

THE GLOBE

Alcohol in Europe A Public Health Perspective



Comment

We highlight a report 'Alcohol in Europe: A Public Health Perspective' commissioned by DG SANCO and prepared by the Institute of Alcohol Studies. The report estimates that the tangible cost of alcohol to the EU is 125 billion Euros, that is 1.3% of GDP. More importantly the cost of suffering (intangible) places a further cost of 270 billion Euros. 115,000 Europeans die each year from an alcohol-related cause. Up to 9 million children are living in families adversely affected by alcohol.

Thus alcohol abuse places a heavy burden of economic and social cost on Europe. If it were any substance other than alcohol there would certainly be parliamentary and ministerial demands for action.

It is the children who pay the price of the last round. Much is said about passive smoking, little recognition is given to third party victims of alcohol.

Action needs political courage but we are dealing with not just an irresistible pleasure but with massive vested interest. Whilst price is a major factor in controlling consumption a less contentious and a more politically feasible action would be to control the volume of advertising and ban sports sponsorship which is the most insidious marketing strategy of the alcohol industry.

We also welcome the initiative of the Centre for Science in the Public Interest in launching their campaign to end the promotion of alcohol in world cup events. See page 21.

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Alcohol in Europe A Public Health Perspective

Background to the report

At the time that the European Commission has been preparing its own strategy on alcohol to cover the full range of activity that takes place at a European level, it has called for an analysis of the health, social and economic impact of alcohol in Europe. This is the present report, which is an expert synthesis of published reviews, systematic reviews, meta-analyses and individual papers, as well as an analysis of data made available by the European Commission and the World Health Organization. The report views alcohol policy as "serving the interests of public health and social well-being through its impact on health and social determinants." This is embedded in a public health framework, a process to "mobilize local, state, national and international resources to ensure the conditions in which people can be healthy". A standardized terminology has been proposed throughout the report based on that of the World Health Organization, the specialized United Nations agency on health matters.

Alcohol and Europe

Alcohol has been produced and drunk in Europe for thousands of years, usually made out of whatever materials were locally available. Laws on alcohol did exist, but normally for reasons of public order or to regulate the market rather than for public health. However, this picture changed with a series of developments in medieval and early modern Europe, including industrialization, improved

communication links, and the discovery of stronger, distilled beverages. Large 'temperance' movements spread across much of Europe in the nineteenth and early twentieth centuries, driven by concerns over spirits before often moving on to an opposition to all alcoholic drinks. In most, but not all, countries the temperance movement faded to a position of little significance at the end of the twentieth century. The idea of 'alcoholism' as a disease also grew during the nineteenth century, with

many European countries developing homes or asylums to treat 'alcoholics'. In recent years, the 'new public health movement' has become the dominant paradigm for discussing alcohol-related problems, allowing a broader discussion than a focus on a small subset of 'alcoholics'.

Today's Europe includes a wide range of uses and meanings of alcohol, ranging from an accompaniment to family meals to a major part of rites of passage. Drinking behaviour is often used to communicate the formality of an event or the division between work and leisure. Drunkenness is equally symbolic, with 'drunken comportment' – how people act under the influence of alcohol – varying across Europe.

Alcohol and the economy of Europe

Europe plays a central role in the global alcohol market, acting as the source of a quarter of the world's alcohol and over half of the world's wine production. Trade is even more centred on Europe, with 70% of alcohol exports and just under half of the world's imports involving the European Union (EU). Although the majority of this trade is between EU countries, the trade in alcohol contributes around 9 billion Euros to the goods account balance for the EU as a whole.

It is hard to place a value on the amount of smuggling in the EU, although the European High Level

Group on Fraud estimated that 1.5bn Euros were lost to alcohol fraud in 1996. Price differences play more of a role in the level of legitimate cross-border shopping, where individuals legally bring back alcohol with them from cheaper countries. At least 1 in 6 tourists returns from trips abroad with alcoholic drinks, carrying an average of over 2 litres of pure alcohol per person in several countries.

The economic role of the alcoholic drinks industry is considerable in many European countries. Alcohol excise duties in the EU15 countries amounted to 25 billion Euros in 2001, excluding sales taxes and other taxes paid within the supply chain – although 1.5 billion Euros is given back to the supply chain through the Common Agricultural Policy. Due to the relative inelasticity of the demand for alcohol, the average tax rates are a much better predictor of a government's tax revenue than the level of consumption in a country.

Alcohol is also associated with a number of jobs, including over three-quarters of a million in drinks production (mainly wine). Further jobs are also related to alcohol elsewhere in the supply chain, e.g. in pubs or shops. However, the size of the industry is not necessarily a good guide to the economic impact of alcohol policies – for example, trends in alcohol consumption show no crude correlation with trends in the number of jobs in associated areas such as hotels, restaurants, and bars, suggesting that the effect of changes in consumption may be relatively weak.

Based on a review of existing studies, the total tangible cost of alcohol to EU society in 2003 was estimated to be 125bn Euros (1.3% GDP), which is roughly the same value as that found recently for tobacco. The intangible costs show the value people place on pain,

suffering and lost life that occurs due to the criminal, social and health harms caused by alcohol. In 2003 these were estimated to be 270bn Euros, with other ways of valuing the same harms producing estimates between 150bn Euros and 760bn Euros. Although these estimates are subject to a wide margin of error, they are likely to be an underestimate of the true gross social cost of alcohol (excluding benefits) given the number of areas where it has been impossible to obtain data. Similarly, while the estimates take into account the benefits of alcohol to health systems and loss of life (valued intangibly), there is no research that would enable the other social benefits to be evaluated.

The use of alcohol in Europe

The EU is the heaviest drinking region of the world, although the 11 litres of pure alcohol drunk per adult each year is still a substantial fall from a recent peak of 15 litres in the mid-1970s. The last 40 years has also seen a harmonization in consumption levels in the EU15, with rises in central and northern Europe between 1960 and 1980, met by a consistent fall in southern Europe. Average consumption in the EU102 is also closer to the EU15 than ever before, although substantial variation remains within the EU10. Most Europeans drink alcohol, but 55 million adults (15%) abstain; taking this and unrecorded consumption into account, the consumption per drinker reaches 15 litres per year.

Just under half of this alcohol is consumed in the form of beer, with the rest divided between wine (1/3) and spirits (1/4), with a harmonization visible over the past 40 years in the EU15. Around 40% of drinking occasions in most of the EU15 are consumed with the afternoon/evening meal, although those in southern Europe are much more likely to drink with lunch than

elsewhere. While the level of daily drinking also shows a north—south gradient, non-daily frequent consumption seems to be more common in central Europe, and there is evidence for a recent harmonization within the EU15.

Drinking to drunkenness varies across Europe, with fewer southern Europeans than others reporting getting drunk each month. This pattern is attenuated when 'binge-drinking', a measure of drinking beyond a certain number of drinks in a single occasion, is instead investigated, suggesting that there are systematic differences in either/both people's willingness to report being intoxicated or the length of a 'single occasion'.

The studies of binge-drinking also show occasional exceptions to the north-south pattern, in particular suggesting that Sweden has one of the lowest rates of binge-drinking in the EU15. Summing up across the EU15, adults report getting drunk 5 times per year on average but binge-drink 17 times. This is equivalent to 40m EU15 citizens 'drinking too much' monthly and 100m (1 in 3) binge-drinking at least once per month. Much fewer data are available for the EU10, but that which exists suggests that some of the wine-drinking is replaced by spirits, the frequency of drinking is lower, and the frequency of binge-drinking higher than in the EU15.

