

HOUSE OF LORDS

European Union Committee

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8th Report of Session 2014-15

# **A new EU Alcohol Strategy?**

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Evidence is published online at <http://www.parliament.uk/eu-alcohol-strategy> and available for inspection at the Parliamentary Archives (020 7129 3074).

Q in footnotes refers to a question in oral evidence.

## SUMMARY

In Europe, alcohol abuse is the third leading risk factor for disease and mortality. It is also a major fuel for public disorder and crime. Europe has the highest per capita alcohol consumption of any part of the world, and United Kingdom consumption is well above the European average.

In 2006 the Commission proposed and the Council adopted “an EU Strategy to support Member States in reducing alcohol-related harm”. Its five priorities were to protect young people, children and unborn children; to reduce deaths and injuries from alcohol-related road accidents; to reduce alcohol-related harm among adults; to increase education and awareness; and to develop and maintain a common evidence base.

The Strategy was given an end date of 2012. The Commission has done nothing to renew or replace it. In this inquiry we have been looking at what has been achieved, and what should come next.

EU competence in this area is limited. There are areas where the EU can usefully coordinate the activities of Member States, but only a few topics where it can act, and where its actions can make a difference. The Strategy failed to differentiate between them. A new EU Alcohol Strategy which is simply a continuation of the previous one would only perpetuate its deficiencies. Future action at EU level should concentrate on the initiatives which the EU can take and which would make a difference, in particular by taking a “health in all policies” approach to its own policies in the areas of taxation, labelling and marketing.

The structure of alcohol taxation must be made more rational. The labelling of alcoholic beverages, for too long exempt from the Food Labelling Regulation, must be brought within its scope. The uncertain mandate of the EU-level bodies set up under the Strategy should be clarified. If the Court of Justice rules that the attempt by Scotland to impose minimum unit pricing (MUP) is lawful, the Government must monitor the effects of its introduction in Scotland. If it appears to be successful in targeting the heaviest drinkers, the Government should implement its undertaking to introduce MUP in England and Wales.

The development and maintenance of a common evidence base, the fifth priority of the 2006–12 Strategy, has not been achieved, and many of the current problems stem from this. There is much disagreement and lack of trust between the public health professionals and the manufacturing, retailing and advertising industries about the available evidence, research and statistics. We have suggested how changes in the commissioning of research might produce evidence which is more trusted and on which policies can be based.

The Latvian Presidency intends to discuss the next steps towards a new EU Alcohol Strategy at an informal Council on 20–21 April 2015. We hope that our recommendations will assist the deliberations of the Member States, and that they will invite the Commission to proceed on the lines we have suggested.

# A new EU Alcohol Strategy?

## CHAPTER 1: INTRODUCTION

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1. Alcohol, when drunk to excess, is a significant cause of disease and premature death, and can be a fuel for public disorder and crime. Most states which do not altogether prohibit the consumption of alcohol have policies aimed at combating alcohol abuse.
2. Article 168 TFEU makes clear that public health matters are primarily the responsibility of Member States, and that action by the EU is designed only to complement those policies. However, the EU has strategies for issues ranging from security in the Sahel to climate change, from counter-terrorism to microbiology. The European Commission has never been inhibited from proposing a strategy on a topic, or the Council from adopting one, merely because the EU has only limited competence in the relevant field. There are so many strategies in the medical area alone that the Director of the Health Directorate of the Commission's Directorate-General for Research, Science and Innovation (DG Research)<sup>1</sup> was uncertain whether the number was 45 or 125.<sup>2</sup>
3. The EU does not however currently have a strategy on alcohol. There was an EU Alcohol Strategy from 2006–2012,<sup>3</sup> which we discuss in detail in Chapter 3. The object of our inquiry, conducted by our Sub-Committee on Home Affairs, Health and Education, has been to consider whether that Strategy was successful in its main object of reducing alcohol-related harm, and the case for further action at EU level.<sup>4</sup>
4. By a significant margin, Europe has the highest *per capita* alcohol consumption of any world region, and the United Kingdom is well above the average of the consumption league.<sup>5</sup> But there are wide variations across the Member States, and indeed regionally within Member States: variations in the type and strength of alcohol consumed, variations in the distribution of consumption by sex and by age, variations in the type and degree of harm caused. There are variations in cost, in duties, in laws on sale and on advertising, in age limits, and in other aspects of policy aimed at reducing alcohol abuse, and at treating the problems it causes. We consider many of these matters in Chapter 2.
5. The EU is not the only multi-national organisation with an alcohol strategy for Europe. As far back as 1992 the European Region of the World Health Organization (WHO) adopted an Alcohol Action Plan, the first WHO Region to do so. In 2012, the date of formal expiry of the EU Strategy, the

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<sup>1</sup> The Directorate-General for Research, Science and Innovation. Prior to the reorganisation of the Directorates under the new Commission, it was the Directorate-General for Research and Innovation.

<sup>2</sup> [Q 145](#) (Dr Ruxandra Draghia-Akli)

<sup>3</sup> Communication from the Commission, *An EU strategy to support Member States in reducing alcohol related harm* ([COM\(2006\)625 final](#)). We will refer to this Strategy as “the Strategy” in this report.

<sup>4</sup> The members of the Sub-Committee are listed in Appendix 1.

<sup>5</sup> WHO Regional Office for Europe, *Alcohol in the European Union: Consumption, harm and policy approaches* (2012): [http://www.euro.who.int/\\_data/assets/pdf\\_file/0003/160680/e96457.pdf](http://www.euro.who.int/_data/assets/pdf_file/0003/160680/e96457.pdf) [accessed 24 February 2015]

WHO adopted a further European Action Plan to reduce the harmful use of alcohol<sup>6</sup> (the 2012 WHO report). We consider this in Chapter 4, since it has a major impact on the case for further EU action which is the main topic of that chapter. In Chapters 5 to 9 we look at the possible policy approaches, at the EU bodies involved, their structures and their achievements, and at research and evidence. In Chapter 10 we pull together the threads and summarise our key recommendations.

6. We received a considerable volume of written evidence,<sup>7</sup> and held fifteen sessions of oral evidence. We are most grateful to all those who took the time and trouble to give us their views.<sup>8</sup> We received evidence from the three Government departments involved, the Department of Health, the Department for Business, Innovation and Skills, and the Home Office—and from Jane Ellison MP, the Parliamentary Under-Secretary of State for Public Health. Four of our evidence sessions were held in Brussels, where our witnesses included the WHO, members of the European Parliament’s Environment, Public Health and Food Safety Committee (ENVI), and officials from the Commission’s DG Research—but not, sadly, from the Directorate General for Health and Consumers (DG SANCO).<sup>9</sup>
7. Our other witnesses came mainly from two sectors with opposing views: the advocates for public health, and those concerned with the manufacture, retailing, marketing and advertising of alcoholic drinks. It was to be expected that their views would differ strongly. We did not, however, expect that they would be able to draw from the same pieces of research views which were diametrically opposed, nor did we anticipate the degree of mistrust with which they viewed each other’s work.
8. Self-evidently, the EU can take action in the fields covered by this report only to the extent that it has competence to do so under the Treaties. The Treaty of Lisbon has amended that competence, though not radically, since the Strategy was adopted in 2006. We set out in Appendix 4 the relevant provisions of the current Treaties, and how they differ from the provisions in force in 2006.
9. We have been fortunate in having as our specialist adviser for this inquiry Professor Betsy Thom, Professor of Health Policy, Middlesex University. We are most grateful for her expert knowledge and wise guidance.
10. **We make this report to the House for debate.**

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<sup>6</sup> WHO Regional Office for Europe, *Alcohol in the European Union: Consumption, harm and policy approaches* (2012): [http://www.euro.who.int/\\_data/assets/pdf\\_file/0003/160680/e96457.pdf](http://www.euro.who.int/_data/assets/pdf_file/0003/160680/e96457.pdf) [accessed 24 February 2015]

<sup>7</sup> Our Call for Evidence is set out in Appendix 3.

<sup>8</sup> The list of witnesses is at Appendix 2.

<sup>9</sup> Since the reorganisation of the Directorates under the new Commission, DG SANCO has been re-named the Directorate-General for Health and Food Safety (DG SANTE). Our witnesses referred to it by its then current title, DG SANCO, and we have done the same.

## **CHAPTER 2: ALCOHOL ABUSE: THE FACTUAL BACKGROUND**

11. Any strategy which “addresses the adverse health effects related to harmful and hazardous alcohol consumption”<sup>10</sup> needs to consider first what the levels of alcohol consumption are in the Member States, what levels can be considered harmful or hazardous, and what are the adverse health effects. The 2006 Strategy did so only in a perfunctory way. It stated that it “recognises that there are different cultural habits related to alcohol consumption in the various Member States”, but it treated the (then 25) Member States as a single area, and their half billion inhabitants as one group of consumers. In this chapter we attempt, while considering the figures for Europe as a whole, to expose the very wide disparities between areas, States, age groups and sexes, before doing the same for the United Kingdom and its constituent parts.
12. It takes time to collect and analyse data, and most of the information on which the Strategy was based is now at least 10 years old. We aim to consider the position as it is now with the latest figures available to us. The 2012 WHO report, which is based on data collected in 2011,<sup>11</sup> is a valuable source of information. We also took oral evidence from two of the report’s authors, Professor Peter Anderson and Dr Lars Møller, Programme Manager, Alcohol and Illicit Drugs, WHO Regional Office for Europe.
13. WHO statistics sometimes refer to Europe—in which Russia is not included—and sometimes to the EU. The same is true of figures from DG SANCO. Within the United Kingdom, some statistics refer to the UK as a whole and some only to its constituent parts. Where we have cited figures, in addition to giving their source we have made clear precisely what they relate to.

### **Terminology**

14. There is no general agreement, either in the relevant literature or in the evidence we received, or indeed between different States or organisations, about descriptions of levels of consumption: what constitutes safe, responsible, harmful or hazardous drinking, binge drinking, or alcohol abuse. Some of the terms used by the WHO are generally recognised.<sup>12</sup>
15. The EU Strategy defined hazardous consumption as “a level of consumption or pattern of drinking that is likely to result in harm should present drinking habits persist”. It used the WHO definition of harmful use of alcohol: “a pattern of alcohol use that is causing damage to health, and the damage may be physical (as in cases of liver cirrhosis) or mental (as in cases of depressive episodes secondary to heavy consumption of alcohol)”.
16. In the United Kingdom the following measures of the strength of alcoholic drinks are generally accepted.

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<sup>10</sup> The opening words of the EU Strategy.

<sup>11</sup> WHO Regional Office for Europe, *Alcohol in the European Union: Consumption, harm and policy approaches* (2012): [http://www.euro.who.int/\\_data/assets/pdf\\_file/0003/160680/e96457.pdf](http://www.euro.who.int/_data/assets/pdf_file/0003/160680/e96457.pdf) [accessed 24 February 2015]

<sup>12</sup> WHO, *Global status report on alcohol and health 2014* (2014): [http://apps.who.int/iris/bitstream/10665/112736/1/9789240692763\\_eng.pdf?ua=1](http://apps.who.int/iris/bitstream/10665/112736/1/9789240692763_eng.pdf?ua=1) [accessed 24 February 2015]

### Box 1: UK measures of alcohol

One unit of alcohol is 10ml or 7.9 grams of pure alcohol. One litre of drink which is x% alcohol by volume (ABV) is therefore x units of alcohol. A 750ml bottle of wine of 12% ABV contains 9 units. A single measure of spirits is 1 unit. A pint (560ml) of normal strength beer or a medium (175ml) glass of wine is 2 units. A large (250ml) glass of wine is 3 units, and a pint of strong beer 4 units. The Government recommends that men should drink no more than 3–4 units a day, and women no more than 2–3 units a day.

17. Even terms such as “responsible drinking” or “safe drinking” cannot easily be quantified. Consumption which would usually be classed as both would generally be regarded as neither safe nor responsible if indulged in by a driver. For our report we believe that the terms “moderate drinking”, “harmful drinking” and “binge drinking” will be generally understood. We use “alcohol abuse” to embrace both harmful and binge drinking.

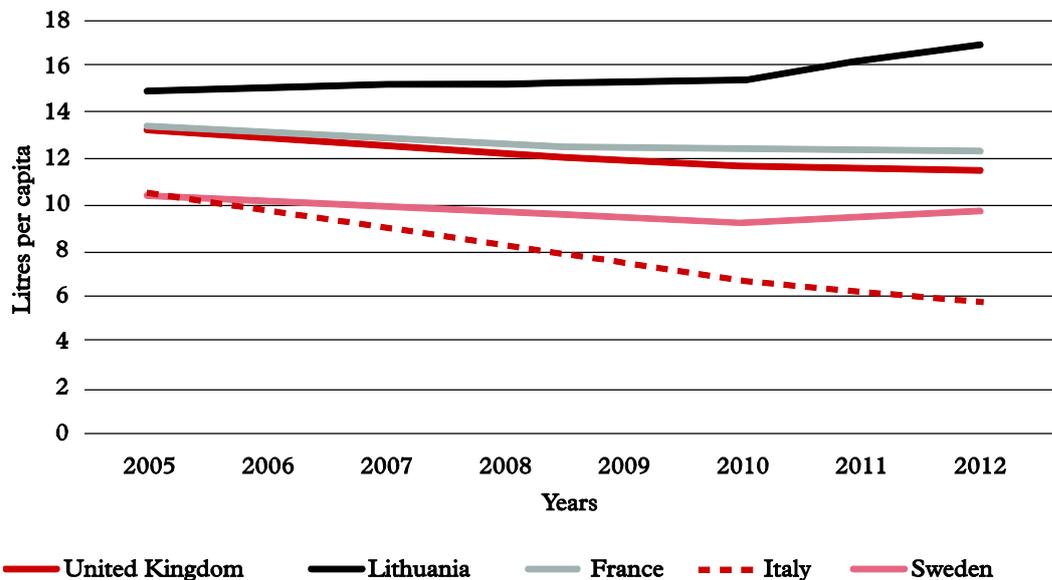
#### European alcohol consumption

18. Europe is the region with the highest *per capita* alcohol consumption in the world. In Europe, alcohol abuse is the third leading risk factor for disease and mortality after tobacco and high blood pressure. The WHO estimated that in 2009, average adult (aged 15+ years) alcohol consumption in the EU was 12.5 litres of pure alcohol—27g of pure alcohol a day, more than double the world average.<sup>13</sup>
19. The WHO divides the EU into four regions. The United Kingdom, together with Ireland, Austria, Belgium, France, Germany, Luxembourg and the Netherlands belong to the ‘Central-Western and Western Europe group’. The region has a high GDP, about 10% above the EU average. Beer has been the preferred drink in all countries except France (which is sometimes grouped with Southern Europe).
20. The ‘Nordic countries’ (which include Denmark, Finland and Sweden) used to experience heavy episodic drinking of spirits, but recently the overall consumption has been lower than the EU average, and spirits are no longer the dominant alcoholic beverage. The countries of ‘Southern Europe’ (Cyprus, Greece, Italy, Malta, Portugal, Spain and, in some classifications, France) have a Mediterranean drinking pattern. Wine has traditionally been produced and drunk, characterized by almost daily drinking of alcohol (often wine with meals), avoidance of irregular heavy drinking and no acceptance of public drunkenness. The overall volume of consumption has traditionally been high, but it has been falling over recent decades.
21. Finally the countries of ‘Central-Eastern and Eastern Europe’ are the A8 which acceded to the EU in 2004, and Bulgaria and Romania—Croatia is not included in the WHO classification. In 2005 their GDP was on average half that of the rest of the EU, but alcohol consumption was on average higher, with a higher rate of unrecorded consumption.

<sup>13</sup> WHO Regional Office for Europe, *Alcohol in the European Union: Consumption, harm and policy approaches* (2012): [http://www.euro.who.int/\\_data/assets/pdf\\_file/0003/160680/e96457.pdf](http://www.euro.who.int/_data/assets/pdf_file/0003/160680/e96457.pdf) [accessed 24 February 2015]. In that report (and hence in our report when quoting from it) ‘Europe’ is defined as the EU plus Norway and Switzerland.

22. There are huge disparities in consumption among the Member States. The chart below shows changes in average *per capita* consumption of alcohol in one Member State from each European region between 2005 and 2012: the UK, Sweden, Lithuania (where in 2012 consumption was highest, at 16.9 litres<sup>14</sup>), and Italy (the lowest consumption of a Member State, at 5.7 litres).<sup>15</sup>

**Figure 1: Litres of pure alcohol consumed per person aged 15+ per year (recorded and unrecorded), time series of 7 years**



Source: European Commission, *European Core Health Indicators (ECHI)*

### United Kingdom expenditure and revenue

23. United Kingdom households spend some £15 billion a year on the consumption of alcoholic drinks, around 18% of their total expenditure on food and drink. The Government collected £10.5 billion in alcohol duties in 2013–14, around 2% of all tax revenue.<sup>16</sup> This accounts for 38.8% of all alcohol duty paid by EU consumers across Member States, more than France, Germany, Italy, Poland and Spain combined. UK consumers pay 68% of all tax on wine raised in the EU.<sup>17</sup> In all Member States alcohol duties are a significant revenue raiser, but in none more than the UK.

<sup>14</sup> This is the equivalent of some 180 bottles of wine 12.5% ABV.

<sup>15</sup> These figures are from European Core Health Indicators (ECHI) for 2012 and are for total recorded and unrecorded consumption for 2012, see [http://ec.europa.eu/health/alcohol/indicators/index\\_en.htm](http://ec.europa.eu/health/alcohol/indicators/index_en.htm) [accessed 24 February 2015]. Total alcohol consumption is defined as the total (recorded + unrecorded) amount of alcohol consumed per adult (15+ years) over a calendar year, in litres of pure alcohol or total Adult Per Capita (Total APC). Recorded alcohol consumption refers to official statistics (production, import, export, and sales or taxation data), while the unrecorded alcohol consumption refers to alcohol which is not taxed and is outside the usual system of governmental control.

<sup>16</sup> HMRC, *Estimation of Price Elasticities of Demand for Alcohol in the UK* (16 December 2014): [https://www.gov.uk/government/uploads/system/uploads/attachment\\_data/file/387513/HMRC\\_WorkingPaper\\_16\\_Alcohol\\_elasticities\\_final.pdf](https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/387513/HMRC_WorkingPaper_16_Alcohol_elasticities_final.pdf) [accessed 24 February 2015]

<sup>17</sup> European Commission, DG Taxation and Customs Union (DG TAXUD), excise duty tables ref 1.037, July 2013, quoted in: Wine and Spirit Trade Association (WSTA), *Budget submission 2014: Supporting a Great British Industry* (2014): <http://www.wsta.co.uk/images/budget/Budget2014FINAL.pdf> [accessed 24 February 2015].

## Differences in consumption levels and patterns

### *Differences between men, women and children*

24. Drinking patterns between men and women, and between adults and children, vary greatly across the Member States, but in every state men drink more than women, and suffer more harm from drinking.
25. The Health and Social Care Information Centre (HSCIC) is an executive agency sponsored by the Department of Health and is the national provider of information, data and IT systems for commissioners, analysts and clinicians in health and social care. The data are for England alone. They show that:
- between 2005 and 2012 the proportion of men who drank alcohol in the week before being interviewed fell from 72% to 64%, and the proportion of women fell from 57% to 52% in Great Britain;
  - among adults who had drunk alcohol in the last week, 55% of men and 53% of women drank more than the recommended daily amounts, including 31% of men and 24% of women who drank more than twice the recommended amounts in 2012;
  - in 2012, 43% of school pupils aged 11–15 said that they had drunk alcohol at least once. This continues the downward trend since 2003, when 61% of pupils had drunk alcohol.
26. Daniel Greaves, the Head of the Home Office Drugs and Alcohol Unit, told us that in recent years there had been “a marked decline” in underage drinking: “Over the last decade the proportion of 11–15 year olds who have ever had an alcoholic drink reduced from 61% to 39%, and those who had drunk in the last week from 25% to 9% ... If we contrast it with 10, 20, 25 years ago, it is much harder for a young person to access a drink than it would have been previously. The penalties are stiffer; there is much greater awareness about the harms associated with early exposure to drink and early drunkenness; and there is much greater focus on standards and policies within retail outlets and pubs, and much greater expectation.”<sup>18</sup> While these trends in underage drinking are welcome, the UK still has some of the highest levels of childhood binge drinking in Europe, with 52% of UK children aged 11–15 reportedly binge drinking in the last 30 days in 2011, compared to the 39% average.<sup>19</sup>
27. In the view of some of our witnesses the real problem is adult drinking. Prof Anderson, commenting on the current EU Youth and Binge Drinking Action Plan, told us: “This is not the problem that Europe faces. The problem that Europe faces is heavy drinking ... including binge drinking among the adult population. If you look back 20 or 30 years, normally what would happen as people aged was that they would start to drink less, but that does not seem to be occurring. As the middle-aged get older, they take forward the heavy drinking pattern and this is going to cause a lot of problems for the European Union; as that group goes on into older age, we will get more and more problems.”<sup>20</sup>

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<sup>18</sup> [Q 172](#)

<sup>19</sup> European School Survey Project on Alcohol and Other Drugs (ESPAD survey), ‘United Kingdom Key results 2011’: <http://www.espad.org/unitedkingdom/> [accessed 24 February 2015] “Europe” here includes Russia, Ukraine, Moldova and Turkey.

<sup>20</sup> [Q 5](#)

*Differences within the United Kingdom*

28. Figures for the UK as a whole disguise large variations between regions. Dr Evelyn Gillan, Chief Executive of Alcohol Focus Scotland, told us: “We know that in Scotland death rates from alcohol-related mortality are seven times higher in areas that we describe as deprived than anywhere else ... that is not because everybody on lower incomes is drinking more ... people on lower incomes on average drink less than people on higher incomes, but those who do drink, drink much more harmfully.” Professor Nick Sheron, the Head of Clinical Hepatology at the University of Southampton added: “There is a ten-fold difference in alcohol-related mortality between the highest and lowest social classes in Wales.”<sup>21</sup>
29. Health, and hence alcohol policy, is a devolved matter in Scotland, Wales and Northern Ireland. Scotland has its own Licensing Act. On 5 December 2014 Scotland reduced its drink driving alcohol level to 50mg of alcohol per 100ml of blood, leaving the rest of the UK, with Malta, as the only countries of the EU with an 80mg limit. In Chapter 6 we explain the variations within the UK on introducing minimum unit pricing (MUP).

**Alcohol-related harm***Harm to the drinker*

30. The passage in the 2012 WHO report dealing with the impact of alcohol on health includes an introduction by Prof Anderson, which is summarised in Box 2.

**Box 2: Impact of Alcohol on Health**

Apart from being a drug of dependence, alcohol has been known for many years as a cause of some 60 different types of disease and condition, including injuries, mental and behavioural disorders, gastrointestinal conditions, cancers, cardiovascular diseases, immunological disorders, lung diseases, skeletal and muscular diseases, reproductive disorders and pre-natal harm, including an increased risk of prematurity and low birth weight. In recent years, overwhelming evidence has confirmed that both the volume of lifetime alcohol use and the combination of frequency of drinking and amount drunk per incident increase the risk of alcohol-related harm, largely in a dose-dependent manner, with the higher the alcohol consumption, the greater the risk.

31. There are differing views as to the correlation of some of these conditions with alcohol consumption, and the degree of consumption which produces some of these diseases, but this general statement of the impact of alcohol consumption on health is not seriously contested.
32. The WHO Report estimates that in the EU in 2004 94,451 men and 25,284 women aged between 15 and 64 years died of alcohol-attributable causes (total 119,735). This corresponds to 13.9% of all deaths in men and 7.7% of all deaths in women in this age category (11.8% of all deaths).<sup>22</sup> Again, these

<sup>21</sup> [Q 39](#)

<sup>22</sup> This contrasts with a drug-induced mortality rate of 17 deaths per million in the same age range in Europe in 2012: European Monitoring Centre for Drugs and Drug Addiction (EMCDDA), *European Drugs Report*

figures mask very large regional variations. Over a quarter of male deaths in that age group in the Baltic States in 2004 were attributable to alcohol-related causes, compared to 9.2% in Southern Europe.

33. The UK figures are 8% of men, and 6% of women. Nevertheless the long-term trend in harm to the drinker's health in the UK, outlined in Box 3, is worrying.

