A brief summary of the Presidency report presenting facts on alcohol

Background

A Presidency report based partly on the Commission's European Comparative Alcohol Studies (ECAS), presenting facts on alcohol in the EU, underlies the Presidency proposal for Council conclusions on a Community strategy to reduce alcohol-related harm. The report addresses the development of consumption, harmful effects and policy in the EU countries. The complete report will be available in English at the Council meeting on 5 June 2001. This is a brief summary of the report.

Most of the ECAS studies concern the populations at national level. These data do not permit any detailed analyses of national differences in drinking patterns, nor is it possible to break down the data into sub-populations, for example, by gender and age. For that reason the ECAS also focused on individual data, both by conducting a review of existing survey data on adult populations and by conducting a special survey in six EU Member States in Spring 2000, namely France, Italy, Germany, the UK, Finland and Sweden. The summary below also draws on information from other sources, using data from the WHO, for example.

As revealed in the Presidency report, alcohol consumption in the European Union shows the following characteristics:

(1) There is strong evidence of an increased convergence in alcohol consumption during the post-war period.

As measured in per capita consumption (litres 100% alcohol per inhabitant aged 15 and over [per capita, 15+]), this statement holds true irrespective of beverage preference. It is noticeable that during the past 20 years alcohol consumption in the Mediterranean wine-drinking countries has declined dramatically and is approaching the per capita consumption of the other EU countries. In the mid-1990s, the average difference in per capita consumption between beer-drinking countries (the central European EU countries, i.e. Austria, Belgium, Denmark, Germany, the Netherlands, and the UK and Ireland) and wine-drinking countries (the Mediterranean countries) amounted to no more than a few decilitres of pure alcohol. The decreasing variation in alcohol consumption, especially between the wine- and beer-drinking countries, is also reflected in the patterns of alcohol-related mortality, suggesting that chronic heavy drinking has also been reduced in these countries.

Especially during the 1980s and 1990s, the differences between the countries in terms of the number of alcohol policy measures have also declined.
The convergence process is slow, however, and still far from complete for all aspects of consumption. Regarding levels of consumption and alcohol-related mortality, it may have slowed down in recent years. In a global perspective, the convergence in per capita consumption is quite high in the EU countries; combined with eastern Europe (with by far the highest level) the level is higher than in any other region of the world.

(2) *There are still large variations in drinking patterns between the EU countries.*

Despite the likelihood of convergence there are still considerable variations:

- Regular or daily drinking is lowest in the former spirits-drinking countries and highest in the wine-drinking countries.

- The quantity of alcohol consumed per drinking occasion and in intoxication-oriented drinking is highest in northern Europe and lowest in southern Europe.

- The concentration of drinking to the weekends is more common in central Europe, and especially in northern Europe, than in the Mediterranean countries. All countries have been influenced by the introduction of a five-day working week, however.

- Regarding drinking in connection with meals, alcohol is more commonly consumed at lunch and dinner in southern Europe. In a six-country EU-study, it was shown that drinking at lunch and dinner accounts for about 75 per cent of all drinking occasions in France and Italy, roughly 50 per cent for Germany, Sweden and the UK, and one-third for Finland. Lunchtime drinking accounts for particularly low proportions of all drinking occasions in the latter four countries.

(3) *Age, drinking and drinking problems.*

- The mean alcohol consumption varies by age group and region. In the former spirits-drinking countries in northern Europe and in the UK, young adults in their early twenties show the highest alcohol consumption. In central and south European countries the mean consumption level increases from the youngest group to the middle-aged group.

- Drinking to intoxication among young people is a growing concern in many countries. It is now being reported in countries where drunkenness has not been a central part of the traditional drinking pattern, e.g., the Mediterranean countries. A compilation of most of the existing reports on young people in the

EU countries indicates increased drinking to intoxication among young people in most of these countries during the 1990s.

- Drinking contexts vary. In the six-country EU-study, it was shown that while drinking alcoholic beverages at lunchtime and at dinner becomes more common with age, the opposite is true of drinking at restaurants/bars. Compared with older people, young people more often consume alcohol at restaurants and bars than in connection with meals.

- Self-perceived alcohol problems are most commonly reported by young people. It is likely that the age differences in the frequency of self-reported alcohol-related problems are greatest in those countries with the most marked age differences in drinking to intoxication, i.e., the Nordic countries, UK and Ireland. Even in southern Europe perceived alcohol problems, as well as drinking to intoxication, are shifting to the younger age groups even though consumption levels are higher in other age groups. In other words, in many EU countries, young people are at greater risk of alcohol-related problems than their consumption level would suggest. One likely cause is the frequency of drinking to intoxication, which is often highest among young people.

