Cour des comptes

ENTITIES AND PUBLIC POLICIES

# POLICIES TO TACKLE HARMFUL ALCOHOL USE

Thematic public report
Public policy evaluation

Summary

June 2016

## DISCLAIMER

**This summary is intended to facilitate the understanding and use of the report produced by the Cour des Comptes.**

**Solely the original report is legally binding on the Cour des comptes.**

**Responses from government agencies and stakeholders are provided at the end of the report.**

# Contents

# Introduction

Drinking is a sensitive issue in France, where alcohol is associated with celebrations, lifestyle and culture. This social and cultural heritage is further strengthened by alcohol's economic clout, and results in a general tolerance towards drinking. This largely explains the challenges in designing and implementing a long-term integrated public health and safety policy.

The French Monitoring Centre for Drugs and Drug Addiction (OFDT) estimates that of the country's 8.8 million regular drinkers, 3.4 million are at risk, only 10% of whom are in care. According to the only recent study available in France, which was published in 2013, approximately 49,000 deaths were attributable to alcohol in 2009, or 13% of deaths among men and 5% among women. A study released in 2015 noted that alcohol was the primary cause of hospitalisation (580,000 patients, estimated cost of €2.6 billion) and that excessive drinking was related to around 60 diseases.

Based on these findings, and pursuant to Article L. 111-3-1 of the Code of Financial Jurisdictions, the Cour des comptes decided to conduct an evaluation of public policies aimed at tackling harmful alcohol use. Conducted in conjunction with the main stakeholders through a support committee, this evaluation sought to assess the impact of these public policies on society, considering positive and negative factors with reference to appropriate foreign examples. Based on the evaluation recommendations have been drawn up to address areas where room for improvement has been identified.

The evaluation consisted in examining data availability, in analysing patterns of harmful alcohol use with regard to the most up-to-date clinical and epidemiological knowledge, in reviewing the main tools employed by relevant stakeholders in the areas of product distribution rules, price-setting, as well as public health and public safety, and in documenting the outcomes. Every effort has been made to ensure that all findings were traceable and verifiable.

# Introduction

**Categories of alcohol use**

The French Society for the Study of Alcohol identifies five categories of alcohol use in France:

- **non-consumption**, i.e. non-drinkers; according to the OFDT (2.3 million people aged between 11 and 75 had never drunk alcohol in 2014);

- **social or low-risk alcohol consumption**, which covers 8.8 million regular drinkers o/w 4.8 million daily drinkers; intake in this category is below 21 units a week or three units a day for men, 14 units a week or two a day for women, four units during one session, with pregnant women abstaining completely;

- **the misuse of alcohol**, which comprises three sub-groups of regular drinkers:

1) **at-risk use**, defined as drinking that exceeds the abovementioned levels, resulting in an increased risk of developing cancer, liver disease (cirrhosis), cardiovascular and digestive problems, and psychiatric problems such as depression or anxiety; people in this group are referred to as regular excessive drinkers of whom there were an estimated 3.4 million in 2014;

2) **use leading to somatic, psychological or social complications** linked to drinking without alcohol dependence;

3) **use with alcohol dependence**, characterised by loss of control of consumption and associated with a variety of complications.

Among the different types of at-risk use, heavy episodic drinking, commonly called binge drinking, is generally defined as the consumption of five or more units in one session for men and four or more units for women, i.e. 50g or 40g of pure alcohol consumed over a short period (two hours or more).

# 1 No consensus on alcohol policy

Because of the special place occupied by alcohol in France's history, culture, economy and social life, there is widespread tolerance when it comes to the consumption of alcoholic beverages, whose adverse effects are heavily underestimated.

## A long-standing tradition of production and consumption

The economic clout of the alcoholic beverages sector explains the high level of sensitivity of stakeholders towards any attempt to challenge the status of alcohol – especially wine – on public health grounds. Wine and alcohol in general form an integral part of the French life-style, which makes it difficult to enforce an effective alcohol control policy by drastically reducing the effectiveness of crackdown action and prevention measures.

## Consumption is on the decline but remains higher than in other countries

Average alcohol consumption in France has fallen steadily by 1.7% a year since 1960. In 2014, it stood at approximately 12 litres of pure alcohol per person per year, according to the latest data provided by the OFDT. Even so, this is considerably higher than the average of European member countries of the Organisation for Economic Cooperation and Development (OECD).

