



Alcohol in the European Union. Consumption, harm and policy approaches

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The half-day conference was organized by the World Health Organization Regional Office for Europe (WHO Regional Office for Europe) in joint collaboration with the European Commission (EC), Alcohol & Society and the Danish European Union (EU) Presidency represented by the National Board of Health. The new WHO Regional Office for Europe publication *Alcohol in the European Union. Consumption, harm and policy approaches*, which was co-sponsored by the EC, was launched at the conference.

Dr Lars Møller, Programme Manager a.i., Alcohol and Illicit Drugs, WHO Regional Office for Europe, chaired the event. Dr Møller opened the conference and welcomed the attendees consisting of 150 participants from throughout Europe. The past year has been a very important year for WHO in regard to alcohol issues. Notable events include the adoption of the European action plan to reduce the harmful use of alcohol 2012-2020, as well as a survey on alcohol and health conducted among Member States (MS). Data collected in the survey were used both in the new publication, *Alcohol in the European Union. Consumption, harm and policy approaches*, and also to update the European Information System on Alcohol and Health (EISAH).

Dr Gauden Galea, Director of the Division of Noncommunicable Diseases (NCDs) and Health Promotion, WHO Regional Office for Europe, summarized some significant events from the past year in the area of NCDs.

Along with the Americas, the European Region has the highest burden of mortality and avoidable mortality from the four major NCDs: cardiovascular disease, cancer, chronic lung disease and diabetes. In the past, these diseases have struggled to be recognized on the policy agenda, but, last year, at both at the European level and globally, these diseases received a high level of attention. In Europe, there were some significant meetings including the Moscow Global Ministerial Conference on Healthy Lifestyles and NCD Control in April 2011, which resulted in a declaration that paved the way for an affective global response. The declaration was recognized by the World Health Assembly and was included as an annex in a resolution.

There were a series of active consultations with MS to identify effective interventions to include within the European NCD action plan. The resulting action plan includes some policy measures. At the same time as the political and technical consultation, the analysis globally drew attention to a series of “best buys” – a package of effective interventions that are not only evidence-based but also cost-effective and affordable. The NCD action plan was approved in Baku, and, a week later, there was a United Nations high-level meeting in New York, and a political declaration was endorsed. This political declaration gave WHO a mandate to develop a set of voluntary targets and indicators to guide the monitoring and control of the epidemic up to 2025.

Ms. Kit Broholm, Senior Adviser, representing the Danish EU Presidency and the National Board of Health, discussed the collaboration between the EU and WHO and the significance of recent WHO activities for the future of the EU alcohol strategy.

Alcohol is one of the main risk factors for health problems in the EU. Since 2006, the EU has had an alcohol strategy with a particular focus on the protection of children, young people and unborn children. This protection includes reducing alcohol use by children and young people but

also extends to protecting these groups from their parents' harmful alcohol use. This implies that the consequences of the harmful use of alcohol have a much broader scope than the health of the drinker.

The WHO global alcohol strategy and the European alcohol action plan adopted in September 2011 address a broad range of negative consequences of harmful use of alcohol. The action plan in particular can inspire European countries to implement evidence-based methods and national alcohol strategies. The global strategy and alcohol action plan could therefore serve as inspiration for the EC in regard to a new EU alcohol strategy.

The existing EU alcohol strategy's focus on common documentation, sharing of knowledge, and common monitoring has resulted in an important and useful collaboration between the EU and WHO on monitoring, which is exemplified by this conference and new publication.

Mr Michael Hübel, Head of Unit, Health Determinants, EC, discussed the joint effort between WHO and the EC to address alcohol-related harm. Since the first EU alcohol strategy was established in 2006, the EC has worked closely with WHO on monitoring and building the evidence around alcohol issues. This collaboration is important for MS because it allows for the coordination of information gathering. The single line of reporting allows for the compilation of data accessible in one central location.

The EU alcohol strategy focuses on key issues on the alcohol-related harm agenda, including addressing young people, alcohol at the workplace, drink-driving, monitoring and evidence building. It is a strategy in support of MS, and a focus is placed on those areas where the EU can have most added value through actions and commitments. One of the pillars is to work with partners across societies (e.g., the health profession, the alcohol production chain, advertising and marketing, and the NGOs).