- There is a link between early drinking and subsequent heavy drinking. Many studies show that the age of onset of alcohol consumption, and heavy drinking habits at an early age, are associated with an increased risk of problem drinking in adolescence. However, most of these studies cover a rather short period, often being limited to a few years during adolescence. A few studies also show an early onset of drinking or a high level of consumption in adolescence to be predictive of alcohol-related problems in adulthood. It is important to note that most of these studies were conducted in the Anglo-Saxon and Nordic countries. The relationship between early and subsequent drinking is probably determined by cultural contexts. Thus, the findings cannot be generalised to apply to other societies with different drinking cultures. In

southern Europe, for example, the associations may be very different, because of the generally earlier age of onset of alcohol consumption.

One crucial question is whether the association between early onset of consumption, heavy drinking and subsequent drinking habits expresses real causal effects. An important and recurrent finding of past research is the link between aggressive behaviour, delinquent activity (behaviour that deviates from social norms) and earlier onset of drinking and problematic use of alcohol. Children with early signs of deviant behaviour are at a greater risk of subsequent behavioural problems, including truancy, drug and alcohol abuse, and criminality. Seen from this perspective, alcohol consumption is only part of a broader syndrome of problem adolescent behaviour that includes the use of other drugs, earlier sexual activity and delinquent or aggressive conduct.

In some drinking cultures it is possible that the age of onset of consumption in itself influences subsequent drinking habits. A strong preventive implication of the link between the age of onset of consumption and subsequent drinking problems is that interventions should aim at postponing the age of onset, a weaker preventive implication is that measures should be implemented for those that do start drinking early.

(4) *Gender and alcohol*.

A review of survey data shows that women's share of the aggregate alcohol consumption in the EU varies between 25 and 35 per cent. Roughly similar shares have been reported by several earlier studies. Except for the Nordic countries, the Netherlands and the UK, there is fairly little information on the possible trends in women's share of alcohol consumption over time. The decline of temperance among women in the former spirits-drinking countries in northern Europe led to a significant increase of women's share in the 1960s and 1970s. In the Netherlands, the increase occurred a little earlier. Beyond this, it is

difficult to say whether or not women's drinking has increased throughout Europe in the post-war years.

(5) *Per capita consumption and alcohol-related mortality*.

A recent study of all EU countries (except Luxembourg) and Norway showed that increased alcohol consumption leads to:

– an increase in cirrhosis or AAA (mainly alcoholism/alcohol dependency, alocohol poisoning and alcohol psychosis) in every country
– an increase in accidents, homicides and total deaths in half of the countries
– an increase in suicides in the north European countries
– no increase or decrease in mortality from heart disease
– generally stronger effects in the north European countries

By and large, these results confirm the significance of per capita consumption. However, a geographical gradient was evident for most aspects, with the effects of alcohol being stronger in northern and weakest in southern Europe. This suggests that cultural factors exert a significant impact on drinking patterns. A succinct expression of this is the link between alcohol and the frequency of suicide: it is quite marked in northern Europe, but weak or non-existent in southern and central Europe. This pattern suggests that the more the use of alcohol is culturally integrated, the less excessive consumption gives rise to social problems and disintegration.

One finding that was independent of country and age groups of men and women was the zero-correlation between alcohol consumption and mortality from ischemic heart disease. This suggests that an increase in consumption does not necessarily have the same protective effect at population level as it might for some individuals. In this context it may also be noted that the relationship between alcohol consumption and total mortality was significantly positive in

the majority of the countries studied; in no country were increases in consumption significantly associated with decreases in mortality.

In the six-country study the highest proportion of male respondents reporting at least one of eight listed alcohol-related problems during the past 12 months were from Finland (44%), the UK (40%), Sweden (33%) and Germany (29%). The lowest figures were for France and Italy (24% and 16% respectively). The highest proportions among women were in the UK (28%) and Finland (26%), with the lowest in France and Italy (9% and 7% respectively). Germany and Sweden were in the middle (16% in both) (see Ramstedt, 2001). Analyses in each country revealed that self-perceived alcohol problems were positively correlated with both the level of consumption and the frequency of drinking to intoxication.

A recent study has shown that more than 8000 deaths of people aged 15–29 in established market economies in Europe (the 15 EU MS, Andorra, Croatia, Czech Republic, Iceland, Israel, Malta, Monaco, San Marino, Slovenia and Switzerland) are attributable to alcohol each year.

(6) *Pregnancy and drinking*.

High alcohol consumption may damage the foetus. As such damage is theoretically 100 per cent preventable, it is important to assess the prevalence of FAS (Foetal Alcohol Syndrome) and other alcohol-induced effects on the foetus and child, and to establish the risks associated with different drinking levels. However, both are very difficult to estimate. The most severe effect, the FAS syndrome, is relatively rare. It is estimated to affect between 0.5 and 3 per 1000 live births in most populations, but a much higher prevalence is reported for some communities, especially minority ethnic groups. The FAS-syndrome is not seen in all infants born to women who are heavy drinkers. The varying susceptibility of the foetus reflects the interplay of genetic factors, social

deprivation, nutritional deficiencies, tobacco and drug use, along with alcohol consumption. Other more minor forms of alcohol-induced damage to the foetus are probably more prevalent, but their extent is unfortunately not known.