The decline is essentially attributable to a reduction in wine consumption. At the same time, however, binge drinking has risen, as have cases of repeated and regular drunkenness , particularly among women and young people.

Moreover, despite the overall decline in consumption, persistent risky behaviour on the part of pregnant women, young people and socially vulnerable people must not be overlooked; nor should the 8.8 million regular drinkers be underestimated .

## The consequences of harmful alcohol use have not been thoroughly assessed

The effects of harmful alcohol use have only been partially assessed due to the limited information available.

In the first place, alcohol consumption has short, medium and long-term health consequences.

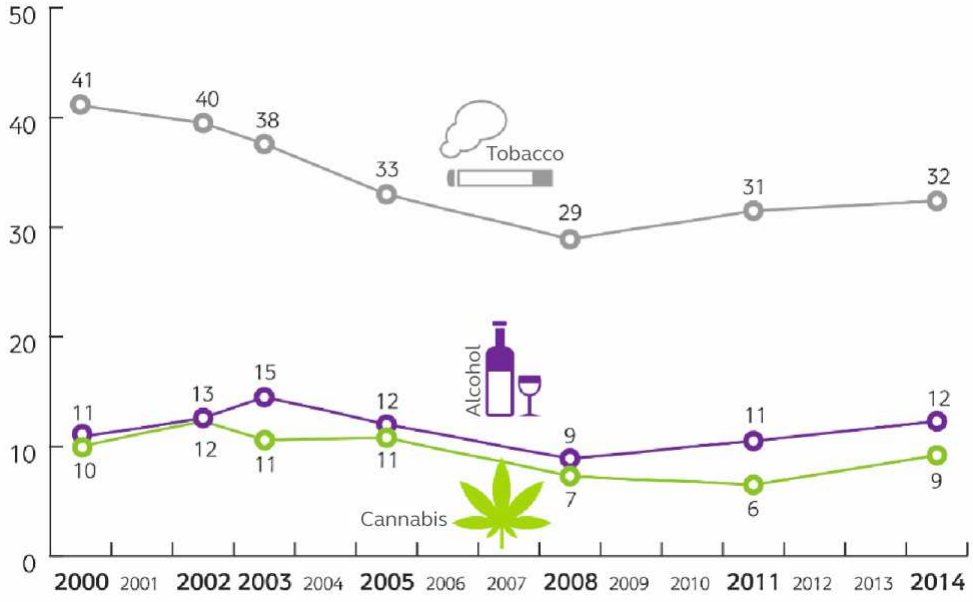
# No consensus on alcohol policy

Yet the data on alcohol-related deaths have only been the subject of two recent studies in France, making rigorous epidemiological monitoring impossible. When it comes to alcohol-related morbidity, it is only possible to identify the number of people benefiting from 100% coverage by the Social security system(which is the case in France for a range of severe diseases) for every alcohol-related disease, either partially or entirely. The data are therefore heavily underestimated.

In addition, the frontier between low-risk and dangerous drinking is hard to draw, and scientists increasingly question the notion that no-risk consumption does not exist. For this reason, the question of drinking guidelines is highly controversial but crucial when targeting prevention messages. For example, many countries revised their recommended limits following the discovery that cancer risks emerge at levels of consumption below the guidelines.

Alcohol abuse can also lead to violence, particularly among relatives, be the cause of anti-social behaviour, crimes and offences, and considerably lessen road safety. While the role of alcohol in road traffic accidents is well measured, its role in personal injury is less clearly identified, since very few studies are available.

**Change between 2000 and 2014 in levels of regular use of the main active ingredients, people aged 17, Metropolitan France (%)**




*Source: HBSC 2010, data employed by OFDT, ESPAD 2011 high school years, OFDT-INSERM-MEN*

# No consensus on alcohol policy

## The challenge of striking a balance between economic, public health and safety issues

There is no consensus in France about the need for a specific public policy about alcohol. Producers stress their economic and social role, while health authorities point to the risks associated with harmful use.

In this respect, public players are at a disadvantage compared with the alcoholic beverages sector, which has easy access to European and National Institutions.

