The Role of Social insurance institutions in the prevention of alcohol-related harm in Europe.

Survey of the

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Introduction

“Alcohol is one of the world’s top three priority areas in public health [and] in Europe, alcohol is also the third leading risk factor for disease and mortality after tobacco and high blood pressure” according to the World Health Organisation[1]. Indeed, Europe continues to be the continent where alcohol consumption is the highest in the world downing “the equivalent of 12.5 litres (2012) of pure alcohol a year” or almost three glasses of wine a day. As alcohol is an important social and health determinant, actions to fight against the harm it may cause are critical in order to improve public health.

Already in 2006, the European Commission published a Communication entitled “An EU [European Union] strategy to support Member States in reducing alcohol-related harm”. The French National Statutory Health Insurance Fund (*Caisse Nationale d’Assurance Maladie des Travailleurs Salariés* – CNAMTS) participated in the discussion with the publication of its contribution in May 2007. In 2008, the CNAMTS established a “European map” of Statutory Health Insurance Funds and Occupational Accident Insurance institutions on behalf of the ESIP (*European Social Insurance Platform*) within the Alcohol and Health Forum. This “European map” was elaborated on the basis of a questionnaire sent to 12 members of these networks, which are involved in the area of health promotion and alcohol-related harm prevention. The objective of this work was to leverage the cooperation of social security institutions at European level in the fight against alcohol-related harm. The final document gave an overview of the actions on alcohol-related harm prevention carried out by the different statutory health and occupational accident insurance funds in the respective countries and was shared with the members of the European Alcohol and Health Forum.

On behalf of ESIP, the CNAMTS has now updated this “European map” on social insurance institutions and alcohol-related harm prevention in Europe. The goal of this revision is to obtain a clear and up-to-date view about the actions of European statutory health insurance funds and occupational accident insurance in the field of health promotion and alcohol-related harm prevention, and to promote the role of social insurers in this field among the EU institutions and the relevant stakeholders.

This update is based on a survey on 8 institutions from 5 different countries (Austria, Estonia, Finland, Germany and France).

[1] Peter Anderson, Lars Møller, Gauden Galea, Alcohol in the European Union, - Consumption, Harm and Policy Approach, World Health Organisation, 2012, 149 p.

1 Health promotion and prevention’s main objectives

In general and according to the answers, it is possible to identify three goals in the field of prevention: improving health, reducing health inequalities and economic efficiency.

1.1 The objective of improving health

As a rule, prevention and health promotion objectives are to improve health or at least to avoid damage by managing potential risks. Indeed, according to the German reply, the health insurance has to maintain, restore or improve the health of people and the compulsory health insurance funds have, since 2000, a new expanded processing framework for primary prevention and occupational health promotion. In Finland, the objective is to ensure a minimum security for everyone, by protecting individuals from the risks of life. For all the institutions, the main objective is the improvement of health.

1.2 The objective of reducing health inequalities

A goal is also often to reduce health inequalities. Prevention can be targeted to the most disadvantaged people, whose access to health is limited because of their low income. This is the case for instance in Germany, where health Insurance funds have the obligation to provide for primary prevention services and where specific access mechanisms for disadvantaged people are implemented to reduce health inequalities. Reducing health inequalities is also part of French health insurance goals, according to the national prevention policy: the health check-up centres shall provide care and prevention for people in a precarious situation.
Likewise, the Finnish system entitles people to a minimum income and security. Indeed, the objective of this system is to fight against inequalities, on an integrated basis.
Social security institutions are solidarity-based and promote universality of access to their services and benefits. Therefore equality of access to healthcare and prevention are an important objective of their health policies.

1.3 The objective of economic efficiency

Health prevention and promotion also pursue economic objectives, in particular decreasing health insurance expenditure. Indeed, it became obvious that treating a disease costs more than ensuring that it would not begin or develop. Therefore, health insurance institutions should better act early and effectively against potential health problems than resort to expensive care that could result in long term care.

2 Prevention organisation and the role of health insurance institutions

In all the surveyed countries, public health policy depends on the ministry of health. It sets general guidelines which can be implemented by different stakeholders and levels of competence. Health and occupational accidents and diseases insurance funds are among the main stakeholders. They develop prevention and health promotion policies and programmes and provide preventive services at national and local level.

2.1 Austria

Health care in Austria is characterised by the cooperation of a large number of actors. Competencies in the health care sector are generally regulated by law. The main actors with regard to health at federal level are the Austrian Parliament (National Council and Federal Council), the Federal Ministry of Health (BMG), the Federal Ministry of Labour, Social Affairs and Consumer Protection (BMASK), the social security institutions and advocacy groups (social partners: representatives of employers and employees as well as professional associations).

Health promotion in Austria has strongly been influenced by activities of the World Health Organisation, WHO (Ottawa Charter for Health Promotion 1986). The Health Promotion Act of 1998 strengthened the role of the Fund for a Healthy Austria (FGÖ) and was an important step to boost health promotion in Austria. The focus is placed on the following settings: workplaces, cities/communities, hospitals and schools. Moreover, initiatives which target specific population groups (the elderly, women, children and young people, people employed in small- and medium-sized enterprises and immigrants) as well activities which are orientated towards specific topics (diet, exercise, cardiovascular health and mental health) have been launched.

