



**COUNCIL OF
THE EUROPEAN UNION**

Brussels, 6 November 2006

**14851/06
ADD 3**

SAN 220

COVER NOTE

from: Secretary-General of the European Commission,
signed by Mr Jordi AYET PUIGARNAU, Director

date of receipt: 30 October 2006

to: Mr Javier SOLANA, Secretary-General/High Representative

Subject: EU strategy to support Member States in reducing alcohol related harm
- Impact Assessment Report

Delegations will find attached Commission document SEC(2006) 1411.

Encl.: SEC(2006) 1411



COMMISSION OF THE EUROPEAN COMMUNITIES

Brussels, 24.10.2006
SEC(2006) 1411

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

IMPACT ASSESSMENT REPORT

(long version, available in English only)

{COM(2006) 625 final}
{SEC(2006) 1358}
{SEC(2006) 1360}

TABLE OF CONTENTS

1.	Executive summary.....	4
2.	The Commission’s “Road Map”	4
3.	Conclusions	5
4.	The case for action at EU level.....	8
5.	Procedural issues and consultation of interested parties.....	10
6.	Problem definition	11
6.1.	Health implications	13
6.2.	Social and economic implications	17
7.	Objectives.....	19
7.1.	Specific objectives	19
7.2.	Policy options	20
8.	Analysis of impacts.....	22
8.1.	Political impact	22
8.2.	The alcohol industry’s contribution to the economy	22
8.2.1.	The value chain of the alcohol industry	22
8.2.2.	The size of the industry	23
8.2.3.	Value added	23
8.2.4.	Employment	24
8.2.5.	Regional distribution.....	25
8.2.6.	Trade	25
8.2.7.	Indirect effects	28
8.3.	The impact of alcohol policy options on society.....	30
8.3.1.	Labour	30
8.3.2.	Opportunity costs.....	31
8.3.2.1.	Health care.....	31
8.3.2.2.	Social security and social care services	31
8.3.2.3.	Crime.....	31
8.3.2.4.	Drink driving	32
8.3.2.5.	Insurance	32

8.3.2.6.	Taxation and public revenues	32
8.4.	Environmental impact	33
8.5.	The impact of alcohol policy options on health	33
8.5.1.	Drinking-driving policies	33
8.5.2.	Responsible server programmes	34
8.5.3.	Education, information and raising public awareness	35
8.5.4.	Pricing	36
8.5.5.	Minimum legal selling and serving age	36
8.5.6.	Marketing	37
8.5.7.	Comprehensive mix of interventions	37
9.	Comparing the options	40
9.1.	Policy options	40
9.1.1.	A general assessment of the options	41
9.1.2.	Specific impacts	42
9.2.	Conclusions	44
9.2.1.	Issues not covered in the IA	45
9.2.2.	Multi-stakeholder and community-based approaches	46
10.	Monitoring and evaluation	46

IMPACT ASSESSMENT¹ ON A COMMISSION COMMUNICATION ON AN EU STRATEGY TO SUPPORT MEMBER STATES IN REDUCING ALCOHOL RELATED HARM

1. EXECUTIVE SUMMARY

In 2001 the Council adopted a Recommendation on the drinking of alcohol by young people, in particular children and adolescents², which invites the Commission to follow-up, assess and monitor developments and the measures taken, and to report back on the need for further actions³.

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 invitation⁴.

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 policies⁵. 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 2005⁶ 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.

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

² Council Recommendation 2001/458/EC – OJ L 161, 16.6.2001, p. 38, 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 (OJ C 175, 20.6.2001, p. 1); 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

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 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.
5. The impact of any of the identified policy options to reduce alcohol harm will depend on their more detailed content, on the preferences and choices of the main actors at all levels and on the way in which the various measures are implemented.

3. CONCLUSIONS

In line with the findings of the reports that have provided input for the Impact Assessment⁷, 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,

⁷ 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

- 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 published by the World Health Organisation (WHO)⁸ and other published reviews on the effectiveness of different policy interventions to reduce alcohol-related health and social harm. 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 or to the influence of other variables not affected, however as a combination of microeconomic elements, productivity gains and budget implications the overall impact on the economy is 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 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

⁸ What are the most effective and cost-effective interventions in alcohol control, WHO Regional Office for Europe, 2004.

inform citizens of the impact of harmful and hazardous alcohol consumption both at EU and at 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.

The Impact Assessment report

1. 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, can 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)⁹. 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. Moreover, alcohol-related harm contributes to inequalities across the EU. Bridging these health inequalities is a matter of increasing importance, in particular with regard to the recent (and next) EU enlargement, which involves countries with a very different health and economic status from EU-15.

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. 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 Safety¹⁰, Health and Safety at work¹¹, and the Convention on the Rights of the Child¹².

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.
- 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.). 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

⁹ Anderson, P. & Baumberg, B. (2006) Alcohol in Europe. London: Institute of Alcohol Studies.

¹⁰ Commission Recommendation 2004/345/EC of 6 April 2004 on enforcement in the field of road safety (OJ L 111, 17.4.2004); 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, 14.2.2001); Communication of the Commission (OJ C 48, 14.2.2004).

¹¹ Community strategy on health and safety at work 2002-2006 - COM(2002) 118.

¹² UN resolution 44/25 of 20 November 1989.

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%)¹³. 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.
- 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 2010¹⁴, and efforts to curb drink-driving can make a substantial contribution to achieving this objective¹⁵.
- 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 productivity¹⁶. It is a net cause of 7, 4 %¹⁷ of all ill-health and early death in the EU and it increases the risk of child abuse and birth deficits.
- Finally, 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 increased 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...).

¹³ 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).

¹⁴ COM(2001) 370 : European transport policy for 2010: time to decide.

¹⁵ 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.

¹⁶ 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

¹⁷ The WHO's Global Burden of Disease Study (Rehm et al 2003a and b, Rehm et al 2004 and Rehm 2005).

5. PROCEDURAL ISSUES AND CONSULTATION OF INTERESTED PARTIES.

In order to give stakeholders and Member States the opportunity to put forward their positions related to alcohol harm, the Commission services have held extensive consultations with Member States' experts and stakeholders (wider alcohol industry and the NGOs). Within this consultation framework the Working Group on Alcohol and Health, consisting of experts nominated by the EU Member States, has held six meetings. Furthermore, a series of meetings with the alcohol beverages industry, advertisers, Self-Regulatory Bodies and NGOs have also taken place, many of these also involving the responsible Commissioner and the Director General for Health and Consumer Protection (SANCO).

One important part of the consultation process has been the active involvement of Youth Organisations. The European Youth Forum has set up a Working Group on Alcohol Policy and an interim report, with concrete proposals on actions, was sent to the Commission services in 2006 and taken into account for defining policy in this area.

In order to provide a coherent basis for approaches on pregnancy and drink-driving warning labels on alcoholic beverages the Commission services launched a dialogue with key stakeholders.

In addition to these consultations the Commission services also participated in the European Policy Centre's (EPC) 'Stakeholders' Roundtable' on "*Alcohol-related harm: Ways forward*" (6 June, 6 July and 19 September 2005, 30 January 2006). The objective of this Roundtable was to assist the Commission in the preparation of the Communication by identifying areas of possible agreement between the stakeholders as to actions that can contribute effectively to the reduction of alcohol-related harm. The EPC has prepared a report on the outcomes of the Roundtable talks which is available at the EPC website (www.theepc.be).

The objectives of the consultation process have been to gather the opinions and views of the stakeholders on issues to be included in the Communication on an EU strategy to support Member States in reducing alcohol related harm, and to monitor and assess the implementation of the 2001 Council Recommendation on the drinking of alcohol by young people, in particular children and adolescents. These consultations have led to the development of two non-papers on a possible alcohol strategy, finalised in July 2004 and in March 2005, which were discussed with the stakeholders.

The work linked to the present impact assessment report was examined by an Inter-Service Steering Group (ISSG) of the European Commission set up in January 2006, and whose mandate is set out in *Annex 1*. The Group was led by the Directorate General for Health and Consumer Protection (DG SANCO). The following Directorate Generals (DGs) and services were involved in the exercise: the Energy and Transport DG, the Enterprise and Industry DG, the Education and Culture DG, the Taxation and Customs Union DG, the Employment, Social Affairs and Equal Opportunities DG, the External Relations DG, the Agriculture and Rural Development DG, the Internal Market and Services DG, the Trade DG, the Regional Policy DG, the European Anti-Fraud Office and the Secretariat General.

The impact assessment work was supported by the assignment, following a public call for tender, of an external contractor (RAND Europe Foundation) who carried out an ex ante assessment on the economic impact of the different policy options identified in the Roadmap

for the alcohol strategy¹⁸ (hereinafter referred to as the ‘IA Background Report’) This report can be consulted at the Commission’s public health web site (http://ec.europa.eu/health/index_en.htm http://ec.europa.eu/health/index_en.htm).

In addition, the Commission has co-financed several projects to collect information on alcohol related harm. In 2003 the Commission services published a call for tender (SANCO/G/3/2003/06) to prepare a report on the health, social and economic impact of alcohol, and to describe options for action at country and European levels. The contract was awarded to the Institute of Alcohol Studies in England, and the ensuing report “Alcohol and Europe – a public health perspective” (an expert synthesis of published reviews, systematic reviews, meta-analyses and individual papers) was peer-reviewed by a panel of researchers proposed by stakeholders in March 2006. The report, together with the comments from the peer-review panel, is published on the Commission’s Health Portal web site (<http://health.europa.eu>).

A separate part of the tender was an invitation to collect the opinions of Member States, representatives from the Alcohol industry and Non-Governmental Organisations (NGOs) on the impact and importance of specified policy measures. This Stakeholder report is also published on the Health Portal of the European Union.

Moreover, a network of expert organisations (“Bridging the Gap”) was supported in 2003 following a call for proposals under the Public Health Programme to exchange information and best practice on alcohol policy. For the moment representatives from 32 countries participate in the network.

These broad consultations, together with the outcome of the Impact Assessment and the above reports and projects, have led to the identification of five main areas for action at EU, national and local level. These are:

- 1) Protect young people, children and the unborn child;
- 2) Reduce injuries and deaths from alcohol related road traffic accidents;
- 3) Prevent alcohol-related harm among adults and reduce the negative impact on workplace
- 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 the EU level.

6. PROBLEM DEFINITION

Alcoholic beverages are mainly sold, consumed and marketed as a commodity under the rules for internal market as any other product. Most adult people consume alcohol without causing any problems and the wider alcohol industry contributes to the EU economy and moreover, it creates work opportunities for EU citizens. However, harmful and hazardous consumption of

¹⁸ CLWP Roadmap, 2005.

alcohol contributes to deaths, ill-health, social problems and it can have an adverse effect on productivity, it can diminished workforce productivity, and on workplaces.

Due to a combination mainly of increased globalisation of the alcohol market, especially cross-border marketing that enables alcohol advertising to reach across and infringe national laws in Member States with restrictions on alcohol marketing, cross-border transport¹⁹, cross-border trade and a long-term convergence of alcohol attitudes and drinking habits among young people, some Member States and representatives of the public health community have indicated that their ability to frame effective alcohol policy at national level has become more limited. They have advocated for public health concerns and better coordination and cooperation at the EU level. This resulted in the adoption of Council occlusions on an EU alcohol strategy in 2001 and 2004.

Some Member States during the latest years, introduced restrictions and regulations based on public health concerns (such as special taxes on Alco-pops, health warning labels on advertisements and beverage containers) which are sometimes challenged as technical barriers to trade. Moreover, the differences in Member States alcohol excise duty rates have created problems in the Community as a whole with smuggling, and in some Member States, in particular Finland and Sweden, the increased cross-border shopping has increased alcohol-related harm. These developments have highlighted the need for EU coordination and joint actions as most of these problems can not be solved solely at Member State level. An agreement on a comprehensive approach on Community level could act as guiding principle for the work done within the various sectors.

While it is true that the average alcohol consumption has been decreasing in the EU, the proportion of, especially young people, with harmful and hazardous consumption patterns has increased in several Member States during the last 10 years according to most available sources. Moreover, harmful and hazardous alcohol consumption is the third largest risk factor for ill-health in the EU²⁰, after high blood pressure and tobacco, and is therefore a major public health concern.

Although many differences between countries remain, there have been several examples of convergence in drinking across Europe, for example in terms of the amount drunk, drinking patterns and styles, and beverage choices. North-south gradients can still be seen for many aspects of drinking, such as more binge drinking in the north and more responsible drinking with meals in the south, but these are less apparent than before. The enlarged EU faces new challenges as drinking patterns appear to be causing more harm in some of the EU-10 countries²¹.

However, this north-south gradient is much weaker in the younger generations. Young southern Europeans are more likely to drink beer and to drink in public places than older generations and less likely to drink as much wine with meals as their parents. Moreover, several Member States have seen a rise in binge-drinking for both boys and girls in the 1990s

¹⁹ There is increasing evidence from different Member States that non-resident drivers flout traffic laws when travelling abroad as they do not fear punishment. The implications are twofold: firstly, their dangerous behaviour can lead to road accidents, and secondly it raises criticism in the country they are travelling as police are not always able to fairly apply the sanctions.

²⁰ 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

²¹ Member States that joined EU in 2004.

followed by mixed trends since the year 2000²², resulting in a narrower gap in binge drinking between the Member States²³.

