

International Policy overview: alcohol

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This overview is based on the EUphact 'alcohol policies', which was published in EUPHIX in November 2007. See: http://www.euphix.org/object_class/euph_alcoholpolicies.html. The EUphact has been updated and restructured.

This overview is linked to the following topic in the National Public Health Compass [in Dutch] (National Kompas Volksgezondheid):

- [Preventie gericht op alcoholgebruik](#) (prevention aimed at alcohol consumption), especially to the sub-topics:
 - [Wat zijn de effecten?](#) (what are the effects of the interventions?), and
 - [Zijn er verschillen tussen Nederland en andere landen?](#) (Are there differences between the Netherlands and other countries?)
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This overview is linked to the following European Community Health Indicators (ECHI):

- 16. Alcohol-attributable deaths (*no documentation available yet*)
- 47. Hazardous alcohol consumption (*no documentation available yet*)
- 87. Policies and practices on healthy lifestyles (*no documentation available yet*)

Currently no data for these indicators are available in the European Health Indicators database/[data presentation tool](#) at the website of the European Commission.

Data for 'pure alcohol consumption' are present in the EC's HEIDI tool.

The European Commission has set up a [Committee on alcohol data collection and indicators](#) and definitions.

1a. Summary

Effective policies restrict supply and availability of alcohol

Proven effective national health policy measures, such as the taxation of alcoholic goods or the establishment of a minimum legal drinking age, restrict the supply and availability of alcohol. An effective policy focuses both on total consumption and on risky drinking patterns. A comprehensive approach, combining a number of policy actions, optimizes effectiveness through mutual reinforcement. Effective alcohol policy measures can have a positive effect on the health of the general population and can also contribute to the reduction of health inequalities.

EU alcohol strategy and priorities

Alcohol consumption has been increasingly recognized as a public health issue for the whole of the European Union (EU). EU reports have mentioned alcohol and related health issues from 1981 onwards. The EU adopted a first Alcohol Strategy in October 2006. Its adoption met with resistance from industry stakeholders, who are generally more opposed to restrictive alcohol policies than others. The main priorities of the EU Alcohol Strategy are:

- protect young people, children and the unborn child;
- reduce injuries and deaths from alcohol-related road accidents;
- prevent alcohol-related harm among adults and reduce the negative impact on the workplace;
- inform, educate and raise awareness on the impact of harmful and hazardous alcohol consumption, and on appropriate consumption patterns, and;
- develop, support and maintain a common evidence base.

Impact of WHO and other international organizations

WHO has shown an interest in alcohol policy since 1979, with its most recent European communication being the Framework on Alcohol Policy in the WHO European Region of 2006. This Framework states that there is a need for concerted action at a supra-national level, especially because national policy initiatives are being increasingly hampered by trade agreements, common markets and increased globalization, despite society's growing recognition of alcohol related problems and the growing awareness of available cost-effective measures.

It should be considered that national health policies can also be influenced by international trade treaties as established by the World Trade Organisation (WTO). Common practice shows that the WTO will prioritize health over trade in some circumstances as proposed health policies must pass a series of strict tests. The impact that WTO treaties will have on health in the long run is unpredictable, however.

European national alcohol policies and strategies show low comprehensiveness and strictness

Compared to some other regions of the world, European national alcohol policies show a low level of comprehensiveness and strictness. Within Europe the different national alcohol policies are starting to show more similarities, however. This is because countries with historically stricter policies have liberalised them, in some cases to comply with EU regulations. Conversely, countries that four decades ago did not have any alcohol policies in place at all have since then put some policies in place. Despite this converging trend, differences remain. The least strict policies can be found in the south of Europe and parts of Central and Eastern Europe, while the strictest policies have been implemented in the north. Although alcohol policies and alcohol consumption influence each other, there are other factors that play a role. Culture, economics and global trends may have an important influence on alcohol consumption, especially on drinking patterns. The Netherlands has implemented a – from a European perspective – average strictness in its alcohol policy.

1b. Samenvatting

Effectief beleid door beperking aanbod en beschikbaarheid van alcohol

Bewezen effectieve nationale beleidsmaatregelen, zoals accijns(verhoging) of alcoholische producten of het vaststellen (en handhaven) van een leeftijdsdrempel voor alcoholgebruik beperken aanbod en beschikbaarheid van alcohol.

Een effectief beleid richt zich zowel op de totale consumptie als op riskante drinkpatronen.

Een brede aanpak, die meerdere beleidsactiviteiten combineert optimaliseert de effectiviteit door wederzijdse versterking. Effectief alcoholbeleid kan een positief effect hebben op de gezondheid van de bevolking en kan bijdragen aan het terugdringen van sociaal –economische gezondheidsverschillen.

De alcohol strategie en prioriteiten van de EU

Alcoholgebruik wordt in toenemende mate herkend als een public health probleem van de hele Europese Unie (EU). EU rapporten hebben alcohol en aan alcohol gerelateerde problemen al vanaf 1981 aangegeven. In oktober 2006 heeft de EU haar eerste Alcohol Strategie aangenomen. Daartegen werd oppositie gevoerd door belanghebbenden uit de alcohol sector, die in het algemeen sterker tegen restrictief beleid gekant zijn dan andere ‘stakeholders’.

De voornaamste prioriteiten in de EU alcohol strategie zijn:

- beschermen van jongeren, kinderen en ongeboren kinderen;
- terugbrengen van ongevallen en sterfte door alcoholgerelateerde verkeersongevallen;
- preventie van aan alcoholgerelateerde gezondheidschade bij volwassenen en reductie van de negatieve gevolgen van alcohol op de werkplek;
- informeren, voorlichten en bewustzijn creëren rond de impact van schadelijk alcoholgebruik en over gepaste drinkpatronen;
- ontwikkelen, ondersteunen en onderhouden van een gezamenlijke ‘evidence base’.

