COMMITTEE PROPOSAL

The Nordic Council

A 1566/velferd

Submitted by:
The Welfare Committee

Committee Proposal

Nordic alcohol and tobacco policies in a public health perspective

1. Committee proposal

The Welfare Committee proposes that

the Nordic Council recommends to the Nordic Council of Ministers

1. *to* establish a new working group with representation from all the Nordic countries, the Faroe Islands, Greenland and Åland to prepare a basis document to MR-S with recommendations and initiatives for a new strategy for sustainable alcohol and tobacco policies in the Nordic Region 2014-2020. The working group will look at the relevance of the initiatives which researchers recommend are the most effective for reducing alcohol-related problems (page 8);

2. *to* strengthen evidence-based research in the Nordic Region in tobacco and alcohol use and chronic diseases, cancer and lifestyle diseases (page 17);

3. *to* strengthen evidence-based research in the Nordic Region on children and young people who grow up with one or more caregivers who suffer from serious alcohol abuse (page 19);

4. *to* strengthen evidence-based initiatives in the Nordic countries and the Faroe Islands, Greenland and Åland to reduce alcohol consumption and the harmful effects of alcohol (page 6);

5. *to* consider the introduction of a total ban on advertising and marketing of alcohol aimed at young people in the Nordic countries and the Faroe Islands, Greenland and Åland (page 14);

6. *to* introduce alcolocks for commercial drivers in the Nordic countries, the Faroe Islands, Greenland and Åland, and for people who have been convicted for drunk driving, and investigate the introduction of alcolocks in all types of vehicles as an alcohol policy measure (page 12);

7. *to* encourage an active dialogue with the largest Nordic companies on the information of the costs associated with alcohol and tobacco, and help to strengthen their support of the Nordic model for alcohol policy measures (page 18);

8. *to* investigate how to ensure public access to lobbying activities from the multinational companies in the Nordic countries (page 21);

9. *to* propose that the Nordic countries, the Faroe Islands, Greenland and Åland initiate work for a tobacco-free Nordic Region by 2040 (page 28);

10. *to* increase Nordic co-operation with the UN, WHO and EU on Nordic, European and global measures to strengthen public health through prevention of the harmful effects of alcohol and tobacco (page 4);

11. *to* prepare a plan for Nordic measures to contribute to a global alcohol reduction by 10 per cent by 2025, through relevant international organisations, cf. the work of the UN, WHO and the EU (page 4);

12. *to* work for a blood alcohol content limit of 0.2 per mille for the operation of all motor vehicles in the Nordic countries, the Faroe Islands, Greenland and Åland (page 11).

2. Background: Alcohol

Some people may question why further alcohol and tobacco policy measures are needed in the Nordic countries, the Faroe Islands, Greenland and Åland, when this issue is already being tackled actively at national, Nordic, European and global levels.

The Welfare Committee wishes to emphasise that the main reason for the initiative to increase alcohol and tobacco policy measures in the Nordic region is the considerable harm caused by alcohol and tobacco, and the enormous costs to society, both economic and human. Statistics on causes of death in Sweden in 2010 show that alcohol is the cause of 4 500 deaths per year, nearly 100 deaths per week (Swedish National Board of Health and Welfare, 2012). The most common causes of death are liver cirrhosis, alcohol dependence, alcohol poisoning, and alcohol psychosis. In addition to deaths diagnosed as being directly caused by alcohol, according to research there are a large number of deaths with other diagnoses that are alcohol related, such as accidents and suicide. In addition, 300 000 people are considered to be alcohol-dependent and over 500 000 are considered to be alcohol addicts (Substance Abuse Inquiry, SOU 2011:35). In other words, one in ten Swedes is addicted to or dependent on alcohol. These figures are almost unfathomably large, but the conditions are well known to authorities and most people. These figures are representative of more of the Nordic countries, and the Faroe Islands, Greenland and Åland.

The number of people killed by tobacco is probably even greater. WHO figures (2012) show that tobacco kills up to half the people that use it, which means nearly six million deaths worldwide. Of these, five million are users and one million are ex-users, and more than 600 000 deaths involve non-smokers exposed to passive smoking.

The Welfare Committee wonders why we as a society accept so many deaths due to harm caused by tobacco and alcohol without taking stronger action. Furthermore, the death toll is just the tip of the iceberg of medical harm caused to the drinker, and harm caused to others, like family,

children, and friends, and socially in work and leisure situations, i.e. harm to third parties.

Another important reason is that the alcohol and tobacco industries are constantly exerting pressure in various arenas to promote their cause to reduce restrictions on distribution and sale of alcohol and tobacco. There are many examples of legal battles taking place, both in the Nordic countries and in the rest of the world: US authorities are fighting for laws to force tobacco companies to put on cigarette packets pictures of the harm caused by smoking; in Australia the authorities have recently won a case to make cigarette packets neutral and include a description of the harm caused by tobacco; and in Norway, the authorities have demanded that tobacco must be kept out of sight in shops and that there must be no advertisements, but the tobacco industry is trying to fight this. There is also increasing pressure for more alcohol advertising, and more hidden advertising in the form of product placement and, for example, through wine and beer columns in newspapers and magazines. The authorities in Norway lost the battle to prohibit the sale of alcopops in grocery stores.

The Welfare Committee is aware that a group of internationally recognised drug researchers have summarised the extensive international knowledge about the effect of various alcohol policy instruments. The book, *Alcohol, No Ordinary Commodity*, was first published in 2003 and has now been republished as a second edition (Babor et al., 2003, 2010). The research group has reviewed the burgeoning international research about alcohol policy strategies and the degree to which various strategies and measures can help to reduce the scale of health and social problems relating to alcohol consumption. The Welfare Committee wishes to emphasise that this international research has unanimously concluded that taxes on alcohol and restrictions in serving hours and the number of selling points and alcohol-serving establishments are effective instruments in reducing alcohol-related harm. The same also applies for enforcement of a minimum age for purchasing alcohol and measures against drunk driving, particularly when the likelihood of arrest is increased. The Welfare Committee also notes that enforcement of a minimum age for purchasing alcohol is effective. The Welfare Committee wishes to point out in simple terms that there are solid research-based arguments for the most restrictive alcohol policy in the Nordic countries and the Faroe Islands, Greenland and Åland.

The Welfare Committee is aware that the significance of treatment is relatively limited at population level compared with the use of other strategies and measures, because the effects benefit few people (Babor et al., 2010). Comprehensive research shows that identification and limited counselling of patients with risky levels of alcohol consumption can reduce their alcohol intake. In contrast, treatment of alcohol problems can be effective, but is often costly to initiate and maintain. This does not mean that treatment of alcohol abuse and dependence is not important for the individual struggling with alcohol, and is particularly important in preventing harm to third parties, like children and family.

The question the Welfare Committee is asking is what must be done to revive interest in considering the problems of alcohol at all levels of initiative, from political decision-makers via national authorities, to local communities, NGOs and the individual. With this Welfare Committee Proposal, the Nordic Council has shown that, at a political level, the importance of a dynamic and active alcohol policy is understood, as it has been placed on the agenda of the Council.

The Nordic welfare model is becoming increasingly well known outside the Nordic boundaries. Characteristic of the Nordic region is the fine-meshed support network in society, and measures to regulate anything known to

be harmful to the individual and/or society. Distribution, sale and use of alcohol and tobacco are therefore strictly regulated in most Nordic countries and in the Faroe Islands, Greenland and Åland.

There is no doubt that the harm caused by alcohol and tobacco represents both a major problem to society and a serious threat to public health. In 2010, the World Economic Forum stated that non-communicable diseases resulting from alcohol use and smoking are a major problem, and a threat, not just to health but also to global development and growth. Non-communicable diseases account for 63 per cent of all deaths, and are the most fatal of all diseases.

Global strategy for reducing harmful use of alcohol

The Welfare Committee is aware that alcohol is one of the most important causes of disability, disease and death in a global public health perspective. Alcohol is the cause of approximately four per cent of deaths on a world basis, and the cause of 4.65 per cent of the global burden of disease in the form of lost years of healthy life. In 2004 it was estimated that on a global basis, approximately 2.5 million people died of alcohol-related injuries, including 320 000 young people aged 15-29. At least 15.3 million people have substance abuse disorders (WHO, 2010).

The Welfare Committee points out that it is easy to see that the consensus that the effects of the alcohol policy measures (Babor et al., 2010) correspond well with measures proposed by the WHO in its global alcohol strategy (WHO, Global strategy to reduce the harmful use of alcohol, 2010).

The Welfare Committee believes that the development of attitudes to alcohol policy shows that decision-makers and the general population need to update knowledge and learn more about the effects of alcohol.

The target areas in the new WHO global alcohol strategy (2010) are:

(1) leadership, awareness and commitment; (2) health services response; (3) community action; (4) drunk driving policies and countermeasures; (5) measures to reduce availability of alcohol; (6) pricing policies; (7) regulations on marketing of alcoholic beverages; (8) measures to reduce the negative consequences of drinking and alcohol intoxication; (9) reducing the public health impact of illicit alcohol and informally produced alcohol; and (10) monitoring and surveillance of alcohol consumption.

The Welfare Committee supports this strategy, and the work must begin with awareness of the consequences of alcohol consumption if retention of the alcohol policy instruments is to be meaningful and important, and if they are to be strengthened through the introduction of new alcohol policy measures in the Nordic countries.

The Welfare Committee observes that the alcohol and tobacco industries are a global problem, and that wealthier countries must show solidarity in tackling the problem by using their national co-operation bodies to influence processes in a positive direction through the UN and WHO. The Welfare Committee therefore states that the implementation of the WHO global strategy will require collaboration with Member States, involvement with international development partners, the civil society and the private sector, and representatives of public health and research institutes.

Consequently, the Welfare Committee proposes that

the Nordic Council recommends to the Nordic Council of Ministers

to increase Nordic co-operation with the UN, WHO and EU on Nordic, European and global measures to strengthen public health through prevention of the harmful effects of alcohol and tobacco;

to prepare a plan for Nordic measures to contribute to a global alcohol reduction by 10 per cent by 2025, through relevant international organisations, cf. the work of the UN, WHO and the EU.

Nordic region

The Welfare Committee finds it paradoxical that alcohol and tobacco would probably not be permitted for use in the Nordic countries if they were new products on the market and if the risk of harm and costs to society and the individual were known.

Total consumption model

The Welfare Committee observes that the alcohol policy in the Nordic countries is largely based on the total consumption model. According to this model, alcohol harm can be limited by restricting total consumption, which is achieved by limiting availability and increasing taxes on alcohol. Results of research indicate that a given increase in consumption increases alcohol harm more in the Nordic countries than in Southern Europe (Babor et al., 2010). This indicates that the risk of somatic harm does not just depend on the amount of alcohol but also on drinking patterns.