The Austrian population is offered a variety of preventive services. One of them is the "mother-child-pass examination programme", which women living in Austria may join free of charge. This programme was created in 1974 and assists mothers and their children during pregnancy and up to the 62nd month of the child's life.
In addition parents receive a vaccination certificate for their children. Since 1998 expenditure for specific vaccinations has been covered by the federal government, the provinces and social insurance, based on the Austrian child vaccination programme.

Since 1974 social health insurance funds have offered annual preventive health check-ups to the Austrian adult population (18 years and older), which focus on a detailed case history, early detection of illness as well as promoting a healthy lifestyle and providing individual counselling. Further preventive measures include annual health examinations of students at schools, health examinations for army recruits as well as caries prophylaxis and initiatives aimed at improving care for people with chronic diseases.

The Main Association of Austrian Social Security Organisations (**HVSVT**) undertakes a number of important coordination functions for the social security institutions. The 22 organisations in charge of statutory insurance in Austria are responsible for health, pension and accident insurance.

2.2 Estonia

Under the Ministry of Social Affair's supervision, the State Agency of Medicine (SAM: protection and promotion of public and animal health, through the supervision of medicines for human and veterinary use), the Health Board, (HB: health care; communicable diseases and control; environmental health; chemical safety; medical devices) and the National Institute for Health Development (NIHD: research, development, implementation of public health activities) are some of the main public health players. The role of the NIHD is to implement national media campaigns to prevent alcohol abuse, but also to help to implement national actions to promote health (setting national goals and recommendations, advertising alcohol use, regulating availability etc.).

The **EHIF** (Estonian National Health Insurance Fund), founded in 2001, is the only organisation in charge of compulsory health insurance. It manages the finance of health insurance, the database needed for its activities, controls quality and the needs of services

covered by health insurance, manages the implementation of international agreements concerning health insurance, participates in the planning of care, gives opinions on draft laws and international agreements and advises about issues related to health insurance.

The latter has a prevention role: the health insurance fund finances national disease prevention activities/projects and supports health promotion. Preventive services are implemented at local level by health care providers (primary care, school health care etc.). The **EHIF** is in charge of the information of the public regarding health (media campaign, brochures) according to risk factors (including alcohol consumption) and health care systems. **EHIF** contributes to the setting of local clinical guidelines following patient guidelines in cooperation with the University of Tartu and the NIHD.

Regional county governments are responsible for the assessment of health needs and problems, the development and the implementation of local strategies and national programmes of public health action plans. Municipalities implement legislation on health protection and organise activities to promote health. The actions of prevention of alcohol abuse are carried out at local level and are integrated in some extent to the actions of prevention of injuries funded by **EHIF**.

Moreover, in the field of occupational health and safety, companies shall implement prevention and health promotion services, for example with the collaboration of the labour inspectorate.

2.3 Finland

Finnish public authorities guarantee health promotion as well as social and medical services for everyone. The Ministry of social affairs and health is in charge of designing the health policy. It holds three great public health research and development institutions working in the field of health promotion and prevention. The ministry currently carries out a special action programme on alcohol and manages a special fund for action and research on health promotion regarding alcohol consumption, smoking and narcotic drugs consumption. The Finnish presidency of the EU in 2006 focused on alcohol issues and the importance of global approach of health promotion. The Finnish Centre for Health Prevention (FCHP), the National Institute for Public Health of Finland and the Research and Development National Centre for Welfare and Health (STAKES) are important players in the field of prevention and health promotion. Besides, municipalities are responsible for the implementation of prevention measures.

Health insurance bodies in Finland also have a prevention role, developed and implemented at local level.

KELA is the Finnish Social Insurance Institution and works under the supervision of the Parliament. Its provides pension insurance benefits, National Health Insurance, unemployment benefits, family benefits, rehabilitation and disease prevention, disability benefits, subsidies for students and school transport and a national service’s allowance.

2.4 France

For several years, France has been expanding its prevention policy to improve health, to reduce premature deaths (before 65 years old) and to tackle health inequalities. Since an important act on public health was adopted in 2004, the State has reorganised its health policy, through strategic multi-year health plans.

The National Institute for Prevention and Health Education (INPES) is responsible for the implementation of prevention measures and Health education policies in accordance with public health policy's guidelines.

The **CNAMTS** is another key actor in the area of prevention (through its network of local organisations), and in particular of medical prevention through its particular relationship with the gatekeeper physicians (General practitioners (GP) or specialist doctors)[2]. Furthermore, the **CNAMTS** contributes significantly to the financing of INPES actions. As the largest statutory French health insurer, the **CNAMTS** covers about 91% of the population. It enables all salaried workers and their families to access high quality health care. It provides coverage for sickness, maternity, paternity, disability and death, either through benefits in kind (daily allowance) or in nature (reimbursements linked to healthcare) and carries out illness prevention activities including health follow-up programmes for insured people (with particular attention to health determinants), medical and social action. The **CNAMTS** is the head of a network of decentralised health insurance organisations (regional primary funds, health check-up centres, etc.). The **CNAMTS** also works in partnership with other bodies: on the one hand the State and devolved bodies, and on the other hand private healthcare professionals, public and private hospitals as well as companies.

Strategic multi-annual health plans are defined every 5 years by law, based on the most important health problems identified by the High Council of Public Health. The five strategic priorities are: cancer, health and environment, rare diseases (including Alzheimer), violence, risky and addictive behaviour, and chronic diseases. The national public health goals adopted by the Parliament are assessed at the end of the 5 year period.