The lack of a comprehensive plan to address harmful alcohol use in France has brought about this imbalance between business and public players and deprived health sector stakeholders of an integrated roadmap involving public authorities.

A number of issues relating to harmful alcohol use in France remain highly controversial. In particular:

- the overall economic appraisal of harmful alcohol use is not framed dispassionately;

- there is no consensus on what constitutes moderate drinking;

- there is a lack of consensus about fields of investigation, guidelines and results of clinical and epidemiological research, with each camp drawing differing conclusions.

The lack of consensus stands in the way of unified public action.

# 2 Public measures are struggling to change behaviour

The evaluation by the Cour des comptes reveals that by inadequately harnessing the available tools – from distribution rules and taxation to penalties for driving under the influence of alcohol (DUI), prevention and provision of health care – Central Government has failed to properly use tools aimed at changing risky behaviour.

## Distribution rules are out of step with changing consumption habits

### Rules fail to take account of market developments

Access to alcoholic beverages is made easier nowadays by the increased number of temporary licensed premises or locations offering takeaway sales, which the current rules do not capture.

The so-called "quota" rule of one licensed premises per 450 people does not apply to takeaway sales (by supermarkets and convenience stores) or to online sales. Furthermore, takeaway sales, particularly by late-night grocery stores, and sales to minors are not covered by checks.

### Successive challenges to the Évin Act

In 1991, France passed the Évin Act, which introduced rules governing the advertising of alcoholic beverages and a ban on the sale of alcoholic beverages to minors aged 16 or under. These arrangements have been held up as an example in Europe.

Successive amendments have diluted the law's effectiveness. The authorisation given to sporting groups to sell alcohol was lifted in 1999. Stricter conditions of sale introduced by the HPST Act of 21 July 2009 were accompanied by rules for online advertising. Article 13 of the Health System Modernisation Act of 26 January 2016 introduced measures to relax these requirements, in the name of supporting local produce and wine tourism. Despite the restrictive legislative framework, alcohol brands employ a wide range of channels, including social networks, to deliver their advertising, tailoring their messages to different target groups. An INPES study in 2015 found that French people feel that advertising is everywhere and represents a threat to young people.

### Lobby groups are lightly regulated

Alcohol lobbying is not sufficiently regulated in France. The current rules, which apply only to members of Parliament, need to be expanded and bolstered.

### Unclear taxation goals

Taxation of alcoholic beverages is closely regulated by European directives. Indirect taxes include VAT and excise duties. Social levies are also applied to some highly alcoholic beverages. Revenues from these taxes, which amount to around €6.6 billion including VAT, are partially earmarked for farmer welfare.

# Public measures are struggling to change behaviour

**Spirits are most heavily taxed**


*Source: Cour des comptes*

There is no link between consumption, revenues and the level of taxation per beverage category. Accordingly, wine accounts for 58% of consumption, 71% of non-export revenues but just 3.6% of excise duties.

Furthermore, excise duty rates are not strictly proportionate to alcohol content or to the specific harmful effects of different alcoholic beverages, except in the case of spirits and and premix drinks. Public health objectives therefore seem to have had little influence on the goals of the tax regime.

## Systems of checks and penalties do a poor job of containing risky behaviour

This is particularly true for drink driving and drunk and public drunkenness.

Testing for drink drivingI has been declining for a number of years because of policing issues and the cumbersome nature of the procedure. Meanwhile, penalties either do not offer a sufficient deterrent (fines) or are hard to implement (suspension of license).

Police action agains public drunkenness also runs into several difficulties: aside from the fact that law enforcement representatives are exposed to aggressive and violent behaviour, these activities are a heavy drain on human resources, and follow-up measures are not in place to assist people in finding primary care assistance once they sober up.

## Insufficient evaluation of health and road safety education initiatives

Health and road safety education initiatives play an important role, but not enough is known about their outcomes.

# Public measures are struggling to change behaviour

### Insufficient assessment of health education initiatives

While INPES is responsible for most preventive activities, other entities are also involved, especially those working in specific environments, such as school and workplace health. Non-profit associations also have a role to play.

INPES, the main public organisation operating in the field of prevention, has sought to adapt, despite declining financial resources.