The Welfare Committee points out that alcohol policies vary between the Nordic countries. In Norway, measures are far-reaching and restrictive, but some popular opinion wants to see regulations eased in matters such as farm sales and opening hours of restaurants and bars. Denmark has the most liberal alcohol laws in the Nordic countries, but there has long been a debate about the problems and some tighter measures have been introduced. In Finland, political support for alcohol policy measures has been less stable in recent years, but experiences after the tax reduction in 2004 has increased support for more restrictive measures. In Iceland, the change of government after the financial crisis has led to tightening of legislation. Sweden has traditionally had a restrictive alcohol policy, but this has been liberalised somewhat since the country joined the EU.

The most acute problem relating to the Swedish alcohol policy is the pressure of public opinion in favour of farm sales and Internet trading. The Swedish Government has chosen not to allow farm sales, but is open to the idea of online sales of alcoholic products from Systembolaget, in the same way that the Norwegian Vinmonopolet has done for several years.

The Welfare Committee is aware that alcohol consumption in the Nordic countries is concentrated around weekends and public holidays, which are often characterised by intoxication. In Southern Europe, consumption is more part of everyday life, often associated with meals, and is therefore more evenly distributed.

A question the Welfare Committee asks is whether alcohol is more dangerous in the Nordic countries than in countries with different drinking patterns? The Welfare Committee points out that most Nordic countries have succeeded in keeping total consumption of alcohol at a relatively low level through restrictive alcohol policies. However, a trend in recent decades is that consumption in Southern Europe has steadily decreased, but it has increased in the Nordic countries (Norström, 2002).

A survey carried out by the Finnish Institute of Public Health (2011) shows

that alcohol consumption in Finland is highest of the Nordic countries. In Finland, alcohol was responsible for 17 per cent of all deaths in the age group 15-64 (Kuussaari, 2005). Each person over 15-years-old in Finland drank an average of 12.5 litres of spirits in 2011. In comparison, Norwegians drink less than half that amount, approximately six litres of alcohol per year on average. Alcohol consumption in Norway is still the lowest in Western Europe, and only Muslim countries have lower alcohol consumption.

In comparison with other European countries, the Danish National Institute of Public Health places the level of what constitutes harmful alcohol consumption extremely high. The Danish Health and Medicines Authority (2011) advises that women who drink over 14 units of alcohol and men who drink 21 units are at risk of alcohol-related harm, while a risk-free level is recommended to be 7 units for women and 14 for men. Nevertheless, every fifth Dane, approximately 860 000 people, drinks more than the official recommendations. Low-income groups are commonly over-represented, but it is actually many with higher education levels that are in the most dangerous part of the scale in terms of alcohol.

According to Danish authorities, alcohol consumption in Denmark costs society approximately DKK 10 billion every year. These figures contrast with the figures from Norway, where calculations show that alcohol-related harm costs society NOK 18 billion per year.

So Danes drink more than Norwegians, yet the costs of alcohol-related harm are nearly double in Norway compared with Denmark. This may indicate different ways of calculating the cost of harm caused by alcohol use.

One of the suggested explanations why alcohol consumption has fallen amongst young people in the Nordic region is the increased playing of computer games. One survey supporting this argument was carried out by the Swedish National Board for Youth Affairs in 2005. The results showed that young people between 13 and 20 who played computer games frequently drank alcohol less frequently than those who only played sporadically. Among the respondents who played computer games very often, 28 per cent stated that they drank alcohol a few times a week or a few times a month, while 49 per cent of those who played computer games only sporadically stated that they drank that frequently.

Levels of regulation vary in the Nordic countries and the Faroe Islands, Greenland and Åland. Norway, Sweden and Iceland have the most extensive regulations regarding the sale and use of alcohol and tobacco, Finland occupies a middle position, and Denmark has the most liberal legislation of alcohol and tobacco.

The Welfare Committee notes that a basic principle of the traditional alcohol policy in the Nordic region, in addition to protecting public health, is to keep the forces of the market economy away from the sale of alcohol, i.e. primarily competition and a profit motive. Denmark is an exception, and chose a different route from an early stage in alcohol policy, with tax increases as the most important and dominant instrument.

Alcohol is not an ordinary commodity where increased consumption brings greater prosperity and a better life, so the Welfare Committee takes the view that alcohol policies provide an enlightened and consistent direction that has brought good results in controlling alcohol consumption. The alcohol monopoly is not a goal in itself, but is an instrument for achieving the objective of the alcohol policy, which is to limit alcohol consumption in order to reduce the associated harm.

Consequently, the Welfare Committee proposes that

the Nordic Council recommends to the Nordic Council of Ministers

> *to* strengthen evidence-based initiatives in the Nordic countries and the Faroe Islands, Greenland and Åland to reduce alcohol consumption and the harmful effects of alcohol.

Significance of EU/EEA membership
Awareness of the monopoly, its reasons and effects, is gradually decreasing in the Nordic countries, particularly since the EEA Agreement and the EU membership of the Nordic countries, with a requirement to abolish both import and wholesaler monopolies. However, the Welfare Committee wishes to emphasise that the retail monopolies (state-run off-licences) in Norway, Sweden, Finland and Iceland are still very powerful instruments that combine the protection of public health with good service and popular support for the use of this instrument in the alcohol policy.

The Welfare Committee refers to a review, commissioned by the US Department of Health and Human Services, of the scientific studies made of the effect of abolishing the retail monopoly. The review showed that sales increased by 44 per cent on average (Hahn, et al. 2012). Modelling of the effects of abolishing Systembolaget's monopoly in Sweden estimates that consumption would increase by 38 per cent (Norström et al., 2010). Reducing alcohol consumption by the same amount that we achieve through the alcohol monopoly, for example through increases in tax, would be very difficult. It is therefore very important to preserve the current alcohol monopolies in the Nordic countries. Since the state retail monopoly for alcohol sales was approved by the EU Court of Justice in 1997, the biggest threat today comes from farm sales and covert retail sales, and resale through distance selling and online selling.

Nordic alcohol policy plan
The Welfare Committee refers to the Nordic alcohol policy plan as mandated by the Nordic Ministers of Health and Social Affairs in 2004. Current trends show that the policy is under pressure, both from the international tobacco and alcohol industries and from farmers who wish to sell alcohol on their farms. All these stakeholders want to dismantle parts of the alcohol policy measures in the Nordic countries. The Welfare Committee therefore requests the Council of Ministers to prepare a revised alcohol policy plan before 2014.

A systematic review of the effective alcohol policy measures according to alcohol research was published in the Lancet. Anderson et al. (2009) reported the following areas as being most effective in reducing alcohol-related harm and problems:

- Taxes on alcohol that are regularly increased in line with inflation
- State retail monopoly on alcohol sales
- Age limits
- Limited availability in the form of a restricted number of selling points and restrictions in opening hours
- Ban on direct and indirect marketing
- Limits for drunk driving of 0.5 or 0.2 per mille, and visible, temporary controls
- Counselling in primary healthcare services and support in the form of more intensive treatment for addiction.

The Welfare Committee feels it is of the utmost importance to continue with and retain the traditional, well-known alcohol policy measures, and to improve their effect. But new times also call for new measures. The policy to control alcohol at national and local level has come under increasing pressure because of conflict with the international trade policy, which wants to treat alcoholic beverages as ordinary commodities, like milk and

bread. Alcohol is regarded as an important commodity when it comes to business opportunities in the retail trade and the hotel and restaurant sectors.

In recent years, a few large companies have started to dominate the international alcohol market. In 2005, 60 per cent of all commercially brewed beer in the world was produced by global companies, of which 44 per cent was produced by the four largest companies: Inbev, Anheuser-Busch, SABMiller and Heineken. A similar trend has occurred in the spirits industry, where Diageo and Pernod Ricard now manage some of the world's leading brands. The size and profitability of these companies mean that marketing can be more integrated at global level. The size also enables the companies to invest considerable resources in directly or indirectly promoting the political interests of the sector. This development encourages the public health sector and authorities to respond with national and global public health strategies to limit the social and health consequences of the growing global market for alcoholic beverages.

When alcohol is regarded as an ordinary commodity, these agreements usually inhibit the alcohol control policy. With increasing emphasis on free trade and free markets, international organisations like the EU have pushed to abolish state retail monopolies on alcohol sales and other restrictions on availability of alcohol, and conflicts over trade agreements have resulted in reduced taxes and various ways of increasing availability. However, the effects of the international trade agreements cannot solely be blamed for the lack of effective alcohol control policies at national level. Although trade agreements restrict how domestic regulatory frameworks are prepared, they also allow authorities to implement special measures to protect the environment and people's health. Objections to restrictions on availability and marketing of alcohol are met by justifying the restrictions as being both necessary and appropriate to attain clearly defined objectives of the government's health policy. Nevertheless, restrictive policies often have elements that protect local economic interests, something that can make them difficult to justify. The Welfare Committee is of the view that considerations regarding alcohol and public health should take precedence over free trade interests at international level.

The Welfare Committee feels that the time has come to revise the alcohol policy action plan from 2004, and proposes that the Nordic Council of Ministers initiates a project to prepare a new Nordic alcohol policy plan 2014-2020.

Consequently, the Welfare Committee proposes that

the Nordic Council recommends to the Nordic Council of Ministers

> *to* establish a new working group with representation from all the Nordic countries, the Faroe Islands, Greenland and Åland to prepare a basis document to MR-S with recommendations and initiatives for a new strategy for sustainable alcohol and tobacco policies in the Nordic Region 2014-2020. The working group will look at the relevance of the initiatives which researchers recommend are the most effective for reducing alcohol-related problems.

Strategies and measures to reduce alcohol-related problems

Regulation of price and availability of alcohol
The Welfare Committee sees that regulation of price and availability of alcohol is effective in limiting alcohol-related harm and problems. There is comprehensive empirical support for a clear link between the price of a

commodity and demand for the commodity. The same applies to the link between availability of and demand for a commodity (Babor et al., 2010). A recently published meta-analysis presents the results of 112 published studies on the link between price and alcohol sales, and these studies unanimously show an inverse relationship between price and sales. In other words, if the price of alcohol increases, sales decrease, and when the price decreases, sales increase (Wagenaar, Salois, and Komro, 2009). Similar relationships have also been identified in studies of other addictive products, including tobacco and heroin (Grossman, 2005).

Consequently, regulation of price and availability through policy instruments can be effective in steering demand for a commodity in a desirable direction. However, when it comes to addictive commodities like tobacco and alcohol, many people believe that an addict does not respond to such regulation of price and availability, and that the addict acquires the commodity (almost) regardless of price and availability costs. It is therefore of particular interest to examine the significance of price and availability regulations for addictive commodities, both with regard to the total demand for the commodity, and the demand for the commodity among addicts or people with particularly high consumption (Rossow, Pape and Baklien, 2010).