Some strategic plans are connected with other additional national and regional programmes such as the Mental Health Plan, the Addiction programme or the Nutrition and Health Programme. A National Health Strategy is under elaboration which includes a new health act to be adopted in 2015.

The public health policy is implemented at regional level by the Regional Health Agencies and the Regional and local Health insurance funds.

2.5 Germany

In Germany, prevention and health promotion are competences of social insurance organisations and public institutions at different levels (federal, Länder and local level). The ministry of health takes a central role in the field of prevention and health promotion. It "relies on specialized institutes such as the Robert Koch Institute and BZGA (Federal centre for health education)"[3].

As biggest promoter of prevention and health promotion, the compulsory health insurance ("Gesetzliche Krankenversicherung") offers a variety of preventive and health promoting benefits. Several institutions are responsible for health insurance and accident insurance in Germany and deal with prevention and health promotion.

The **GKV-Spitzenverband** (National Association of Statutory Health Insurance Funds) has taken on a central role in the German healthcare system from 1 July 2008, being by law the central association of the statutory health insurance funds at federal level. It shapes the outline conditions for healthcare in Germany. It is one of the largest health insurance

[2] General practitioner or specialist doctor with whom the patient is registered in the framework of the coordinated healthcare pathway.
[3] INPES, External Relations Department, *Aperçu de la promotion de la santé en Europe*.

organisations in Germany (70 million of insured people). The Association of social health insurance (SHI) Funds defines the fields of action and qualitative criteria for prevention and health promotion within the SHI Guide on Prevention (Leitfaden Prävention), in cooperation with the SHI associations at federal level. These criteria are binding for the provision of the on-site services provided by the SHI Funds.

The **AOK** (National Federation of Local Health Insurance Funds) is also one of the largest health insurance organisations in Germany (24 million of insured people) and deals inter alia with disease prevention, disability and disease management and rehabilitation. The **BKK** (National Federation of Enterprise Health Insurance Funds, 10 million of insured people) gathers together health insurance companies. It has a coordinating function, represents their interests, supports the legislating bodies and the authorities, creates regulation and agreement structures with service providers, and advises the regional associations and companies' insurance funds. It includes a department for "health, rehabilitation and nursing care".

DAK-Gesundheit (6.4 million of insured people) is a nationwide German health insurer with headquarters in Hamburg.

The **DGUV** (German Social Accident Insurance) is the umbrella organisation gathering the institution responsible for statutory accident insurance and prevention for trade and industry and the public sector accident insurers. The **DGUV** main legal responsibilities are: the prevention of occupational accidents, accidents at school and kindergartens, commuting accidents, occupational diseases and work-related health hazards as well as accident insurance. It is involved in the following fields of activities: occupational safety, occupational medicine and first aid, medical and professional rehabilitation, coordination and information in the areas of compensation and recourse, research and testing in occupational health and safety, basic and advanced training for the employees of statutory accident insurance institutions, expert advice on safety, organisational, commercial and administrative matters and liaison office. The **DGUV** also provides insured people with various services and offers cash benefits. It advises the institutions for statutory accident insurance and prevention on all aspects of occupational health and safety and develops evidence-based occupational health and safety guidelines. For this purpose it designs integrated methods and models, provides for economic incentive systems and develops prevention campaigns.
The **DGUV** coordinates several prevention committees which prepare drafts for occupational health and safety rules and regulations, test technical tools and equipment, advice manufacturers and institutions responsible for statutory accident insurance and prevention on health and safety issues and they represent the institutions.

There are also other stakeholders in the field of prevention and health promotion, such as the "German Network for Workplace Health Promotion" (DNBGF) or the "Health and Work Initiative" (Initiative Gesundheit und Arbeit [IGA]). Furthermore, the law requires that private companies implement prevention and health promotion services as well.

However, since 2000, health insurance and insured people share the responsibility of maintaining a high level of health through a healthy lifestyle and an early participation in prevention and care measures; self-help promotion has become a compulsory mission. The role (as defined by the Law) of Health Insurance is to assist insured people in educating and advising. Regarding the occupational Health and safety sector, statutory health insurance organisations and occupational accidents and diseases health insurance organisations have to collaborate for primary prevention and health promotion at the workplace.

3 The actions of the health insurance institutions in the area of prevention and health promotion

3.1 Primary prevention

Actions in **primary prevention** take place upstream, before the appearance of disease symptoms. The aim of primary prevention is to avoid the problem to arise, tackling it at its source. Therefore, the focus must be on factors that may influence the potential arising of a disease or health problem. Health determinants, for example hygiene, lifestyle, nutrition and so on are some examples of these factors. In general, primary prevention plays a crucial role in reducing diseases and health disorders. It is also considered as a key component of a strategy of sustainability of the healthcare system.

First of all, the missions of the social insurance institutions regarding primary prevention organisation vary depending on the country. The actions carried out can be divided in four categories of activities. The first area is awareness raising, health literacy and the provision of information, through different channels: communication campaigns (TV, Internet, printed Medias or social networks), personalised counselling, accompaniment, the organisation of events, training, etc. Social insurers also reimburse preventive healthcare (for instance free check-ups) to their insured people. In addition, they often participate to the funding of programmes or other organisations in charge of the development of health promotion and prevention measures. Finally, many institutions carry out controls and monitoring in companies in the field of occupational health and safety.

