# PREVENTION OF CHRONIC DISEASES

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# Executive summary

*Alcohol is a major contributor to loss of life and to the burden of chronic disease in Europe. The harmful use of alcohol is associated with a wide range of physical, psychological and social harms, and the costs to individuals, communities and society are widely recognised.*

*While a single uniform alcohol policy relevant to all member states is close to impossible, there is a necessity to complement national actions, create synergy between individual national policies and share best practice.*

*This report suggests that progress has been made at both strategic EU and Member State levels, with a decline in consumption and changes in drinking patterns in some countries over the past thirty years. However, Europe's per capita alcohol consumption still remains the highest in the world and a coordinated and collaborative EU response is therefore imperative.*

*There is currently a unique window of opportunity in Europe for a significant expansion of activity in the prevention of alcohol-related harm. This committee proposes strong recommendations supported by sound evidence aimed at changing the way in which alcohol-related harm is prevented at a European level.*

# I. INTRODUCTION

Alcohol is a major contributor to loss of life and to the burden of chronic disease in Europe. The harmful use of alcohol is associated with a wide range of physical, psychological and social harms and the costs to individuals, communities and society are widely recognised.

While a single uniform alcohol policy relevant to all Member States is close to impossible, there is a necessity to complement national actions, create synergy between individual national policies and share best practice.

This report suggests that progress has been made at both strategic EU and Member State levels, with a decline in consumption and changes in drinking patterns in some countries over the past thirty years. However, Europe's per capita alcohol consumption still remains as the highest in the world and therefore, a coordinated and collaborative EU response is still imperative.

An emerging theme from the paper is that there is currently a unique window of opportunity in Europe for a significant expansion of activity in the prevention of alcohol-related harm. This committee proposes strong recommendations supported by sound evidence aimed at changing the way in which alcohol-related harm should be prevented at a European level.

# II. ALCOHOL CONSUMPTION & HEALTH HARM

Alcohol is a psychoactive substance with dependency-producing properties. It is a causal factor in more than 200 disease and injury conditions (World Health Organisation, 2014). High alcohol consumption is associated with an increased risk of developing chronic diseases, specifically mental and behavioural disorders, alcohol dependence, liver cirrhosis, some cancers and cardiovascular diseases.

The WHO *Global Status Report on Alcohol* (2014) estimates that worldwide 3.3 million lives are lost annually as a result of the harmful use of alcohol, which represents 5.9% of all deaths worldwide. In the EU, alcohol abuse is the leading risk factor for ill-health and premature deaths for the working age population (25-59 years) (Scientific Opinion of the Science Group of the European Alcohol and Health Forum, 2011).

Although many of the problems outlined are associated with high levels of alcohol consumption, long term moderate alcohol consumption is also known to increase the risk of developing NCDs (OECD, 2014). Likewise, both heavy and long term moderate drinking can have devastating effects for women during pregnancy often leading to miscarriages and a range of birth defects, known as foetal alcohol spectrum disorders (FASD) (Mullally, et al., 2011).

While average alcohol consumption has been decreasing in the EU, the proportion of young people displaying harmful and hazardous consumption patterns has increased in many member states. Europe is home to 7.3% of the world's population yet accounts for roughly a quarter of total alcohol consumption worldwide, making it the highest consumer of alcohol in the world (World Health Organisation, 2014). This ratio has obvious negative consequences, the most worrying being the high number of alcohol-related fatalities. Alcohol-related harm is responsible for 1 in 7 male deaths and 1 in 13 female deaths in the group aged 15–64 years in the EU, resulting in approximately 120,000 premature deaths each year (World Health Organisation, 2012a).

The EU region records the highest percentage of heavy episodic drinkers; 22.9% of European drinkers "binge drink" according to the WHO (World Health Organisation, 2014). As studies have shown, the consumption of large quantities of alcohol in short periods greatly increases the risk of alcohol-related diseases, such as liver cirrhosis (McCambridge, 2006). In addition, the type and strength of the alcohol consumed are significant factors for a person's risk of disease.

Many member states have displayed a strong convergence of drinking habits, especially among younger demographics. For example, within 12 member states, among the 15-19 year old age group, more than 30% participate in "binge drinking" (World Health Organisation, 2014). Although the reasons for such convergence are multifactorial, there is no doubt that the availability and low cost of alcohol has supported this type of binge drinking culture. As a general rule, high-income countries have the highest per capita alcohol consumption and the highest prevalence of heavy episodic drinking (Ibid.).

