muscular diseases, reproductive disorders and pre-natal harm, including an increased risk of prematurely born children and low birth weight. The frequency and the volume of episodic heavy drinking are of particular importance for increasing the risk of injuries and violence.

5. THE CASE FOR ACTION AT EU LEVEL

Health is one important key to Europe's growth and prosperity. Bad health, and social problems caused by harmful and hazardous alcohol consumption, lead to productivity loss, shorter working lives, and high social, law enforcement and healthcare costs. Based on a review of existing studies, the total tangible cost of alcohol to EU societies in 2003 was estimated to be €125 billion, equivalent to 1.3% GDP (which is in the same order of magnitude as the cost for tobacco)[14]. The impact assessment shows that a less harmful use of alcohol across the EU would contribute to the European Council's Lisbon objective of more Healthy Life Years for All.

Although most Member States have taken actions to reduce alcohol-related harm, the level of harm, especially among young people, for the unborn child, on roads and at workplaces is still unacceptably high. Moreover, studies carried out at national and EU level show that better implementation, coordination and enforcement of interventions with a proven effect is needed to reduce alcohol related harm in the EU[15]. The Council has on two occasions underlined the need for developing a comprehensive strategy at EU level, and invited the Commission to put forward proposals aimed at reducing alcohol-related harm (Council Conclusions of 5 June 2001 and of 2 June 2004).

EU action to reduce alcohol-related harm would also support the implementation of other relevant policy objectives already agreed at EU level e.g. on Road Safety[16], Health and Safety at work[17], and the Convention on the Rights of the Child[18].

There are several reasons why action at EU level is required to support and complement Member States' activities:

– Member States and stakeholders have announced that some of them are facing difficulties in solving alcohol related problems at national level, especially when individual Member States' efforts are diluted due to cross-border activity, like exposure to cross-border advertising or cross-border private imports.

– Although cultural and national differences in alcohol consumption and drinking patterns still exist in the EU, there has been a convergence across its Member States in alcohol consumption levels and beverage preferences (see fig. 1 in the annex). Beer is becoming the most popular alcoholic beverage in some of the wine producing countries, and wine consumption is increasing (in the adult population) in the non-wine producing countries. In parallel, there has been a globalisation of the alcohol market: one quarter of the alcohol market is now operated by multinational drinks operators.

– Most Member States report concerns about irresponsible drinking habits and changing alcohol attitudes among youth and young adults, i.e. consuming alcohol outside meals with a clear intention of becoming intoxicated instead of consuming alcohol with the afternoon/evening meal. The highest numbers of binge drinking amongst 15-16 year olds are reported in Ireland (32%), the Netherlands (28%), the United Kingdom (27%), Malta (25%) and Sweden (25%)[19]. Countries with the lowest binge drinking figures are Hungary (8%), France (9%), Cyprus (10%), Romania (11%), Poland (11%) and Greece (11%). In a majority of the EU Member States participating in the ESPAD study, binge drinking amongst girls increased between 1995 and 2003 (*cf. table 1 and fig. 2-3 in the annex*).

– 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[20], and efforts to curb drink-driving can make a substantial contribution to achieving this objective[21].

– 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 and productivity[22]. It is a net cause of 7,4 %[23] of all ill-health and early death in the EU and it increases the risk of child abuse and birth deficits.

– The impact assessment has revealed that there is an acute need to develop comparative and comprehensive information and monitoring systems and exchange of best practise between Member States at the EU level in order to fill the existing research gap.

These developments and findings have highlighted the need for Community involvement and support in order to coordinate and complement national and local activities, especially in order to curb young people's and young adults' harmful drinking patterns, reduce injuries and the number of children born with alcohol-related birth deficits (exploitation of synergies, exchange of best practice).