In Germany, the health insurance funds finance prevention programmes and work with the statutory accident insurance in the sector of occupational hazards prevention and health promotion. **GKV-Spitzenverband** and **BKK** provide courses, counselling and incentives to promote healthy lifestyles, prevention services to promote health equity, services for health and occupational health promotion in companies, vaccination programmes and preventive medical services (e.g. check-ups). **DGUV** also carries out several activities in the fields of prevention and health promotion, including the design and management of effective and transparent prevention measures, innovative concepts for occupational health and safety and emergency rescue services, work process-orientated research and development and the testing of tools and equipment, the use of innovative means of communication, the integration of new methods and subject areas in basic and advanced training, extending the scope of activity at international level and performing supranational duties as required under social security law. The **DAK-Gesundheit** offers subsidies for prevention-courses and provides information on prevention and the promotion of a healthy lifestyle. In Austria, the **HVSVT** draws up the agenda of public health relevant topics, develops and coordinates strategic projects. Furthermore, the Austrian health insurance funds contribute to an immunisation programme for children and finance a part of vaccinations for adults. In Estonia, the **NHIF** finances prevention projects launched by the Ministry. In Finland, the act on rehabilitation and rehabilitation benefits plans the proportion of the annual insurance premium of insured people which will be dedicated to prevention. **KELA** manages this budget and significantly contributes to it. In France, the **CNAMTS** is the main stakeholder in the field of prevention. It finances regional and local prevention actions through a National Fund for Prevention and Health Education (FNPEIS – 324 Million financed by **CNAMTS** in 2013) and a National Fund for Prevention of Occupational Accidents. The National Health insurance fund also finances the health examination centres (CES) network that carries out around 520,000 periodic health check-ups a year. The **CNAMTS** also participates in the definition and implementation of regional and national priorities and programmes.

Social insurance institutions also have different focuses of action in the area of prevention and health promotion, such as occupational health and safety, road safety, diabetes, addictive substances, etc.

Healthy lifestyle is an important dimension of Social insurers' activities especially in Germany (**GKV-Spitzenverband**, **BKK**, **DAK-Gesundheit**), Austria (**HVSVT**) and France (**CNAMTS**). This dimension includes the promotion of healthy nutrition, physical activity and the prevention of alcohol and tobacco related harm. Promotion of dental health is also part of the social insurers' activities especially in Germany (**GKV-Spitzenverband**, **BKK**), in Austria (**HVSVT**) and in France (**CNAMTS**). In Germany (**GKV-Spitzenverband**, **BKK)**, stress management is an important topic. Immunisation programmes are carried out for example in Austria (**HVSVT**) and France (**CNAMTS**). Social insurers are also in charge of workplace risk prevention and health promotion for instance in Germany (**DGUV**) and in France (**CNAMTS**). Finally, the prevention of injuries and accidents at school and in kindergartens (**DGUV, HVSVT**) or on the road (**KELA** for instance) are sometimes an activity carried out by social insurers.

In these different intervention areas, we can mention some programmes, action plans or strategies which are designed or managed by social insurers or within which they participate. In Germany, a concept programme called "more health for everyone" and an integration programme about work and health (IGA) have been implemented. Several networks have also been established: a **BKK** development and coordination network for health promotion, prevention and self-help, a German network for health promotion (DNBGF), a German network called "companies for health" (UfG) and the European Network for Workplace Health Promotion (ENWHP). In Austria, the **HVSVT** participates in national projects such as the national strategy for health promotion in schools, smoking prevention strategies or the national programme for child immunisation. **HVSVT** is also a member of the Austrian network for occupational and health promotion. The **EHIF** finances the ministry's national health strategies and established occupational health networks. In Finland, a special alcohol action programme is currently implemented. The **CNAMTS** is involved in different plans and programmes, often multi annual (see above), on various health topics. For instance, it has put in place a medical accompaniment service for pregnant women, which includes personalised counselling and advice to help them to manage their pregnancy.

3.2 Secondary and tertiary prevention

The objective of **secondary prevention** is to detect the disease in time to better treat it and prevent it from worsening. It often develops screening actions or awareness-raising on problems already existing. For example, many widespread diseases, such as cancer or obesity may be the subject of screening campaigns.

These campaigns may comprise call-up actions for specific screening programmes (for example in Germany, employed by the **GKV-Spitzenverband** and **DAK** for different target groups, similarly in Austria (**HVSVT**) for high risk groups, or in Estonia, France and Germany for particular cancers), or offering free tests (as implemented in Austria andGermany, and offered by the French health insurance, for example: free dental check-ups for teenagers, and since 2014 check-ups for pregnant women in France). Screening may also be realised through interviews by doctors with patients to detect potential risk behaviour, like in most countries. Self-help groups are another example of the activities carried out by social insurers. The **BKK** for instance has set up the "Partners of self-help" to launch self-help projects in specific areas. The funding of rest homes or convalescent homes to avoid the development of disease or risk factors, like in Austria by **HVSVT**, can also be considered as secondary prevention.

Last but not least, the objective of **tertiary prevention** is to limit the consequences of chronic disease or disability, for example through rehabilitation.