To address these problems, it is helpful to describe the current policy context to see where improvements might be made.

# III. CURRENT HEALTH SPENDING AND RESOURCES DISTRIBUTION

Health expenditure in the EU accounts for around 10% of GDP and almost 15% of public spending (European Commission, 2013). There is a strong relationship between the overall income level of a country and how much the country spends on health. It is therefore not surprising that in 2012 the Netherlands (EUR 3,829), Austria (EUR 3,676) and Germany (EUR 3,613) were the highest per-capita spenders on health, (adjusted for countries' different purchasing powers), well above the EU average (EUR 2,193). Romania (EUR 753) and Bulgaria (EUR 900) were the lowest-spending countries among EU members in the same year (OECD, 2014).

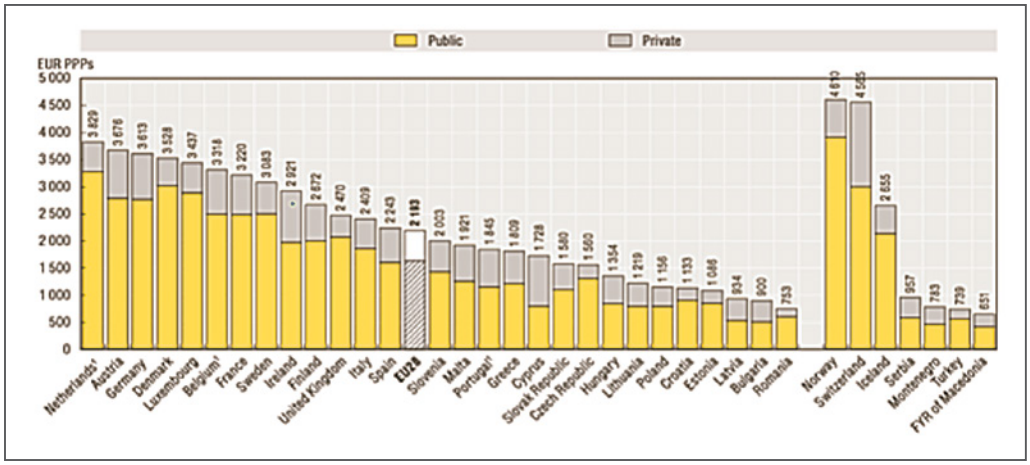


*Figure 1: Health expenditure per capita, 2012.*

*Source: OECD Health Statistics 2014, http://dx.dol.org/10.1787/health-data-en, Eurostat Statistics Database, WHO Global Health Expenditure Database, retrieved the 13.05.2015.*

On average, around three-quarters of health spending comes from public sources and the ranking by public share of spending is similar to overall health spending. Of the EU member states, only Cyprus sees private spending on health outweighing public financing, though Latvia and Bulgaria also have high levels of private spending. By contrast, the Netherlands, the United Kingdom and most of the Nordic countries have levels of public financing exceeding 80% (Ibid.).

The breakdown of health spending across the EU reveals that most spending is accounted for by inpatient and outpatient care – almost two-thirds of current health expenditure on average in 2012. A further quarter of overall health spending is typically allocated to medical goods (mainly pharmaceuticals), while 10% goes towards long-term care, and the remaining 6% to collective services, including public health and prevention services and administration. At present, 97% of health budgets are spent on treatment, whereas only 3% are invested in prevention (European Commission, 2007).