Invloed van de WHO en andere internationale organisaties

De WHO heeft sinds 1979 aantoonbare belangstelling voor alcohol en later (2006) is een Raamwerk Alcoholbeleid in de Europese WHO regio opgesteld. Dit Raamwerk stelt dat gezamenlijke actie op een supranationaal niveau nodig is, vooral omdat nationaal beleid steeds vaker gehinderd wordt door handelsovereenkomsten, open markten en globalisering, ondanks het toegenomen maatschappelijk bewustzijn van alcohol gerelateerde problemen en van het feit dat er kosteneffectieve maatregelen tegen bestaan.

Handelsovereenkomsten, zoals die van de WTO (World Trade Organisation) kunnen nationaal beleid dus beïnvloeden. Gewoonlijk zal de WTO gezondheid boven handelsbelangen laten prevaleren, maar niet altijd en gezondheidsbeleid wordt aan een aantal strikte tests onderworpen. Er is echter onzekerheid over de lange termijn effecten van dergelijke overeenkomsten op de gezondheid.

Nationaal alcoholbeleid in Europese landen is niet erg breed of strikt

Vergeleken met andere regio’s in de wereld vertoont het alcoholbeleid in Europese landen weinig breedte of striktheid. Binnen Europa begint het nationale alcoholbeleid te convergeren en op elkaar te lijken. Dit komt omdat landen met een historisch gezien strenger beleid dit beleid hebben geliberaliseerd, soms om aan Europese regelgeving tegemoet te komen. Anderzijds hebben landen die veertig jaar geleden geen alcoholbeleid hadden nu enig beleid ingesteld. Ondanks de convergerende trend blijven er veel verschillen. Het minst strenge beleid vinden we in Zuid Europese landen en in delen van Centraal en Oost Europa, het strengste beleid in het Noorden. Hoewel alcoholbeleid en alcoholgebruik elkaar beïnvloeden spelen veel andere factoren ook een rol. Culturele, economische en globale ontwikkelingen kunnen een belangrijke invloed hebben op alcoholgebruik en drink patronen. Nederland heeft – Europees gezien - een gemiddeld streng alcoholbeleid.

2. Definition and scope

Problem to be addressed: What policies can reduce the threat of alcohol to public health?

In most western countries Alcohol is a legally accepted product that may have both beneficial and harmful effects. Historically, alcohol is used as socially accepted natural stimulant and it was also used before in medicine for its stimulating and presumed healthful effects. In western countries alcohol has/had a central role in certain rituals (mass wine) and at official gatherings and festivities. The desired effects of alcohol include, besides the socially desirable effects, also positive health effects among which a protective effect of moderate use on the incidence of cardiovascular diseases in certain groups. Still, alcohol is the third leading preventable cause of premature death and loss of quality of life in terms of DALY's (Disability Adjusted Life Years) in Europe.

Alcohol is most often produced from agricultural products (grapes, other fruit, grains, rice) and both its production and dissemination are extensive business activities that provide economic benefits to the many people involved.

Besides social and economic benefits, however, there are many undesirable effects of alcohol (ab)use and alcohol addiction. These effects pertain both to health and to social consequences. We mention a few: increased incidence and prevalence of certain diseases including mortality, increased rates of injuries and accidents and undesirable social and societal consequences such as interpersonal violence, increased sick-leave and working-disability with their associated economic consequences.

What kind of policies is described in this overview?

Alcohol policy is defined as the aggregate of measures designed to control the supply of and/or affect the demand for alcoholic beverages in a population (usually national), including education and treatment programs, alcohol control, harm reduction strategies, etc. (WHO, 2007). This policy overview focuses on policies that aim to prevent the harm caused by alcohol. For the most part, no special distinction is made between alcohol policies that aim to prevent health harm and those that aim to prevent social harm.

The information on alcohol policies in this overview is described at a rather general level, as to provide a quick overview of what is known about effectiveness of different types of strategies and about the international (policy) framework. In addition it provides information on what kind of strategies are being applied in various countries. This means that policies and strategies will not be described in detail at the level of specific settings (e.g. workplace, prison, school). More details can be found in the literature and resources that were used for compiling this policy overview.

Alcohol policies are valued differently by different stakeholders. Representatives of the alcohol industry, compared to representatives of governmental organizations and NGOs, are more in favor of educational measures than of regulatory measures such as tax and price measures. Additionally, while industry stakeholders view their involvement in the policy development process as important, NGOs see industry lobbying as a major barrier to effective policy to reduce alcohol-related harm (Anderson & Baumberg, 2005).

Are there relevant subgroups to address?

Alcohol related harm is currently in Europe particularly pertinent to males as compared to females. Children and elderly people are more susceptible to alcohol-related harm. Protecting young people, children and the unborn child is one of the main priorities of the EU Alcohol Strategy.

However, we will not address policies and strategies specifically aimed at these subgroups, as this would be too detailed for the purpose of this overview. We will occasionally refer to EU projects focusing at subgroups, such as the VINTAGE- project (section 3) focusing on alcohol related harm in the elderly.

Drinking alcohol is more common among people with a low socio-economic background, and consequently the burden of alcohol related harm is higher in this group as well. Therefore in section 3 the potential to reduce socio-economic inequalities in alcohol related harm is briefly addressed.

Limitations related to mapping policies

When describing policies, one mostly is limited to official documents, e.g. laws or national strategy papers. This implies that often it is not clear to what extent rules and regulations are being enforced in practice, or to what extent plans have actually been put into action. This limitation should be taken into account while reading this policy overview. An additional limitation comes from the fact that only information available in English and/or Dutch has been used for compiling this overview.

Geographical scope

The focus in this overview mainly is on Europe. A lot of information has been compiled for the European Union Member States and the broader European region of WHO under the regulatory mental health frameworks provided by the European Union and WHO.