For example, in Germany, the **GKV-Spitzenverband** carries out self-help promotion, services for disabled children or those at risk of disability, services of early intervention, physical activity and supplementary services for rehabilitation (training and instruction for patients with chronic diseases) and outpatient rehabilitation to prevent disability and the need for long-term care. Also in Germany, the statutory accident insurance institutions are responsible for the provision of all rehabilitation services in the case of occupational accidents, accidents at school and of kindergartens, commuting accidents and occupational diseases. They control and co-ordinate medical treatment (medical rehabilitation) as well as reintegration into professional life (professional rehabilitation). Thus, the **DGUV** has established the "Disability Management" programme, which is even recognised at international level. The **DAK** has initiated networks of specialised experts in the field of rehabilitation and special treatments for the insured persons who suffer from diabetes, heart disease, breast cancer, COPD (chronic obstructive pulmonary disease), and asthma. In Austria, the **HVSVT** has set rehabilitation measures to empower patients. In Estonia, gatekeeper physicians have been given the responsibility by the **EHIF** to regularly monitor patients with chronic disease. The French **CNAMTS** also has an action in this field. It organises accompaniment for patients with long-term diseases in the framework of the "quality life plan", accompaniment of patients with chronic diseases (Sophia programme) or rehabilitation following hospitalisation (Prado service). This means personalised programs of tertiary prevention targeted to a limited number of important pathologies in medical and financial terms (like cardiovascular pathologies, diabetes, asthma or obesity) or following hospitalisation.

4 The role of health insurance institutions in alcohol-related harm prevention

4.1 Cross-cutting measures, methods and means of action

According to the responses to the questionnaire, social insurance institutions also support important horizontal actions in the fight against high alcohol consumption and alcohol-related harm.

Indeed, in Germany (**GKV-Spitzenverband** and **BKK)** an evaluation of alcohol consumption is included in standard health check-ups for teenagers and adults and if necessary, guidance is provided to avoid harmful alcohol consumption. The **BKK** offers a variety of prevention oriented courses especially for insured persons with a high risk of alcohol addiction. Courses are given by qualified professionals (psychologists, teachers, social workers, specialists in social and health sciences, doctors) and their objective is to inform, educate, and encourage responsible consumption through individual strategies and strengthening personal skills and resources for the healthy management of stress and strain. This programme includes information on the effects of alcohol consumption on health, a reflection on individual drinking habits, etc. In 2012, about 13000 people attended courses and seminars for insured people who wanted to reduce their alcohol and tobacco consumption.

Estonia has initiated a health promotion tradition which has experienced a spill over phenomenon (incremental process), especially at local level. Indeed, Estonian municipalities develop today their own actions, especially in the area of alcohol sale and advertising in places frequented by children.

In France, the **CNAMTS** provides assistance and funding to the national prevention programme against alcohol abuse in partnership with the INPES (National Institute for Prevention and Health Education) and its local network. Finally, it subsidises national alcohol prevention associations. The **CNAMTS** is also actively involved in setting up a treatment policy for alcohol addiction. It undertakes to avoid any separation between in- and outpatient

care, between healthcare and social well-being, and to ensure equity of treatment throughout France.

4.2 Protection of young people, children and the unborn child (reduction of alcohol exposure during pregnancy and of the number of children suffering from fœtal alcohol syndrome (FAS)

The **BKK**, the **CNAMTS,** the **HVSVT and** the **EHIF** have all declared activities in this field.

During pregnancy, a zero consumption level is promoted by Health insurers in all the countries investigated. This is sometimes supported by law as for example in France, where the labelling of alcohol products with a warning pictogram for pregnant women is compulsory.

In Germany, the evaluation of alcohol consumption is part of routine antenatal care and all pregnant women that are insured in a SHI Fund are counselled by their gynaecologist on dietary questions and also the consumption of alcohol and other drugs. Actions can also use original awareness methods, without using traditional communication tools. The **BKK** has developed for example self-help groups in the project “Alcohol during pregnancy and nursing period”.

As already mentioned above, in 2008 in France the **CNAMTS** launched a prevention programme which includes the medical accompaniment of pregnant women and alcohol-related harm prevention, in the framework of an "attentive pathway" set up by the French compulsory health insurance. It is a comprehensive programme with a strengthened focus on disadvantaged populations. The actions comprise consumer information and education, medical follow-up, the organisation of workshops by local health funds for pregnant women involving health professionals, a personal account and a public prevention section on the website Ameli.fr, which contains a "Prevention Section" offering a wide list of prevention information including a special section called "Pregnancy".

The **HVSVT** (Austria) is involved in the development of several health promotion projects. They are especially based on information and action on alcohol related harm such as “healthy eating from the start” (a health promotion programme for pregnant and breastfeeding women and children up to 3 years of age).

Furthermore, social insurers develop actions to protect children and young people against alcohol-related damage. Alcohol and addiction prevention schemes are often promoted in schools and during extracurricular activities, and special communication tools are produced for teenagers (leaflets, flyers, interactive workshops, alcohol prevention posters). Teaching aids for raising awareness about the risks of alcohol are produced and used specifically in places where young people go.
As regards children and adolescents, **GKV-Spitzenverband**’s focus lies on the prevention of early consumption of alcohol and drugs. Actions are considered as particularly effective when they are carried out within the living environment of children and adolescents. The SHI guide on prevention (Leitfaden Prävention) recommends that Health Insurance Funds promote prevention and healthy lifestyles based on a “settings-for-health-approach“.
Also in the context of primary prevention, according to national law and the SHI guide on prevention, health insurance funds promote personalised counselling and experience-based learning courses for the prevention of alcohol addiction among teenagers with serious drinking habits, who had to be hospitalised as a result of high levels of alcohol consumption. Personalised measures for the prevention of addictions have to be carried out at local level together with, for instance, restrictions on sales of alcohol in night clubs, etc. This should be controlled by a municipal network for drug prevention. An example of a SHI-funded drug prevention project for young people with hazardous alcohol consumption combined with

behavioural and proportionate preventive orientation is the project "Hart am LimiT (HaLT)" (www.halt-projekt.de).