**Box 3: Alcohol attributable and alcohol-specific deaths in the UK, 2001–11**

Alcohol-attributable deaths in England rose by 7%, from 14,000 in 2001 to 15,000 in 2010. In contrast, deaths from all causes in England fell by 7% over this period. Over the same period, alcohol-specific deaths rose by 30%. The rate of liver deaths in the UK has nearly quadrupled over 40 years, a very different trend from most other European countries. Approximately 60% of people with liver disease in England have alcoholic liver disease, which accounts for 84% of liver deaths. In addition, the rate of alcohol-related hospital admissions has also continued to rise by an average of 4% each year over the eight years 2002–03 to 2010–11. Alcohol is now one of the three biggest lifestyle risk factors for disease and death in the United Kingdom, after smoking and obesity.<sup>23</sup>

34. The more recent figures are slightly more encouraging. ONS figures for alcohol-related deaths of all age groups in the United Kingdom in 2012 are summarised in Box 4.<sup>24</sup>

**Box 4: Alcohol-related deaths in the UK, 2012**

- In 2012 there were (excluding road traffic and other accidents) 8,367 alcohol-related deaths in the UK, 381 fewer than in 2011 (8,748).
- Males accounted for approximately 65% of all alcohol-related deaths in the UK in 2012.
- Death rates were highest among men aged 60 to 64 years (42.6 deaths per 100,000 population) and women aged 55 to 59 years (22.2 deaths per 100,000).
- Of the four UK constituent countries, death rates have been lowest in England, significantly higher in Wales and Northern Ireland, and much higher in Scotland.
- In 2002 the death rate in Scotland was twice that in the rest of the UK (for males 40 deaths per 100,000 population compared to 15 in England; for females 16 compared to 7); by 2012 rates in England were substantially unchanged, but rates in Scotland were down to 25 for males and 10 for females.

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2014: *trends and developments* (2014): [http://www.emcdda.europa.eu/attachements.cfm/att\\_231875\\_EN\\_EDRTD2014-annotated.pdf](http://www.emcdda.europa.eu/attachements.cfm/att_231875_EN_EDRTD2014-annotated.pdf) [accessed 24 February 2015]. In other words, in Europe some 7,000 times as many men and women aged between 15 and 64 die of alcohol-attributable causes as die of drug overdoses.

<sup>23</sup> Home Office, *A Minimum Unit Price for Alcohol: Home Office Impact Assessment* (1 November 2012): [https://www.gov.uk/government/uploads/system/uploads/attachment\\_data/file/157763/ia-minimum-unit-pricing.pdf](https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/157763/ia-minimum-unit-pricing.pdf) [accessed 24 February 2015]. The terms “alcohol-attributable” and “alcohol-specific” are those used in that Impact Assessment.

<sup>24</sup> *Ibid.*

35. For England only, the HSCIC figures show that in 2012–13 there were an estimated 1,008,850 hospital admissions related to alcohol consumption where an alcohol-related disease, injury or condition was the primary reason or a secondary diagnosis, making 1,890 alcohol-related hospital admissions per 100,000 population. Of the overall admissions, 65% were male patients; however among under 16s, females accounted for 55% per cent of all admissions to hospital with alcohol related diseases, injuries and conditions.
36. Within England, there are also wide variations. HSCIC figures show that in 2012–13 the rate of alcohol-related admissions to hospital varied from an estimated 2,500 per 100,000 population in North East Region to 1,500 admissions per 100,000 population in South East Region. Figures from the Office for National Statistics (ONS) show that in England, alcohol-related death rates were highest among regions in the North and lowest among those in the South throughout the period 2002–12.<sup>25</sup>
37. The ONS figures show that in England and Wales, 63% of all alcohol-related deaths in 2012 were caused by alcoholic liver disease, with 16% of these deaths occurring among those aged 55 to 59 years. Prof Sheron, whose specialism is liver diseases, gave us graphic illustrations of the correlation between alcohol consumption and liver disease, giving as an example “countries such as France, Spain and Italy, which historically have had very, very high levels of *per capita* alcohol consumption, liver mortality and alcohol-related harm. Alcohol consumption has been in freefall in those countries, and liver mortality has followed it almost exactly.”<sup>26</sup>
38. Dr Gillan agreed, giving us the converse argument: “People often think that the UK has always had this heavy drinking culture, but in 1960 the UK had one of the lowest liver cirrhosis mortality rates in western Europe ... We have moved from a position of having one of the lowest liver cirrhosis rates in western Europe to having one of the highest.”<sup>27</sup>

### *Harm to others*

39. We thought it important to hear from witnesses who have experience in England of the treatment of alcohol abuse, and its effect on their families and on the wider community. We took evidence from Adrian Brown, Alcohol Liaison Nurse at Northwick Park and Central Middlesex Hospitals, who told us that the change in the culture of people who were drinking had gone from “mostly male to more like 50–50 men to women in younger people”. Among this group, the people seen in A&E were just as likely to be female as male.<sup>28</sup>
40. We also heard from Vivienne Evans, the Chief Executive of Adfam, a charity supporting families affected by drug and alcohol use. She told us that ChildLine received on average 100 calls a week from children and young people about substance misuse by their parents, and the majority of these were about alcohol.<sup>29</sup>

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<sup>25</sup> ONS *Statistical bulletin, Alcohol-related deaths in the United Kingdom registered in 2012* (19 February 2014): [http://www.ons.gov.uk/ons/dcp171778\\_353201.pdf](http://www.ons.gov.uk/ons/dcp171778_353201.pdf) [accessed 24 February 2015]

<sup>26</sup> [Q 34](#)

<sup>27</sup> [Q 37](#)

<sup>28</sup> [Q 219](#)

<sup>29</sup> [Q 218](#)

41. The harm caused to the unborn child by heavy drinking is also beyond dispute. Many of our witnesses discussed how labelling could minimise consumption during pregnancy. We consider this further in Chapter 7.

#### *Drink driving*

42. Drink driving has the most obviously serious effect on third parties. In the EU in 2010 1.04 deaths per 100,000 people (0.56 deaths per 100,000 women and 1.55 deaths per 100,000 men) were caused by alcohol-attributable motor vehicle accidents and assaults. This burden of alcohol-attributable harm to others was greatest in the Central-Eastern and Eastern country group, with 2.23 deaths per 100,000 people (1.20 deaths per 100,000 women and 3.36 deaths per 100,000 men).<sup>30</sup>
43. The European Transport Safety Council (ETSC) has reported that of the 31,000 deaths in road collisions in the EU in 2010, official statistics attribute 11.5% to drink driving. However, it is thought that massive under-reporting distorts the picture: the Commission estimates that 25% of all road deaths across the EU are alcohol-related. Using this figure, the ETSC estimates that 6,500 deaths would have been prevented in 2010 if all drivers had obeyed the law on drink driving.<sup>31</sup> Within the UK, in the last 10 years road casualties caused by drink driving have fallen dramatically, but in 2012 there were still 230 deaths in the UK due to drink driving, accounting for 13% of all road fatalities.<sup>32</sup>

#### *Domestic violence*

44. Adrian Lee, the Chief Constable of Northamptonshire and National Police Lead for Alcohol Licensing and Harm Reduction, told us in written evidence that it was estimated that alcohol was a factor in a third of all domestic abuse incidents.<sup>33</sup> The third parties in these cases were not just the offender's partner or other direct victims, but extended to any children within the relationship. As a result of witnessing incidents, children might develop anxiety or behavioural issues, for example, becoming withdrawn, exhibiting violence themselves, suffering sleep disturbance and performing poorly at school.

#### *Other criminal offences*

45. Mr Greaves told us that alcohol also played a large part in the amount and extent of public disorder:

“We know from the Crime Survey for England and Wales that in about 49% of violent incidents the victim believed the perpetrator to be under the influence of alcohol. This is particularly the case where the violence is committed by a stranger. It rises to 70% in those cases ... one-fifth of people perceive people being drunk and behaving antisocially as a very

<sup>30</sup> WHO *Status Report on alcohol and health in 35 European countries* (2013): [http://www.euro.who.int/data/assets/pdf\\_file/0017/190430/Status-Report-on-Alcohol-and-Health-in-35-European-Countries.pdf](http://www.euro.who.int/data/assets/pdf_file/0017/190430/Status-Report-on-Alcohol-and-Health-in-35-European-Countries.pdf) [accessed 24 February 2015]

<sup>31</sup> ETSC, *4th Annual Road Safety Performance Index (PIN) Report* (June 2010): <http://etsc.eu/4th-annual-road-safety-performance-index-pin-report/> [accessed 24 February 2015]

<sup>32</sup> These figures from the Department for Transport include drivers as well as third parties.

<sup>33</sup> Faculty of Public Health of the Royal College of Physicians of the United Kingdom, *Alcohol and Violence—Briefing Statement* (2005)

or fairly big problem in their area. We know that a quarter of penalty notices for disorder issued by the police are for drunk and disorderly in a public place. That equated to some 16,000 notices in the year ending June 2014.”<sup>34</sup>

46. Chief Constable Lee told us that in order to obtain a comprehensive snapshot of the demands that alcohol-related incidents place on local policing, he had commissioned a thorough review of all incidents that were reported to Northamptonshire Police during a 24-hour period on Saturday 21 September 2013. The results established that 27% of incidents were alcohol-related and ranged from violence and disorder to other categories such as burglary, criminal damage, drugs offences, missing people, welfare concerns, road traffic matters and suspicious circumstances.<sup>35</sup>
47. Chief Constable Lee also pointed out that the time and associated costs required to deal with a drunk detainee were significantly greater than the equivalent for a sober suspect. Drunk prisoners could not be interviewed, or evidence taken from them, until they were sober, and this extended offenders’ periods in custody and increased associated costs.
48. Mr Greaves estimated that the cost to society of alcohol-related crime at 2010–11 prices was “some £11 billion ... broken down into three components. The first is in the cost incurred in anticipation of crime, so security expenditure. The second is consequence of crime, such as property stolen, and emotional and physical impact. The third is in response to crime; that is, cost to the police and criminal justice system.”<sup>36</sup>

### **The effect of alcohol consumption on the wider economy**

49. The negative effect of alcohol abuse on the wider European economy—death, injury, effects on health of the drinker, effects on others including unborn children, effects on productivity, and many other matters—is almost impossible to quantify. One estimate given to us by Mariann Skar, the Secretary General of Eurocare, was €156 billion. In the UK, the Institute of Alcohol Studies has estimated that absenteeism from the workplace and loss of productivity could alone cost £7.3 billion a year.<sup>37</sup>
50. There is a positive economic effect which should not be overlooked. In their written evidence the British Beer & Pub Association (BBPA), the leading body representing Britain’s brewers and pub companies, pointed out that their members owned around half of the nation’s 49,500 pubs, and that in the UK overall pubs and brewing supported over 900,000 jobs and contributed around £22 billion to the UK economy annually.<sup>38</sup> The Scotch Whisky Association (SWA) told us that the industry supported around 40,000 jobs across the UK, and that the value of Scotch whisky exports in 2013 was £4.3 billion, accounting for nearly 25% of the UK’s total food and drink exports.<sup>39</sup>

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<sup>34</sup> [Q 172](#)

<sup>35</sup> Written evidence from the Association of Chief Police Officers ([EAS0021](#))

<sup>36</sup> [Q 175](#)

<sup>37</sup> Institute for Alcohol Studies, *Economic Aspects of Alcohol Factsheet* (May 2013)

<sup>38</sup> Written evidence from BBPA ([EAS0013](#))

<sup>39</sup> Written evidence from SWA ([EAS0020](#))

51. In other Member States the alcohol industry plays an even more important part. Italy is the world's largest wine exporter by volume and, until last year when it was again overtaken by France, was the world's largest wine producer.<sup>40</sup> Its 200,000 producers employ 1.25 million people and have a combined turnover of €9.5 billion, half of which is raised from exports.<sup>41</sup> Though France exports less than Italy by volume, in 2013 its wine exports were worth €7.6 billion.<sup>42</sup>

### **Medical and social effects of moderate alcohol consumption**

52. Even the smallest quantities of tobacco are harmful, but it is thought by some that, for those in their 60s and 70s or older, alcohol has a preventative effect against cardiovascular mortality which may partly, or in later years even wholly, counteract mortality from other causes.<sup>43</sup> Prof Anderson conceded that a small amount of alcohol could reduce the risk of heart attacks and certain types of stroke, but he argued that “the evidence increasingly shows you need only a really very small amount to get this protective effect and that probably the protective effect is not nearly as big as the previous studies have shown.”<sup>44</sup>
53. And finally, in a report dealing almost exclusively with ways to combat the harm caused by alcohol abuse, we think it should not be forgotten that alcohol, drunk responsibly and in moderation is, rightly in our view, regarded by many people as a pleasure, a social lubricant, and an aid to relaxation and celebration.

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<sup>40</sup> Italian Wine Central, ‘Facts and Figures’: <http://italianwinecentral.com/resources/facts-figures/> [accessed 24 February 2015]

<sup>41</sup> Coldiretti, ‘Vino: Coldiretti, all'estero più della metà della vendemmia 2014’: <http://www.coldiretti.it/News/Pagine/616--%E2%80%9319-Settembre-2014.aspx> [accessed 24 February 2015]

<sup>42</sup> Vin et société, ‘Key figures of the wine industry’: <http://www.vinetsociete.fr/chiffres-cles> [accessed 24 February 2015]

<sup>43</sup> Liverpool John Moores University, *Updating England-specific alcohol-attributable fractions* (2013)—a study commissioned by the Department of Health, Figures 3 and 4. This however is contested by others, including a recent report from the INGT-NTO, a Swedish temperance union, and the Swedish Society of Medicine, *Alcohol and Society 2014, the effects of low-dose alcohol consumption* (2014).

<sup>44</sup> [Q 4](#)

## CHAPTER 3: THE EU ALCOHOL STRATEGY 2006–12

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### Background

54. In June 2001 the Council invited the European Commission to propose an EU strategy to complement national policies, aimed at reducing alcohol-related harm.<sup>45</sup> Five years later, in October 2006, the Commission proposed and the Council adopted the first EU Alcohol Strategy with a Communication on ‘An EU strategy to support Member States in reducing alcohol related harm’. The Strategy identified five priority themes under which action was to be taken to address the adverse health effects related to harmful and hazardous alcohol consumption in the EU.

#### Box 5: Priorities of the EU Alcohol Strategy 2006–12

- Protecting young people, children and the unborn child
- Reducing injuries and death from alcohol-related road accidents
- Reducing alcohol-related harm among adults, including in the workplace
- Increasing information, education and awareness raising
- Developing and maintaining a common evidence base

55. Within each of these themes, the Strategy identified the rationale and aims for action, as well as highlighting cases of good practice. It noted the different contexts in which national alcohol strategies operate and stressed the importance of local action. It also set out a ‘health in all policies’ approach by emphasising that “EU competence in health is not confined to specific public health actions. Where possible, the Commission will seek to improve the coherence between policies that have an impact on alcohol-related harm”. The merits of this approach are examined in Chapter 5.
56. Given the EU’s limited competence in the field of public health,<sup>46</sup> the Commission took on a mainly coordinating role. In order to support Member States in implementing the Strategy, a European Alcohol and Health Forum (EAHF) and a Committee on National Alcohol Policy and Action (CNAPA) were established in 2007.
57. The EAHF is a platform where bodies such as European NGOs and trade associations can debate and commit themselves to actions intended to tackle alcohol-related harm.<sup>47</sup> CNAPA is composed of national delegates appointed by the Member States. Its main objectives are “sharing good practices and aiming to achieve the broadest possible consensus and convergence of alcohol policies within the EU”.<sup>48</sup> Unlike the EAHF, CNAPA is not referred

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<sup>45</sup> Council Conclusions of 5 June 2001 on a Community strategy to reduce alcohol-related harm (OJ C 175, 20.6.2001, p. 1): [http://europa.eu/legislation\\_summaries/public\\_health/health\\_determinants\\_lifestyle/c11564a\\_en.htm](http://europa.eu/legislation_summaries/public_health/health_determinants_lifestyle/c11564a_en.htm) [accessed 24 February 2015]

<sup>46</sup> See Appendix 4.

<sup>47</sup> European Commission, ‘European Alcohol and Health Forum: More information’: [http://ec.europa.eu/health/alcohol/forum/forum\\_details/index\\_en.htm](http://ec.europa.eu/health/alcohol/forum/forum_details/index_en.htm) [accessed 24 February 2015]

<sup>48</sup> European Commission, ‘Committee on National Alcohol Policy and Action’: [http://ec.europa.eu/health/alcohol/committee/index\\_en.htm](http://ec.europa.eu/health/alcohol/committee/index_en.htm) [accessed 24 February 2015]

to in the Strategy. The structure and functioning of both bodies is discussed in more detail in Chapter 8.

58. The Commission further allocated funding to a wide range of projects and research on alcohol-related harm, which was provided through the EU's health and research programmes. A list of projects on alcohol funded since 2003 is available on the Commission's public health website.<sup>49</sup> We consider this further in Chapter 9.
59. In 2012 DG SANCO commissioned an evaluation of the Strategy and its added value,<sup>50</sup> which found that several Member States introduced or strengthened national alcohol strategies between 2006 and 2012, and that the Strategy's five priorities remained relevant. The evaluation was criticised by the Commission's Unit for Evaluation for failing to establish a causal relationship between these developments and the implementation of the Strategy, and for describing "outputs rather than outcomes". This was in a sense inevitable, as the Strategy had no inbuilt evaluation mechanism and did not include quantitative targets, a problem to which we refer below in paragraphs 64–66. Nonetheless many of our witnesses, including the Government, endorsed the 2012 evaluation and regarded it as confirmation that the Strategy had generally been useful and should continue in some form, albeit taking into account their numerous suggested modifications.<sup>51</sup>

### Impact on the United Kingdom

60. We were told of no concrete benefits to the UK in terms of reduction in alcohol consumption or alcohol-related harm which could specifically be attributed to the Strategy, and witnesses could not identify any particular national policy approach which might have been influenced by the Strategy.<sup>52</sup> However, there was a feeling among witnesses that this was due to the pre-existing high standards of UK alcohol policies.
61. Ms Ellison, for instance, stated that "I have not seen a huge impact on us, but I think that is because we probably took alcohol policy and the enforcement of various aspects of alcohol policy pretty seriously."<sup>53</sup> Nonetheless, she regarded the Strategy as a useful point of reference for the UK, in that it constituted an international agreement which the Government was keen to observe and "report against".<sup>54</sup>
62. Furthermore, Miles Beale, Chief Executive of the Wine and Spirits Trade Association, was of the opinion that through the Strategy, the UK had been able to positively influence other Member States: "[the Strategy] is more useful to countries other than the UK, because ... the UK has made great

<sup>49</sup> European Commission, 'Alcohol Projects': [http://ec.europa.eu/health/alcohol/projects/index\\_en.htm](http://ec.europa.eu/health/alcohol/projects/index_en.htm) [accessed 24 February 2015]

<sup>50</sup> COWI-Milieu, *Assessment of the added value of the EU strategy to support Member States in reducing alcohol-related harm* (December 2012): [http://ec.europa.eu/health/alcohol/docs/report\\_assessment\\_eu\\_alcohol\\_strategy\\_2012\\_en.pdf](http://ec.europa.eu/health/alcohol/docs/report_assessment_eu_alcohol_strategy_2012_en.pdf) [accessed 24 February 2015]. In this report we refer to this document as "the 2012 evaluation".

<sup>51</sup> Written evidence from the Advertising Association ([EAS0015](#)), Association of Convenience Stores, ([EAS0010](#)) BBPA ([EAS0013](#)), spiritsEUROPE ([EAS0025](#)) and UK Government Department of Health ([EAS0019](#)); [Q 14](#) (Crispin Acton), [Q 119](#) (Simon Spillane)

<sup>52</sup> [Q 37](#) (Dr Evelyn Gillan)

<sup>53</sup> [Q 228](#)

<sup>54</sup> [Q 228](#)

progress and those ideas have been picked up disproportionately elsewhere.”<sup>55</sup>

### Key achievements and shortcomings

63. When asked to assess whether the Strategy had met its overall objective of reducing alcohol-related harm in the EU, many witnesses highlighted the difficulty of attributing outcomes accurately to any one policy measure or strategy. The complexity of policy-making and the many cultural, economic and social differences between Member States to which we have referred in the previous chapter, mean that it is rarely possible to establish a clear causal connection between a particular measure and increases or decreases in the level of alcohol-related harm.<sup>56</sup>
64. This problem is exacerbated by the lack of indicators, standardised data collection systems or an evaluation mechanism by which it would have been possible to assess whether or not the Strategy had achieved its objective. Eric Carlin, the Director of the NGO Scottish Health Action on Alcohol Problems (SHAAP), noted that, in the absence of SMART targets,<sup>57</sup> it was difficult to assess what would have been achieved had the Strategy not been in place.<sup>58</sup> This problem was also acknowledged by the 2012 evaluation of the Strategy, which stated that “as there is limited availability of timely EU-wide data, evidence of the added value of EU level action may only become available in the long term”.
65. Prof Anderson was therefore critical of the Strategy’s overall effect, stating that “there is little evidence that it has had any impact in reducing alcohol-related harm in Europe ... There is no doubt the Strategy made a lot of noise and brought a lot of people together, but if you judge it in terms of whether or not it has had an impact in reducing harm, which was its main goal, one would have to say that it has not achieved that.”<sup>59</sup> Professor Petra Meier from the University of Sheffield supported this view, adding that: “What the Strategy lacked was a clear focus on how to achieve change. It said it would do all sorts of things, but there was nothing in there that was clear, action-focused messaging.”<sup>60</sup>
66. Other witnesses were more positive, and felt that despite not meeting its broad aims, the Strategy had been useful in general and also in some specific respects. Many felt that it had focused the discussion on alcohol-related harm, and Mr Carlin said: “The fact that the alcohol Strategy exists keeps in the public profile that alcohol harm remains significant ... Just its very existence makes a statement that has an impact.”<sup>61</sup>
67. Glenis Willmott MEP, a member of the European Parliament’s Environment, Public Health and Food Safety Committee (ENVI), thought that the Strategy had provided an important impetus for action in several

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<sup>55</sup> [Q 188](#)

<sup>56</sup> [Q 102](#) (Mariann Skar and Eric Carlin), [Q 129](#) (Simon Spillane)

<sup>57</sup> SMART targets are those which are specific, measurable, attainable, realistic and timely.

<sup>58</sup> [Q 102](#)

<sup>59</sup> [Q 2](#)

<sup>60</sup> [Q 2](#)

<sup>61</sup> [Q 102](#)

Member States: “More countries now have national alcohol strategies in place. Ten countries adopted or revised a national strategy after 2006, so that has to be seen as a positive thing ... All Member States do awareness-raising activities that they would not have done in the past.”<sup>62</sup> The industry representative body spiritsEUROPE agreed, writing that: “The Strategy has offered a stimulus to action and has pushed stakeholders towards meaningful action to reduce alcohol-related harm.”<sup>63</sup>

68. Many witnesses suggested that the Strategy’s key achievement was its ability to facilitate the exchange of best practices through CNAPA and the EAHF.<sup>64</sup> Ms Skar noted that in this way, the Strategy “has increased partnerships and networking across Europe”.<sup>65</sup> Representatives of the alcohol and advertising industries were particularly eager to maintain the ‘multi-stakeholder approach’ introduced through the EAHF, which was seen as an “effective way of exchanging good practice”,<sup>66</sup> and described by Mr Ashworth, Chief Executive of the Portman Group, as “very valuable”.<sup>67</sup> This approach has not been without difficulties, as we explain in Chapter 8.
69. There was consensus among witnesses that the Strategy had been more successful in some of its five priority areas than others. Crispin Acton, Programme Manager for Alcohol Misuse at the Department of Health, referred to the 2012 evaluation of the Strategy to describe steps taken under its first priority area: “There have been quite a lot of moves towards greater commonality on underage purchasing, so there is much more similarity in the age levels for underage purchasing and improved enforcement.”<sup>68</sup>
70. Ms Ellison and Mr Acton also mentioned a reduction in drink driving incidents as a specific area in which the Strategy had influenced and improved action across the EU.<sup>69</sup> In this regard Katherine Brown, the Director of the Institute of Alcohol Studies, said: “There have been some specific improvements; for example, some Member States have lowered their blood alcohol limit for the legal limit for drink driving ... at the moment the UK and Malta remain the only countries with the highest legal limit that is above the recommended European Commission limit.”<sup>70</sup>
71. Prof Sheron thought that the Strategy had been successful in increasing information and raising awareness, its fourth priority: “The Strategy has done quite a bit to do that, and the research projects funded by the Strategy, such as the ALICE RAP project,<sup>71</sup> have also contributed.”<sup>72</sup>

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<sup>62</sup> [Q 153](#)

<sup>63</sup> Written evidence from spiritsEUROPE ([EAS0025](#))

<sup>64</sup> For example [Q 53](#) (Guy Parker) and [Q 202](#) (Henry Ashworth)

<sup>65</sup> [Q 100](#)

<sup>66</sup> [Q 187](#) (Miles Beale), written evidence from the Advertising Association ([EAS0015](#))

<sup>67</sup> [Q 202](#)

<sup>68</sup> [Q 14](#)

<sup>69</sup> [Q 228](#) (Jane Ellison MP)

<sup>70</sup> [Q 34](#). Since Ms Brown gave evidence, on 5 December 2014 Scotland reduced its drink driving alcohol level to 50mg of alcohol per 100ml of blood.

<sup>71</sup> ALICE RAP is a European research project, co-financed by the European Commission, which started in April 2011 and aims to stimulate a broad and productive debate on science-based policy approaches to addictions.