Terminology applied in international context

Some confusion may occasionally arise over the precise definitions of terms like 'heavy drinking', 'binge drinking', 'harmful alcohol use', 'excessive drinking', 'hazardous alcohol consumption', etc. These are for a large part addressed in the *Lexicon of alcohol and drug terms*, published by WHO Geneva:

http://www.who.int/substance_abuse/terminology/who_lexicon/en/

3. Evidence for effective policy measures and interventions

Effective policy focuses both on total consumption and on risky drinking

Alcohol policy measures should combine both policies directed at the whole drinking population and measures directed at more risky drinkers with more detrimental drinking patterns (Babor, 2002; Edwards, 2001; [Allamani et al, 2001](#)). This is because much alcohol-related harms stems mainly from alcohol consumption in the general population, rather than from alcohol consumption by a specific group of risky drinkers. Therefore, reducing the total alcohol consumption will result in a reduction in alcohol-related public health problems, while implementing interventions focused on high-risk drinking, like interventions to reduce drink-driving, will result in a reduction of specific types of harm, such as accidents. Interventions directed at drinkers in general will however also affect heavy and risky drinkers (Edwards, 2001; Babor, 2002; Farrell et al, 2003; Cooke & Moore, 2002).

Policies reducing supply and availability are the most effective

A broad body of evidence shows that policies restricting the supply and availability of alcohol are the most effective in reducing health and social harm caused by alcohol (Babor, 2010). Examples of such policies are those on taxation (alcohol taxes: the part of the total cost of an alcoholic beverage paid by consumers that goes to the government), a minimum legal drinking age, reduced hours of sale, and policies on number, type or location of sales outlets.

Cost-effectiveness studies also show that taxation is a strong policy. In regions with high-risk alcohol use, such as most European countries, taxation has the greatest and most cost-effective impact on reducing the average burden of high-risk alcohol use (Chisholm et al, 2004; Chisholm et al, 2006).

Drink-driving countermeasures are also effective if vigorously enforced. Additionally, drink-driving can be reduced by server training and server liability (the concept of making servers of alcoholic beverages legally liable for resulting harm). Some evidence indicates that restricting advertisements leads to reduced alcohol consumption and alcohol-related harm.

In contrast, programs and policies that are directed at the individual or at groups, such as school-based educational programs have limited effect. There is one exception: brief interventions by primary health care professionals directed at hazardous drinkers are effective in reducing the harm caused by alcohol (Anderson & Baumberg, 2006; Babor et al., 2003; Edwards, 2001; Chisholm et al., 2004; Chisholm et al., 2006; Clossen, 2006).

Population based interventions have a proven impact

Several policy interventions directed at the population as a whole have been proven to be effective in reducing the harm done by alcohol consumption in a population. In contrast: most interventions directed at individuals do not impact public health. However these intervention-approaches can be effective in reducing harmful drinking in individuals. The following categories can be distinguished from the broad range of available interventions to reduce the harm done by alcohol (Babor et al, 2003; [Anderson & Baumberg, 2006](#)):

- Policies that reduce drinking and driving;
- Policies that regulate the alcohol market (regulating physical availability; taxation and pricing; regulating alcohol promotion);
- Policies that support the reduction of harm in drinking and surrounding environments;
- Policies that support interventions for individuals (treatment and early intervention);
- Policies that support education, communication, training and public awareness.

The latter policies are currently under scientific scrutiny for their impact;

More detailed information about the effectiveness of the various possible strategies and interventions is given in Table 1 and 2 below.

Table 1. Alcohol policy areas, strategies and interventions with their measures of effectiveness.

Policy area	Strategy / intervention	Effectiveness *	Breadth of research support *	Cross-national testing *	Cost Efficiency **
Pricing and taxation	Alcohol taxes	+++	+++	+++	+++
	Differential price by beverage	+	+	+	
	Special or additional taxation on alcopops and youth-oriented beverages	+	+	+	
Regulating physical availability	Minimum legal purchase age	+++	+++	++	++
	Rationing	++	++	++	+++
	Government monopoly of retail sales	++	+++	++	+++
	Hours and days of sale restrictions	++	++	+++	+++
	Restrictions on density of outlets	++	+++	++	+++
Modifying the drinking environment	Staff and management training to better manage aggression	++	+	++	+
	Enhanced enforcement of on-premises laws and legal requirements	++	++	++	+
	Server liability	++	++	+	+++
Drink-driving countermeasures	Random breath testing	+++	++	++	+
	Lowered BAC limits	+++	+++	+++	+++
	Administrative licence suspension	++	++	++	++
	Low BAC for young drivers ('zero tolerance')	+++	++	++	+++
	Graduated licensing for novice drivers	++	++	++	+++
Restrictions on marketing	Legal restrictions on exposure	+ / ++	+++	++	+++
Education and persuasion	College student normative education and multicomponent programmes	+	+	0	+
	Brief interventions with high risk students	+	+	0	
Treatment and early intervention	Brief intervention with at-risk drinkers	+++	+++	+++	++
	Mutual help/self-help attendance	++	++	++	
	Mandatory treatment of drink-driving repeat offenders	+	++	0	
	Medical and social detoxification	+++	++	++	++
	Pharmaceutical therapies	+	++	++	

Sources: * Babor et al, 2010; ** Babor et al, 2003. Adapted table kindly provided by James Higgerson (University of Manchester).

Table 1 does not represent an exhaustive list of policy options. Alcohol consumption is associated not just with the health, but the domains of agriculture, criminal justice, employment, social care and many others. This means that many policies in these areas can also have an impact on alcohol consumption, albeit indirectly. These policies have not been included as they are not 'directly alcohol focused'.

Policies were also excluded from the table if they were not practiced anywhere in Europe. For example, the total ban of sales is known to be a highly effective measure of alcohol control, but is unlikely to be implemented anywhere in the region.