The heaviest drinkers account for a substantial amount of the alcohol drunk in a country, with the top 10% of the population consuming one-third to one-half of all the alcohol drunk. While 266 million adults drink alcohol, but up to 20g (women) or 40g (men) per day, over 58 million adults (15%) consume at harmful levels above this, with 20 million of these (6%) drinking at over 40g (women) or 60g per day (men). Unlike abstinence, heavy drinking is linked to collective changes in drinking, so

that changes in consumption tend to be seen across the drinking spectrum. Looking at addiction rather than drinking levels, we can also estimate that 23 million Europeans (5% of men, 1% of women) are dependent on alcohol in any one year.

In every culture ever studied, men are more likely than women to drink at all and to drink more when they do, with the gap greater for riskier behaviour. Although many women give up alcohol when pregnant, a significant number (25%-50%) continue to drink, and some continue to drink to harmful levels. Patterns in drinking behaviour can also be seen for socio-economic status (SES), where those with low SES are less likely to drink alcohol at all. Despite a complex picture for some aspects of drinking (with some measures showing opposite trends for men and women), getting drunk and becoming dependent on alcohol are both more likely among drinkers of lower SES.

Nearly all 15-16 year old students (>90%) have drunk alcohol at some point in their life, on average beginning to drink at 12 years of age, and getting drunk for the first time at 14 years. The average amount drunk on a single occasion by 15-16 year olds is over 60g of alcohol, and reaches nearly 40g even in the lower-consuming (for 15-16 year olds) south of Europe. Over 1 in 8 (13%) of 15-16 year olds have been drunk more than 20 times in their life, and more than 1 in 6 (18%) have 'binged' (5+ drinks on a single occasion) three or more times in the last month.

Although two countries saw more drunkenness on some measures in girls than boys for the first time in 2003, boys continue to drink more and get drunk more often than girls, with little reduction in the absolute gap between them. Most countries show a rise in binge-drinking for

boys from 1995/9 to 2003, and nearly all countries show this for girls (similar results are found for non-ESPAD countries using other data). This is due to a rise in binge-drinking and drunkenness across most of the EU 1995-9, followed by a much more ambivalent trend since (1999-2003).

The impact of alcohol on individuals

Although the use of alcohol brings with it a number of pleasures, alcohol increases the risk of a wide range of social harms, generally in a dose dependent manner - i.e. the higher the alcohol consumption, the greater the risk. Harms done by someone else's drinking range from social nuisances such as being kept awake at night through more serious consequences such as marital harm, child abuse, crime, violence and homicide.

Generally the higher the level of alcohol consumption, the more serious is the crime or injury. The volume of alcohol consumption, the frequency of drinking and the frequency and volume of episodic heavy drinking all independently increase the risk of violence, with often, but not always, episodic heavy drinking mediating the impact of volume of consumption on harm.

Apart from being a drug of dependence, alcohol is a cause of some 60 different types of diseases and conditions, including injuries, 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 prematurity and low birth weight. For most conditions, alcohol increases the risk in a dose dependent manner, with the higher the alcohol consumption, the greater the risk.

The frequency and volume of episodic heavy drinking are of particular importance for increasing the risk of injuries and certain cardiovascular diseases (coronary heart disease and stroke).

A small dose of alcohol consumption reduces the risk of heart disease, although the exact size of the reduction in risk and the level of alcohol consumption at which the greatest reduction occurs are still debated. Better quality studies that account for other influences find less of a risk and find that the reduced risk occurs at a lower level of alcohol consumption. Most of the reduction in risk can be achieved by an average of 10g of alcohol (one drink) every other day.

Beyond 20g of alcohol (two drinks) a day - the level of alcohol consumption with the lowest risk - the risk of coronary heart disease increases. In very old age, the reduction in risk disappears. It is alcohol that mainly reduces the risk of heart disease rather than any specific beverage type. There is evidence that alcohol in low doses might reduce the risk of vascular caused dementia, gall stones and diabetes, although these findings are not consistent across all studies.

The risk of death from alcohol is a balance between the risk of diseases and injuries that alcohol increases and the risk of heart disease (which mostly occurs at older age) that, in small amounts, alcohol decreases. This balance shows that, at least in the United Kingdom, the level of alcohol consumption with the lowest risk of death is zero or near zero for women under the age of 65 years, and less than 5g of alcohol a day for women aged 65 years or older. For men, the level of alcohol consumption with the lowest risk of death is zero under 35 years of age, about 5g a day in middle age, and less than 10g a day when aged

65 years or older, (and probably returning to zero in very old age).

There are health benefits to the heavier drinker from reducing or stopping alcohol consumption. Even for chronic diseases, such as liver cirrhosis and depression, reducing or stopping alcohol consumption are associated with rapid improvements in health.

The impact of alcohol on Europe

Alcohol places a significant burden on several aspects of human life in Europe, which can broadly be described as 'health harms' and 'social harms'. Seven million adults report being in fights when drinking over the past year and (based on a review of a small number of national costing studies) the economic cost of alcohol-attributable crime has been estimated to be 33bn Euros in the EU for 2003. This cost is, split between police, courts and prisons (15bn Euros), crime prevention expenditure and insurance administration (12bn Euros) and property damage (7bn Euros). Property damage due to drink-driving has also been estimated at 10bn Euros, while the intangible cost of the physical and psychological effects of crime has been valued at 9bn-37bn Euros (52bn Euros for the cost of alcohol-related crime).

Alcohol also impacts on the family, with 16% of child abuse and neglect attributed to alcohol use and 4.7m-9.1m children (6%-12%) living in families adversely affected by alcohol. An estimated 23 million Europeans are dependent on alcohol in any one year, with the pain and suffering this causes for family members leading to an estimated intangible impact of 68bn Euros. Estimates of the scale of harm in the workplace are more difficult, although nearly 5% of drinking men and 2% of drinking women in the EU15 report a

negative impact of alcohol on their work or studies. Based on a review of national costing studies, lost productivity due to alcohol-attributable absenteeism and unemployment has been estimated to cost 9bn-19bn Euros and 6bn-23bn Euros respectively.

Looking from a health perspective, alcohol is responsible for about 195,000 deaths each year in the EU, although it is also estimated to delay 160,000 deaths in older people mainly through its cardioprotective effect for women who die after the age of 70 years (although due to methodological problems, this is likely to be a considerable over-estimate of the number of deaths delayed).

These figures are also relative to a situation of no alcohol use, and the net effect would be much greater looking at the lowest-risk level of drinking. Measuring the impact of alcohol through Disability-Adjusted Life Years (DALYs) lessens this problem, and shows that alcohol is responsible for 12% of male and 2% of female premature death and disability, after accounting for health benefits. This makes alcohol the third highest of twenty-six risk factors for ill-health in the EU, ahead of overweight/obesity and behind only tobacco and high blood pressure.

This health impact is seen across a wide range of conditions, including 17,000 deaths per year due to road traffic accidents (1 in 3 of all road traffic fatalities), 27,000 accidental deaths, 2,000 homicides (4 in 10 of all murders) 10,000 suicides (1 in 6 of all suicides), 45,000 deaths from liver cirrhosis, 50,000 cancer deaths, of which 11,000 are female breast cancer deaths, and 17,000 deaths due to neuropsychiatric conditions as well as 200,000 episodes of depression (which also account for 2.5 million DALYs). The cost of treating this ill-health is estimated to be 17bn Euros, together with 5bn

Euros spent on treatment and prevention of harmful alcohol use and alcohol dependence. Lost life can either be valued as lost productive potential (36bn Euros excluding health benefits), or in terms of the intangible value of life itself (150bn-710bn Euros after accounting for health benefits).

Young people shoulder a disproportionate amount of this burden, with over 10% of youth female mortality and around 25% of youth male mortality being due to alcohol. Little information exists on the extent of social harm in young people, although a third of a million (6%) 15-16 year old students in the EU report fights and 200,000 (4%) report unprotected sex due to their own drinking.