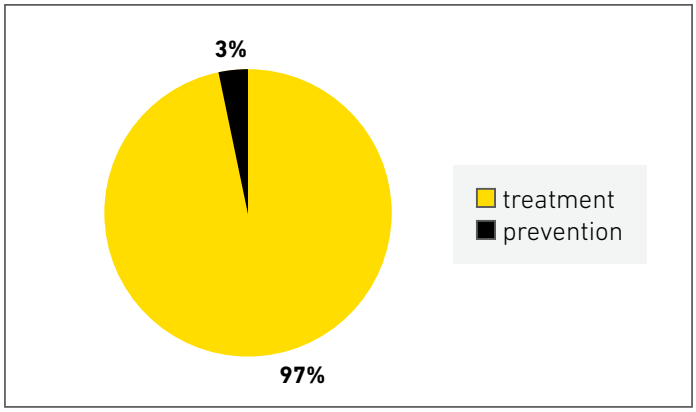


*Figure 2: Budgetary expenditure on treatment and prevention in the EU*

As the economic crisis emerged in 2008, health budgets were initially maintained, but began to fall in 2009 in some of the countries hardest hit by the economic crisis (e.g. Estonia). More widespread reductions were observed in 2010 and 2011 in response to fiscal pressures and the need to reduce large deficits and debts (Morgan and Astolfi, 2014). By 2012, some countries experienced renewed growth in health spending, albeit at much lower rates compared to the pre-crisis period. But health spending continued to fall in 2012 in Greece, Italy, Portugal and Spain, as well as in the Czech Republic and Hungary. Greece has seen per capita health spending fall by 9% each year since 2009, in contrast to yearly growth of more than 5% between 2000 and 2009. This has left the per capita level 25% lower in 2012 than in 2009. Ireland and the Slovak Republic also suffered significant reversals in per capita health spending after previously strong growth (OECD, 2014). Health spending in EU countries generally comes from national governments' budgets. However, the European Commission supports some investments in health across the EU, through Horizon 2020 – health research (EUR 6bn), European Structural and investment funds for health (EUR 5.3 bn), and the EU Health programme 2014-2020 (EUR 321 mn).

# IV. STATE OF PLAY: EU AND NATIONAL HEALTH POLICY

Prior to his appointment as President of the European Commission, Jean-Claude Juncker accepted that there had been a "lack of social fairness" in the European economy since the crisis of 2008 (Juncker, 2014). In his *political guidelines for the next Commission*, he clearly outlined that he wanted to see the renewal of Europe's social economy (Ibid.). It is hard to judge if this recalibration towards the social market economy has occurred, but it is conspicuous within Juncker's "10 point plan" that health is absent from that agenda (Juncker and Timmermans, 2014). Likewise, in Juncker's mission letter to Commissioner for Health and Food Safety Vytenis Andriukaitis, there is no reference to prevention of NCDs. It is also difficult to know whether Commissioner Andriukaitis will focus on prevention of alcohol-related harm as he has yet to release a work programme. However, DG SANTE has listed the prevention of NCDs and specifically alcohol-related harm as a priority in the *Third Health Programme 2014 – 2020* (European Commission, 2014), while prevention of disease is addressed in the recent Commission staff working document, *Investing in Health* (European Commission, 2013). The lack of priority given to health in the high level objectives of the European Commission is of concern.

Alcohol-related harm is one of the priorities for WHO at the global level, since alcohol not only causes NCDs but also increases the risk of acute health conditions (e.g. accidents). For that reason, and with the objective of reducing the worldwide burden caused by alcohol abuse, WHO launched in 2010 the *Global Strategy to Reduce the Harmful Use of Alcohol*, which focuses on ten areas for national action, including health services' response, alcohol availability, marketing, pricing and drink-driving policies.

In previous work on reducing the harmful use of alcohol, the Commission adopted an EU alcohol strategy in 2006 (European Commission, 2006), and progress has been made in some areas - most notably, establishing the Committee for National Alcohol Policy and Action (CNAPA), the European Alcohol and Health Forum (EAHF) and the Committee on Alcohol Data, Indicators and Definitions[1]. These EU coordinated initiatives have assisted in the development of alcohol policies in many member states. They have led to improvements in the collection of quality data, the sharing of information and best practice between member states, the implementation/review of national alcohol strategies, the convergence of member states' alcohol policies, and a framework for common indicators on alcohol-related harm. The EU alcohol strategy has also mobilised the industry, the NGO sector and member states - which, in 2014, called for a new and ambitious strategy to tackle harmful use of alcohol (Committee on National Alcohol Policy and Action, 2014ab.

1 The CNAPA consisted of a forum whereby member states could coordinate health policies and share evidence of best practice, the EAHF was comprised of stakeholders such as industry and NGOs, where it was hoped that constructive dialogue would eventually lead to progressive and innovative commitments aimed at reducing alcohol related harm and finally the Committee on Alcohol Data, Indicators and Definitions has been set up to develop key indicators for alcohol consumption and alcohol related harm.