Regulation of alcohol availability
Restrictions on alcohol availability focus on regulation of selling points, times and situations where consumers can obtain alcohol, and therefore partly involves a complete ban on sales of alcohol. There are large variations in regulation of alcohol availability. The Welfare Committee refers to research that shows clearly that consumption and alcohol-related problems increase in line with availability of alcohol, regardless of whether the alcohol is obtained from commercial or social sources. However, when availability is reduced, alcohol use and the related problems also decrease. This is best shown in studies of changes of availability in retail sales, including reduction in opening hours and restrictions in the number of selling points and alcohol-serving establishments. The Welfare Committee emphasises that consistent enforcement of the regulations is important to the effect of the measures.

The Welfare Committee feels that regulation of availability to alcohol is very effective. The cost of restricting alcohol availability is low compared with the cost of the health-related consequences of alcohol use. However, the Welfare Committee is also aware that restricting availability has some undesirable consequences, including a larger illegal market (e.g. home production and illegal import).

When the governments have monopolies on the selling points for alcohol, alcohol availability can be extensively regulated. There are strong grounds for claiming that a state monopoly on sales of alcohol restricts alcohol consumption and alcohol-related problems, and that abolishing such a monopoly may increase total alcohol consumption. Privatisation increases the number of selling points, extends opening hours, and reduces enforcement of the prohibition of sale to minors. Denmark, which has chosen this model in its alcohol policy, is facing challenges in these areas.

The Welfare Committee also notes that commercial activities that increase sales and consumption, for example marketing in shops with advertising placards, product placement, special offers, etc. are avoided through the monopolies, which do not have a profit motive and thereby have no interest in boosting sales, and so do not use the methods commonly used in the sale of everyday goods,

Regulation of price through taxes
Another type of instrument to restrict the total consumption of alcohol is

to increase prices by imposing a tax on the products. The Welfare Committee observes this is a traditional practice in the Nordic countries, and many econometric studies have shown this to be effective (Österberg 1995, Babor et al., 2010).

But the use of this instrument has clear limitations. After Sweden and Finland joined the EU, alcohol prices came under increasing pressure from other parts of the internal market where prices were much lower. As long as the Nordic countries could maintain certain quotas for tax-free import of alcohol in conjunction with cross-border travel, the pressure could be withstood to a certain extent, but when all the restrictions in the EU were removed in 2004, the situation became much more difficult.

Denmark reduced taxes on spirits by 45 per cent from October 2003. From March 2004, Finland reduced taxes on spirits by 44 per cent, fortified wine by 40 per cent, ordinary wine by 10 per cent, and beer by 32 per cent. Sweden has also made some adaptations, including a 39 per cent reduction in taxes on beer in 1997 and a 19 per cent reduction in taxes on wine in 2001, but otherwise has largely resisted pressure on prices from the other EU countries. Norway has also felt the pressure, particularly in the form of cross-border trading, and has reduced taxes on alcohol. The biggest reductions were for fortified wine, where taxes were reduced by 46 per cent in 2000 because of changes in tax rules, and for spirits where taxes were reduced by a total of 25 per cent over two years (2002 and 2003).

Sweden stopped increasing taxes on alcohol in the mid-1990s. The real price of alcohol has therefore fallen while the disposable income has risen. Norway has higher taxes on alcohol, so the cross-border trade in alcohol is more profitable than if Sweden had regulated its tax on alcohol in line with inflation.

Vulnerable groups also affected
It is worth noting that particularly vulnerable groups such as young people and alcohol addicts also respond to price changes, and drink less when the prices go up and vice versa (Cook & Moore, 2002). The cited studies of tax changes have, to a certain extent, shown larger effects on harm and problems associated with alcohol abuse than on alcohol consumption. This suggests that the perception that alcohol prices do not affect consumption by addicts is erroneous, and instead indicates the opposite, i.e. that the use of alcohol taxes can also be an important instrument in limiting consumption among alcohol addicts.

In addition to the use of taxes, the authorities can also regulate alcohol prices through other instruments, such as by setting minimum prices and limiting discounts and promotional campaigns. The Norwegian Alcohol Act prohibits the sale of alcohol with discount. The international research literature includes few studies that have examined the effect of this, and studies are of poor quality (Babor, et al., 2010). One example is an American study that showed that binge drinking among college students occurred more frequently when there were special offers and bulk discounts on alcohol (Kuo, Wechsler, Greenberg, and Lee, 2003).

Age limits
An increase in the minimum age for alcohol purchase results in fewer sales to young people and fewer problems. The Welfare Committee notes that it is well documented that changes in the age limit for buying alcohol have significant effects on traffic fatalities and other injuries.

In Norway, the age limit for buying beer, wine and alcopops is 18, and 20 for buying spirits. Compared with countries in southern and central Europe, the age limit in Norway is high, but it corresponds

(approximately) with the age limit in several other Nordic countries and is lower than in USA. Several studies have shown that minors continued to buy alcohol, both in shops, in alcohol-serving establishments and at Vinmonopolet (Buvik & Baklien, 2006; Rossow, Pape, & Storvoll, 2005).

The ESPAD survey (2012) – a large, comparative study of alcohol, tobacco and drug use amongst 15/16-year-olds in over 30 European countries – showed that young people in Denmark drank most in Europe. Kit Broholm from the Danish Health and Medicines Authority believes that the availability of alcohol causes massive group pressure for upper secondary school students to drink at parties. Mads Koch Hansen of the Danish Medical Association points out that young Danish people hold the European record in binge drinking.

The significance of age limit is shown by experiences from Denmark, where the age limits for buying alcohol in shops were abolished in 1970 and then reintroduced in 1998. The reason for introducing an age limit of 15 years at that time was concern about young people's use of alcopops, and also because the first surveys of 11-17-year-olds showed that alcohol consumption and alcohol intoxication decreased when the age limit was introduced, primarily amongst young people under 15 but also among those older (Møller, 2002).

The interpretation of the findings was that introduction of an age limit had an effect on alcohol consumption amongst minors. Also, the public debate surrounding the introduction of the age limit probably also caused more restrictive attitudes amongst parents and thereby affected consumption among young people older than 15.

The Welfare Committee points out that the significance of an age limit clearly depends on how, and the extent to which, limits are enforced. The Welfare Committee therefore feels that the authorities in the Nordic countries should consider measures to ensure that the age limit measure works as it was intended, which is to reduce alcohol consumption among young people.

Drunk driving limits
The Welfare Committee points out that Norway was the first country in the world to introduce a legal blood alcohol content limit, 0.5 per mille, in 1936. When Sweden reduced the legal limit from 0.5 to 0.2 per mille in 1990, pressure increased for a corresponding reduction in Norway, and in 2001 the blood alcohol content limit in Norway was reduced to 0.2 per mille.

Blood alcohol content limits in traffic

Finland[1]:	Car:	0.5 per mille
	Boat:	1.0 per mille
	Commercial vessels:	0.5 per mille
	Aircraft:	0.5 per mille
	Train:	0.5 per mille
Norway[2]:	Car:	0.2 per mille
	Commercial drivers:	0.0 per mille
	Boat (small):	0.8 per mille
	Boat (over 15 m):	0.2 per mille
	Commercial vessels:	0.5 per mille
	Aircraft:	0.5 per mille
	Train:	0.5 per mille

[1]Source: Criminal Code 19.12.1889/39, Chapter 23, Section 5-7

[2]Source: SOU 2006:12, Drunk driving and intoxication at sea

Denmark[3]:	Car:	0.5 per mille
	Boat:	0.5 per mille
	(leisure boats are exempted)	
Sweden[4]:	Car:	0.2 per mille
	Boat:	0.2 per mille
	(min. 15 knots or at least 10 metres)	
Iceland[5]:	Car:	0.5 per mille

Consequently, the Welfare Committee proposes that

the Nordic Council recommends to the Nordic Council of Ministers

> *to* work for a blood alcohol content limit of 0.2 per mille for the operation of all motor vehicles in the Nordic countries, the Faroe Islands, Greenland and Åland

Alcolock
An alcolock is an electronic device that prevents a car being started if the driver is under the influence of alcohol.

The Welfare Committee has observed that, in France, alcolocks were introduced on all motor vehicles apart from scooters and mopeds from 1 July 2012. By law, an alcometer of approved type must be kept in all vehicles covered by the law, and includes all vehicles driven on French roads and even vehicles that are registered outside France. The idea is that, if a driver is in any doubt about their blood alcohol content level, they can test the level before starting the car. Motorists stopped without an alcometer in their car will be fined EUR 11. In France, the blood alcohol content limit is 0.5 per mille. Cheap, disposable alcometers (éthylotest) can be bought for EUR 1-2 at petrol stations, supermarkets and pharmacies. They last for two years, but can only be used once.

In 1999, an experiment was started in Sweden with voluntary use of alcolocks for people convicted of drunk driving offences. An offer was made to convicted drink-drivers that they could keep their driving licence if an alcolock was installed in the car and if they agreed to take part in a two-year follow-up programme. Initially, the arrangement was limited to drivers of private cars in three counties, but in 2003 the scheme was extended throughout the country, and applied to all driving licence classes apart from motor-cycle. In Sweden, as in Norway, drunk driving is one of the most common causes of road accidents. Alcolocks are an effective measure to prevent people convicted of drunk driving repeating the offence by driving in an intoxicated state. This is shown in a review carried out by the Institute of Transport Economics (TØI) in Norway, commissioned by the Swedish Transport Administration. According to the report, the Swedish experiment has had a long-term effect, with less drunk driving and fewer road accidents involving the participants.

The Welfare Committee believes that a similar system could be introduced for boats of a certain motor power, although the consequences of such a system must be studied. It is equally important to ensure that people driving boats do not drive with excessive blood alcohol content levels.

The Welfare Committee feels that it would be appropriate to consider corresponding systems with alcolocks for all vehicles in the Nordic

[3]Act on Safety at Sea

[4]Source: Maritime Act 1994:1009

[5]Source: WHO database: European Information System on Alcohol and Health (EISAH)

countries and the Faroe Islands, Greenland and Åland. The Swedish Abstaining Motorists' Association (MHF) has received support from the Swedish National Police Board, which has given the green light to a measure comprising automatic barriers with alcolocks in all Swedish ferry terminals.

In Sweden, 3.3 million vehicles are driven off ferries every year. In the future, all vehicles will pass through the controls. This will double the total number of breathalyser tests in Sweden compared with current checks. Only a few of today's tests are carried out in ferry terminals, but experience shows that twice as many intoxicated drivers are stopped in such controls as elsewhere in traffic.

Consequently, the Welfare Committee proposes that

the Nordic Council recommends to the Nordic Council of Ministers

> *to* introduce alcolocks for commercial drivers in the Nordic countries, the Faroe Islands, Greenland and Åland, and for people who have been convicted for drunk driving, and investigate the introduction of alcolocks in all types of vehicles as an alcohol policy measure.