Interventions with limited evidence of effectiveness are not included in Table 1, even though they might be in widespread use across Europe. These are given in Table 2. An example of this would be mass media education campaigns, which most countries in Europe implement to some extent, despite the lack of evidence of long-term benefits to the amount of alcohol consumed and the patterns in which this consumption takes place.

Additionally, policies that are receiving more attention in recent years, but still lack evidence of effectiveness have been removed from the table. Minimum pricing of alcohol has a lot of support and is being debated in many European nations at present, but there is no breadth of research support at present. Similar conclusions can be made for bans on discounts and promotions, and the banning of drinking in public places.

Table 2. Alcohol intervention strategies lacking evidence of effectiveness

Policy area	Strategies with no evidence of effectiveness
Pricing and taxation	Minimum price
	Bans on price discounts and promotions
Regulating physical availability	Bans on drinking in public places
Modifying the drinking environment	Late-night lockouts of licensed premises
	Staff training and house policies relating to responsible beverage service (RBS)
	Voluntary codes of bar practice
Drink-driving countermeasures	Designated driver and ride services
	Severity of punishment
Restrictions on marketing	Legal restrictions on content
	Alcohol industry's self-regulation codes
Education and persuasion	Mass media campaigns, including drink-driving campaigns
	Warning labels and signs
	Social marketing
	Classroom education

Source: Babor et al, 2010. Adapted table kindly provided by James Higgerson (Univ. Manchester).

Brief interventions directed at individuals can have public health effects

The full group of currently existing brief interventions that are directed at individuals with hazardous alcohol consumption or dependence can have an overall effect on public health. Effects of these treatments are, however, primarily restricted to the individual. Effective early interventions can prevent future healthcare costs, a wider benefit to society.

There exists a wide range of individual therapies and interventions. Research has shown that many of these treatments are effective and that there is little difference in their effectiveness. For individuals there is not a 'best option' for the treatment of alcohol problems. Some examples of effective treatments ([Raistrick et al, 2006](#)):

- Motivational enhancement therapy;
- Cognitive behavioural therapy;
- 12-step facilitation;
- Marital and family therapies;
- Coping and social skills training;
- Benzodiazepines (medication for alcohol withdrawal);
- Acamprosate and naltrexone (medication for long-term treatment of alcohol addiction).

Community programmes have preventive potential

Community prevention programmes have the potential to effectively reduce alcohol-related harm. In community prevention programmes several partners and agencies work together, and different types of prevention measures are combined in one programme within a community (e.g. a city). Results of experiments vary. Some show substantial reductions in high-risk drinking and related harm, while others show minimal results in the long term (Holder, 1998; Holder et al, 2000; NIAAA, 2006; Stafström et al, 2006; Stafström, 2007; Sweet & Moynihan, 2007).

European projects and organisations like [‘Building Capacity’](#), [AMPHORA](#) and [EUROCARE](#) had among their goals to develop knowledge on community alcohol action. The fact that community prevention can have big effects, confirms that a comprehensive approach is best for alcohol prevention policies. Experts have concluded this for local as well as regional and international levels (Edwards, 2001; [Horlings & Scoggins, 2006](#)).

Alcohol policies are important in preventing socio-economic health differences

Alcohol consumption is an important entry point for policies and interventions to reduce socio-economic inequalities in health. This is because the level of alcohol consumption varies between different socio-economic groups. In some European countries, socio-economic differences in alcohol-related mortality have a great contribution to socio-economic differences in total mortality, while in other European countries the impact is less pronounced. Possibly drinking pattern differences within populations are partly responsible for these socio-economic differences ([Eurothine, 2007](#)). Regarding specific alcohol policies: price policies seem to have a greater impact on the lower socio-economic classes than on other classes. Negative economic changes, such as the recent ‘economic crises’ may lead to increased hazardous consumption in lower socio-economic classes.

Little knowledge about alcohol related harm among elderly and how to tackle it

In its 2009 opinion on [‘How to make the EU strategy on alcohol related harm sustainable, long-term and multisectoral’](#), the European Economic and Social Committee stated that it ‘believes that more needs to be done to address the wellbeing of the ageing population in the EU, including information about the effects of harmful alcohol consumption on healthy and dignified ageing at an EU level.’ The European Commission funded the [VINTAGE project](#) (good health into older age), which ran in the period 2009-2010, to provide a contribution to the requested evidence base. In their first summary report [‘Alcohol and older people: a public health perspective’](#), the authors conclude: ‘Although there is a very strong evidence base for the impact of a range of alcohol policies, none of these have been specially evaluated with respect to their differential impact on older people. The VINTAGE report concluded that of the known effective alcohol policies summarized, the policy option that is likely to have the biggest impact on older people is price, but availability may be important as well.’

Increasing the price of alcohol relative to other goods and disposable income reduces alcohol consumption, heavy drinking, alcohol dependence and the chronic conditions related to the use of alcohol, such as liver cirrhosis. Education programmes have not been specifically evaluated amongst older people. But in general they show no impact on alcohol-related behaviour. Comprehensive community based programmes can reduce harmful patterns of drinking, but have not been evaluated for their specific impact on older people. Work place based programmes have some limited impact in reducing alcohol-related harm and could be implemented as ‘pre-retirement measures’. The [VINTAGE](#) project has published a report (Segura et al, 2010) on “Best practices on preventing the harmful use of alcohol amongst older people, including transition from work to retirement”.

Evidence-base for effective alcohol policy is geographically limited

The evidence base for effective alcohol policy is still largely dominated by studies from North America, Northern Europe, Australia and New Zealand. However, this evidence is also of significance for Europe as a whole ([Anderson & Baumberg, 2006](#)).

New WHO Report on effectiveness of alcohol interventions

In 2009 WHO Euro has issued a summary report that addressed '[Evidence for the effectiveness and cost-effectiveness of interventions to reduce alcohol related harm](#)' (WHO, 2009).