An evaluation of the EU alcohol strategy is currently underway and will assess how well the EU has supported MS in their actions and activities, as well as other components including the work across society and the work of the Alcohol and Health Forum. This evaluation will help inform decisions on future steps to address alcohol in the EU. Partners have expressed support for the EU-coordinated approach to alcohol-related harm. There is optimism that, although the evaluation of the strategy will identify the weak points, overall the outcome will be positive.

The new publication, *Alcohol in the European Union. Consumption, harm and policy approaches*, is modelled on a prior report prepared for the EC, *Alcohol in Europe*. It provides an update of themes from the prior report but also includes information gathered from the MS monitoring.

Dr Anette Søgaard Nielsen, Chairman, Alcohol & Society, Denmark, introduced the new umbrella organization for Danish NGOs, Alcohol & Society. The organization was established this year and represents a united effort among NGOs. The organization has no religious affiliation and is not an abstinence-based organization. Rather, the aim is to reduce consumption and minimize the harm done by alcohol.

Alcohol tends to have positive cultural connotations in Denmark, and, in the past, alcohol issues were rarely on the political agenda. Denmark does not yet have a national alcohol action plan. Danes (14+ years old) drink between 11 and 12 litres of pure alcohol per capita per year, the

equivalent of 3.5 bottles of vodka per month. Alcohol & Society offers a platform for Danes to work with politicians to raise awareness of alcohol issues in Denmark and to take action. Alcohol & Society is very grateful to have the information from the EU and the WHO, which provides a platform to work with Danish politicians and a framework that the public can operate within when working to lower alcohol intake and minimize the harm done by alcohol.

Professor Jürgen Rehm, Director, Social and Epidemiological Research Department, Centre for Addiction and Mental Health, Toronto, Canada, WHO Collaborating Centre for Mental Health & Addiction, presented information on the societal burden of alcohol.

Alcohol exposure in the EU has remained stable, at a high level. The European Region has the highest consumption of alcohol in the world. Alcohol consumption in the EU is slightly lower than in some parts of eastern Europe but it is still high. The recorded consumption of alcohol (for those individuals age 15+) has remained at approximately 11 litres for the past 10 years. Including unrecorded alcohol, in 2009-2010, the per capita consumption of alcohol was approximately 12.5 litres in Europe, which is more than double the world's average. Wine consumption in the wine growing countries has been decreasing for the past 35 years, and some of the wine growing countries (e.g., Spain) now drink more beer per capita in pure alcohol than wine. Overall, in southern Europe, the total per capita consumption has been falling for the last 30 years, and this trend seems to be continuing. In the Nordic countries, however, there has been an increase in adult per capita consumption. Thus, although overall per capita consumption of alcohol in Europe has remained stable, there have been varying trends in the different European Regions.

The amount of spirits consumed in Europe, which is much less than beer or wine, has been fairly stable. Wine consumption has been decreasing slightly, and, now, beer is the most prominent alcoholic beverage in Europe.

Compared to other parts of Europe, there is less total alcohol consumption in some southern European countries (e.g., Greece and Italy), which is partly due to the reduction in wine consumption. In general, the Eastern and Central-Eastern countries consume more alcohol than other areas of the EU.

What is considered unrecorded alcohol (e.g., cross border shopping, surrogate alcohol, undeclared wine production, moonshine, etc.) varies among European countries. Overall, unrecorded alcohol consumption is not as significant as in other parts of the world (1.6 litres or 13% of total per capita consumption are unrecorded in Europe compared to 30% globally).

Looking at regional differences in Europe, the Central-Eastern and Eastern parts of Europe consume the most alcohol compared to the other regions, while the Nordic countries consume the least; however, both the Central-Eastern/Eastern and Nordic region have been increasing their consumption overall in the past 10 years. The Southern countries and the Central-Western and Western countries have decreased consumption during the same period. Unrecorded consumption is highest in the Eastern countries, followed by southern Europe.