<sup>72</sup> [Q 35](#)

72. Several witnesses criticised the failure by the Strategy to achieve its goals in the fifth priority area, the development of a common evidence base. Representatives of the Government and the European spirits industry were disappointed that not enough progress had been made with regard to collecting comparable standardised data on alcohol consumption and alcohol-related harm across the EU.<sup>73</sup> Furthermore, the alcohol and advertising industries were highly critical of EU-funded research conducted under the Strategy. We consider both these issues in Chapter 9.

### EU action on alcohol-related harm since 2012

73. At the beginning of 2014, the ENVI Committee of the European Parliament started work towards a resolution calling on the European Commission to develop a new EU Alcohol Strategy. The final text was expected to be adopted in the April Plenary session of the European Parliament, but the EU Alcohol Strategy resolution was not included in its final discussions. The ENVI Committee last discussed the current state of play regarding the EU Alcohol Strategy at its meeting on 29 January 2015.
74. In January 2014 a Joint Action on Reducing Alcohol Related Harm (RARHA) was created within CNAPA in order to “continue work on key priorities of the EU Alcohol Strategy”.<sup>74</sup> Over the course of three years, the Joint Action will focus on three core work areas: providing comparable cross-country data on levels and patterns of alcohol consumption and alcohol-related harm (including third party harms), fostering consensus on good practice regarding the setting of guidelines on low-risk drinking, and facilitating the exchange of good practices among health authorities by establishing a toolkit on using information and education to reduce alcohol-related harm.
75. On 16 September 2014 CNAPA endorsed an Action Plan on youth and heavy episodic drinking for the period 2014–16.<sup>75</sup> The Action Plan identifies six areas for action including related actions and operational objectives. It claims to do so as “part of the continuing work under the EU Alcohol Strategy”. The Summary Report of the 15th Plenary Meeting of the EAHF confirms this relationship, stating that the Action Plan “is not intended to replace an EU strategy but rather builds upon and complements some objectives of the existing Strategy.”<sup>76</sup>

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<sup>73</sup> Q 23 (Crispin Acton), Q 130 (Paul Skehan)

<sup>74</sup> RARHA, ‘Background and Purpose’: <http://www.rarha.eu/About/BackgroundPurpose/Pages/default.aspx> [accessed 24 February 2015]

<sup>75</sup> CNAPA, *Action Plan on Youth Drinking and on Heavy Episodic Drinking (Binge Drinking) (2014–16)* (September 2014): [http://ec.europa.eu/health/alcohol/docs/2014\\_2016\\_actionplan\\_youthdrinking\\_en.pdf](http://ec.europa.eu/health/alcohol/docs/2014_2016_actionplan_youthdrinking_en.pdf) [accessed 24 February 2015]

<sup>76</sup> European Alcohol and Health Forum, *15th Plenary Meeting, summary report* (6 November 2014): [http://ec.europa.eu/health/alcohol/docs/ev\\_20141106\\_sumrep\\_en.pdf](http://ec.europa.eu/health/alcohol/docs/ev_20141106_sumrep_en.pdf) [accessed 24 February 2015]

### Box 6: Objectives of the Action Plan on Youth and Heavy Episodic Drinking

- Reduce heavy episodic drinking (binge drinking)
- Reduce accessibility and availability of alcoholic beverages for youth
- Reduce exposure of youth to alcohol marketing and advertising
- Reduce harm from alcohol during pregnancy
- Ensure a healthy and safe environment for youth
- Support monitoring and increase research

76. CNAPA is currently carrying out a scoping exercise for the Commission in order to inform its next steps. In addition, the current Latvian Presidency has confirmed that it will “follow the work of [CNAPA], and is in the process of developing a scoping paper on the vision of future actions to be taken in the area of an alcohol policy in the EU. The Presidency will put in the effort required to bring the attention of EU health ministers to issues regarding alcohol and nutrition.”<sup>77</sup>

#### The current status of the 2006–12 Strategy

77. The terminal date of 2012 is given to the Strategy in its final section: “the Commission ... presents a comprehensive strategy to reduce alcohol-related harm in Europe until the end of 2012”. This begs the question what the significance, if any, is of the last words “until the end of 2012”.
78. The wording of both the RARHA Joint Action and the 2014–16 Action Plan seems to indicate that the EU Alcohol Strategy has remained valid as a policy tool past its expiry date of 2012. This is confirmed by the Summary Report of the 15th Plenary Meeting of the EAHF on 6 November 2014, which states that “For the time being, the existing goals and objectives of the alcohol Strategy remain valid.”<sup>78</sup>
79. This was also the view of many of our witnesses, but not of several public health representatives, who thought that the failure to renew the Strategy in 2012 meant that there was currently a dangerous gap in EU alcohol policy. For example, the Institute for Alcohol Studies regarded “the failure to establish a renewed Strategy in 2012 as a significant setback for achieving progress on reducing alcohol harm in Europe.”<sup>79</sup> Eurocare submitted that “The absence of a current EU Alcohol Strategy means that there is no comprehensive policy framework in existence at the EU level that can be compared to the WHO Global Alcohol Strategy or WHO EU Alcohol Action Plan.”<sup>80</sup>

<sup>77</sup> *The programme of the Latvian Presidency of the Council of the European Union*: [https://eu2015.lv/images/PRES\\_prog\\_2015\\_EN-final.pdf](https://eu2015.lv/images/PRES_prog_2015_EN-final.pdf) [accessed 24 February 2015]. See also written statement by Jane Ellison MP: HC Deb, 9 December 2014, [col 33WS](#).

<sup>78</sup> European Alcohol and Health Forum, *15th Plenary Meeting, summary report* (6 November 2014): [http://ec.europa.eu/health/alcohol/docs/ev\\_20141106\\_sumrep\\_en.pdf](http://ec.europa.eu/health/alcohol/docs/ev_20141106_sumrep_en.pdf) [accessed 24 February 2015]

<sup>79</sup> Written evidence from Eurocare ([EAS0006](#)), Alcohol Health Alliance UK ([EAS0012](#)), Balance ([EAS0017](#)), Institute for Alcohol Studies ([EAS0002](#)), and SHAAP ([EAS0001](#))

<sup>80</sup> Written evidence from Eurocare ([EAS0006](#))

80. Ms Willmott suggested that delays in implementing a new strategy in 2012 may have been due to the pending European elections, and that to remedy such difficulties a new strategy “should cover the whole Parliament and slightly beyond that in future so we have time to have a new strategy in place.”<sup>81</sup> She further noted that, despite subsequent political agreement in the European Parliament’s ENVI Committee on the need for a new strategy, the Commission seemed reluctant to move forward: “We were very disappointed by the Commission’s answer when we brought representatives to the committee and asked them what is happening to the alcohol Strategy. To be honest, they just prevaricated and did not really give much of a clear answer.”<sup>82</sup>
81. According to Ms Skar, in 2012 stakeholders across all sectors were keen to see a new EU Alcohol Strategy put into place: “Eurocare was not the only NGO that called for it ... Even industry was sending press releases calling for the Commission to move forward. A number of Member States were calling ... I think the Commission was simply dragging its feet or was not willing to do it.”<sup>83</sup>
82. We think this is a likely explanation. Among its many strategies the EU had a Drugs Strategy, which was the subject of our report *The EU Drugs Strategy*.<sup>84</sup> That Strategy too expired at the end of 2012. Drugs, unlike alcohol, were then the responsibility of the Directorate-General for Justice, and so subject to the Hague Programme for Justice and Home Affairs from 2005–10, and then to its successor, the Stockholm Programme, from 2010–15. That Programme, adopted by the European Council in April 2010, stated:
- “The Union Drugs Strategy (2005–2012) advocates for a global, balanced approach, based on the simultaneous reduction of supply and demand. This strategy will expire during the Stockholm Programme. It must be renewed on the basis of a detailed evaluation of the EU Drugs Action Plan for 2009–2012,<sup>85</sup> carried out by the Commission with the support of the European Monitoring Centre for Drugs and Drug Addiction and Europol.”<sup>86</sup>
83. There is no doubt that those were the views of the Commission, since these words were taken verbatim from a Commission Communication of 10 June 2009.<sup>87</sup> Yet when, for our inquiry into the EU Drugs Strategy, we took evidence from Viviane Reding, then a Vice-President of the Commission and the Commissioner for Justice,<sup>88</sup> she described the Strategy to us as “a thing of the past” and “a nice piece of literature”. Later she said: “You know strategy is wishful thinking”.<sup>89</sup> Despite those views, following an evaluation

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<sup>81</sup> [Q 155](#) (Glenis Willmott MEP)

<sup>82</sup> [Q 155](#) (Glenis Willmott MEP)

<sup>83</sup> [Q 105](#) (Mariann Skar)

<sup>84</sup> European Union Committee, *The EU Drugs Strategy* (26th Report, Session 2010–12, HL Paper 270)

<sup>85</sup> The EU Drugs Strategy 2005–12 included two Action Plans, the second running from 2009–12.

<sup>86</sup> [OJ C 115](#), 4 May 2010, paragraph 4.4.6

<sup>87</sup> Communication from the Commission to the European Parliament and the Council on an area of freedom, security and Justice serving the citizen, [COM\(2009\)262 final](#), paragraph 4.3.1

<sup>88</sup> Now MEP

<sup>89</sup> Oral evidence taken on 28 November 2011 (Session 2010–12), [QQ209, 227](#)

of the Drugs Strategy, the Commission proposed and the Council endorsed on 7 December 2012 a new Drugs Strategy running from 2013–20.

84. Notwithstanding the similar evaluation of the Alcohol Strategy, the Commission undertook no comparable initiative for its renewal, and also refrained from issuing a clear statement on its current status. Unfortunately we were unable to ask DG SANCO to respond to these concerns. We invited Philippe Roux, Head of Unit for Health Determinants, to attend an evidence session in Brussels or, alternatively, to submit written comments to provide us with the Commission's views on issues covered by our inquiry. He declined both opportunities to comment on the record, referring the Committee instead to the outdated 2012 evaluation report of the Strategy as an illustration of the Commission's views on the matter.
85. At the time of the Committee's request, DG SANCO was preparing to welcome the new Commissioner for Health, following the establishment of the new Commission in the autumn of 2014. Since the Strategy had not been renewed two years earlier, it was understandable that Mr Roux did not wish to commit himself to any statements on the future of the Strategy. However, the apathy with which the Commission seems to have greeted the expiry of the previous Strategy has resulted in uncertainty over its current status and on how best to proceed in the interim before the Commission proposes a renewed, amended or entirely new strategy—if indeed this is its intention.

## CHAPTER 4: THE CASE FOR CONTINUED EU ACTION

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### Added value to national action on alcohol-related harm

86. Many of the policy options discussed in this report remain partly or wholly within Member State competence. We received a large amount of evidence emphasising the differences in drinking cultures, patterns and levels of harm across EU Member States, along with the great importance of local action in reducing alcohol-related harm. The question therefore arose, whether it would not be best to leave action on alcohol-related harm entirely to the Member States.
87. In the 2006–12 Strategy, the Commission described the reasons for action at EU level as well as what it perceived to be its own role. It described its main role as raising awareness on major public health concerns at EU and Member State levels, and cooperating with Member States in addressing these; initiating action at EU level when this relates to its field of competence; and supporting and coordinating national actions. Such actions are intended to “complement Member State efforts, to add value to their actions and, in particular, to deal with issues that Member States cannot effectively handle on their own.”
88. The evaluation of the Strategy carried out in 2012 intended to set out its added value, and according to several of our witnesses succeeded in doing so.<sup>90</sup> Speaking generally, Mr Carlin quoted the WHO to say that “national and local efforts produce better results when they are supported by regional and global action within agreed policy frames.”<sup>91</sup>
89. We asked our witnesses to explain what role they thought the EU should and could play to assist national action on alcohol-related harm. Only Janice Atkinson MEP submitted that there should be no EU action on alcohol-related harm at all.<sup>92</sup> All others were more positive, and their comments regarding the success of the Strategy demonstrated that the EU’s role in focusing the discussion, enabling the exchange of best practice and facilitating cross-border research were regarded as key in this respect. Mr Carlin linked this issue to the matter of competence discussed above, saying “That is the concept of subsidiarity and we absolutely agree that every Member State should remain free to develop and implement its own health policies, but the EU policy complements national actions.”<sup>93</sup>
90. The Sheffield University Alcohol Research Group (ScHARR) said that “the EU can play an important role by assessing whether Member States’ alcohol policies are likely to achieve (a) their stated aims and (b) the aims of the EU Alcohol Strategy.”<sup>94</sup> Referring to the interaction between alcohol policy at the national, regional and EU level, spiritsEUROPE believed that “the Commission should have a coordinating role in ensuring the coherence of messages from Member States, ensuring that there is no gap between the

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<sup>90</sup> For example [Q\\_141](#) (Ruxandra Draghia-Akli).

<sup>91</sup> [Q\\_107](#) (Eric Carlin)

<sup>92</sup> Written evidence from Janice Atkinson MEP, UKIP ([EAS0003](#))

<sup>93</sup> [Q\\_107](#)

<sup>94</sup> Written evidence from the University of Sheffield Alcohol Research Group ([EAS0014](#))

policies and orientations chosen in various international fora—given the autonomy Member States have in setting their respective national alcohol policies.”<sup>95</sup>

91. Some witnesses stressed that EU action should be clearly limited, not only by the EU’s competence, but also to areas of added value, leaving all else to the Member States. A number of potential areas for action were identified as particularly suited to EU action, as they could not be sufficiently addressed by unilateral Member State action. These were primarily cross-border issues related to the trade of alcohol within the EU, including taxation and labelling, which we consider in Chapters 6 and 7.<sup>96</sup>
92. On the other hand, some alcohol-related policy areas were explicitly excluded as unsuited to EU action, notably licensing arrangements and alcohol-related crime. Mr Greaves noted that such crime cost the UK around £11 billion each year, but he still cautioned that “It is just a question of the added value of EU co-operation, of which we remain to be convinced.”<sup>97</sup>
93. Mr Greaves also said that the previous Strategy’s focus on alcohol-related health and other linked harms largely reflected the competence of the EU to take action to complement national policies directed towards improving public health. The EU’s competence in relation to criminal matters did not explicitly cover alcohol-related crime. Before considering inclusion of alcohol-related crime in the Strategy, Ministers would need to be assured that any such action respected the limits of the EU’s competence and the principle of subsidiarity. Aside from illicit alcohol, alcohol-related crime was not necessarily cross-border by nature: “There are not very new or fast-moving issues to be dealt with in this issue, as there are perhaps in drugs or other areas, and patterns of harm and the domestic responses around licensing regulations and criminal justice systems are very different by member state. Therefore, we remain to be convinced there is a compelling case for further co-operation in this area, but this is something that Home Office Ministers would be consulted on and consider on a case-by-case basis.”<sup>98</sup>
94. **Action is worth formulating at EU level only to the extent that it supplements and supports what Member States can do independently.**

#### Added value to international action on alcohol-related harm

95. The WHO has supported EU Member States in reducing alcohol-related harm through its European Regional Office since the 1970s. The WHO European Action Plan on reducing the harmful use of alcohol was first implemented in 1992 and last updated in 2012. In 1995, the WHO European Charter on Alcohol was adopted at the European Conference on Health, Society and Alcohol, “in furtherance” of the European action plan.<sup>99</sup> Since 2002, the WHO has collected data through the European Alcohol

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<sup>95</sup> Written evidence from spiritsEUROPE ([EAS0025](#))

<sup>96</sup> For example [Q 6](#) (Peter Anderson).

<sup>97</sup> [Q 181](#)

<sup>98</sup> [Q 181](#)

<sup>99</sup> WHO, *European Charter on Alcohol* (14 December 1995): [http://www.euro.who.int/\\_data/assets/pdf\\_file/0008/79406/EUR\\_ICP\\_ALDT\\_94\\_03\\_CN01.pdf](http://www.euro.who.int/_data/assets/pdf_file/0008/79406/EUR_ICP_ALDT_94_03_CN01.pdf) [accessed 24 February 2015]

Information System, as part of the Global Information System on Alcohol and Health.<sup>100</sup>

96. The WHO European action plan is closely linked to the WHO's Global Strategy to reduce the harmful use of alcohol 2010,<sup>101</sup> and utilises the 10 areas for national action identified by the Global Strategy.

**Box 7: Ten action areas of the WHO European Action Plan 2012–20**

- Leadership, awareness and commitment
- Health services' response
- Community and workplace action
- Drink–driving policies and countermeasures
- Availability of alcohol
- Marketing of alcoholic beverages
- Pricing policies
- Reducing the negative consequences of drinking and alcohol intoxication
- Reducing the public health impact of illicit alcohol and informally produced alcohol
- Monitoring and surveillance

97. Of the ten action areas, the WHO has identified measures relating to availability, marketing and pricing as 'best buys': interventions which are cheap, feasible and most cost-effective in reducing alcohol-related harm.<sup>102</sup> We received a large amount of evidence on the value of policies restricting alcohol advertising and regulating the price of alcoholic beverages, with much less being said about labelling or about policies restricting availability. This is probably due to the fact that setting licensing requirements and age limits for purchasing alcohol are solely within the competence of Member States. We discuss interventions on pricing, advertising and labelling in Chapters 6 and 7.
98. In the light of the WHO's extensive work on reducing alcohol-related harm in Europe, we asked whether there was any need for additional EU action in this area, and if so, what shape such action should take in order to constitute real added value.
99. Dr Møller noted that the WHO's remit was limited to health matters and that it therefore interacted only with national health ministries. He said "We can work with other sectors, but it has to pass through the ministry of health. I think the European Commission has better links to the different ministries

<sup>100</sup> WHO, 'Global Health Observatory Data Repository (European Region)': <http://apps.who.int/gho/data/?showonly=GISAH&theme=main-euro> [accessed 24 February 2015]

<sup>101</sup> WHO, *Global Strategy to reduce the harmful use of alcohol* (2010): [http://www.who.int/substance\\_abuse/alcstratenglishfinal.pdf](http://www.who.int/substance_abuse/alcstratenglishfinal.pdf) [accessed 24 February 2015]

<sup>102</sup> For example WHO, *From Burden to "Best Buys": Reducing the Economic Impact of Non-Communicable Diseases in Low- and Middle-Income Countries* (2011), p 7: [http://www3.weforum.org/docs/WEF\\_WHO\\_HE\\_ReducingNonCommunicableDiseases\\_2011.pdf](http://www3.weforum.org/docs/WEF_WHO_HE_ReducingNonCommunicableDiseases_2011.pdf) [accessed 24 February 2015]; see also Q.7 (Peter Anderson)

that have impacts on alcohol policies. Therefore, the EU can be used to focus on more cross-border issues, which we are not able to do in the same way.”<sup>103</sup>

100. Ms Brown agreed: “There are also very important things which the EU can do within its mandate that the WHO cannot do. The European Union is a trading region and there are many elements where collective action is going to be stronger than Member States or nation states trying to implement policies on their own.” In this regard she mentioned pricing, marketing and labelling of alcoholic beverages as “areas where the European Union could enact its mandate in order to ensure that the policies are implemented across the region and are not undermined by cross-border issues that could be introduced by individual Member States.”<sup>104</sup>
101. These statements illustrate the difference between alcohol health policy and alcohol policy more widely. We found our witnesses’ arguments that the EU should reach beyond the WHO’s health mandate by taking a “health in all policies” approach particularly convincing. The merits of such an approach will be discussed further in Chapter 5.
102. We also considered how the EU and WHO alcohol strategies should interact in order to be most effective, and how this interaction had worked thus far. Dr Møller stated that cooperation between CNAPA, the European Commission and the WHO European Regional Office had been successful, in particular in the area of developing indicators. He was particularly positive about EU funding, which had enabled the WHO to proceed with research projects it would otherwise not have had the means to pursue.<sup>105</sup>
103. Other witnesses stressed that there should not be any duplication between the WHO and EU Strategies.<sup>106</sup> Ms Ellison agreed, stating that while an EU Alcohol Strategy should be aligned with the objectives and indicators of the WHO action plan, the Government “definitely [did] not want to see the two strategies duplicating each other”, and was in favour of a new strategy “addressing areas within its current rules and areas of competence while taking account of the WHO view.”<sup>107</sup> The Institute of Alcohol Studies added that “a new EU Alcohol Strategy should complement existing WHO strategies by including targets and indicators that have been endorsed by Member States.”<sup>108</sup>
104. **Although the recommendations made to Member States by the WHO Global Strategy and European Action Plan are not legally binding, EU action should not conflict with these recommendations.**
105. **EU action on alcohol should continue to facilitate cooperation between the WHO European Regional Office and the Commission in the field of alcohol-related harm, in order to add to the evidence base**

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<sup>103</sup> [Q 77](#)

<sup>104</sup> [Q 37](#) (Katherine Brown)

<sup>105</sup> [Q 77](#)

<sup>106</sup> Written evidence from the British Beer and Pub Association ([EAS0013](#)) and the Department of Health ([EAS0019](#))

<sup>107</sup> [Q 231](#) (Jane Ellison MP)

<sup>108</sup> Written evidence from the Institute of Alcohol Studies ([EAS0002](#))

**and avoid duplication, in particular in the development and application of indicators.**

### **Future work at EU level**

106. For the reasons outlined above, all but one of our witnesses were in favour of some form of continued EU action on alcohol, and the majority supported action continuing along the same or at least similar lines to those of the 2006–12 Strategy. Only one industry body indicated that a strategy might not necessarily be the most effective form of action against alcohol-related harm in Europe.<sup>109</sup> All others were adamant that there should continue to be an EU Alcohol Strategy, though they differed greatly in their opinions on what such a strategy should look like.
107. Industry representatives all favoured, rather than an entirely new strategy, a “continuation” of the 2006–12 Strategy,<sup>110</sup> which would “build on the previous Strategy rather than seeking to create something entirely different.”<sup>111</sup> Sue Eustace, Director of Public Affairs at the Advertising Association, described the Strategy as “still fit for purpose”,<sup>112</sup> and Mr Beale felt that “We do not need to reinvent the wheel”.<sup>113</sup> This view was also supported by the British Beer and Pub Association, The Brewers of Europe, the Scotch Whisky Association and spiritsEUROPE.<sup>114</sup>
108. Industry witnesses such as Simon Spillane, Senior Adviser to The Brewers of Europe, also felt that the five priority areas of the Strategy were still relevant, and should remain the focus of EU action on alcohol-related harm: “These are areas that are still valid priorities and, to be honest, they will not ever go away entirely.”<sup>115</sup> Eurocare agreed that the priorities remained valid, but felt strongly that they should be added to in the light of developments since 2006.<sup>116</sup> Lundbeck Ltd highlighted alcohol-related harm in the workplace as an area which needed increased attention,<sup>117</sup> while Eurocare advocated that this be separated from alcohol-related harm among adults more generally.
109. We agree that the five themes remain relevant generally to addressing alcohol-related harm in EU Member States. However, given their varying success rates and developments since 2006, it is time to reconsider how suited they are to EU action, including coordination activities. If areas are to be described as ‘priorities’, they should be more specific and the responsibilities for taking action under them should be clearly allocated. Where the EU can act, it should take action based on the available evidence. Member States need some flexibility, but not so much that any standards imposed by the EU have no real effect.

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<sup>109</sup> Written evidence from WSTA ([EAS0016](#))

<sup>110</sup> [Q 201](#) (Henry Ashworth)

<sup>111</sup> Written evidence from BBPA ([EAS0013](#))

<sup>112</sup> [Q 201](#)

<sup>113</sup> [Q 186](#)

<sup>114</sup> Written evidence from BBPA ([EAS0013](#)) and SWA ([EAS0020](#)); [Q 118](#) (Paul Skehan); [Q 119](#) (Simon Spillane)

<sup>115</sup> [Q 119](#)

<sup>116</sup> Written evidence from Eurocare ([EAS0006](#))

<sup>117</sup> Written evidence from Lundbeck Ltd ([EAS0011](#))

110. Our evidence has shown significant shortcomings in how the Strategy operated and still operates, in particular regarding CNAPA, the EAHF and research. Priority 5, relating to the establishment of a common evidence base, should be restated as a main priority and indeed a prerequisite for success in the remaining priority areas. These are specific issues which need to be addressed in a way that the previous Strategy did not, so while its underlying principles and priorities may still be valid, simply ‘continuing’ is not an option.
111. **There is much to be said for EU action which deals with matters within EU competence and addresses the weaknesses which our evidence has revealed. However, we see no point in the Member States agreeing on a new EU Strategy which is simply a continuation of the previous one.**
112. **Any future EU action on alcohol abuse should state realistic, clearly defined and measurable objectives, and include an evaluation mechanism to assess its progress and added value.**
113. In the following chapters we consider those matters where it is in our view appropriate and potentially beneficial for the EU to take action. We look first at the possible policy approaches, and then at two of the WHO ‘best buy’ policies: pricing and marketing.