4. Alcohol policies in an international perspective

European countries work on their alcohol policies within different supra- and international settings. They are Member States of the supranational European Union (EU) and have to work under EU rules, regulations and agreements. Next, they collaborate under the umbrella of intergovernmental organizations such as the World Health Organisation (WHO), the Organisation for Economic Cooperation and Development (OECD), and the Council of Europe. Both perspectives will be addressed here. In the paragraph on intergovernmental organizations of this policy overview the impact of WHO will be described, well as the potential impact on alcohol policy of international trade agreements negotiated by the World Trade Organization (WTO).

4.1 EU policies and strategies

Alcohol consumption has become a public health issue in the EU

Over the years the European Union has shown an increasing interest in alcohol as a public health matter; originally alcoholic beverages were primarily treated as economic commodities in EU policies. Alcohol was mentioned by the EU as a public health issue from 1981 onwards in publications on issues such as consumer safety, traffic safety and TV advertising ([Anderson & Baumberg, 2006](#)).

Public concern about the popularity of alcopops (see textbox) and growing alcohol consumption by young people led to a [European Council resolution \(2001/458/EC\) on drinking by young people](#), in 2001. As a consequence the Council invited the European Commission to produce a strategy on alcohol-related harm in Europe.

Alcohol Strategy adopted by European Commission in 2006

The [EU Alcohol Strategy](#) faced a lot of resistance as it was being prepared. Especially alcohol industry organizations were opposed to it and argued that EU Member States should only have national policies (Kubosova, 2005; <http://euobserver.com/9/20264>).

Textbox: Alcopop definition

Alcopop: A form of alcoholic beverage characterized by carbonation, artificial colouring, sweeteners and sale by the 300 ml bottle. More formal names are 'pre-mixed spirits', 'flavoured alcoholic beverages' and 'designer drinks' (Babor et al, 2003).

The Brewers of Europe sponsored a report on alcohol consumption in Europe, and used it to support this claim ([Weinberg Group, 2006](#)). This report was published almost at the same time as the EU funded Alcohol in Europe report ([Anderson & Baumberg, 2006](#)) on which the EU Strategy is partly based. In October 2006, the European Commission adopted the first [Alcohol Strategy](#) for the EU. The European Parliament adopted a

resolution in which it welcomes the strategy, but calls upon the Commission to formulate 'ambitious general objectives for the Member States with a view to curbing hazardous and harmful alcohol consumption'.

Five priorities in the EU Strategy on alcohol

The first [EU Alcohol Strategy](#) identifies five priorities:

- protect young people, children and the unborn child;
- reduce injuries and deaths from alcohol-related road accidents;
- prevent alcohol-related harm among adults and reduce the negative impact on the workplace;
- inform, educate and raise awareness on the impact of harmful and hazardous alcohol consumption, and on appropriate consumption patterns, and;
- develop, support and maintain a common evidence base.

Several structures established to further the implementation of the EU Alcohol Strategy

Since the adoption of the Strategy, work has been carried out by the Commission, the Member States and the wider stakeholders to set up the infrastructure for its implementation. New implementing structures include the Committee on National Alcohol Policy and Action, the European Alcohol and Health Forum and the Committee on Data Collection, Indicators and Definitions. More information on these implementing structures is provided in the textbox. In 2009 the European Commission published the [first progress report on the implementation of the EU Alcohol Strategy](#) (see paragraph 5. National alcohol policies and strategies). The next progress report is expected in 2012.

EU Committee on National Alcohol Policy and Action

The [Committee on National Alcohol Policy and Action](#) consists of representatives from national governments of the EU Member States who share information, knowledge and good practice on reducing harmful alcohol consumption. The first meeting of the Committee was in November 2007, and since then the Committee came together twice a year.

EU Alcohol and Health Forum

The [Charter](#) establishing the [EU Alcohol and Health Forum](#) (EAHF) was signed in a launch meeting in June 2007 by 40 founding members. To become a member of the Forum organizations must meet certain requirements and make one or more specific commitments for action. Under the Forum three task forces have been established:

- [Task force on marketing communication](#) – examining initiatives relating to the regulation and practice of marketing for alcoholic beverages.
- [Science Group](#) – providing scientific guidance to the work of the Forum.
- [Task force on youth-related aspects of alcohol](#) – developing good practice approaches to addressing under-age drinking, drink driving, educating and empowering young people, promoting responsible selling and serving, and protecting young people from the consequences of alcohol abuse by others.

One of the spin-offs of the task force on youth-related aspects of alcohol is [RAYPRO](#), an on-line database, which enables users to share information on projects and activities to reduce alcohol-related harm among children and young people, and promotes good practice based on evaluation of effectiveness. Following an outline created by the task force, DG SANCO, assisted by an advisory board, has set up RAYPRO for a pilot phase through to 2011.

Committee on Data Collection, Indicators and Definitions

The task of the [Committee on Data Collection, Indicators and Definitions](#) is to develop key indicators for monitoring overall performance of the strategy. The results of their work are described in a [report](#), which was published in February 2010.

EU Council has called upon Member States: take further action to reduce alcohol related harm

The Council, in their [Council Conclusions of 1 December 2009 on alcohol and health](#), recognizes that despite results achieved so far the burden of alcohol related harm remains high in the European Union. They therefore invite the Member States to:

- implement the good practices presented in the EU's Alcohol Strategy, and make use of existing evidence on effective measures to reduce alcohol-related harm, taking into account the five priority themes identified (see above),
- foster a multi-sectoral approach and, in coordination with work at the EU level, strengthen or develop, as appropriate, comprehensive national strategies or action plans tailored to national needs and report on developments and results to the Commission by 2011,
- make use of the most effective measures to provide regulation and enforcement in the area of alcohol policy at national level,
- consider the role of pricing policy such as regulations on happy hours, special taxes on mixed drinks and 'drinks for free' offers, as an effective tool, particularly when associated with other prevention measures, in the toolbox to reduce alcohol-related harm and evaluate its impact,
- address the well-being of the ageing population in the EU, including the effects of harmful alcohol consumption on healthy and dignified ageing at an EU level, and contribute to raising awareness among care professionals, informal carers, and older citizens of potential interactions between medication and alcohol.