Between countries, alcohol plays a considerable role in the lowered life expectancy in the EU10 compared to the EU15, with the alcohol-attributable gap in crude death rates estimated at 100 (men) and 60 (women) per 100,000 population. Within countries, many of the conditions underlying health inequalities are associated with alcohol, although the exact condition may vary (e.g. cirrhosis in France, violent deaths in Finland). Worse health in deprived areas also appears to be linked to alcohol, with research suggesting that directly alcohol-attributable mortality is worse in deprived areas beyond that which can be explained by individual-level inequalities.

Many of the harms caused by alcohol are borne by people other than the drinker responsible. This includes 60,000 underweight births, as well as 16% of child abuse and neglect, and 5-9 million children in families adversely affected by alcohol. Alcohol also affects other adults, including an estimated 10,000 deaths in drink-driving accidents for people other than the drink-driver, with a substantial share of alcohol-attributable crime also

likely to occur to others. Parts of the economic cost are also paid by other people or institutions, including much of the estimated 33bn Euros due to crime, 17bn Euros for healthcare systems, and 9bn-19bn Euros of absenteeism.

Natural experiments and time-series analyses both show that the health burden from alcohol is related to changes in consumption. The impact of a one-litre change in consumption is highest in the low-consuming countries of the EU15 (northern Europe), but still significant for cirrhosis, homicide (men only), accidents, and overall mortality (men only) in southern Europe. While some have argued that the greater change in northern Europe reflects the 'explosive' drinking culture there, this may also reflect the greater proportional size of a one-litre change in the low-consuming northern European countries. Overall, it has been estimated that a one litre decrease in consumption would decrease total mortality in men by 1% in southern and central Europe, and 3% in northern Europe.

Evaluating alcohol policy options

The drinking-driving policies that are highly effective include unrestricted (random) breath testing, lowered blood alcohol concentration (BAC) levels, administrative license suspension, and lower BAC levels for young drivers. The limited evidence does not find an impact from designated driver and safe drive programmes. Alcohol locks can be effective as a preventive measure, but as a measure with drink driving offenders only work as long as they are fitted to a vehicle. 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 Euros each year.

The impact of policies that support education, communication, training and public awareness is low. Although the reach of school-based educational programs can be high because of the availability of captive audiences in schools, the population impact of these programs is small due to their current limited or lack of effectiveness. Recommendations exist as to how the effectiveness of school-based programmes might be improved. On the other hand, mass media programmes have a particular role to play in reinforcing community awareness of the problems created by alcohol use and to prepare the ground for specific interventions.

There is very strong evidence for the effectiveness of policies that regulate the alcohol market in reducing the harm done by alcohol. Alcohol taxes are particularly important in targeting young people and the harms done by alcohol in all countries. If alcohol taxes were used to raise the price of alcohol in the EU15 by 10%, over 9,000 deaths would be prevented during the following year and an estimate suggests that approximately 13bn Euros of additional excise duty revenues would also be gained. The evidence shows that if opening hours for the sale of alcohol are extended more violent harm results. The World Health Organization has modelled the impact of alcohol being less available from retail outlets by a 24 hour period each week; applying this to the Union finds an estimated 123,000 years of disability and premature death avoided at an estimated implementation cost of 98 million Euros each year.

Restricting the volume and content of commercial communications of alcohol products is likely to reduce harm. Advertisements have a

particular impact in promoting a more positive attitude to drinking amongst young people. Self-regulation of commercial communications by the beverage alcohol industry does not have a good track record for being effective. The World Health Organization has modelled the impact of an advertising ban; applying this to the Union, finds an estimated 202,000 years of disability and premature death avoided, at an estimated implementation cost of 95 million Euros each year.

There is growing evidence for the impact of strategies that alter the drinking context in reducing the harm done by alcohol. However, these strategies are primarily applicable to drinking in bars and restaurants, and their effectiveness relies on adequate enforcement. Passing a minimum drinking age law, for instance, will have little effect if it is not backed up with a credible threat to remove the licenses of outlets that repeatedly sell to the under-aged. Such strategies are also more effective when backed up by community-based prevention programmes.

There is extensive evidence for the impact of brief interventions, particularly in primary care settings, in reducing harmful alcohol consumption. The World Health Organization has modelled the impact and cost of providing primary care-based brief interventions to 25% of the at-risk population; applying this to the Union finds an estimated 408,000 years of disability and premature death avoided at an estimated cost of 740 million Euros each year.

Using the World Health Organization's models, and compared to no policies at all, a comprehensive European Union-wide package of effective policies and programmes that included random breath testing, taxation, restricted access, an advertising ban

and brief physician advice, is estimated to cost European governments 1.3 billion Euros to implement (about 1% of the total tangible costs of alcohol to society and only about 10% of the estimated income gained from a 10% rise in the price of alcohol due to taxes in the EU15 countries), and is estimated to avoid 1.4 million years of disability and premature death a year, 2.3% of all disability and premature death facing the European Union.

European and global alcohol policy

The most prominent international legal obligations that affect alcohol policy are the General Agreement on Tariffs and Trade (GATT) dealing with goods, and the General Agreement on Trade in Services (GATS). Past cases on these have shown that the World Trade Organization (WTO) will prioritize health over trade in some circumstances (for example, a ban on asbestos imports), although policies must pass a series of strict tests in order to be maintained.

However, by far the greater effect on alcohol policy in practice has come from the trade law of the European Union (EU). Most of the cases relating to alcohol stem from the 'national treatment' rule on taxation, which means that states are forbidden from discriminating – either directly or indirectly – in favour of domestic goods against those from elsewhere in the EU. No exceptions can be made to this on health grounds, with the result that countries face certain restrictions in the design of their tax policy. In contrast, the increasingly influential European Court of Justice (ECJ) has unambiguously supported advertising bans in Catalonia and France, accepting that "it is in fact undeniable that advertising acts as an encouragement to consumption".

Standardized excise duties are a longstanding goal of the EU in order to reduce market distortions, where large differences in tax rates between nearby countries lead to large amounts of shopping abroad. This leads to lost revenue for the high-tax government, as well as creating pressure to lower taxation rates, as has occurred in some of the Nordic countries.

The production of alcoholic drinks in the form of wine receives 1.5 billion Euros worth of support each year through the Common Agricultural Policy (CAP), including the co-financing of sales promotion campaigns on "the health benefits of moderate wine consumption". The economic and political importance of these subsidies, and in particular the problems of wine producers, makes it hard to progress from a public health perspective.

The international body most active on alcohol has been the World Health Organization (WHO), whose European office has undertaken several initiatives to reduce alcohol-related harm in its 52 Member States. These include the Framework for Alcohol Policy in the European Region, the European Charter on Alcohol and two ministerial conferences, which confirmed the need for alcohol policy (and public health more broadly) to be developed without any interference from commercial or economic interests.

Although the EU itself cannot pass laws simply to protect human health (Member States have not conferred this power on the European institutions), some policies dealing with the internal market can incorporate substantial health concerns, such as the alcohol advertising clause within the Television Without Frontiers Directive. Otherwise, the EU's action on alcohol has come through 'soft law', in the form of non-

binding resolutions and recommendations urging Member States to act in a certain way.

Member State alcohol policy

Every country in the European Union (EU) has a number of laws and other policies that set alcohol apart from other goods traded in its territory, often for reasons of public health. Despite the ubiquity of alcohol policies, just under half the EU countries still do not have an action plan or coordinating body for alcohol. Even so, most countries have programmes for one aspect of alcohol policy, of which school-based education programmes are the most common throughout Europe. All countries also have some form of drink-driving restrictions, with everywhere except the UK, Ireland and Luxembourg having a maximum blood alcohol limit for drivers at the level recommended by the European Commission (0.5g/L).

Sales of alcohol are generally subject to restrictions in most EU countries, in a few cases through retail monopolies but more often through licences, while the places that alcohol can be sold are frequently restricted. Over one-third of countries (and some regions) also limit the hours of sale, while restrictions on the days of sale or the density of off-premise retailers exist in a small number of countries.