## CHAPTER 5: POSSIBLE POLICY APPROACHES

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### Health in all policies

114. Both the Government and public health interest groups strongly urged that the EU adopt a ‘health in all policies’ approach to alcohol-related harm by the EU. Mr Carlin described the rationale for such an approach: “The alcohol Strategy has been located within and led by DG SANCO, but it should be an overarching strategy owned by Member States and by the whole Commission.”<sup>118</sup> Ms Brown said that, in future, policy-makers in the Commission “need to have an awareness that alcohol is everybody’s business: it crosses all the Directorates-General across Europe and is not just an issue for DG SANCO. We need to have an education process whereby colleagues in DG Tax, DG Info and DG Trade understand the impact that alcohol has across their policy briefs and that alcohol harm has in general across society.”<sup>119</sup>
115. Mr Acton added that the Government “would like a new strategy that focuses more on a Health in All Policies approach as far as the EU’s own policies are concerned. There are quite a number of EU rules and pieces of legislation that were devised some time before the current EU alcohol Strategy.”<sup>120</sup> He also provided evidence of the concrete benefits which such an approach has yielded in the past: “One positive example that I could give is to do with the common market organisation for wine. The reform of that regime has led, and is leading, to positive developments such as a reduction of subsidies for cheap spirits and the EU promoting quality wine much more.”<sup>121</sup>
116. We agree that this approach should form the core of any future EU action on alcohol-related harm. Given the EU’s limited competences in the field of health, it seems to us that this is where the EU can add real value to Member State action by ensuring that, where it does have competence, its own policies are not at odds with the public health goals enshrined in the Treaties. Such a mainstreaming approach should nonetheless be combined with explicit action on alcohol abuse as a distinct policy area.
117. **Future EU action on alcohol abuse should not be confined to action under health policy, but should take a ‘health in all policies’ approach reflected through EU policies on related areas such as food labelling, cross-border marketing and taxation.**

### Targeted or overall population measures

118. Witnesses disagreed on whether EU action on alcohol-related harm should aim to reduce the overall level of drinking across the EU’s population through so-called ‘whole population measures’.
119. Industry representatives strongly contested such measures in both oral and written evidence, commending the Strategy for not adopting them. They

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<sup>118</sup> [Q 104](#)

<sup>119</sup> [Q 37](#)

<sup>120</sup> [Q 15](#)

<sup>121</sup> [Q 15](#)

instead advocated targeted measures addressing harmful alcohol use only, arguing that whole population measures unjustly penalise drinkers who are moderate consumers, to which group they claim the “vast majority” of adults belong.<sup>122</sup>

120. For the same reason they opposed the WHO’s ‘best buy’ measures, of which Dr Møller said: “It is very clear that the industry does not want to have any population-wide measures. It wants to have individual-based approaches to change people’s behaviour, such as targeting those who drink too much. That is completely different from our evidence.”<sup>123</sup>
121. Witnesses from the public health sector, on the other hand, insisted that whole population measures were a key component to any policy seeking to reduce alcohol-related harm in the long term. The Minister agreed, stressing the complexity of policy-making and explaining that the most effective policy approach was one which combined various types of measures. Giving the UK’s own approach to alcohol policy as an example, she said that “pragmatically, it tends to be a combination of both. It is clearly up to member states how far each one’s strategy adopts the population or individual approach, but I think that in practice most people will use a blend of the two.”<sup>124</sup>
122. She then set out a very clear justification for choosing a blend of measures:
- “One of the challenges in taking an either/or approach ... is that, first, I do not think that anyone thinks of themselves as a binge drinker ... I had a conversation recently with someone within the industry who had the potential to be quite influential in a particular area of policy and I was quite interested to discover that there was a complete misunderstanding between us as to who we were talking about. His view was that we were talking about street drinkers when we referred to harmful drinkers, whereas we were talking about people who were just drinking more than is good for their health as defined by medical guidelines ... We want to talk to that person, too, and that is why you have to talk in terms of population measures and those more general terms, because otherwise there is a danger that people just think, ‘They’re not talking about me’.”<sup>125</sup>
123. **We believe that the most effective policy approach is one which combines measures at population level intended to reduce overall levels of consumption, with targeted measures intended to reduce harmful consumption. Such measures, if adopted at EU level, should allow enough flexibility for Member States to adapt to them to their specific national context.**

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<sup>122</sup> Written evidence from BBPA ([EAS0013](#)), WSTA ([EAS0016](#)), SABMiller ([EAS0009](#)), spiritsEUROPE ([EAS0025](#)) and Portman Group ([EAS0018](#))

<sup>123</sup> [Q 91](#)

<sup>124</sup> [Q 234](#)

<sup>125</sup> [Q 235](#)

## CHAPTER 6: PRICING

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### Taxation

124. Within the EU, the rates of taxation and the structure of the taxation of alcohol products are laid down in two Directives of 1992.

#### *Rates of excise duties*

125. The minimum rates of taxation of alcoholic beverages are laid down in Directive 92/84/EEC.<sup>126</sup> It is open to Member States to tax drinks at a rate higher than the minimum rate, and the UK has one of the highest rates of tax: “a litre of wine in France incurs less than four euro cents excise duty and a similar litre of wine here in the UK incurs £2.73 excise duty”.<sup>127</sup> This explains the busy cross-channel trade in wine bought for personal consumption in the UK. It also explains why, as Mr Cummins told us, “alcohol duty fraud is one of the largest tax crimes in the UK; HMRC’s published estimates suggest it costs taxpayers around £1.3 billion a year. They advise that the problem has grown somewhat since the introduction of the European single market in the early 1990s, and there is no doubt that the significant differences in excise duty rates between Member States can help, to some extent, to incentivise that fraud.”<sup>128</sup>
126. Harmonisation of the levels of duty is not even a distant dream. In 2013–14 the Government collected £10.5 billion in alcohol duties, around 2% of all tax revenue collected by HM Revenue and Customs (HMRC). Most of the revenue came from wine (£3.7 billion), beer (£3.3 billion) and spirits (£3.1 billion), with cider making a much smaller contribution to receipts (£0.3 billion). Alcohol duty’s contribution to HMRC receipts has remained around 2% since 2005. As Ms Willmott told us, “the problem is that every time there is a discussion about harmonised taxation, all the British MEPs go, ‘Oh no’, because we know this is something that the UK will not even discuss.”<sup>129</sup> In 2006, at the specific request of the Council, the Commission put forward a proposal for amendment of the Directive by ‘revalorising’ the rates of excise duties,<sup>130</sup> but it was last discussed in the Council in 2010, and the Commission’s Work Programme for 2015 proposes that it should be withdrawn because there is “no foreseeable agreement”.<sup>131</sup> We regret that the Commission’s attempt to update minimum rates of duty set over twenty years ago should have been blocked in the Council in 2010 and not subsequently discussed.

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<sup>126</sup> Council Directive 92/84/EEC of 19 October 1992 on the approximation of the rates of excise duties on alcohol and alcoholic beverages ([OJ L 316](#), 31 October 1992, page 29).

<sup>127</sup> [Q 183](#) (Stephen Cummins)

<sup>128</sup> *Ibid.*

<sup>129</sup> [Q 162](#)

<sup>130</sup> Proposal for a Council Directive on amending Directive 92/84/EEC on the approximation of the rates of excise duty on alcohol and alcohol beverages, [COM\(2006\) 486 final](#)

<sup>131</sup> Annex 2 to a Communication from the Commission to the European Parliament, the Council, the European Economic and Social Committee and the Committee of the Regions on the Commission Work Programme 2015: A New Start, [COM\(2014\) 910 final](#)

*The Structure of Taxation*

127. Amending the structure of taxation is another matter. The principal provisions of the relevant Directive<sup>132</sup> are as set out in Box 8.

**Box 8: Structure of EU taxation of alcoholic beverages**

The excise duty on beer is fixed by reference to the number of hectolitre/degrees of finished product.<sup>133</sup> Member States may divide beers into categories and may charge the same rate of duty per hectolitre on all beers falling within each category.

Member States may apply reduced rates, which may fall below the minimum rate, for beer with an actual alcoholic strength by volume not exceeding 2.8%.

The excise duty levied on still wine and sparkling wine and on other fermented beverages, including cider, is fixed by reference to the number of hectolitres of finished product.

Member States will be required to levy the same rate of excise duty within each category of alcoholic beverages.

Member States may apply reduced rates of excise duty to any type of wine and other fermented beverages, except for beer, with an actual alcoholic strength by volume not exceeding 8.5%.

128. The illogicality of the current position was explained in the written evidence of SchARR:

“Specifying that wine and ciders must be taxed by product volume while permitting beer and spirits to be taxed by ethanol content prevents excise duty being levied in a way which reflects the public health risk associated with products. Under the current system, a 750ml bottle of wine must attract the same level of duty irrespective of whether it contains 90ml of ethanol or 120ml ethanol, despite the public health risk being greater in the latter case. In terms of duty levied per UK unit of alcohol, a 500ml can of normal strength cider would attract substantially more duty per unit than a 3L bottle of high strength cider (8p per unit vs. 5p per unit at current UK duty levels). For those motivated to purchase the maximum ethanol for the minimum price, such duty structures create perverse incentives to purchase beverages with higher alcohol contents in greater quantities. Consideration should be given to reforming alcohol duty structures to permit taxation which consistently reflects the alcohol content of products and the public health risk which this entails.”

129. In her oral evidence Prof Meier elaborated on this: “The way taxation is currently legislated in EU Directives is such that you cannot tax all alcohol by alcohol strength. Alcohol strength is the driver of harm, so it entirely makes sense to have something that is proportionate to alcohol content. You can do that for beer and spirits but not for wine or cider under current EU

<sup>132</sup> Council Directive 92/83/EEC of 19 October 1992 on the harmonization of the structures of excise duties on alcohol and alcoholic beverages ([OJL 316](#), 31 October 1992, page 21).

<sup>133</sup> In essence, a measure of alcohol by volume.

legislation. Several countries have tried to find ways around that, but it is not currently possible.”<sup>134</sup>

130. This was the only topic on which the health lobby and the manufacturers and retailers had a measure of agreement, though perhaps for the manufacturers this is less a matter of principle and more a desire to see wine taxed more highly. In written evidence the Scotch Whisky Association told us: “The defect of existing EU legislation is that it produces distortions of competition by taxing differently the same level of alcohol purely because it appears in a different kind of drink. The SWA supports all alcoholic beverages being taxed on the same basis according to alcohol content, with clearer horizontal minimum rates applying to all alcohol. We believe this is the only fair and responsible way to tax alcohol.” The WSTA agreed, and thought that this was “an area in which a reviewed strategy could more reasonably be involved and provide potential benefits to consumers in a less intrusive and possibly more effective way than Minimum Unit Pricing.”
131. As Prof Sheron pointed out, wine, unlike beer and spirits, is taxed in bands: “There is a band at 7.5% and at 15%, so there is no financial incentive for manufacturers to make weaker wines, which, given the population-level link, would be much healthier.”<sup>135</sup> A revised structure might also promote the sale of weaker beers: Brigid Simmonds, the Chief Executive of the British Beer and Pub Association (BBPA) explained: “Under the Structures Directive ... low-strength beer can be taxed at a lower rate only if it is less than 2.8%. We would like to have the ability to innovate and to make the taste better by raising that to 3.5%.”<sup>136</sup>
132. The Government also agrees on the desirability of amending the Structures Directive. Mr Acton said: “The Directive already allows taxation to relate closely to alcoholic strength for beer and spirits but not for wine and cider. You can argue that that is illogical ... We are arguing that it should be possible for duty across the board to relate to alcohol strength.”<sup>137</sup>
133. **EU rules on the structure of alcohol taxation should be reviewed to allow the implementation of variable tax rates for wines and ciders in line with alcoholic strength, and to give an incentive to the manufacture of lower strength beers.**

### Pricing

134. There is a considerable measure of agreement that one of the main causes of binge drinking in the UK is ‘pre-loading’. Paul Waterson, Chief Executive of the Scottish Licensed Trade Association (SLTA), explained: “We see many young people now pre-loading before they come out, so they come into the pubs and nightclubs and they have already had parties at home, where they are drinking significant amounts of alcohol ... people, especially younger inexperienced drinkers, are seduced into drinking more than they would normally by price. Within the [Licensing (Scotland) Act 2005] there is a package of measures in Scotland to stop irresponsible promotions, but it cannot be totally prescriptive. Minimum pricing would be a far more efficient

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<sup>134</sup> [Q 6](#)

<sup>135</sup> [Q 37](#)

<sup>136</sup> [Q 192](#)

<sup>137</sup> [Q 28](#)

way of stopping irresponsible promotions.” He did not agree with the idea that alcohol “should be sold cheaper than water and more or less given away as a loss leader to get people into stores to make money off other products”.<sup>138</sup>

135. Needless to say, industry representatives did not agree with this view. Mr Beale’s dismissive comment was: “What often gets in the way of a good story are the facts.”<sup>139</sup> He was referring to the reduction in recent years in under-age drinking. This reduction, however, does not seem to us to be inconsistent with the sort of conduct described by Mr Waterson.
136. It is entirely within the competence of Member States to take steps to prevent alcohol being “sold cheaper than water” or “given away as a loss leader”. A ban on selling alcohol below the “permitted price” was introduced through the Licensing Act 2003 (Mandatory Conditions) Order 2014<sup>140</sup> and came into force on 28 May 2014. The schedule to the Order defines the “permitted price” as the level of alcohol duty plus VAT. This means that a 440 ml can of average strength lager (4% ABV) cannot be sold for less than 40p, a 70 cl bottle of vodka (37.5% ABV) for less than £8.89, or a 75 cl bottle of wine (12.5% ABV) for less than £2.46.<sup>141</sup> Sale at these prices still results in a loss to the retailer.
137. **We recommend that the Government review the formula laid down by the 2014 Order for calculating the minimum permitted price of alcoholic drinks. We hope that other Member States may take equivalent action.**

### Minimum Unit Pricing

138. Minimum unit pricing (MUP) of alcohol is a legislative prohibition against the sale of alcoholic drinks at a price below a fixed cost per unit of alcohol. It is not to be confused with minimum pricing, which does not relate to the price per unit but is the prohibition of the sale of an alcoholic drink below a fixed price—for example, a prohibition on the sale of wine below cost price as a loss leader.
139. No Member State currently has a MUP law. Indeed John Duffy, a statistics and policy consultant, told us that MUP had “never been applied anywhere in the world”. He explained that a policy applied by certain Canadian Provinces, described to us by Professor Theresa Marteau, the Director of the Behaviour and Research Unit at the University of Cambridge, in fact related to minimum pricing rather than minimum unit pricing.<sup>142</sup>

### *The MUP debate*

140. MUP is a highly controversial topic on which we received a great deal of evidence, with sharply polarised views. ScHARR has carried out modelling studies into the impact that the introduction of MUP would have on drinkers

<sup>138</sup> [Q 190](#)

<sup>139</sup> [Q 190](#)

<sup>140</sup> The Licensing Act 2003 (Mandatory Conditions) Order 2013, [SI 2014/1252](#)

<sup>141</sup> Home Office, *Guidance on banning the sale of alcohol below the cost of duty plus VAT for suppliers of alcohol and enforcement authorities in England and Wales* (May 2014): [https://www.gov.uk/government/uploads/system/uploads/attachment\\_data/file/311735/Guidance\\_on\\_BBCS\\_3.pdf](https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/311735/Guidance_on_BBCS_3.pdf) [accessed 24 February 2015]

<sup>142</sup> [Q 68](#)

across the different socio-economic groups. In written evidence ScHARR concluded: “MUP would provide a substantial public health benefit which, for a 45p MUP implemented in England in 2014–15, was estimated to be a reduction in alcohol-related deaths of 860 per year, in hospital admissions of 29,900 per year and reductions in direct costs to the NHS of £561m over 10 years.”

141. Ms Brown, describing the work of ScHARR, said:

“Their modelling predicts that the people who would benefit the most in terms of reduced rates of liver disease, negative health outcomes and social problems would be the heaviest drinkers from the lowest social economic groups. So this is a specifically targeted policy that could help to reduce the gap in inequalities across the UK. That is such an important message that needs to be understood from the research that is coming out. This is exactly the solution that we want to see, because it does not unfairly penalise responsible drinkers across the board, be they from high or low incomes; it just targets drinkers who drink the very strong, cheap drink.”<sup>143</sup>

142. Prof Sheron supported this view: “a minimum unit price does not affect the price of all alcohol, only the price of the cheapest alcohol. Specifically, we are talking about 7.5%, three-litre bottles of electric soup cider, which is what my patients with cirrhosis are drinking—and frankly, if you are drinking that stuff, you have a drink problem. Normal people do not drink that stuff. So it is not perfect, but it is very heavily targeted to where the problem is compared to a general increase in taxation.”<sup>144</sup>

143. On the other side of the fence is the industry, led by the Scotch Whisky Association, who gave us both written evidence and oral evidence through their Chief Executive, David Frost. In their written evidence, supported by spiritsEUROPE, they cited the same Sheffield research to reach the opposite conclusion: “According to modelling by [ScHARR], hazardous and harmful drinkers do not anyway mainly drink alcohol which is cheap relative to its strength (and most such drinkers are relatively well-off anyway)”.

144. Mr Frost amplified these views: “We think that minimum unit pricing is quite a heavy-handed way of getting people who already drink responsibly to drink slightly more responsibly by making their drink that bit more expensive, while having no effect on those who drink harmfully or hazardously ... all the international studies that we are aware of suggest that harmful and hazardous drinkers, in those circumstances [if the price is increased], simply cut other things in order to maintain alcohol consumption or they go to illicit alcohol instead. In other words, the price responsiveness of heavy drinkers is close to zero.”<sup>145</sup>

145. Mr Beale supported this view and strongly criticised the Sheffield model: “Any economist will tell you that this [MUP] is a population-based measure. It is in no way targeted; it cannot be. As a result, it hits the poorest drinkers hardest. There is no evidence to suggest that they are the most irresponsible

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<sup>143</sup> [Q 40](#)

<sup>144</sup> [Q 40](#)

<sup>145</sup> [Q 190](#)

drinkers—quite the reverse ... Equally, the heaviest drinkers we know very well are the least responsive to price. The only thing I am sure about with minimum unit pricing is disappointment will ensue.”<sup>146</sup>

146. Mr Waterson explained to us that the SLTA had supported MUP since the late 1960s, and that MUP would be an efficient way of stopping “the constant race to the bottom in supermarkets on price”.<sup>147</sup> But he was the only one of our witnesses from the industry to support MUP.

### *The position in Scotland*

147. Health in Scotland is a devolved matter. As we have explained in Chapter 2, Scotland has particularly high rates of alcohol abuse and alcohol-related harm, and aims to be the first country in the world to introduce MUP. One of the leading protagonists has been Scottish Health Action on Alcohol Problems (SHAAP), an independent medical advocacy organisation set up by the Scottish Medical Royal Colleges, who sent us very full written evidence. The Scottish Government carried out a consultation in 2008, and in November 2009 Nicola Sturgeon MSP, then the Scottish Health Secretary, introduced a Bill to give effect to MUP by amending the Licensing (Scotland) Act 2005. The MUP provisions of the Bill were opposed by the parties other than the SNP, and those provisions were removed. After the 2011 election a second Bill was introduced, and the Alcohol (Minimum Pricing) (Scotland) Act 2012 received Royal Assent on 29 June 2012.<sup>148</sup> There is, as we explain below, a challenge to its legality, but if and when it enters into force, it will prohibit the sale on licensed premises of alcoholic drinks at a price which is less than the product of the volume, strength and minimum price per unit. The price will be set by Order, and Scottish Ministers propose a minimum price of 50p per unit.

### *The position in England and Wales*

148. The United Kingdom Government is of course responsible for health in England and Wales.<sup>149</sup> The Government’s Alcohol Strategy of March 2012<sup>150</sup> included the following commitment: “We will introduce a minimum unit price (MUP) for alcohol meaning that, for the first time ever in England and Wales, alcohol will not be allowed to be sold below a certain defined price. We will consult on the level in the coming months with a view to introducing legislation as soon as possible.” This was specifically endorsed by the Prime Minister in his Foreword: “So we are going to introduce a new minimum unit price.”
149. This is not what happened. In November 2012 the Home Office issued a consultation paper, entitled *A consultation on delivering the Government’s*

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<sup>146</sup> [Q 190](#)

<sup>147</sup> [Q 190](#)

<sup>148</sup> The distinction between minimum pricing and minimum unit pricing is not helped by the fact that the Scottish legislation refers to ‘minimum pricing’ and ‘minimum price’. Only later in the legislation is it made clear that the minimum price is calculated by reference to a minimum price per unit.

<sup>149</sup> So that MPs representing Scottish constituencies have responsibility for policy in England and Wales, but MPs representing English or Welsh constituencies have no responsibility for policy in Scotland—the West Lothian question.

<sup>150</sup> *The Government’s Alcohol Strategy*, Cm 8336, March 2012, presented to Parliament, not by the Secretary of State for Health, but by the Home Secretary: [https://www.gov.uk/government/uploads/system/uploads/attachment\\_data/file/224075/alcohol-strategy.pdf](https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/224075/alcohol-strategy.pdf) [accessed 27 February 2015]

*policies to cut alcohol fuelled crime and anti-social behaviour*, which, as anticipated in the Strategy, sought views on the proposal that the minimum price per unit should be 45p. In July 2013 the Home Office issued a further paper, entitled *Next steps following the consultation on delivering the Government's alcohol Strategy*,<sup>151</sup> in which the Home Secretary stated: “[The consultation] has not provided evidence that conclusively demonstrates that Minimum Unit Pricing (MUP) will actually do what it is meant to: reduce problem drinking without penalising all those who drink responsibly. In the absence of that empirical evidence, we have decided that it would be a mistake to implement MUP at this stage. We are not rejecting MUP—merely delaying it until we have conclusive evidence that it will be effective.”

150. In other words, 16 months after giving a commitment to introduce legislation for MUP “as soon as possible”, following a consultation ostensibly limited to the level of the minimum price per unit, the Government changed its mind because of opposition from 56% of respondents to the consultation. That opposition was, however, to the specific suggestion of a 45p minimum price; the Minister conceded that he did not know how many thought the minimum price should be higher, or lower, or were opposed to MUP altogether.<sup>152</sup>

#### *The lack of evidence*

151. The Government is not alone in using the argument that there is “no conclusive evidence” that MUP would be effective. We heard this also from the SWA in their written evidence: “Accordingly, there is no convincing evidence that MUP as a policy will reduce alcohol-related harm because it has not been shown that it will reduce the number of hazardous and harmful drinkers.”<sup>153</sup> The written evidence of spiritsEUROPE was identical. The WSTA written evidence concluded: “There is no evidence that Minimum Unit Pricing of alcohol would promote public health and it fails to take into account differing taxation levels, consumer prices, consumption, cultures and harm across each of the EU Member States.”<sup>154</sup> In Brussels Paul Skehan, the Director General of spiritsEUROPE, told us: “It astonishes me how much people talk about the robust evidence that is behind it [MUP]. It is a model and a model depends on the data you put in and the assumptions you apply to those data. If you put in the right assumptions you might get good evidence coming out. If you do not, you will not. We have seen the Sheffield model change two or three times now. We do not have a lot of faith in it.”<sup>155</sup>
152. It is of course true that there is no hard evidence that MUP will work in reducing alcohol-related harm, especially among the lowest socio-economic groups; there could not be, since it has never been tried. But that alone is not a reason for not trying it; if governments never embarked on any policy without proof that the policy would be successful, they would be giving a

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<sup>151</sup> Home Office, *Next steps following the consultation on delivering the Government's alcohol strategy* (July 2013): [https://www.gov.uk/government/uploads/system/uploads/attachment\\_data/file/223773/Alcohol\\_consultation\\_response\\_report\\_v3.pdf](https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/223773/Alcohol_consultation_response_report_v3.pdf) [accessed 24 February 2015]

<sup>152</sup> Jeremy Browne MP, Minister of State, Home Office: HC Deb, 17 July 2013, [col 1120](#)

<sup>153</sup> Written evidence from SWA ([EAS0020](#))

<sup>154</sup> Written evidence from WSTA ([EAS0016](#))

<sup>155</sup> [Q 137](#)

poor example of leadership. As the Prime Minister said in his Foreword to the Alcohol Strategy: “Of course, I know the proposals in this strategy won’t be universally popular. But the responsibility of being in government isn’t always about doing the popular thing. It’s about doing the right thing.” We agree, and we regret that the Government has decided not to introduce the legislation to which it was committed.

153. The Scottish Government is faced with a particularly acute problem of alcohol-related harm. It has carried out a consultation. The SNP went into the 2011 election with MUP as one of its key policies. Having been elected, it introduced the legislation. It cannot, however, be predicted whether the legislation, if and when it enters into force, will be successful.

