Alcohol policy in Europe
What can the European Union do?

PETER ALLEBECK •

In February 2001 the Swedish government, which now holds the presidency of the European Union (EU), will host a WHO ministerial conference on youth and alcohol. This is a follow-up to the European Conference on Health, Society and Alcohol, held in Paris 1995, at which the European Charter on Alcohol was adopted. This charter sets out ten strategies that provide the framework for implementing the WHO European Alcohol Action Plan (EAAP), which was adopted by the WHO Regional Committee for Europe in 1992.1 The first phase of the EAAP was evaluated in 1998 and, in 1999, the Regional Committee agreed a second phase to span the period 2000–2005.2 Both the Charter on Alcohol and the EAAP are good examples of how action at a European level can help reduce alcohol related harm in society.

The fact that the conference will bring together both the WHO and the EU is not simply coincidence. In its most recent National Alcohol Action Plan the Swedish government has stressed its willingness to contribute to an inter-sectoral strategy to reduce alcohol related harm within the EU and has emphasised the need to promote an increased exchange of ideas between the WHO and the EU.3 While alcohol has long been an important part of the agenda of WHO Europe, its place in EU health policy has been less clear. Instead, alcohol has generally been left to agricultural or industrial policy. This has been a particular concern for Sweden but also for some other countries that have recently joined the EU. In particular, there is concern about the contradictions that arise when ministers strongly endorse initiatives to reduce availability of alcohol at meetings of the WHO Regional Committee and then support increased imports of alcohol at EU meetings the following month. Thus, any move that improves relations between the WHO and EU in the area of alcohol policy should be strongly supported by the public health community.

Of course, the WHO and EU are different bodies. One is composed of 51 member states, the other of 15, which may become 27 in an uncertain future. One has health as its main objective while the other emphasises free movement of persons, products and capital. However the EU also emphasises its contribution to peace, democracy and social progress and article 152 of the Amsterdam Treaty highlights public health as a goal to be pursued. Thus, it is clear that health policy issues could and should be given a higher priority within the Union than they do at present.

Europe offers many opportunities to observe the effects of differences in drinking culture and alcohol policy. Some would argue that comparisons of alcohol policy over time and between countries or regions are impossible due to confounding by ethnic differences, perhaps even biological differences, cultural traditions, economic development, etc. But there are so many ‘natural experiments’, so many high quality data bases and so much alcohol research capacity in Europe that we now have an overwhelming mass of research – and data still to be analysed – on the relations between drinking cultures, alcohol policy and alcohol related harm across Europe.

Comparative data between west European countries, i.e. the countries that now form the EU, have been available for decades. One general conclusion that can be drawn is that there has been a convergence of both drinking patterns and at least some aspects of alcohol policy. During the period 1970–1990 there has been a remarkable reduction of alcohol consumption in the previously high consuming countries in southern Europe, particularly France and Italy, whereas the consumption in some northern countries, such as Finland and Denmark, has increased.4 There has also been a convergence in the pattern of beverage preferences, in the sense that countries that previously had one dominant beverage type (e.g. wine in Italy, Portugal and France, beer in England, Ireland and Austria, Spirits in Iceland) have converged on a mix of around 50% beer, 35% wine and 15% distilled beverages.4 In the policy arena, although large differences in alcohol policy remain between EU countries, there has also been convergence in some areas, such as drinking and driving regulations, attitudes to alcohol at work and (at least to some extent) restrictions on alcohol advertising.

The situation within the former eastern European countries is far more complex and there are many fewer high quality data. But the recent experiences of these countries offer remarkable opportunities for comparative research on the effects of policy changes on drinking...
patterns and alcohol related harm. While changes in western Europe have resulted in overall beneficial trends in indicators in both consumption and alcohol-related mortality and morbidity, trends in the former communist countries are less encouraging. Although sales data from the Baltic republics suggest low levels of consumption compared to western Europe, alcohol related mortality is almost twice as high and data from surveys have confirmed that consumption is high. Indicators of alcohol related harm in the Baltic countries display a dip around 1985, also seen in other former Soviet republics, generally attributed to the drastic anti-alcohol policy under Gorbachev. Also in Hungary, official consumption levels are not very different from those in southern Europe, but the mortality from liver cirrhosis is around three times higher than in these countries, and has been increasing during the 90s. In a comparison of Hungary and Poland, Varvasovsky et al. pointed out that, in spite of many similarities, alcohol related mortality in Poland has been lower and they have suggested that this can be attributed to differences in national alcohol policies.