The **BKK** supports training activities with for example teaching and research projects to reach young people. It is very active in schools and managed to reach more than 1.3 million children in 2013.

DAK-Gesundheit initiated the "Aktion Glasklar" (www.dak.de/aktionglasklar), a campaign aimed at preventing children from alcohol abuse and a poster contest called "*Kunst gegen Komasaufen*" ("Art against binge drinking"), to which 11000 schools are invited to contribute every year. The jury looks for pictures and messages against "binge drinking". In this project for adolescents between 12 and 17 years, the pupils become ambassadors in the fight against the abuse of alcoholic drinks.

In Austria, a health promotion project from the **HVSVT** provides early help for families to protect children at school, based on health promotion actions.

CNAMTS carries out a teaching aid activity to raise awareness about alcohol among young people in places they frequent. It also launched a prevention programme in cooperation with gatekeeper physicians, within the framework of the medical convention signed by the health insurance fund and the general practitioners. The convention requires doctors to ensure preventive care and to contribute to promote good health.

The **EHIF** has also launched communication actions for young people and children, with for instance a social campaign for alcohol abuse prevention among young people in 2008. It also produced two films, called "Alcohol-enemy n°1" and "Know your enemy", for teenagers. In addition, in cooperation with an NGO, the **EHIF** carried out a conference on the topic "Child in dangerous ground".

4.3 Reduction of the number of injuries and deaths caused by alcohol on the roads

Firstly, it is interesting to compare the different countries' regulations on maximum authorised levels of alcohol in the blood while driving. Table 2 in the annex shows that a minority of countries fixes a zero rate of alcohol in the blood while driving. In Estonia, Hungary, Czech Republic and Slovakia alcohol is completely forbidden when driving. In these countries, alcohol consumptions are below the European average of 12.5 litres in 2012. Most EU countries have set a maximum level of 0.5 milligrams of alcohol per millilitre of blood with the exception of Spain, which reduced the maximum authorised level from 0.5 to 0.2 milligrams of alcohol per millilitre of blood, Lithuania (0.4 mg/ml), Malta (0.8 mg/ml), Poland (0.2 mg/ml), the UK (0.8 mg/ml) and Sweden (0.2 mg/ml) and which is the third lowest consumer of alcohol in Europe.

Alcohol-related harm prevention in the field of road safety mostly consists of awareness-raising activities.
The **DGUV** has the financial responsibility for commuting accidents. It promotes and financially supports the German Road Safety Council. It focuses on road safety related to occupational activity and has launched a work-related road safety programme concerning "alcohol, drugs and pharmaceuticals in road traffic" (http://www.dvr.de/site.aspx?url=html/sonst/127.htm). It provides information on the impact of alcohol, drug, and pharmaceutical consumption on roadworthiness as well as practical details on how to avoid journeys under the influence of alcohol and other intoxicants. The target groups are motorists, in particular young drivers without experience. In addition, the **DGUV** coordinates and ensures the implementation of the measures carried out by the

institutions. The **CNAMTS** finances prevention campaigns and awareness-raising in partnership with the National Association for Alcohol and Addiction Prevention (ANPAA).

4.4 Reduction of alcohol-related harm for adults (chronic mental and physical problems and deaths caused by alcohol)

According to the replies, actions by the institutions aimed at alcohol-related harm prevention in adults consist of information and awareness-raising, early detection of alcohol-related problems and financial support of projects or associations.

The **HVSVT** organises check-ups and screening including alcohol consumption screening for adults older than 18. The **BKK** focuses on participative information and advising policy, with a participative assistance for disadvantaged people (unemployed and homeless people): the "FIT" consultancies. A one-hour individual consultancy talk with a questionnaire is given to the patient, to speak about his behaviour regarding health and lifestyle. Similarly, the health-oriented self-management is also training people at risk of unemployment. It begins with an initial interview to identify individual problems which it is followed by a five-hour meeting. An open programme targeted to homeless people finally enables the patients to formulate their own objectives. It includes 10 training days over a period of three to four months. The **EHIF** and the **CNAMTS** support alcohol prevention for adults through project financing. Indeed, the **EHIF** has been financing local projects since 2006, especially in the field of alcohol-related casualties, giving autonomy to the municipalities to implement their own actions.

Health insurers also reimburse healthcare or finance actions for people with alcohol addiction.
In Germany, social health insurance covers costs for detoxification care. The **GKV-Spitzenverband** participates in the development of the remuneration system for health professionals, recently especially in the field of psychiatry. Detoxification is often followed by rehabilitation during several months. It is usually performed in in-patient or out-patient rehabilitation institutions. In the context of health-related self-help promotion, the SHI funds and their associations support self-help groups, self-help organisations and self-help agencies with approximately 41 million euros. Support is given to self-help structures dealing with addiction at federal, regional and local level.