European Commission has funded a broad range of alcohol projects

A range of alcohol-focused projects have been carried out under Community Public Health Programme 2003-2008, focusing on monitoring, capacity building, piloting interventions, and gathering information and tools, and addressing the entire population or specific subgroups such as youngsters or elderly people. A [graphic representation](#) of the specific areas of interest of the alcohol projects funded under the Programme 2003-2008 is available at the website of DG SANCO, as is an [overview](#) of these projects and the alcohol projects funded under the current Health Programme 2008-2013.

European Union Information System on Alcohol and Health jointly developed by EC and WHO

The European Commission cooperates with the WHO Regional Office for Europe to carry out joint surveys of trends and developments in alcohol consumption, alcohol-related harm and alcohol-related policies across the EU. The data gathering builds on the survey instrument developed for the WHO Global Information System on Alcohol and Health ([GISAH](#)) and includes additional components to respond to information needs pertinent to the situation in the EU.

The European Union Information System on Alcohol and Health ([EUSAH](#)) enables queries focused specifically on EU Member States and candidate countries. Besides information gathered in joint European Commission/WHO surveys, the database contains information made available in GISAH which enables to examine long-term trends, on some indicators since the 1961.

4.2. Impact of WHO and other international organizations

WHO is the most active international body on alcohol issues

The World Health Organization (WHO) has been the most active international body on alcohol. In 1975 WHO sponsored a monograph (Bruun et al, 1975) entitled 'Alcohol Control Policies in Public Health Perspective'. Next in 1979 the WHO World Assembly discussed the problems related to alcohol ([Anderson & Baumberg, 2006](#)). From 1992 to 2005 the [European Alcohol Action Plan](#) provided a basis for the development and implementation of alcohol policies and programmes in Member States. It was complemented in 2001 by the [Stockholm Declaration on Young People and Alcohol](#), which included specific targets, policy measures and support activities to protect children and young people from the pressures to drink and reduce the harm done to them directly or indirectly by alcohol. The Declaration continues to be the leading policy statement of the WHO European Region on the topic. The WHO [framework for alcohol policy in the European Region](#) replaced the European Alcohol Action Plan in 2006.

WHO's 1995 [European Charter on Alcohol](#) was based on the five principles (see: Textbox 1) that still form the basis of the WHO alcohol policy (WHO, 1995). The [Framework for Alcohol Policy in the WHO European Region](#), of 2006, the most recent WHO-Europe communication on alcohol policy (see above), states that there is a need for concerted action at a supra-national level, especially because national policy initiatives are being increasingly hampered by trade agreements, common markets and increased globalization, despite society's growing recognition of alcohol related problems and the growing awareness of available cost-effective measures. The framework also identifies the need for coordinated and strategic national efforts.

Textbox: WHO's five ethical principles and goals for alcohol policy

The WHO adopted the [European Charter on Alcohol](#) on the 1995 European Conference on Health, Society and Alcohol in Paris, France. Next to ten strategies for action, it has stated 5 five ethical principles and goals for alcohol policies:

1. All people have the right to a family, community and working life protected from accidents, violence and other negative consequences of alcohol consumption.
2. All people have the right to valid impartial information and education, starting early in life, on the consequences of alcohol consumption on health, the family and society.
3. All children and adolescents have the right to grow up in an environment protected from the negative consequences of alcohol consumption and, to the extent possible, from the promotion of alcoholic beverages.
4. All people with hazardous or harmful alcohol consumption and members of their families have the right to accessible treatment and care.
5. All people who do not wish to consume alcohol, or who cannot do so for health or other reasons, have the right to be safeguarded from pressures to drink and be supported in their non-drinking behaviour.

Core areas and instruments for national action in WHO Framework for alcohol policy

The [Framework for alcohol policy in the WHO European Region](#) identifies the need for regional level action. But additionally it describes a need for coordinated and strategic national efforts. In relation to national alcohol action plans it states that:

- there is a need for supporting local communities in the development and implementation of effective measures in order to effectively prevent or reduce alcohol-related harm;
- a strong case can be made for restricting availability;
- availability plays a particularly important role in youth drinking, with social availability of alcohol, through parents and friends, calling for wider action;
- education and information should be combined with other measures in a comprehensive strategy;
- local regulation and enforcement can effectively reduce rates of alcohol-related problems like drink-driving accidents, violence and public disturbance;
- the efficacy of screening and brief intervention for hazardous drinking in primary health care is supported by a large body of international research literature; and that
- alcohol policies in the workplace need to be adopted to reach hazardous drinkers through workplace interventions.

Recent activities of WHO in field of prevention of alcohol related harm

In 2010 the general assembly of WHO adopted a new [Global Strategy](#) to reduce the harmful use of alcohol (WHO, 2010).

WHO Euro has published a series of documents related to the prevention of alcohol related harm:

- [Handbook for action to reduce alcohol-related harm](#) (WHO, 2009)
- [Best practice in estimating the costs of alcohol – Recommendations for future studies](#) (WHO, 2010)

In 2009 WHO Euro has issued a summary report that addressed '[Evidence for the effectiveness and cost-effectiveness of interventions to reduce alcohol related harm](#)' (WHO, 2009).

Furthermore WHO Euro has recently published (2010) a comprehensive overview of alcohol use and alcohol policies in the countries that belong to the WHO European Region ([European Status Report on Alcohol and Health](#)).