6.1. Health implications

The vast majority of EU citizens consume alcohol moderately most of the time. In general, for adult people with no chronic diseases, not consumed during pregnancy, while driving or working, such a moderate consumption does not appear to create health risks in general. Moderate alcohol consumption²⁴ appears to offer some protection against coronary heart disease in older people (45 and above depending on gender and individual differences), but below that age the protective factor of alcohol consumption is questioned and recent research has shown that it can be as low as zero. This statement should not be interpreted as suggesting that moderate consumption in young adults is causing harm – it just implies that in this age group, there is no proven protective factor against coronary heart disease.

The protective effect of alcohol is greater for non-fatal heart attacks than for fatal heart attacks, for men than for women and for people followed-up in Mediterranean countries than in non-Mediterranean countries²⁵. The exact size of the reduction in risk and the level of alcohol consumption at which the greatest reduction of the risk of heart disease occurs are still under debate.

General population studies have found that *low risk* alcohol consumption relates to positive sensations and improved subjective health, influenced by culture, the setting in which drinking occurs, and people's expectations about alcohol's effects²⁶

The current impact of harmful and hazardous alcohol consumption in the EU as described in the WHO Global Burden of Disease Study, and in the report 'Alcohol in Europe – a public health perspective'²⁷, can be summarized as follows:

Alcohol impacts on the individual through three intermediate and linked variables: direct biochemical effects, intoxication and episodic heavy drinking, and dependence. Alcohol (ethanol) is a substance with addictive potential as it enhances the activity in the brain reward system by increasing the release of the brain Beta-endorphin, thus leading to alcohol-induced euphoria. According to WHO and most researchers harmful and hazardous consumption may cause 60 different types of diseases and conditions²⁸, 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.

²² ESPAD survey 1995, 1999 and 2003.

²³ ESPAD and national surveys in EU.

²⁴ There is no common agreement on any exact definition of the level of moderate consumption.

²⁵ Alcohol in Europe A public health perspective, P Anderson and B Baumberg, Institute of Alcohol.

²⁶ Alcohol in Europe A public health perspective, P Anderson and B Baumberg, Institute of Alcohol.

²⁷ 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).

²⁸ 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.

Premature deaths are measured in terms of years of life lost (YLL). For example if a man died at age 45 in an alcohol-related car accident, he would lose 35 years of life if he lived in a Member State with an average life expectancy at birth of 80 years for men. However, a disease may have outcomes other than death and still have a significant effect on the individual and society. In order to capture these non-fatal effects, the concept of disability is used. Disability measures the impact of diseases on functionality, i.e., the extent to which a person’s activities are hindered by a disease. In order to measure disability caused by a particular disease, each disease condition is assigned a disability weight. These weights are then used to measure Disability-Adjusted Life Years (DALYs), an indicator which combines years of disability with years of life lost due to premature mortality. The figure²⁹ below shows the alcohol- attributable burden of death and ill-health in the EU in 2004.

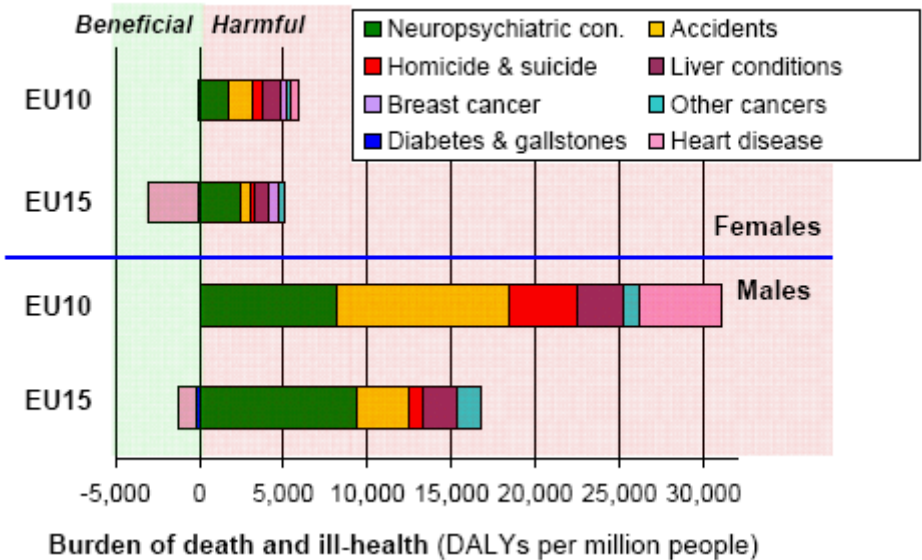


Figure 1

Harmful alcohol consumption is estimated to be responsible for about 195 000 deaths each year in the EU although it is also estimated to delay about 160 000 deaths only in older people^{30, 31}. It is a net cause of 7, 4% of all ill-health and early death in the EU³². The impact of alcohol measured though DALY’s shows that harmful alcohol consumption accounts for 12% of male and 2% of female premature deaths under the age of 75 years³³. One out of four fatalities on EU roads is caused by drink-driving (approximately 10 000 per year).

Harmful alcohol consumption does not only cause problems among young people, but can also cause problems in elderly people. A few Member States have reported that they are experiencing problems with excessive alcohol consumption among elderly men and women. The figure below shows the burden of alcohol-attributable mortality in the EU in 2004.

²⁹ Addapted from the WHO’s Global Burden of Disease Study (Rehm et al 2004).
³⁰ Anderson , P Baumberg B (2006) Alcohol and Europe. London Institute of Alcohol Studies.
³¹ According to a new meta-analysis study this could be an over-estimate. Kay Fillmore et al, Addiction Research and Theory (doi:10.1080/16 983) 2006.
³² WHO, Global Disease Study.
³³ The WHO’s Global Burden of Disease Study (Rehm et al 2003a and b, Rehm eet al 2004 and Rehm 2005).

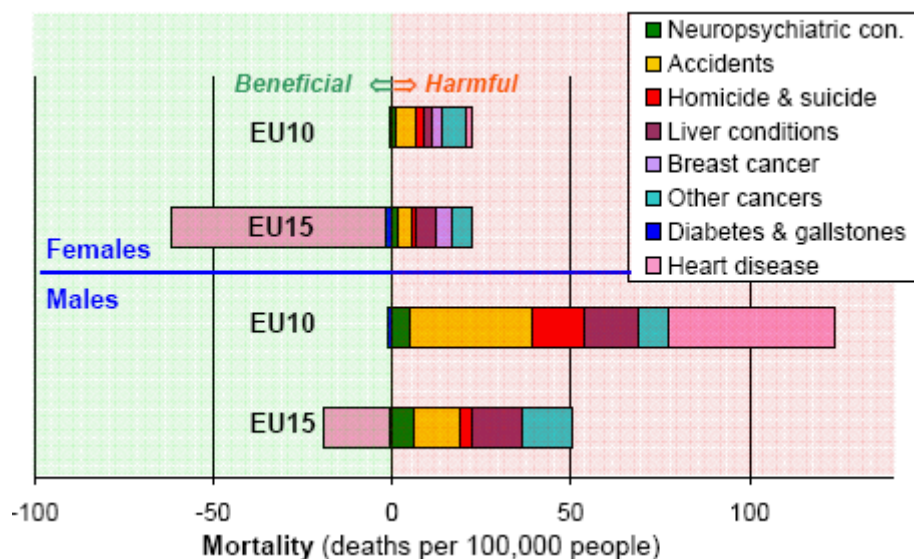


Figure 2

This makes harmful alcohol consumption the third-leading risk factor for death and disability in the EU according to WHO's Global Burden and disease study 2004 (Figure 3).

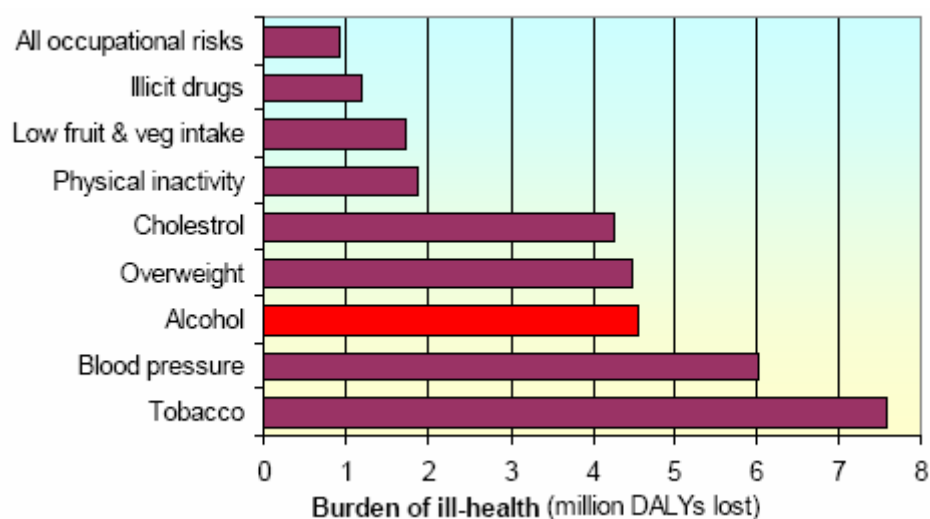


Figure 3

The young shoulder a disproportionate amount of this burden with over 10% of youth female mortality and around 28% of youth male mortality due to alcohol (13 - 15 000 deaths/year). Alcohol-related deaths peak in the age group 15-29³⁴.

Among EU citizens, harmful and hazardous alcohol consumption is responsible for approximately 12 % of total male and 2% of female premature death and disability, in the EU 25. In recent years some Member States report a new and increasing trend of deaths from chronic liver cirrhosises and unintentional injuries among

³⁴ Estimates from Alcohol in Europe report taken from the age-disaggregated paper presented by Rehm (Rehm and Gmel 2002).

young men as harmful drinking patterns appears to be on the rise among this population³⁵. Moreover, alcohol related harm is one factor behind the difference in male life expectancy between the EU-10 and EU-15³⁶.

Every third year the trends in youth alcohol consumption, drinking habits/patterns and self-reported harm are measured in the European School Survey (ESPAD). The table below sets out information on reported drunkenness and binge drinking (drinking more than 5 standard drinks at the same occasion). The cultural differences in experienced ‘drunkenness’ are very clear. The number of boys and girls from the Mediterranean Member States reporting being drunk is low.

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

³⁵ A report of the Academy of Medical Science in UK 2004 and a paper presented at the Health in all Policies conference in Kuopio Finland September 2006), Country reports from Bridging the Gap project published at www.eurocare.org.

³⁶ The WHO’s Global Burden of Disease Study (Rehm et al 2003a and b, Rehm et al 2004 and Rehm 2005, Anderson, P. & Baumberg, B. (2006) Alcohol in Europe. London: Institute of Alcohol Studies.

6.2. Social and economic implications³⁷

Alcohol consumption is in almost all European cultures a social activity, linked to gatherings, festivities, and to help social transitions. In general light and moderate alcohol consumption have few negative social and economic implications, whereas alcohol dependence and heavy drinking tend to lower productivity³⁸ and increase absenteeism³⁹, and increase the risk of social and economic harm. It is estimated that 8–14 million working days in the United Kingdom are lost annually to alcohol-related problems; with regard to safety, up to 25% of workplace accidents and around 60% of fatal accidents at work may be associated with alcohol⁴⁰. The implication on society and economy of drinking patterns has been underestimated according to several researchers. Drinking patterns are more related to acute health outcomes, various social endpoints, and risk of alcohol abuse and dependence than consumption levels that are more related to chronic diseases like liver cirrhoses⁴¹.

Notably with regard to the Lisbon strategy and the phenomenon of ageing societies the economic effects of harmful and hazardous drinking of alcohol need to be taken into account. In addition to what was shown in the preceding section regarding premature death and disability, such negative economic factors encompass effects that occur long before very serious diseases and fatal events happen. They range from lower productivity at work, over losing the job due to alcohol consumption, to early drop-outs from the labour market, notably due to early retirement. These effects go against the objectives of the renewed Lisbon strategy, which calls for an increase in healthy life years as a crucial factor in achieving the objective of modernising social protection systems⁴². At the same time it is important to underline that even if the health implications of harmful alcohol consumption are causing problems in the EU, this does not mean that policy should necessarily be based on health consequences alone, as other implications - such as societal and economic factors - must also be taken into consideration

The harmful and hazardous consumption of alcohol has harmful effects not only on the drinker but also on others such as the unborn child, children and society as a whole. An estimated 23 million Europeans (5% of the EU population) are dependent on alcohol in any one year, with the pain and suffering this cause for family members. Moreover, alcohol is estimated to be a causal factor in 16% of child abuse and neglect⁴³, and between 4.7m and 9.1m children in the EU (6%-12%) live in families adversely affected by alcohol⁴⁴. More than 6% of 15-16 year old students report suffering problems with their parents due to their drinking, equivalent to over 700,000 young people⁴⁵.

³⁷ The contributions of the alcohol industry to the economy is dealt with in 5.2.

³⁸ Klingeman and Gmel 2001.

³⁹ Rehm and Rossow 2001.

⁴⁰ Hughes K, Bellis MA. Alcohol: some sobering statistics from the NWPHO. NorthWest Public Health Observatory, 2000.

⁴¹ Rehm et al, 2003b.

⁴² EC: growth and jobs - working together for Europe's future. A new start for the Lisbon strategy, Luxembourg 2005, page 27).

⁴³ English et al.

⁴⁴ Anderson, P. & Baumberg, B. (2006) Alcohol in Europe. London: Institute of Alcohol Studies.

