EU CANCER STRATEGY:

HARM REDUCTION OF THE LICIT DRUGS WITH A FOCUS ON SOCIALLY VULNERABLE GROUPS

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ABOUT US

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EXECUTIVE SUMMARY

In recent years, a major shift in the European Union's perception of health, both physical and mental, has started to manifest in several new initiatives. It has manifested in the publication of the EU Cancer Plan in 2021, or the new impulse presented by the Commission's President Ursula von der Leyen in her 2022 State of the Union speech.

The study enters the public debate on the future orientation of EU decision-making in the area of health, in particular about the impacts of alcohol and tobacco addictions. It explores the dual relationship between the harmful consumption of licit drugs and the situation of socially vulnerable groups, representing a vicious circle that negatively influences the health conditions of millions of European households.

The study illustrates what role social and economic factors, including inequalities, poverty, marginalization, or lack of access to public services, have in the development of behaviour harmful to the health situation of individuals and their families. At the same time, it analyses negative feedback represented by the effects of the harmful use of tobacco and alcohol on the social situation of individuals, their families, and consequently communities they are living in.

To address the mutually reinforcing effects of addictions and socio-economic determinants it is illustrated in the evaluation of existing strategies of selected EU Member States that a better balance between individual/micro-level approach and macro-level policy-making approach needs to be achieved. In particular, it is important to integrate issues such as improved social policies, access to public services, and better-focused, evidence-based regulation, into a new comprehensive EU strategy on beating cancer, as well as on improving the mental health of European citizens.

Based on the findings described in the study, a number of action recommendations are identified. These include: mainstreaming addiction-related concerns into social policies; integrating socio-economic perspective into Member States´ strategies addressing harmful use of alcohol and tobacco; improving access to public services, in particular, counseling and health care for socially vulnerable groups; improving awareness about the link between mental health and addictions; improve access to mental health services; increase evidence about the possibilities of harm reduction strategies; improve the regulatory framework to better protect the health of EU citizens and reduce risks of harmful use of tobacco and alcohol.

INTRODUCTION

In February 2021, the European Commission presented Europe´s Beating Cancer Plan which represents a renewed commitment to cancer prevention, treatment, and care. The Cancer Plan aims to tackle the entire disease pathway and focus on the areas where the EU can add the most value in terms of prevention, diagnosis, and treatment as well as the quality of life of patients. The key aim of the Plan is to raise awareness of and address key risk factors such as smoking, harmful alcohol consumption, obesity, exposure to pollution, and others. It also has the ambition to take into account health determinants such as education, socio-economic status, gender, etc.

The study also reflects the recent discussion at the level of EU institutions regarding the EU Cancer Plan. In particular, the EP´s response to the Cancer Plan adopted in February 2022 serves as a relevant reference for this study. The report Strengthening Europe in the fight against cancer contains a number of recommendations on risk prevention as well as on risk/harm reduction. The European Parliament highlights among others the need to differentiate the negative impacts of different products, effectively use existing options for smoking cessation, or increase scientific evidence of the health risks of some of the alternative tobacco products. The report, in addition, called for more attention to be paid to the most vulnerable socially excluded groups and the possibility of creating system changes through population-wide public policies that can influence individual behaviour. In this context, this study contributes to evidence-based policymaking as asked for in the European Parliament's BECA Report.

The third point of reference of this study is the ongoing debate on a new EU Mental Health Strategy. While the European Commission has long paid attention to mental health issues, the comprehensive approach of the EU to various mental issues Europeans are facing has been missing. The need for a new strategy was stressed by the European Commission president Ursula von der Leyen in her State of the Union speech in September 2022. In this context, the vicious cycle between mental illnesses and addictions has to be more explored. WHO, for example, brought this connection to the international community´s attention in the last couple of years.(1) It is again the socioeconomic dimension to this connection that needs to be further explored to better understand how vulnerable socioeconomic background can play a role in the development of both addictions and mental illnesses. This study aims to contribute to an evidence-based debate that can steer policymaking toward a comprehensive strategy and policy option.

This study aims to improve our understanding of the dual relationship between one of the key health determinants, social vulnerability, on the one hand, and harmful consumption of legally available addictive products, i.e. smoking and harmful alcohol use on the other. The ambition is to contribute to the debate on how the Cancer Plan can contribute to tailoring actions that will improve people's lives, focusing specifically on socially vulnerable groups, access to information, and tools they need to make healthier choices and reduce the risks of cancer development.

In particular, the study focuses on the concept of harm reduction and its potential role in the implementation

(1) WHO, Tobacco use and mental health, WHO Policy Brief (2021). Or see WHO´s news release: The vicious cycle of tobacco use and mental illness – a double burden on health (who.int)

of the EU´s Cancer Plan. The harm reduction policy has been a vividly discussed issue ever since its introduction in early 2000 for example in the report of the Institute of Medicine.(2) It has been associated with a lot of controversial meanings. In general terms, the harm reduction policy is an approach supposed to decrease harm associated with the use of drugs (licit and illicit) to its users or to others.(3)

Harm reduction is mainly divided into two models of interventions: at the level of community and the individual level. The level of community is directed by Governments or by local authorities who propose laws or decrees that aim to limit access to drugs, etc. The individual level is mostly concerned with behavioural factors with an important role of non-governmental organizations as well as the private sector, focusing primarily on certain groups, e. i. the vulnerable, socially excluded, and marginalized groups, etc.(4)

The study focuses on the potential of harm reduction approaches to address the impacts of alcohol consumption and smoking as two main health-related risk factors. It aims to bring more light on its potential as well as limitations in the disrupting two-way relationship between social and economic status and harmful consumption of legal drugs in vulnerable, i.e. socially excluded groups and communities such as national minorities, single-parent families, people living in socially excluded communities or people in serious indebtedness. In this context, the aim of the study is not to illustrate in detail the health impacts of alcohol consumption and smoking in vulnerable groups, which has been already well documented in several existing specialized studies. Instead, it aims to explore socio-economic factors as one of the key health determinants for the EU Cancer Plan and to contextualize harm reduction strategies in socially vulnerable groups as well as the existing potential to address social and health-related risks of alcohol and tobacco abuse.

The method used is the case study of the situation in the Czech Republic, with an elementary comparison of the situation in Poland and Germany. The case study is elaborated using desk and grey literature research in combination with qualitative research based on structured interviews with the representatives of socially vulnerable social groups.