6. THE PREFERRED OPTION

In line with the findings of the reports that have provided input for the Impact Assessment[24], and based on the consultations held, the preferable approach from both a public health and economic point of view would be to develop an EU-wide strategy to reduce alcohol related harm (option 3) that would incorporate option 2 (coordination of activities at EU level. The following reasons underpin this choice:

– Firstly, there is strong support from research findings and stakeholder consultations that an approach which is

  - based on evidence and a culturally adapted policy mix,
  - involving multi-stakeholder action that is implemented and supported at all levels,
  - aiming at creating an environment which helps citizens make healthy choices for themselves and for their children

  would in the long run, complemented with coordinated efforts aimed at enforcing existing national legislation, contribute to reducing alcohol-related harm and to increasing the number of healthy life years in the EU. A comprehensive EU-wide

strategy would facilitate the implementation of such an approach, especially by strengthening the involvement of all relevant stakeholders, improving the evidence base and disseminating information and best practice to all relevant actors.

– Secondly, option 3 is in line with findings on the effectiveness of different policy interventions to reduce alcohol-related health and social harm[25]. According to WHO the most effective way to reduce alcohol related harm would be, at the EU or national level, to combine drink driving countermeasures, measures to protect young and other vulnerable people, awareness raising activities involving all relevant parties at all levels, evidence based preventive measures to reduce harmful and hazardous alcohol consumption, brief counselling interventions in primary health care, research and data collection etc., in a comprehensive and coherent long-term strategy. These findings are relevant for all levels of responsibility, against all cultural backgrounds and across all Member States.

– Thirdly, option 3 could contribute to developing integrated EU-level approaches to important cross-cutting health issues such as drink-driving, harmful drinking patterns among youth or consumer information on alcohol and health. It would also provide a framework, underpinned by the objectives of the strategy, for integrating multi-stakeholder and community-based approaches, as its comprehensive nature provides opportunities for the integration of efforts across all societal sectors and at all levels (local, regional, national and international).

– Finally, according to the IA Background Report, option 3 also appears to provide more individual, micro- and macroeconomic and sectoral benefits than options 2 and 4. The direct macroeconomic impacts of option 3 may not be significant relative to the size of the EU economy; however, due to a combination of microeconomic factors, productivity gains are expected to be substantial. Option 3 also performs better than the three other options with regard to opportunities for synergy.

Key areas for joint approaches under option 3, following a mapping exercise and based on a mix of preventive initiatives and enforcement of existing national legislations and found to be cost-effective in the IA Background report, are:

- Drink-driving: a combination of national enforced low blood alcohol limits, random breath testing, license suspension, treatment and awareness raising activities is found to be most effective to reduce alcohol-related road accidents in all Member States. These measures should be supported by coordinated actions to inform citizens on the impact of harmful and hazardous alcohol consumption both at EU and national level.
- Actions to protect young people, children and the unborn child: enforced national age-limits, address commercial communication targeting or likely to influence young people, responsible server training, life-skills training supported by family programmes. An EU-wide strategy would enable stakeholders and Member States to better coordinate and target their actions and to develop and enforce guidelines and codes across the EU.
- Consumer information and education on the effect of harmful drinking and on appropriate patterns of drinking, provided by all relevant actors.
- Strengthened and coordinated prevention activities at workplaces to inform about the impact of alcohol on health and safety at work.

Annex 1: Tables and Figures

Table 1: Drunkenness and binge drinking among boys and girls in the EU25, 2003

	drunk 3 times or more in the last 30 days		binge drinking 3 times or more in the last 30 days	
	boys	girls	boys	girls
Denmark	30	21	31	18
Finland	15	17	18	15
Sweden	12	9	18	14
Ireland	27	25	31	33
UK	22	25	26	29
Austria	22	11	•	•
Belgium	12	4	28	14
Germany	11	8	31	24
Netherlands	10	4	37	20
Cyprus	6	1	17	6
France	5	2	13	7
Greece	3	3	14	8
Italy	9	3	19	8
Malta	7	4	32	19
Portugal	6	2	20	10
Czech Republic	17	10	24	13
Estonia	23	13	26	15
Hungary	11	5	12	5
Latvia	12	7	24	18
Lithuania	17	8	19	7
Poland	13	5	17	5
Slovakia	14	8	20	12
Slovenia	16	8	23	18