⁴⁵ Population-weighted EU averages presented – population data of 15-16 year olds taken from Eurostat; young people's reported harms from the ESPAD study (Hibell et al. 2004).

Most studies show that harmful effects of alcohol also tend to be greater in less advantaged social groups and are particularly high in some EU-10 countries and in Member States with a high percentage of harmful and hazardous drinking patterns.

Harmful alcohol use is associated (not causal) with crime in all European countries, and is particularly associated with violent crimes. A survey within the ECAS⁴⁶ project found the highest rates of people who report being in a fight when drinking come from Germany, the UK (both >5% of drinking men) and Ireland (>10%), with the lowest rates of around 1% coming from Italy and Sweden⁴⁷.

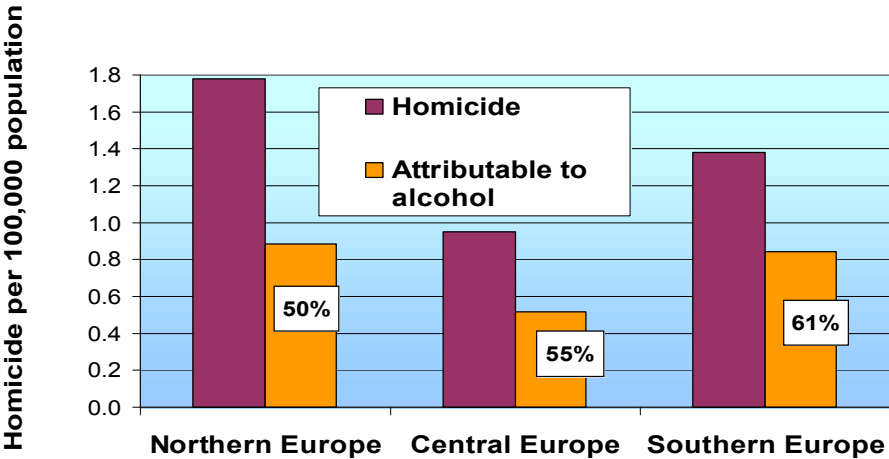


Figure 4: Alcohol and homicide

Estimates of the scale of harm in the workplace are more difficult, although nearly 5% of drinking men and 2% of drinking women (out of all men and women reporting drinking alcohol) in the EU-15 report a negative impact of alcohol on their work or studies⁴⁸. Problems related to harmful alcohol consumption at the workplace appear to be much more common for 19-34 year olds than in older age groups (both for men and women)⁴⁹.

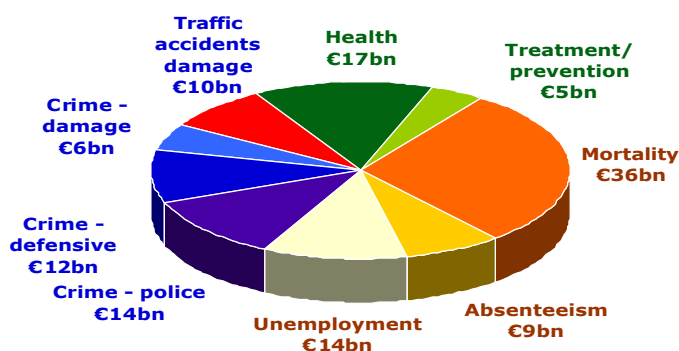
The reported changing drinking patterns in the EU 25, and particularly the reported long-term increasing trends in binge-drinking, in hazardous and harmful drinking and in high frequency under-age drinking not only affect public health but could also have a long-term impact on the risk of a wide range of social harms. Another alarming trend (not causal) is the reported poly-drug use (mixing illegal drugs and alcohol) among young people, especially reports on poly-drug use causing road accidents and violence.

⁴⁶ European Comparative Alcohol Study, 2002 a study co-financed by the European Commission.
⁴⁷ Ramstedt and Hope 2003.
⁴⁸ Ramstedt and Hope 2003.
⁴⁹ Mäkelä et al. 1999.

Based on a review of existing studies, the total tangible cost of alcohol to EU societies in 2003 was estimated to be €125bn (€79bn - €220bn), equivalent to 1.3% GDP (which is in the same order of magnitude as the cost for tobacco)⁵⁰. These estimates are subject to a wide margin of error but represent the first real estimate of cost at EU level. The following graph gives a breakdown for this estimate.

Figure 5

Estimated cost of alcohol to EU society in 2003 - total tangible cost €125bn



7. OBJECTIVES

In response to the issues outlined in the previous section, the general objective of the EU alcohol approach as stated in the Commission's Roadmap of 2005⁵¹ is to reduce the health and social harm due to alcohol consumption and thereby contribute to higher productivity and a sustainable economic development in line with the objectives set out in the European Council's Lisbon objective of more Healthy Life Years for all.

7.1. Specific objectives

In order to target the identified health and social problems described above, a number of specific objectives were identified in the process leading up to the Roadmap.

In order to protect young people, children and the unborn child the proposed specific objectives identified are:

- To curb under-age drinking, reduce hazardous and harmful drinking among young people, in cooperation with all relevant stakeholders
- To reduce the harm suffered by children in families with alcohol problems and

⁵⁰ Anderson, P. & Baumberg, B. (2006) Alcohol in Europe. London: Institute of Alcohol Studies.

⁵¹ Part of the Commission's Legislative Work Plan for 2006 .

- To reduce of exposure to alcohol during pregnancy, thereby reducing the number of children born with Foetal Alcohol Disorders

In order to reduce injuries and deaths from alcohol related road traffic accidents the identified objective is:

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

The European Union has set a goal to halve the number of people killed on European roads from 50,000 people in the year 2000 to 25,000 people by the year 2010⁵².

In order to reduce harmful and hazardous alcohol consumption among adults (including elderly) the identified objectives are:

- To decrease alcohol-related chronic physical and mental disorders
- To decrease the number of alcohol related deaths.
- To provide information to consumer to make informed choices
- To contribute to the reduction of alcohol-related harm at the workplace, and promote workplace related actions.

In order to inform, educate and raise awareness on the impact of alcohol the identified objective is:

- Increase EU citizen's awareness on the impact of harmful and hazardous alcohol consumption on health, especially on alcohol's impact on the foetus, on under-age drinkers and on working and driving performance

In order to develop and maintain a common evidence base at EU level the identified objectives are:

- To obtain comparable information on alcohol consumption, especially on young people, definitions on harmful and hazardous consumption, on drinking patterns on the social and health effects of alcohol, and on the impact of alcohol policy measures and of alcohol consumption on productivity and economic development.
- To evaluate the impact of initiatives taken on the basis of this Communication.

7.2. Policy options

The general objective of the EU alcohol approach as stated in the Commission's "Road Map" published in 2005⁵³, is to reduce the health and social harm due to alcohol consumption and thereby contribute to higher productivity and a sustainable economic development in line with the objectives set out in the European Council's Lisbon objective of more Healthy Life Years for all.

⁵² COM(2001) 370 : European transport policy for 2010: time to decide.

⁵³ 2005/SANCO/032; http://ec.europa.eu/atwork/programmes/docs/wp2006_roadmaps.pdf

The Commission's "Road Map" published in 2005 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 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.

The impact of any of the identified policy options to reduce alcohol harm will depend on their more detailed content, on the preferences and choices of the main actors at all levels and on the way in which the various measures are implemented.

8. ANALYSIS OF IMPACTS

The impact of new actions and policies addressing complex issues such as alcohol and health is mainly indirect (it is seldom causal, which complicates the assessment of the effect of interventions). The most conclusive evidence in the behavioural and medical sciences derives from randomized clinical trials where an “unaffected” control group is compared to an intervention group. Randomized studies are rare in the prevention and promotion field of health and moreover it is not possible to conduct randomized studies when assessing the impact of a future strategy. Moreover, impacts may differ depending on the different scenarios and synergies and trade-offs with other policy areas, such as transport, trade, and taxation policies.

Moreover, as defined precisely in Impact Assessment Guidelines in ‘*broad policy-defining documents – For White Papers, Action Plans, other Communications setting out strategic orientations (...) assessment of impacts will necessarily be preliminary and will not provide detailed quantitative data.*’. If Member States or the Community institutions decide to pursue some of the actions or solutions identified in this very paper, the analysis of impacts of these actions, if necessary, would be carried out then.

Moreover, possible future impacts will emerge from changes in the behaviour of different groups of stakeholders (such as consumer and health NGOs, the alcohol beverage industry, Member States), and it is particularly difficult to measure the impact on all stakeholders together. It is even more difficult to measure the social, economic and health impact of policies at EU level.

Taking the above mentioned limitations into consideration this impact assessment draws on the findings of the IA Background report and the results of other reports and the consultations set out under chapter 5 above.

8.1. Political impact

The political impact of a more coherent EU approach will most probably be positive, as actions aimed at reducing alcohol-related harm at EU level have been requested repeatedly by the Member States since 2001. Moreover one of the main objectives is to support Member States in their efforts to strengthen public health policy and contribute to a better multi-stakeholder cooperation both at the EU and Member States level; it is not to demonise alcohol as such.

8.2. The alcohol industry’s contribution to the economy

The following chapter intends to give a brief description of the alcohol industry’s main contribution to the EU economy; it builds on data and analyses contained in the IA Background Report⁵⁴.

8.2.1. *The value chain of the alcohol industry*

The alcohol industry is an elaborate industry with extensive forward and backward linkages. The value chain of alcohol production involves a host of economic activities ranging from the

⁵⁴ IA Background Ret - An ex ante assessment of the economic impacts of EU alcohol policies, Hurlings and Scoggins, RAND 2006.

production of basic inputs (e.g. hops, malt, and grapes), semi-manufactures (e.g. bottles) and supporting services (e.g. advertising) to outputs (e.g. wine, beer, spirits) and trade (retail, wholesale and catering). Any change in alcohol consumption will affect the manufacturers of alcoholic beverages as well as their suppliers and customers throughout the value chain, although, due to the circumstances described above, it is difficult to measure the exact impact. The result of the economic analysis is described more in detail in chapter 6.

8.2.2. *The size of the industry*

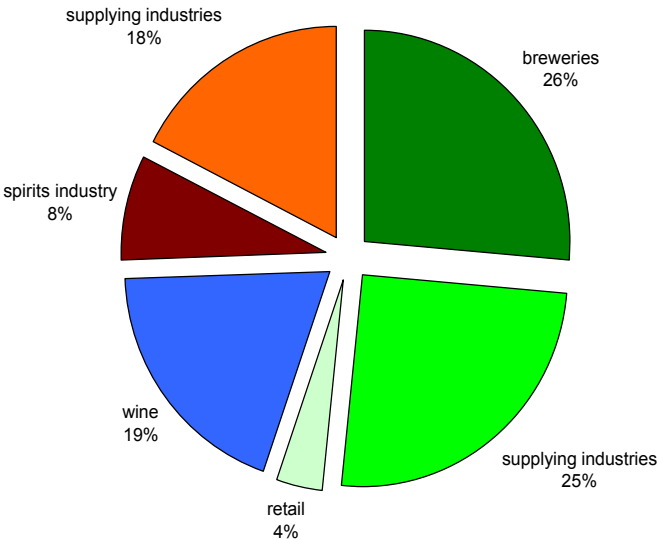
Households in the EU annually spend about €95, billion on alcoholic beverages per year, equal to 13.9% of total expenditure on foodstuffs and 1.6% of total consumer expenditure. (Eurostat Online Database)

8.2.3. *Value added*

The contribution of an industry to Gross Domestic Product is its value added. Value added is equal to total turnover minus expenditure on inputs, such as raw materials, semi-manufactures, energy, and other goods and services purchased from other industries.

The data presented in Figure 6⁵⁵ set the total size of the alcohol industry at roughly €45 billion (23% of the food industry and 0.4% of EU25 GDP). The brewing sector has presented another study indicating that the brewing sector alone values its contribution to EU economy at €57, 5 billion. (The supplying industries are showed separately for breweries and other alcohol industries)

Contribution of the alcoholic beverages industry to Gross Domestic Product, c. 2004 (share of sectors in the total value added of the alcoholic beverages industry)



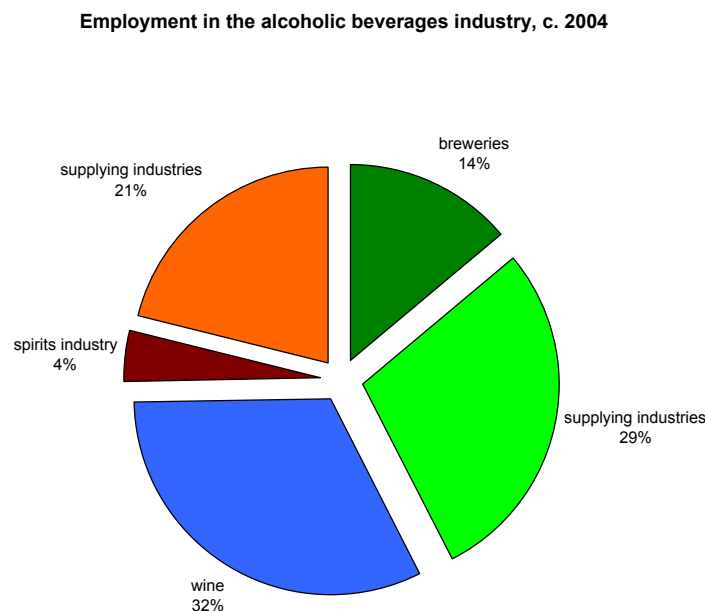
⁵⁵ IA Background Report An ex ante assessment of the economic impacts of EU alcohol policies, Horlings and Scoggins, RAND 2006.