There is no overarching vision of the different initiatives in place for schools, synergies between health and education personnel are struggling to emerge, and interventions by law enforcement representatives are not evaluated.

In post-secondary education, there is a shortage of resources for preventive medicine and health promotion services. In the workplace, the dearth of data on harmful alcohol use, workplace practices and alcohol-related accidents makes it impossible to design an appropriate strategy.

### Insufficient evaluation of road safety education

Preventive road safety measures are now chiefly divided between national communication campaigns conducted by the central government road safety and traffic control Delegation (DSCR) and measures undertaken as part of département-level road safety action plans (PDASRs). However the effectiveness of these measures is not evaluated sufficiently.

Moreover, self-test solutions, such as mandatory alcohol sensors and alcolocks, though useful, are not widely used.

### Primary care physicians do not play enough of a role

Patients who drink to excess or suffer from alcohol-related diseases may be cared for at several different levels, without necessarily having a formal treatment pathway. This situation suffers from a lack of involvement by primary care physicians, particularly general practitioners, but also from the fragmented approach to specialised treatments and the lack of interaction in many cases among medical and socio-medical services.

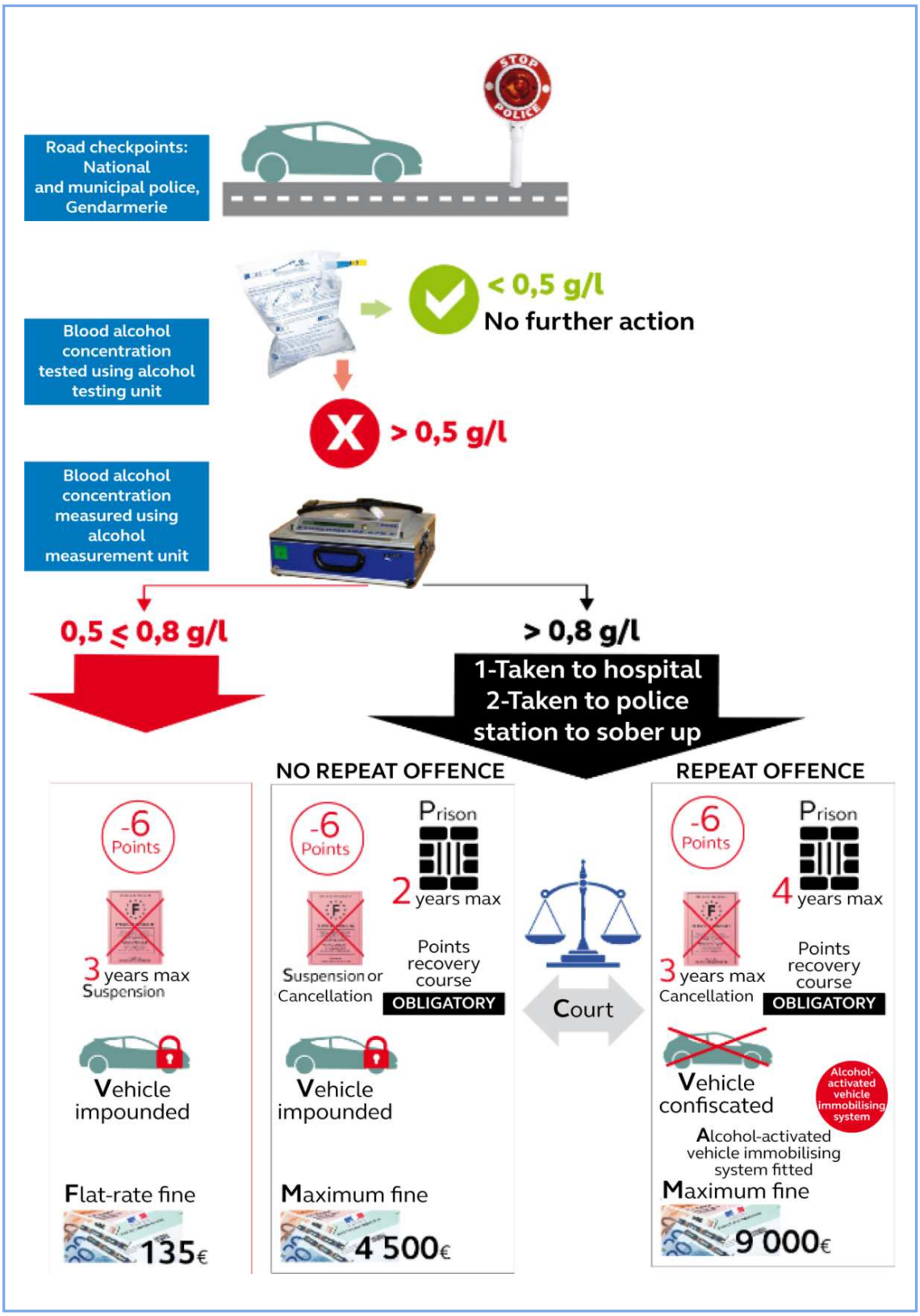
For example, a survey by IFOP commissioned by the Cour des comptes found that two-thirds of general practitioners surveyed were unfamiliar with the alcohol screening and. brief intervention mechanism, and that just 2% of them used it in a formal manner.