Although alcohol has positive effects on health in the areas of diabetes (incidence), ischaemic heart disease, and ischaemic stroke, the detrimental effects of alcohol far outweigh the benefits. Furthermore, these benefits are related to drinking in low quantities without binges, and the beneficial effects disappear if there are heavy drinking occasions.

More than 30 diseases (in the International Classification of Disease) would not exist without alcohol. Among the detrimental effects of alcohol is an increased risk of cancer (mouth and oropharyngeal, esophageal, liver, colon/rectal, and female breast). Alcohol is also linked to neuropsychiatric diseases (alcohol use disorders and primary epilepsy), cardiovascular diseases (hypertensive diseases and hemorrhagic stroke), gastrointestinal diseases (liver cirrhosis, pancreatitis), conditions arising during the perinatal period (low birth weight, fetal alcohol syndrome), unintentional injury and intentional injury. These conditions are those where alcohol has been determined to be causal. Alcohol is related to the incidence of various diseases and also to the outcomes of those diseases.

For men between 15 and 64 (premature mortality), 1 in 7 deaths were caused by alcohol in 2004 in Europe. For women of the same age category, 1 in 13 deaths were caused by alcohol. Countries in Eastern and Central-eastern Europe have the highest rate of alcohol-attributable deaths for both sexes (nearly 1 in 5 for men and 1 in 10 for women).

Approximately 110 000 deaths among males per year in the EU are caused by alcohol and approximately 15 000 deaths are avoided due to the beneficial effects.

Higher levels of alcohol consumption create an exponential risk increase for most diseases, so if very heavy drinking occasions were eliminated, the number of deaths and risk of disease would be decreased over-proportionally. Alcohol is related to over 130 disease categories.

In terms of disability-adjusted life years (DALYs), in the Nordic countries, there are many more years of life lost due to premature mortality and disability respective to the consumption. This is mainly due to the drinking style and high prevalence of alcohol use disorders.

Mental and neurological disorders comprise the largest proportion of the alcohol-attributable burden of disease as measured in DALYs for both men and women in the EU.

Very conservative estimates of harm to others (based mainly on drink-driving, homicides and fetal alcohol syndrome) show that between 3-4% of the overall alcohol-attributable deaths in the EU are caused by harm to others.

In summary, alcohol consumption is stable in the EU and causing considerable harm. Overall, harm is higher in the Central Eastern part of Europe. This area of Europe drinks the most and drinks in the most detrimental way. In the Nordic countries, alcohol-attributable years lost due to disability are relatively high, especially given the consumption (mainly due to the higher toll of alcohol use disorders). Harm to others due to alcohol is considerable.

Dr Dinesh Sethi, Programme Manager a.i. Violence and Injury Prevention, WHO Regional Office for Europe, presented on reducing injuries and death from alcohol-related road crashes.

Each year approximately 43 500 people die on the roads in the EU, and road traffic injuries are the leading cause of death in children and young adults aged 5-29 years. The burden is unevenly distributed in the EU and within countries. The majority of deaths are in car users. However, 41% of the deaths are in vulnerable road users (pedestrians, cyclists, and riders of motorized two- or three-wheelers). Alcohol is a risk factor for all road users.

Alcohol consumption impairs cognition, vision and reaction time. At any blood alcohol concentration (BAC) over zero, the risk of a road crash increases. For the general driving

population, the risk rises significantly at BAC levels over 0.4 g/l. Drivers aged 16-20, at any BAC, are 3 times more likely to crash than drivers who are over 30 years old.

The risk of crash increases exponentially as the BAC rises. Alcohol consumption also increases the risk of adopting other risky behavior (e.g., speeding and not wearing seatbelts or helmets). Alcohol is estimated to be used by 3.5% of drivers.

Approximately 33% of road traffic injuries in males and 11% in females are due to alcohol. For pedestrians, 40% of male and 17% of female deaths resulting from road traffic injuries are estimated to be due to alcohol, while, for cyclists, the figures range from 20% for males to 18% for females. The risk varies with age and sex (higher among younger males). The risk also varies with countries, and this variation reflects both the actual deaths and the enforcement and measurement.