All countries prohibit the sale of alcohol to young people beneath a certain age in bars and pubs, although four countries have no policy on the sale of alcohol to children in shops. The cut-off point for allowing sales to young people also varies across Europe, tending to be 18 years in northern Europe and 16 years in southern Europe.

Alcohol marketing is controlled to different degrees depending on the type of marketing activity. Television beer adverts are subject to legal restrictions (beyond content

restrictions) in over half of Europe, including complete bans in five countries; this rises to 14 countries for bans on spirits adverts. Billboards and print media are subject to less regulation though,

with one in three countries (mainly in the EU10) having no controls. Sports sponsorship is subject to the weakest restrictions, with only seven countries having any legal restrictions at all.

The taxation of alcoholic beverages is another consistent feature of European countries, although the rates themselves vary considerably between countries. This can be seen clearly for wine, where nearly half the countries have no tax at all, but one in five countries has a tax rate above PPP1,000. In general, the average effective tax rate is highest in northern Europe, and weakest in southern and parts of central and eastern Europe. Four countries have also introduced a targeted tax on alcopops since 2004, which appears to have reduced alcopops consumption since.

When the different policy areas are combined into a single scale, the overall strictness of alcohol policy ranges from 5.5 (Greece) to 17.7 (Norway) out of a possible maximum of 20, with an average of 10.8. The least strict policies are in southern and parts of central and eastern Europe, and the highest in northern Europe – but the scores

Conclusions

Alcohol and the Economy of Europe

Conclusion 1

The trade in alcohol contributes around 9 billion Euros to the goods account balance for the European Union as a whole, with such trade not necessarily affected by European and domestic policy to reduce the harm done by alcohol.

Conclusion 2

An important source of government revenue, alcohol tax revenues (25bn in 2001 in the older EU15 countries) are more closely related to tax rates than to the overall level of alcohol consumption.

Conclusion 3

Declining consumption will not necessarily lead to job losses in the economy as a whole, and may not even lead to large changes in employment in sectors linked to alcohol such as restaurants and bars.

The social costs of alcohol

Conclusion 4

The tangible costs of alcohol to the European Union were estimated to be 125bn Euros in 2003, including 60bn worth of lost productivity through absenteeism, unemployment and lost working years through premature death.

Conclusion 5

The intangible costs of alcohol (which describe the value people place on suffering and lost life) to the European Union were estimated to be 270bn Euros in 2003.

The use of alcohol in Europe

Conclusion 6

The differences in alcohol consumption are much less evident now than they were 40 years ago, with the occurrence of drinking with meals and binge drinking both much more similar across Europe than commonly believed.

Conclusion 7

Drunkenness is an important cause of violent injuries not only in northern Europe, but also in southern Europe.

Conclusion 8

Where you live in Europe remains a major determinant of the harm done by alcohol.

Alcohol and Health

Conclusion 9

Alcohol is a health determinant, responsible for 7.4% of all disability and premature death in the European Union.

Conclusion 10

Alcohol is a cause of harm to others than the drinker, including some 60,000 underweight births and 10,000 traffic deaths to people other than the driver in the European Union each year.

Conclusion 11

Alcohol is a cause of health inequalities both between and within Member States, causing an estimated 90 extra deaths per 100,000 men and 60 extra deaths per 100,000 women in the newer EU10 countries, compared to the older EU15 countries.

Alcohol and government policy
Conclusion 12
Governments have a responsibility to intervene in the market, and benefit from doing so, with, for example, a 10% increase in the price of alcohol across the older EU15 Member states bringing in approximately 13bn Euros in extra alcohol taxes in the first year.
Conclusion 13
Educational interventions, which are the least effective in reducing the harm done by alcohol are not an alternative to measures that regulate the alcohol market, which have the greatest impact in reducing harm, also amongst heavier and younger drinkers.

Alcohol and European policy
Conclusion 14
Continuing differences in alcohol policy across Europe, such as tax rates, impair the ability of countries to implement effective policies.
Conclusion 15
Different policies between Member States are sometimes ruled as legitimate to protect public health, such as the European Court's 2004 ruling in favour of the French advertising law.

do not all decrease from north to south, as seen in the high score in France. This picture of alcohol policy is very different from the one visible fifty years ago, with the overall levels of policy now much closer together, largely due to the increased level of policy in many countries, particular in the area of drink-driving where all countries have a legal limit. Marketing controls, minimum ages to buy alcohol, and public policy structures to deliver alcohol policy are also much more common in 2005 than in 1950.

I. Defining an alcoholic beverage

Defining an alcoholic beverage	Relevant actor
1. Public policies need to define alcoholic beverages in a uniform way across the European Union. A starting point could be the lowest definition for tax purposes (0.5% alcohol concentration).	(I) European institutions

II. Creating the evidence base

Recommendations for research	Relevant actor
1. European infrastructures should be established and financed to undertake collaborative cross-country alcohol research (see Box 10.1).	(I) European institutions (II) Member States and regions
2. European infrastructures should be created and financed to review and disseminate all major research outcomes in alcohol policy through, for example, registries and databases; the evidence base should be translated into easily understood policies and practices through practical toolkits and guidelines.	(I) European institutions (II) Member States and regions
3. Long-term publicly-funded alcohol research programmes should be established and financed (see Box 10.1).	(I) European institutions (II) Member States and regions
4. Research capacity in alcohol policy should be developed through professional development programmes.	(I) European institutions (II) Member States and regions

II. Creating the evidence base

Recommendations for information	Relevant actor
6. A European Alcohol Monitoring Centre (EAMC), with country-based counterparts, should be established and financed.	(I) European institutions (II) Member States and regions
7. Alcohol-related indicators dealing with consumption, harm and policy and programme responses should be strengthened and refined in the European Community Health Indicators list.	(I) European institutions
8. Alcohol surveillance programmes should be established so that data are comparable and analysable across Europe (see Box 10.1).	(I) European institutions (II) Member States and regions
9. A European database of laws and regulations and of effective policies and programmes at European, Member State and municipal level should be established and maintained.	(I) European institutions (II) Member States and regions (III)Municipal

III. Preparing and implementing resourced strategies and plans

Recommendations for strategies and action plans	Relevant actor
1. A European mechanism and focal point for alcohol policy should be strengthened within the European Commission with adequate staff and financial resources to oversee the development of European alcohol policy and the implementation of the Commission's strategy on alcohol.	(I) European institutions
2. Coordinating mechanisms and focal points for alcohol policy should be established or reinforced and adequately financed.	(I) European institutions (II) Member States and regions
3. Action plans on alcohol with clear objectives, strategies and targets should be formulated and implemented.	(III) Municipal (I) European institutions
4. A predictable funding system should be set in place for organizations, programmes and human resources involved in reducing the harm done by alcohol. Analyses should be undertaken of the practicality and desirability of earmarking a proportion of alcohol taxes (hypothecated tax) to fund these.	(II) Member States and regions (III) Municipal (I) European institutions (II) Member States and regions (III) Municipal
5. Support for alcohol policy measures amongst civil and political society should be promoted through awareness-raising campaigns and initiatives.	(I) European institutions (II) Member States and regions (III) Municipal
6. Regular reports on alcohol should be prepared and made accessible to a wide public audience.	(I) European institutions (II) Member States and regions (III) Municipal

IV. Other policies and actions and cross border support

Recommendations for impact assessment & collective action	Relevant actor
1. Health policy-makers and advisers should monitor the risks inherent in the process of trade liberalization and should ensure that health concerns are accounted for in trade negotiations at both the global and European levels.	(I) European institutions (II) Member States and regions
2. Analytical and feasibility studies should be undertaken to determine when collective action on alcohol policy at both the European and global level is more appropriate and how comity of countries in relation to alcohol policy can be strengthened	(I) European institutions (II) Member States and regions
3. Increased resources should be provided to undertake thorough assessments of the impact of European community policies and activities (including agricultural policy) on the harms and costs associated with alcohol.	(I) European institutions