### Efforts made to structure hospital-based care, care overly fragmented in the socio-medical and non-profit sector

While hospital-based care is now fairly well organised, other types of care are overly fragmented. Care is shared between the medical and hospital sector, the specialised socio-medical sector, which includes addiction treatment, support and prevention centres (CSAPAs) and drug user risk reduction drop-in and support centres (CAARUDs), and the non-profit sector.

# Public measures are struggling to change behaviour

**Testing and penalties for DUI**



# 3 Insufficiently coordinated and evidence-based policies

Not enough is known about the health, economic and social costs arising from harmful alcohol use. In France, there is no comprehensive policy but merely a series of measures placed side by side with a view to preventing harmful alcohol use. Without the necessary coordination to address conflicts between measures, outcomes are broadly disappointing and inadequately evaluated.

## Costs have still to be measured

Unlike some countries, France does not adequately measure alcohol's health and social costs.

Health costs are broadly underestimated, given that estimates by the national health insurance fund for salaried workers (CNAMTS) include just three sets of diseases that are entirely attributable to alcohol (alcoholic cirrhosis, aerodigestive tract cancers and alcohol-related mental illnesses).

Prevention costs, meanwhile, are hard to isolate, since they are spread across a wide array of participants, including interministerial structures, central government directorates, health agencies, social security, devolved and decentralised departments, and subsidised non-profit associations.

Finally, the economic and social costs of harmful alcohol use are not measured by the public authorities but by researchers, such as Professor Pierre Kopp, an economist, who estimated in 2015 that the social costs of alcohol abuse in 2010 amounted to €120 billion.

The Cour des comptes notes that other countries, such as Sweden, Norway, the UK and Italy, have equipped themselves better, setting up tools that monitor data on harmful alcohol use more effectively, more routinely and on a more centralised basis than the solutions employed in France.

## A lack of investment in training and research

In France, instruction and research in the field of alcohol have not been given priority in recent years.

Instruction on alcohol addiction in medical and paramedical training courses varies from region to region but is broadly inadequate.

Compared with what is going on abroad, research is unambitious, whether in the medical field or in public health.

# Insufficiently coordinated and evidence-based policies

## Incomplete coordination of participants

### Interministerial steering arrangements remain unclear

In France, an interministerial unit, the MILDECA, was given responsibility for designing and implementing the 2013-2017 drug and addiction prevention plan, which covers all addictions, although alcohol, unlike tobacco, does not have its own specific programme. However, the Health Directorate (DGS) is responsible for alcohol-related public health policy and plans.

There is no national strategy for drink-related delinquency and violence, but rather public action plans containing varying measures to prevent harmful alcohol use.

### Local steering arrangements are shared between prefects and regional health agencies (ARS)

Ever since HPST law was passed in 2009, the ARS have been responsible for designing and implementing their own strategic health priorities in their region based on the national framework. The prefects of the *département*, meanwhile, are responsible for applying other national policies, particularly in terms of road safety, by coordinating the various territorial bodies tasked with putting these policies into practice. This dual governance arrangement, combined with the non-alignment of decision-making levels, has many disadvantages, especially since other local participants, including municipal authorities and *département* and regional councils, also act within the scope of their own responsibilities. This situation undermines the clarity of local policies aimed at addressing harmful alcohol use.