Figure 6

8.2.4. Employment

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 agriculture⁵⁶. 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 Report⁵⁷ the number of workers in the wine sector is estimated at 385,000. Notably, in the impact assessment conducted by the Commission services on the wine reform it was estimated by other sources at 1,5 million AWU (annual work unit)⁵⁸. Figure 7 summarizes an estimate of employment across the entire alcohol beverage industry from the IA background report. The total amounts to a minimum of 1.2 million jobs in the EU. In addition, the beer industry claims responsibility for a total employment of 2.6 million jobs in hotels, restaurants and cafes⁵⁹ (the HoReCa sector is estimated by the Brewers to represent 7, 847 million jobs out of which they estimate that 1,935 to be beer-related). Although there is undoubtedly a relationship between the development of this segment of the labour market and the economic performance of the alcohol industry, these jobs (total) involve more than the sale of just alcoholic beverages; furthermore, many people in the catering industry work part-time.

Figure 7: Employment in the alcohol beverage industry



⁵⁶ Ernst & Young 2006.

⁵⁷ IA Background Report - An ex ante assessment of the economic impacts of EU alcohol policies, Horlings and Scoggins, RAND 2006.

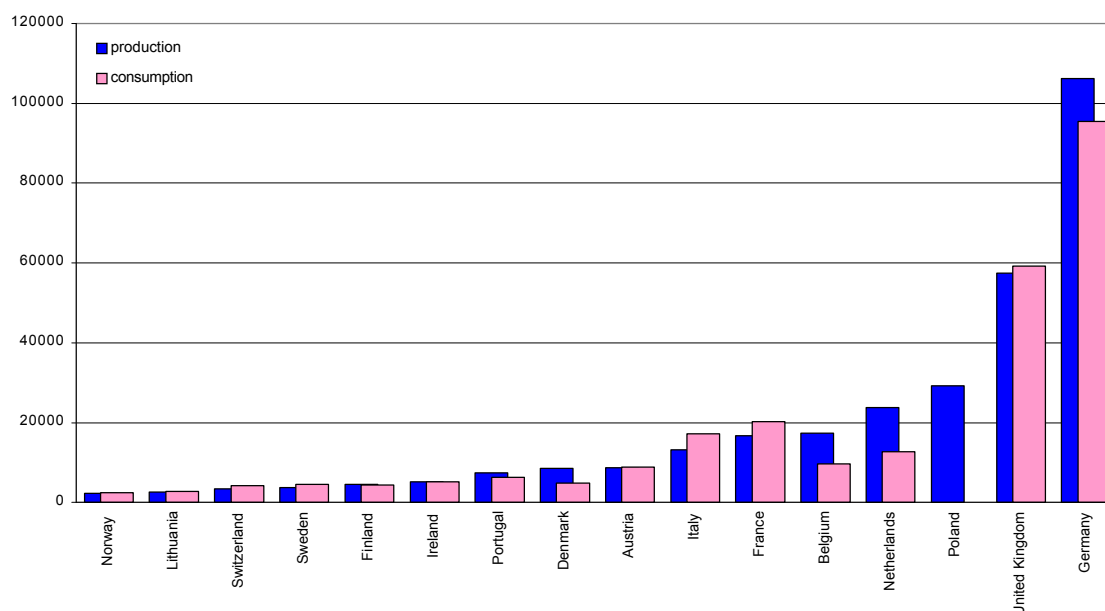
⁵⁸ http://ec.europa.eu/agriculture/markets/wine/studies/rep_econ2006_en.pdf Source: EC DG Agriculture 2006.

⁵⁹ Ernst & Young 2006.

8.2.5. Regional distribution

According to the IA Background Report alcohol is consumed in comparable quantities across the EU, but production is regionally concentrated. EU wine production is almost entirely concentrated in six Member States: France, Italy, Spain, Portugal, Germany, and Greece. France, Italy and Spain account for as much as 79% of vineyard acreage. Beer is produced in every Member State, but a few countries are Europe’s major producers (Germany, the United Kingdom, Poland, and the Netherlands). Belgium, France and Italy also produce considerable amounts.

Figure 8: Beer production and consumption in selected European countries, 2004 (‘000 hl)



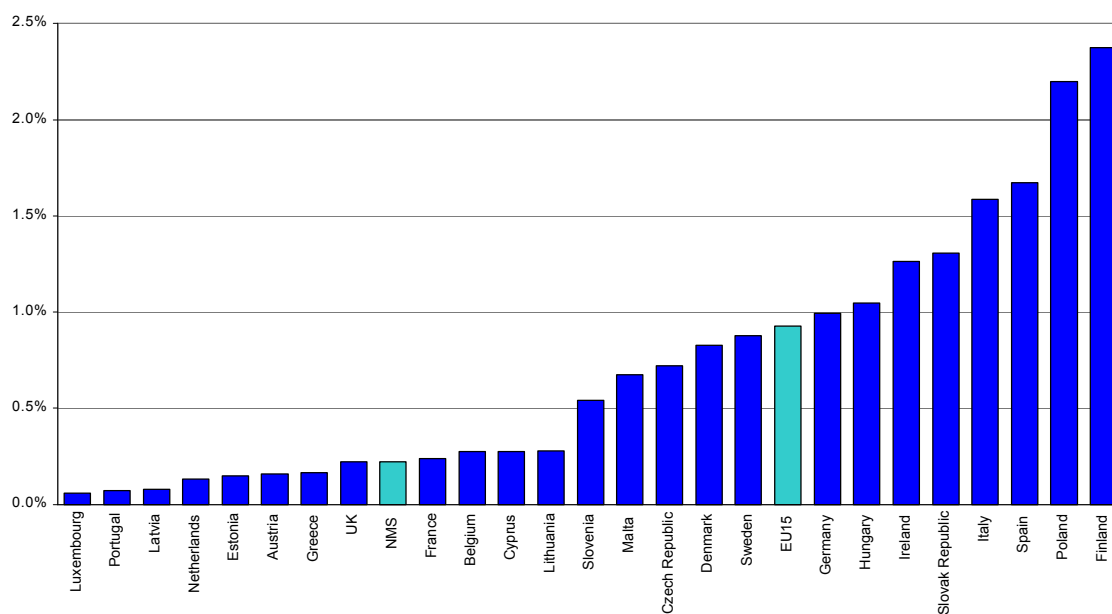
Source: Brewers of Europe [http://stats.brewersofeurope.org/stats_pages/employees.asp].

8.2.6. Trade

The IA Background Report⁶⁰ estimates exports of alcoholic beverages to account for just less than 1 percent of total exports in the EU-15, and for 0.2 percent in the EU-10. Alcoholic beverages contributed significantly more than 1% in six Member States, most notably in Poland and Finland (Figure 9). In terms of absolute value, six Member States stand out. France, the United Kingdom, Italy, Spain, Germany and the Netherlands are the EU’s main exporters of alcoholic beverages. Together they export €27.6 billion in beer, wine, spirits and other alcoholic products. Figure 10 does include intra-European trade (exports from EU Member States to other EU Member States).

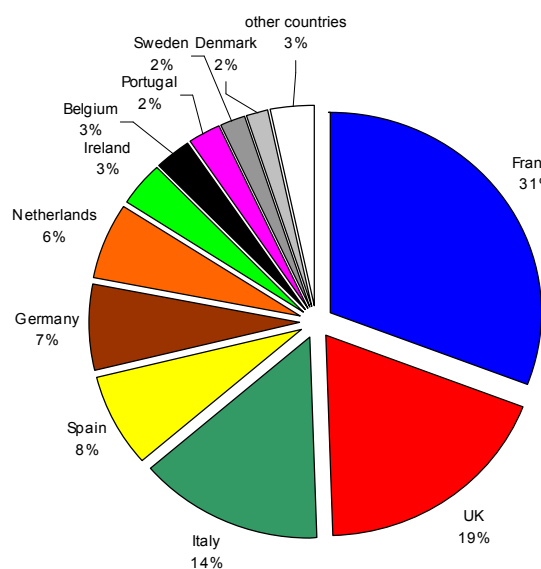
Figure 9: Exports of alcoholic beverages as a percentage of the total value of exports, 2004 (%)

⁶⁰ For more exact information on exports and definitions of terms used we recommend the full report by RAND.



Source: COMTRADE database of the United Nations Statistics Division; International Trade Centre UNCTAD/WTO.

Figure 10: Share of Member States in EU25 exports of alcoholic beverages, 2004 (%)



Note: The trade figures include intra-EU exports (from EU MS to other EU MS).

Source: COMTRADE database of the United Nations Statistics Division; International Trade Centre UNCTAD/WTO.

Even the main exporting Member States also import alcohol. Table 2 presents national data on the balance of trade (exports minus imports) with third countries. These data show that 9 of the 25 Member States had net exports in 2004 and that overall the EU 25 exported more than \$10 billion more than it imported.

Table 2: Balance of trade in alcoholic beverages, 2004
(thousands of dollars)

Austria	-184,093
Belgium	-528,017
Cyprus	-32,685
Czech Republic	-4,510
Denmark	-203,974
Estonia	-49,406
Finland	-207,881
France	7,846,658
Germany	-1,203,089
Greece	-217,452
Hungary	-11,258
Ireland	513,514
Italy	3,259,173
Latvia	-9,238
Lithuania	-46,385
Luxembourg	-143,143
Malta	-26,940
Netherlands	634,433
Poland	-71,022
Portugal	469,626
Slovak Republic	-47,844
Slovenia	16,799
Spain	648,289
Sweden	26,222
UK	137,312
EU25	10,565,089
EU15	10,847,578
NMS	-282,489

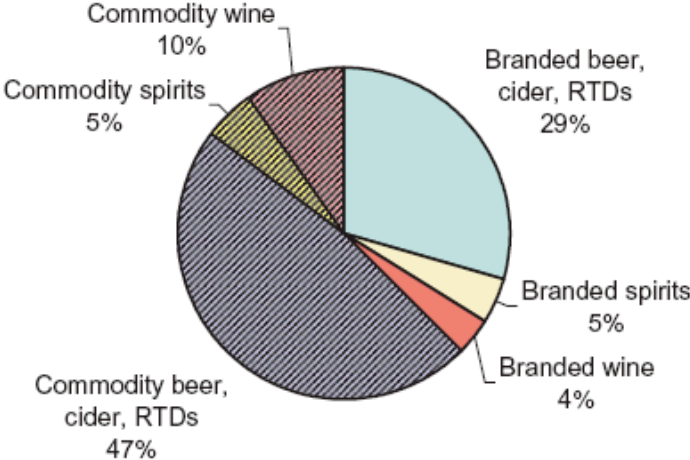
Note: Value of exports minus the value of imports. Net exporters in bold type.

Source: COMTRADE database of the United Nations Statistics Division; International Trade Centre UNCTAD/WTO.

The large majority of alcoholic beverages is produced by small domestic manufacturers, geared towards local markets, and is not traded internationally. These so-called “commodity” drinks constitute almost two-thirds of the volume of worldwide alcohol sales (Figure 11). The other market segment of “branded” beverages is dominated by large companies⁶¹. Almost the total wine production comes from small and medium enterprises. More than 30% of it is traded internationally, and intra-EU.

⁶¹ ICAP 2006.

Figure 11: The composition of the volume of world alcohol sales, 2004 (%)

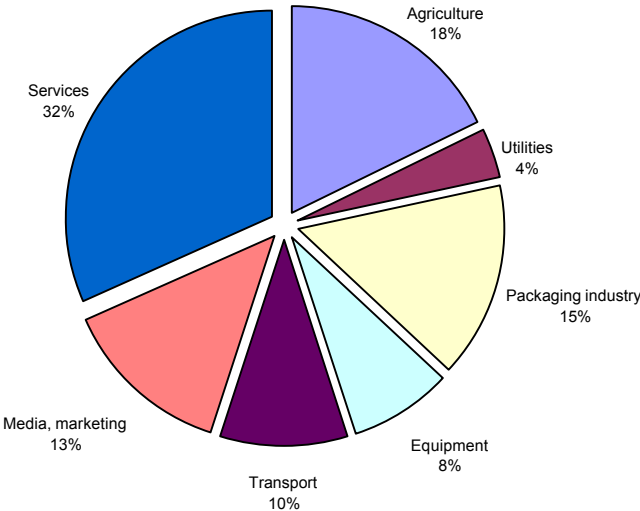


Source: ICAP 2006.

8.2.7. Indirect effects

The alcohol industry creates significant value and employment through its backward and forward linkages (from agriculture to hospitality and advertising). As an example the value of purchases by the beer industry from other sectors amounts to more than €20,000 million in the EU-25 (Figure 12).

Figure 12: Expenditure by the beer industry on purchased goods and services, 2004 (€millions)



Advertising expenditure is a significant component of the industry’s purchases, especially for the branded alcoholic beverages. Worldwide, the vast majority of alcoholic beverages are not advertised. In developed economies, and particular among branded beverages, advertising is standard practice.