In terms of interventions, there is consistent evidence that the introduction and/or reduction of legal BAC levels for driving, when enforced, reduce crashes and fatalities. There is also consistent evidence for the introduction of sobriety checkpoints and random breath-testing.

There is some evidence that crashes and fatalities can be reduced by lower legal BAC levels for novice drivers, license suspensions, brief advice and mandatory treatment of drivers with alcohol dependency, and alcohol locks. There is no evidence that designated driver and safe ride programmes reduce crashes and fatalities.

All EU countries have legislation that prohibits driving under the influence of alcohol. Four countries have set a limit of zero, but two countries still have a BAC limit of 0.8g/l. Survey results show that 70% of countries reported that enforcement is suboptimal. One euro invested in random breath-testing could save 36 euros.

Some points for action may be proposed: for any country with a BAC limit above 0.5 g/l, it would be beneficial to reduce the level to 0.5 g/l; for those countries with a BAC limit of 0.5 g/l, additional benefit could be gained by reducing it to 0.2 g/l; the legal BAC level for novice and professional drivers should be reduced to 0.2 g/l or less; coverage of testing for BAC levels should be improved; enforcement must be enhanced (made highly visible through, for example, social marketing); and greater engagement of the health sector.

Mr Esa Österberg, Senior Researcher, Department of Alcohol, Drugs and Addiction, National Institute for Health and Welfare, Helsinki, Finland, presented information on the availability and pricing of alcohol.

Alcohol availability regulations are divided in two areas: those affecting the physical availability of alcohol and those affecting the economic availability of alcohol.

Economic measures

The most common measure used by the public sector to affect the economic availability of alcohol is taxation (e.g., setting excise duties or value added taxes). However, other measures are also employed, such as minimum prices or regulation of discount prices. When other factors affecting alcohol consumption remain the same, an increase in alcohol price generally leads to a decrease in alcohol consumption, and a decrease in price usually leads to an increase in alcohol consumption.

There have been three recent meta-analyses on the effect of alcohol prices and taxes on drinking. These studies show that a price change of the same magnitude either upwards or downwards seems to have a smaller effect on beer than on wine or spirits. An explanation could be that beer is a common beverage consumed during everyday leisure activities or meals in the countries where the studies were conducted. In a country where wine is an ordinary beverage with meals, however, wine can be quite price-inelastic. Price elasticities are not inherent properties of alcoholic beverages. The substitution between different alcoholic beverages as well as other commodities mainly depends on the uses of the alcoholic beverages. For instance, in a country where wine is an ordinary beverage with meals, an increase in wine prices could increase the consumption of milk or water but not home-distilled spirits. However, in a country where alcoholic beverages are mainly used as intoxicants, an increase in home-distilled beverages or illicit drugs would be more likely.

Price changes affect all types of beverage and all kinds of drinker, from light to heavy drinkers. Changes in alcohol taxes do influence the rates of problem drinking. For instance, the reduction in alcohol taxation in Finland in 2004 had substantial effects on alcohol-related sudden deaths and overall alcohol-related mortality.

Alcohol affordability increased during the period of 1996-2004 in almost all EU MS, mainly because of an increase in income. This indicates that the relative prices of alcoholic beverages have remained relatively stable or increased only moderately. Moreover, in the period of 1995-2010, developments in excise duty rate were not uniform in the EU MS. For instance, in the Nordic countries, alcohol excise duty rates were lower in nominal terms in 2010 than in 1995. In only a few countries (e.g., Greece and Italy), the nominal values of excise duty rates were increased so much that the excise duty rates increased in real terms. Despite increases in alcohol excise duty rates by the new EU MS, the lowest excise duty rates are still found among them.

A complementary measure to tax increases is to set a minimum price per gram of alcohol; this measure has a far greater impact on heavy consumers than light consumers.

Physical availability

Physical availability of alcohol refers to the ease of obtaining alcohol. Regulations on physical availability include the monopolization or licensing of on- or off-premise sales of alcohol; limits on opening times for retail sales; legal age limits for selling, buying, possessing, or drinking alcohol; and refusing the sale of alcohol to intoxicated persons.