(2) Institute of Medicine, *Clearing the Smoke: Assessing the Science Base for Tobacco Harm Reduction*, Washington (DC): National Academic Press.

(3) Lenka Vavrinčíková, Harm reducon a alkohol, Klinika adiktologie, 1. lékařská fakulta Univerzity Karlovy v Praze a Všeobecná fakultní nemocnice v Praze, (Prague: publishing TOGGA, 2012), 21, https://www.adiktologie.cz/file/357/imprim-harmreduct-alkohol-via-03.pdf (downloaded 7/15/2022).

(4) Ibid., 23.

1. ALCOHOL

1.1 SOCIAL AND HEALTH CONSEQUENCES OF ALCOHOL CONSUMPTION

The body of existing research has already identified the dual, two-way, link between harmful alcohol consumption and the social situation of affected people. In general, harmful alcohol consumption has social consequences while socioeconomic factors contribute to increased use of alcohol. First, increased alcohol use has long-term impacts on the social environment of the users. It may trigger many social and other issues: situations within a family (financial burden, psychical consequences with alcohol addicted individual); situations outside of the family (traffic accidents leading to injuries; death of alcohol consumer; non-personal influencing such as creating fear around his/her living neighbours, etc.). In addition, alcohol consumption is one of the factors that influence the individual´s social status due to its impact in terms of productivity, ability to accept responsibility, and the insecure financial situation resulting from these factors.(1) Moreover, alcohol addiction causes damage to the alcohol-addicted individual regarding the somatic and psychical spheres: "*not fulfilling a social role or failing to fulfill it, fear of staying in public space or economic costs.*"(2)

At the same time, the socio-economic status of individuals or households is considered to be one of the stressors that contribute to the increase in harmful alcohol consumption. Socio-economic factors, such as economic inequalities, risk of poverty, living in socially excluded communities, etc., influence the probability of the development of harmful behaviour, including alcohol abuse. It is also considered that they make a number of existing strategies less effective in terms of lower awareness and information intake about related risks and effects, socioeconomic but also health risks, and less effective communication from the side of relevant authorities. In consequence, these limits are translated into a lower capacity to reduce or prevent health-related harms and risks of alcohol addictions. In general, therefore, one must deal with the vicious circle of alcohol consumption, the socio-economic situation of individuals and households, and the resulting increased risks of the development of serious health problems.

(1) Elizabeth Nováková, Viktor Mravčík, „Dopady užívání alkoholu na okolí uživatele", *Hygiena* 65, No. 1, (2020), 11, https://hygiena.szu.cz/artkey/hyg-202001-0002_dopady-uzivani-alkoholu-na-okoli-uzivatele.php

(2) Ibid., 11.

1.1.1 INEQUITIES CAUSED BY THE HARMFUL ALCOHOL CONSUMPTION

Any addiction is closely associated with social and other consequences for the individual, his/her social standing, his/her social and economic perspectives, and the inequalities she/he is facing. For example, poor or socially disadvantaged groups are affected by lower household budgets due to alcohol consumption, live in a neighbourhood with more alcohol consumers, and are more likely to suffer from mental and physical health problems and other issues.(1)

The groups who are most likely to be exposed to factors connected with high consumption of alcohol or experience alcohol-related harm are affected by push and pull factors, meaning that if e.g. children who have adverse experiences in their families are most likely to continue in these steps which they have seen in their families. Then, they bring current steps to their future children, and such harm will involve the next generations.(2)

The main factor that creates and conserves the low socioeconomic status of vulnerable groups is stressful situations. They are more common in poor communities than in groups with higher incomes. Also, poor people are in a worse position to face these stressful situations. One of the examples could be stressful work, when people with high-income face usually only stressful work, vulnerable groups are most likely to face not only stress during work, but lower income also affects their everyday lives.(3)

Vulnerability, as an object, can be divided into two sections: natural ("*lower levels of resilience or social support*" (4)) and biological ("*women and children are vulnerable to increased harm from a given level of alcohol consumption*").(5)

In addition, co-morbidities are another factor causing vulnerabilities stemming from harmful alcohol consumption. One of the best-known co-morbidities is obesity which may be happened from consuming alcohol. That means and is also connected, that alcohol has a major influence on the health status of consumers, where the most affected groups are again the vulnerable ones.(6)

(1) Belinda Loring, „Alcohol and inequities: Guidance for addressing inequities in alcohol-related harm", *World Health Organization, Regional Office for Europe*, (2014), 9, https://apps.who.int/iris/handle/10665/344496 (accessed 9/6/2022).

(2) Loring, *Alcohol and inequities: Guidance for addressing inequities in alcohol-related harm*, 13.

(3) Ibid., 15.

(4) Ibid., 15.

(5) Ibid., 15.

(6) Loring, *Alcohol and inequities: Guidance for addressing inequities in alcohol-related harm*, 15.

1.1.2 INTERVENTIONS TO TACKLE VULNERABILITIES CAUSED BY HARMFUL ALCOHOL CONSUMPTION

In the previous part, the factors increasing socio-economic vulnerabilities resulting from alcohol abuse have been illustrated. To address them, the existing body of literature identifies the need to combine different policies (Fig. 6), e. g. to treat "*the symptoms or attempt to compensate for inequities in the social determinants of health (SDH).*"[1] A holistic approach is required for any intervention, both short-term, and mainly long-term to ensure that they have a positive effect on the two-way relationship between harmful alcohol consumption and socio-economic status of affected individuals.

In addition, there are several suggestions (see Table 1, Table 3, and Table 4) proposing new interventions to consider among specific groups connected with inequities. They are divided by sources (sections) and into interventions that may be considered to improve current issues regarding the inequities coming from alcohol addiction.[2]

In light of the EU Cancer Plan, it is worth exploring a number of options to improve the situation regarding the social determinants of health and to disrupt the vicious circle of vulnerability and addictions. At the level of individuals, the provision of social and health-related services is among the first to be applied. It is also clear that the role stress plays and improving the quality of mental health can significantly contribute to both prevention and more importantly reduction of harm caused by excessive use of alcohol (to add community-based approaches and information to motivate better-informed choices).

At the level of the Member States and the EU, there is a need to shift macro-level policies. First of all, the quality of public services for vulnerable social groups needs to be at the centre of any long-term approach. If the two-way relationship between harmful alcohol consumption on the one hand and poverty and social exclusion is to be broken, access to social protection, quality education and training, and health care should be improved across the EU.