Restrictions on marketing
Alcohol is marketed worldwide. The Welfare Committee is aware that many countries are now subjected to a lot of sophisticated marketing that has not been seen before, both through traditional media like TV, radio and the press, and through new media like the Internet and mobile telephones, sponsorship agreements, and direct marketing, including branded goods and displays at selling points.

The Welfare Committee points out that research shows that the exposure of young people to alcohol marketing hastens the drinking debut and increases alcohol consumption among those people who already drink.

Legislation that imposes restrictions on advertising of alcohol is a well-established preventative measure that is used by authorities in many parts of the world, despite opposition from the alcohol sector. However, the Welfare Committee notes that many advertising bans in several Nordic countries are only partial; for example, the ban only applies to spirits or at certain TV times, and only applies to some of the media in which marketing takes place. These prohibitions often work side by side with the sector's own regulations, which specify the content in, or the permitted forms of, alcohol advertising.

The Welfare Committee refers to a ruling by the Supreme Court of Norway in the Pedicel case (Pedicel publishes the *Vinforum* journal). Pedicel had appealed against the ban on alcohol advertising, which conflicted with EEA provisions. In the ruling, which Pedicel lost, it was pointed out that, in addition to the direct effect of a ban on advertising, there is the more indirect effect. The ruling quotes from a report by Associate Professor Bendik M. Samuelsen and PhD candidate Lars Erling Olsen: "In addition, there is a strong argument that any acceptance of advertising for alcohol by the authorities may act as a significant signal that society accepts drinking and a drinking culture. Such acceptance in itself could have significance for the effect on consumption, in addition to the effect of the advertising itself."

The same correlation is pointed out in the EU Commission's proposal to a tobacco directive in 2001 (COM 22001), where an example from the UK is used to explain the significance of the indirect of tobacco advertising. Two-thirds of all adults who smoke say they would like to give up

smoking, but half of them say that smoking cannot be so dangerous as long as the authorities permit alcohol advertising.

The Welfare Committee emphasises that exposure to marketing has a significant impact on alcohol consumption, and requests that this issue of regulation of advertising be placed high on the political agenda. Høybråten, MP and member of the Norwegian Christian Democrat Party (KrF), has recently submitted a parliament question about the Norwegian exemption from alcohol advertising in the EEA agreement. The EU Commission has now stated that it does not wish to extend Norway's exemption from the regulations on alcohol advertising. The issue has not been decided and the Norwegian authorities are working consistently to retain the ban on advertising of alcohol.

The Welfare Committee notes that Norway, Sweden and France have restrictive legislation against the marketing of alcoholic products.

Self-regulation through the sector's own rules does not appear to stop the type of advertising that has an effect on young people. The Consumer Ombudsman in Denmark announced that Dansk Ungdomsferie ApS, a travel company offering holidays aimed at young people, was fined DKK 55 000 in 2011 for its marketing that encouraged alcohol consumption and was aimed at young people under 18. The ruling is the first in this area in Denmark, and establishes that there is no place for alcohol in advertising aimed at the youngest consumers.

The Welfare Committee refers to research that shows the effect of the current quantity of marketing on the recruitment of heavy drinkers among young people, and shows the need to consider a total ban on alcohol marketing aimed at young people. The Welfare Committee states that, although the research base is limited, it is probable that a total ban on all types of marketing could have an effect on alcohol consumption among young people, particularly if redirection of advertising funds to other media is stopped.

Consequently, the Welfare Committee proposes that

the Nordic Council recommends to the Nordic Council of Ministers

> *to* consider the introduction of a total ban on advertising and marketing of alcohol aimed at young people in the Nordic countries and the Faroe Islands, Greenland and Åland.

Information measures and attitude-changing strategies
Information measures and attitude-changing strategies are one of the most common measures initiated by authorities and NGOs to prevent alcohol-related problems. Some school-based programmes providing information about alcohol have been shown to increase awareness of alcohol and change attitudes to it, but drinking behaviour is usually unaffected. The Welfare Committee points out that the alcohol sector provides information, including information to schools. In this matter, the Welfare Committee wishes to emphasise the importance of educational material being checked for quality by the appropriate public health authority. The Welfare Committee feels it is important that the authorities do not collaborate with the alcohol and tobacco industries, even if is not manifestly a direct collaboration on alcohol or tobacco. A bond between the authorities and the tobacco and alcohol industries may reduce the effect of the preventative measures.

The Welfare Committee points out that research shows that attitude-changing campaigns have minimal effect, and that the effects are usually modest and short-lived (Babor et al., 2010).

The Welfare Committee is aware that the best effects have been seen in connection with programmes aimed at high-risk groups, an approach that involves identification and early intervention. The Welfare Committee observes that information measures and attitude-changing strategies apparently have little effect. Consequently, an exclusive focus on information to the individual, trying to persuade them to change their drinking behaviour without changing the broader situation, cannot be regarded as an effective strategy.

Alcohol-related harm and problems

Chronic diseases are not just discussed by the WHO, but also by the UN, the World Bank, World Economic Forum and OECD. The World Economic Forum classified chronic diseases as one of the major global problems in its risk report 2010, which focuses on lifestyle-related harm in a long-term perspective (Global Risks 2010, World Economic Forum). The UN held a general assembly on this issue in 2011.

The WHO is working with standards and targets for the global work against chronic diseases. The alcohol industry is working hard to retain its market shares and counteracts the reduction in alcohol consumption stated as an objective in the WHO's proposal to the UN.

The chronic diseases can largely be prevented by avoiding the four main lifestyle factors that cause them: tobacco, alcohol, lack of physical activity and poor diet. Alcohol is the second biggest cause of cancer after tobacco, which causes 18 per cent of all deaths attributed to cancer (IARC, *Attributable Causes of Cancer in France in the year 2000*).

The Welfare Committee notes figures from Norway, showing that Norwegians know least in Europe about the harmful effects of alcohol. Only one in three Norwegians realises that alcohol increases the risk of cardiovascular disorders. Only one in five knows that alcohol use can lead to cancer. According to the Welfare Committee, this indicates the importance of general information to the public about the harmful effects of alcohol use, preferably as early as possible, for example through schools.

Chronic diseases and harm

The Welfare Committee points out that cardiovascular disorders, breast cancer, tuberculosis, road accidents, cirrhosis and suicide are among the most common alcohol-related types of harm at individual level. Accidents, suicide and violence form the largest proportion of burden of disease that can be attributed to alcohol. Alcohol consumption is also a risk factor for a large number of social problems. The Welfare Committee also wishes to emphasise that alcohol consumption can have negative consequences for other people than the person who drinks, including alcohol-related criminality, domestic violence, family problems, road accidents and problems at workplaces. Although there is evidence of a direct causal link between alcohol and violence, the relationship is more complex when it comes to problems like divorce, child abuse and problems at work.

The Welfare Committee notes that there is strong documentation about the relationship between the total alcohol consumption in the population and the extent of alcohol-related problems (Babor, et al., 2010). When alcohol prices affect demand for alcohol, a relationship between alcohol prices and extent of alcohol-related problems can therefore be expected. A number of studies also find such a relationship (Chaloupka, Grossman, & Saffer, 2002; Wagenaar, et al., 2009), and have shown that an increase in alcohol prices is linked with a decline in, for example, drunk driving and road accidents, cirrhosis-caused deaths, suicide, violent and acquisitive

criminality.

Alcohol and elderly people

The Welfare Committee points out that the population in the Nordic countries is ageing. In the Nordic countries, approximately 30 per cent of the population will comprise people aged 65+, and approximately 10 per cent will be 80+ in 2028 (*Eldre, alkohol og legemiddelbruk* [Old People, Use of Alcohol and Medicines], Frydenlund, 2011). In Norway, within a couple of decades, one in five will be aged 65+, and this figure is expected to rise to one in four by 2050. The Welfare Committee notes that the increase is attributed to greater life expectancy and lower birth rates.

The Welfare Committee observes that, in the past decades, there have also been major changes in alcohol policy relating to price and availability. In a health survey of elderly people (60+) and alcohol (HUNT, Støver et al., 2012), results show that older people are now living longer and also enjoy greater economic freedom, and have become a distinct market segment for sellers of alcohol. The probability of large consumption and health damage also increases accordingly. Although interest appears to be growing in elderly people's use of addictive substances, research in this field is very limited. Many of the alcohol surveys of the population carried out in the Nordic countries exclude elderly people. A few Nordic studies have been carried out, but no comparative studies, and there is also a lack of studies that examine alcohol consumption of elderly people combined with their use of medicines.

The HUNT Survey (Støver et al., 2012) identifies a number of reasons why this field should be made a subject of research in the future. One is the lack of knowledge about the social and health effects of alcohol consumption in elderly people, both in the Nordic countries and the rest of Europe. Increases in alcohol consumption and the proportion of elderly people mean that society will probably be facing major challenges relating to this in the years to come. In the future, specific research on alcohol use among older people will be important. The Welfare Committee notes that the HUNT Survey recommends that there should be a focus on development and validation of screening instruments that are specially adapted to old people. It is emphasised that healthcare services will face major challenges relating to mapping and detection of alcohol problems, and greater knowledge about alcohol use amongst old people should be included in medical training.

The Welfare Committee notes that there are reasons to assume that measures that lead to higher prices can be effective in preventing alcohol problems. The Welfare Committee refers to the fact that taxes on alcohol are the most commonly used alcohol policy instrument to influence alcohol prices.

Harmful effects increase when taxes are lowered

The Welfare Committee notes that, in Denmark, taxes on spirits were reduced in 2003 by 45 per cent, to counteract tourist-related import from other EU countries. Sales of spirits in Denmark increased considerably after the tax reduction; in the fourth quarter of 2003, sales were 41 per cent higher than in the corresponding period the previous year. At the same time, there was a steady decline in sales of beer in Denmark, and overall sales of alcohol have continued to show the downward trend that began at the end of the 1990s. Although data from the survey of the Danish population did not show any changes in self-reported alcohol consumption or alcohol-related problems after the tax reduction, this is a clear example of how the tax policy steers consumption. However, although total consumption did not increase, data from hospital accident & emergency departments in Denmark showed an increase in the scale of

acute alcohol poisoning among young people that was correlated with the reduction in tax on spirits (Bloomfield, Rossow, & Norström, 2009).

In addition, the Welfare Committee notes that Finland also reduced alcohol taxes in 2004. This was an attempt to counteract the import of alcohol by tourists from countries such as Estonia. The tax reduction in Finland was greatest for spirits (44%), slightly less for beer (32%), and smallest for wine (10%).

Alcohol sales in 2004 increased by 17 per cent for spirits and 5 per cent for beer, but wine sales were not affected. Total sales of alcohol in Finland increased by 7 per cent in 2004. A clear increase was observed in the frequency of alcohol-related deaths, diseases and poisonings, arrests for public drunkenness, and drunk driving in the period after the changes in 2004. Parallel with the reduction in taxes and increased alcohol sales in Finland, there was also an increase in unregistered alcohol consumption resulting from tourist imports from Estonia. Consequently, the increase in frequency of alcohol-related problems cannot only be attributed to the reduction in taxes on alcohol, but also to the increased cross-border trade in alcohol (Mäkelä & Österberg, 2009).