In many countries, a license is required before alcoholic beverages can be sold. Most often, licensing is used to prevent harm and public disorder by limiting the supply of alcohol. Restrictions on the number of outlets have been shown to have an effect on alcohol consumption and related harm. Some studies indicate that changing either the hours or days of alcohol sales can affect alcohol-related harm. Government monopolies on off-premise retail sales of alcoholic beverages can also affect alcohol consumption and related harm to both young people and adults.

Changes in laws for minimum drinking ages can have substantial effects on drinking by young people and alcohol-related harm. These effects often last well after the young people reach the

legal drinking age. The full benefits of legal drinking-age limits are only realized if these limits are effectively enforced.

Availability changes affect alcohol consumption and alcohol-related harm. However, it should be noted that the effects of availability changes differ across countries, time periods and categories of alcoholic beverages. Thus, national and local drinking habits should be taken into account when alcohol policy measures that affect the availability of alcohol are planned.

Professor Peter Anderson, Newcastle University and Maastricht University, presented an overview of the cost–effectiveness of alcohol policy.

As background for the United Nations high-level meeting on NCDs last year in September, the Harvard School of Public Health and the World Economic Forum conducted a study of the global economic burden of NCDs. The cumulative world cost of NCDs and mental health over the next 20 years is estimated to be 47 trillion dollars. The WHO and the World Economic Forum presented a solution to reduce the economic impact of NCDs by outlining some “best buys” (i.e., policies that cost little to implement and result in huge economic and health gains). The best buys related to alcohol are: tax increases; restricted access to retail alcohol; and bans on advertising.

The British government recently launched the United Kingdom’s alcohol strategy. Some notable features of this strategy are that it promotes joined-up action across governmental sectors and that it is a strategy about “*alcohol*” rather than just, for example, a strategy to reduce the harmful use of alcohol. Furthermore, it is evidence-based and aligned with the “best buys” (outlined below). Lastly, it seeks meaningful commitments from the alcohol industry, supported by incentives.

Bans on advertising

Advertising has an impact on people’s drinking, particularly on young people’s drinking. This is demonstrated by an experiment conducted at a Dutch University which found that seeing alcohol cues on the screen (either in films or commercials) directly influenced the actual drinking behavior of adolescents (Engels *et al.* 2009). Students who watched a film which included many portrayals of alcohol interrupted by alcohol commercials drank twice as much alcohol during the viewing than those who saw a neutral film with neutral commercials.

The current problems with alcohol promotion are reminiscent of those seen before tobacco advertising was banned, when attempts to control content and adjust targeting simply resulted in more cryptic and imaginative campaigns (Hastings *et al.* 2010).

Social media now plays an important role, as banned advertisements are still available through sites such as YouTube.

Restricted access to retail alcohol

A meta-analysis conducted by the Centers for Disease Control in the USA showed that, in general, an extra day of alcohol sale results in an increase in alcohol consumption, assaults, and motor vehicle accidents. Regarding a change in hours of sale, it is very difficult to demonstrate a change of impact when the change is less than two hours; however, a change of more than two hours results in an increase in some negative outcome indicators. Therefore,

days and hours of sales do matter. The more available alcohol is, the more likely there is to be increased consumption and harm.

Tax increases

Some issues have been raised about tax increases:

- *Shouldn't increase prices in economic crisis.* However, during an economic crisis, suicides and alcohol dependence increase.
- *Price increases unfairly harm lighter drinkers.* According to the Sheffield University estimates, a 10% price increase on alcohol in England would impact harmful drinkers much more than moderate drinkers in terms of consumption and cost.
- *Price increases unfairly harm the poor.* People in the lowest income group are less likely to drink alcohol than those in the highest income group; the people in the highest income group are also more likely to be drinking moderately, hazardously, or harmfully than those in the lowest income category. The lower income households are less likely to be purchasing cheap alcohol because less of them are drinking. Thus, an implementation of a minimum unit price on alcohol will have less impact on the lower income group than would be expected.
- *Price increases promote cross border trade.* When the Finish government reduced the tax on alcohol and harm went up, the poorest groups in the population were the most affected. The tax reduction increased harm and was regressive in the sense that a much higher burden of the harm was borne by the lower income group than the higher income group.
- *Highly targeted taxes are better.* This is not true. For example, when Germany introduced a tax on spirit-based ready to drinks (RTDs), there was an initial drop in annual per capita spending on RTDs; however, the German beer producers began producing beer-based RTDs, which were not part of the tax. The overall sales of RTDs then returned to the pre-tax level. The tax failed because of its specificity; it was not broad enough to cover the whole category.
- *Taxes do not necessarily increase prices.* When there is a tax increase, the producers and retailers may absorb some of the tax increase, and, therefore, there may not be a price increase. A way to avoid the problem of retailers selling the product below cost is to implement a minimum unit price. Estimates of the impact of minimum pricing in Scotland indicate that there would be savings in health and crime costs and employment-related benefits. The alcohol industry would also benefit in terms of increased income.