In addition, the tax policies in the EU need to come up with new incentives that will make financial and economic reasons for less-harmful alternatives stronger. For instance, there is a need to make alcohol more expensive to reach the intervention within low-income groups.

Furthermore, the need to make better focus on interventions is necessary not just to implement quick and automatically direct steps to cause and effect. Such a quick and direct implementation "*will not solve the underlying causes that give rise to the alcohol-related inequities in the first place.*"[3]

(1) Loring, *Alcohol and inequities: Guidance for addressing inequities in alcohol-related harm*, 9.

(2) Ibid., 12-17.

(3) Loring, *Alcohol and inequities: Guidance for addressing inequities in alcohol-related harm*, 10.

1.2 HARMFUL ALCOHOL CONSUMPTION AND HARM REDUCTION STRATEGIES BY SELECTED EU MS

1.2.1 CASE STUDY – CZECH REPUBLIC

The National Strategy on Addictive Behaviour Prevention and Harm Reduction defines the need for "*a set of preventive, educational, therapeutic, social, regulatory, control and other measures, including law enforcement measures, carried out on the international, national, regional and local level.*"(1) Since 2019 the document provides the main guidelines for both the prevention and treatment of addictions and harm reduction (social, health, etc.) caused by addictive behaviour at the individual level as well as at the societal level. The strategy provides an in-depth evaluation of the existing situation and outlines the main challenges for Czech society from different forms of addictive behaviour, including harmful alcohol use. At the same time, the document identifies a broad range of measures that are necessary to tackle individual problems associated with the use of alcohol.

In the case of alcohol, the strategy provides a number of observations that should navigate policymaking to reduce harm for both individuals and society resulting from alcohol use. While it identifies key factors contributing to the dismal situation manifested in the intensive use of alcohol in the Czech population, the lack of implementation of recommended measures remains the key challenge. It is illustrated by the persisting problem of easy access to alcohol. The Czech Republic´s legal framework and regulatory environment do not sufficiently restrict access to alcohol in order to change consumption behaviour, and moderate supply and demand. It disposes of relatively limited restrictions on alcohol use through legal acts and also through local measures such as local decrees. In principle, the existing measures focus on issues such as regulation of advertising, age restrictions, or local regulation of time or locations where alcohol can be served or sold. At the same time, these measures neglect specific situations of individuals with vulnerable backgrounds, including their perceptions and attitudes informing their behaviour and choices.(2)

The key deficiency of the National Strategy and its implementation lies in the lack of attention that is paid to the specific situations of vulnerable groups and to comprehensively addressing socioeconomic factors that are one of the main root causes of harmful alcohol use. The main points that the National strategy highlights are the following: strengthening prevention and increasing the informative campaign, quality and accessible network of addiction services, effective regulation of markets with addictive substances and addictive products, effective management, coordination, and financing, etc.(3)

While the National strategy aims to increase public awareness of related health and law issues, decrease the rate of addiction within the youth population, and shift the first contact with the addictive substance, or also,

(1) SEKRETARIÁT RADY VLÁDY PRO KOORDINACI PROTIDROGOVÉ POLITIKY. „National Strategy on Addictive Behavior Prevention and Harm Reduction 2019-2027". (Praha: Úřad vlády České republiky, 2019), P. 5, https://www.vlada.cz/assets/ppov/protidrogova-politika/strategie-a-plany/Narodni_strategie_2019-2027_fin.pdf (accessed 7/15/2022).

(2) Vavrinčíková, Harm reduction a alkohol, 24.

(3) SEKRETARIÁT RADY VLÁDY PRO KOORDINACI PROTIDROGOVÉ POLITIKY, „National Strategy on Addictive Behavior Prevention and Harm Reduction 2019-2027", (Praha: Úřad vlády České republiky, 2019), 23-26, https://www.vlada.cz/assets/ppov/protidrogova-politika/strategie-a-plany/Narodni_strategie_2019-2027_fin.pdf (accessed 7/15/2022).

extending of the screening (as a part of the primary care), there is very limited attention paid to macro-level policies addressing socioeconomic causes and dual-relationship between socioeconomic vulnerability and harmful alcohol use relatively limited.[4] The Strategy identifies the need to prevent social exclusion as one of the priorities, however, it does not elaborate on this dimension in more detail.

Regarding the topic of harm reduction focused on alcohol and tobacco, within this topic, the Strategy only generally observes that there is a need for a "*conceptual understanding of harm reduction measures for alcohol and tobacco users*".[5] In practical terms, there are no propositions of specific measures or policy options addressing the need to reduce social and health harm caused by alcohol use included in the Strategy.

Carrying out new economic and marketing models of regulations is then connected with better management, coordination, and financing, with respect to more financial sources and better allocating them. To make management more effective, there are strategies to strengthen local authorities and their better improvement. After the local authorities, also a strong part of the management and coordination is supposed to "*support for partnership and cooperation of professional societies, research institutions, overarching institutions of service providers and, where appropriate, self-help and patient organizations in the implementation of policy at all levels.*"[6]

Alongside the general implications of alcohol restrictions, which are envisaged in the National Strategy, there are so-called community projects, created by community actors (local authorities, police, etc.). Community projects emerged from the community strategies, and they are supposed to be focused on certain locations, such as bars, and clubs, or also on their visitors.[7]

An example of community projects in the Czech Republic comes from the city of Pilsen, wherein the period between 2007 and 2009 was implicated in a project, inspired by the Swiss equivalent called "*Safer Clubbing*"[8] combined with an implementation in the United Kingdom. Such a project was focused on "*supporting the responsible approach of club and discotheque operators and their staff with regard to the safety of visitors and mediate cooperation with the local government to ensure a peaceful nightlife.*"[9]

(4) Ibid., 23.

(5) Ibid., 24.

(6) SEKRETARIÁT RADY VLÁDY PRO KOORDINACI PROTIDROGOVÉ POLITIKY, *National Strategy on Addictive Behavior Prevention and Harm Reduction 2019-2027*, 26.

(7) Ibid., 24.

(8) Ibid., 24.

(9) Vavrinčíková, *Harm reduction a alkohol*, 24.