Last year, through CNAPA, member states produced the *Action Plan on Youth Drinking and on Heavy Episodic Drinking* (Binge Drinking), which focuses on prevention of alcohol related harm in the fields of youth drinking and heavy episodic drinking (Committee on National Alcohol Policy and Action, 2014b). Meanwhile on the International stage, the WHO has been active in promoting global strategies to reduce alcohol-related harm. In 2010, the WHO reached consensus, for the first time, among all its 193 members on a global strategy to reduce harmful use of alcohol (World Health Organisation, 2010). And in 2012, the WHO European region's 53 member states endorsed an action plan to reduce harmful use of alcohol by 2020 (World Health Organisation, 2012b). Nonetheless, there is more work that can be done at EU and international level to assist member states in reducing alcohol related harm. In this paper we call for a number of new measures at EU level.

At present, member states have the main responsibility for alcohol policy in the EU. As a result, there are 28 member states implementing and focussing on different alcohol policies. Such policy dispersion, together with diverse levels of prosperity, has weakened effective implementation of an EU-wide policy. For example, many member states have not adopted a written national policy on alcohol (World Health Organisation, 2014). Six member states have no national legislation to prevent illegal alcohol either in the production or sale. There is still no EU-wide age limit on purchasing alcohol. Taxation measures and rates of tax on alcohol products vary greatly across the EU; some member states do not imposes any tax on wine. The availability of alcohol is also not uniform across the Union; some countries have little regulation, and any amount of alcohol can be sold to consumers at any time of day. Two member states have still not established maximum blood alcohol content for driving (BAC) of 0.5 mg/ml or less (Zamparutti, et al., 2012). Only France has legislated for health warnings to be placed on alcoholic beverages, while no country has made it mandatory for alcohol producers to provide ingredient/nutrition information on their products - although .In recent weeks, some alcohol producers have committed to voluntarily provide nutritional information. Members of the European Parliament have voted in favour of a Resolution calling on the European Commission to create a new EU Alcohol Strategy that would include mandatory nutritional labelling (Cirio et al., 2015).

The EU's problem with alcohol-related harm has no easy 'quick fix', since is no clear EU health policy on alcohol. Likewise, because of the disparate nature of health policy in the EU, which is formulated by 28 member states of different levels of wealth, alcohol consumption and alcohol-induced NCD burdens, addressing one of the EU's main problems remains difficult. All alcohol related deaths are, nevertheless, avoidable, and could be prevented through adequate policy measures.

Although public health is a direct competence of the member states, only supported by the EU, the EU should take a more proactive role in supporting member states in regulation. It should support member states legislation on public health issues such as alcohol, and clearly define the terms and conditions so as to deflect accusations of distorting the internal market and enforcing uncompetitive trade restrictions.

# V. A NEW AND STRENGTHENED EU ALCOHOL STRATEGY

The most recent EU Alcohol Strategy was developed a decade ago (2006). Since then, many advances have been made in data collection, including on the burden of alcohol, consumption patterns and the effectiveness of health policies. But alcohol-related harm continues to need priority attention, through the EU Alcohol Strategy 2006-2012, and other actions.

On 29 April 2015, the European Parliament adopted a Resolution calling on the European Commission to present a new EU Alcohol Strategy to tackle health harm for 2016-2020. This resolution is in line with the call from EU Health Ministers for the Commission to take action on the health impacts of alcohol (Sneiders, 2015). The members of the EHP consider this a turning point that opens possibilities for stronger and more targeted actions in preventing alcohol-related harm. A new and strengthened EU Alcohol Strategy could become a coordinated action of different policies and recommendations to minimise one of the key health determinants of NCDs.

Recalling the EP Resolution of April 2015, the members of the EHP have outlined below key areas where the new EU Alcohol Strategy should be developed and enhanced:

# Governance

The Committee on National Alcohol Policy Action (CNAPA) has proven to be a valuable mechanism for the dissemination of evidence-based knowledge and support to member states to reduce alcohol related harm. However, since it was established the committee has only met five times, consequently hindering real advances in the sharing of information and best practice. We therefore recommend:

- The CNAPA meet on a quarterly basis to review trends in alcohol consumption and harm across member states.
- A report on the development and implementation of policy, along with the publication of annual reports and recommendations to the EC and member states.

We also believe that the European Alcohol Health Forum needs a similar review:

- The EAHF needs clear goals aligned with the priorities of the Alcohol Strategy;
- It should develop goals aimed at reducing alcohol consumption in young people
- It should monitor and analyse commitments made, for benefit and for correct implementation. Monitoring is essential to ensure commitments are effective.