The United Kingdom alcohol strategy notes that the industry has a direct and powerful connection and influence on consumer behaviours. People consume more when prices are lower; marketing and advertising affect drinking behaviour; store layout and product location affect the type and volume of sales. Thus, by offering consumers a wider choice of lower strength products and smaller servings, the industry can remove millions of litres of pure alcohol from the market, which is beneficial for all.

This is a win-win situation. The industry can make the same profit from their products, but if they reduced the alcohol strength and make smaller servings, people will be purchasing less alcohol. Reducing the alcohol content would be akin to the food industry reducing the salt content.

Dr Anette Søgaard Nielsen, Chairman of Alcohol & Society, presented the work of NGOs in Denmark.

The alcohol culture in Denmark presents a challenge for NGOs in the alcohol field. NGOs began work in the area of alcohol in Denmark in the nineteenth century, as the Copenhagen women's "coffee wagons" were introduced to offer workers an alternative to beer in order to reduce alcohol consumption. Present-day NGO work on alcohol emphasizes treatment and caring for the poor and vulnerable parts of society rather than prevention.

Twenty per cent of Danes (age 16+) are heavy drinkers, and, compared to other countries, Danish adolescents are among the heaviest drinkers, especially in terms of binge drinking. Denmark also has the fewest abstainers in Europe. Thus, because alcohol is so much a part of Danish culture, NGO work on alcohol is challenging, and it is difficult to highlight alcohol on the political agenda.

Danes drink so much alcohol because it is easily available; it is accepted (a part of many social occasions); and there is a lot of alcohol marketing.

The role of Alcohol & Society is to reduce the harmful use of alcohol through networking, raising awareness, advocacy and having a "watchdog" position. The aim of Alcohol & Society is to have less alcohol consumption and more society.

Ms. Kit Broholm, Senior adviser, Alcohol prevention, National Board of Health, Denmark, presented information on community action on alcohol in Denmark.

In Denmark, the National Board of Health has supported alcohol prevention in the 98 municipalities. This community action in Denmark is consistent with the European alcohol action plan. The main strategy in Denmark has been to support control policy at the municipality level, systematic early detection, brief intervention, and referral to qualified alcohol treatment.

The alcohol culture in Denmark creates problems not only for the drinker but also for relatives of the drinker. In 2008, 15% of the Danish population (860 000 persons) had alcohol dependence or harmful use of alcohol, and 632 000 persons grew up in families with alcohol problems. Only 12 000 per year receive regular alcohol treatment. Thus, many families do not receive any help and, consequently, prevention is a priority.

A goal has been to support prevention structures and routines in the municipalities for systematic early detection and brief interventions in order to help more families receive alcohol counseling or treatment. This focus also draws attention to the fact that alcohol harms others than the drinker and has a big economic cost for the municipalities.

The Danish Health Institute has calculated that the total social and health cost for all municipalities due to people with alcohol dependence in hospital treatment and in the hospital due to alcohol-related illnesses is 3.1 billion Danish kroner per year. In comparison, the total cost for alcohol treatment is 283.5 million Danish kroner per year. Thus, the municipalities have the opportunity to save significant amounts of money if they prioritize alcohol prevention, early detection, brief intervention, and alcohol treatment.