Compounding this complexity, funding for local initiatives is heavily restricted and insufficiently targeted.

# 4 Make preventing harmful alcohol use a public policy priority

The evaluation by the Cour des comptes makes it clear that harmful alcohol use has highly detrimental effects on public health and public safety and that the health and social costs far exceed alcohol-related tax revenues. Similarly, the fragmented nature of previous policies and the lack of targeted objectives and instruments to measure the effectiveness of initiatives on the ground mean that France falls short of the best practices recommended by the World Health Organisation (WHO) and the OECD.

A unified policy to address harmful alcohol use would help to raise awareness among consumers about the damaging effects of alcohol on health and social life, and make people more personally accountable in terms of their relationship to alcohol. This kind of awareness is a pre-requisite for effective public policy.

Given the existing fragmented governance arrangements, steps should be taken to implement a consistent long-term plan at the highest level of government.

## Draw up a programme to reduce harmful alcohol use

To address the urgent need for public action, an interministerial action programme needs to be drawn up and led at the very highest level, i.e. by the Prime Minister, as is the case, for example, in the UK. This programme should be backed by the necessary resources and regularly evaluated.

### A comprehensive and regularly evaluated programme

The strategy to prevent harmful alcohol use prepared as part of this nationwide programme should be based on objectives derived from epidemiological and socio-economic data and identify the most appropriate tools for each action area.

Action taken under the programme should be followed up using pre-determined indicators, rounded out by specific monitoring for certain measures. An assessment every three or four years would be used to measure progress, taking account of the latest scientific advances, and make any necessary adjustments. An undeniable identification of the health and socio-economic costs due to harmful alcohol use would support this assessment.

# Make preventing harmful alcohol use a public policy priority

### A programme based on scientific evidence

To be effective over the long run, a health policy for alcohol will require efforts to continue to advancing knowldege through an evidence-based medicine approach. This will entail examining the scientific literature with a view to identifying the most appropriate level of intervention for each patient.

### Ensure that the programme is steered effectively

Programme implementation will require clear governance. The programme will be steered at the national level. Interministerial coordination will be vital, with the Health Minister occupying a key role, supported by the Interior Minister on questions of public safety. Local implementation of the programme should be entrusted to regional and *département* prefects, with ARS handling the health component, supported by the MILDECA project leader. Regional and *département* councils and the most involved municipal authorities would also be invited to participate.

### Earmark the necessary resources

Implementing a programme to reduce harmful alcohol use will require human and financial resources to provide for prevention, other priority areas, research and training.

## Use every tool available

Every available tool must be used, including information, prevention and support. Action should also be taken on pricing, which would entail raising taxes. Introduction of a minimum price – a good solution because of its comparative effectiveness – would have to include steps ensure compliance with the Treaty on the Functioning of the European Union.

Meanwhile, the use of alcohol is subject to a wide array of rules, chiefly concerning advertising, product information, lobbying, product availability and DUI. These rules need to be strengthened and improved to combat harmful use, which remains too widely tolerated in France.

### Come up with more effective information and preventive measures

An effective strategy needs to be based both on measures that address the general population and measures aimed at clearly identified target groups. If regular excessive drinkers are targeted too closely, there is a danger of overlooking other at-risk regular drinkers.

It is equally vital to conduct specific measures particularly for young people, pregnant women and people in specific or vulnerable situations.

The preventive message for pregnant women should be to recommend complete abstinence, given that it is not possible to set a level of use that would be acceptable for the foetus.

In addition to schools, three other parts of the population deserve special attention: post-secondary institutions, the workplace and offenders.

# Make preventing harmful alcohol use a public policy priority

For the workplace, the Labour Code should be amended to place a total ban on bringing alcohol to work, as is the case in Italy. A limited number of temporary exemptions could be authorised over the course of the year. Two action areas could be usefully expanded: first, implementation of the alcohol screening and brief intervention process by medical staff at the workplace; second, measures to provide guidance to people with drinking problems.

### Step up training and involvement of health professionals to more effectively identify risky behaviour

First, a target needs to be set for alcohol-related training in medical and paramedical courses of study, followed up by mandatory knowledge testing.