V. Reducing drinking and driving

Recommendations for drinking and driving	Relevant actor
1. A maximum blood alcohol concentration limit of 0.5 g/L should be introduced throughout Europe; countries with existing lower levels should not increase them.	(I) European institutions (II) Member States and regions
2. A lower limit of 0.2 g/L should be introduced for young drivers and drivers of public service and heavy goods vehicles; countries with existing lower levels should not increase them.	(I) European institutions (II) Member States and regions
3. Unrestricted powers to breath test, using breathalysers of equivalent and agreed standard should be implemented throughout Europe.	(I) European institutions (II) Member States and regions
4. Common penalties with clarity and swiftness of punishment, with penalties graded depending at least on the BAC level should be implemented throughout Europe.	(I) European institutions (II) Member States and regions
5. Driver education, rehabilitation and treatment schemes, linked to penalties, based on agreed evidence-based guidelines and protocols should be implemented throughout Europe.	(I) European institutions (II) Member States and regions
6. Action to reduce drinking and driving should be supported by a Europe wide campaign.	(I) European institutions
7. Existing designated driver campaigns should be evaluated for their impact in reducing drink driving accidents and fatalities before financing and implementing any new campaigns.	(I) European institutions (II) Member States and regions
8. Effective and appropriate training for the hospitality industry and servers of alcohol should be implemented to reduce the risk of drinking and driving.	(III) Municipal
9. Comprehensive community-based educational and mobilization programmes, including urban planning and public transport initiatives should be implemented to reduce drinking and driving.	(III) Municipal

VI. Supporting education, communication, training and public awareness

Recommendations for education and public awareness	Relevant actor
1. Educational programmes should not be implemented in isolation as an alcohol policy measure, or with the sole purpose of reducing the harm done by alcohol, but rather as a measure to reinforce awareness of the problems created by alcohol and to prepare the ground for specific interventions and policy changes.	(II) Member States and regions (III) Municipal
2. Funding should be provided to evaluate the design and impact of individual based programmes that may show some promise.	(II) Member States and regions (III) Municipal
3. Broad educational programmes, beginning in early childhood, should be implemented to inform young people of the consequences of alcohol consumption on health, family and society and of the effective measures that can be taken to prevent or minimize harm.	(II) Member States and regions (III) Municipal
4. Educational type programmes imported from another country or culture should first be evaluated in the new setting before being widely implemented.	(II) Member States and regions (III) Municipal
5. Media campaigns should be used to inform and raise awareness among citizens on implementation of policy initiatives.	(I) European Institutions (II) Member States and regions (III) Municipal

VII. Consumer labelling

Recommendations on labelling	Relevant actor
1. Containers of alcoholic products should carry warnings determined by health bodies, describing the harmful effects of alcohol when driving or operating machinery, and during pregnancy, or other messages as appropriate.	(I) European institutions (II) Member States and regions
2. Alcohol product packaging and labelling should not promote an alcoholic product by any means that are likely to create an erroneous impression about its characteristics or health effects, or that directly or indirectly appeals to minors.	(I) European institutions (II) Member States and regions

VIII. Policies that regulate the alcohol market

Recommendations for tax, cross border purchases and smuggling	Relevant actor
1. Minimum tax rates for all alcoholic beverages should be increased in line with inflation; should be at least proportional to the alcoholic content of all beverages that contain alcohol; and should at least cover the social costs of alcohol as determined by an agreed and standardized methodology.	(I) European institutions (II) Member States and regions
2. Member States should retain the flexibility to use taxes to deal with specific problems that may arise with specific alcoholic beverages, such as those that prove to be appealing to young people.	(II) Member States and regions
3. Alcoholic products should be marked to determine their origin and movement in trade, to enable estimates to be made of the value of the amount of alcohol smuggling in the EU.	(I) European institutions (II) Member States and regions
4. Member States should have the flexibility to limit individual cross-border purchases so as not to diminish the impact of their current tax policies.	(I) European institutions (II) Member States and regions
Recommendations for minimum purchase age and availability	Relevant actor
5. A minimum system of licensing for the sale of alcoholic products should be implemented throughout Europe, respecting existing licensing systems, where these are stronger.	(I) European institutions (II) Member States and regions (III) Municipal
6. The sales of alcoholic products to persons under the age set by domestic law, national law or eighteen years, whichever is the higher, should be prohibited and enforced.	(II) Member States and regions
7. Jurisdictions that manage outlets through number and density, location and hours and days of sale should consider not relaxing their regulations; jurisdictions without such regulations or with very limited regulations should analyze the impact of introducing or strengthening them.	(II) Member States and regions (III) Municipal
8. A range of increasingly severe penalties against sellers and distributors, such as withdrawal of license or temporary and permanent closures, should be implemented in order to ensure compliance with relevant measures.	(III) Municipal
Recommendations for commercial communications	Relevant actor
9. A level playing field for commercial communications should be implemented across Europe, building on existing regulations in Member States, with an incremental long-term development of no advertising on TV and cinema, no sponsorship, and limitation of messages and images only referring to the quality of the product.	(I) European institutions (II) Member States and regions
10. Article 15 of the Television Without Frontiers Directive should be strengthened in terms of both content and volume, and an analysis of its adherence across Member States should be commissioned.	((I) European institutions (II) Member States and regions
11. Where self-regulatory approaches adopted by the beverage alcohol industry or marketing industry are in place, they should be monitored and adjudicated by a body that is independent of the alcohol and marketing industries.	(I) European institutions (II) Member States and regions

IX Reducing harm in drinking and surrounding environments

Recommendations for drinking and surrounding environments	Relevant actor
1. Urban planning, community strategies, licensing regulations and restrictions, transport policies and management of the drinking and surrounding environments should work to minimize the negative effects that result from alcohol intoxication, particularly for local residents.	(III) Municipal
2. Effective and appropriate training should be implemented for the hospitality industry and servers of alcohol to reduce the harmful consequences of intoxication and harmful patterns of drinking.	Alcohol industry
3. Adequate policing and enforcement of alcohol sales and licensing laws should be implemented, targeted at premises associated with a higher level of harm.	(III) Municipal
4. Well-resourced community mobilization and intervention projects, involving different sectors and partners should be implemented to create safer drinking environments and to reduce the harm done by alcohol.	(III) Municipal

X. Interventions for hazardous and harmful alcohol consumption and alcohol dependence

Recommendations for interventions	Relevant actor
1. Integrated evidence-based guidelines for brief interventions for hazardous and harmful alcohol consumption should be developed and implemented in different settings to harmonize upwardly the quality and accessibility of care.	(II) Member States and regions (III) Municipal
2. Training and support programmes to deliver brief interventions for hazardous and harmful alcohol consumption should be developed and implemented in different settings to harmonize upwardly the skills of primary care providers.	(II) Member States and regions (III) Municipal
3. Resources should be made available to ensure the widespread availability and accessibility of identification and intervention programmes for hazardous and harmful alcohol consumption and alcohol dependence.	(II) Member States and regions (III) Municipal

Alcohol intelligence

Linda Hill

No, it's not just a vodka slogan and a contradiction in terms. It's a new policing strategy being implemented in Australia and New Zealand to reduce crime and traffic crashes by reducing drinking to intoxication on licensed premises.