The Danish National Board of Health is building prevention structures and routines through several major projects in collaboration with the municipalities: 1) a project with the aim of developing a general alcohol policy for the whole municipality and building an organization across the different administrations to coordinate implementation of the alcohol policy and

action plan; 2) a project with a focus on the early detection of parents with alcohol problems in the social sector, schools and kindergartens; 3) a project about quality in alcohol treatment for the whole family.

Alcohol policy is essential for municipalities in reducing harmful use of alcohol by changing collective rather than individual behavior. Alcohol policy is the central norm and frame setting method in the municipality.

Twenty municipalities in Denmark have worked with developing an alcohol policy and alcohol organization. Eight of the municipalities have worked to reduce the availability of alcohol. Seventy-eight municipalities have worked with early detection of alcohol problems among parents in the social sector, kindergartens and schools.

Ms. Maria Renström, Ministry of Health and Social Affairs, Sweden, presented comments and reflections on the conference.

The crucial next step is not to relax but, rather, to keep prioritizing alcohol issues. Thanks to the WHO global strategy, the WHO European action plan, and the EU alcohol strategy, we have seen a slight decline during the last years in most of the countries. However, as soon as we stop prioritizing a problem, it reemerges.

Twenty years ago, WHO did not have an alcohol action plan, and only in the last 10 years has the EU adopted an alcohol policy. Thus, much has been achieved in recent years due to the EU alcohol strategy and EU funding, which has financed most of the research, data collection and networking. Without this type of high-level policy commitment, alcohol issues would not be prioritized.

It is the harmful effects of alcohol (e.g., health harms, social harms, inequalities, and problems for the individual and society), rather than the consumption level, that must be highlighted in order for politicians to prioritize the issue. Due to cooperation between the WHO and EU, a centralized database is being created, which facilitates work among MS. Key indicators should be developed measuring harm to others, especially with a focus on children.

Over the last two years, the focus on NCDs has increased. Looking at the four major risk factors for NCDs (alcohol being one), should we focus on the interconnection between the risk factors or should we continue to address each risk factor independently? It is important to maintain a separate alcohol strategy or action plan, but it is also important to see the links between the risk factors for the major NCDs and coordinate the work at all levels.

Alcohol differs from other risk factors because it is also a risk factor for injuries, violence and mental illness.

There is a need for high-level policy-making, such as the work produced by WHO and the EU, because it leads to governmental action and priority. It is crucial to have continued work at the EU level. MS that would like to continue the cooperation, exchange of experience and support of the EU to reduce alcohol-related harm need to mobilize. The MS need to take the lead and discuss the next steps for the EU alcohol strategy.

Mr Michael Hübel, Head of Unit, Health Determinants, European Commission, reflected on the conference.

The focus on chronic diseases and their prevention, which is a much larger agenda than alcohol, is about how we organize our health and social systems and our policy response, including the risk factors.

The area of media development was mentioned in some presentations. In terms of marketing and communication and the public health response, we have some forms of media at our disposal; in the target group of young people, social media is the preferred media. The public administration has not used these media as effectively as it should.

There is a need to reflect on how we can be faster in understanding trends across society that are important for health so that we know more quickly if policy measures have had an effect. We either need to change the way we look at the different indicators or look at the speed with which we collect data and process it.

Alcohol-related harm and alcohol and health are issues that will remain a priority on the public health agenda, including at the EU level.

Dr Gauden Galea, Director of the Division of NCDs and Health Promotion, WHO Regional Office for Europe, concluded the conference with some reflections and acknowledgements.

The types of interventions mentioned during the conference and in the book will hopefully add to knowledge sharing across Europe. There is a major challenge in terms of increasing the skills and capacity of public health practitioners to be able to extend themselves into the areas of legislation, drafting of regulations, enforcement, negotiations across sectors, health economics and all issues related to the government becoming part of the public health armamentarium.

Thank you to the EC for the support and valuable partnership that has extended beyond the alcohol issue to other areas of NCDs.

Dr Lars Møller, Programme Manager a.i., Alcohol and Illicit Drugs, WHO Regional Office for Europe, concluded by thanking the conference co-organizers, the conference participants, the speakers, and the WHO staff involved in the event.