Also, health professionals, whether they work in oncology, emergency units, surgery or maternity wards, need better training in precisely identifying alcohol use. Increased training hours in study courses and the opening of addiction specialist positions in universities and hospitals would be a good step forward.

General practitioners and workplace physicians could play a much bigger role in both detection and primary care.

Various avenues could be used to encourage general practitioners to step up their use of alcohol screening and brief intervention. This procedure needs to be part of a global approach to addictions, such as inclusion in public health objectives-based remuneration (ROSP), the addition of extended consultations for addiction detection and care to the list of procedures, and development of shared case management by physicians and clinical nurses.

Hospitals, notably emergency units, also need to be part of efforts to step up primary care involvement. It is important to encourage emergency units to do more to spot patients with alcohol problems and guide them towards primary care through channels that are coordinated with addiction services. These arrangements need to be adjusted on a case by case basis to reflect the intervention capabilities of addiction liaison and treatment teams (ELSAs) and the scope for cooperation among interested services.

### Raise prices to reduce harmful use

Pricing and tax-based measures are mentioned in all recent papers (including the OECD's most recent study in 2015) as among the most effective ways to promote public health and lower the social costs of alcohol.

Minimum pricing essentially targets the consumption of low-cost alcoholic beverages by regular excessive drinkers, who often come from disadvantaged backgrounds. Following a reference for a preliminary ruling brought by the Scottish Court of Session, the Court of Justice of the European Union (CJEU) ruled that the introduction of a minimum price had to be conditional on the establishment of precise public health goals and that the inadequate effectiveness of national taxation would have to be demonstrated.

# Make preventing harmful alcohol use a public policy priority

### More effective rules governing advertising, product information and lobbying

Restrictions on advertising are viewed as an appropriate and effective way to limit consumption, particularly among young people, who are a priority group in France. Restrictions on advertising need to cover all dissemination channels, including digital ones.

Lessons also need to be drawn from the way in which lobbying by producers has seen public health come off second-best in decisions on most measures involving the sale of alcoholic beverages. There are procedures to make lobbying as transparent as possible, along the lines of long-standing arrangements within European institutions or, more recently, for tobacco lobbyists.

### Overhaul the laws on licensed premises and set aside resources to enforce compliance

The rules governing licensed premises are outdated and not subject to adequate checks. They need to be overhauled and enforced, since some offences, such as the sale of alcohol to minors, are not subject to adequate checks.

### Improve the effectiveness of DUI measures

Future measures should be guided by the need to punish those who drive under the influence of alcohol more effectively and decisively and to get public opinion behind the idea that drinking and driving do not go together.

Communication campaigns need to be more effectively directed through better assessment, while the preventive aspect of insurance could be more effectively directed through progressive penalties for offenders. At the same time, steps should be taken to build up a prevention system, primarily by developing self-test procedures.

Without ruling out the notion of lowering the blood alcohol concentration limit for all drivers to 0.2 g/l, the first priority should be to simplify testing procedures, which are currently random, time-consuming and complicated, to increase the likelihood that individual drivers may be checked, emulating the effectiveness of automatic speed cameras.

To make testing more efficient, standard fines for offences involving excessive blood alcohol concentrations need to be revised, and the maximum level should be raised from 0.8 g/l to 1.2 g/l. This would lead to more effective punishment of the most common cases of excessive blood alcohol concentration.

Moreover, it would be more efficient to use a single type of device to measure blood alcohol concentration and establish the burden of proof. This new device would combine the features of the existing testing and measurement units and could thus identify blood alcohol concentration if the authorised threshold has been breached.

The requirement to install alcolocks, which have shown their effectiveness on repeat offenders, could be extended by strengthening the network of garages authorised to install such devices.

# Conclusion and recommendations

In concluding this evaluation, the Cour des comptes offers six main findings and proposes three guidelines to achieve more effective prevention of harmful alcohol use.