Alcohol is a significant aggravator of disorder, crime, domestic violence, injuries and road fatalities. It is estimated that 50-70 percent of incidents attended by Australian police are alcohol related. Recent New South Wales police data shows that 35 percent of all offenders who had been drinking – and 60 percent in urban areas – had been doing so on licensed premises. Half had been drinking on just 10 percent of the premises. Similarly in Wellington, New Zealand, 38 percent of drinking offenders had their last drink on licensed premises, with half coming from just 12 percent of the premises.ⁱ In Wellington and New South Wales, over three-quarters of the offenders who had been drinking on licensed premises were described by police as moderately or extremely intoxicated.ⁱⁱ

It has long been known that improved enforcement of existing sale of liquor laws and high profile policing on licensed premises can reduce crime and other alcohol related harm.ⁱⁱⁱ Australasian research has linked harm to drinking on certain types of premises, particularly late night pubs with high volume sales.^{iv} It has also been shown that good servicing practices are more likely to be sustained if there is an expectation of enforcement.^v Laws routinely prohibit licensees from serving

intoxicated patrons, but the first court prosecution for this in New Zealand was taken only recently. Frontline police tend to focus on what is happening on the streets rather than what's happening in pubs and clubs where, it is often said, drinking behaviour is 'supervised'. From a police perspective, identified barriers to the enforcement of sale of liquor laws are lack of routine 'intelligence' and cost-effective enforcement strategies, as well as limited resources and a low priority given to alcohol issues.^{vi} However, all that is about to change.

New Zealand's Alcolink

In September 2005, NZ Police's nation-wide Alcolink project became fully operational. Its aim is to help reduce crime and crashes associated with drinking on licensed

premises through enhanced alcohol intelligence. Since 1 March 2005 police officers have recorded on all custody or charge sheets and traffic offence notices whether those involved have been drinking, assessed their level of intoxication on a four point scale and asked them where they had their last drink. If it was on licensed premises, the name and address of the bar or restaurant is recorded (see box). All operational staff have undergone a 30 minute training package on how to identify levels of intoxication for the purposes of the Alcolink questions on charge sheets.

This information collected on charge sheets is then entered into a national computer database for analysis. In September, this new system began feeding back alcohol information to police districts as well as being used to analyse data for local or national patterns and trends. In each police district, the information on individual premises is fed back to licensees and used to inform cost-effective intelligence-based policing – that is, to identify certain premises for closer monitoring, as shown in the following example.

ALCOLINK ALCOHOL QUESTIONS

Did this person consume alcohol prior to the offence? Yes - CONTINUE No Not known

Observed level of intoxication at scene or if not known at scene, then at time of charge, if changed within 12 hrs of offence

Nil Slight Moderate Extreme Not seen within 12 hours of offence

Reported by Licensed Premises Yes No

Time last drink consumed: Date Time OR Not known

Place of last drink: Licensed Premises Home/Private Premises Special Licence Only Venue Public Place

Licensed Premises name:

Licensed Premises address:

Why last drink not known: Question not asked Refused to respond Unable/unfit to respond

Example of offences linked to licensed premises, July-November 2004

Licensed Premises	Station	Total No. of people	Reported by premises	Seriously Affected	Moderately Affected	Slightly Affected	Not Affected	Total No. of Occurrences
Jesters Bar	Wellington	18	2	1	11	6	0	16
The Whistle Inn	Wellington	13	0	4	5	3	1	10
Summerville Sports Bar	Wellington	8	0	0	7	1	0	7
Jim's Sports Cafe	Wellington	2	1	1	0	1	0	2
The Kings Hotel	Wellington	3	3	1	0	2	0	1
Total (All licensed premises)		44	6	7	23	13	1	36

This example comes from related research, undertaken as police geared up for the Alcolink project. This evaluated policing and regulatory responses to problem premises in Wellington city, under the auspices of its 'safer city' policy. The aim was to identify the level of enforcement needed to maintain responsible serving practices and to develop a policing model that can be transferred to other districts following up on local findings from Alcolink. Licensees were informed that there would be increased enforcement of the law against serving intoxicated patrons, through late night visits by the local licensing team of police, licensing inspector and public health officer, and through a high police presence on identified problem premises. The research included factors that may influence effectiveness, such as the nature of police interactions with serving staff and patrons. The research design of two periods of heightened enforcement within a six month period, with limited base

line data for measuring crime and injury outcomes, meant the study suggested effectiveness on some indicators and was inconclusive on others. A further, longer study period is needed. One lesson learned was that monitoring needs to be backed by prosecutions, not used as an alternative. During the period the licensing team set a high threshold of non-compliance before prosecuting or apply for licence cancellation. The licensees of targeted premises felt an on-going high police presence was unfair, and bad for business, if police found insufficient grounds for prosecution. Resentment was thought likely to undermine compliance rather than increase it.^{vii}

A parallel study in the same city evaluated the policing of a ban on alcohol in public spaces. Local government powers were increased in 2000 and Wellington City implemented a liquor control bylaw in November 2003. Contrary to expectations, the ban did not reduce vandalism, public disorder

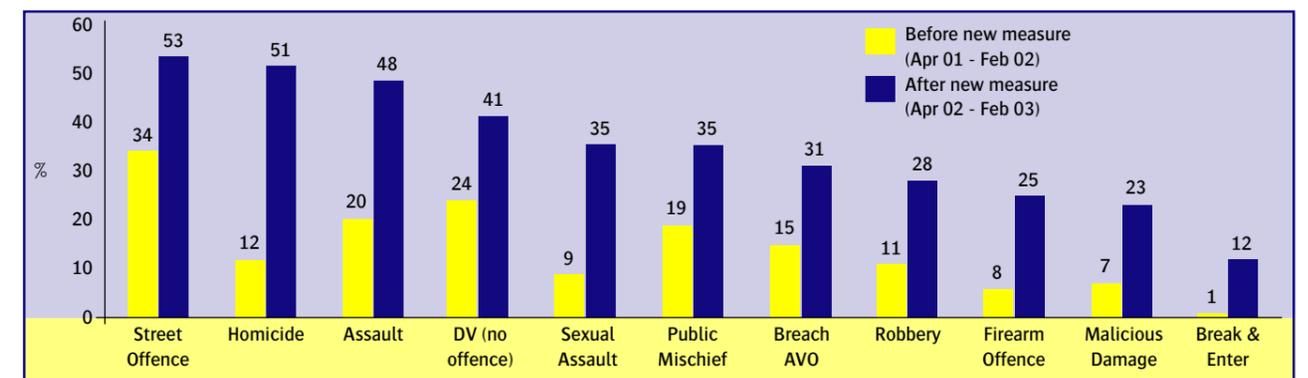
and violence in its first year of operation. This ineffectiveness may relate to relatively light-handed policing, using warnings and infringement notices to minors rather than arrests.^{viii}

Alcohol Linking Project, New South Wales

In New South Wales, an Alcohol Linking Project has been under way since early 2002, and has greatly increased awareness of the role that alcohol plays in crime (see graph). In western New South Wales, 50 incidents a day involve offenders who have been drinking and in 19 of these the victims have also been drinking.

Police feed the information back to licensees and audit the worst 8 percent of premises to ensure they are complying with the Liquor Act. For example, between April 2002 and March 2003 there were 191 incidents linked to one night club. After three feedback letters and two covert audits with feedback, the

NSW Alcohol Linking Programme: Improved identification of the extent of alcohol-related harm.



linking data was used in evidence for a police complaint under S.104 of the Act. Additional conditions were placed on the licence and the licensee changed both servicing practices and the firm providing him with door security. Incidents linked to this night club fell to 81 in the year that followed.