**EU targets:** At present, there are wide disparities between individual member states alcohol policies, implementation and sharing best practice. Therefore, we recommend:

- The EU, in agreement with member states, set clear annual targets for the implementation of alcohol policies such as national alcohol strategies;
- The EC set targets for the reduction of NCDs over a clear timetable;
- The EC produce annual Country Specific Recommendations to member states outlining their progress in implementation of health policies and;
- All targets and policies agreed upon at EU level should have a horizontal approach towards other health policies of the EU and member states.

# Labelling

Labelling provides a unique opportunity for governments to disseminate health messages and allow consumers to make informed choices. However, despite being classified by WHO as a group 1 carcinogen (International Agency for Research on Cancer, WHO, 1988), alcohol is exempt from current EU regulations on labelling of food products and soft drinks.

The food label 'is one of the most highly valued and sought after communication channels in the marketplace' (Blewett et al., 2011). Despite small improvements taking place thanks to CNAPA efforts, the assessment of the EU Alcohol Strategy showed that only 'limited' progress had been achieved in labelling (Zamparutti et al., 2012). The EHP believes that the EU is missing an opportunity to reduce alcohol-related harm by failing to include clear information and health warnings on the labels of alcoholic consumables.

## INCLUSION OF HEALTH WARNINGS

The most frequent criticism of alcohol labelling in the EU is that there is no requirement to feature warnings about the possible consequences of alcohol consumption. Labels are not required to carry advice for pregnant women (currently any print information on certain brands of wine is a voluntary measure), warnings about drinking and driving, or information about the health outcomes of excessive alcohol consumption (such as liver cirrhosis and/or cancer). According to a Eurobarometer (2010) study, 79% of European citizens questioned are in favour of alcoholic drinks labels including health warnings on drinking during pregnancy and driving with alcohol.

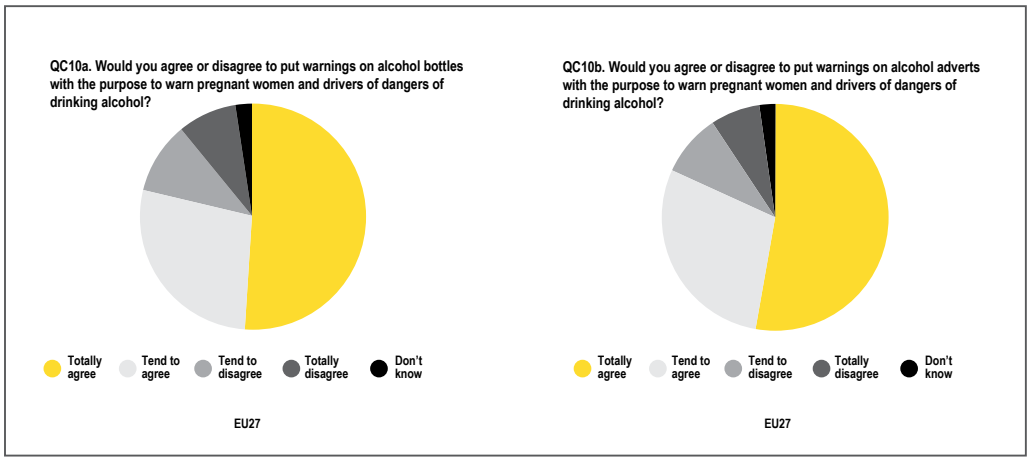


*Figure 3: Survey about labelling of alcoholic beverages*

*Source: Special Eurobarometer, "EU's citizens attitudes towards alcohol", 2010, http://ec.europa.eu/health/alcohol/docs/ebs_331_en.pdf, retrieved the 13.05.2015.*

The EU should build upon the recent tobacco labelling experiences, which have proven to be a success. Good quality studies report that tobacco warnings have an effect on behaviour, including quitting smoking, attempting to quit or reducing smoking (Argo and Main, 2004), and that pictorial warnings seem to have greater impact than text-only warnings (Beatty and Allsop, 2009). However, research suggests that warning labels may increase awareness of the risks associated with excessive alcohol consumption, but this does not necessarily translate into behavioural changes in at-risk groups (Wilkinson and Room, 2009). Some studies indicate that pictorial health warnings about alcohol have a more positive effect on behaviour change (Guillemont and Léon, 2008) and that this change may be easier in certain groups than others.