Finally, Legal imports of alcohol by European tourists also have some effect. The figure below show the legal import by people aged 18-64, in litres of pure alcohol per tourist (excluding alcohol over the indicative travellers allowances)

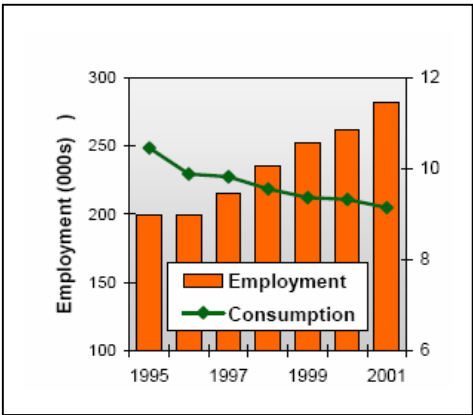
	Finland	France	Germany	Italy	Sweden	UK
Beer	0.3	0	0	0	0.2	0.1
Wine	0.4	0.1	0.1	0	0.3	0.4
Spirits	0.2	0	0.3	0	0.2	0.6
TOTAL *	1.1	0.1	0.5	0.04	0.9	1.4
TOTAL per importer *	2.5	1.4	2.9	0.8	2.3	5

* Adjusted upwards by 1.25 to correct for under-reporting of numbers of trips (based on data from Sweden)
 Source: ECAS study (Leifman 2001)

Conclusions on the economic importance of the alcohol industry in the EU

According to the economic analysis in the IA Background Report⁶², the alcohol industry represents 23% of the food industry’s contribution to GDP, and 0, 4% of EU-25 GDP. Wine production exceeds 20 – 30 % of the total agricultural production in some EU regions and the numbers concerned are significant, in the impact assessment conducted by the Commission services on the wine reform it was estimated at 1, 5 million AWU (annual work unit)⁶³; any change in economic performance – brought on, for example, by a change in the level of consumption – will have a significant impact on economic growth and employment in these regions. Moreover, the effects of such a change will be felt in sectors outside the alcohol beverage industry (packaging industry, transport sector, HoReCa etc), which create employment and generate value added in a range of industries. National alcohol policies can directly impact on the performance of those industries, for example by imposing restrictions on alcohol advertising (impact on the media and the advertising industry) or by limiting the number of outlets or opening hours (the retail and catering industries).

The impact of a change in alcohol consumption on the economic performance of the alcohol industry will be felt more strongly in some countries than in others: it will have the strongest impact in the 10 Member States that are the main producers and exporters of alcoholic beverages, namely France, Italy, Spain, Portugal, Germany, Greece, the United Kingdom, Poland, the Netherlands, and Belgium.



However, most importantly trends in alcohol consumption show no crude correlation with trends in the number of working opportunities in areas such as the hotels, restaurants and catering sector. A reduction in spending on alcohol would also be expected to free consumer funds to be spent on other areas, with the economic impact depending on exactly what this new expenditure is⁶⁴.

⁶² IA Background Report.
⁶³ http://ec.europa.eu/agriculture/markets/wine/studies/rep_econ2006_en.pdf Source: EC DG Agriculture 2006.
⁶⁴ Alcohol in Europe, Anderson and Baumberg 2006.

8.3. The impact of alcohol policy options on society

8.3.1. Labour

An individual's harmful and/or hazardous alcohol consumption can reduce his or her working capacity, and in the worst case lead to unemployment or early retirement. The impacts of a successful alcohol policy on employment, productivity and competitiveness work mostly through labour input. A high consumption of alcohol at the workplace increases the likelihood of occupational accidents as it impacts on the span of attention of workers and will also increase the rate of various types of occupational diseases. It's also important to underline the impact of a successful alcohol prevention policy on the human cost side and not only the social cost. National costing studies do underestimate the impact of absenteeism due to alcohol consumption. Reducing absenteeism at work will raise output and will increase productivity.

Each is, however, subtly different:

- Absenteeism combines a loss of productivity with continued wage payments, thus raising the costs of production.
- Unemployment involves a social cost that is not balanced by an individual economic contribution, thus imposing a negative externality on (working) taxpayers.
- Premature mortality ends all individual and social costs and benefits that are related to the deceased and is often viewed from a lifetime rather than a short-term perspective.

Every 1% increase in labour input will produce less than 1% increase in output and a decline in average labour productivity⁶⁵. A higher educational attainment will improve the average employment opportunities of students and the quality of labour input, in addition to reducing unemployment as well as the psychosocial problems that may lead to harmful or hazardous alcohol consumption. The lower burden of absenteeism on wage costs and of unemployment on public expenditure and the tax burden improve the competitive position of industry. Even though the direct macroeconomic impacts are not likely to be significant, the indirect overall impact on the economy is expected to be substantial (micro effects, efficiency gains, budget implications). The main reasons are the following:

- The harmful and hazardous consumption itself inflicts physical damage on drinkers and poor health has an adverse effect on productivity (when the employee still works) or output (when the employee is absent or become unemployed) or the "entering" into workforce (youth drinking negatively influences educational attainment)
- Harmful and hazardous alcohol consumption alters the behaviour of drinkers and diminishes their capacity to perform complex tasks and can lead to mistakes and accidents that cause damage or otherwise disrupt the production process.
- Harmful and hazardous consumption can have an impact on third parties, such as co-workers and can undermine trust (social capital).

⁶⁵ IA Background Report.

The link between productivity, earnings, and employment opportunities are obvious at an individual or microeconomic level. Macroeconomic analysis shows a weaker link as it deals with the marginal rather than the absolute or average effect and the relationship between total output or value added and the use of production factors.

8.3.2. *Opportunity costs*

8.3.2.1. Health care

If the proposed alcohol policy is successful, one of its most important achievements would be a reduction in alcohol-related morbidity and mortality. The resources that are liberated could potentially contribute to macroeconomic performance. According to the IA Background Report, the short-term opportunity costs of alcohol-related morbidity and mortality as associated effects relate mainly to the potential benefits of a reallocation of resources within the health care sector (for example moving health care resources from emergency care to prevention or treatment of diabetes). One such benefit would occur as resources are shifted from treatment (dealing with alcohol-related diseases and injuries) to prevention. A far more important effect of the reduction in health care expenditure on alcohol-related deaths and diseases would be a shift in resources to the treatment of other diseases and to prevention. This could improve the general health status of the labour force, thus adding to its efficiency.

A reduction of binge drinking would reduce the strain on accident and emergency services, which are very high-cost elements of the medical system and are heavily rationed. A reduction in weekend night overcapacity is often viewed as extremely desirable in terms of the cost-effectiveness of care delivery to other types of patients.

According to the Alcohol in Europe report brief advice (advice given by doctors and nurses in primary health care) heads the list of evidence based treatment methods⁶⁶. The WHO' CHOICE has modelled the impact and cost of providing primary care based brief advice to 25% of the at-risk population. Applying this to the EU finds an estimated 408,000 years of disability and premature death avoided at an estimated cost of €740 million each year.

8.3.2.2. Social security and social care services

The IA Background report has not assessed the impact of a decline in harmful effects of alcohol to other agencies, for example the impact on cost for housing, social care services and social security systems. This is an area that needs to be further explored.

8.3.2.3. Crime

A decline in the harmful effects of alcohol use would lead to savings through a reduction in property damage (assuming a fall in crime across all types of crime). The same decline would lead to lower prevention and insurance costs though most probably with a lag. The IA Background Report' does not expect that the cost of law enforcement and the police cost related to alcohol-related crime and violence should fall immediately. These costs include high fixed costs that would be redirected to the prevention of other crimes rather than reallocated to productive purposes.

⁶⁶ There have been at least 56 controlled trials of effectiveness, 14 meta-analyses or systematic reviews that confirms this.

8.3.2.4. Drink driving

A decline in drink driving and alcohol-related traffic accidents would free resources, albeit at the expense of the value added generated by car manufacturers, car repair companies, and rescue and emergency services. Time savings would yield economic gains mainly through the amount of time involved in transporting freight and other production-related transport.

An estimation of the inferred loss of Gross Domestic Product attributable to alcohol-related deaths and injuries in the EU produces fairly modest results. A 10% reduction in the number of deaths would liberate a mere €10 million in GDP losses. Injuries account for a larger proportion of immediate output losses with savings amounting to between €24 and €118 million depending on assumptions. The combined effect would then approximately amount to €34 to €128 million.

The WHO's choice modelled two independent effects on alcohol-related traffic injuries: drink-driving laws, adjusted for the current level of implementation; and enforcement via random breath testing (RBT). The model found that the full implementation of random breath testing (compared to no random breath testing) throughout the EU prevents between 161 and 460 DALYs per million people per year at an estimated cost of between €43 and €62 per 100 people per year.

8.3.2.5. Insurance

A reduction in alcohol-related morbidity, mortality, traffic accidents, and crime will in time translate into lower insurance premiums unless the specific risks had already been internalized.

8.3.2.6. Taxation and public revenues

The IA Background Report notes that, under normal conditions, an increase in excise duty raises the price and lowers demand; at the same time, there are limits as to what excises can achieve, in particular as consumers may switch between different types of alcoholic beverages depending on price changes. Furthermore, there are considerable differences between Member States in patterns of alcohol production, consumption, purchase power and level of excise rates.

The IA Background Report further examines own price elasticities and cross price elasticities, and considers a number of scenarios for the harmonisation of excise duties across the EU-25, albeit in relation to beer and wine only. It concludes that different changes in excise duties have a very low effect on average per capita beer consumption, and only a modest effect on wine consumption. The decrease in consumption would not lead to a fall in public revenue, as it would be offset by the increase due to the higher excise rates.

Increasing excise duties alone will therefore not lead to a sustained decline in alcohol use or an associated change in harmful behaviour, but there is evidence that such increases can be effective with respect to particular groups of consumers (heavy drinkers and young

drinkers⁶⁷). Beyond levels of drinking, price has been found to influence drinking to intoxication⁶⁸.

Finally, the IA Background Report considers the social costs of unrecorded consumption, defined as illegal production, counterfeiting and smuggling, and notes that increasing the levels of excise duty may cause a decline in alcohol consumption and an increase in revenues. However, in Member States with high levels of unrecorded consumption revenues may actually fall as consumers switch to illicit products. Illicit products could also create severe health problems as the quality of these products for understandable reasons is not controlled

Although alcoholic beverages appear to behave in the market like most other consumer goods, the demand for alcoholic beverages in some consumers may differ because of the addictive nature of alcohol. The effect of increased prices on alcoholic beverages is found to be stronger in Scandinavian countries. It is estimated that there would be a 6 – 7 % fall in suicide deaths and accidents, together with a 20% decrease in directly alcohol-related deaths from men and a 40% fall in women if the price of alcohol should rise with 10%⁶⁹.

8.4. Environmental impact

There is no significant impact on environment as the different options do not include any suggestions to reform the alcohol economy or the common market of wine, beer or spirits.

8.5. The impact of alcohol policy options on health

Considerable progress has been made in the scientific understanding of the relationship between alcohol policies; alcohol consumption and alcohol-related harm⁷⁰. This section of the IA builds on the result of time series analyses, econometric analyses, community studies and randomized controlled trials of interventions. Although it is changing, the evidence base is still largely dominated by studies from North America, northern Europe, and Australia and New Zealand.

Additional to alcohol policy, social and economic policies that seek to improve conditions for the healthy development of children and youth, reduce inequalities, increase equity, and strengthen communities will have a range of benefits including lower rates of the harm done by alcohol⁷¹.

8.5.1. Drinking-driving policies

Drinking- driving policies are highly effective if they are enforced and include low blood alcohol concentration (BAC) levels, unrestricted (random) breath testing, administrative license suspension, and lower BAC levels and graduated licenses for young drivers, and drivers of buses and dangerous goods. To be effective, drink driving laws must be publicized. If the public is unaware of a change in the law or an increase in its enforcement, it is unlikely

⁶⁷ Grossman et al. 1987, Coate and Grossman 1988, Laixuthai and Chaloupka 1993, Chaloupka and Wechsler 1996, Cook and Moor 2002).

⁶⁸ One large studie, Sloan et al 1995, found that a 10% increase in price would decrease the number of intoxication episodes per month by 8%.

⁶⁹ From Alcohol in Europe, based on WHO Global Status Report on Alcohol 2004.

⁷⁰ Bruun et al. 1975; Edwards et al. 1994; Babor et al. 2003.

⁷¹ Blane et al. 1996; Marmot and Wilkinson 1999.

that it will affect their drinking and driving. When incorporated as part of community programmes, drink driving measures appear to have increased effectiveness⁷².

Lowering BAC levels consistently produces positive results in drink-driving behaviour at all levels and also leads to further reductions in alcohol road traffic accidents⁷³.

The introduction of low BACs of 0.2g/l for young or inexperienced drivers has led to reductions in fatal crashes of from 9% to 24%. Studies in California demonstrated that publicity doubled the impact of new laws and new enforcement efforts⁷⁴.

The reduction of the legal BAC limit in Austria from 0.8g/l to 0.5g supported by breath tests lead to a decrease by 22.9 % of the number of drivers who were found to have a BAC on or above 0.8g/l (compared to the same period before the reduction).

Moreover, the reduction of the legal BAC limit from 0.8g/l to 0.5g/l in New South Wales found a 7% reduction in all serious crashes, an 8% reduction in fatal crashes, and an 11% reduction in single vehicle night time crashes⁷⁵. In comparison, random breath testing was associated with decreases of 19%, 48% and 26%, respectively. A simple pre-post comparison of the aggregate crash data for the three years prior to and following the introduction of the lower BAC limit from 0.8g/l to 0.5g/l in Queensland revealed net reductions of 11% for crashes which resulted in a hospital admission, 15% for injury crashes (but for which no one was admitted), and 12% for property damage crashes⁷⁶.