In the debate on the enlargement of the EU, the issues that are at the top of the agenda mainly relate to economic development, agricultural policy and the common labour market. The scale of the health divide within the EU (unless something really remarkable happens in the next few years) is hardly ever mentioned. Alcohol related mortality and morbidity is a major contributor to this divide.

The EAAP offers a framework for alcohol policy in Europe that all EU countries, and perhaps even more the candidate countries, would benefit from implementing to a higher degree than is the case at present. The EU offers an institutional and regulatory infrastructure that could do much for implementation of alcohol policy. The example of Bovine Spongiform Encephalitis (BSE) shows that when there is a political pressure and consumer action, the EU can take drastic and very costly measures in the field of public health. It has recently been agreed that all cattle slaughtered at over 30 months will be tested for BSE, a huge undertaking. Without detracting from the seriousness of BSE, at least for cattle, its impact on human population health is still small. This should be contrasted with the hundreds of alcohol-related deaths in Europe on any weekend. Would it not be appropriate to decide on intensified breath testing for drink-driving, particularly on major holidays?

We are faced with a dilemma: Generally, health and social issues fall outside the scope of EU regulation. Any country that would like to strengthen its policies to reduce alcohol-related harm is, in principle, fully entitled to do so. But when Sweden and Finland sought to maintain monopolies on production, import/export and sale of alcohol on grounds of public health this was deemed to be contrary to the gospel of free trade and an open, common market. The accession of Sweden to the EU is a long story of how many elements of alcohol policy, on which there was broad political consensus, had to be abandoned in tedious negotiations about import quotas, production and distribution systems, and sales regulation.

The EU must realise that alcohol policy is a part of social and public health policy, which in some instances must have priority over industrial and trade interests. Many of the actions agreed on in the EAAP aim to reduce the availability of alcohol, which by necessity means restrictions in trade and marketing of alcohol. Examples cited from the EAAP and comments on what they might imply for EU policy are:

- Control the availability of alcohol at major public events where alcohol-related harm occurs.
- Prohibit alcohol at under-age leisure time activities or sporting events and provide a wide range of food and non-alcoholic beverages.
- Many public events are sponsored by the alcohol industry. Is the EU prepared to restrict such sponsoring, particularly at events targeted at youth? Typically, the beer industry offers light beverages, but with poorly hidden advertisements for stronger beer.
- Ensure high levels of enforcement of current drinking-driving legislation.
- Promote high visibility breath testing on a random basis. The need to increase and raise the visibility of breath testing has already been mentioned. Furthermore, in many countries, alcohol is sold in restaurants and shops on the motorways - both for drinking on the premises as well as in bottles to buy. European motorways are major axes for intercontinental transport, a large part of which is commercial traffic. Should we not restrict access to alcohol on European motorways? Those who wish to enjoy a good lunch with a glass of wine would have to go to a nearby town - to the benefit of local economies!
- Develop a taxation policy that ensures a high real price of alcohol.
- Use alcohol taxes to fund alcohol control activities, including health education, research into alcohol policy and support to health services. In the evaluation of the EAAP it was noted that some countries had reduced the alcohol tax, in part as a move towards tax harmonisation within the EU. Governments face huge pressure from industry to reduce taxes further. How can we raise awareness within the EU about the contribution of fiscal policy to alcohol policy and thus to public health?

In summary, there are a number of areas where EU regulations, or at least recommendations, could help member states implement effective alcohol policy. The broad framework, as well as some concrete recommendations, have been outlined in the EAAP and the European Charter on Alcohol, on which all EU members have agreed.

As the BSE case illustrates, the EU is prepared to restrict free trade in the interests of public health. It is time to raise awareness within the policy making bodies of the EU about the role of alcohol as a major public health issue, and show that the EU does have instruments that might reduce alcohol-related harm in society.
Editorial

REFERENCES


EDITORIAL NOTE

MARTIN MCKEE, Editor-in-Chief

The Institute for scientific information has recently begun calculating an impact factor for the journal. When accessed in early February (http://jcr.isihost.com/) the figure was 1.000. This compares relatively favourably with other journals in the field of public health, exceeding the Journal of Public Health Medicine (0.911), Public Health (0.509), and the Scandinavian Journal of Public Health (0.032). We still lag behind the Journal of Epidemiology and Community Health (1.698) and the American Journal of Public Health (3.015) but we hope that our position will improve when we are listed on MEDLINE. We hope that a decision on this will be made shortly after this edition has gone to press.