**The EHP strongly recommends that all EU member states:**

- IInclude a clear pictorial health warning outlining the risk of drinking during pregnancy;
- Include a clear pictorial warning about alcohol reducing the ability to drive safely.

## CLEAR INFORMATION ON MAXIMUM RECOMMENDED CONSUMPTION

The maximum recommended consumption of alcohol varies according to the alcoholic graduation/ concentration of beverages (NHS Choices, 2015), which makes it difficult for consumers to assess if they are exceeding the recommendations.

**The EHP recommends that:**

- The new EU Alcohol Strategy implements the "unit" as the standardised measure for alcohol consumption;
- All alcoholic beverages containers indicate the daily maximum intake recommendation for men and women;
- Spirits containers provide additional measures to empower customers to correctly estimate their consumption (e.g., cap dosage system; units indicated with marks in the bottles);

## INCLUSION OF CALORIC CONTENT AND INGREDIENTS

Alcohol is said to provide "empty calories", as it is rich in sugar but contains no nutrients (proteins, fats, vitamins) (Drinkaware, 2013). As a highly caloric good, its overconsumption can result in overweight or obesity. However, in a clear violation of the consumers' right to information, alcohol is currently exempted from stating its caloric content in labels. Additionally, consumers should have the right to be informed about all the ingredients alcoholic products contain, as is the case with all other drink and food products.

**The EHP recommends that:**

- The inclusion of calorific content in labels be compulsory and enforced within a reasonable period of time, as an EP ENVI Committee Resolution from April 2015 requested (European Parliament, 2015).
- All alcoholic products labels feature a list detailing all the ingredients and components.

## INCLUSION OF AGE LIMIT

We strongly recommend the inclusion of a defined age limit for the consumption of alcohol on the labels of all alcoholic products, as well as indications of the legal consequences of sales to underage consumers.

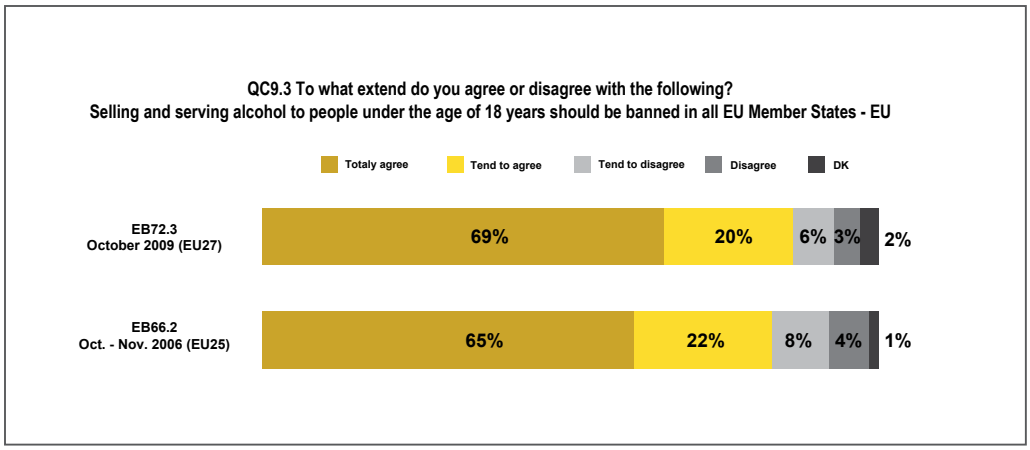


*Figure 4: Survey on legal drinking age,*

*Source: Special Eurobarometer, "EU's citizens attitudes towards alcohol", 2010, http://ec.europa.eu/health/alcohol/docs/ebs_331_en.pdf, retrieved the 13.05.2015.*

# Marketing

Some member states already have regulation in place to control marketing of alcohol (e.g. the Loi Evin, in France). At EU level the Audiovisual Media Services Directive (2010/13/EU) states that alcohol beverages shall not be aimed specifically at minors, but young people are still often targeted or not appropriately protected from marketing on alcohol (e.g. exposure through sponsorship of major sports and music events).