1.2.2 CASE ANALYSIS – POLAND AND GERMANY

POLAND

The Polish National Strategy of Health (Narodowy Program Zdrowia – NPZ) represents the key framework for tackling the problems caused by the harmful use of alcohol. It has been updated for the period from 2021 to 2025. In a similar way to the Czech National Strategy, the NPZ provides both analysis of the main challenges the Polish society is facing in terms of addictive behaviour, and policy recommendations. It recognizes a number of factors that need to be addressed in order to substantially improve the situation. Among other measures, it defines key priorities such as "*extending standards for a prevention, diagnosis, and therapy of the FASD (Spectrum of Fetal Disorders Alcoholic beverages); an early recognition and short intervention in primary health care for patients who consume alcohol in a risky and harmful way; reducing the physical and economic availability of alcohol; increasing the effectiveness in complying with the law in the field of production, distribution, sale, advertising, promotion, and consumption of alcoholic beverages; and limiting the scale of smuggling and the number of illegal alcohol decontamination sites.*"(1)

Based on the above-mentioned priorities for alcohol-related interventions, there is no specific focus on vulnerable groups. Socioeconomic causes are to a large extent neglected and addressed only in general terms without a comprehensive set of measures to tackle the root causes in the Polish Strategy.

Moreover, the Polish local authorities are expected to take over a substantial part of the responsibilities in the implementation of both prevention as well as harm reduction measures at their levels. Regulation of access to alcohol represents one of the main policy options available for local authorities. Measures such as limiting outlets or hours of operation of facilities selling alcohol are considered to be relatively effective and easily implemented. While some communities and local authorities are interested in putting in place these kinds of interventions, for example by establishing alcohol-free zones around public spaces, the lack of motivation is caused by concerns over negative impacts on budgetary income from licensed alcohol outlets.(2)

The Polish approach, which is based on the decentralized implementation of measures aimed at the prevention and harm reduction of alcohol consumption, is confirmed and further developed in the "*Recommendations for the implementation and financing of municipal programs for the prevention and resolution of alcohol-related problems in 2022.*" The document was prepared and published by the State Agency for Solving Alcohol Problems (PARPA). Although it further elaborates on potential interventions that might be implemented by local authorities, the importance of state authorities and macro-level policies is undervalued and neglected. Instead of designing a comprehensive and holistic strategy to tackle harmful alcohol use, the Polish approach can be considered to be fragmented and unable to effectively exploit all measures available for reducing social and health harm for both individuals and society as a whole.

(1) Rada Ministrów, „Narodowy Program Zdrowia na lata 2021-2025", (30th March 2021), 16, https://wolomin.org/wp-content/uploads/2021/09/narodowy-program-zdrowia-na-lata-1.pdf (accessed 10/10/2022).

(2) SEKRETARIÁT RADY VLÁDY PRO KOORDINACI PROTIDROGOVÉ POLITIKY, National Strategy on Addictive Behavior Prevention and Harm Reduction 2019-2027, 15.

GERMANY

In the case of Germany, the addiction policy was incepted already in 2012 when the National Strategy on Drug and Addiction Policy was adopted. The strategy provides a relatively general framework for action in which responsibility is shared at federal, state, and local levels with a focus on key areas such as prevention, safety, and consumption of specific social groups (especially children and adolescents). The priorities of the approach endorsed by the German authorities include "*the emphasis must be placed on the dangers of developing an addiction, on high-risk consumption patterns and, thus, on the development of competence in dealing with the risks.*"(1)

Particular attention is paid to the protection of youth against the harm caused by alcohol consumption. The strategy acknowledges that the increase in high-risk and binge drinking is among the major problems affecting the young generation. It is reflected in three out of eight goals of the strategy. It emphasizes the need to promote responsible alcohol consumption, increasing awareness of risks as well as full implementation of the Protection of Young Person Act to mitigate problems associated with alcohol use.(2)

Other areas of focus of German addiction policy related to alcohol involve largely a combination of increasing access to information for self-regulation, improving diagnoses and applying control measures. Firstly, it is the emphasis on the promotion of absolute sobriety in a particular place and time. The Strategy goals are to achieve complete abstinence at the workplace which is related to both health reasons as well as safety reasons. Second, it targets the risks of alcohol use during pregnancy which is considered to have significant social and health implications. Thirdly, the Strategy pays attention to threats to safety related to high-risk alcohol consumption, namely the risks of alcohol-related violence and of driving under the influence.

While the strategy has performed well in some areas, as confirmed by the OECD, more action is needed to improve the situation regarding alcohol consumption.(3) It is a matter of fact that the existing German strategy fundamentally neglects a whole range of possible measures that could primarily reduce the effects of risky alcohol use. Also, the Strategy does not reflect the possible contribution of harm reduction strategies. The need for improvement has been confirmed by the German Bundestag´s health committee at a hearing on alcohol policy held in March 2021.(4)

Access to alcohol represents one of the areas where improvements could be achieved. Especially the restrictions on the availability of alcohol for vulnerable groups are missing in the existing repertoire of measures. Another area of possible future action is the regulation of advertising, particularly in the case of social media. (5) Existing addiction policy has not envisaged heavier regulation of alcohol advertising with exception of protection of children and adolescents.

Another area where the German approach seems to be rather reductionist concerns the macro-level policies. While the Strategy acknowledges the need to understand the individual background of people affected by the harmful use of alcohol, it largely overlooks broader socio-economic causes.

While the role of federal authorities is considered to be of high importance, the Strategy also considers the importance of local action to tackle alcohol-related problems. There are a number of examples, where local authorities developed innovative approaches to address these problems. In Kiel, for example, there has been established the first drinking room. Such a new method was made to make the city safer and to offer visitors and the city's citizens to have clean, safe, and more enjoyable places. High-drinking consumers can visit this newly created drinking room, where they can bring their alcohol, such as beer or sangria. Also, there is a possibility to buy a coffee, for example. The room has approximately 70 regular visitors between 18 and 70 years. The project was so successful that the other German authorities want to realize this project, too. The project has been extended to services offering rehabilitation for vulnerable groups, offering jobs, teaching them to communicate e. g. with their landlords, and, in general, to take control of their lives.(6)

(1) Drug Commissioner of the Federal Government (2012) *National Strategy on Drug and Addiction Policy*. Germany. P. 12.

(2) Ibid.

(3) OECD (2021), *Preventing Harmful Alcohol Use*, OECD Health Policy Studies

(4) Alcohol's Economic Harm Causes Concern for German City of Dortmund - Movendi International

(5) Ibid.

(6) Ibid., 19.

1.3 CONCLUSION

In breaking the vicious circle of harmful alcohol consumption and social vulnerability, it is clear that an integrated policy approach is needed to address different push and pull factors. It will need to address both the individual level where the two-way relationship emerges and the macro-level of policies and regulations. In this integrated approach the role of public services, namely education, health care, and social protection, is of utmost importance. In addition, individual or community-based support to address the issues such as mental health needs more attention.