Alcohol and violence
The Welfare Committee draws attention to the relationship between alcohol and violence. Much physical violence is carried out by people who are under the influence of alcohol. Time-series analyses show a clear relationship between alcohol sales and violent criminality, but the relationship is complex. For example, there is no context that shows that a country with high alcohol consumption has more incidents of violence than countries with lower alcohol consumption. There are also many incidents of violence that do not involve alcohol, and most occasions of alcohol consumption do not lead to violence. Research shows that people under the influence of alcohol turn to violence in situations of frustration and stress. Alcohol is mainly a triggering factor, but is not the only explanation for violent actions. It also has significance for understanding of why criminal violence changes over time (Lenke, 1990).

The significance of the alcohol factor is best documented for road accidents, but is also documented for other types of accident, such as falling and drowning (Med Norström, 2005). The link between alcohol and suicide is indicated by a number of studies that show a higher risk of suicide among alcohol addicts (Rossow, 1996).

Consequently, the Welfare Committee proposes that

the Nordic Council recommends to the Nordic Council of Ministers

> *to* strengthen evidence-based research in the Nordic Region in tobacco and alcohol use and chronic diseases, cancer and lifestyle diseases.

Costs of alcohol to society, working life and the business community
The Welfare Committee points out that different ways of calculating the costs of alcohol to society give different results. In the report *Alcohol in Europe*, commissioned by the EU Commission, it is argued that the best calculation is 1.3 per cent of GNP. For Sweden, this corresponds to just over 45 billion kroner at 2011 level. Other calculations lie between 20 and 158 billion kroner for Sweden.

The Swedish Addiction Commission (SOU 2011:6) reported that the 68 000 addicts who have greatest need for help cost society no less than SEK 66 billion. Each person costs SEK 940 000 per year – 214 000 for the municipality, 115 000 for the county council, 164 000 for the judicial

system and 447 000 in production losses.

The Welfare Committee notes that it is not just the heaviest addicts that cause costs. There are major consequences for working life and productivity, for example through sickness absence and through reduced productivity of people who are at work. Thor Norström (2006) estimated that an increase in alcohol consumption by one litre is linked to an increase in sickness absence of 11 per cent for men and 6 per cent for women. A similar Norwegian study gave the same result for men (Norström and Moan, 2009).

The Welfare Committee notes that the effect of reduced productivity at work is as large as, or larger than, losses caused by sickness absence (Scientific Opinion of the Science Group of the European Alcohol and Health Forum, 2011). The Welfare Committee points out that the business community appears to bear a great deal of the consequences of alcohol consumption. The Welfare Committee believes that this knowledge could help make employers more interested in alcohol policy measures, not just in working life but in society in general.

The Welfare Committee notes that the Norwegian report *Rus og voksenbefolkningen - tidlig intervensjon ut fra et arbeidslivsperspektiv* [Substance abuse and the adult population – early intervention from an employment perspective] (Cecilie Schou Andreassen, 2011) recommends that further work on a preventative aspect in employment would be best served by focusing on reaching the "masses" of employees. Early intervention in the workplace assumes that management and HSE bodies are proactive in the preventative work on substance abuse, and that they are provided with effective strategies and models for selective interventions in working life. According to the Welfare Committee, support in the workplace is vital in attaining tangible results in reducing alcohol consumption among employees.

The Welfare Committee sees an opportunity to encourage the Nordic Council and the Nordic Council of Ministers to enter into dialogue with the largest Nordic companies to examine whether there are grounds for initiating collaboration in working life and health and to see whether large Nordic companies can openly support the Nordic model's measures relating to alcohol policy. This would give positive signals outside the Nordic region, and show that Nordic companies are taking seriously their social responsibility for use of alcohol in working life.

Consequently, the Welfare Committee proposes that

the Nordic Council recommends to the Nordic Council of Ministers

> *to* encourage an active dialogue with the largest Nordic companies on the information of the costs associated with alcohol and tobacco, and help to strengthen their support of the Nordic model for alcohol policy measures.

Effect of alcohol on third parties
The Welfare Committee notes that there has been less research into the role of alcohol in injuries and harm to third parties than medical aspects, but what we do know is that the role of alcohol is much bigger than that of tobacco and at least as big as the alcohol-related medical harm to the consumer.

The Welfare Committee notes that, in a UK study of the harm caused by a number of narcotic substances, tobacco and alcohol, it was found that alcohol was the most harmful. It can be difficult to compare legal and illicit substances, but alcohol was found to be nearly three times more harmful

than tobacco, both of them legal substances. The harmful effects of alcohol on other people than the consumer were found to be nearly double that of the total harm caused by tobacco (Nutt et al., Lancet 2010).

The Swedish National Institute of Public Health has calculated that approximately 385 000 children live in families where substance abuse occurs (*Barn i familjer med alkohol och narkotikaproblem* [Children in families with alcohol and drug problems], R 2008:28).

The Welfare Committee draws attention to a report by the Swedish National Board of Health and Welfare in 2009 about children and young people in families where substance abuse occurs; the report points out a lack of knowledge about children and young people living with substance abuse problems. The report showed that 21 per cent of the women who started treatment for substance abuse in 2008 lived with children, while the corresponding figure for men was 13 per cent. Half of the women who had children were single parents, while men with children often had co-habiting partners.

The Welfare Committee notes that not enough priority has been given to research into children and young people who live in families where substance abuse occurs, and particularly families in which the problem is alcohol abuse. The Welfare Committee feels it is particularly important that the conditions for these children, and their quality of life and opportunities for development, are reviewed in relation to future consequences.

In 2008, the Welfare Committee worked with the main theme of how abused children become sick adults. Abused children largely become the adults with whom the treatment system comes into contact (Kirkengen, 2009). During this process, it became clear that children and young people who live under conditions of abuse, with possible psychological and physical assault and experience of violence in the family, can be affected later in life. The effect manifests itself in absence from school, poor relationship to employment, criminality, substance abuse, development of psychological and physical problems, and other problems. In homes where substance abuse dominates, it can be difficult to create sensitive interaction and a safe, mutual bonding process between children and parents, something that is thought to be of fundamental importance to the development of psychological, social and cognitive skills (Fonagy et al., 2002; Killen, 2003; Schore, 2001). The longer the child is exposed to the parents' substance abuse, and the more family members that have problems of substance abuse, the greater the risk of the child experiencing negative consequences (Burke et al., 2006; Hussong et al., 2008).

The Welfare Committee points out that both long-term increased alcohol consumption and episodes of great intoxication clearly increase the risk of negative consequences for children and young people. The same applies to children exposed to drug use (Rossow et al., 2009).

There is extensive research-based knowledge about harm and suffering of children that can be related to substance abuse by parents. Epidemiological studies show that the numbers of children affected are large, and the harm has been demonstrated, for example, through clinical studies that monitor children over time. It is pointed out that the Welfare Committee has a proposal concerning ADHD, where alcohol can be a contributory factor (A1551/Velferd: *On ADHD diagnosis and medication of children and young people in Nordic countries*).

In Norway, as in many other countries, there has been a lot of focus on using information about the harm caused by alcohol use during pregnancy

as an important preventative measure. We are facing a major challenge in terms of identifying children at an early stage who are growing up in conditions characterised by substance abuse. Two reports from SIRUS, the Norwegian Institute for Alcohol and Drug Research, (Solbakken & Lauritzen, 2006; Solbakken et al., 2005) describe the importance of this, and propose models for reaching various risk groups. The Welfare Committee notes that France has chosen to label wine bottles with warnings to women who are pregnant.

In Norway, a Report to the Storting was submitted in summer 2012 about children growing up with parents who misuse alcohol, "See Me! A Comprehensive Drug Policy", Storting Report No. 53/2012. A strong Government initiative is taking place to coordinate early intervention for children of addicts, psychological suffering and somatic disorders. Substance abuse has been shown to be part of an often difficult home situation, so prevention of injury and disabilities in affected children is largely through general health and social policy instruments.

Consequently, the Welfare Committee proposes that

the Nordic Council recommends to the Nordic Council of Ministers

> *to* strengthen evidence-based research in the Nordic Region on children and young people who grow up with one or more caregivers who suffer from serious alcohol abuse.

Farm sales
The Welfare Committee notes that farm sales of alcoholic beverages, together with this form of selling and reselling through distance trading, are the main challenges facing the field of alcohol policy. This was confirmed by the head of Vinmonopolet, Kai G. Henriksen, in a meeting with the Welfare Committee in January 2012.

There are major consequences for the retail monopoly if farm sales are allowed. The Welfare Committee reports that all parties in Sweden state that they do not want farm sales if it puts the alcohol monopoly at risk. Two Swedish reports have concluded that farm sales, i.e. where Swedish producers in rural areas are allowed to sell their alcoholic products direct to the consumer, are discriminatory and conflict with EU law. The Welfare Committee notes that the Commission says openly that the same applies to sale of farm liquor in Finland, and will also apply for sales of fruit and berry wine in Finland.

The Welfare Committee emphasises that the Swedish Office of the Chancellor of Justice says that the EU Court of Justice may review the entire Swedish alcohol legislation and that the result may be that Swedish legislation is not approved by EU law. The Welfare Committee points out that the consequences for public health of farm sales of alcohol would probably be very great.

Internet trading
The Welfare Committee is aware that, when private import of alcoholic products was permitted by Swedish law after Sweden lost the Rosengren case in the EU Court of Justice, a large number of commercial enterprises were set up whose objective was to sell alcoholic beverages in Sweden. Some of them have extensive activities in Sweden, while others only sell alcohol that can be sold in food shops. The Welfare Committee points out that if these businesses are allowed to continue, they can become so many that they will pose a genuine threat to the existence of the Swedish retail trade in alcohol, and thereby also affect the retail monopoly in the other Nordic countries. Sales have grown exponentially (XXXXXX), and a lot of activity is taking place to increase sales, including service to

consumers, events, wine-tasting (at which alcohol may subsequently be bought), subscriptions (packaged goods), trade promotions, newsletters, etc. Advertising in both new and traditional media is increasing, in the form of advertisements, direct marketing, etc.

The Welfare Committee points out that alcohol can be ordered directly via a mobile telephone, through social media, and in forums on the Internet. The Welfare Committee refers to both Finland and Norway, which have implemented much stricter rules than Sweden for Internet sales of alcohol. After an amendment to the Norwegian Alcohol Act in 2009, carriers of privately imported alcohol must be registered. The carrier must be independent of the seller and may not have fixed delivery points. In Finland, the Alcohol Act opposes reselling of alcohol. The alcohol must also be paid for before it enters Finland and is transported directly to the customer. There are also regulations stipulating that alcoholic products may not be delivered together with food items to the customer's home.