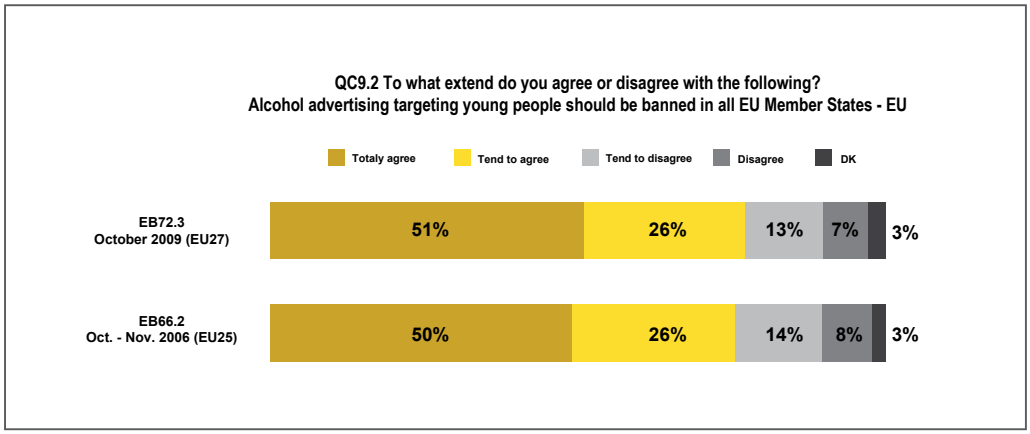


*Figure 5; Survey on the marketing of alcohol targeted at young people,*

*Source: Special Eurobarometer, "EU's citizens attitudes towards alcohol", 2010, http://ec.europa.eu/health/alcohol/docs/ebs_331_en.pdf, retrieved the 13.05.2015..*

**The EHP recommends strengthening the implementation of the AVMS Directive at national level:**

- The locations and messages of alcohol marketing should be regulated. Building upon the success of tobacco marketing controls and the French Loi Evin, alcohol advertising should be limited in public settings
- Commercial communication should be messaged appropriately, with sensitivity applied when targeting minors, so as to prevent the impression that consumption contributes towards social or sexual success.

# Pricing: Taxation

## TAXATION

There is evidence that "price affects drinking in all types of beverages and across the population of drinkers from light drinkers to heavy drinkers" (Karlsson and Österberg, 2009). Higher taxes have often been used to achieve non-fiscal targets, such as on cigarettes, so as to reduce tobacco consumption, or on cars and fuel, to lessen the negative environmental impact of driving. WHO studies found that increasing taxes on alcoholic beverages helps attain public health goals. But a study by Rand Europe for the European Commission reported that "the real value of the EU alcohol minimum excise duty rates, and of member states alcohol taxation, has decreased since the mid-1990s in most EU countries"(Rand Europe, 2009).

We applaud the efforts of the Scottish government to bring in a Minimum Unit Price (MUP) to address Scotland's increasing alcohol consumption, and we await the ruling of the European Court of Justice on this matter.

**The EHP recommends that**, in order to deter people from consuming large amounts of alcohol, and to improve the health of Europe's population, Excise duties be increased and wine excise duties introduced.

- Retailers of alcoholic drinks should no longer be permitted to absorb the excise duties, but must pass them on to consumers.
- Minimum excise duty rates should be streamlined across the EU in line with a country's per capita GDP.
- The revenues gathered through taxation should be invested in promoting citizens' health, via education campaigns and other preventive measures for tackling alcohol and related health problems, availability of alcohol-free activities, promotion of healthy lifestyles, etc.

# Role of EU health systems in supporting prevention and reducing alcohol related harm

The new remote monitoring tools offered by eHealth and mHealth applications have a role in monitoring the habits of individuals and providing advice when needed. Uptake of eHealth and mHealth implies the development of adequate regulations at EU level, notably in data privacy and electronic health records. Health applications could raise awareness about individual consumption on alcohol, or information and education on alcohol-related harm. Health professionals could make greater use of eHealth tools to target wider but also younger populations with information on health determinants.

To support shifts towards prevention in people's behaviour, health systems should target the young population, and take health education to communities, schools and workplaces, as a public health measure. Health systems should change their focus from treating diseases to promoting prevention.

**The EHP recommends**

- Increased support to gather evidence about the use of applications to promote health education and monitor lifestyles (like alcohol consumption) among the population, especially young people.
- Measures in some member states to reduce access to and availability of alcohol among high-risk communities - through restricting opening times, locations and quantities for alcohol purchases.