Source: ESPAD.2003

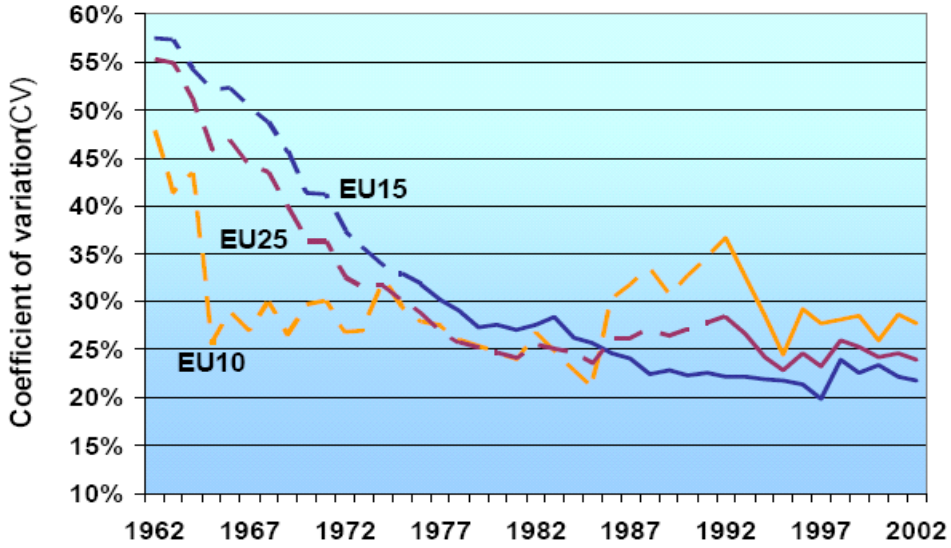

Figure 1: Convergence in alcohol consumption across Europe

Source: WHO Health for All Database (1961-9 trend from WHO Global Alcohol Database) (based on an analysis of the Coefficient of Variation (CV), a measure of relative dispersion calculated as the absolute dispersion (Standard Deviation) of the country values divided by their mean (i.e. a 50% CV is where the standard deviation of the EU country values is half the value of the mean). This is identical to the ECAS study (Leifman 2001b), except that the trends in this figure use population-weighted values)

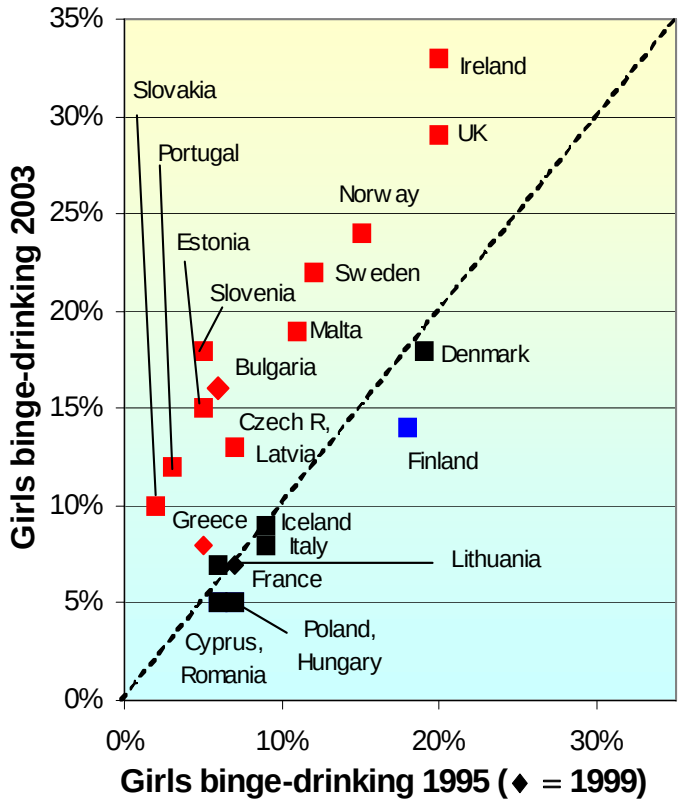

Figure 2: Changes in reported binge-drinking among girls (between 1995 or 1999 and 2003). 11 out of 22 countries reported increased binge-drinking among girls.