When considering available options to reduce the harm caused by alcohol consumption, the price incentive is the main option available. In addition to the improvement to access to public services and to community-based support, interventions on the prices of alcohol are among the most effective harm reduction alternatives as illustrated in more detail in Part 3. It can be also combined with an option where the alcohol sellers will have to offer non-alcoholic drinks for lower prices than alcoholic ones.(1)

However, the price regulations are likely to be more complicated. There are 5 defined problems connected with the alcohol price policies: the relationship between price and income growth, domestic counterfeit and illegal alcoholic products, cross-border purchases, alcohol tax, and price manipulation by end sellers.(2)

The first issue is due to the fact that "*if the price remains the same, despite rising incomes, consumption will increase. If the price remains the same while the relative price of other goods in the shopping basket increases, consumption also increases.*"(3)

The biggest issue regarding the fiscal policy is that every EU member state has different fiscal policies which pressure the neighbouring citizens of a current state to buy alcohol cross-border, wherein the neighbouring state is the alcohol cheaper.(4)

Regarding the increase of the taxes on alcohol, there is a possibility that the alcohol prices will not be higher. Such a situation is because producers and retailers are likely to hold the prices at a lower level than is expected, or the end sellers may manipulate prices to increase their incomes by lowering the prices under the production costs. Therefore, it can be set a minimum price of sold alcohol per gram. It may bring a more efficient tax increase which could also pressure alcohol-addicted people to convince them to buy less alcohol.(5)

(1) Úřad vlády České republiky, „Zaostřeno: alkohol – opomíjená závislost", *Národní monitorovací středisko pro drogy a závislosti*, No. 1, (Prague, 2/4/2016), 3, https://www.drogy-info.cz/data/obj_files/29004/705/Zaostreno_2016-01_v03.pdf (accessed 8/14/2022).

(2) Úřad vlády České republiky, *Zaostřeno: alkohol – opomíjená závislost*, 3.

(3) Ibid., 3.

(4) Ibid., 3.

(5) Úřad vlády České republiky, *Zaostřeno: alkohol – opomíjená závislost*, 3.

2. TOBACCO

2.1 SOCIAL AND HEALTH CONSEQUENCES OF TOBACCO USE

In the case of the use of tobacco, the body of knowledge concerning the two-way relationship between smoking and socioeconomic status has been largely asymmetric. Whilst there has been robust evidence regarding the prevalence of tobacco smoking in more disadvantaged groups in society, the impact of smoking on the socioeconomic status of individuals and households proves to be more complex and less tangible compared to alcohol use. According to existing international surveys, the concentration of tobacco users in vulnerable groups has increased compared to other social groups over time. While smoking prevalence has been declining in the general population in the most developed societies (Europe, the US, Japan, etc.), the situation in vulnerable groups remains relatively unchanged. In general, there is a direct link between smoking and socioeconomic status – the level of nicotine/smoking addiction increases as social vulnerability and deprivation increase.(1)

On the other hand, the understanding of reversed causal relationship, i.e. how smoking impacts socioeconomic status is less documented by existing research and demonstrates substantial complexity of effects of individual factors. Indeed, there has been strong evidence that smoking is the main cause of premature death worldwide. In addition to having a serious impact on physical health, it is associated with mental health issues, even though more research will be needed to understand the mutual effects of smoking and the mental health of individuals. Also, harms emerging from smoking are not just internal, for the user only, but they have secondary effects as they harm other people around the smoker. In the existing research, therefore, two criteria of tobacco smoking harm were established: "*to users*" and to "*others*", continuing in the division to other, more detailed criteria (see Graph 1). Then, there is a table that extends such criteria into much bigger details (see Table 5).(2)

Health-related risks of tobacco smoking remain the most relevant in the context of the two-way understanding of the relationship between the use of addictive products and socioeconomic status. Increased risks of serious health problems also increase social and economic vulnerability through higher sickness rates, increased health care costs, and increased risk of premature death of one of the members of the household. Weak health, especially frequent illnesses, represents an additional economic burden on disadvantaged groups, hence contributing to inequalities. In addition, however, it is necessary to improve our understanding of the crowding-out effects of tobacco smoking where relatively little data are available to propose any serious causal relationship between smoking and socioeconomic status.

(1) McNeill A. et all (2015), p. 40.

(2) Nutt, Phillips et al., *Estimating the Harms of Nicotine-Containing Products Using the MCDA Approach,* 220.

2.1.1 INEQUITIES CAUSED BY TOBACCO SMOKING

In general, tobacco-related harms contribute to increased inequalities through similar effects as described in the connection with alcohol-related harm inequities (socioeconomic context, different exposures, etc.). Nonetheless, there are important differences between the two risk factors – tobacco smoking and harmful alcohol use. Alcohol addiction has direct and more tangible social impacts such as less stable partnerships, higher prevalence of domestic violence, negative impacts on the social behaviour of individuals with possible economic consequences, etc. On the other hand, the impacts of tobacco smoking are largely indirect and caused by higher risks of health problems that could undermine or further worsen the socioeconomic situation of individuals and households. In particular, tobacco smoking increases significantly the risk of chronic diseases which in consequence deepens socioeconomic vulnerability by increasing the risk of long-term unemployment, lower household income, and also less stable working conditions. Levels at which health inequities can arise and be addressed, and other steps regarding the inequities, can be found in the diagram and other graphs included in the section on the alcohol topic, which is described in the same approach. (1)

At the same time, tobacco users and their relatives are also exposed to additional live stressors related to smoking. For instance, these are related to decreasing social acceptance of smoking (for example smoke-free workplaces, etc.). Moreover, these stressors can be related to the constraints on household budgets where the costs of tobacco smoking have serious crowd-out effects on other essential expenses or even on the indebtedness of the individual and household. Nonetheless, these are still relatively under-documented factors, and more research will be needed if we are to better understand all possible negative impacts of tobacco smoking on socio-economic status.

In general, the same approach to smoking policies can be recommended as in the case of alcohol use. At the macro-level, the attention to improving access to public services and community-based support can tackle some of the root causes of tobacco smoking. In addition, targeted interventions and support for individuals especially in their cessation efforts can be optimized. Last but not least, a number of harm reduction options can complement both macro-level policies and targeted support.

(1) Belinda Loring, „Tobacco and inequities: Guidance fr addressing inequities in tobacco-related harm", World Health Organization, Regional Office for Europe, (2014), 12, https://apps.who.int/iris/handle/10665/344628 (accessed 09/19/2022).