However, it does appear that some of the impact of lowering BAC levels wears off over time. Making motorists uncertain about the real risk of detection is found to be a key to cost-effective deterrence⁷⁷.

The World Health Organization has modelled the impact and cost of unrestricted breath testing compared with no testing; applying this to the Union finds an estimated 111,000 years of disability and premature death avoided at an estimated cost of €233 million each year⁷⁸.

The impact of designated driver campaigns is being evaluated by the Commission within the Road Safety Strategy.

8.5.2. *Responsible server programmes*

A study in North America (Hingson 1995) found that between 33% and 50% of all repeated drunk-drivers (both alcohol and drugs) last consumed alcohol before driving in bars or restaurants. This has led to the introduction of responsible serving programmes. Training programmes for servers and bartenders have been evaluated in North America, Australia, and the Netherlands. When implemented as part of more comprehensive community-based programmes, responsible server programmes have been found to be effective, particularly for night time crashes involving young people⁷⁹;

⁷² Anderson, P. & Baumberg, B. (2006) *Alcohol and Europe*. London: Institute of Alcohol Studies.

⁷³ Jonah et al. 2000.

⁷⁴ Voas and Hause 1987.

⁷⁵ Henstridge et al. 1997.

⁷⁶ Smith 1987; 1988.

⁷⁷ Homel 1988; Nagin 1998.

⁷⁸ Anderson, P. & Baumberg, B. (2006) *Alcohol in Europe*. London: Institute of Alcohol Studies.

⁷⁹ Wagenaar et al. 2000.

8.5.3. *Education, information and raising public awareness*

Actions in the fields of education and information are the most commonly used and popular tools in Member States in order to address alcohol-related harm. The evidence for a change of behaviour is low, although effective educational and information campaigns can lead to increased awareness and knowledge. For example, although the quality of counter-advertising has often been poor, mass media marketing can be used to reinforce community awareness of the problems created by alcohol use and to prepare the ground for specific interventions⁸⁰. Education and public information approaches can be used not just to persuade the individual drinker to change his or her behaviour, but also to mobilise public support for prevention approaches that have demonstrated their effectiveness⁸¹. Media advocacy can be used to support a shift in public opinion for policy changes, one example is the introduction of standard drinks labelling on all Australian alcohol containers⁸².

The impact of maternal harmful alcohol consumption is clinically noticeable when the person consumes three glasses or more of alcoholic beverages per day. Below this threshold of three glasses per day, it is not possible to conclude that alcohol is harmless. However, the existence of a threshold below which there is absolutely no risk has not been proven. This is why pregnant women in, in some Member States, are advised not to drink alcohol during pregnancy. A study in France showed that only half of the French population, and in particular pregnant women, believes that the risk of alcohol consumption during pregnancy only relate to excessive consumption. On this background the French Government are introducing health warning labels on alcohol containers, supported by publicity campaigns, information in schools and counselling by the medical/social sector. (Introduced 3rd October 2006).

A fairly extensive amount of research has been conducted in connection with mandatory warning labels on alcoholic beverage containers in the United States. Studies have found that a significant proportion of the population report having seen warning labels⁸³, and there is evidence that warning labels may increase knowledge regarding the risks of drinking and driving, and of drinking during pregnancy⁸⁴, with some evidence for a dose-response relationship between conversations about drinking while pregnant and the number of types of messages seen⁸⁵. However, warning labels and information activities are mostly seen as a part of consumer policy and, in particular during pregnancy, when taking medication or when driving or operating machinery, consumers should, as a part of consumer policy, be informed about the risks, even if the evidence for the impact of such specific warning labels or educational activities on behaviour is limited.

There are very few evaluations of the impact of educational messages on behaviour. Public service announcements, public education campaigns, and particularly those that focus on low risk drinking guidelines have so far shown limited evidence for effectiveness. Even if systematic reviews show little impact all people need to be informed about harmful and hazardous consumption of alcohol and about low risk drinking patterns.

⁸⁰ Casswell et al. 1990; Holder and Treno 1997.

⁸¹ Casswell and Gilmore 1989.

⁸² Stockwell and Single 1997.

⁸³ Hilton 1993; Graves 1993; Greenfield et al. 1993; Kaskutas and Greenfield 1992.

⁸⁴ Kaskutas and Greenfield 1992; Greenfield 1997; Greenfield and Kaskutas 1998; Greenfield et al. 1999; Kaskutas and Greenfield 1997.

⁸⁵ Kaskutas et al. 1998.

School based education, health warning labels and awareness raising campaigns cannot work on their own, to be effective they must be complemented with other interventions such as counselling by medical doctors or nurses in maternity care. Furthermore, research⁸⁶ shows that early intervention can prevent many adolescent risk behaviours, for example harmful alcohol and drug consumption. A cost-benefit impact assessment could be useful before taking any definitive decisions on future activities to improve consumer information on alcohol.

8.5.4. Pricing

The effect of price is under debate. There are studies that have found that increases in the price of alcohol reduce the alcohol consumption of young people, with a greater impact on more frequent and heavier drinkers than on less frequent and lighter drinkers⁸⁷. The price of alcohol has also been found to influence drinking to intoxication. One large survey in the US found that a 10% increase in price would decrease the number of intoxication episodes per month by 8% (defined as consuming 5+ drinks on one occasion)⁸⁸. Other studies have found effects of price on dependence and frequency of drinking among adult heavy drinkers⁸⁹. There are also studies that have found that increased alcohol prices have reduced cirrhosis death rates, injuries and violence⁹⁰ and some studies have found that increasing the price of alcoholic beverages reduces road traffic accidents and fatalities among people of all ages, but particularly for younger drivers⁹¹. Apart from the direct price effect on young people and heavier drinker's research has shown that purchasing power within a specific group also has an impact on alcohol consumption and harm. This reduces the impact on price and consumption.

The level of price is also important in relation to illicit alcohol. Too high prices can lead to a switch over to illicitly produced alcohol, especially among young people and high risk drinkers.

8.5.5. Minimum legal selling and serving age

Laws that raise the minimum legal selling and serving age are shown to reduce alcohol sales and problems among young drinkers⁹². Although legal restrictions in the EU on the age at which young people may purchase alcohol vary from 16 to 18 years of age, almost all countries legally restrict these sales. A review of 132 studies published between 1960 and 1999 found very strong evidence that changes in minimum drinking age laws (when enforced) can have substantial effects on youth drinking and alcohol-related harm, particularly on road

⁸⁷ Coate and Grossman 1988; Laixuthai and Chaloupka 1993; Chaloupka and Wechsler 1996; Cook Grossman and Moore 2002, An evaluation of the introduction of special taxes on Alco-Pops by The Ministry of Finance in Germany, An evaluation of increased taxation in Ireland.

⁸⁸ Coate and Grossman 1988; Laixuthai and Chaloupka 1993; Chaloupka and Wechsler 1996; Cook Grossman and Moore 2002, An evaluation of the introduction of special taxes on Alco-Pops by The Ministry of Finance in Germany, An evaluation of increased taxation in Ireland.

⁸⁹ Sloan et al. 1995.

⁹⁰ Coate and Grossman 1988; Kenkel 1993, 1996, Manning et al 1995, Farrell et al 2003.

⁹¹ Grossman 1993; Cook and Tauchen 1982, Sloan et al 1994, Grossman and Markowitz 1999, Ohsfeldt and Morrissey 1997, Cook and Moor 1993, Sloan et al 1994.

⁹² Saffer and Grossman 1987a,b; Kenkel 1993; Ruhm 1996 Chaloupka and Laixuthai 1997 Dee 1999; Mast et al. 1999; Dee and Evans 2001; Chaloupka et al. 2002 Saffer and Chaloupka 1989; Evans et al. 1991; Chaloupka et al. 1993; Sloan et al. 1994a; Mullahy and Sindelar 1994a .

⁹² Grube and Nygaard 2001; Babor et al. 2003.

traffic accidents.⁹³ . Many studies in the US have found that raising the minimum legal drinking age from 18 to 21 years decreased single vehicle night time crashes involving young drivers by 11% to 16% at all levels of crash severity⁹⁴. Changes in the minimum drinking age are related to changes in other alcohol related injury admissions to hospitals.

It is particularly noteworthy that the full benefits of a higher drinking age are only realized if the national law is enforced.

8.5.6. *Marketing*

In 2002 in the US, underage youth saw 45% more beer and ale advertising, 12% more distilled spirits advertising, 65% more low alcohol refresher advertising, and 69% less advertising for wine than persons 21 years and older⁹⁵ . Girls aged 12 to 20 years were more likely to be exposed to beer, ale, and low-alcohol refresher advertising than women in the group aged 21 to 34. Furthermore, between the year 2001 and 2002 girls' exposure to low-alcohol refresher advertising increased by 216 %, while boys' exposure increased by 46 %.

Later studies have suggested significant effects of alcohol advertising on alcohol related problems⁹⁶ . Since advertisements have a particular impact in promoting a more positive attitude to drinking amongst young people, and, even in advertisements that do not portray drinking of alcohol, young people perceive the characters as heavy drinkers, it is likely that restricting the content of advertisements and well functioning self-regulation could reduce harm, although this has not been specifically evaluated.

8.5.7. *Comprehensive mix of interventions*

A summary of the estimated impact of different interventions (DALYs prevented per million people per year) is presented in the report Alcohol in Europe. The most cost efficient option would according to the authors be a comprehensive programme that is modelled to reduce the burden of harmful and hazardous alcohol consumption to the Union. They have estimated that a reduction of alcohol related harm by nearly one third would only cost the governments of the EU as a whole an estimated €1.3 billion a year, about 1% of the total tangible cost of alcohol to society. The cost effectiveness of different policy options is presented in the figures below⁹⁷. The vertical axis is the cost (€) per 100 million people per year and the horizontal axis is the number of DALYs prevented per million people per year. The blue diagonal lines (moving from right to left) show the cost effectiveness in Euros per DALY prevented, ranging from €100 per DALY (bottom right) to € 10, 000 per DALY (top left). There is one figure per sub-regions of the European Union (WHO standard). The policy interventions (in different colours and shapes) are presented in figures 12-15 below.

⁹³ Waagenar and Toomey 2000.

⁹⁴ Klepp et al. 1996; Saffer and Grossman 1987a,b; Wagenaar 1981 1986; Wagenaar and Maybee 1986; O'Malley and Wagenaar 1991; Voas and Tippet 1999.

⁹⁵ Jernigan et al. 2004.

⁹⁶ Saffer 1991 1997; Saffer and Dave 2004.

⁹⁷ Source: Chrisholm et al (2004).

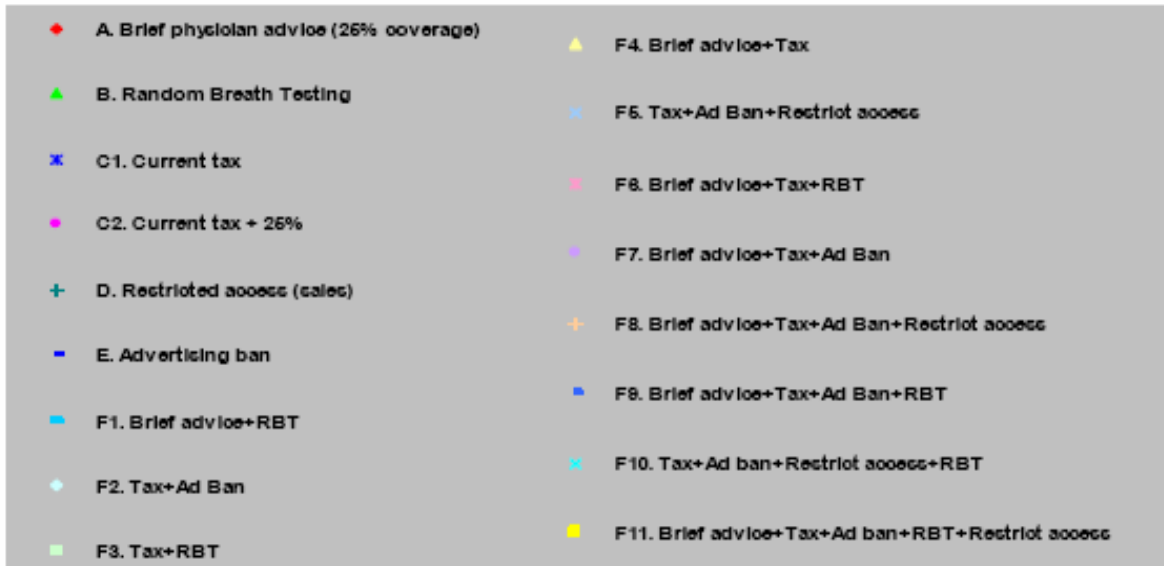


Figure 12: The different interventions

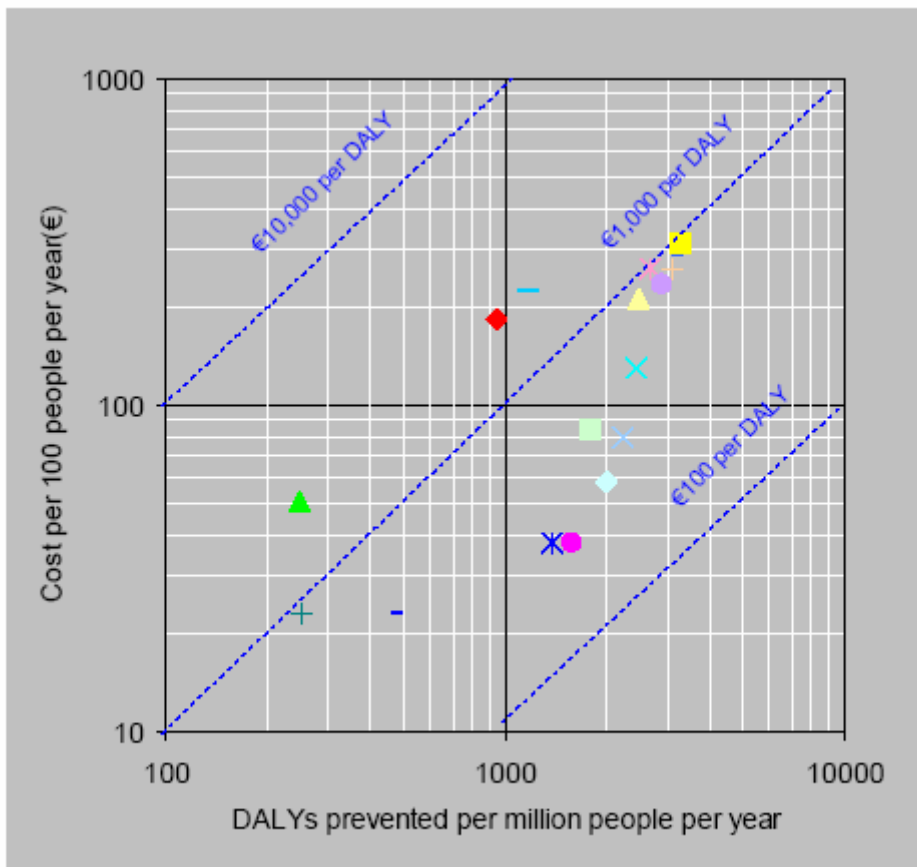


Figure 13: Cost effectiveness of different policy options for EU25 A countries. Source: Chrisholm et al (2004) (adapted by Anderson and Baumberg 2006)