*The legality of MUP under EU law*

154. Within a month of the Scottish Act receiving Royal Assent, the SWA, together with two European groups of wine and spirit manufacturers, petitioned for judicial review of the Act. Shortly before the hearing in the Outer House of the Court of Session they abandoned the argument that this was not a devolved matter, and so was outwith the powers of the Scottish Parliament. They maintained however that the Act, and any Order made under it, were contrary to the prohibition by Article 34 TFEU of quantitative restrictions on imports and measures having equivalent effect, and not saved by the derogation in Article 36 which provides that these prohibitions do not preclude prohibitions or restrictions justified on grounds of the protection of public health.
155. Lord Doherty dismissed the petition and declined to refer questions to the Court of Justice. The petitioners appealed to the Inner House. There the Lord Advocate and the Advocate-General for Scotland conceded that the Act would be in breach of Article 34 TFEU unless justified under Article 36. The court decided that the relationship between the two Articles was unclear, and referred a number of questions to the Court of Justice of the European Union (CJEU) for decision. There the matter now rests.
156. Since the United Kingdom is the Member State concerned, the United Kingdom Government has intervened in support of the Scottish Government, and in written evidence to the Committee the Department of Health said: “In our response in July 2013 to the consultation on a proposed minimum unit price of 45p for England and Wales, we made clear that we remain confident of the legal basis for the policy and we will continue to support the Scottish Government in the current legal case.”
157. The Commission will in due course be submitting its observations to the Court, but its views are already known. Article 8 of the Directive on technical standards<sup>156</sup> requires Member States to seek clearance from the Commission for any new technical regulation. Accordingly on 25 June 2012 the UK Government sent to the Commission the draft Alcohol (Minimum Price per Unit) (Scotland) Order 2013,<sup>157</sup> under which Scottish Ministers would set

<sup>156</sup> Directive 98/34/EC of the European Parliament and of the Council of 22 June 1998 laying down a procedure for the provision of information in the field of technical standards and regulations.

<sup>157</sup> The Draft Alcohol (Minimum Price per Unit) (Scotland) Order 2013: [http://www.scottish.parliament.uk/S4\\_HealthandSportCommittee/General%20Documents/2012.06.26\\_Cab\\_Sec\\_EC\\_notification\(1\).pdf](http://www.scottish.parliament.uk/S4_HealthandSportCommittee/General%20Documents/2012.06.26_Cab_Sec_EC_notification(1).pdf) [accessed 24 February 2015]

the 50p minimum price per unit. The Commission's opinion was that the draft Order would be in breach of Article 34, noting that 82% of French brandy was sold at a price lower than a 50p minimum price, and that all major supermarket chains would have to increase the price of French brandy. The Commission then considered the possible justification under Article 36, but concluded that MUP would be a disproportionate way of achieving the goal of reducing alcohol-related harm. Its view therefore was that the draft Order, if made, would be in breach of Article 34 TFEU. Mr Carlin described the Commission's response as "ill-informed, inaccurate and plainly wrong and strongly influenced by industry lobbying". He added: "From the discussions that we have subsequently had with DG SANCO officials, it appears that they were not even involved in preparing that response."<sup>158</sup>

158. The Commission took it upon itself to advise the Government that, in its view, a better way of achieving its object would be to raise alcohol duties. It does not seem to us to be any part of the Commission's functions to advise a Member State on the policy it should adopt in a matter almost entirely within its competence. Moreover, as a number of our witnesses pointed out, the EU Directive on the structure of alcohol taxation actually prohibits a taxation system for all beverages based on their alcoholic strength.<sup>159</sup>
159. It is regrettable that the Commission's decision appears to favour economic interests over the health and well-being of EU citizens, and seeks to deny Scotland the opportunity to test whether MUP will achieve the result it seeks.
160. **If the Court rules that minimum unit pricing is lawful under EU law, we recommend that the United Kingdom Government monitor the effects of its introduction in Scotland. If MUP does appear to be successful in bringing health benefits to the heaviest drinkers, the Government should implement the undertaking it gave in 2012 to introduce MUP in England and Wales.**

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<sup>158</sup> [Q 104](#)

<sup>159</sup> Written evidence of Eurocare ([EAS0006](#)), Institute of Alcohol Studies ([EAS0002](#)), and Balance ([EAS0017](#)), among others.

## CHAPTER 7: MARKETING

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### Advertising

161. We mentioned in Chapter 1 the diametrically opposing views of the advocates for public health, and those concerned with the manufacture, marketing and advertising of alcoholic drinks. Nothing illustrated this opposition more starkly than the evidence we received on advertising. The Advertising Association, which provides a single voice for the UK advertising industry, went so far as to say in its written evidence: “In fact, the assumption that advertising exposure is even relevant to harm should be challenged—in recent years, there has been an inverse correlation between advertising exposure and levels of consumption.” This raises the question of why the industry is prepared to spend £800 million a year on advertising its products.<sup>160</sup>
162. Ms Eustace gave us one possible reason: “If you are launching a new low-alcohol product, for example, you will be trying to gain market share against other similar products in that sector. You are not looking at growing total consumption. That is not your goal as the company. You are looking at brand share, and you are also looking at promoting the reputation and the value of the brand.”<sup>161</sup> But even if this were true, there is still the fact that advertising is seen by young people who are not yet drinking. In the words of Dr Winpenny: “the problem is not really about brand switching if they have not already developed some kind of brand allegiance”.<sup>162</sup>

### Advertising regulation

163. In the United Kingdom, the advertising of alcohol is regulated jointly by OFCOM, the Advertising Standards Authority (ASA), and the Portman Group. OFCOM is an independent NDPB, funded by the taxpayer, and regulating television sponsorship and advertising. The ASA is funded by the advertising industry, but claims to be “the UK’s independent regulator for ensuring that advertising in all media is legal, decent, honest and truthful”.<sup>163</sup> It regulates advertising on television, radio, in the press, on posters, in the cinema, by direct mail, and on the internet. It issues Codes of Practice for advertisers to follow, and monitors compliance.
164. The Portman Group told us that it is “the responsibility body for UK drinks producers. We regulate the promotion and packaging of alcoholic drinks sold or marketed in the UK; challenge and encourage the industry to market its products responsibly; and lead on best practice in alcohol corporate social responsibility.”<sup>164</sup> The Portman Group is funded by the drinks industry. Witnesses criticised its Code of Practice on the Naming, Packaging and Promotion of Alcoholic Drinks for not including any oversight of retailers’

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<sup>160</sup> IAS, Marketing and Alcohol Factsheet (May 2013): <http://www.ias.org.uk/uploads/pdf/Factsheets/Marketing%20and%20alcohol%20FS%20May%202013.pdf> [accessed 24 February 2015] See also the evidence submitted to, and obtained by, the Commons Health Committee, *Alcohol* (First Report, Session 2009–10, HC 151–I).

<sup>161</sup> Q 204

<sup>162</sup> Q 73 (Dr Eleanor Winpenny)

<sup>163</sup> Written evidence from the Advertising Standards Authority (EAS0008)

<sup>164</sup> Written evidence from the Portman Group (EAS0018)

approach to alcohol sales. The fact that it is a voluntary code means that, if a complaint is upheld, “there is no sanction available other than a request to address relevant issues”.<sup>165</sup>

*The effects of advertising*

165. Guy Parker, the Chief Executive of the ASA, told us that in 2004 the Government looked at all the evidence that was available then, which identified a possible link between younger people’s awareness and appreciation of alcohol advertisements and their propensity to drink. In response, in 2005 the UK Advertising Codes administered by the ASA were strengthened by the inclusion of tougher rules on avoiding appeal to under 18 year-olds and on linking alcohol with sexual success. Mr Parker also cited another report commissioned by the Department of Health from SCHARR in 2009, which found that alcohol advertising had a small but consistent effect on alcohol consumption, including by young people.<sup>166</sup> Thus even though the ASA is funded by the advertising industry, its Chief Executive seemed to have no doubt about the correlation between alcohol advertising and the propensity of young people to drink.
166. This was not the view of the advertisers themselves, as was clear from the evidence we received from them on the RAND report. RAND Europe is a not-for-profit research organisation which was commissioned by the Commission to carry out an assessment of young people’s exposure to alcohol marketing through television and online. Its report, *Assessment of young people’s exposure to alcohol marketing in audiovisual and online media*, found that in the UK, young people aged 10–15 were exposed to 11% more alcohol advertising than adults aged 25 years or older, and that television alcohol advertisements containing features considered appealing to youth were more common in the UK than in Germany and the Netherlands.
167. These findings were strongly contested in written evidence submitted by the Advertising Association, which called upon the European Commission to withdraw the RAND report. The Advertising Association commissioned its own analysis, which claimed that 10–15 year olds in fact see 53% less alcohol advertising than adults, and that RAND’s findings on exposure were “the polar opposite to any other data we have seen”. This analysis further criticises RAND’s data interpretation based on a number of “technical flaws”. We took oral evidence from Prof Marteau and Dr Eleanor Winpenny, who were two of the authors of the RAND report, and also from Chris Baker, the consultant commissioned by the Advertising Association to conduct an analysis of the report. The oral opinions expressed were as far apart as the written views, and did little more to enlighten us.
168. Three of our witnesses from the public health sector—Prof Anderson, Prof Meier, and Prof Hastings—had no doubt about the effect of advertising on harmful drinking, and Prof Hastings summed up their views: “In this field we have a very, very likely interpretation, which just happens to coincide with common sense, that if you market something very actively and seductively and as powerfully as you possibly can, people tend to consume it.”<sup>167</sup>

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<sup>165</sup> Written evidence from the Association of Chief Police Officers, paragraphs 53–56 ([EAS0021](#))

<sup>166</sup> [Q 55](#)

<sup>167</sup> [Q 12](#)

169. Prof Meier spoke for all three of them about their frustration at the attitude of industry, not just in relation to advertising research but in relation to research generally:

“All of us have had recent experience, especially with the minimum unit pricing debate. We have had industry critique after industry critique— basically always saying the same thing and not responding to our rebuttals. We have always responded to these industry critiques, but the same points have just been rehashed without making any reference to anything we have said. Often it is misrepresentation of evidence, of methodologies, or picking up on minor inconsistencies that are already corrected in a final version, but then rehashing that same thing.”<sup>168</sup>

170. In 2008 the EAHF commissioned its Science Group “to look in more depth at the diverging points of view on the relationship between marketing and volume of consumption (especially by young persons)”.<sup>169</sup> The Science Group analysed a number of studies and concluded that “the overall description of the studies found consistent evidence to demonstrate an impact of advertising on the uptake of drinking among non-drinking people, and increased consumption among their drinking peers.” On the other hand Credos, a think-tank created by the Advertising Association in 2010, decided to undertake a “rigorous and fresh review” of this report, which disagreed with its findings, and concluded that “more substantial research will allow conclusions to be drawn based on firm evidence.”<sup>170</sup>

### *Our conclusions*

171. Professors Anderson, Meier and Hastings were our first witnesses. At that stage of our inquiry we had not heard oral evidence from the manufacturing, retail or advertising industries. Now that we have done so, we can understand and sympathise with the views of our first witnesses. Industry witnesses were quick to criticise evidence contrary to their interests. They were less adept at putting forward evidence to persuade us of views which seem to us to fly in the face of common sense, such as the supposed inverse correlation between advertising exposure and harm.
172. In considering this conflicting evidence on the effects of advertising, we believe the view of Mr Acton is probably closest to the truth:

“We had a systematic review in the UK of the evidence on alcohol advertising, which found good evidence for an impact on adults’ alcohol consumption. The effect was quite a small one, but the evidence for it is quite solid. For the impacts on children and young people, we have accepted in our national alcohol strategy that there is good evidence of an impact on children and young people’s alcohol consumption from advertising; but there are some important evidence gaps, so we do not have a fully quantified impact. There is very little evidence on effective

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<sup>168</sup> **Q 12.** The reaction of the Advertising Association to the EAHF report, which we mention in paragraph 170 below, is an excellent example of this.

<sup>169</sup> Opinion of the Science Group of the EAHF, *Does marketing communication impact on the volume and patterns of consumption of alcohol beverages, especially by young people* (2008): [http://ec.europa.eu/health/archive/ph\\_determinants/life\\_style/alcohol/forum/docs/ev\\_20090311\\_co04\\_en.pdf](http://ec.europa.eu/health/archive/ph_determinants/life_style/alcohol/forum/docs/ev_20090311_co04_en.pdf) [accessed 24 February 2015]

<sup>170</sup> Credos, *Responsible drinking: Time for a responsible debate* (March 2011): <http://www.adassoc.org.uk/wp-content/uploads/2014/09/Responsible-Drinking.pdf> [accessed 24 February 2015]

interventions to restrict advertising. Those are important gaps. Some European research projects have contributed to the knowledge here but there is really a lot more to do, and the EU could play an important role.”<sup>171</sup>

### *Alcohol advertising and sport*

173. In France, advertising of alcohol is regulated, not by self-regulation or voluntary codes of practice, but by a law passed in 1991 and known as the Loi Evin, after the Minister of Health who proposed it.<sup>172</sup> It has since been amended a number of times, but still includes the key prohibitions we list in Box 9.

#### **Box 9: The Loi Evin**

- No advertising to be targeted at young people.
- No advertising on television (including sporting events which are televised) or in cinemas.
- No sponsorship of cultural or sport events is permitted.

Advertising is permitted only in the press for adults, on billboards, on radio channels (under precise conditions), at special events or places such as wine fairs and wine museums.

When advertising is permitted, its content is controlled. Messages and images must refer only to the qualities of the products such as degree, origin, composition, means of production, or patterns of consumption.

A health message must be included on each advertisement to the effect that “*l’abus d’alcool est dangereux pour la santé*” (alcohol abuse is dangerous to health).

174. The Loi Evin, which applies only in France, means that cultural or sporting events taking place outside France which include alcohol advertisements or sponsorship cannot be shown in France. Foreign teams sponsored by alcohol manufacturers must wear different kits when playing in France.
175. In 2002 the question of the compatibility of the Loi Evin with EU law came before the CJEU in two related proceedings. The first was a request by the French Cour de Cassation for a preliminary ruling following civil proceedings brought in France by Bacardi.<sup>173</sup> The second was an application by the Commission for a declaration that the Loi Evin was incompatible with what is now Article 56 TFEU on the freedom to provide services, because it prevented the televising in France of sporting events taking place in other Member States if hoardings displayed at those events promoted alcoholic beverages.<sup>174</sup> The United Kingdom Government intervened in support of the Commission.<sup>175</sup> The Court ruled that the law was indeed a restriction on the

<sup>171</sup> [Q 23](#)

<sup>172</sup> Loi n° 91–32 du 10 janvier 1991 relative à la lutte contre le tabagisme et l’alcoolisme

<sup>173</sup> Case 429/02

<sup>174</sup> Case 262/02

<sup>175</sup> The French Government also intervened in the first proceedings. In the second proceedings it was the defendant. No other Member State intervened. A joint hearing was held in the two cases on 25 November 2003 in which Bacardi, the French and United Kingdom Governments, and the Commission took part.

freedom to provide services, but was justified under the public health exception in what is now Article 52(1) TFEU. The association at sporting events of alcohol with sports persons seen by the young as role models is to be discouraged, and the Loi Evin shows how this can be done compatibly with EU law.

176. Whatever the effect of this law, the fact remains that between 2005 and 2010 binge drinking among young adults increased in France, and this trend continues. A report published in May 2013 gave the results of a survey in 2010 which showed that for young adults aged between 18 and 25 there was an increase in binge drinking and drunkenness, with nearly twice as many men and more than twice as many women affected by drunkenness in 2010 than in 2005.<sup>176</sup>

### *EU Action*

177. In 1989 a Directive known as the Television without Frontiers Directive<sup>177</sup> was adopted, which included in Article 15 restrictions on the content of television advertisements for alcoholic drinks. After a number of amendments, including a change to its name, it was consolidated in 2010 into the Audiovisual Media Services Directive or AVMS Directive,<sup>178</sup> Article 22 of which is given in Box 10.

#### **Box 10: AVMS Directive, Article 22**

Television advertising for alcoholic beverages shall comply with the following criteria:

- (a) It may not be aimed specifically at minors or, in particular, depict minors consuming these beverages;
- (b) It shall not link the consumption of alcohol to enhanced physical performance or to driving;
- (c) It shall not create the impression that the consumption of alcohol contributes towards social or sexual success;
- (d) It shall not claim that alcohol has therapeutic qualities or that it is a stimulant, a sedative or a means of resolving personal conflicts;
- (e) It shall not encourage immoderate consumption of alcohol or present abstinence or moderation in a negative light;
- (f) It shall not place emphasis on high alcoholic content as being a positive quality of the beverages.

178. This Directive, though welcome, does little more than give legislative effect to prohibitions which, in the UK and many other Member States, are already contained in codes of practice governing self-regulation. The new

<sup>176</sup> Institut national de prévention et d'éducation pour la santé, *La consommation d'alcool des 18–25 ans en 2010 en France: spécificités et évolutions depuis 2005* (May 2013): [http://opac.invs.sante.fr/doc\\_num.php?explnum\\_id=8913](http://opac.invs.sante.fr/doc_num.php?explnum_id=8913) [accessed 10 February 2015]

<sup>177</sup> Council Directive 89/552/EEC of 3 October 1989 on the coordination of certain provisions laid down by Law, Regulation or Administrative Action in Member States concerning the pursuit of television broadcasting activities, *OJ L 298*, 17 October 1989, page 23.

<sup>178</sup> Directive 2010/13/EU of 10 March 2010 on the coordination of certain provisions laid down by law, regulation or administrative action in Member States concerning the provision of audiovisual media services (Audiovisual Media Services Directive), *OJ L 95*, 15 April 2010, page 1.

Commission's Work Programme for 2015 states that results are expected in 2015 from a study "to assess whether rules on audio-visual commercial communication for alcoholic beverages have afforded minors the level of protection required, and thereby contributing to assessing the [Directive's] regulatory fitness".

179. Section 6.3.3 of the EU Strategy, entitled 'Commercial Communication', includes the following commitments by the Commission:

"The Commission services will work with stakeholders to create sustained momentum for cooperation on responsible commercial communication and sales, including the presentation of a model of responsible consumption of alcohol. The main aim will be to support EU and national/local government actions to prevent irresponsible marketing of alcoholic beverages, and to regularly examine trends in advertising and issues of concern relating to advertising, for example on alcohol. One aim of this joint effort will be to reach an agreement with representatives from a range of sectors (hospitality, retail, producers, media/advertising) on a code of commercial communication implemented at national and EU level. Benchmarks for codes/strategies at national level could be agreed. As part of this approach, the impact of self-regulatory codes on young people's drinking and industry compliance with such codes will also be monitored."

180. These were ambitious commitments, and we are not aware of any concrete developments flowing from them. This is regrettable, since the Commission, if it were prepared to take the initiative, could do much to promote harmonisation of self-regulation in different Member States, and to see where self-regulation proves inadequate. It does not need a current strategy for the Commission to undertake these tasks.
181. **We recommend that the Government, in addition to any scrutiny which it undertakes of the adequacy of self-regulation of alcohol advertising, should encourage the Commission to reconsider the undertakings it gave nine years ago to work to prevent irresponsible marketing of alcoholic beverages, and to monitor the impact of self-regulatory codes.**

### Labelling

182. The labelling of food and drink is an area of shared EU competence. Since 1979 it has been a requirement of EU law that the labels of drinks containing more than 1.2% alcohol by volume should indicate the actual alcoholic strength by volume.<sup>179</sup>
183. The power to prescribe labelling requirements is now contained in Article 114 TFEU, which allows the Parliament and the Council to adopt measures on the approximation of the laws of the Member States "which have as their object the establishment and functioning of the internal market." In 2011 a

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<sup>179</sup> Article 3 of Council Directive 79/112/EEC of 18 December 1978 on the approximation of the laws of the Member States relating to the labelling, presentation and advertising of foodstuffs for sale to the ultimate consumer, [OJL 33](#), 8 February 1979, p 1.

Regulation was adopted<sup>180</sup> consolidating earlier measures on food labelling going back many years. The Regulation came into force on 13 December 2014.<sup>181</sup> The definition of ‘food’ includes drink, and the Regulation in principle applies to alcoholic drinks. This therefore was an opportunity for the EU to legislate more prescriptively about the content of alcohol labelling. However, drinks containing more than 1.2% alcohol by volume are exempted from the obligation to list their ingredients or to provide nutritional information.<sup>182</sup>

184. Thus, although alcoholic drinks account for approximately 10% of calorie intake among adults who drink, there is no requirement of EU law for drinkers to be informed of this. Ms Willmott told us: “They need to have the information (calories) and then they can decide that they want to ignore it and drink as many glasses of wine as they want, but they have the information to make an informed choice. I was very keen to get calories labelled on all alcohol but unfortunately I did not succeed, I hate to say.”<sup>183</sup> The failure to include calorific content and sugar content on labels was also a particular concern of Lord Brooke of Alverthorpe’s.<sup>184</sup>
185. Member States are not precluded from applying stricter national regimes on labelling. France is the only State to have a mandatory requirement for a health warning on the packaging of alcoholic drinks. It reads (in translation): “Drinking alcoholic beverages during pregnancy even in small quantities can have serious consequences for the health of the baby.” Alternatively a pictogram can be displayed. Those we have seen are far from prominent: they are often very small, and the same colour as the label.

### *The Responsibility Deal*

186. The Public Health Responsibility Deal (PHRD) was an initiative by the Government in 2011 to bring together government, business, public health organisations and local government, allowing business to make voluntary commitments within their sphere of influence to improve public health. In the United Kingdom, apart from the requirement under the EU Labelling Regulation to give alcoholic strength, there is no legislation on the health labelling of alcoholic drinks; instead it is the subject of voluntary commitments by the industry under Pledge A1 of the PHRD. The pledge reads: “We will ensure that over 80% of products on shelf (by December

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<sup>180</sup> Regulation (EU) No 1169/2011 of the European Parliament and of the Council of 25 October 2011 on the provision of food information to consumers, amending Regulations (EC) No 1924/2006 and (EC) No 1925/2006 of the European Parliament and of the Council, and repealing Commission Directive 87/250/EEC, Council Directive 90/496/EEC, Commission Directive 1999/10/EC, Directive 2000/13/EC of the European Parliament and of the Council, Commission Directives 2002/67/EC and 2008/5/EC and Commission Regulation (EC) No 608/2004, [OJL 304](#), 22 November 2011.

<sup>181</sup> With the exception of rules relating to mandatory nutritional labelling for processed food, which come into force on 13 December 2016.

<sup>182</sup> Article 16(4). There are a few specific nutritional requirements in other legislation, such as the obligation of wine labels to list sulphites and other potential allergens in Commission Implementing Regulation (EU) 579/2012.

<sup>183</sup> [Q 156](#)

<sup>184</sup> Written evidence from Lord Brooke of Alverthorpe ([EAS0005](#))

2013) will have labels with clear unit content, NHS guidelines and a warning about drinking when pregnant.”<sup>185</sup>

187. The 101 ‘partners’ currently committed to this pledge include all the major manufacturers and retailers in the UK. SABMiller plc, the largest drinks company in the UK, told us in their written evidence: “The PHRD has proved an effective framework for government and private sector business collaboration. It has encouraged and led the retailers and producers of beer, wine and spirits to work together with government to identify visionary solutions to alcohol-related harms.”<sup>186</sup>
188. Each ‘partner’ in the PHRD submits an annual update of its pledge. Box 11 gives the pledge of Miller Brands UK, the UK subsidiary of SABMiller.

**Box 11: Responsibility Deal annual update of Miller Brands UK, April 2014**

“Miller Brands UK continues to apply all 5 aspects of the Government’s recommended alcohol responsibility messaging to all of its brands. This includes the three compulsory elements, namely i) clear unit content ii) daily recommended drink guidelines and iii) a warning about drinking when pregnant. We also continue to display a responsibility message, such as “know your limits” and the Drinkaware web address on all our labels.”

189. In 2014 the Department of Health and the Portman Group commissioned Campden BRI to carry out an independent market survey to assess whether the 80% target had been achieved. Their conclusion was that only 69.9% of alcohol on a market share basis complied with all three elements (unit content, drink guidelines and warning about drinking when pregnant) in accordance with the assessment criteria they had been given. Wine labels were by far the worst. The 80% target was just reached if labels were included which did contain information but not in conformity with the assessment criteria. Only 47% of labels were fully compliant and also accorded with best practice.<sup>187</sup>
190. Even if the 80% target had been fully complied with, the pledge begs the question, why should it apply to only “80% of products on shelf”? What about the remaining 20%? It is unlikely that self-regulation and voluntary commitments will ever achieve 100% compliance. Should there be legislation at UK level or EU level? We put this question to Ms Ellison. She replied:

“One of the reasons why we have pursued a voluntary approach on labelling so vigorously through the Responsibility Deal is that we are very aware of the time that it would take, even if we were successful in getting that flexibility, to get that through. We have been able to report some really important steps forward with the voluntary approach.

<sup>185</sup> Department of Health, ‘Public Health Responsibility Deal collective pledges’: <https://responsibilitydeal.dh.gov.uk/public-health-responsibility-deal-collective-pledges/> [accessed 24 February 2015]

<sup>186</sup> Written evidence from SABMiller (EAS0009)

<sup>187</sup> Campden BRI, *Audit of compliance of alcohol beverage labels available from the off-trade with the Public Health Responsibility Deal Labelling Pledge* (October 2014): <https://responsibilitydeal.dh.gov.uk/wp-content/uploads/2014/11/Campden-BRI-Audit-of-PHRD-labelling-compliance-2014-FINAL-report-October2014-final.pdf> [accessed 24 February 2015]

Sometimes, on labelling in particular, I struggle to get colleagues in the Commons to understand that there is this EU competence ... robust voluntary action can sometimes get you further faster than taking a legislative route ... we had an independent report on it, which was published in November this year, which showed that just under 80% of bottles and cans of alcohol on our shelves now have the correct unit and health information ... That has been delivered more quickly than if we had done it by notifying national legislation to the EU.”<sup>188</sup>

191. In the time the Responsibility Deal has been running, domestic legislation could certainly have been enacted to deal with the one in five products that still do not comply with these labelling criteria.