2.1.2 INTERVENTIONS TO TACKLE VULNERABILITIES CAUSED BY TOBACCO SMOKING

Whilst more research will be needed to improve our understanding of the complex link between tobacco smoking as a risk multiplier of social and economic vulnerability, it is rather accepted that a holistic approach will be required to address the main risks, especially those related to the health impacts of smoking. Any holistic approach will need to take as a point of departure the fact that the prevalence of smoking is higher in more disadvantaged groups of society. Indeed, multiple reasons explain this evidence, but low level of awareness, lower education, and poverty-related stress are among the factors most often referred to in existing research. Having taken this evidence into account, any approach to improve the situation requires "*shifting macro-level policies to a longer-term focus to reduce poverty and promote resilience*"(1) in order to tackle the root cause of the increased probability of tobacco smoking. It is the most comprehensive long-term solution to the negative both-way causal relationship between tobacco smoking and social and economic vulnerability. At the same time, it requires the mobilisation of substantial resources and strong socio-economic policies with effects materializing only in the mid-term to long-term horizon.

Therefore, it is considered necessary to accompany the comprehensive modification of macro-level policies with targeted interventions and strategies to reduce tobacco smoking and its consequent negative impacts. In this respect, it is also necessary to ensure that these strategies fully take into consideration existing inequalities in order to proportionately improve the situation of most disadvantaged social groups by facilitating access to public services, assistance, and support from treatment to harm reduction options. In the case of smoking cessation support, there are inequities in access to such support, especially when there are socio-economic vulnerabilities in play. Members of disadvantaged social groups have lower access to information about the support and treatment of tobacco addiction. Other evidence also shows that there is a lower level of support for smoking cessation compared to better-off social groups that are often actively searching for medical treatment or other kinds of support available for the cessation process. At the same time, there needs to be more support for targeted intervention based on different challenges in different periods of life which acknowledge the social context in which addiction emerges. Also, financial and other economic barriers caused by inequalities need to be addressed to improve access to interventions that can eliminate or reduce the risks associated with tobacco smoking.(2)

Moreover, any comprehensive approach needs to provide individualized options that will aim to improve one's situation including access to less-harmful alternative tobacco products. According to the number of existing surveys and studies, nicotine dependence increases with the increase in social and economic deprivation and vulnerability. When taking this fact into account, any comprehensive approach needs to strike a balance between optimal outcomes and realistic outcomes of dependence reduction. In this regard, the issue of the flexible application of harm reduction strategies comes into discussion even though there is a number of open questions about their practical implementation and compatibility with other strategies. Nonetheless, there is evidence which shows that that harm reduction policy, while sub-optimal, contributes by either decreasing the number of cigarettes consumed or by increasing the probability of cessation attempts by tobacco smokers.(3)

In addition, harm reduction strategies need to take into account social inequalities as a relevant factor. Firstly, the lower level of awareness and access to information in disadvantaged social groups are relevant and should be reflected when designing harm reduction strategies and corresponding regulatory frameworks for alternative tobacco products. Secondly, the existing inequalities represent barriers to the acceptance of options that can reduce risks related to health and indirectly to the socio-economic situation of individuals or households due to financial considerations.

(1) Loring, *Tobacco and inequities: Guidance for addressing inequities in tobacco-related harm*, 14.

(2) Loring, *Tobacco and inequities: Guidance for addressing inequities in tobacco-related harm*, 19.

(3) See for example McNeill A. et al. (2015)

2.2 SMOKING AND HARM REDUCTION STRATEGIES OF SELECTED EU MS

2.2.1 CASE STUDY – CZECH REPUBLIC

In the Czech Republic, a number of interventions have been promoted to reduce tobacco smoking, support smoking cessation, or to prevent individuals from starting to smoke. Most of these interventions and measures are based on age limitation, area limitation[(1)], product limitation regarding tobacco smoking and its selling, tax policy, and restrictions on advertising showing tobacco products. Nonetheless, these measures were not implemented in a comprehensive way or as a part of a holistic approach to various factors involved in tobacco addiction development. 2019-2027 National Strategy on Addictive Behaviour Prevention and Harm Reduction represents an effort to remedy some of these deficiencies. In particular, it attempts to provide a more integrated approach to a number of problems associated with tobacco smoking.

While a broad spectrum of issues is considered in relation to tobacco smoking, the Strategy gives clear preference to tobacco control and smoking prevention measures. Six key interventions are defined and prioritized in the Strategy: monitoring of tobacco use and prevention policies; protection from tobacco smoke; offering assistance in cessation of tobacco use; warning of the dangers associated with tobacco use; enforcing a ban on tobacco product advertising, promotion, and sponsorship; raising tobacco taxes.[(2)]

The Strategy also acknowledges the potential role to be played by the harm reduction measures that are already implemented in some countries. In particular, the potential of alternatives, such as e-cigarettes or orally used tobacco, for reducing the health risks and in assisting in cessation efforts are considered relevant to the goals of the Strategy. As the following part (Section 3) illustrate, it is also necessary to take into consideration perceptions and attitudes, especially when it comes to the most vulnerable social groups. The overall picture becomes more complex when for example the priorities in terms of optimal outcomes are confronted with barriers on the side of regular smokers. The Strategy outlines uncertainties regarding the harm reduction measures, which will need to be addressed by bringing in more evidence. It is in line with the European Parliament Resolution on Strengthening Europe in the fight against cancer.[(3)]

In addition, the existing strategic framework for tackling risks associated with tobacco smoking does not reflect in detail on socioeconomic causes which are often related to the increased stress of individuals that is translated into an increased tendency to use tobacco as a way to relax or ease the stress (see Section 3). In this regard, the Strategy does not cover the relevance of macro-economic policies that are considered to be an integral part of successful long-term solutions to the harm that smoking causes to society and individuals.

(1) By the area limitation regulates which retailers are allowed to sell any type of tobacco products, smoking aids, herb products made for smoking or e-cigarettes. These products can be offered only in shops.

(2) SEKRETARIÁT RADY VLÁDY PRO KOORDINACI PROTIDROGOVÉ POLITIKY, *National Strategy on Addictive Behavior Prevention and Harm Reduction 2019-2027*, 49.

(3) European Parliament resolution of 16 February 2022 on strengthening Europe in the fight against cancer – towards a comprehensive and coordinated strategy, (2020/2267(INI)).