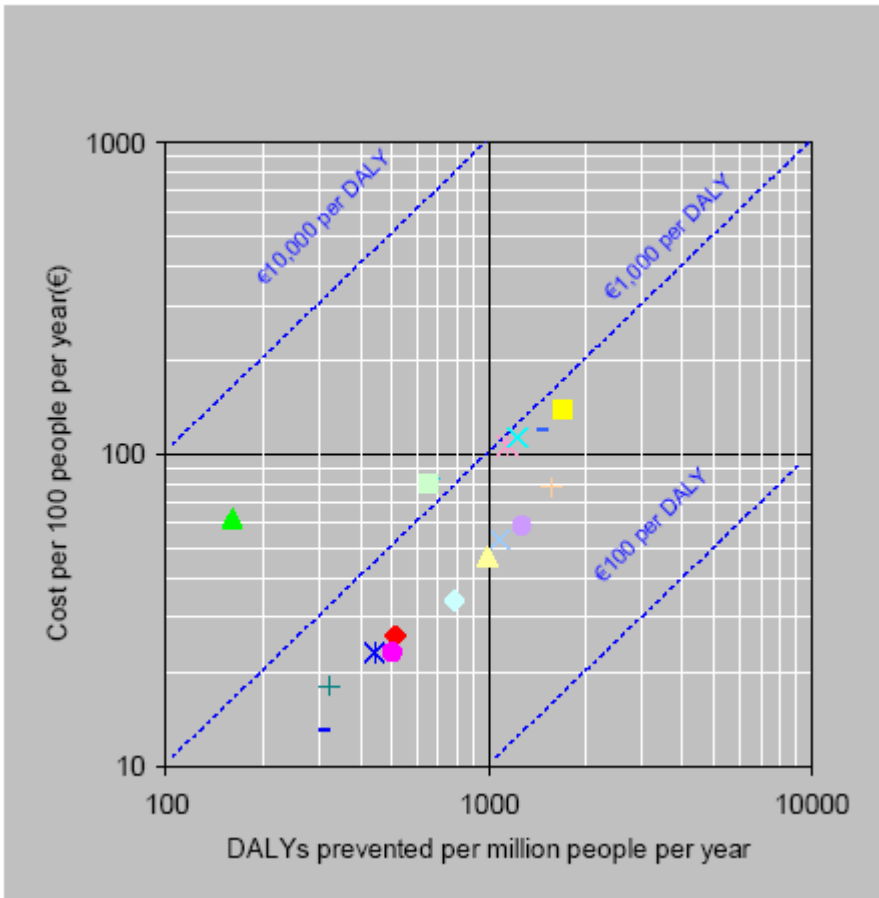


Figure 14: Cost effectiveness of different policy options for EU25 B countries. Source: Chrisholm et al (2004) (adapted by Anderson and Baumberg 2006)

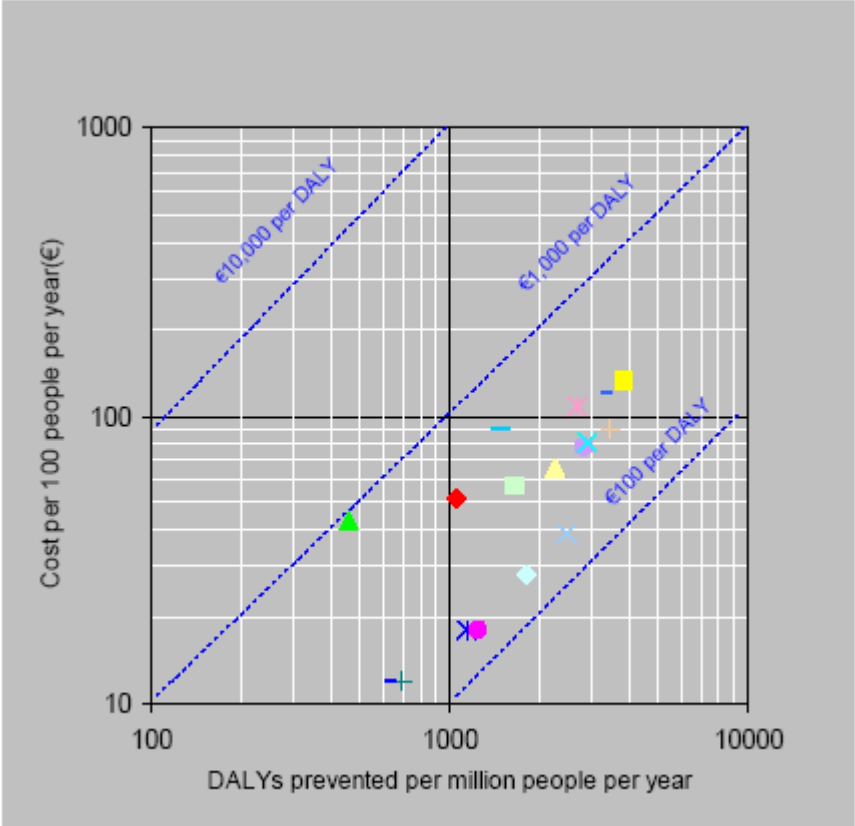


Figure 15: Cost effectiveness of different policy options for EU25 C countries. Source: Chrisholm et al (2004) (adapted by Anderson and Baumberg 2006)

9. COMPARING THE OPTIONS

9.1. Policy options

As mentioned in chapter 7 the Commission has identified four options for future alcohol policy:

- (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 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.

The impact of any of the identified policy options to reduce alcohol harm will depend on their more detailed content, on the preferences and choices of the main actors at all levels and on the way in which the various measures are implemented.

9.1.1. A general assessment of the options

In the IA Background Report a general assessment of cost effectiveness and a general assessment on the impact on alcohol harm of the four options were conducted:

A comparison of the four options⁹⁸

	Scope, particularly use versus behaviour	(Cost) effectiveness	General assessment
Option 1: No change	Current mix of national policy instruments, some aimed at behaviour and others at use.	As is.	Harmful effects of alcohol consumption will remain. Their development will be determined by trends and patterns in alcohol consumption and by the effectiveness of current EU, Member State, and industry initiatives.
Option 2: Coordination	Same mix of instruments as in option 1, but with greater collaboration and knowledge exchange	Higher efficiency through coordination balanced against higher transaction costs of collaboration and	Probably more efficient version of option 1, e.g. with better treatment of cross-border issues and synergies

⁹⁸ IA Background Report’.

	between Member States (e.g. copying best practices) and stakeholders (e.g. co- and self-regulation).	communication.	between policy areas, but without structural improvement in alcohol policy.
Option 3: Comprehensive framework	Combination of policies aimed at use and behaviour, with the emphasis on encouraging responsible behaviour. This option may capitalize on the synergies between different policy approaches (especially education versus regulation) and on the economies of scale and scope inherent in a pan-European strategy.	Stronger emphasis on communicative instruments (information, awareness, training, education) –which tend to be less (cost) effective– backed up by regulation and legislation. Communication, regulation and treatment can, however, reinforce each other when used in a carefully designed comprehensive package.	Potentially most efficient and effective approach in that it combines policies intended to lower harmful alcohol use with activities aimed at behavioural change. A European strategic approach would combine the synergies of international collaboration (option 2) and the effectiveness of regulation (option 4) with a campaign to achieve a sustained or innate change in behaviour.
Option 4: Regulation	Focus mostly on alcohol use with behavioural change as a secondary effect. Taxation, restrictions on access and availability, and advertisement bans target alcohol consumption as the most easily observable fact.	Regulatory instruments are among the most effective and cost-effective methods. A focus on regulation would mainly involve more stringent rules and, above all, an increase in monitoring and enforcement. The latter activities are less (cost) effective, especially because an emphasis on regulation raises the risk of non-compliance.	A focus on regulation will lower alcohol use. This will contribute to a reduction in the harmful effects of drinking, for example because heavy drinkers are more sensitive to higher prices than moderate drinkers and because youth drinking will be discouraged. Yet without a supporting information and education campaign, changes in use may not become engrained in consumer behaviour.

9.1.2. Specific impacts

Based on the analysis in and the assessment of the four options the IA Background Report also makes an assessment on the impact of each option on a range of policy areas with an emphasis on the economic aspects. Option 1 is considered the baseline estimate: in this option all trends will continue, and problems will persist.

Impacts relative to the baseline scenario of option 1 per policy domain ⁹⁹

	Option 2: Coordination	Option 3: Comprehensive framework	Option 4: Regulation
Productivity			
Labour	(+) mild effect on absenteeism and unemployment but not expected to be significant; more effective policies in the workplace through co- and self-regulation	+ improvement in the behaviour of workers, drivers, and other potential harmful alcohol users; higher educational attainment of new entrants into the labour market; education and (on-the-job) training of workers	(+) no direct effect but one through changes in alcohol use and its effects on drink-driving and alcohol abuse among the young
Opportunity costs			
Health care	≈	+ lower incidence of alcohol	+ decline in heavy drinking;

⁹⁹ IA Background Report’.

Impacts relative to the baseline scenario of option 1 per policy domain ⁹⁹

	Option 2: Coordination	Option 3: Comprehensive framework	Option 4: Regulation
		use across the board; decline in heavy drinking and youth drinking; reduction in alcohol-related traffic accidents	and youth drinking; reduction in alcohol-related traffic accidents; increase in consumption of illicit alcohol in some Member States
Pensions	≈	– longer life expectancy increases the burden on pension funds	(–) most effective on extreme drinkers and the young as well as drivers
Crime and violence	≈ more effective policies but little impact in the area of crime and violence	++ change in behaviour in addition to decrease in use backed up by regulation	(+) strict regulation may elicit non-compliance and stimulate criminal behaviour ¹⁰⁰
Drink driving	≈	+ decline induced by behavioural change supported by regulation to compensate for lower effectiveness of “soft” policy instruments	++ decline but at high public costs
Competitiveness, public revenues, and the alcohol industry			
Competitiveness	≈ modest impact through the greater efficiency of policies and collaboration between stakeholders, including industry	+ lower absenteeism, lower accident-related congestion, more responsible behaviour of workers, all directly targeted by comprehensive policy package; supported by productivity gains	(+) lower use provides benefits to employers but possibly increase public administrative and regulatory costs for taxpayers; stricter regulation may be perceived as a disadvantage in the location and investment decisions of investors
Public revenues	≈	(+) decline in use through awareness and education, but there is room for industry to profit (i.e. increase sales) through cooperation	+ higher excise duties but still an increase in revenues; a rise in unrecorded consumption may eat into these gains
Performance of the alcohol industry	(+) collaboration and coordination as well as the role of co- and self-regulation provide industry with a degree of leverage	(+) lower alcohol use, but emphasis on responsible behaviour rather than decline in overall use; targeting extreme drinking and youth drinking to the detriment of producers of specialist beverages (e.g. alcopops)	-- ban on alcohol advertising and strict regulation on access, availability and excise taxation will harm the industry
General assessment			
	the efficiency of current policies and interventions is increased with coordination	focus on behavioural aspects of alcohol use more than on use itself improves the potential for a sustainable impact	tackles use more than behaviour and focuses on compliance rather than encouragement

¹⁰⁰ Compare the impact of Prohibition in the USA on the rise of organized crime and the effect of a strict drug policy on petty crime.

Impacts relative to the baseline scenario of option 1 per policy domain ⁹⁹

Option 2: Coordination	Option 3: Comprehensive framework	Option 4: Regulation
---------------------------	--------------------------------------	-------------------------

Notes: \approx = no change relative to the baseline of option 1; -- = very negative; - = negative; (-) = somewhat negative; (+) = somewhat positive; + = positive; ++ = very positive.