A major study of the risks associated with moderate consumption, the European multi-centre study EUROMAC, found that children whose mothers drank more than 120 grams of alcohol per week had a lower birth weight than those whose mothers drank less. The results suggested a possible threshold level of consumption for lower birth weight to be 60 grams per week. The main conclusion, however, was that consumption levels of below 120 grams per week could not be proven to increase the risk of foetal damage.

(7) *Alcohol and the workplace*

The social costs of alcohol have been estimated at 1–3% of GNP in Western societies. The most serious economic consequences of alcohol consumption are to be found in the workplace – on labour supply and productivity. Studies of alcohol-related problems in the workplace have concentrated on Anglo-Saxon and Nordic countries, and it cannot be assumed that their findings would apply in southern and central EU countries.

Among other things a causal relation has been found between alcohol consumption and:

- Workplace accidents resulting in injury or death. Alcohol consumption has been estimated to play a role in 3–4% of work-related injuries, although higher figures have been reported. In former West Germany, alcohol was estimated to be involved in 7–10% of all industrial accidents. Risks of work-related accidents are higher among high consumers and those with drinking problems than among others, and the risk increases with an increasing level of drinking.

- Absenteeism. A British study estimated the annual costs of alcohol-related absenteeism at £779 million. This was almost certainly an underestimate of the real costs since it was mainly based on data on heavy drinkers only. A Norwegian study showed that 15–20% of short-term sick leave (less than four days)was alcohol-related.

(8) *Drinking and driving*.

The links between alcohol consumption and driving impairment and traffic accidents are well documented in the scientific literature. Studies have shown that the risk of being involved in a collision is more than doubled for drivers with a Blood Alcohol Concentration (BAC) of 0.5‰. There is clear evidence that the risk of motor vehicle accidents increases with alcohol consumption. In addition:

- Young and elderly drivers are over-represented both in fatal and non-fatal accidents.

- Drunken driving is the single major cause of death for young adults in most developed countries, and fatally injured drivers between the ages of 20 and 35 are particularly likely to have been under the influence of alcohol (WHO, 2000).

- In the EU-countries, and probably in many other countries as well, fatal motor-vehicle accidents are the single biggest fatal accident category. They comprise about half of all fatal accidents involving men and women in southern and central Europe; in northern Europe they comprise one-third of those involving men and one-half of those involving women (Skog, 2001). Alcohol plays a bigger role in motor-vehicle accidents in southern, and especially central Europe, than in northern Europe.

- Data on the number of traffic accidents involving alcohol are available for most EU-countries but, because of major differences in measurement and reporting methodology, the data are not comparable.

(9) *Alcohol policy*.

Results from the ECAS show that while attempts to control production and sales of alcoholic beverages and to regulate their availability have decreased, measures intended to curtail the demand for alcohol or address alcohol-related problems (e.g., restrictions on advertising, drunken driving legislation) have become more prevalent. Increasingly, countries are adopting new measures or approaches for alcohol control and abandoning others. As a result, the measures used to control alcohol in the countries studied have become more homogeneous in the second half of the 20th century. At the same time, because the effects of alcohol vary in different parts of the EU, it is appropriate for national alcohol policies to differ.

A comparison of excise taxes imposed on alcohol in the different countries shows a great variation. In the Mediterranean countries – Greece, Italy, Portugal and Spain – very low alcohol taxes are levied on each beverage category; in the Nordic countries – Finland, Norway and Sweden – alcohol taxes are very high. Denmark, Ireland and the UK also have reasonably high alcohol taxes. The levels in Austria, Belgium, France, Germany and the Netherlands fall somewhere in between. Wine-producing countries do not usually levy excise duties on wine.

Econometric studies show that

- Economic conditions have a bearing on changes in alcohol consumption. The real price of alcohol and real incomes affect the overall consumption (as measured in alcohol sales). The income elasticities were rather similar in all the

countries studied, whereas the price elasticities were stronger in northern Europe and weakest in southern Europe, but still statistically significant in the three groups of countries: the wine-producing countries in southern Europe, the monopoly countries in northern Europe, and the central European countries (excluding the Netherlands). Within these three groups of countries, the price parameters were equal.

- Analyses of the effects of non-economic factors showed that country-specific parameters other than price and income levels seem largely to account for the variation in alcohol consumption between the countries.

The greatest volume of legal and illegal 'commerce' (privately imported alcohol and smuggling) is seen in those EU countries where prices are highest, and it is in these countries that this commerce has increased in recent years. This development has led to strong external and internal pressures to reduce taxes on alcoholic beverages in these countries.

(10) Comparability of data

Because of major differences in measurement and reporting methodology, few of the available data are comparable. The development of a comprehensive Community strategy on alcohol requires improved, consistent data collection methods to provide a better basis of scientific and comparative information on the causal factors, alcohol consumption, distribution and patterns, the nature and the scale of the problems and the effect of different policy measures.