This project was evaluated using a randomised controlled trial. For premises that received intervention of this kind, alcohol-related incidents reported by police dropped 36 percent, compared to a 21 percent drop for premises that received normal policing methods. In a subsequent effectiveness evaluation involving 2500 police implementing the programme as part of routine policing practice, there was a 13 percent drop in incidents linked to premises that received targeting enforcement policing, with a 32 percent drop in major motor vehicle accidents and an 11.7 percent drop in assaults linked to these premises.^{ix}

Last Drink Surveys

Although New South Wales has taken the lead with state-wide implementation of this approach, the concept originated in New Zealand. When the 1989 Sale of Liquor Act liberalised liquor licensing, the number of outlets rapidly doubled and hours of trading increased. The national Liquor Licensing Authority retained most decision-making power but administration and monitoring was devolved to local level. Licensing inspectors are now employed by councils, and district police and the regional Medical Officer of Health have specific reporting and enforcement roles. In the first years under the new Act, a community health action research project was funded to encourage collaboration between these three local agencies.^x One of the project’s initiatives was called the Last Drink Survey. Public health units (or contracted

community health organisations) undertook to process and analyse information on alcohol and intoxication, including the place of last drink, that police recorded in relation to traffic offences. Findings were fed back to the police, the licensing inspector and to local bars and restaurants. Premises that ranked high in the survey were visited by inspectors, offered advice by health promoters and targeted by traffic police.

The validity of findings was initially questioned, as licensees thought patrons might lie rather than jeopardise their favourite watering hole. However, the Liquor Licensing Authority accepted Last Drink Survey findings as part of presented evidence on poor management and lack of suitability to hold a liquor licence.

Over 15 years, most New Zealand police districts have collected and used Last Drink Survey data at least sporadically for traffic offences. Police districts are operationally independent and continuous; consistent data collection has been difficult to achieve. However, by the late 1990s, one public health unit had a regional data series that it analysed to show the effects of a drinking age change on drink-driving.

Alcohol questions were included on a nationally-used charge sheet for domestic violence, but were seldom analysed. Police districts in the Auckland region extended this to charge sheets for all crimes. Alcohol Healthwatch, the alcohol advocacy organisation analysing the Auckland data, developed an improved methodology and began offering training to other areas.

In 2002, it was contracted to undertake a national review of Last Drink Surveys. This led to the current commitment by NZ Police to a nationally consistent operational practice with a fully analysable national database.



Policing bars and public spaces in Wellington (NZ Police)

Partnership between police and health promoters

In both New Zealand and Australia, this approach developed as a successful collaboration between police and health promoters – with assistance at key points from alcohol researchers and health research funding sources. The current police projects are partly funded by the Accident Compensation Corporation, a state agency with a role in accident prevention as well as socialised compulsory injury insurance.

The essence of the strategy is feedback to licensees, with follow-up visits to encourage compliance, as part of targeted and, therefore, cost-effective enforcement practices. Continual feedback is also the key to successful police implementation. Faced with increased form-filling, police must ensure that accurate data collection on alcohol is important for them, that it will be analysed promptly to become a tool they can use in effective enforcement.

Evidence of reduced local harm linked to changed bar practices fed back to front line police can also reinforce commitment.^{xi} Effective implementation of an alcohol intelligence and enforcement strategy rests on front-line officers being confident that this will help them reduce the alcohol-related harm they see in their community every weekend.

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International study questions health benefits of moderate drinking

The majority of studies suggesting that “moderate” drinking helps prevent heart disease may be flawed, according to an international research group.

In a new report, researchers from the U.S., Canada, and Australia analyze 54 studies that linked how much people drink with risk of premature death from all causes, including heart disease. Researchers from the University of Victoria in British Columbia and the University of California, San Francisco led the team.

‘Sick Quitters’

The researchers investigated a suggestion put forth by scientific

skeptics of the ‘alcohol protects against heart attacks’ theory, that many of the studies conducted so

far on drinking and premature death made a consistent and serious error by including as ‘abstainers’ people who had actually cut down or quit drinking due to declining health, frailty, medication use or disability. When such studies show a higher death rate for abstainers than for moderate drinkers, this result may reflect the poor health of some abstainers who recently quit drinking rather than indicating a protective effect for alcohol.

The team found just seven studies that included only long-term non-drinkers in the ‘abstainers’ group. The results of these seven studies showed no reduction in risk of death among the moderate drinkers compared with abstainers. When the researchers combined the data from these studies, they showed that it was possible to perform new analyses that appeared to show a protective effect of moderate drinking – but only when they deliberately included the error of combining long-term abstainers with people who had cut down or quit drinking more recently.

The authors caution that their report has not disproved the notion that light drinking is good for

International study questions health benefits of moderate drinking

health, as too few error-free studies have been performed. They suggest, however, that the extent to which these benefits actually translate into longer life may have been exaggerated.

“The widely held belief that light or moderate drinking protects against coronary heart disease has had great influence on alcohol policy and clinical advice of doctors to their patients throughout the world,” said Tim Stockwell, PhD, of the Centre for Addictions Research at the University of Victoria. *“These findings suggest that caution should be exerted in recommending light drinking to abstainers because of the possibility that this result may be more apparent than real.”*

“We know that older people who are light drinkers are usually healthier than their non-drinking peers,” said Dr Kaye Fillmore of the UCSF School of Nursing. *“Our research suggests light drinking is a sign of good health, not necessarily its cause. Many people reduce their drinking as they get older for a variety of health reasons.”*

The authors emphasize that there is a need for more well-designed research in the future that assesses people’s alcohol intake and abstinence more precisely as their drinking patterns change with age.

Meta-analysis

The research that the team analyzed consisted of prospective studies, including hundreds of thousands of individuals who were followed over a number of years. Most studies were from North America and Europe, some from the Caribbean and Asia. The majority of the results were published in the 1980s and 1990s, with one study published in 1974 and one as recently as 2004.

The team investigated this body of research using meta-analysis – a method that synthesizes the results from many different studies to

determine if their results are in agreement, statistically significant and the degree to which there is variation in the results of the studies.

Light drinking was defined as having two drinks or fewer per day (or about 30mls of pure alcohol per day) and drinking at least once a month. Moderate drinking was 2 to 4 drinks per day. The effects of other factors that influence health and life expectancy were controlled as far as possible in analysis.

Two parallel analyses were carried out: one for 54 studies evaluating death from all causes including heart disease and the other for 35 studies evaluating heart disease deaths specifically. The two analyses showed similar results. Moderate drinking was associated with protection from premature death in the majority of studies – those containing the ‘abstainer error.’ Protection was not found in the few studies without the error, e.g. where moderate drinkers were compared with long-term abstainers.

Previous meta-analyses that combined data from many studies have shown that moderate drinking appeared to have a protective effect against heart disease deaths and against premature death in general. These studies did not address the effect of the ‘abstainer error.’ *“By ignoring this error, these meta-analyses perpetuated it,”* Fillmore said.

“In this analysis, every attempt was made to test the proposition of a health benefit more thoroughly than ever before in the past,” Fillmore said. *“Many other factors may account for the different findings across studies. Fully 57 characteristics of these studies were tested (e.g., smoking, health status, measurement characteristics). None was found to challenge the finding that the ‘abstainer’ error was responsible for alcohol’s apparent protective effect.”*

Stockwell noted that other diseases and conditions have been found to have a protective effect as a result of the use of alcohol (in contrast to abstaining from alcohol). *“It is critical that future research tests whether faulty measurement may have contributed to their findings,”* he said. *“Also, it is well to remember that the types of research usually used to find links between lifestyle factors (e.g. diet, exercise, medication use, in addition to alcohol use) and disease later in life have a high potential for error and on their own cannot prove causation.”*

The authors credit British researcher Professor Gerry Shaper of the Royal Free and University College Medical School in London, England, for first proposing the possibility of an ‘abstainer error’ in the design of prospective studies of the association between alcohol use and heart disease risks. The new study supports Professor Shaper’s conclusion that while the known biological effects of alcohol on risk factors for coronary heart disease are of scientific interest, they have very limited significance for public health.