9.2. Conclusions

In line with the findings of the reports that have provided input for the Impact Assessment¹⁰¹, and based on the consultations held, the preferable approach from both a public health and economic point of view would be to develop a 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 published by the World Health Organisation (WHO)¹⁰² and other published reviews on the effectiveness of different policy interventions to reduce alcohol-related health and social harm. 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

¹⁰¹ 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.

¹⁰² What are the most effective and cost-effective interventions in alcohol control, WHO Regional Office for Europe, 2004.

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 or to the influence of other variables not affected, however as a combination of microeconomic elements, productivity gains and budget implications the overall impact on the economy is 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 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 of the impact of harmful and hazardous alcohol consumption both at EU and at 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.

9.2.1. *Issues not covered in the IA*

The Council Conclusions from 2001 underline the desirability of developing a comprehensive strategy, addressing among other things excise duties and other internal market issues. On subsidiarity grounds, Member States are free to set their excise duty rates on alcohol at those levels which they consider appropriate for their own national circumstances, subject only to the respect of the minimum rates. The Commission has already proposed amendments to current regulations: adjustment of the minimum rates of excise duty in line with inflation in order to avoid a fall in the real value of these duties¹⁰³; a proposal to introduce a quantitative limit for beer of 16 litres (no limit is applied today) and to increase the quantitative limit for wine from 2 to 4 litres when these beverages are brought into the EU from third countries¹⁰⁴. Therefore, excise duties on alcoholic beverages as a public health tool must be left to Member States own preferences as long as this is not creating conflicts with other EU-level rules. In the event of any such conflict action at EU-level may be necessary.

¹⁰³ Council Directive amending Council Directive 92/84/EEC on the approximation of the rates of excise duty on alcohol and alcoholic beverages.

¹⁰⁴ COM(2006)76.

A fairly extensive amount of research on health warning labels has been conducted in connection with mandated warning labels in the United States. However, the cost-effectiveness of health warning labels has not been possible to assess in this Impact Assessment report.

9.2.2. *Multi-stakeholder and community-based approaches*

The Commission's initiatives in the field of nutrition and physical activity / obesity prevention, and in particular the multi-stakeholder European Platform for Action on Diet, Physical Activity and Health¹⁰⁵ illustrate that EU actions to promote public health need to involve all relevant stakeholders (public authorities, health and consumer NGOs, industry, health professionals, retailers, media, educators...), and need to be carried out at all levels (local, regional, national and international). As public health interventions need to be implemented at local level in order to reach EU citizens, it is in fact particularly important to support and stimulate actions at local level; local communities' involvement is required in order to assure such successful implementation. This approach is also relevant for the implementation of an EU- wide alcohol strategy.

10. MONITORING AND EVALUATION

As stated in the EC Impact Assessment Guidelines (SEC (2005) 8 June 2005) the road map for monitoring progress should "set measurable indicators to cover both the quality of outcomes and the implementation process, and define plans for evaluation. The foreseen Commission Communication on an EU strategy to support Member States in reducing alcohol related harm will include proposals on a solid information system at the EU level. The preferred option will enable future monitoring and evaluation as the policy mix with examples of efficient and good practises can be used as a basis for monitoring progress.

The health indicators, already developed in the European Health Survey System will be in place in 2006. Trends in harmful and hazardous alcohol consumptions and trends in drinking patterns will also be able to monitor via the Eurobarometer. The World Health Organisation (WHO) has developed a surveillance and information system (the European Alcohol Information System) and there are ongoing discussions on better coordination of the two systems. Through the Public Health Programme there are several public health projects that already know are conducting surveys and evaluations of different policy options (drink-driving actions, consumer information, actions against binge-drinking). Furthermore, tools for conducting effective health and economic impact assessment of different policy options are being developed at Member State level and there is a need to, in close cooperation with the WHO, coordinate this work at the EU level.

Future indicators, timeframes, benchmarks and actors will be identified and developed in cooperation with relevant partners and stakeholders. Based on this, the Commission services are planning to carry out continuous and overall monitoring of the process. The intention is to seek support for this purpose from the European School Survey (ESPAD) and Eurostat and cooperation with the World Health Organisation (WHO). Moreover, through the proposed 7th Research Framework Programme (2007 – 20013) there will be opportunities to examine how research at the European level brings value to an EU strategy to support Member States.

¹⁰⁵ http://ec.europa.eu/health/ph_determinants/life_style/nutrition/platform/platform_en.htm

Furthermore, appropriate monitoring and evaluation provisions will be made in order to evaluate the effectiveness of EU actions proposed in the foreseen Communication on an EU strategy to support Member States in reducing alcohol related harm.

**INTER-SERVICE GROUP FOR THE IMPACT ASSESSMENT ON A PROPOSAL FOR A
COMMISSION COMMUNICATION ON ALCOHOL POLICY**

MANDATE

DECISION OF THE COMMISSION

Based on calls from the Council in 2001 and 2004 preparations of a Community strategy to reduce alcohol related harm Commission services started broad consultations in 2004. A Communication on Alcohol and Health is included in the Commission's Legislative Work Plan for 2006¹⁰⁶. The intention of the Communication is to suggest actions to support Member States, to facilitate exchange of best practice, to develop a common evidence base, and propose actions with a clear aim to reduce alcohol related harm.

ISSUE AT STAKE

Alcohol-related harm is a key public health and social concern across the Community. The EU has an obligation to ensure that "A high level of human health protection shall be ensured in the definition and implementation of all Community policies and activities (Article 152 of the Treaty). Health is also mentioned in Articles 153 (Consumer policy), Article 175 (Health and environment), 137 (Workers safety), Article 3 (Health protection, and Article 95 (3) (Health, safety, environment and consumer protection).

According to the World Health Organisation, a significant proportion of the burden of disease in the EU is attributable to alcohol (7,4 % of disease burden in EU25¹⁰⁷) leading to an important cost to society in health, welfare, and the criminal justice sector.

Young people shoulder a disproportionate amount of this burden. Alcohol is responsible for 12% of male and 2% of female premature death and disability after accounting for health benefits in EU25¹⁰⁸. During recent years there has been an increasing trend of deaths from chronic liver cirrhoses and unintentional injuries among young men and women in some MS as harmful drinking patterns are on the rise among young people, especially young adult men¹⁰⁹. Alcohol consumption among young girls is likewise increasing in several MS¹¹⁰

One out of four fatalities on EU roads is caused by drink-driving. The EU has set a goal to halve the number of people killed on European roads. Drink-driving countermeasures can be highly effective in preventing alcohol-related traffic accidents and injuries.

¹⁰⁶ Roadmap on Alcohol and Health.

¹⁰⁷ World Health Organisation 2005.

¹⁰⁸ WHO - Global Burden of Disease (GBD) Study conducted under the umbrella of the WHO (Disability-Adjusted Life Years (DALYs).

¹⁰⁹ UK, Chief Medical Officer, changes 1970-2000 in deaths from chronic liver disease with 959% among men in the age group 25 – 44 (in real terms from 49 per year to 470 per year), some of the increase is due to infection with Hepatitis C virus but the main part is according the UK Chief Medical Officer alcohol- related. Deaths among women aged 25 – 44 has increased from 29 in 1970 to 268 in 2000 (924%).

¹¹⁰ National alcohol surveys reported to EU.

Harmful and high alcohol consumption lowers productivity at workplaces. The cost due to alcohol-related harm resulting for example from absenteeism, alcohol-related diseases and premature mortality is high.

Harmful alcohol consumption contributes to inequalities within countries as harmful effects of alcohol tend to be greater in less advantaged social groups¹¹¹. It is also contributing to inequality between EU Member States as alcohol- disease burdens according to WHO varies between EU MS.

Some of the drivers behind the experienced problems are for example; changed drinking-patterns, from drinking with meals to drinking as leisure time activity, increased globalisation and mobility and increased binge-drinking among young people.

There are both Community and transnational aspects related to alcohol. EU policies have an influence on alcohol (wine, beer and spirits) production, marketing, trade, consumption and harm reduction policies (cross-border trade, tax approximation, cross border TV and marketing, harmonisation of labelling).

It is foreseeable that young people's drinking habits, if the trend continues, could have a negative impact on the competitive position of EU business.

Several MS have expressed a need to move the focus of alcohol policy away from mainly a national responsibility to an area for more cooperation on relevant policy areas, information and exchange of best practise.

Europe plays a central role in the global alcohol market. The trade in alcohol contributes around €9bn¹¹² to the goods account balance for EU. Alcohol excise duties in EU15 amounted to €25bn in 2001.

THE IMPACT ASSESSMENT

The impact assessment on the foreseen Communication on Alcohol and Health will follow the set of logical steps recommended in the European Commissions Impact Assessment Guidelines SEC (2005)791. The impact assessment's depth is determined by the likely impact of the proposed action. For broad policy-defining documents the analysis generally will be rather broad in its problem description and objectives.

An external study on the impact of alcohol related harm on economic development will be conducted as a part of the Impact Assessment.

¹¹¹ Report from the UK Conference in 2005 on Inequality in Health; national data and the GBD study (WHO).

¹¹² Eurostat's External Trade (XTNET) database for 2002 (List of the value of imports and exports involving EU countries to all other countries for beer (class number 2203, Wine including grape must (2204), vermouth and flavoured wines (2205), cider, perry, mead et al (2206) and spirits, liqueurs and undenatured alcohol <80% (2208). Excluded is CN2207 undenatured alcohol >80%, 2201 and 2202 (soft drinks) and 2209 (vinegar). Extract of total value of imports and exports between each EU country and (i) all other countries (includes other EU countries), (ii) EU 15 countries, (iii) EU10 countries; (IV) other countries' group.

CONSULTATION OF INTERESTED PARTIES

Gathering opinions and information from interested parties is an essential part of the policy-development process. All stakeholders are currently involved in a broad consultation process, for example a Commission Working Group on Alcohol and Health with MS public health experts has had two meetings in 2005 as well as several bilateral meetings with Stakeholders representing the broader alcohol industry. One part of the consultations has been the discussions under the auspices of European Policy Centre (EPC) “Stakeholders Roundtable” on Alcohol-related harm. In 2005 and 2006 the EPC hosted four Roundtables with a selected number of alcohol companies representing beer, wine and spirit producers NGOs, the research society and MS representatives.

ASSESS AND ANALYSE THE PROBLEM

One of the main objectives with the Impact Assessment is to assess and analyse the social (health), economic and environmental problems related to harmful and hazardous alcohol consumption, especially among young people and in some key settings like traffic, workplaces and during pregnancy. This aim will mainly be achieved by:

- Collecting information and data from Member States, Stakeholders and the research society;
- A call for tender issued in 2003 resulting in a report on Health, Social and Economic impact of Alcohol (to be published in April 2006);
- An external contractor (RAND) on alcohol’s impact on economic development (report in April 2006);
- Inter-Service Steering –Group on IA.

IDENTIFY OBJECTIVES

In its strategic objectives, Commission services have developed an innovative tool called SANCO Scoping Paper. The tool is used to early identify key objectives, options and impact. This tool was used by SANCO to prepare the CLWP2006.

The main objectives identified in the work leading up to the Roadmap on the proposal for a Communication on Alcohol and Health (published at SecGen’s web site) is to reduce alcohol related harm and thereby contribute to higher productivity and a sustainable economic development in EU in line with the objectives set out in the Lisbon Strategy.

The objectives should be directly related to the problem and its root causes. The Steering group should identify the specific objectives in relevant policy areas (additional to public health) that might contribute the main objective for the strategy.

IDENTIFY THE OPTIONS

After the set of objectives the next step of the IA will be to establish which policy options and delivery mechanisms are most likely to achieve those objectives.

The policy options available are:

A. Do nothing/no change at EU level.

B. Co-ordination of activities at EU level

Stakeholders, i.e. self-regulation, common codes, exchange of best practice, MS, i.e. actions based on legal obligations under Article 152

C. A comprehensive strategy to tackle alcohol related harm at Community level.

Strategy to involve relevant policy areas

D. Purely regulatory measures

The foreseen Communication will be on Alcohol and Health. The Steering Group should contribute with their expertise in order to select the most preferable option (to reach the main objective of the EU policy). Moreover the group should also identify tools/measures within their policy areas, besides public health, that could be used in order to reach this target.

ANALYSE THE IMPACT

The analysis of impacts involves trying to predict, across a range of different policy areas, the likely consequences of each option. The Steering Group should contribute with expertise on “who” will be affected by the policy options and over what timescale.

COMPARE THE OPTIONS

The next step in the work on the IA will be to compare the identified options to allow consideration of the strengths and weaknesses of the policy options in relation to the main objective, respecting the principles of proportionality and subsidiarity set out in Article 5 of the Treaty.

EVALUATION

Within the framework of the Impact Assessment analysis, an attempt should be made to define some core indicators for the main policy objectives and to outline the monitoring and evaluation arrangements envisaged.

TIMETABLE

January 2006	Starting point work external contractor on impact on alcohol economy Steering Group IA
February	High-Level meeting between Commissioner and Stakeholders
March	Steering Group IA
April	Publication of Alcohol in Europe tender report together with comments from a peer review panel selected by Stakeholders from alcohol industry, NGOs and Member States. Steering Group IA Subgroup of Inter Service Group on Health
May/June	Draft Communication for Intra-SANCO consultation and completion of IA
June	Foreseen information Council
July	CIS launch
September	Adoption by the College