The six findings are as follows:

- first, there is no consensus in France on such basic points as the overall economic impact of harmful alcohol use or the relationship between consumption and risk for individuals;

- second, notwithstanding the overall decline in consumption, risky behaviour is on the rise, particularly among young people, women and vulnerable groups, and it is now established that regular, non-excessive drinking may also carry risk;

- third, insufficient research is being done to robustly document the damaging effects of different forms of alcohol use so as to more effectively design appropriate health strategies;

- fourth, public action is struggling to change behaviour because of insufficiently effective use of tools that have proven their usefulness in other countries;

- fifth, health responses to harmful alcohol use come too late and are inadequately coordinated;

- the sixth and final finding relates to policy design and implementation: not only is there not a clear roadmap for participants in the shape of a specific national programme focused on preventing harmful alcohol use, but also no authority has the necessary clout to advocate for public health in the face of business interests and ensure the necessary interministerial coordination of measures. These governance problems are found at the local level as well.

Therefore the Cour des comptes proposes the following broad guidelines:

- as part of the national addiction plan, draw up a programme to prevent harmful alcohol use, which should be based on scientific evidence and led at the very top level of government. This programme should come with indicators so that measures can be carefully tracked over time, enabling the programme to be regularly evaluated and adjusted based on actual outcomes;

- raise awareness and prevent the risks of harmful alcohol use through appropriate information campaigns and prevention initiatives that are informed by the latest scientific progress;

- strengthen the impact of existing tools, which are not efficient enough in many cases. While some tools deserve special attention because they are currently underused (such as screening and brief intervention or price and taxation measures), others could be more simply overhauled and adjusted to meet public policy needs (such as the rules on distribution, lobbying, advertising, and DUI checks and penalties).

**To the Prime Minister:**

**1.** design a national programme to reduce harmful alcohol use; the programme should come with adequate indicators and establish procedures to ensure that it is effectively steered both at national and local levels. Regularly evaluate the programme using an internationally recognised method and make its result public;

**To the Minister for Higher Education and Research:**

**2.** set up a multi-year policy for alcohol research (fundamental, translational, clinical, public health, social sciences) with a focus on interdisciplinary work and international collaboration;

**To the Health Minister, the Interior Minister, the MILDECA and the National Public Health Agency:**

**3.** tailor messages targeting consumers with a risky behaviour based on the findings of work on drinking guidelines and current research on morbidity and mortality rates attributable to alcohol;

**To the Health Minister, the MILDECA and the National Public Health Agency:**

**4.** develop prevention and communication measures targeting the most vulnerable groups (young people, pregnant women with a view to preventing foetal alcohol syndrome, people in difficulty); pay special attention to preventing violence against women;

**To the Labour Minister and the Health Minister:**

**5.** legislate to eliminate the authorisation to bring and consume wine, beer, cider and perry in the workplace, as currently provided for by the Labour Code, and refer to company bylaws as regards implementation requirements and applicable exemptions;

**To the Health Minister and the Minister for Higher Education and Research:**

**6.** expand detection and follow-up for at-risk drinkers based on the codified procedure for alcohol screening and brief intervention within the framework of the medical

approach. To this end, step up initial and ongoing addiction training, involve nursing staff more closely in implementing alcohol screening and brief intervention and systematically check for the presence of alcohol when admitting people to emergency units or healthcare establishments;

**To the Minister for the Economy and Finance and the Health Minister:**

**7.** increase the excise duties on all alcoholic beverages to reduce at-risk drinking;

**To the Minister for the Economy and Finance and the Health Minister:**

**8.** prepare to introduce a minimum price per unit of pure alcohol contained in each beverage, consistent with European law, to reduce consumption by alcohol-dependent people;

**To the Minister for the Economy and Finance and the Health Minister:**

**9.** apply restrictions on advertising alcoholic beverages to all digital media (internet and social media), consistent with the judgment by Cour de cassation, France's supreme court on 3 July 2013;

**To the Minister for Economy and Finance, the Interior Minister and the Health Minister:**

**10.** extend the training rules applicable to on-premises sales establishments to all other forms of sale of alcoholic beverages and set up a national digital repository of permanent and temporary license applications, which may be consulted by law enforcement agencies; ;

**To the Interior Minister, the Justice Minister, the Minister for the Economy and Finance, and insurance companies:**

**11.** increase the likelihood of being checked and receiving on-the-spot penalties: by using a single approved portable device for measuring blood alcohol concentration levels that breach the thresholds for standard and more serious offences; by increasing flat-rate fines for DUI up to class 5; by applying the regime of on-the-spot penalties for offences to blood alcohol concentration levels of up to 1.2 g per litre of blood.