The "disease index" (Krankheitsverzeichnis), which indicates the diseases which are eligible for funding, explicitly includes alcohol addiction disorders. Both patient groups as well as groups for relatives (Alcoholics Anonymous, relatives of Alcoholics Anonymous) are being supported. The aim of self-help is to help people with alcohol addiction and their families to fight against the addiction and to restore social contacts, create new perspectives, and to overcome isolation and exclusion. In France, the **CNAMTS** also give financial support to local self-help associations in order to reduce chronic physical and mental problems caused by heavy drinking. Although the well-known Alcoholics Anonymous association gives people the chance to share experiences and offers collective help to solve a common problem, there are numerous other associations that have set up listening services and local discussion groups. The services specifically target people suffering from alcohol-related problems by recommending them health check-ups. Listening is a means of detecting addiction and therapeutic education and one-to-one interviews help reduce consumption in those identified as addicts. In rural areas, information and discussion meetings are organised for groups of villages and usually cover a broad range of psychoactive substances.

4.5 Reduction of alcohol-related harm in the workplace

Reduction of alcohol-related harm in the workplace is often an activity of social insurers where they are in charge of accident insurance and/or health promotion and prevention at the workplace.

In Germany, SHI Funds promote zero alcohol consumption at the workplace through the education of employers and management and the provision of adequate guidance for employees[4]. The **DGUV**, as social insurer for accident at work and occupational diseases, is responsible for prevention of occupational hazards, including alcohol-related hazards. The **DGUV** provides several services in the area of alcohol prevention at the workplace. They include consultation, motivation and information, as well as initial education and continuous training for safety specialists in particular: they advise employers, supervisors and staff on issues of health and safety at work; safety officers (members of company staff with particular responsibility for safety and health directly at the workplace) as regards prevention of alcohol addiction and alcohol related harm; and finally addiction Commissioners ("Suchtbeauftragte"). Moreover, an expert committee of the **DGUV** has developed a general regulation "principles of prevention" which provides for the shared responsibility of the employee and the employer as regards alcohol. According to this regulation, the employee shall not, by consuming alcohol or other intoxicating substances, put themselves in a state in which they might pose a risk to themselves or others. The employer has a responsibility in preventing this risk at the workplace.

As a member of the European Network for Workplace Health Promotion (ENWHP), the **BKK** promotes collaboration with European organisations in the field of workplace health promotion. ENWHP is a platform for all stakeholders interested in the improvement of workplace health.

The **HVSVT** in Austria has been involved in the coordination and implementation of workplace based health promotion actions concerning alcohol related harm. In Estonia, the **EHIF** has launched a network to exchange best practices, including on the topic of alcohol consumption in the workplace.

In France, the "occupational hazards" branch of **CNAMTS** is responsible for prevention of work-related hazards. Regional funds implement the measures developed at national level and work with companies to encourage and help them to build a comprehensive and collective prevention strategies aimed at designing healthy and safe working environments for their employees. Where an alcohol consumption problem is identified at the workplace, employers are encouraged to take preventive measures in order to eliminate or reduce this problem. The advised measures are based on a technical, organisational or "human approach". The "human approach" consists in raising awareness, informing, training and improving prevention skills.

KELA focuses on the compensation of the employers costs in case of alcohol problems at the workplace.

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[4] www.sucht-am-arbeitsplatz.de

5 Conclusion

In Europe, prevention is organised differently in the different countries. It usually concerns different levels of authority: national, deciding on the main objectives and responsibilities for prevention; the social insurance funds, implementing prevention; and the companies with regard to occupational health and safety. Finally, especially in decentralised systems such as in Finland or Germany, the local level may implement prevention policies and guidelines that have been decided at national level. Thus, health professionals like the gatekeeper physician may have an important role: local level implementation allows prevention measures to be adapted to a specific audience.

Alcohol-related harm prevention is already the aim of numerous actions by social insurance funds. Communication and awareness-raising actions are very important, especially for prevention of alcohol-related harm among young people, who are particularly vulnerable and difficult to reach. They require the development of innovative, original and adapted prevention tools. For adult audiences, self-help groups are widely available. Training for professionals and patients organised by social security institutions also has an important role to play and serves to build a genuine competence in prevention. Finally, the increasing involvement of local health professionals in the early identification of potentially excessive drinkers seems to be widespread. Indeed, the gatekeeper physician treats and follows his patients throughout their life and is more likely to be trusted, especially since he is bound to professional secrecy. His local situation makes him easily accessible and facilitates the implementation of an individualised approach to prevention (unlike collective mass-media campaigns). Similarly, German initiatives for unemployed or homeless people, which carry out personal interviews, questionnaires and self-analysis, are a solution to reach a very specific and disadvantaged population.

In conclusion, social insurance institutions are central players in the field of prevention, health promotion and alcohol-related harm prevention and are increasingly involved in this field.

We can already see some positive results of alcohol-related harm prevention, in spite of the ongoing economic and financial crisis. Indeed, alcohol consumption has shown signs of reducing over the last six years (see annex “comparative table of European countries' alcohol consumption”). This improvement shows that social insurers remain convinced that health is wealth and that economic recovery depends on the high level of health of the society.