### *EU Legislation*

192. At EU level, where the industry again secured in 2011 an exemption from the Food Labelling Regulation,<sup>189</sup> recital 40 of the Regulation reads: “Taking into account the specific nature of alcoholic beverages, it is appropriate to invite the Commission to analyse further the information requirements for those products. Therefore, the Commission should, taking into account the need to ensure coherence with other relevant Union policies, produce a report within 3 years of the entry into force of this Regulation concerning the application of the requirements to provide information on ingredients and nutrition information to alcoholic beverages.” Article 16(4) converts this into a mandatory obligation, and gives the Commission the deadline of 13 December 2014.
193. The previous Commission could of course have met this deadline by reporting before the end of October 2014, when it relinquished office. No report was then published and, despite the deadline, no report has been published since the current Commission took office. Officials told us that no report should be expected in the coming months. They preferred to wait “in order to obtain a political line on the directions for the labelling of such drinks.” Once the policy line was defined, they would “resume discussions with the Member States and interested parties in order to adopt the report as soon as possible.”
194. **We recommend that the Government should press the Commission to propose amendments to the Food Labelling Regulation. These should make it mandatory for labelling on alcoholic beverages to include information on the strength, the ingredients, nutrition, and the dangers of drinking during pregnancy.**
195. **We recommend that the Commission propose such amendments, and that thereafter the Government should support their rapid enactment.**

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<sup>188</sup> [QQ 233, 241](#). Mr Skehan had earlier told us ([Q 132](#)) that “we had the Department of Health and the Minister for Health in the UK saying it is somewhere between 80% and 90%.”

<sup>189</sup> See paragraph 183.

## **CHAPTER 8: BODIES TO SUPPORT ACTION AT EU LEVEL**

196. Witnesses across all sectors were positive about the exchange of expertise and best practice in reducing alcohol-related harm across EU borders, which was regarded as one of the main benefits of the Strategy. Two bodies set up under the Strategy, the Committee on National Alcohol Policy and Action (CNAPA) and the European Alcohol and Health Forum (EAHF), were repeatedly cited as having contributed to this achievement. At the same time, public health interest groups and government representatives were particularly vocal about the shortcomings of these bodies.
197. Alongside some specific issues, there are two overarching problems which affect all bodies set up under the Strategy to some degree: unclear and informal mandates and remits; and unclear and informal relationships between them.

### **The Committee on National Alcohol Policy and Action (CNAPA)**

198. The 2012 review of the Strategy used six evaluation questions to assess CNAPA as an instrument for coordinating national alcohol policies. It found that CNAPA had “supported information exchange and convergence of Member State policies, including through cross-policy discussions”, and made two main suggestions for the improvement of CNAPA’s work: greater political visibility and strengthened consistency and continuity.<sup>190</sup>
199. CNAPA was not mentioned in the text of the Strategy, which was silent on its role or objectives. Instead, some information on CNAPA’s mandate can be found in the Annex to the 2007 Charter establishing the EAHF, which states that “The main objective of this group will be to further coordinate government-driven policies aimed at reducing alcohol-related harm at national and local level, building upon the examples of good practice identified in the Commission’s Strategy.” The Charter also describes CNAPA’s tasks as reviewing national and regional alcohol policy development, “with a view to disseminating best practice across the EU”.<sup>191</sup>
200. CNAPA can make an important contribution to EU action on alcohol-related harm by enabling Member State representatives to exchange best practice and coordinate national policies. Examples of CNAPA’s work include RARHA and the Joint Action on Youth and Heavy Episodic Drinking, as well as its role in carrying out a scoping exercise following the expiry of the Strategy. However, our evidence has also shown some limitations to its practical value.
201. The Advertising Association felt that “the role of CNAPA as speaking for all Member States is unclear. We understand that some Member States send representatives to CNAPA who do not speak for government departments.”<sup>192</sup> Mr Carlin agreed, adding: “I think Member States need to

<sup>190</sup> COWI-Milieu, *Assessment of the added value of the EU strategy to support Member States in reducing alcohol-related harm* (December 2012): [http://ec.europa.eu/health/alcohol/docs/report\\_assessment\\_eu\\_alcohol\\_strategy\\_2012\\_en.pdf](http://ec.europa.eu/health/alcohol/docs/report_assessment_eu_alcohol_strategy_2012_en.pdf) [accessed 24 February 2015]

<sup>191</sup> EAHF, *Charter establishing the European Alcohol and Health Forum* (June 2014): [http://ec.europa.eu/health/ph\\_determinants/life\\_style/alcohol/documents/Alcohol\\_charter2007.pdf](http://ec.europa.eu/health/ph_determinants/life_style/alcohol/documents/Alcohol_charter2007.pdf) [accessed 24 February 2015]

<sup>192</sup> Written evidence from the Advertising Association ([EAS0015](#))

prioritise and nominate officials to CNAPA who are equipped to speak on behalf of their governments and to act to ensure that they gain cross-government support for the policy positions that they take.”<sup>193</sup>

202. Some witnesses agreed with the findings of the 2012 evaluation. Lundbeck Ltd suggested that “CNAPA would benefit from more political visibility. For example, beyond the exchange of best practices, CNAPA could open a structured dialogue with the forthcoming EU Trio Presidencies and with the [European Parliament] Health Coordinators to present CNAPA’s recommendations on how to take EU policy action on alcohol to the next level.”<sup>194</sup> Ms Willmott suggested that CNAPA’s role could also be strengthened by establishing it as a full working party under the Council structures.<sup>195</sup>
203. A number of public health NGOs felt that CNAPA’s role should also be enhanced in practice.<sup>196</sup> The Alcohol Health Alliance UK wrote: “As CNAPA is the body representing Member States, it is essential that its role be strengthened to reflect its position as the driving force for the design and implementation of a new EU Alcohol Strategy.”<sup>197</sup>
204. The current confusion over CNAPA’s exact powers, as well as its relationship to the EAHF, Member States and the Commission, may hamper its effectiveness. While this confusion may in part be due to its lack of formal status, it is likely to have been compounded by the Commission’s attitude towards its role within the Strategy, which we discuss below.
205. **We recommend that the Commission review the structure and functioning of CNAPA in order to ensure that it is fully capable of carrying out its coordination function. In particular, it should encourage Member States to nominate officials who are in a position to represent their governments’ views.**

### **The European Alcohol and Health Forum (EAHF)**

206. The EAHF was established in 2007, following its inclusion in the Strategy under the heading ‘coordination of actions at EU level’. The text of the Strategy stated that “The overall objective of this Forum will be to support, provide input for and monitor the implementation of the Strategy”. In practice it has mainly done so by enabling industry and NGO partners to enter into voluntary commitments intended to reduce alcohol-related harm.
207. The 2012 evaluation of the Strategy noted that several sectors and Member States are under-represented in the EAHF. This was supported by a 2013 report on commitments made by members of the EAHF, which found that all but one of the member organisations at the time were from the EU15

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<sup>193</sup> [Q 116](#)

<sup>194</sup> Written evidence from Lundbeck Ltd ([EAS0011](#))

<sup>195</sup> [Q 158](#)

<sup>196</sup> Written evidence from Alcohol Health Alliance UK ([EAS0012](#)), Balance ([EAS0017](#)), Eurocare ([EAS0006](#)) and the Institute for Alcohol Studies ([EAS0002](#))

<sup>197</sup> Written evidence from Alcohol Health Alliance UK ([EAS0012](#))

countries,<sup>198</sup> with 10 out of 34 Member-State level members being based in the United Kingdom.<sup>199</sup>

208. The evaluation also recommended that the Forum should re-focus its work on fewer well-defined action areas and implement outcome and impact indicators, as well as strengthening its relationship with CNAPA, which we discuss below. Again, our witnesses—many of whom are themselves members of the EAHF—broadly agreed with these findings and felt that, in general, the Forum was a valuable body worth keeping. However, when we began taking oral evidence, it quickly became apparent how greatly the opinions of the industry on the one hand, and the public health lobby on the other hand, differed as to the value of the key feature of the EAHF: the involvement of the alcohol industry.

### *Industry involvement*

209. Unsurprisingly, representatives of the alcohol industry were positive about the structure of the EAHF, which exemplified the “inclusive multi-stakeholder approach”<sup>200</sup> taken by the Strategy. Mr Beale even considered the Forum to be the Strategy’s “key advantage and benefit”.<sup>201</sup> The Advertising Association was also particularly enthusiastic, describing the EAHF as “an extremely important mechanism for dialogue between industry, the NGO community and the European Commission ... It, or an equivalent channel for this dialogue, must be retained in any future Strategy.”<sup>202</sup>

210. Notwithstanding the importance of such a dialogue, spiritsEUROPE was disappointed that the policy debate on alcohol at EU level had become “too polarised and inefficient”.<sup>203</sup> The background to this statement is what the Advertising Association described as “repeated complaints from the NGO community about the extent of industry’s representation in the EAHF”, which were “consistent with public health lobbyists’ general suspicion of co- and self-regulation.”<sup>204</sup>

211. Witnesses from the public health sector were indeed a great deal less positive about the manner in which the EAHF had been conducting its work and the value of its output. It is also true that many of their concerns related to the extent of industry representation in the EAHF, although it seemed to us that in most cases these were grounded in their first-hand experience as EAHF members.

212. In fact, many public health witnesses appreciated that there was some benefit to involving the alcohol industry at some stage of the EU policy cycle. Eurocare, a member of the EAHF, saw “value in maintaining a mechanism whereby NGOs and public health bodies can discuss with the European

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<sup>198</sup> The 15 Member States of the European Union prior to the 2004 enlargement.

<sup>199</sup> COWI-Milieu, *Summary report on commitments made by members of the European Alcohol and Health Forum* (October 2013): [http://ec.europa.eu/health/alcohol/docs/eahf\\_commitments\\_2013\\_en.pdf](http://ec.europa.eu/health/alcohol/docs/eahf_commitments_2013_en.pdf) [accessed 24 February 2015]

<sup>200</sup> For example written evidence from SABMiller ([EAS0009](#)) and the Advertising Association ([EAS0015](#))

<sup>201</sup> [Q 142](#)

<sup>202</sup> Written evidence from the Advertising Association ([EAS0015](#))

<sup>203</sup> Written evidence from spiritsEUROPE ([EAS0025](#))

<sup>204</sup> Written evidence from the Advertising Association ([EAS0015](#))

Commission how economic operators can contribute to actions that will reduce alcohol harm.”<sup>205</sup> Towards the end of an oral evidence session in which all three public health witnesses had been particularly critical of the alcohol industry, Dr Gillan conceded that “of course you have to talk to the industry—of course they are a stakeholder. No one is suggesting that we ignore them completely. However, we have to be clear about where the industry’s expertise lies ... For example, the industry has a clear role in server training, labelling—there are a number of things that are to do with its role as producers, marketers and sellers of alcohol, and that is what the role should be confined to.”<sup>206</sup>

213. Similarly, Prof Sheron confirmed that he was in fact in favour of speaking to representatives of the industry, although he continued: “I have met many members of the drinks industry who were quite committed to doing the best they can to reduce alcohol-related harm, but I have not met a single one who would put the health of the population above the health of their company.”<sup>207</sup>
214. The concerns of the public health witnesses related not so much to the fact of industry involvement in the EAHF as to its extent, and the effects which this had on the Forum’s priorities. ScHARR told us:
- “Action following the EU Alcohol Strategy has largely been translated as industry action, with alcohol producers and retailers strongly represented on EAHF. Whilst economic actors have a role to play in tackling alcohol-related harm, they also have major conflicts of interest ... Permitting the alcohol industry to have such a dominant voice in implementing the EU Alcohol Strategy and influencing future policy development is not an effective way to safeguard public health.”<sup>208</sup>
215. Public health NGOs, including Eurocare and SHAAP, also had some specific concerns about industry involvement with regard to the interpretation of the Forum’s mandate: “Despite the EAHF having no official role in policy development, views of Forum members were sought throughout the development of the EU Alcohol Action Plan, and objections from economic operators to scientific reports produced on behalf of the Forum have been upheld.” Eurocare therefore wished to emphasise that, despite their seeing value in the EAHF, “alcohol industry activities should be restricted to their core roles as developers, producers, distributors, marketers and sellers of alcoholic beverages and that they should have no role in the formulation of alcohol policies, which must be protected from distortion by commercial or vested interests.”<sup>209</sup>
216. Of all our witnesses, Government representatives seemed to present the most balanced and realistic picture of industry involvement in alcohol policy. In reference to the UK Responsibility Deal, which we discussed in Chapter 7, Lindsay Wilkinson, Deputy Director of Drug and Alcohol Policy at the Department of Health, said: “Alcohol manufactures and retailers can reach

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<sup>205</sup> Written evidence from Eurocare ([EAS0006](#))

<sup>206</sup> [Q 47](#)

<sup>207</sup> [Q 49](#)

<sup>208</sup> Written evidence from the University of Sheffield Alcohol Research Group (ScHARR) ([EAS0014](#))

<sup>209</sup> Written evidence from Eurocare ([EAS0006](#))

their customers in a way that other people cannot ... We have a long history of working with the alcohol industry, and we find that it does some things that we are not able to do through any other means.”<sup>210</sup> She was, though, also careful to point out that “Ultimately policy formulation is a matter for Member States and governments. There is no reason why the industry cannot say what it believes we should do, but that does not mean that it is part of the decision-making about what happens.”<sup>211</sup>

217. It seems that this crucial distinction has been lost in the workings of the EAHF, thanks in particular to its unclear mandate and its involvement in policy setting. This has blurred the line between policy debate and policy formulation, which we regard as unacceptable in the light of the significant industry presence in the Forum.

*Suggestions for improvement*

218. In recognition of the Forum’s general usefulness, and in order to improve its functioning, several witnesses felt that the Forum should become a more focused body, with fewer priorities and clearer indicators to measure the success of commitments. Eurocare and SHAAP suggested the implementation of a work plan by the Commission, aligned to a set of core objectives agreed by CNAPA and drawn up in consultation with Forum members.<sup>212</sup> This would provide a practical framework within which commitments could be made in the EAHF.

219. ScHARR suggested an alternative structure for the EAHF which would separate discussions on alcohol health policy from discussions on policy areas touching upon alcohol-related harm more widely:

“One committee would focus on trade and, where appropriate, implementation (e.g. for interventions impacting directly on retail or production). Alcohol industry membership would be confined to this committee where their expertise would be utilised and legitimate interests addressed. A second committee would focus on impacts on health and well-being, with membership predominantly drawn from the public health and scientific communities.”<sup>213</sup>

220. In the light of the evidence described above, we question whether the Strategy’s “multi-stakeholder approach”, so lauded by the alcohol industry, has actually been a success. It seems that the enthusiasm about its functioning is rather one-sided, while a successful model for cooperation, and in particular dialogue, would require satisfaction by all partners. We believe that there is merit in involving the industry at some stage of the policy cycle. But steps must be taken to address the shortcomings we have identified, in order to make the most of that involvement and foster true cooperation, in place of the “polarised and inefficient” debate that has arisen from the current arrangements.

221. Most witnesses were willing to accept industry involvement at some stage and in some way. It therefore seems to us that it is not the involvement of the

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<sup>210</sup> [Q 30](#)

<sup>211</sup> [Q 31](#)

<sup>212</sup> Written evidence from Eurocare ([EAS0006](#)) and SHAAP ([EAS0001](#))

<sup>213</sup> Written evidence from the University of Sheffield Alcohol Research Group (ScHARR) ([EAS0014](#))

alcohol industry *per se*, but rather the nature of that involvement, combined with the unclear mandate of the Forum itself, which is undermining the EAHF. The EAHF is a valuable policy tool and should be retained, but it should be made clear that it is a tool for the formulation of voluntary commitments to support European alcohol policies, not for setting policy objectives, which should be the role of the Commission and Member States.

222. **We recommend that the Commission restate the remit of the EAHF and review its structure and functioning. The terms of reference of the Forum should clearly state the roles and responsibilities of all participating stakeholders, including the alcohol industry.**

### The Science Group

223. The mandate of the Science Group is found in Annex 3 of the Charter establishing the EAHF: “The main tasks of the Group are to stimulate cross-EU networking of scientific activities around the issues before the Forum and, on request, to: provide scientific guidance ... offer guidance on monitoring/ evaluation ... provide in-depth analyses of key issues.”<sup>214</sup> These tasks include issuing Scientific Opinions when requested by the EAHF. In the six years of the 2006–12 Strategy, only two such Opinions were produced.
224. Prof Anderson—himself an expert member of the Science Group—attributed this low output to uncertainty about the responsibility and funding of the Group: “The problem with the Science Group as it was formulated was that it was never given a very clear mandate and it was not sure what it was supposed to be doing. There was no money whatever to support its work, so the two reports that it did were done completely voluntarily.”<sup>215</sup> As a result, the Group’s meetings became irregular and rare, with attendance gradually decreasing until the Group became practically defunct.
225. Prof Anderson also had concerns about the selection of the Group’s members, stating that they “were not necessarily the ones you might want to discuss policy issues: there were a mixture of people, who were chosen more to represent different interest groups and to get people there.”<sup>216</sup> Mr Spillane noted that “After four years of the Science Group, every meeting struggled to have a quorum and, in the end, it was driven largely by scientists linked to organisations that were able to fund their science. Consequently, you ended up with probably the most polarised people sitting in these groups.”<sup>217</sup>
226. In March 2014, a group of NGOs called for the Science Group to be strengthened through, among other measures, a new call for experts, additional financial means and improved interaction with the EAHF and CNAPA. The NGOs emphasised the Science Group’s key tasks in “moving discussions forward that are blocked due to a lack of conclusive scientific

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<sup>214</sup> EAHF, *Charter Establishing the European Alcohol and Health Forum* (June 2007), Annex 3, page 12: [http://ec.europa.eu/health/ph\\_determinants/life\\_style/alcohol/documents/Alcohol\\_charter2007.pdf](http://ec.europa.eu/health/ph_determinants/life_style/alcohol/documents/Alcohol_charter2007.pdf) [accessed 24 February 2015]

<sup>215</sup> Q 9

<sup>216</sup> Q 9

<sup>217</sup> Q 136

evidence” within the EAHF and CNAPA, as well as “bringing together top scientists in alcohol research”.<sup>218</sup>

227. Some witnesses also suggested tasks which a strengthened and well-resourced Science Group could carry out in order to contribute more fully to the Strategy. These included: “setting the scene in each EAHF session on the health consequences of harmful use of alcohol and on new evidence published of interest to the EAHF; identifying research gaps and priorities for EU funding based on discussions with the healthcare members of the EAHF.”<sup>219</sup> Written evidence from public health NGOs added that the Group could “ensure that EU alcohol policies are underpinned by an up to date evidence base of effectiveness moving forward, and that the evidence advising such policies is independently verified and free from commercial vested interests.”<sup>220</sup> We welcome these constructive suggestions.
228. We agree that an independent Science Group could make a significant contribution to EU action on alcohol-related harm. It would address several of the concerns identified in this report, including the tension between public health and industry representatives in the EAHF, agenda-setting for EU-funded research, and the development of a common evidence base through standardised data collection. If it is to satisfactorily fulfil all these tasks however, it will need to be re-established as an independent body with adequate resources.
229. **We recommend the re-establishment of the Science Group, which should be independent from the EAHF and include experts from all Member States. The Science Group should receive adequate support as well as sufficient financial resources from the Commission.**

### **The relationship between supporting bodies**

230. The 2012 evaluation of the Strategy explicitly pointed out deficits in the interaction between the bodies intended to assist in its implementation. These findings were endorsed and confirmed by several of our witnesses.<sup>221</sup> When we asked them for their opinions on the structures in place more generally, the unclear and at times troubled relationships amongst the bodies, as well as between them and the Commission, emerged as a concern shared by all sectors.

### *The EAHF and the Science Group*

231. The creation of the Science Group from within the EAHF caused some concern among witnesses from the public health sector. Most of these concerns related to the level of industry influence in the Forum, which we have already described. Prof Meier stated that “there is a very substantial

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<sup>218</sup> Eurocare, ‘Call for the Science Group of the European Alcohol and Health Forum to be strengthened’: [http://www.eurocare.org/library/updates/call\\_for\\_the\\_science\\_group\\_of\\_the\\_european\\_alcohol\\_and\\_health\\_forum\\_to\\_be\\_strengthened](http://www.eurocare.org/library/updates/call_for_the_science_group_of_the_european_alcohol_and_health_forum_to_be_strengthened) [accessed 10 February 2015]

<sup>219</sup> Written evidence from Lundbeck Ltd (EAS0011)

<sup>220</sup> Written evidence from Alcohol Health Alliance UK (EAS0012), Balance (EAS0017), Eurocare (EAS0006), Institute for Alcohol Studies (EAS0002)

<sup>221</sup> For example written evidence from the Advertising Association (EAS0015) and the Department of Health (EAS0019)

industry representation, so any reports that the Science Group sends to the Forum get filtered through an industry interpretation process.”<sup>222</sup>

232. We also received written evidence from several public health NGOs saying that “the Science Group ... would be better placed if it reported directly to CNAPA. This would enable policy discussions on the evidence to support interventions to reduce alcohol harm to be free from commercial conflicts of interest ... The Science Group of the EAHF should therefore be re-established as an independent expert group, free from membership from economic operators.”<sup>223</sup> We agree that, if the Science Group is to act as a broker for discussions on scientific evidence, including within CNAPA, it should have a status separate from the EAHF.
233. Ms Skar and Prof Anderson both emphasised the need for a body similar to the Science Group, regardless of the form it would finally take. Prof Anderson said: “What the Commission needs is a scientific expert body on which it can call and get scientific advice. Looking to the future, I would find a way of reformulating the work of the science group; rather than being the science group for the forum, it should be like an expert or an evidence-based group for the Commission itself.”<sup>224</sup> Ms Skar added that “we do believe it is good to have a Science Group, whether it is EMCDDA or the Joint Research Centre or whether we let the Commission use their own. It is not so important how it is organised, but we should have some body that is relatively independent.”<sup>225</sup>

#### *CNAPA and the EAHF*

234. There was feeling among industry EAHF members that “it would be good to see the CNAPA and the European Alcohol and Health Forum working more closely together.”<sup>226</sup> The WSTA and SWA were particularly concerned about the lack of coordination between the two bodies, highlighting that there “is currently little or no interaction between the Forum and CNAPA; some Member States do attend the Forum meeting but attendance is low and variable.”<sup>227</sup> SpiritsEUROPE added: “More information, communication, and interaction between the Forum members and CNAPA would be welcomed: there is no indication as to the level of awareness of CNAPA members about the discussions, conclusions and, even more broadly, the commitments made in the EAHF over the past seven years.”<sup>228</sup>
235. Mr Acton confirmed this, albeit from CNAPA’s perspective: “For most of [the EAHF’s] existence, there has been almost semi-exclusion of the Member State role. Although we have been notified of Forum meetings, sometimes we do not get the papers, so we cannot decide how important it is

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<sup>222</sup> [Q 9](#) (Professor Meier)

<sup>223</sup> Written evidence from Alcohol Health Alliance UK ([EAS0012](#)), Balance ([EAS0017](#)), Eurocare ([EAS0006](#)), Institute for Alcohol Studies ([EAS0002](#))

<sup>224</sup> [Q 9](#) (Professor Anderson)

<sup>225</sup> [Q 165](#)

<sup>226</sup> [Q 186](#) (Brigid Simmonds)

<sup>227</sup> Written evidence from the Wine and Spirits Trade Association ([EAS0016](#)) and the Scotch Whisky Association ([EAS0020](#))

<sup>228</sup> Written evidence from spiritsEUROPE ([EAS0025](#))

to attend. There is no formal process for seeking Member States' opinions on Forum commitments."<sup>229</sup>

236. At the moment, the only document setting out how CNAPA and the EAHF are to interact is the 2007 Charter establishing the EAHF, which states, in a rather scant section entitled 'relations with other structures': "The plenary meetings of the Forum are open to members of [CNAPA and the Committee on data collection and indicators]. Where the work of the Forum is relevant to their agenda, the Committees may invite members of the Forum to contribute to their discussion, alongside other sources of input."
237. Based on the experience of our witnesses from both the EAHF and CNAPA, it seems that the level of interaction between the two bodies is insufficient and should be reviewed. The WSTA and SWA commented: "It would be useful to have formal exchanges between the two bodies. Forum commitments should be on the agenda of each CNAPA meeting, and reciprocally, CNAPA members should present Member States' national developments at Forum meetings." Lundbeck Ltd suggested that the interaction between CNAPA and the EAHF could be improved by "the presence of representatives from the EU Trio Presidencies and CNAPA members at the EAHF meetings—who could report back to CNAPA members on points of relevance".<sup>230</sup>

#### *CNAPA and the Commission*

238. Mr Carlin argued that CNAPA would benefit from a clear delineation of its responsibilities, as opposed to those of the Commission. Specifically, he suggested that:

"a new energised and empowered CNAPA needs to make clear to Commission officials that the Commission's role is to support CNAPA's policy decisions, not to block, undermine or even partially disown them as sometimes happens—for example with the new Action Plan, where a bit of a battle went on behind the scenes to get the Commission to include mention of CNAPA within the action plan."<sup>231</sup>

239. Eurocare argued that "to date CNAPA's view has not been awarded sufficient attention, with several calls for a renewed EU Strategy since 2010 failing to result in action from the European Commission ... It is essential that the views and priorities of CNAPA are given active consideration in developing and implementing European alcohol policy."<sup>232</sup> We agree, and believe the Commission should be more supportive of CNAPA's role.