**Investments in Health Promotion:** Health promotion should become a cultural habit in our societies, overcoming the challenge that it is not the most effective tool where habits are long-established. Information about the consequences should be made clear to all citizens. Health professionals should be adequately trained to provide guidelines and advice on alcohol consumption and related harm.

- The EHP recommends more investment in health professionals' education to enhance their role in informing and warning citizens about alcohol related harm.

# Changing the EU drinking culture through education

Drinking forms part of Europe's culture and it is considered as part of a social activity, important for social relations, behaviour, and interactions. The Eurobarometer study confirms the important role alcohol plays in our lives.

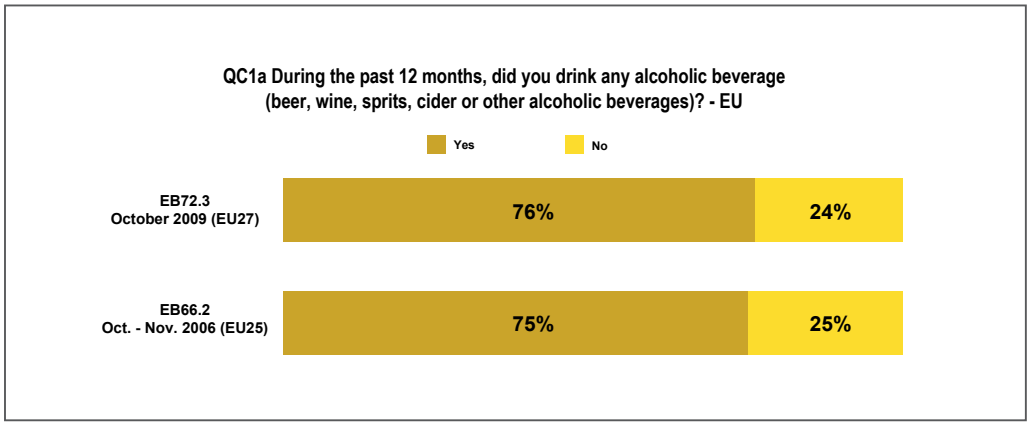


*Figure 6: Survey on the frequency of alcohol consumption,*

*Source: Special Eurobarometer, "EU's citizens attitudes towards alcohol", 2010, http://ec.europa.eu/health/alcohol/docs/ebs_331_en.pdf, retrieved the 13.05.2015.*

Unofficial rules and the self-imposed protocols of drinking rituals have more influence on levels of consumption and drinking behaviour than 'external' controls. Alcohol can differentiate the 'insider' and 'outsider' group in a society or among peers.

Experimenting with alcohol is a common phase for many teenagers in the transition to adulthood. It is present during important moments of people's lives and carries a symbolic message of success or luxury. Advertising and promoting an image of alcohol related to social success is particularly powerful in these periods, making education campaigns and limitations in publicity and marketing all the more important.

**The EHP recommends:**

- Increasing the availability of information about alcohol-related harm, and the health consequences arising from the consumption of alcohol. This information should be displayed in schools, universities and public spaces in a variety of formats, including an "ex-alcoholic programme" to raise awareness by using the personal experiences of people that suffered the consequences of abusing alcohol.
- Increasing the presence of educational campaigns in the communication channels most used by young people.
- Diminishing the positive image of alcohol conveyed by advertising, and disconnecting it from the context of leisure.

# VI. CONCLUSION

Alcohol is part of European culture, and the EU benefits economically from the production and sale of alcoholic beverages. But Europe is experiencing the high health and social cost of alcohol abuse, and its links to chronic disease. The EHP therefore makes evidenced-based recommendations in this paper and encourages EU and national policy makers to consider implementing these proposals as a way to reduce the harmful effects of alcohol consumption.

Although cultures and habits vary across the EU, and not all approaches can or should be mandated across the region, there should be an EU alcohol policy which can assist member states in tackling alcohol-related harm. Local and individual targeted approaches should be supplemented by select, unified measures applicable across all member states. The rationale is simple: Europe as a region suffers disproportionately from alcohol-related harm and needs to confront this problem through the cooperation of all member states, which can be most effective through EU-wide policies. That is why we call for a new EU alcohol strategy.

A coordinated package of alcohol policies must be implemented, including economic measures such as pricing and taxes, as well as more effective promotion of education and information on labels of alcoholic beverages. If these policies are implemented across the EU they will reduce the burden of alcohol related harm and the chronic disease associated with it.

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