Even more recently, WHO (Geneva) has published the [Global status report on alcohol and Health](#) (WHO, 2011)

International trade treaties may influence national alcohol policies

National health policies are influenced by international trade treaties, established by the World Trade Organisation ([WTO](#)). Common practice shows that the WTO will prioritise health over trade in some circumstances, but for this to be the case the health policies concerned must pass a series of strict tests. For example there needs to be proof that they serve a legitimate purpose and that no alternative measure is available that is less commercially restrictive (Anderson & Baumberg, 2006; Grieshaber-Otto, 2008). The impact that WTO treaties will have on health in the long run is unpredictable, however. Negotiations are ongoing and the economic and political values in relation to free trade do not always prove to be compatible with public health values (Anderson & Baumberg, 2006; Babor, 2002).

5. National alcohol policies and strategies in Europe

Cultures, economics and global trends affect alcohol consumption

Besides alcohol policies, factors such as culture, economics and global trends also contribute to alcohol consumption and changes in alcohol use within countries (Leifman, 2002). Especially qualitative features of drinking patterns, like binge drinking and beverage preferences are subject to cultural influences: they change slowly and are difficult to alter by policy measures ([Simpura et al, 2002](#)). Thus policy action is not the only factor responsible for changes in national alcohol consumption patterns. Over the last few decades alcohol consumption has, however, risen in European countries that have weakened their alcohol policies, such as Sweden and Finland, and declined in countries that are showing an increasing interest in alcohol policy (Leifman, 2002).

Growing similarity between national alcohol policies within Europe

Over the last five decades the alcohol policies of the different European countries have become increasingly similar. About 50 years ago, crudely speaking, low-consumption (Nordic) countries had a high level of alcohol control; the medium-drinking (Central European) countries had a medium level of alcohol control; and high-consumption (Southern European) countries had a low level of alcohol control (Leifman, 2002). Since 50 years ago things have changed: in 2000, national alcohol policies showed more similarities. The comprehensiveness and strictness of national alcohol policies had converged, although differences remained ([Österberg & Karlsson, 2002](#)). The converging trend is the result of two developments:

- Policies affecting availability were used to a lesser extent. For example, Swedish policies were weakened because of EU regulations (Crombie et al, 2007). Countries that have become increasingly interested in alcohol policy have not focused on controlling the availability of alcohol, but on education instead.
- Alcohol control measures that were in place have become increasingly similar: such as the BAC-levels (BAC = the concentration of alcohol present in the blood; also called BAL: blood alcohol level) for drink-driving and the legal age-limits for selling alcohol (Anderson & Baumberg, 2006).

National alcohol policies: low comprehensiveness and strictness

On average, European countries have fewer alcohol policy measures in place than the rest of the world ([Anderson & Baumberg, 2006](#)). The policies in European countries are also generally less strict. For example, in a number of EU countries the minimum age for buying alcohol is 16 (though age limits may be

graduated in relation to the type of beverage), while outside Europe a higher age limit of 18 is more popular. In general the least strict policies are in Southern Europe and parts of Central and Eastern Europe. Most of the strict policies can be found in Northern European countries. Countries that have stricter policies also tend to have high taxation levels. Exceptions to this rule are France (strict policy, low tax), Ireland and the UK (both low policy, high tax) ([Anderson & Baumberg, 2006](#)).

Rough comparison of alcohol policies in European countries based on a 2006 overview report

The way in which alcohol policies have been implemented in the different European countries varies. A selection of policy actions is summarized and similarities and differences between countries are mentioned below ([Anderson & Baumberg, 2006](#)):

- Education and public awareness: Most countries have a minimum of school-based education programmes.
- Drink-driving countermeasures: All countries have some form of drink-driving restrictions. The Maximum blood alcohol level (BAL), i.e. the concentration of alcohol (ethanol) in the blood is 0,5 g/L in most EU25 countries, except in the UK, Ireland and Luxembourg. However, these restrictions are not optimally enforced in all countries.
- Restrictions on the availability of alcohol: Most EU countries have restrictions on the sale of alcohol: in a few cases (Nordic countries) through retail monopolies, more often though through licenses, i.e. the licensing of outlets. This authorizes outlets to sell alcoholic beverages and includes rules to control the hours when sale is permitted. All European countries have legal age limits for the sale of alcohol in bars and pubs, but not all have such age limits for shops. The actual age limit also varies, with it being 18 years in most northern European countries and 16 in most southern countries.
- Advertising controls: Alcohol marketing is controlled in different ways across Europe. The control measures employed varies for different types of marketing. For example: TV marketing restrictions are more common than billboard marketing restrictions. The EU-10 countries (new EU members in 2004) mostly have uncontrolled advertising environments. The EU-15 countries mostly have voluntary agreements in place. In France and Sweden, as well as in the non-EU country Norway, a total legal ban on TV advertising for alcohol has been implemented.
- Pricing and taxation: Taxation is a commonly employed policy that has been implemented in a wide range of different ways across Europe. The highest average effective tax rate on alcohol has largely been implemented in northern Europe, and the lowest in southern and parts of central and eastern Europe. Five countries, namely Denmark, France, Germany, Ireland and Luxembourg, started introducing a tax on alcopops from 2004 onwards ([EU Alcohol Strategy, 2006](#)).

Comparing national alcohol policies to advise on a new national strategy

In 2008 the Dutch National Institute for Public Health and the Environment (RIVM) published the report '[Learning from our Neighbours. Cross-national inspiration for Dutch public health policies: smoking, alcohol, overweight, depression, health inequalities, youth, screening](#)' (Van der Wilk et al, 2007). It made the following observations: *'Policies to discourage alcohol use differ greatly among European Countries. Germany, Switzerland, France and Denmark impose an additional tax on premixed drinks (breezers). France has a special law ('Loi Evin') that heavily restricts the advertising of alcohol targeted at, for example, youths and children. Half of the EU countries ('wine countries') did not have a tax on wine, but in some of these countries a tax is sometimes imposed on beer or liquor. The alcohol sector recently tried to stop an authoritative book on effective alcohol policy (T. Babor et al. Alcohol: No Ordinary Commodity, 2003) being used as a reference for Dutch policy makers. The report also mentioned that the then former alcohol policies for youths in Finland, the United Kingdom and Quebec have not been effective'*.