#### **Conclusions**

240. The bodies created under the EU Alcohol Strategy 2006–12 have the potential to facilitate the exchange of expertise and best practices across the EU, and therefore to make an important contribution to EU alcohol policy. None of our witnesses, many of whom had first-hand experience and were

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<sup>229</sup> [Q 240](#) (Crispin Acton)

<sup>230</sup> Written evidence from Lundbeck Ltd ([EAS0011](#))

<sup>231</sup> [Q 116](#)

<sup>232</sup> Written evidence from Eurocare ([EAS0006](#))

critical of their functioning, suggested that any of the bodies should be abolished.

241. Despite the contributions made by these bodies, our evidence revealed significant problems with how they operate in practice. Problems common to all bodies are a lack of clear mandates and unclear relationships between them. Putting the existing structures on a more formal footing may go some way to addressing these concerns, including those surrounding the relationships between bodies. In particular, a clear remit for each body, including more limited priorities, could avoid the duplication of tasks and thus waste of resources.
242. In the light of the evident tensions between bodies, as well as between CNAPA and the Commission, further steps are needed to encourage more active cooperation. We consider that the nature and extent of relationships between the bodies should be included in any document formalising the status of CNAPA and an independent Science Group. Links between CNAPA and the EAHF should be strengthened through regular exchanges and mutual representation at meetings, while the administrative links between the EAHF and the Science Group should be severed to ensure the latter's independence.
243. **EU action on alcohol should continue to be supported by bodies facilitating the exchange of expertise and best practices, which is seen by many as the key benefit of the EU Alcohol Strategy 2006–12.**
244. **We recommend that the roles and mandates of CNAPA, the EAHF and the Science Group should be formalised and reviewed periodically. In each case the role should include a clear work plan in line with the stated objective of any future EU action on alcohol abuse, as well as an explanation of the relationships between bodies and the Commission, which should be agreed by the Council.**

## CHAPTER 9: RESEARCH

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245. As we said in Chapter 3, the Fifth Priority of the Strategy was to “Develop, support and maintain a common evidence base”. This was underpinned by Aim 10: “To obtain comparable information on alcohol consumption, especially on young people; definitions on harmful and hazardous consumption”. In our request for written evidence we specifically asked whether the EU’s alcohol policies were in fact underpinned by a sound scientific base.
246. Witnesses who answered this question thought, without exception, that any strategy and indeed any action on alcohol policy should have a sound scientific base. We agree. Indeed, this is true of any policy, and President Juncker, in a recent letter to the Chairman of this Committee, has confirmed that he is “a strong believer in the necessity to ground policies in solid evidence, with the help of independent scientific advice”.<sup>233</sup>

### Research Commissioned by the EU

247. Sarah Godman from the NHS European Office described to us the relevant research over the last 10 years:

“The EU’s Health Programme has supported 37 projects since 2004 on alcohol-related harm in support of the alcohol Strategy. The existence of the strategy has helped to focus the funding that is channelled through that programme. There have been projects that supported all areas of the Strategy. It is probably also worth noting that the research programme, which has larger funds apportioned to it, has also funded a number of research programmes that underpin the research that is necessary for a lot of the public health work that is funded through the EU’s public health programme. The 37 projects funded through the EU Health Programme came to about €15 million of EU support. There are four strong significantly relevant projects funded through the research programme, which amounted to another €15 million of support. Those four projects had strong involvement from the UK, particularly from higher education institutions.”<sup>234</sup>

248. Looking at rather different dates, the 2012 evaluation of the Strategy stated: “Since 2007, the EU Health Programme has supported alcohol related projects with approximately €9 million, and the EU Research Framework Programmes provided approximately €49 million for studies on alcohol and health. These amounts represent, respectively, less than 3% of the total budget of the Health Programme for 2008–2013, and less than 1% of the budget for health under Seventh Research Programme.”<sup>235</sup>

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<sup>233</sup> Letter of 16 January 2015 from the President of the Commission to Lord Boswell of Aynho, Chairman of the House of Lords European Union Committee, and the Earl of Selborne, Chairman of the House of Lords Science and Technology Committee.

<sup>234</sup> [Q 21](#)

<sup>235</sup> COWI-Milieu, *Assessment of the added value of the EU strategy to support Member States in reducing alcohol-related harm, Final Report* (December 2012), paragraph 2.5: [http://ec.europa.eu/health/alcohol/docs/report\\_assessment\\_eu\\_alcohol\\_strategy\\_2012\\_en.pdf](http://ec.europa.eu/health/alcohol/docs/report_assessment_eu_alcohol_strategy_2012_en.pdf) [accessed 24 February 2015]. These figures were cited by a large number of our witnesses in written evidence, including Eurocare ([EAS0006](#)), Alcohol Health Alliance UK ([EAS0012](#)), Balance ([EAS0017](#)), Institute for Alcohol Studies ([EAS0002](#)), and SHAAP ([EAS0001](#)), and Katherine Brown [Q 45](#).

249. One of the projects we heard most about was AMPHORA.<sup>236</sup> This was a four year project funded by the 7th Framework Programme of the European Commission, which aimed to contribute new evidence on scarcely explored or unexplored areas of alcohol consumption and alcohol-related harm in Europe. It involved research institutions from 12 European states in collaboration with organisations from all the Member States. Among the research areas covered by AMPHORA were an update on European epidemiological data; the definition of standard common indicators of alcohol consumption and harm; the measurement of the strength of alcohol policies; the study of contextual determinants of alcohol consumption, the analysis of the impact of marketing on youth; the availability of treatments at a European level; and two areas of harm reduction (contamination of illegal or surrogate alcohols and the reduction of harm in drinking venues).
250. Ms Godman told us that one of the biggest projects funded by the research funds in the 7th Framework Programme was ALICE RAP,<sup>237</sup> “which did research into addiction—broadly, not just alcohol—and lifestyles in contemporary Europe. Around €8 million was given to that project alone. It had 42 participants, twelve of whom were from the UK.”<sup>238</sup>
251. For the future, DG Research currently has a programme, Horizon 2020, running from 2014 to 2020, which has a budget of €7.5 billion allocated to health, democratic change and well-being. Within this programme, Ms Godman told us that “the Council has recommended an ongoing area focusing on effective health promotion, disease prevention, preparedness, screening and research that tries better to understand health, ageing and disease. There is definitely scope for projects on alcohol harm-related projects or on understanding the impact of alcohol on health, ageing and disease.”<sup>239</sup> In addition to the funding of Horizon 2020, the EU’s health programme provides approximately €450 million for health research from 2014 to 2020.<sup>240</sup>
252. DG Research provides funding in response to bids from researchers. In Ms Godman’s words, it “basically waits for excellent proposals. It is a competitive funding line. It is driven by the kind of proposals that it receives. If there are excellent research projects on alcohol, they have every chance of success. This programme is demand driven. It is supposed to be grass-roots research on expert opinion.”<sup>241</sup>
253. Dr Ruxandra Draghia-Akli and her colleagues confirmed this in the evidence we took from them. They explained that they were sponsoring programmes “around the biology of ageing, addiction and the mechanism of ageing—it is not alcohol only, it is the link between alcohol and nicotine and the link between alcohol and transport, driving and behaviour and all these areas that

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<sup>236</sup> Alcohol Measures for Public Health Research Alliance

<sup>237</sup> Addictions and Lifestyles in Contemporary Europe Reframing Addictions Project

<sup>238</sup> [Q 22](#)

<sup>239</sup> [Q 21](#) (Sarah Godman)

<sup>240</sup> European Commission, *The Third Health Programme 2014–2020: Funding Health Initiatives Factsheet* [http://ec.europa.eu/health/programme/docs/factsheet\\_healthprogramme2014\\_2020\\_en.pdf](http://ec.europa.eu/health/programme/docs/factsheet_healthprogramme2014_2020_en.pdf) [accessed 24 February 2015]

<sup>241</sup> [Q 21](#)

are interlinked.”<sup>242</sup> In other words, the policy of DG Research is not to take the initiative, but to respond to proposals from researchers, and requests for funding. This is essential to provide a scientific basis for developments in health and wellbeing, and it is right that researchers should take the initiative in proposing the topics for such research.

*The perceived quality of research*

254. Where the formulation of policy requires additional research into specific issues, this has to be commissioned by DG SANCO, which is responsible for the formulation of the Commission’s alcohol policy. The fact that those formulating the policy are also commissioning the research does not in our view mean that the quality of that research is necessarily compromised, but it can give rise to such a perception, in particular where the alcohol industry might be adversely affected by policies which the research might support. SpiritsEUROPE told us they had “concerns about the way research on alcohol-related harm is funded, conducted and presented by DG SANCO, believing much of the ‘evidence’ generated provides misleading signals to policy-makers.”<sup>243</sup>
255. Speaking for the WHO, Dr Møller told us that they had been “extremely happy” with the quality of the EU-supported research: “we published a book ... where we went through all the 10 action areas [of the Strategy] and the evidence for all these policies. A lot of that was based on the EU-supported research, so we had a very good evidence base when we drafted our action plan.”<sup>244</sup>
256. However, the quality of much of the research was the subject of sustained criticism from the industry, retailers and advertisers. The WSTA told us that “The quality of the research in a number of projects funded by the European Commission has been poor and this has been challenged by the European body representing national trade associations and the alcohol industry.”<sup>245</sup> Mr Baker too thought that the quality of research was “patchy and haphazard”.<sup>246</sup>
257. The Scotch Whisky Association wrote:
- “It is important that research used by policy-makers is relevant, neutral and objective, fair and transparent, robust and based on appropriate engagement with all stakeholders, and subject to the highest levels of scrutiny and accountability. It should be conducted to the highest methodological standards, with data sources that are transparent and accessible. These principles have not always been respected in the past. We have seen projects funded by the EU which have been presented to the EAHF. In our opinion, a number of those reports have had pre-judged conclusions and been conducted with the aim of justifying a

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<sup>242</sup> [Q 141](#) (Maria Vidal, Head of Unit for Medical Research)

<sup>243</sup> Written evidence from spiritsEUROPE ([EAS0025](#))

<sup>244</sup> [Q 80](#)

<sup>245</sup> Written evidence from WSTA ([EAS0016](#))

<sup>246</sup> [Q 64](#)

particular policy recommendation. These reports are now being widely quoted by health stakeholders as irrefutable evidence.”<sup>247</sup>

### *Independence of researchers*

258. The problems are compounded when the researchers and the policy-makers who are also in charge of the funding are seen to be getting too close. Mr Skehan told us:

“What we see time and again is that we have a whole group of people who are not quite making a living from this but certainly it is a part of their life and they are drawing down funds to produce material that we do not have trust in. We are not against research. I come back to this. We firmly believe it is the way it should be, but we would love to see it be more neutral, less biased, with oversight by some neutral body.”<sup>248</sup>

259. SpiritsEUROPE made a similar point, saying they had “concerns about the way research on alcohol-related harm is funded, conducted and presented by DG SANCO, believing much of the ‘evidence’ generated provides misleading signals to policy-makers ... We have noted that the funds available have been repeatedly allocated to the same entities, even though the quality of the reports produced was consistently questioned. Of nearly €15 million awarded in research contracts between 2009 and 2012 across 10 projects, RAND Europe were awarded three projects,<sup>249</sup> the Dutch Institute for Alcohol Policy (STAP (NL)) gained three, and the same researchers—and research topics—crop up time and again.”<sup>250</sup>

260. The same point was made by Mr Beale: “Eleven projects have been conducted, to the tune of €15 million, and some organisations—and I shall not name them—appear four or five times, so that is almost 50%.”<sup>251</sup> Mr Duffy said: “My view of the AMPHORA and ALICE RAP projects is that while they may well be extremely worthy, they always involve the usual suspects. The scientific quality is variable.”<sup>252</sup>

261. The criticism of a lack of independence is not all one way. ScHARR told us that “Senior researchers have encountered inappropriate involvement of the alcohol industry in the research process, particularly around the lack of promotion and utilisation of research findings which are contrary to industry interests.”<sup>253</sup> On the other hand, as Mr Ashworth said, “If the drinks industry were to do research, the public health community would not accept that research.”<sup>254</sup>

262. The Minister thought it unrealistic to expect all concerned to agree on evidence: “I do not think that we see it as [a] primary aim to obtain universal

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<sup>247</sup> Written evidence from SWA ([EAS0020](#))

<sup>248</sup> [Q 134](#)

<sup>249</sup> One of these was the report by RAND Europe on the assessment of young people’s exposure to alcohol marketing in audiovisual and online media, which we have referred to in Chapter 5.

<sup>250</sup> Written evidence from spiritsEUROPE ([EAS0025](#))

<sup>251</sup> [Q 198](#). The bodies Mr Beale declined to name are those listed by spiritsEUROPE in their written evidence, quoted in the previous paragraph.

<sup>252</sup> [Q 65](#)

<sup>253</sup> Written evidence from the University of Sheffield Alcohol Research Group (ScHARR) ([EAS0014](#))

<sup>254</sup> [Q 36](#)

consensus on evidence, because I think we fear that we would never act if that was the bar that was set. It is almost inevitable that there will be disagreements about evidence, and even if we have really good evidence, such as on the relationship between high levels of alcohol consumption and increased health risks or the relationship between price and consumption, it might not be accepted by some, so I think it is always the case that even when one group says, ‘We are absolutely convinced that this is solid evidence’, there will be others who will dispute it.”<sup>255</sup>

263. We accept that there will be disagreements about the value of evidence and the strength of any conclusions based on it. But we do not think progress will be made unless there is a degree of mutual trust in the researchers and their work. Policies cannot sensibly be discussed, whether at EU or national level, unless there is a basis of evidence derived from research which is trusted by all, including the public health lobby and the industry.
264. It is clear from our witnesses that there is scarcely a single matter on which the evidence is currently trusted by all concerned. Whether what is at issue is an attempt to measure the harm caused by excessive and irresponsible drinking or the effect which pricing, advertising or labelling policies have in reducing alcohol-related harm, or any other relevant issue, research is currently trusted only if its results happen to coincide with the interests of those considering it.
265. We are not ourselves qualified to evaluate any of the research which has been criticised, and we do not take a position on the criticisms of its quality. Nor are we suggesting that there is or has been any bias in the selection of researchers, or defects in the conduct of research, or lack of integrity in its conclusions.
266. **Where those responsible for formulating policy, in this case DG SANCO, identify a need for further information, they are best placed to commission such research.**
267. **The quality of research will be questioned if it is carried out by researchers who are perceived to have vested interests in the outcome. The best way to diminish any such perception is to commission research from as wide and varied a network of researchers as possible. This should be done through competitive tendering.**
268. **It should be no part of the researchers’ task to suggest what policies should be based on their findings. Any attempt to do so will give rise to the perception of a lack of independence.**

#### **Where research is needed**

269. We received a considerable quantity of evidence on the matters which witnesses felt needed further research. Mr Acton commented: “We need to distinguish between areas of policy that are under-researched and those where there is lots of evidence ... there is a lot of evidence on alcohol, taxation and price. There are a lot of areas of alcohol policy that are under-researched, including harms to young people. Although having a lot of evidence does not guarantee consensus, if you have very little evidence there

is still less chance of consensus.” The Minister agreed: “We would be keen to see the EU focus on areas that have been under-researched and where the research would be the most helpful.”<sup>256</sup> Four such areas identified to us by witnesses were behavioural change; the impact of advertising on consumption by children and young people; harm to others; and alcohol-related crime.

### *Behavioural change*

270. Dr Møller advocated further research into behavioural change:

“We know very little about how to change behaviour, but we know that policies do change behaviour. We can see that with the smoke-free environment ... A little more about behaviour, binge drinking and so on would be interesting ... We have these differences: some countries binge drink, while other countries do not, and we see much more harm when you binge drink ... We do not have very good evidence about whether education, training and awareness has any impact. So far the evidence is that it is not very useful.”<sup>257</sup>

### *The impact of advertising on consumption by children and young people*

271. We have already quoted<sup>258</sup> the view of Mr Acton that, although there is “quite solid” evidence for the effect of advertising on adults’ alcohol consumption, there are evidence gaps on the effect of advertising on consumption by children and young people. There was also, in his view, very little evidence on effective interventions to restrict advertising.<sup>259</sup> Given that such research as there has been on these topics, and the evidence and findings derived from it, are so strongly contested, we agree that this must be a priority area for future research.

### *Harm to others, and alcohol-related crime*

272. Data on alcohol-related harm to others are at best patchy, both at UK and EU levels. Ms Brown told us: “there are definitely gaps with regard to monitoring levels of harm, particularly harms to third parties: rates of alcohol-related domestic abuse, child abuse, rates of foetal alcohol spectrum disorder, and ... rates of exposure of alcohol marketing and advertising to children.... If we can quantify that burden and that harm, that will produce more evidence and more incentive to governments to take action and implement effective policies, and that is where better data collection will be able to help. Dr Gillan agreed: “Where we have the gap is harm to people other than the drinker. We did a national survey in Scotland that showed that one in two people reported being harmed in some way as a result of someone else’s drinking, and one in three people had a heavy drinker in their life.”<sup>260</sup>

273. Mr Ashworth made the same point in relation to alcohol-related crime: “There is no comparable alcohol-related crime data, such as government statistics comparing one country to another in terms of alcohol-related crime.

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<sup>256</sup> [QQ 236–237](#)

<sup>257</sup> [Q 96](#)

<sup>258</sup> Paragraph 172

<sup>259</sup> [QQ 23–24](#)

<sup>260</sup> [QQ 42–43](#)

We know in the UK that violent crimes related to alcohol have decreased 32% since 2004 and 47% since 1995. Are we doing better or worse than other countries, and why would that be?”<sup>261</sup>

274. **Behavioural change, the impact of advertising on consumption by children and young people, harm to others and alcohol-related crime are some of the many areas where there are gaps in knowledge and where further research would significantly assist policy formulation.**

*Standardised terminology and measurement*

275. Member States have different ages of majority and different minimum ages for buying alcohol, so that the use in research of words like ‘child’, ‘young person’ and ‘adult’ may not compare like with like, and should therefore be avoided. The WHO refers to ‘adult (aged 15+)’. It seems to us that the only sensible classification is to refer to ages, and that the EU could influence researchers and the authorities of Member States to use common age ranges.
276. Mr Beale thought that “Better comparability of data across the EU can really only be done at EU level, for the Commission, for Eurostat, for others. One area where this is a problem, for example, is that WHO, Eurostat and Member States all have slightly different definitions of alcohol-related harm, and that gives you obvious comparability problems in looking at the figures across the union.”<sup>262</sup>
277. Eurocare suggested that: “Common measurement standards could be agreed across the EU in order to monitor and evaluate alcohol harm and interventions to reduce harm and help to prevent cross-border discrepancies. For example, a common unit of alcohol or standard drink would harmonise consumption trend data across the region and also allow for common EU consumer information such as low risk drinking guidelines and health information on labels.”<sup>263</sup>

*Role of the Science Group*

278. Prof Sheron said: “There is a role here for the Science Committee, perhaps reporting to CNAPA or to the Commission itself, not only giving a verdict on establishing the evidence base and stamping its imprimatur on it, but outlining where the research gaps are.”<sup>264</sup>
279. **The Science Group could play a useful part in identifying gaps in the knowledge surrounding alcohol-related harm, and suggesting the parameters for research. It could also promote standardised terminology and common measurement standards to improve the comparability of research across the EU.**

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<sup>261</sup> [Q 216](#)

<sup>262</sup> [Q 187](#)

<sup>263</sup> Written evidence from Eurocare ([EAS0006](#))

<sup>264</sup> [Q 44](#). See also the evidence from Lundbeck Ltd ([EAS0011](#)) quoted in paragraph 227.

## **CHAPTER 10: A NEW EU ALCOHOL STRATEGY?**

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280. The five priorities for action of the 2006–12 Strategy, which we listed in Box 5, are still the right priorities today. None of our witnesses has suggested otherwise. They are goals for the Member States individually as much as for the EU. With the possible exception of “developing and maintaining a common evidence base”, we believe some progress has been made on all of them, though views on this differ widely, as do views on the extent to which that progress can be attributed to the Strategy.
281. Some of our witnesses, especially those from the industry, argue that there has been considerable progress, especially in the UK, on reducing under-age drinking, on the regulation of advertising, and on awareness of the dangers of irresponsible drinking. They therefore believe the right approach is ‘more of the same’, and would like to see a new Strategy building on the old one, in substance repeating what it says.
282. Given the continuing prevalence of alcohol-related harm in Europe, the uncertainty surrounding the achievements of the old Strategy, and the weaknesses identified by our inquiry, we do not see any value in simply changing the date on the old Strategy and making a few minor amendments. A more radical approach is needed which concentrates EU action on those areas where it has competence and where it can make a difference, whether they are part of the ‘health in all policies’ approach, or are actions specifically under health policy.
283. One such area would have been the updating of the minimum rates of duty which were set over twenty years ago. We regret that the Commission’s attempt to do so should have been blocked in the Council in 2010 and not subsequently discussed.
284. **There is much to be said for EU action which concentrates on those areas where it has competence and addresses the weaknesses which our inquiry has revealed. A new Strategy which goes no further than its predecessor would achieve little.**
285. **We have identified the structure of the taxation of alcohol and the labelling of alcoholic beverages as matters where the EU must exercise its competence to enact necessary legislation. It will be for the Commission to take the initiative.**
286. **The self-regulation of advertising, the organisation and powers of CNAPA, the EAHF and its Science Group, and research, are among the areas where the Commission should work with Member States to improve the position, in accordance with our recommendations.**
287. **The EU Alcohol Strategy 2006–12 took the form of a Communication from the Commission to the Council. A similar Communication, whatever its title, which embodies the Commission’s determination to make these changes, and which is approved by the Council, would in our view make a significant contribution to reducing alcohol-related harm in the EU.**
288. **The Latvian Presidency intends to discuss the next steps towards a new EU Alcohol Strategy at an informal Council on 20–21 April 2015.**

**We hope that our recommendations will assist the deliberations of the Member States, and that they will invite the new Commission to make the preparation of such a Communication an urgent priority.**

- 289. We recommend that the United Kingdom Government make every effort, through the Council, to bring this about.**

## **LIST OF CONCLUSIONS AND RECOMMENDATIONS**

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### **The case for continued EU action**

1. Action is worth formulating at EU level only to the extent that it supplements and supports what Member States can do independently. (Paragraph 94)
2. Although the recommendations made to Member States by the WHO Global Strategy and European Action Plan are not legally binding, EU action should not conflict with these recommendations. (Paragraph 104)
3. EU action on alcohol should continue to facilitate cooperation between the WHO European Regional Office and the Commission in the field of alcohol-related harm, in order to add to the evidence base and avoid duplication, in particular in the development and application of indicators. (Paragraph 105)
4. There is much to be said for EU action which deals with matters within EU competence and addresses the weaknesses which our evidence has revealed. However, we see no point in the Member States agreeing on a new EU Strategy which is simply a continuation of the previous one. (Paragraph 111)

### **Possible Policy Approaches**

5. Any future EU action on alcohol abuse should state realistic, clearly defined and measurable objectives, and include an evaluation mechanism to assess its progress and added value. (Paragraph 112)
6. Future EU action on alcohol abuse should not be confined to action under health policy, but should take a ‘health in all policies’ approach reflected through EU policies on related areas such as food labelling, cross-border marketing and taxation. (Paragraph 117)
7. We believe that the most effective policy approach is one which combines measures at population level intended to reduce overall levels of consumption, with targeted measures intended to reduce harmful consumption. Such measures, if adopted at EU level, should allow enough flexibility for Member States to adapt to them to their specific national context. (Paragraph 123)

### **Taxation**

8. EU rules on the structure of alcohol taxation should be reviewed to allow the implementation of variable tax rates for wines and ciders in line with alcoholic strength, and to give an incentive to the manufacture of lower strength beers. (Paragraph 133)
9. We recommend that the Government review the formula laid down by the Licensing Act 2003 (Mandatory Conditions) Order 2014 for calculating the minimum permitted price of alcoholic drinks. We hope that other Member States may take equivalent action. (Paragraph 137)

### **Minimum Unit Pricing**

10. If the Court rules that minimum unit pricing is lawful under EU law, we recommend that the United Kingdom Government monitor the effects of its introduction in Scotland. If MUP does appear to be successful in bringing

health benefits to the heaviest drinkers, the Government should implement the undertaking it gave in 2012 to introduce MUP in England and Wales. (Paragraph 160)