“This study was performed in the spirit of the tradition that all scientific findings are open to challenge,” Fillmore said. *“Competing hypotheses, even if unpopular, should be encouraged and tested to be sure that accepted beliefs about health are sound.”*

Moderate alcohol use and reduced mortality risk: Systematic error in prospective studies

Kaye Middleton Fillmore, William C. Kerr, Tim Stockwell, Tanya Chikritzhs, and Alan Bostrom

Addiction Research and Theory 2006. Published online.

CSPI launches resolution against alcohol link to the World Cup

The American Center for Science in the Public Interest has launched a global resolution to end the promotion of alcoholic beverages in World Cup events. The resolution focuses on the World Cup but is intended to highlight the inappropriate use of sports in general to market alcoholic beverages, especially to audiences that include millions of impressionable young people.

The resolution calls on FIFA, the World Cup governing body, to examine the role of alcohol in its games and to adopt policies that would minimise and eventually eliminate alcohol promotion and advertising from future World Cup competition.

CSPI is seeking the endorsement of concerned public health and safety activists and encouraging them to send the resolution to relevant organisations and individuals – health, sports, consumer rights, youth and other organisations concerned about alcohol marketing.

Global Resolution to End Alcohol Promotion in World Cup Events

Whereas sports play a central role in the development of health, physical fitness and teamwork; in the values of competition, fair play and cross-cultural exchange for young people worldwide; and millions of youth get socialization cues from sports;

Whereas tens of millions of people worldwide, including millions of young people, have an intense interest in international sports competition, including the World Cup, Olympics, and other events, and follow the games closely in person and on television or radio, identifying with the games’ athletes and teams and idolizing their teams’ heroes;

Whereas millions of fans in stadia view World Cup contests, and, in 2002, a cumulative audience of more than 28 billion people in 213 countries watched more than 41,000 hours of television coverage, including more than 1 billion viewers who watched the final match;

Whereas alcohol marketers have used international athletic competition as a means to cue young people to beer and drinking, and beer sponsorship and television ads distort the positive, youth-development values of sports;

Whereas mounting evidence around the world shows that exposure to television advertising for alcoholic beverages increases the likelihood that children will drink and consume more heavily;

Whereas The World Health Report 2002 determined that 4% of the burden of disease and 3.2% of all deaths globally were attributed to alcohol, and that alcohol was the foremost risk to health in low-mortality developing countries and the third in developed countries;

Whereas the 58th World Health Assembly resolved that harmful drinking is among the foremost underlying causes of disease, injury, domestic violence against women and children, disability, social problems and premature deaths; is associated with mental ill-health; has a serious impact on human welfare affecting individuals, families, communities and society as a whole; and contributes to health inequities;

Whereas FIFA, the organizer of the World Cup, “acknowledges the prominent role of sports, and especially football, as a vehicle for delivering clear and firm messages to eradicate blights undermining society around the world;”

Whereas FIFA “has set up strategic alliances with international organizations that have long-established aims, such as UNICEF, WHO, ILO, UNHCR, SOS Children’s Villages, and others, to link the power of football with the experience and ability of those who ... are striving to make a better world” and states that better health for children is one of its priorities;

Whereas FIFA has “become aware of the wider impact that promoting health issues can have on the everyday lives of people throughout the world” and points to its elimination in 1986 of tobacco advertising in all its tournaments;

CSPI launches resolution against alcohol link to the World Cup

Therefore, the undersigned organizations, representing countries, call on FIFA and future World Cup host countries to:

- Examine the role of alcohol sponsorship, venue signage, and television advertising of alcoholic beverages in the World Cup for consistency with the values of sport, health, and fair play represented by international sports competition; and
- Adopt clear policies about the promotion and advertising of alcohol that are designed to minimize and eventually eliminate their presence from World Cup games.

SIGNED: -----

We invite endorsements of concerned organizations and government officials.

Please return your endorsement with the following information by June 6:

Organization:
Authorized Signer:
Address:
Email:
Phone:
Fax:
Website:

Return by email to:
jhedlund@cspinet.org
Jay Hedlund
Manager,
Campaign for Alcohol - Free Sports TV,
Center for Science in the Public Interest,
1875 Connecticut Avenue NW #300
Washington, DC 20016 USA
Phone: 1-202-777-8322
Fax: 1-202-265-4954

Netdoctor.co.uk 4th April 2006

Alcohol makes cancer tumours 'grow faster'

Having just two alcoholic drinks a day can cause cancer tumours to grow more rapidly and make them bigger, a new US study has claimed.

University of Mississippi research shows that alcohol seems to increase the body's production of vascular endothelial growth factor (VEGF) which can aid the growth of tumours by helping them develop a system of blood vessels without which they would otherwise die.

The researchers, led by the study's author Professor Wei Tan, looked at the effect of alcohol on tumours in mice.

Instead of giving the mice large amounts of alcohol, they gave them only the equivalent of two to four glasses a day.

Six mice were given drinking water with one per cent alcohol for eight hours each night during the month-long experiment. In the second week the mice were injected with mouse melanoma.

Professor Tan found that the mice who had the alcohol, compared to the group who were given plain drinking water were almost twice as heavy, showed a dramatic increase in blood capillaries and had more VEGF in their system.

Co-researcher Professor Jian-Wei Gu said the study showed that people with cancer should not drink at all.

He also said that usually the body's immune system can fight off small tumours, but that alcohol could make them grow so big that the immune system could not cope.

Professor Tan concluded: "It's very important to have a model of how to prevent cancer, and this study provides that model."

"Epidemiologists have recognised alcohol as a risk factor for cancer for 100 years, but this study examines how that happens."

The findings were presented at the Experimental Biology Conference 2006 in San Francisco at the beginning of April.



Further publications available from the Institute of Alcohol Studies

Counterbalancing the Drinks Industry

Counterbalancing the Drinks Industry: A Report to the European Union on Alcohol Policy
A response to a report published by the European drinks industry and a defence of the WHO Alcohol Action Plan for Europe.

Alcohol Policy and The Public Good

Alcohol Policy and the Public Good: A Guide for Action
An easy-to-read summary of the book written by an international team of researchers to present the scientific evidence underpinning the WHO Alcohol Action Plan for Europe.

Medical Education

Medical Education in Alcohol and Alcohol Problems: A European Perspective
A review of educational programmes on alcohol and alcohol problems in European medical schools, identifying gaps in provision and proposing guidelines for a minimal educational level within the normal curriculum of under- and post-graduate medical students.

Alcohol Problems in the Family

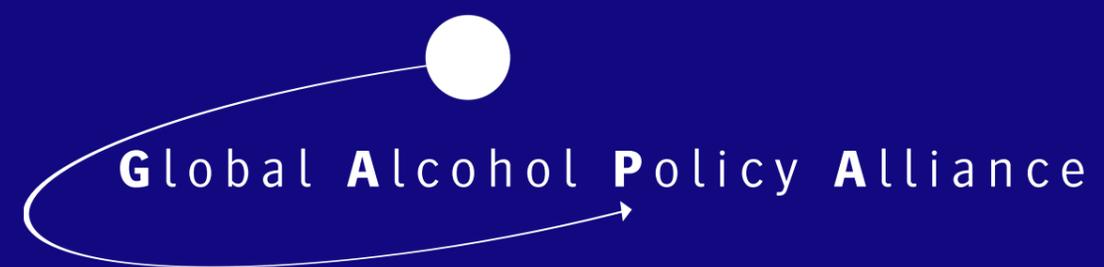
Alcohol Problems in the Family: A Report to the European Union

A report produced with the financial support of the European Commission describing the nature and extent of family alcohol problems in the Member Countries, giving examples of good practice in policy and service provision, and making recommendations to the European Union and Member Governments.



Marketing Alcohol to Young People

Children are growing up in an environment where they are bombarded with positive images of alcohol. The youth sector is a key target of the marketing practices of the alcohol industry. The booklet depicts the marketing strategies of the industry and shows how advertising codes of practice are being breached.



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