The Welfare Committee wishes to emphasise that, if a channel is established for sale and marketing of alcoholic beverages to consumers outside the alcohol monopoly in Norway, Sweden, Finland or Iceland, the issue of retail monopoly on alcohol may be taken up by the EU Court of Justice for review. A possible consequence of this is that the EU Court of Justice may rule that the alcohol policy is no longer a cohesive and systematic policy to protect public health against the harmful effects of alcohol. Such a ruling may force Sweden to change its laws in line with the EU Court of Justice, and the alcohol monopoly is then at risk.

Increased cross-border trading
The Welfare Committee believes that there is no doubt that trade with alcohol over the borders in the EU has increased considerably. This presents a trade policy problem for the countries in the EU that wish to retain high taxes as an alcohol policy instrument. The quantity of alcohol that a person may import over the borders of EU countries is the equivalent of two years' consumption. Norway, which is not a member of the EU, is entitled to restrict such imports of alcohol according to the EEA agreement; import is permitted but only in small quantities. Norwegian alcohol producers are therefore protected by restrictions on the import of alcohol from other countries, but at the same time they are restricted because they are not entitled to market their products in Norway. Alcohol commercials reach Norway indirectly via television channels that are produced outside Norway and through international newspapers and magazines, but Norwegian producers have no channel through which to market their products.

Tax-free
The Welfare Committee observes that the EU has a basic principle that alcohol may not be sold tax-free on departure from or arrival in any country in the European Union. The principle in the EU is that excise duty will be paid in the country in which the alcohol is consumed, but that is the only exception from the principle of the country of consumption. What may justify limited tax-free sales is the idea that control will be less demanding if a certain quota is accepted by the travellers.

The Welfare Committee is aware that experiences from Norway show that the quantity of alcohol that is sold through tax-free arrangements is problematical from an alcohol policy perspective, and that there are reasons for prohibiting tax-free sales. This is contradictory for Norway, which has the strictest alcohol legislation in the Nordic countries, while having considerable sales of tax-free alcohol products. The main airport in Oslo now allows travellers to buy tax-free alcohol and tobacco on arrival in Norway.

The Welfare Committee believes that every country and autonomous area in the Nordic region should be entitled to set their own levels of legislation that protect public health, of which alcohol tax is an example. It is reasonable that the principle of taxation in the country of consumption is maintained.

The Welfare Committee observes that the Venstre party in Norway, in its election manifesto for 2013, proposes to abolish the tax-free system (5 September 2012).

The Welfare Committee points out that offers like "Buy three and get a fourth bottle free" is particularly a problem in Denmark, but it also applies to ferries between Sweden and Finland. Here the Welfare Committee states that an examination must be made of which laws, national or international, apply.

Transparency and lobbying
It is clear that the tobacco and alcohol industries are strong lobbyists on international, Nordic and national levels. It would be a step forward to be able to monitor this lobbying as a contribution to the argument to protect public health in the Nordic countries. The objective of this lobbying is to reduce policy measures relating to production, distribution, sale and use of alcohol and tobacco in the population. It is not easy to see how such lobbying could be made more transparent. The Welfare Committee encourages the Council of Ministers to propose appropriate measures that would ensure transparency of lobbying by the large multinational companies in the Nordic countries.

The Welfare Committee observes that the WHO warns of collaboration between the authorities and representatives of the tobacco and alcohol industries, even where there is no manifestly direct link to alcohol or tobacco.

Consequently, the Welfare Committee proposes that

the Nordic Council recommends to the Nordic Council of Ministers

> *to* investigate how to ensure public access to lobbying activities from the multinational companies in the Nordic countries

Relationship between smuggling and high alcohol prices
The Welfare Committee notes that there are arguments against high prices and reduced availability – these measures lead to smuggling and revenues for organised criminal networks. The Welfare Committee is aware that unregistered consumption takes place, but the quantity is included as an estimate in alcohol statistics. Nevertheless, high taxes on alcohol are an effective way of reducing alcohol consumption, while increasing tax revenues.

It is also true that countries with low taxes on alcohol, surprisingly, also have a higher proportion of unregistered sales and consumption of alcohol. Consequently, reducing alcohol taxes will not necessarily reduce smuggling, and the customs service and the policy must increase monitoring activities. This is well illustrated in the case of tobacco, particularly in developing countries where the conclusion is that tax increases are effective, both to reduce consumption and to increase tax revenues. Unregistered consumption is primarily determined by the level of control. This is confirmed by the EU in the book "*Tobacco or Health in the European Union*" published by the European Commission (2004).

The Welfare Committee points out that the relationship between tax and smuggling is not as well studied for alcohol as it is for tobacco. However,

in an appendix to the research report that was written on commission of the European Commission, "*The effects of tax changes on crossborder and other unrecorded consumption"* (RAND, 2012), it is pointed out that the area is not sufficiently examined, but that data indicates that tax increases are effective in reducing consumption and harm, although they may change the distribution between registered and unregistered alcohol consumption.

The Welfare Committee therefore takes the view that it is important to strengthen measures against smuggling and resale of smuggled goods, by prioritising the work of the customs and police to counteract large-scale smuggling and also small-scale frequent smuggling.

The free importation of alcohol for private use is justified within the EU by the abolition of border controls. The Welfare Committee believes that the argument is hardly sustainable, as tobacco cannot be imported for more than for one month's consumption. The alcohol quota is for two years' consumption, which is the maximum limit for low-risk consumption over two years. The Welfare Committee understands that these provisions are difficult to change, because this would require consensus in the EU Council of Ministers. One measure that may help to reduce the importation of alcohol between the countries in the EU is to place this issue on the agenda in all EU Member States in order to reduce the levels that can be imported. The Welfare Committee points out that this is an area where the Nordic Ministers of Health and Social Affairs could join forces and work on a united front. At the same time, the Welfare Committee points out that measures could be considered to remove the consumers' opportunity to import their two-year quota more than once in a two-year period. Anyone importing alcohol more than once in this period could be charged with smuggling, or pay taxes and duties for the quantity that exceeds the permitted quantity of alcohol that may be imported in the course of two years.

3. Background: Tobacco

The Welfare Committee points out that tobacco is the only commodity that is sold legally that can harm everyone exposed to it, and that kills half of the people that smoke it. Tobacco is common all over the world, on account of low prices, worldwide aggressive marketing, lack of awareness of the dangers associated with smoking, and inconsistent political measures to prevent smoking.

Tobacco, a harmful commodity

Tobacco products are products wholly or partly made from tobacco leaves, which are smoked, sucked, chewed or snuffed. The Welfare Committee is aware that the main ingredient in tobacco is nicotine, which is an addictive substance. Nicotine is absorbed quickly in the lungs and gives biologically measurable effects within a few seconds after inhalation. It produces positive rewards in the brain's reward system and also activates the 'alarm system', which increases alertness. Abstinence, i.e. when nicotine addicts lack nicotine, can lead to problems of handling situations, aggressiveness, tension, worry, and concentration difficulties.

The Welfare Committee points out that cigarette smoke contains 4 000 health-damaging chemical substances, many of which are dangerous (WHO). Smoking can cause damage wherever the inhaled air passes and blood flows, i.e. in virtually all the organ systems in the body. All organ systems in the body are damaged by tobacco smoking, everyone who smokes is harmed, and half of those that smoke die prematurely.

The Welfare Committee notes that smoking increases the risk of developing over 50 different diseases, including the major public health

diseases: heart failure and other cardiovascular disorders, cancer (lung cancer, etc) and chronic obstructive lung disease. Smoking is also linked to increased risk of a number of other diseases.

Despite this, smoking is common all over the world. The degree of harm caused by smoking depends, of course, on the amount of smoke a person exposes themselves to (i.e. the smoker), or is exposed to (passive smoking, harm to third party). Because there is a time lag of many years between when people start to smoke and when they start to develop smoking-induced health problems, the epidemic of tobacco-related symptoms and death has only just begun.

Passive smoking also kills people
The Welfare Committee emphasises that passive smoking in the home, in restaurants, offices or other enclosed spaces entail the same type of harm as active smoking. No level of passive smoking is harmless; even short-term exposure can, for example, provoke stronger and more frequent asthma attacks in children that already have asthma (U.S. Department of Health and Human Services, USDHHS, 2006).

Tobacco that is inhaled (primary smoke) burns at a higher temperature than the smoke that fills the room when the cigarette is glowing (secondary smoke). Because of this, the secondary smoke has a higher concentration of particles, making it even more dangerous than the primary smoke inhaled by the smoker. Passive smoking is associated with both acute discomfort (in the nose, eyes, throat and airways) and long-term effect on health (heart failure, lung cancer, sinus cancer (Swedish Council for Information on Alcohol and Other Drugs, CAN).

Passive smoking increases the risk of both lung cancer and heart failure by 30 per cent, and COPD by 40-80 per cent, compared with people not exposed to smoking (Swedish National Institute of Public Health, 2009a).

The Welfare Committee notes that children are particularly vulnerable to the harmful substances in cigarette smoke. In addition to the increased risk of developing a number of respiratory disorders, it is also proven that children exposed to passive smoking are more likely to experience frequent infections of the middle ear. In addition, passive smoking involves a greater risk of Sudden Infant Death Syndrome, SIDS (USDHHS, 2006; (2011).

The tobacco industry
The Welfare Committee notes that the tobacco industry includes parties that store, import and distribute tobacco products, and whose objective is to, directly or indirectly, make profit from tobacco products. The tobacco industry promotes tobacco, even though it has known for years that both smoking and passive smoking harm people's health. Although the industry in 1954 promised to carry out studies and share all research findings with the public, the tobacco industry has concealed facts and continues to deny the effect of tobacco products, in order to retain their profits and increase sales (WHO, 2012).

The Welfare Committee is aware that the tobacco industry tries to exert influence in many ways, for example by trying to undermine anti-tobacco campaigns. Its goal is to influence all levels and sectors of governments and NGOs, including the private sector and civil society. The industry tries to come across as an indispensible contributor to economic and social welfare.