### **Marketing**

11. We recommend that the Government, in addition to any scrutiny which it undertakes of the adequacy of self-regulation of alcohol advertising, should encourage the Commission to reconsider the undertakings it gave nine years ago to work to prevent irresponsible marketing of alcoholic beverages, and to monitor the impact of self-regulatory codes. (Paragraph 181)
12. We recommend that the Government should press the Commission to propose amendments to the Food Labelling Regulation. These should make it mandatory for labelling on alcoholic beverages to include information on the strength, the ingredients, nutrition, and the dangers of drinking during pregnancy. (Paragraph 194)
13. We recommend that the Commission propose such amendments, and that thereafter the Government should support their rapid enactment. (Paragraph 195)

### **Bodies that support action at EU level**

14. We recommend that the Commission review the structure and functioning of the Committee on National Alcohol Policy and Action (CNAPA) in order to ensure that it is fully capable of carrying out its coordination function. In particular, it should encourage Member States to nominate officials who are in a position to represent their governments' views. (Paragraph 205)
15. We recommend that the Commission restate the remit of the European Alcohol and Health Forum (EAHF) and review its structure and functioning. The terms of reference of the Forum should clearly state the roles and responsibilities of all participating stakeholders, including the alcohol industry. (Paragraph 222)
16. We recommend the re-establishment of the Science Group, which should be independent from the EAHF and include experts from all Member States. The Science Group should receive adequate support as well as sufficient financial resources from the Commission. (Paragraph 229)
17. EU action on alcohol should continue to be supported by bodies facilitating the exchange of expertise and best practices, which is seen by many as the key benefit of the EU Alcohol Strategy 2006–12. (Paragraph 243)
18. We recommend that the roles and mandates of CNAPA, the EAHF and the Science Group should be formalised and reviewed periodically. In each case the role should include a clear work plan in line with the stated objective of any future EU action on alcohol abuse, as well as an explanation of the relationships between bodies and the Commission, which should be agreed by the Council. (Paragraph 244)

### Research

19. Where those responsible for formulating policy, in this case DG SANCO, identify a need for further information, they are best placed to commission such research. (Paragraph 266)
20. The quality of research will be questioned if it is carried out by researchers who are perceived to have vested interests in the outcome. The best way to diminish any such perception is to commission research from as wide and varied a network of researchers as possible. This should be done through competitive tendering. (Paragraph 267)
21. It should be no part of the researchers' task to suggest what policies should be based on their findings. Any attempt to do so will give rise to the perception of a lack of independence. (Paragraph 268)
22. Behavioural change, the impact of advertising on consumption by children and young people, harm to others and alcohol-related crime are some of the many areas where there are gaps in knowledge and where further research would significantly assist policy formulation. (Paragraph 274)
23. The Science Group could play a useful part in identifying gaps in the knowledge surrounding alcohol-related harm, and suggesting the parameters for research. It could also promote standardised terminology and common measurement standards to improve the comparability of research across the EU. (Paragraph 279)

### A new EU Alcohol Strategy

24. There is much to be said for EU action which concentrates on those areas where it has competence and addresses the weaknesses which our inquiry has revealed. A new Strategy which goes no further than its predecessor would achieve little. (Paragraph 284)
25. We have identified the structure of the taxation of alcohol and the labelling of alcoholic beverages as matters where the EU must exercise its competence to enact necessary legislation. It will be for the Commission to take the initiative. (Paragraph 285)
26. The self-regulation of advertising, the organisation and powers of CNAPA, the EAHF and its Science Group, and research, are among the areas where the Commission should work with Member States to improve the position, in accordance with our recommendations. (Paragraph 286)
27. The EU Alcohol Strategy 2006–12 took the form of a Communication from the Commission to the Council. A similar Communication, whatever its title, which embodies the Commission's determination to make these changes, and which is approved by the Council, would in our view make a significant contribution to reducing alcohol-related harm in the EU. (Paragraph 287)
28. The Latvian Presidency intends to discuss the next steps towards a new EU Alcohol Strategy at an informal Council on 20–21 April 2015. We hope that our recommendations will assist the deliberations of the Member States, and that they will invite the new Commission to make the preparation of such a Communication an urgent priority. (Paragraph 288)

29. We recommend that the United Kingdom Government make every effort, through the Council, to bring this about. (Paragraph 289)

## APPENDIX 1: LIST OF MEMBERS AND DECLARATIONS OF INTEREST

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### Members

Baroness Benjamin  
Lord Blencathra  
Viscount Bridgeman  
Lord Faulkner of Worcester  
Lord Jay of Ewelme  
Lord Judd  
Baroness Prashar (Chairman)  
Lord Morris of Handsworth  
Lord Sharkey  
Earl of Stair  
Lord Tomlinson  
Lord Wasserman

### Declarations of interests

Baroness Benjamin  
*No relevant interests declared*

Lord Blencathra  
*No relevant interests declared*

Viscount Bridgeman  
*No relevant interests declared*

Lord Faulkner of Worcester  
*No relevant interests declared*

Lord Jay of Ewelme  
*Non-Executive Director, Associated British Foods*  
*Shares in Diageo plc (Manufacturer of alcoholic drinks)*

Lord Judd  
*No relevant interests declared*

Baroness Prashar  
*No relevant interests declared*

Lord Morris of Handsworth  
*No relevant interests declared*

Lord Sharkey  
*Occasional unpaid advice to the Advertising Association, and spoke at their conference*

Earl of Stair  
*No relevant interests declared*

Lord Tomlinson  
*No relevant interests declared*

Lord Wasserman  
*Shares in Diageo plc (Manufacturer of alcoholic drinks)*

The following Members of the European Union Select Committee attended the meeting at which the report was approved:

Lord Boswell of Anyho (Chairman)  
Earl of Caithness

Baroness Eccles of Moulton  
 Lord Foulkes of Cumnock  
 Lord Harrison  
 Baroness Henig  
 Baroness Hooper  
 Lord Kerr of Kinlochard  
 Lord MacLennan of Rogart  
 Baroness O’Cathain  
 Baroness Parminter  
 Baroness Prashar  
 Earl of Sandwich  
 Baroness Scott of Needham Market  
 Lord Tugendhat

During consideration of the report the following Member declared an interest:

Lord Tugendhat  
*Shares in Diageo plc (Manufacturer of alcoholic drinks)*

A full list of Members’ interests can be found in the Register of Lords Interests <http://www.parliament.uk/mps-lords-and-offices/standards-and-interests/register-of-lords-interests>

Professor Betsy Thom acted as Specialist Adviser for this inquiry and declared the following interests:

*Member of the research advisory group of the International Alliance for Responsible Drinking (EARD), formerly ICAP. In that capacity, has recently been a consultant on the project Alcohol Education Guide: Reducing Underage and Other Harmful Drinking*  
*Consultant to the evaluation team for the evaluation of the 2006–12 EU Alcohol Strategy*  
*Has previously collaborated with some of the public health witnesses who presented evidence to the Committee*  
*Is currently collaborating in the EU funded Alice Rap and RARHA research projects*

## APPENDIX 2: LIST OF WITNESSES

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Evidence is published online at <http://www.parliament.uk/eu-alcohol-strategy> and available for inspection at the Parliamentary archives (020 7219 3074)

Evidence received by the Committee is listed below in chronological order of oral evidence session and in alphabetical order. Those witnesses marked with \*\* gave both oral and written evidence. Those marked with \* gave oral evidence and did not submit any written evidence. All other witnesses submitted written evidence only.

### Oral evidence in chronological order

- |    |  |                                  |
|----|--|----------------------------------|
| *  | Professor Peter Anderson, Professor of Substance Use, Policy & Practice, Newcastle University                      | <a href="#"><u>QQ 1–12</u></a>   |
| *  | Professor Petra Meier, Professor of Public Health and Acting Director of Research, University of Sheffield         |                                  |
| *  | Professor Gerard Hastings OBE, Director of the Institute of Social Marketing at the University of Stirling         |                                  |
| ** | Crispin Acton, Programme Manager, Alcohol Policy Team, Department of Health  | <a href="#"><u>QQ 13–32</u></a>  |
| ** | Lindsay Wilkinson, Deputy Director, Drug and Alcohol Policy, Department of Health                                  |                                  |
| *  | Sarah Godman, NHS European Office  |                                  |
| *  | Susannah Simon, Director, European Reform Directorate, the Department for Business Innovation and Skills           |                                  |
| *  | Dr Evelyn Gillan, Chief Executive, Alcohol Focus Scotland  | <a href="#"><u>QQ 33–51</u></a>  |
| *  | Professor Nick Sheron, Senior Lecturer and Head of Clinical Hepatology, University of Southampton                  |                                  |
| ** | Katherine Brown, Director of the Institute of Alcohol Studies  |                                  |
| *  | Guy Parker, Chief Executive, Advertising Standards Authority   | <a href="#"><u>QQ 52–62</u></a>  |
| *  | Chris Baker, Consultant, Bacon Strategy and Research   | <a href="#"><u>QQ 63–73</u></a>  |
| *  | John Duffy, Statistics and Policy Consultant   |                                  |
| *  | Professor Theresa Marteau, Director, Behaviour and Health Research Unit, University of Cambridge                   |                                  |
| *  | Dr Eleanor Winpenny, Analyst, RAND Europe  |                                  |
| *  | Dr Lars Møller, Programme Manager, Alcohol and Illicit Drugs, World Health Organisation Regional Office for Europe | <a href="#"><u>QQ 74–98</u></a>  |
| ** | Mariann Skar, Secretary General, Eurocare  | <a href="#"><u>QQ 99–116</u></a> |

- \*\* Eric Carlin, Director of Scottish Health Action on Alcohol Problems
- \*\* Paul Skehan, Director General, SpiritsEUROPE [QQ 117–139](#)
- \* Simon Spillane, Senior Adviser, Beer & Society and Communications, The Brewers of Europe
- \* Dr Ruxandra Draghia-Alki, Director, Health Directorate, DG Research [QQ 140–152](#)
- \* Maria Vidal, Head of Unit for Medical Research
- \* Karim Berkouk, Deputy Head of Unit, Chronic Diseases and Ageing
- \* Giovanni La Via MEP, (EPP, IT), Chair of ENVI Committee [QQ 153–168](#)
- \* Glenis Willmott MEP, (S&D, UK), Member of ENVI Committee
- \* Valentina Barbuto, Parliamentary Assistant to Piernicola Pedicini MEP (EFDD, IT), Member of ENVI Committee
- \*\* Stephen Cummins, Policy Lead on Alcohol, Home Office [QQ 169–185](#)
- \*\* Daniel Greaves, Head of Drugs And Alcohol Unit, Home Office
- \*\* Miles Beale, Chief Executive, Wine and Spirits Trade Association [QQ 186–199](#)
- \*\* David Frost, Chief Executive, Scotch Whisky Association
- \*\* Brigid Simmonds, Chief Executive, British Beer & Pub Association
- \* Paul Waterson, Chief Executive, The Scottish Licensed Trade Association
- \*\* Henry Ashworth, Chief Executive, Portman Group [QQ 200–216](#)
- \*\* Sue Eustace, Director of Public Affairs, Advertising Association
- \* Adrian Brown, Alcohol Liaison Nurse, Northwick Park and Central Middlesex Hospitals, CNWL NHS Foundation Trust [QQ 217–227](#)
- \* Vivienne Evans OBE, Chief Executive, Adfam
- \*\* Jane Ellison MP, Parliamentary Under Secretary for Public Health, Department of Health [QQ 228–242](#)
- \*\* Crispin Acton, Programme Manager, Alcohol Policy Team, Department of Health

**Alphabetical list of all witnesses**

**	Advertising Association (QQ 200–216)	<a href="#"><u>EAS0015</u></a>
**	Advertising Standards Authority (QQ 52–62)	<a href="#"><u>EAS0008</u></a>
	Alcohol Health Alliance	<a href="#"><u>EAS0012</u></a>
*	Alcohol Focus Scotland (QQ 33–51)	
*	Professor Peter Anderson, Professor of Substance Use, Policy and Practice, Newcastle University (QQ 1–12)	
	Association of Chief Police Officers	<a href="#"><u>EAS0021</u></a>
	Association of Convenience Stores	<a href="#"><u>EAS0010</u></a>
*	Chris Baker, Consultant, Bacon Strategy and Research (QQ 63–73)	
	Balance, the North West Alcohol Office	<a href="#"><u>EAS0017</u></a>
*	Valentina Barbuto, Parliamentary Assistant to Piernicola Pedicini MEP, Member of ENVI Committee (QQ 153–168)	
*	Brewers of Europe (QQ 117–139)	
**	British Beer & Pub Association (QQ 186–199)	<a href="#"><u>EAS0013</u></a>
	Lord Brooke of Alverthorpe	<a href="#"><u>EAS0005</u></a>
*	Adrian Brown, Alcohol Liaison Nurse, Northwick Park and Central Middlesex Hospitals, CMWL NHS Foundation Trust (QQ 217–227)	
*	Department for Business, Innovation and Skills (QQ 13–32)	
*	Department of Health (QQ 13–32)	
*	John Duffy, Statistics and Policy Consultant (QQ 63–73)	
**	Jane Ellison MP, Parliamentary Under Secretary of State for Public Health, Department of Health (QQ 228–248)	<a href="#"><u>EAS0019</u></a> <a href="#"><u>EAS0028</u></a>
**	Eurocare (QQ 99–116)	<a href="#"><u>EAS0006</u></a>
*	Dr Ruxandra Draghia-Akli, Director, Health Directorate, Maria Vidal, Head of Unit for Medical Research and Karim Berkouk, Deputy Head of Unit for Medical Research, DG Research, European Commission (QQ 140–152)	
*	Vivienne Evans OBE, Chief Executive, Adfam (QQ 217–227)	
*	Professor Gerard Hastings OBE, Director of the Institute for Social Marketing at the University of Stirling (QQ 1–12)	
**	Home Office (QQ 169–185)	<a href="#"><u>EAS0027</u></a>
**	Institute for Alcohol Studies (QQ 33–51)	<a href="#"><u>EAS0002</u></a>

- \* Giovanni La Via MEP, Chair of ENVI Committee,  
European Parliament (QQ 153–168)

Lundbeck Limited [EAS0011](#)
- \* Professor Theresa Marteau, Director, Behaviour and  
Health Research Unit, University of Cambridge (QQ 63–  
73)
- \* Professor Petra Meier, Professor of Public Health and  
Acting Director of Research, University of Sheffield  
(QQ 1–12)
- \* NHS European Office (QQ 13–32)
- \*\* Portman Group (QQ 200–216) [EAS0018](#)  
[EAS0026](#)
- \* RAND Europe (QQ 63–73)

SABMiller plc [EAS0009](#)
- \*\* Scotch Whisky Association (QQ 186–199) [EAS0020](#)
- \*\* Scottish Health Action on Alcohol Problems (QQ 99–  
116) [EAS0001](#)
- \* Scottish Licensed Trade Association (QQ 186–199)

Sheffield University Alcohol Research Group [EAS0014](#)
- \* Professor Nick Sheron, Senior Lecturer and Head of  
Clinical Hepatology, University of Southampton  
(QQ 33–51)
- \*\* SpiritsEUROPE (QQ 117–139) [EAS0025](#)

Janice Atkinson MEP, United Kingdom Independence  
Party [EAS0003](#)
- \* Glenis Willmott MEP, Member of ENVI Committee,  
European Parliament (QQ 153–168)
- \*\* Wine and Spirits Trade Association (QQ 186–199) [EAS0016](#)
- \* World Health Organisation Regional Office for Europe  
(QQ 74–98)

### APPENDIX 3: CALL FOR EVIDENCE

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The House of Lords EU Home Affairs, Health and Education Sub-Committee, chaired by Baroness Prashar, is launching an inquiry into the EU's Alcohol Strategy. Written evidence is sought by 26 September 2014.

#### Background

The European Commission adopted the first EU Alcohol Strategy in October 2006 with its Communication on "An EU strategy to support Member States in reducing alcohol related harm". The Strategy addressed the adverse health effects related to harmful and hazardous alcohol consumption, and identified five priority themes for action for the period until 2012:

- Protect young people, children and the unborn child;
- Reduce injuries and death 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;
- Develop and maintain a common evidence base at EU level.

#### *Rationale for the inquiry*

The inquiry takes place at the time of the gestation of the next Alcohol Strategy (2016–2022) which will replace the current Strategy. The aim of the inquiry is to consider: (i) how successful the existing Strategy has been in its stated aims, (ii) how the Treaty of the Functioning of the European Union (TFEU) has affected EU policies in terms of protecting public health on the one hand as against securing the free movement of alcoholic goods in the internal market on the other and, (iii) developments at the EU Member State and international levels. In the light of this assessment, the inquiry aims to make suggestions about the content of the next EU Alcohol Strategy and how it might be made more effective.

Particular questions raised to which we invite you to respond are as follows:

- (1) Should there be another EU Alcohol Strategy? If so, bearing in mind the wide social and health implications of alcohol consumption, what should the content, focus and purpose of the next Strategy be, with reference to the previous strategy and evaluations thereof?
- (2) Are the EU's alcohol policies underpinned by a sound scientific base?
- (3) Are the EU's alcohol policies in line with existing international frameworks to tackle alcohol misuse, for example the World Health Organisation (WHO)?
- (4) Are the mechanisms created in the last strategy for facilitating discussion, cooperation and the exchange of good practice between Member States, industry, civil society organisations and EU institutions, for example, the EU Alcohol and Health Forum (EAHF) and the Committee on National Alcohol Policy and Action (CNAPA), still appropriate?

- (5) Is the EU funding allocated to alcohol-related research and harm reduction programmes sufficient to achieve the stated aims?<sup>265</sup>
- (6) Do EU policies on the taxation of alcohol and the rulings of the Court of Justice of the European Union (CJEU) balance successfully the aims of the single market with the wishes of the individual EU Member States to promote public health within their borders, for example through minimum pricing?

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<sup>265</sup> Funding for alcohol-related research under the EU's seventh research programme (FP7) from 2007 to mid-2012 was 49 million euro, which represented less than one per cent of the FP7 Programme's budget for health.

## APPENDIX 4: EU COMPETENCE

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1. Self-evidently, the EU can take action in the fields covered by this report only to the extent that it has competence to do so under the Treaties. In 2006, when the EU Alcohol Strategy was formulated, those Treaties were the Treaty on European Union (TEU) and the Treaty establishing the European Community (TEC). While the Member States retained primary competence in the field of health, Article 3(1) TEC provided that the activities of the Community should include “a contribution to the attainment of a high level of health protection”.<sup>266</sup> This was expanded on in Article 152 TEC which was the basis of the Strategy.
2. The Treaty of Lisbon did not alter the fact that the primary competence in health matters remains that of the Member States, but did make significant changes. The principle of conferral, previously in Article 5 TEC, is now explained more fully in Article 5 of the amended TEU. In particular, it is now spelt out that “the Union shall act only within the limits of the competences conferred on it by the Member States in the Treaties to attain the objectives set out therein. Competences not conferred upon the Union in the Treaties remain with the Member States.”<sup>267</sup>
3. The areas of Union competence are now spelt out in Title I of Part One of the Treaty on the Functioning of the European Union (TFEU). Article 4(2) TFEU lists, among the areas where there is shared competence between the Union and the Member States, “(k) common safety concerns in public health matters, for the aspects defined in this Treaty”. Article 6 TFEU lists, among the areas where the Union has competence “to support, coordinate or supplement actions of the Member States”, “(a) protection and improvement of human health”.
4. Article 152 TEC is now superseded by Article 168 TFEU. The first two paragraphs of Article 168(1) read as follows.

### Box 1: Article 168(1) TFEU

A high level of human health protection shall be ensured in the definition and implementation of all Union policies and activities.

Union action, which shall complement national policies, shall be directed towards improving public health, preventing physical and mental illness and diseases, and obviating sources of danger to physical and mental health. Such action shall cover the fight against the major health scourges, by promoting research into their causes, their transmission and their prevention, as well as health information and education, and monitoring, early warning of and combating serious cross-border threats to health.

5. The second paragraph of Article 168(2) explains the procedure for such action, the competence of the Commission, and in particular its power to act on its own initiative.

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<sup>266</sup> Article 3(1) (p) TEC

<sup>267</sup> Article 5(2) TEU

**Box 2: Article 168(2) TFEU**

The Union shall encourage cooperation between the Member States in the areas referred to in this Article and, if necessary, lend support to their action. It shall in particular encourage cooperation between the Member States to improve the complementarity of their health services in cross-border areas.

Member States shall, in liaison with the Commission, coordinate among themselves their policies and programmes in the areas referred to in paragraph 1. The Commission may, in close contact with the Member States, take any useful initiative to promote such coordination, in particular initiatives aiming at the establishment of guidelines and indicators, the organisation of exchange of best practice, and the preparation of the necessary elements for periodic monitoring and evaluation. The European Parliament shall be kept fully informed.

6. Finally Article 168(5), which is new in the TFEU, makes a specific mention of alcohol abuse.

**Box 3: Article 168(5) TFEU**

The European Parliament and the Council ... may also adopt incentive measures designed to protect and improve human health and in particular to combat the major cross-border health scourges, measures concerning monitoring, early warning of and combating serious cross-border threats to health, and measures which have as their direct objective the protection of public health regarding tobacco and the abuse of alcohol, excluding any harmonisation of the laws and regulations of the Member States.

7. There are many other provisions of the TFEU giving the Union competence in areas which impinge directly and indirectly on action on alcohol abuse, of which the following are the most important:
- Article 36, a derogation from the principle of free movement of goods, which provides that the prohibitions on quantitative restrictions on imports do not preclude prohibitions or restrictions justified on grounds of the protection of public health—a provision of particular significance for minimum unit pricing;
  - Article 53(1), applied to services by Article 62, the legal base for the Audiovisual Media Services (AVMS) Directive, which includes in Article 22 restrictions on the television advertising of alcoholic beverages;
  - Article 114(3) which requires the Commission, when making proposals for the approximation of laws which concern health, safety, environmental protection and consumer protection, to “take as a base a high level of protection, taking account in particular of any new development based on scientific facts”;
  - Article 169 on Consumer Protection, the legal base for Regulation 1169/2011 on food labelling;
  - Articles 179–188 and 190 dealing with Research.

**APPENDIX 5: ACRONYMS AND ABBREVIATIONS**

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AA	Advertising Association
ASA	Advertising Standards Authority
ABV	Alcohol by volume
ACPO	Association of Chief Police Officers
Adfam	A charity supporting families affected by drug and alcohol use
ALICE RAP	Addictions and Lifestyles in Contemporary Europe Reframing Addictions Project
AMPHORA	Alcohol Measures for Public Health Research Alliance
AVMS Directive	Audiovisual Media Services Directive
BAC	Breath Alcohol Content
BBPA	British Beer & Pub Association
CAP	Community Alcohol Partnership
CNAPA	Committee on National Alcohol Policy and Action
CJEU	Court of Justice of the European Union
DALYs	Disability Adjusted Life Years
DG AGRI	Commission Directorate-General for Agriculture and Rural Development
DG Research	Commission Directorate-General for Research, Science and Innovation (formerly Research and Innovation)
DG SANCO	Commission Directorate-General for Health and Consumers (now DG SANTE)
DG SANTE	Commission Directorate-General for Health and Food Safety (successor to DG SANCO)
EAHF	European Alcohol and Health Forum
EASA	European Advertising Standards Alliance
ECHI	European Core Health Indicators
EMCDDA	European Monitoring Centre for Drugs and Drug Addiction
ENVI	European Parliament, Environment, Public Health and Food Safety Committee
EP	European Parliament
ETSC	European Transport Safety Council
GDP	Gross Domestic Product
HSCIC	Health & Social Care Information Centre
HMRC	Her Majesty's Revenue and Customs
IAS	Institute for Alcohol Studies
ICAP	International Centre for Alcohol Studies

MEP	Member of the European Parliament
MPU	Minimum price per unit
MSP	Member of the Scottish Parliament
MUP	Minimum Unit Pricing
NGO	Non-Governmental Organisation
NICE	National Institute for Health and Care Excellence
OECD	Organisation for Economic Cooperation and Development
OFCOM	Office of Communications, the UK statutory communications regulator
ONS	Office for National Statistics
PHRD	Public Health Responsibility Deal
RAND	Research and Development Corporation
RARHA	Joint Actions on Reducing Alcohol-related Harm
SHAAP	Scottish Health Action on Alcohol Problems
ScHARR	The Sheffield University Alcohol Research Group
SLTA	Scottish Licensed Trade Association
SMART	Specific, Measurable, Achievable, Realistic and Timely (targets)
STAP (NH)	Dutch Institute for Alcohol Policy
SWA	Scotch Whisky Association
TEC	Treaty establishing the European Community
TEU	Treaty on European Union
TFEU	Treaty on the Functioning of the European Union
UKREP	United Kingdom Permanent Representation to the European Union
WHO	World Health Organization
WSTA	Wine and Spirit Trade Association