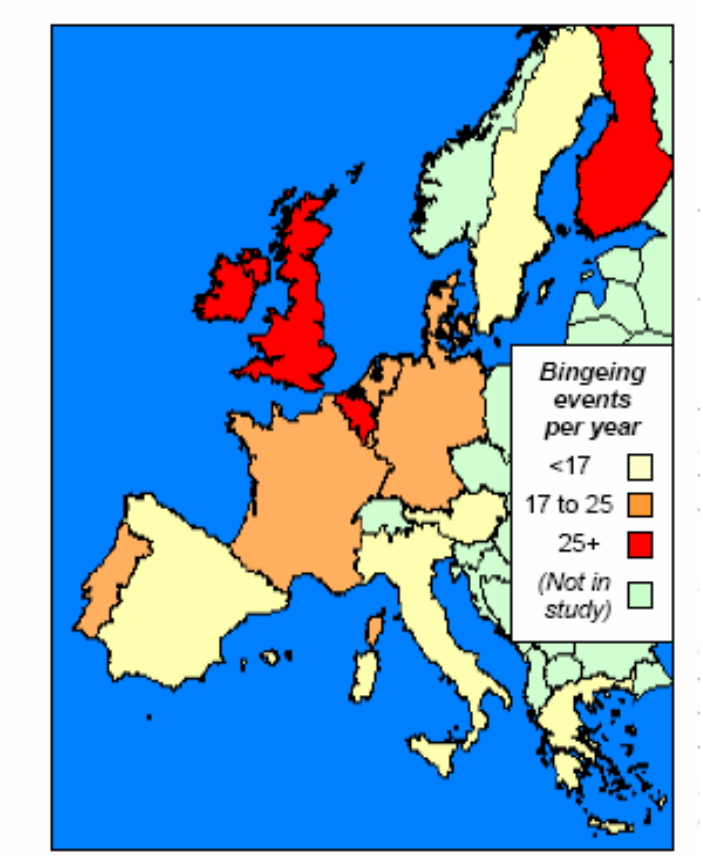

Figure 3: Binge drinking among adults

Source: Eurobarometer 2003, Binge drinking = 5 pints of beer, 1 bottle of wine, 5 shots of spirits on a single occasion

ANNEX 2: References

[1] On the basis of SEC (2005) 791 of 15 June 2005 (Impact Assessment Guidelines)

[2] 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

[3] Full report published at *http://ec.europa.eu/comm/health*

[4] 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)

[5] RAND Europe Foundation: An ex ante assessment of the economic impacts of EU alcohol policies, Horlings and Scoggins, RAND 2006

[6] 2005/SANCO/032; http://ec.europa.eu/atwork/programmes/docs/wp2006_roadmaps.pdf

[7] The brewing sector has presented another study indicating that the brewing sector alone values its contribution to EU economy at €57,5 billion.

[8] Ernst & Young 2006

http://ec.europa.eu/agriculture/markets/wine/studies/rep_econ2006_en.pd .

[10] Eurostat online database

[11] IA Background report

[12] There is no common agreement on any exact definition of the level of moderate consumption that would give some protection

[13] Rehm J, Room R, Monteiro M, Gmel G, Graham K, Rehn T, Sempos CT, Frick U, Jernigan D. (2004). Alcohol. In: WHO (ed), *Comparative quantification of health risks: Global and regional burden of disease due to selected major risk factors*. Geneva: WHO

[14] Anderson, P. & Baumberg, B. (2006) Alcohol in Europe. London: Institute of Alcohol Studies

[15] 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)

[16] 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 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

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

[18] UN resolution 44/25 of 20 November 1989

[19] ESPAD Alcohol and Other Drug Use Among Students in 35 European Countries (Hibel et al 2003) (Austria, Germany, Luxembourg and Spain not covered in binge-drinking survey)

[20] COM(2001) 370 final European transport policy for 2010: time to decide

[21] 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.

[22] 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

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

[24] An ex ante assessment of the economic impacts of EU alcohol policies, Horlings and Scoggins, RAND 2006; Anderson , P Baumberg B (2006) Alcohol and Europe. London Institute of Alcohol Studies

[25] cf. What are the most effective and cost-effective interventions in alcohol control?, WHO Regional Office for Europe, 2004