2.2.2 CASE ANALYSIS – POLAND AND GERMANY

POLAND

In comparison with the Polish approach to alcohol, in the case of smoking, Poland has a wider tobacco harm reduction strategy, the implementation of which is not left to local authorities only. Ministry of Health publishes the "*Program for Limiting the Health Consequences of Smoking Tobacco in Poland*", set over a period of 4 years. There are 6 main areas focused on tobacco smoking: monitoring, protection against tobacco smoke, treatment of tobacco addiction, and information campaign against tobacco smoking; and the last two areas are focused on marketing and economic affairs.(1) There is no change in the sense that Polish Government would be focused on tobacco differently than in the alcohol harm reduction strategy.

The first task, monitoring, is set to take focus on several aspects: on Polish residents older than 15 years, monitoring of tobacco cultivation, searching for harmful tobacco species, and controlling the additives coming from tobacco.(2)

In the task of the protection against tobacco smoke, it is stressed that every citizen has a right to protect his/her own health and be protected from second-hand smoke. Thus, several points are established regarding this right such as: improving current legislature, creating an information campaign alongside new law solutions, addressing local authorities to create non-smoke areas, or also creating protections against tobacco smoke in workplaces in the light of safe and hygienic conditions. (3)

The tobacco addiction treatment task takes medical advice, helplines, and specialist therapies to support quitting smoking. Family doctors, cardiologists, pulmonologists, and other specialists should be prepared to interact with their patients in the sense of primary care of tobacco smoking, for example, to make therapeutic measures. The main goal is to organize courses for training the hospital personnel, improve access to specialized therapies for people addicted to smoking, and establish a helpline centre for smokers.(4)

Strongly connected is the information about the health risks coming from smoking taken as an effective approach to convince people to quit smoking. There are several events described in this task regarding the information campaign: "*World No Tobacco Day (announced by the WHO, addressed to the general public), World Stop Smoking Day*", and several conferences.(5) The last two tasks are close to the Czech implications, the limiting advertisements, and the tax policy. The advertisement needs to be eliminated as much as it can be alongside the elimination of any kind of tobacco products promotion. Such two main steps are the main key anti-tobacco implications. Another strategy, tax policy, is then considered to be the most successful implication on tobacco products, mainly focused on poor socio-economic groups, children, and young people.(6)

(1) Rada Ministrów, „Program Ograniczania Zdrowotnych Następstw Palenia Tytoniu W Polsce: Cele I Zadania Na Lata 2014-2018", (2013), 20-26, https://www.gov.pl/attachment/29b8cd5f-5c85-4cc5-acc7-2c3a4e1dd1a4 (accessed 10/10/2022).

(2) Ibid., 20.

(3) Ibid., 22.

(4) Ibid., 23.

(5) Ibid., 24.

(6) Rada Ministrów, Program Ograniczania Zdrowotnych Następstw Palenia Tytoniu W Polsce: Cele I Zadania Na Lata 2014-2018, 25-26.

GERMANY

In the context of the EU, and even compared to the Czech and Polish strategies for tobacco control and harm reduction, Germany´s approach was and to large extent is rather light-handed and limited in its scope and ambitions. It can be largely explained by the long-term tradition of industry self-regulation, but also by cultural and historical factors [1]. And while progress has been certainly achieved in the past two decades, Germany falls behind most of the European Union member states when it comes to the introduction and implementation of measures that could improve the situation regarding tobacco smoking. It is not, therefore surprising, that Germany scored the lowest on the Tobacco Control Scale among all EU countries.[2]

As in the case of alcohol, the priorities for the prevention, control, and reduction of the risks of tobacco addiction are outlined in the National Strategy on Drug and Addiction Policy. Its main motivation is the prevention of health problems and especially premature death caused by tobacco smoking. Therefore, it defines the general goal of reducing the share of smokers both among children and adolescents, as well as among the adult population. In order to achieve this goal, the Strategy identifies five sets of measures to be implemented in order to protect individual groups, namely children, adolescents, and non-smokers. When it comes to adult tobacco smokers, the German approach is based on the one hand on risk awareness and on the other hand on improving counselling measures.[3]

While a number of goals of the National Strategy have been implemented, leading to progress in monitoring or health warning, the improvement in other areas has been rather moderate according to the recent WHO report.[4] It concerns cessation programs, taxation, or advertising. Therefore, accessibility remains one of the key challenges German authorities are expected to tackle.

At the same time, the priorities of the National Strategy do not address deeper causes of tobacco smoking. It does not provide guidance for macro-level policies with a focus on the relationship between socio-economic factors and the prevalence of smoking among vulnerable groups. In this context, it can be seen as one of the reasons why the prevalence of smoking is relatively higher compared to other European countries with similar socio-economic structures.[5]

When it comes to harm reduction strategies, they are not acknowledged in the National Strategy which focuses on prevention through counselling and other measures that aim to allow individuals to make more informed choices regarding cessation. At the same time, there are also a lot of misconceptions about harm reduction strategies and a lack of knowledge regarding the positive relationship between alternatives and cessation efforts.[6] In addition, a new tax on alternative products has been introduced since 2021 which confirms that German authorities do not consider harm reduction strategies to be complementary to existing measures.

(1) Hampsher S., Prieger J., Fuchs J., Hunt E., (2021) Smoking cessation in Germany: Drivers and Barriers. BOTEC Analysis. Available at: https://www.smokefreeworld.org/wp-content/uploads/2021/12/Germany%20Report%20Botec.pdf?_t=1640030104

(2) Joossens L, Feliu A, Fernandez E. The Tobacco Control Scale 2019 in Europe. Brussels: Association of European Cancer Leagues, Catalan Institute of Oncology; 2020. Available from: http://www.tobaccocontrolscale.org/TCS2019.pdf

(3) Drug Commissioner of the Federal Government (2012) National Strategy on Drug and Addiction Policy. Germany. P. 12.