Nevertheless, alcohol consumption in the EU remains high and a lot remains to be done. For this reason, it is very important that the social insurance funds, in cooperation with relevant stakeholders and European institutions, continue to strengthen their prevention programmes. To improve alcohol-related harm prevention, close cooperation at European level can be beneficial. The involvement of social insurers at European level in the field of prevention shows a will to collaborate and to exchange practices beyond national borders. This is indeed the case today through networks like the *European Social Insurance Platform* (ESIP) and the *European Network for Workplace Health Promotion* (ENWHP), and previously the European Network “Social Insurance for Health” (ENSifH) and the European Action on Drugs EAD (2009-2012).

Annexes

The involvement of Health insurance institutions in European and International networks

	ESIP[5]	AIM	ISSA
Austria : **HVSVT (*Hauptverband der österreichischen Sozialversicherungsträger* / Federation of Social Security Institutions)**	X		X
Estonia : **EHIF (*Eesti Haigekassa* / Estonian Health Insurance Fund)**		X	
Finland : **KELA (The Social Insurance Institution in Finland)**			X
France : - **CNAMTS (*Caisse Nationale d'Assurance Maladie des Travailleurs Salariés* / National Health Insurance Fund)**	X		X
Germany : - **BKK (*Bundesverband der Betriebskrankenkassen* / Federal Association of Companies Health Insurance Funds)**	X	X	X
- ***DAK-Gesundheit* / Statutory Health Insurance)**			
- **DGUV (*Deutsche Gesetzliche Unfallversicherung e. V.* / German Social Insurance for Occupational Accidents and Diseases)**	X		X
- ***GKV-Spitzenverband /*** National Association of Statutory Health Insurance Funds**)**	X		X

ESIP : *European Social Insurance Platform*
AIM : *Association Internationale de la Mutualité* (international association of *mutuelles*)
ISSA : *International Social Security Association*

[5] Member of the European forum "Alcohol and Health"

Comparative table of European countries' alcohol consumption

Country	Litres of pure alcohol per capita (15+) in 2006	Litres of pure alcohol per capita (15+) in 2012	Maximum rate of alcohol in the blood (mg/ml) on the road in 2013 (2006)
Germany	11,8	11	0,5
Austria	**12,6**	**12,2**	0,5
Belgium	10,7	9,8	0,5
Cyprus	11,4	9,2 (2010)	0,5 (before 0,9)
Denmark	**12,2**	9,3	0,5
Spain	11,9	9,8	0,2 (before 0,5)
Estonia	**13,4**	**12,3**	Total ban
Finland	10,1	9,3	0,5
France	**12,9**	11,8	0,5
Greece	8,8	7,9 (2010)	0,5
Hungary	**13,2**	11,4	Total ban
Ireland	**13,4**	11,6	0,5 (before 0,8)
Italy	7,3	6,1 (2010)	0,5
Latvia	9,9	10,5 (2010)	0,5 (before : Total ban)
Lithuania	**12,5**	**12,9**	0,4
Luxembourg	**12**	11,4 (2010)	0,5 (before : 0,8)
Malta	6,7	6,6 (2010)	0,8
Netherlands	9,6	9,3 (2010)	0,5
Poland	9,9	10,2	0,2 (before : Total ban)
Portugal	11,7	10,8	0,5

Czech Republic	11,9	11,6	Total ban
United Kingdom	11,1	10,6	0,8
Slovakia	10,6	10,1	Total ban
Slovenia	**12,2**	11	0,5
Sweden	6,9	7,3	0,2
Average	**10,98**	**10,16**	**0,38**

RED = negative development
Green = positive development (compared to 2006)

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http://apps.who.int/gho/data/node.main-euro.A1147?lang=en

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http://www.oecd.org/health/healthdata

Contacts

Organisation	Name / surname	E-mail
Austria :		
• HVSVT		
Health promotion and prevention :	Spitzbart, Stefan	stefan.spitzbart@hvb.sozvers.at
Smoking prevention :	Stürzenbecher, Stephanie	Stephanie.stuerzenbecher@hvb.sozvers.at
Mental health prevention	Spitzbart, Stefan	stefan.spitzbart@hvb.sozvers.at
Addictive behaviour prevention	Fasching, Elisabeth	elisabeth.fasching@hvb.sozvers.at
Estonia :		
• EHIF		
Every prevention areas :	Vaask, Sirje	sirje.vaask@haigekassa.ee
Local health promoting projects, projects targeted to the health promotion networks and also patient education materials :	Tõemets, Tiina	tiina.toemets@haigekassa.ee
Finland :		
• KELA		
Alcohol and mental health prevention :	Koivisto, Pekka	pekka.koivisto@kela.fi
Obesity prevention :	Dr. Hakala, Paula	paula.hakala@kela.fi
France :		
• CNAMTS :	Dr. Gouëllo, Martine	martine.gouello@cnamts.fr
Germany :		
• BKK		
Every prevention areas :	Dr. Breuker, Gregor	Gregor.Breucker@bkk-dv.de
• DGUV		
Every prevention areas :	Bindzius, Fritz	fritz.bindzius@dguv.de
• DAK		
Alcohol-related harm prevention and smoking prevention:	Kremer, Ralf	ralf.kremer@dak.de
Obesity prevention:	Willms, Silke	silke.willms@dak.de
• GKV -Spitzenverband		
Every prevention areas	K. Schreiner-Kürten, Dr. V. Wanek	praevention@gkv-spitzenverband.de