The Welfare Committee draws attention to the WHO, which reports that

the tobacco industry tries to exert influence in various areas:

- Manoeuvres to hijack political and legal processes. This is done, for example through lobbying to market decisions on the pretext that they benefit the general public when the decisions, in fact, benefit their own interests. They exploit legal loopholes, demand a place at the conference table with authorities, and support voluntary regulation over legislation. Another strategy is to collaborate with various ministries in order to finance joint projects, such as sports events for children, support for human rights, etc. Other strategies include supporting political campaigns and supporting regulatory activities that prioritise trade over health.
- Exaggerate the economic importance of the tobacco industry. The tobacco industry exaggerates its importance in providing employment, paying contributions in the form of tax and supporting other economic indicators of a country's economy. The information is not only exaggerated, but ignores the negative economic effect of tobacco and smoking.
- Manipulation of opinion to appear respectable. The tobacco industry invests huge sums of money to promote its message using PR companies.
- Fabricates support through front groups. These front groups are organisations that seem to be representing the general public, but they are actually working on behalf of a third party (in this case the tobacco industry) to which they do not disclose any connection.
- Discrediting of research results. Because there is considerable research that has shown that smoking and passive smoking are harmful, the tobacco industry must discredit this research to ensure weaker control and legislation that does not limit tobacco sales.
- Threatens authorities with legal action. It is becoming more frequent to initiate lawsuits against government laws and regulations about tobacco. The tobacco industry lies behind these lawsuits, backed up by a whole army of lawyers.

WHO

The Welfare Committee is aware that smoking of tobacco is globally the leading cause of death that can be prevented. Tobacco kills 6 million people every year, through cancer, heart disorders, lung disorders, child sicknesses, etc. This is more than the total number of people who die from tuberculosis, HIV/AIDS and malaria combined. Tobacco causes several hundred billion dollars in economic losses all over the world (WHO, 2011).

In the course of the 21st century, smoking can kill nearly 8 million people a year, unless strong measures are taken to reduce the use of tobacco (Chan, 2012).

Tobacco is the cause of death in the world that can be most easily prevented and avoided. The Welfare Committee points out that we know how to reduce the tobacco epidemic. WHO has produced the Framework Convention on Tobacco Control (FCTC) and 173 countries plus the EU countries have pledged to work together to implement the convention. The Welfare Committee notes that the purpose of the convention is to protect present and future generations from smoking-related health problems, social, environmental and economic consequences of smoking, and from passive exposure to tobacco smoke. "The tobacco epidemic is entirely man-made, and it can be turned around through the concerted efforts of governments and civil society," Dr. Margaret Chan (WHO, 2012).

WHO launched a plan in 2008 – *MPower* – which involves six measures known to be preventative against the sale and use of tobacco:

- Increase prices and taxes

- Enforce bans on tobacco marketing, promotion and sponsorship
- Protection from passive smoking
- Warn about the dangers of tobacco smoking
- Help those who want to stop smoking
- Monitor the development and effects of these measures

WHO notes that tobacco taxes are the most effective way to reduce tobacco use, particularly amongst young people and people with low incomes. According to WHO, a 10 per cent increase in taxes reduces consumption by four per cent in high-income countries and by up to eight per cent in middle-income countries.

Anti-smoking measures increased the number of people protected from passive smoking from 354 million in 2008 to 739 million in 2010.

A comprehensive ban on marketing, launches and promotions, and sponsorship activities relating to tobacco and the tobacco industry, can reduce tobacco sales by an average of seven per cent, and in some countries by as much as 16 per cent (WHO, 2008). Only 19 countries in the world have comprehensive legislation against tobacco advertising and promotions and sponsorship activities relating to the tobacco industry.

Graphic and grotesque pictures on cigarette packets of the consequences of smoking, and anti-smoking campaigns, reduce the number of children who start smoking and increase the number of adults who stop (WHO, 2008). According to WHO, campaigns in the mass media can reduce the use of tobacco, influence protection of non-smokers, and persuade young people to stop smoking.

Nordic region
The Welfare Committee notes that the proportion of everyday smokers in Europe varies, but in many countries more than one in three smoke. The Welfare Committee points out that figures from 2010 (WHO) show that 24.9 per cent of the adult population smokes. In Finland 20 per cent of adult men and women smoke daily, in Iceland 17.3 per cent, and in Norway 22 per cent. Sweden has one of the lowest proportion of smokers in the world; 13-15 per cent of Swedes smoke daily, plus occasional smokers.

These are figures from the WHO database for European countries from 2010. The Welfare Committee is pleased to note that the number of smokers is decreasing in all the Nordic countries.

In Sweden, smoking has become most common amongst working-class people, people with low education levels, unemployed people, and people who are on sick leave or who receive social security benefits. Among those people who are socially vulnerable in other ways in Swedish society (those with mental illness, alcohol and drug dependency), smoking is twice as common as in the rest of the population. More women than men smoke, and the majority of those that smoke are in the age group 45-64 (Swedish Council for Information on Alcohol and Other Drugs, CAN). Figures from Norway show the same trend of smoking being a class-related phenomenon (Lund and Lindbak, 2007; Vedøy, 2011).

Young people
The Welfare Committee is aware that average figures from the WHO's international survey of health behaviour in school-aged children shows that school children in most European countries start smoking in the age group 11-13, and by the age of 15, 16-18 per cent of young people smoke daily (HBSC Study). The earlier children smoke their first cigarettes, the earlier they become everyday smokers. In Northern and Western Europe, girls smoke just as much, or more, than boys.

The Welfare Committee points out that, of the Nordic countries, Sweden has the lowest proportion of smokers among young people. Of 15-year-olds, four per cent of boys and six per cent of girls smoke daily. In addition, 11 per cent of boys and one per cent of girls use snuff daily (HBSC Study from 2005-06, Danielson 2006). Snuff may not be sold in the EU, but Sweden is exempt from the regulations (Swedish National Institute of Public Health). The Welfare Committee notes that the numbers of young people in Sweden who smoke fell noticeably between 2010 and 2011 in both compulsory school and upper secondary school, according to the CAN figures. However, it is too early to see whether this is a break in the trend. Water pipes have become more common and this is a phenomenon involving young people. Water pipes are smoked more sporadically, a few times a month.

Most smokers want to stop
At least 70 per cent of adult smokers, and nearly half of the adults who use snuff, want to stop. Approximately one-third want help to stop. In both compulsory school and upper secondary school, 75-90 per cent of young people want to stop, and one-third of these want to stop immediately (Henriksen & Leifman, 2011).

Ethnic differences
Among adult immigrants in Norway, smoking behaviour varies greatly according to gender. Very few women from Pakistan, Sri Lanka and Vietnam smoke (Kumar et al., 2008). Among men born in Turkey, Iran, Vietnam and Pakistan, the proportion of smokers is high, but the proportion of smokers among men from Sri Lanka is lower than among men born in Norway. Girls with parents from countries where there is a Muslim majority smoke less than girls with Norwegian backgrounds. Among boys, the opposite applies (Grøtvedt et al., 2008).

Smoking, poor health, and death
The Welfare Committee points out that tobacco is a risk factor for six of the eight leading causes of death in the world today. The WHO has calculated that half of smokers die earlier than they would have done had they not smoked. In the western world today, smoking is the largest single cause of illness and premature death (Lopez et al., 2006).

The Welfare Committee refers to the WHO project "*Global Burden of Disease*" (GBD), which has calculated:

- The number of deaths that can be attributed to use of the various substances, and
- How many years of healthy life are lost because of this use of substances, i.e. the number of years lost through premature death and the number of years people live with poor health.

Figures from 2004 show that smoking was the second most important cause of death, after high blood pressure. Alcohol use was ranked as the eighth biggest cause of death. In terms of the cause of loss of years of healthy life, alcohol was ranked number three after malnutrition and unprotected sex. Tobacco was ranked as number six (WHO, 2009).

Overall, for all high-income countries, smoking was ranked as the most important risk factor for both death and loss of years of healthy life. Alcohol use was ranked as the second most important for loss of years of healthy life, and number nine in terms of deaths.

The Welfare Committee points out that tobacco use causes more deaths than use of alcohol or drugs. However, most deaths caused by smoking occur at a relatively high age, while deaths and illness caused by alcohol usually affect young adults. Alcohol use is therefore responsible for nearly

as many losses of years of healthy life as tobacco use. Drug use (and particularly injection of opiates) is linked with high instances of illness and fatality, but because drug use is much less common in the population, drug use contributes much less to fatalities and loss of years of healthy life than either alcohol or tobacco use (WHO, 2009).

Estimated eight million deaths a year by 2030
The Welfare Committee is aware that WHO has reported that the total number of tobacco-related deaths is expected to rise to nearly eight million a year by 2030. The number of smoking-related deaths is expected to be lower in western countries as a result in the decline in the number of smokers in this part of the world. Consequently, smoking-related mortality is expected to double in low- and middle-income countries, when the consequences of the increase in smoking we have observed in recent years in these areas make an impact (Mathers & Loncar, 2006).

The Welfare Committee notes that in Sweden, 6 400 people die each year as a result of their own smoking, and a further 200 die as a result of passive smoking (CAN, Sweden). In Norway, the estimated numbers of fatalities caused by smoking fell from 6 700 men and women in 2003 to approximately 5 100 in 2009, which was the equivalent of 13 per cent of all deaths that year. On average, every person who dies of smoking loses 11 years of life.

The Welfare Committee points out that, in addition to risk of death, smoking involves the risk of living many years with poor health. A Danish survey showed that smokers on average experience 5-7 years of poor health compared with non-smokers (Brønnum-Hansen & Juel, 2001). American surveys have shown that smokers are more often absent from work than non-smokers, and that when they become sick they take longer to recover. Smokers visit doctors more frequently, they are more frequently admitted to hospital, and they remain in hospital for longer periods compared with people who do not smoke (USDHHS, 2004). In addition to the strain this places on the smokers themselves, illness caused by tobacco use costs society huge sums of money each year.

Snuff
The Welfare Committee points out that snuff does not harm health in the same way as smoking, but the nicotine addiction is just as strong. The Welfare Committee notes that, while the proportion of smokers in western countries has decreased significantly in recent years, the use of snuff has increased. Several summaries of the risks associated with snuff use have been published, both in Norway (Dybing et al., 2005) and internationally (Cogiliano, 2004; *Scientific Committee on Emerging and Newly Identified Health Risks* (SCENIHR), 2008; Royal College of Physicians [RCP], 2007). The studies conclude that the use of snuff does not increase the risk of lung cancer or other lung-related disorders associated with smoking, nor has increased risk of cardiovascular disorders been proven. However, a correlation has been proven of a link between use of snuff and cancer of the pancreas and oesophagus. The Welfare Committee sees that the risk is much lower than for smoking. There is also a certain association between oral cancer and use of snuff. However, the risk of oral cancer caused by snuff use, with its low content of tobacco-specific nitrosamines, is regarded as small or non-existent (RCP, 2007).

The Welfare Committee notes that snuff appears to have replaced cigarette smoking to a certain extent among many young people and young adults. Among tenth-year students in six counties in Norway in 2000-2004, 21 per cent of the boys and four per cent of the girls used snuff daily or occasionally. In the county of Hedmark, the survey was repeated in 2009 and showed that the proportions had increased, to 29 per cent of boys and 18 per cent of girls (Youth Studies). Figures for the

whole country in 2011 showed that 25 per cent of men in the age group 16-24 used snuff daily and 16 per cent occasionally, giving a total of 41 per cent. Eleven per cent of women used snuff daily, and just as many used it occasionally (Statistics Norway, 2011).