Overall the '*Learning from our Neighbours*' report, which aimed to support policy making by the ministry of Health concluded for the Netherlands:

1] The Netherlands has a moderately strict alcohol policy that could be refined and provided with a more integrated approach

There are still effective policies possible that have already been implemented in other countries which reduce the harm caused by alcohol consumption; we mention: increasing excise tax, advertisement restrictions and more strictly enforcing existing regulations. An integrated and intersectoral approach with more attention for research, policy evaluation and monitoring seems to be advised.

2] Dutch alcohol policy is ‘moderately’ strict and somewhat irregularly organized

Dutch alcohol policy receives an average score on the international ECAS scale for strictness of alcohol policies. Also according to the alcohol field’s own assessment, the Netherlands has a somewhat moderate alcohol prevention policy.

Although national alcohol policies keep changing over time and comparing policies is therefore like shooting at a moving target, these kinds of international policy comparisons provide options for adding new elements or alter existing ones in national alcohol strategies.

New European alcohol report by WHO provides more information on national alcohol policies

Alcohol policies keep changing and occasional renewal and expansion of information in that area is relevant. Very recently (2010) WHO Europe has published a new comprehensive survey-based overview of many aspects of alcohol use and of national alcohol policies in WHO’s European Region ([European Status Report on Alcohol and Health](#)). This may used, together with the EU reports on implementation of the EU Alcohol Strategy (next paragraph) to collect recent information on national alcohol policies in EU countries.

First report on implementation of the EU Alcohol Strategy: convergence towards good practices

In 2009 the first [progress report on the implementation of the EU Alcohol Strategy](#) was published by the European Commission. Its main conclusion was that across the EU Member States there has been a steady convergence of actions towards those identified as good practice. Most Member States now have a written alcohol policy in place (see table 3). There is a continuous trend towards an age limit of 18 years for selling and serving alcohol, and towards lowered Blood Alcohol Concentration limits for drivers of motorized vehicles. In the report a more detailed overview is given of the progress achieved by the Member States related to the priorities of the EU Alcohol Strategy. Detailed information per country is also available in the [country profiles](#) on the DG SANCO website, which were produced by WHO at the request of the European Commission. The next progress report on the implementation of the strategy is expected in 2012.

Table 3: Status of national strategies on alcohol in EU Member States (source: first [progress report on the implementation of the EU Alcohol Strategy](#), European Commission, 2009)

National strategy adopted or revised 2006 or later	8	Cyprus, Finland, Italy, Latvia, Netherlands, Poland, Slovak Republic, UK
National strategy revised before 2006	8	Czech Republic, Germany, Ireland, Lithuania, Portugal, Romania, Spain, Sweden
No national strategy on alcohol or strategy at sub-national level only	11	Austria, Belgium, Bulgaria, Denmark, Estonia, France, Greece, Hungary, Luxembourg, Malta, Slovenia

6. Resources and references

Organizations

- European Union
 - European Commission, alcohol policy: http://ec.europa.eu/health/alcohol/policy/index_en.htm
 - EU Alcohol and Health Forum: http://ec.europa.eu/health/alcohol/forum/index_en.htm
- WHO, regional office for Europe, policy on alcohol use: <http://www.euro.who.int/en/what-we-do/health-topics/disease-prevention/alcohol-use/policy>
- World Trade Organization (WTO): <http://www.wto.org/index.htm>

Projects

- Projects on alcohol funded under EU Public Health Programme 2003-2008 and Health Programme 2008-2013: http://ec.europa.eu/health/alcohol/projects/index_en.htm
- VINTAGE project (good health into older age): <http://www.epicentro.iss.it/vintage/default.asp>

Databases

- RAYPRO, on-line database on projects and activities to reduce alcohol-related harm among children and young people, including information on effectiveness: https://webgate.ec.europa.eu/sanco_eahf/raypro/public/introductionForm.html
- The Global Information System on Alcohol and Health (GISAH): <http://apps.who.int/globalatlas/default.asp>
- The European Information System on Alcohol and Health (EISAH): <http://www.euro.who.int/en/what-we-do/health-topics/disease-prevention/alcohol-use/facts-and-figures/the-european-information-system-on-alcohol-and-health>

Policy Documents

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Council

- Council Recommendation of 5 June 2001 on the drinking of alcohol by young people, in particular children and adolescents: <http://eur-lex.europa.eu/LexUriServ/LexUriServ.do?uri=OJ:L:2001:161:0038:0041:EN:PDF>
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European Parliament

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- European Economic and Social Committee
- Opinion of the European Economic and Social Committee on 'How to make the EU strategy on alcohol related harm sustainable, long-term and multisectoral' (Exploratory opinion) (2009/C 318/03): <http://eur-lex.europa.eu/LexUriServ/LexUriServ.do?uri=OJ:C:2009:318:0010:0014:EN:PDF>

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<http://www.euro.who.int/en/what-we-do/health-topics/disease-prevention/alcohol-use/publications/pre-2009/framework-for-alcohol-policy-in-the-who-european-region>
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http://www.euro.who.int/_data/assets/pdf_file/0008/79406/EUR_ICP_ALDT_94_03_CN01.pdf
- Handbook for action to reduce alcohol-related harm. WHO, 2009:
<http://www.euro.who.int/en/what-we-do/health-topics/disease-prevention/alcohol-use/publications/2009/handbook-for-action-to-reduce-alcohol-related-harm>
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