Smoking and pregnancy
The Welfare Committee emphasises that, in addition to the health risks associated with passive smoking, there are proven risks of damage to the foetus when the mother smokes during pregnancy. Women's smoking involves, for example, risk of ectopic pregnancy, premature rupturing of membranes, and bleedings. Smoking during pregnancy also increases the risk of placenta previa and risk for premature dissolving of the placenta. Women who smoke can also give birth to babies that weigh less than babies of women who do not smoke (USDHHS, 2004).

The Welfare Committee points out that smoking during pregnancy may lead to reduced birth weight, so the child may be less robust. The interaction between genetic factors and smoking increases, for example, the risk of the child being born with cleft lip and palate (Institute of Public Health Report, 2006:3).

Prohibition of tobacco
The Welfare Committee points out that, today, it would be unthinkable to introduce a stimulant on the market that is not only addictive but also kills half of the long-term users, in the way that tobacco does. According to an article in the *Dagens medisin* journal by Karl Erik Lund from the Norwegian Institute for Alcohol and Drug Research, nearly 30% of the adult population in Norway would like to see a ban on the sale of cigarettes and smoke tobacco from 2020. He reports that more than 6 500 die from tobacco-related diseases every year. At current rates of starting and stopping smoking, it would probably take 30-40 years for the proportion of smokers to decrease to 10%. Although Norway has now introduced most of the recommended measures, nearly 1.3 million Norwegians continue to smoke, so a total ban may be the next step in the fight against tobacco. Intensification of the existing instruments would probably only have a moderate effect on today's smokers. Karl Erik Lund therefore raises the issue of whether a total ban on sales will be the next step in the fight against tobacco.

The Welfare Committee is aware that the Icelandic Parliament has debated a proposal from the chairman of the Welfare Committee, Siv Friðleifsdottir (F) Iceland, to prohibit the sale of cigarettes in grocery stores, petrol stations, convenience stores and in tax-free outlets. According to the proposal, only pharmacies would be able to sell cigarettes as a prescription drug. Another proposal is that doctors should encourage addicts to give up smoking, through special programmes for example.

The Welfare Committee observes that the proposal to sell cigarettes through pharmacies on prescription arouses reactions and stimulates debate. The Welfare Committee notes that reactions in the population and in related industries in Norway were also intense, when Norway became the first Nordic country to introduce a ban on smoking in public places. This first came into effect in 1988, but restaurants were exempted until 1993, and then a total ban was introduced in 2004. Now, however, an overwhelming majority support the smoking laws in Norway.

The Welfare Committee points out that the proposal for the Nordic countries, and the Faroe Islands, Greenland and Åland to work for a tobacco-free Nordic region by 2040 will show that the Nordic region does not regard tobacco as an ordinary commodity, but as a harmful product whose sale cannot be permitted here.

The Welfare Committee notes that Finland is working towards becoming a smoking-free country by 2040. The Welfare Committee sees that it is necessary to work not only towards a vision but also to have a concrete goal for when sales of tobacco will be prohibited in the Nordic region.

Consequently, the Welfare Committee proposes that

the Nordic Council recommends to the Nordic Council of Ministers

> *to* propose that the Nordic countries, the Faroe Islands, Greenland and Åland initiate work for a tobacco-free Nordic Region by 2040

The Welfare Committee is aware of the danger of stigmatising smokers, and adopting a moral and scapegoat mentality in relation to smokers. The Welfare Committee wishes to point out that it is society's task to enable measures that can help people stop smoking, and measures that prevent people starting.

Is the 'e-cigarette' part of the solution to the tobacco problem?
The Welfare Committee points out that the nicotine market has developed a type of cigarette that allegedly causes less harm, known as the electronic cigarette. The electronic cigarette contains no tobacco, and does not burn, but contains nicotine ampoules that are heated by energy from a battery. During inhalation, the battery activates a bulb that allows water vapour to be inhaled with nicotine, and a mist is exhaled. The ampoules are purchased separately as refills and are available with varying nicotine content and with different tastes.

Interest in e-cigarettes has grown strongly since the product was introduced on the European nicotine market in 2006 and on the American market in 2007. Marketing and sale of the product have mainly been via the Internet, but in USA and UK, e-cigarettes are also sold in convenience stores and petrol stations. Some producers have published websites on social media like Facebook, while others have placed clips on YouTube. The e-cigarette is also advertised on search engines like Google, Yahoo and MSN.

Use of e-cigarettes by celebrities in Hollywood has made the product attractive, also for non-smokers.

Due to the rapid growth in demand for e-cigarettes and lack of clarity around the regulations relating to the product, authorities in many countries are consulting the WHO for advice. The WHO issued a report in January 2010 which concluded that there is little research-based knowledge about e-cigarettes.

SIRUS has summarised the available research on the e-cigarette (2012).

Researchers from UCLA, Berkeley and Boston University School of Public Health have reviewed 16 studies that have characterised the chemical components in e-cigarettes, and concluded that the product appears to contain fewer and far less harmful substances than cigarettes.

The Welfare Committee points out that many people are concerned for the following reasons: certain flavourings may attract children and young people, and lead to a subsequent temptation to try conventional cigarettes; the e-cigarette undermines hard-won regulations about smoking bans; the availability of e-cigarettes may delay decisions to stop smoking and lead to use of both types; refill nicotine ampoules may present a danger to small children as they can be placed in the mouth and swallowed; and the e-cigarette may be used for consumption of other

drugs, as the refill holders can be filled with cannabis oil (Lund, 2012).

However, the research community broadly agrees that the e-cigarette represents a less harmful alternative to cigarettes, but that the precise consequences for health are difficult to estimate. Furthermore, it appears that the e-cigarette could be an appropriate method when giving up smoking, but this should be confirmed in experimental and observational studies before the product can be recommended as a general method.

4. Conclusion

Consequently, the Welfare Committee proposes that

the Nordic Council recommends to the Nordic Council of Ministers

1. *to* establish a new working group with representation from all the Nordic countries, the Faroe Islands, Greenland and Åland to prepare a basis document to MR-S with recommendations and initiatives for a new strategy for sustainable alcohol and tobacco policies in the Nordic Region 2014-2020. The working group will look at the relevance of the initiatives which researchers recommend are the most effective for reducing alcohol-related problems (page 8).

2. *to* strengthen evidence-based research in the Nordic Region in tobacco and alcohol use and chronic diseases, cancer and lifestyle diseases (page 17).

3. *to* strengthen evidence-based research in the Nordic Region on children and young people who grow up with one or more caregivers who suffer from serious alcohol abuse (page 19).

4. *to* strengthen evidence-based initiatives in the Nordic countries and the Faroe Islands, Greenland and Åland to reduce alcohol consumption and the harmful effects of alcohol (page 6).

5. *to* consider the introduction of a total ban on advertising and marketing of alcohol aimed at young people in the Nordic countries and the Faroe Islands, Greenland and Åland (page 14).

6. *to* introduce alcolocks for commercial drivers in the Nordic countries, the Faroe Islands, Greenland and Åland, and for people who have been convicted for drunk driving, and investigate the introduction of alcolocks in all types of vehicles as an alcohol policy measure (page 12).

7. *to* encourage an active dialogue with the largest Nordic companies on the information of the costs associated with alcohol and tobacco, and help to strengthen their support of the Nordic model for alcohol policy measures (page 18).

8. *to* investigate how to ensure public access to lobbying activities from the multinational companies in the Nordic countries (page 21)

9. *to* propose that the Nordic countries, the Faroe Islands, Greenland and Åland initiate work for a tobacco-free Nordic Region by 2040 (page 28)

10. *to* increase Nordic co-operation with the UN, WHO and EU on Nordic, European and global measures to strengthen public health through prevention of the harmful effects of alcohol and tobacco (page 4)

11. *to* prepare a plan for Nordic measures to contribute to a global alcohol reduction by 10 per cent by 2025, through relevant

international organisations, cf. the work of the UN, WHO and the EU (page 4)

12. *to* work for a blood alcohol content limit of 0.2 per mille for the operation of all motor vehicles in the Nordic countries, the Faroe Islands, Greenland and Åland (page 11)

Gøteborg, 26 September 2012

Anders Andersson (KD)
Anders Karlsson (S)
Anne Louhelainen (saf)
Christer Adelsbo (S)
Elisabeth Björnsdotter Rahm (M)
Finn Sørensen (EL)
Helgi Abrahamsen (sb)
Siv Friðleifsdóttir (F), Chairman
Sonja Irene Sjøli (H)
Sonja Mandt (A)
Vigdis Giltun (FrP)

All the Welfare Committee members in the Nordic Council agree on proposals 1 to 8. Reservations have been made concerning proposals 9, 11 and 12.

Reservation against proposals 9, 11 and 12:
The member from the Progress Party (FrP), Vigdis Giltun, Norway, wishes to put forward an alternative proposal for a vote on points 9, 11, and 12.

FrP says that it must be possible to have two ideas simultaneously. It should be perfectly possible to work for a major reduction in the harmful effects without getting involved in which stimulants people use. Society should only be interested in trying to reduce the harmful effects, but people should be able to decide for themselves if they want to use tobacco and/or alcohol. The state should have other things to do than get involved in people's own free choices, as long as the choices do not have consequences for public health.

Consequently, the Progress Party proposes amendments to the proposals as follows:

9. *to* propose that the Nordic countries and the Faroe Islands, Greenland and Åland initiate work, through information activities and positive campaigns about tobacco-related harm, for a Nordic region free from harmful effects by 2040.

11. *to* prepare a plan for Nordic measures to considerably reduce alcohol-related harm by 2025, through relevant international organisations such as the UN, WHO, and EU

12. *to* work for or a blood alcohol content limit of 0.2 per mille in the operation of all motor vehicles in the Nordic countries, and to increase research into the effects of lower alcohol limits for motor-driven vessels on water in the Nordic countries, the Faroe Islands, Greenland and Åland.

Göteborg, 27 September 2012

Vigdis Giltun (FrP)

Reservation against proposal 12:
The member from The Finns Party (saf), Anne Louhelainen, Finland, wishes to make a reservation against proposal 12:

to work for a blood alcohol content limit of 0.2 per mille when using all motor vehicles in the Nordic countries, the Faroe Islands, Greenland and Åland,

and proposes the following instead:

> *to* retain the existing blood alcohol content limits in the Nordic countries, the Faroe Islands, Greenland and Åland.

Helsinki, 31 October 2012

Anne Louhelainen (saf)

Reservation against proposal 9:
The member from the Red-Green Alliance (EL), Finn Sørensen, Denmark, wishes to make a reservation against proposal 9 and wishes to delete the point entirely from the Committee Proposal.

Finn Sørensen therefore proposes that the Nordic Council make no undertakings regarding proposal 9.

Göteborg, 27 September 2012

Finn Sørensen (EL)