(4) WHO (2021), WHO report on the global tobacco epidemic, available at: https://www.who.int/publications/i/item/9789240032095

(5) https://www.smokefreeworld.org/health-science-research-2/health-science-technology-agenda/data-analytics/global-state-of-smoking-landscape/state-smoking-germany/

(6) https://www.smokefreeworld.org/health-science-research-2/health-science-technology-agenda/data-analytics/global-state-of-smoking-landscape/state-smoking-germany/

3. HARM REDUCTION STRATEGIES IN VULNERABLE GROUPS - QUALITATIVE ANALYSIS

The study builds also on individual interviews that have been conducted with the representatives of different vulnerable groups. It includes single-parent families, members of minority groups, people in long-term unemployment, or individuals and households facing debts and risk of seizure. The aim is to illustrate their perspective on the relationships between their socioeconomic vulnerability and addictions. In addition, the research focused on their perception of health-related risks, attitudes to harmful behaviour, as well as awareness about the access and attitudes to alternatives for reducing risks associated with alcohol use and tobacco smoking. While the aim of this study is to improve our understanding of attitudes, the research did not have the ambition and scope to come up with a generalization of causal relations between socioeconomic factors and addictions which has been elaborated in the previous parts based on grey literature and desk research.

3.1 SOCIAL AND HEALTH-RELATED RISKS: AWARENESS AND PERCEPTION

The research has identified that there are important differences in risk perceptions in the case of alcohol use and in the case of tobacco smoking. While almost all interviewed persons were tobacco smokers, and smoking was considered socially more acceptable, the attitudes to alcohol were more diverse. The majority of respondents expressed concerns, even though often very vague, about the potential social impacts of alcohol abuse. Some of the respondents even had a negative attitude towards alcohol, which was based largely on personal experiences from the family or the social environment. In particular, the experience of negative impacts of alcoholism of partners or close relatives informed the preferences of individuals. As one respondent testified "*my dad was an alcoholic. Maybe that's why I don't like alcohol.*"

These general concerns over the negative impacts of alcohol use are declared by respondents to be among the reasons for restraint when it comes to their personal alcohol consumption. However, an interesting finding is that the perception of the amount of alcohol consumed by the respondents does not necessarily confirm restraints presented by respondents. None of them admitted that they had a problem with alcohol in contrast to tobacco. At the same time, the quantity of consumed alcohol was not small. It can indicate that the perception of what is and what is not an acceptable amount of alcohol is rather high among vulnerable groups. In addition, respondents often portray themselves in a better light in interviews and they are not always able to admit their problems to themselves. This was shown, for example, in a conversation with a couple, when he played down his problem with alcohol, while his wife admitted it. "*I would say that sometimes yes (the man has a problem with alcohol). He has trouble breathing, and it's not good to get drunk completely dumb.*"

While awareness of social risks and negative impacts on social relations associated with harmful alcohol use was relatively present in conversations, the health-related risks were considered to be less relevant. In particular, since most respondents were not aware of any problems with alcohol, they had no need to address them in any way. In some cases, they admitted that they were warned by their attending physicians about their increased alcohol use and its potential risks. In several cases, at the suggestion of a doctor and especially due to health problems, they limited their consumption for a certain period of time.

It would be possible to state that in the case of alcohol, social risks are perceived much more intensively in socially vulnerable groups than health risks associated with increased alcohol consumption. In the case of tobacco smoking, however, the picture is rather the opposite. While the majority of respondents considered smoking to be too large extent socially acceptable, at least from the perspective of impact on their social

relationships, such as with family members or with people in their neighbourhood or workplace, a general awareness of health risks was higher, and these risks were also taken more seriously by a large number of respondents compared to the health risks contributed to alcohol use. In order to identify the reasons for this differential awareness about the risks more detailed research will be needed.

While minor differences might be identified, both alcohol use and tobacco smoking are associated with relaxation on the one hand, or as a remedy to stress, even escape from problems. In the case of alcohol, it was perceived as a means of relaxation and associated with fun by a substantial part of respondents. Even respondents who considered themselves to be very restrained in alcohol consumption admitted that occasionally they drink during festivities or celebrations. "*I don't drink at all, but I was at a birthday party and I told myself that I was going to relax myself, that I needed to switch off. So, I had the hard alcohol*". It also applies to smoking as some respondents said. "*Some women go after work, hey, they go with some friends. So maybe they'll have a cake, a coffee, have a cigarette. You know how it is, right?*" At the same time both alcohol consumption and smoking I considered to ease stress or even to help overcome difficult life situations. "*I had problems with my wife, so I started at home (drinking again after he stopped).*" In the case of tobacco, stress was mentioned more frequently as the main reason for a person smoking. It can also explain why more respondents were not able to reduce their consumption.

3.2 POTENTIAL AND LIMITATIONS OF HARM REDUCTION STRATEGIES IN VULNERABLE SOCIAL GROUPS

One of the key goals of the survey has been to identify and analyse potential incentives that can trigger positive behavioural changes. It focused on three main potential sources of motivation for changing harmful behaviour. First, it assessed the perception and effects of information from professionals as well as access to relevant information about the social and health risks (see also above). Second, it inquired into the effects of price incentives on vulnerable groups' consumption patterns. Third, it focused on perceptions of the possibilities to reduce the risks associated with harmful, or addictive, behaviour.

When it comes to price incentives, the survey identified important differences in terms of their effects on either alcohol use or tobacco smoking. In this regard, the main finding is that there is generally a higher willingness and ability to reduce the consumption of alcohol in comparison to tobacco smoking. According to respondents' statements, they are able to give up alcohol use much easier. In particular when prices increase, or they do not have the necessary financial resources to buy alcohol. "*Not having alcohol, (choosing) between cigarettes..., just cigarettes, because I have cigarettes every day - as I smoke - and I don't need alcohol that much. Like I'll drink it cool, but I don't have to do it that much.*" Nonetheless, these findings can be determined by the fact that none of the respondents was highly addicted to alcohol even though they regularly consume alcoholic drinks.

Moreover, it also seems that the respondents are much more receptive to price signals in the case of alcohol compared to tobacco. When they have the funds, they can afford it and indulge in it. When they do not have the funds, they limit alcohol consumption or change consumption behaviour. On the contrary, the price elasticity of tobacco smoking seems to be lower compared to alcohol as one respondent confirmed in his response that *"when I really don't have it anymore, like I really don't, I'll borrow it from a girl. But it's not for the alcohol, but for the cigarettes or smaller home consumption.*" In addition, a number of respondents admitted that they are able to borrow money in order to buy cigarettes which was not the case for purchasing alcohol. In addition to making the consumption of alcohol more price-responsive, higher prices can also change the way alcohol is used. With higher prices, respondents confirmed that they tend to drink at home rather than consume alcohol in pubs or restaurants. Another strategy for how respondents reacted to increasing prices of alcohol was to buy cheaper brands or to buy alcohol on sale.

As for tobacco smoking, the situation can be illustrated by one statement from a male respondent who said that: "*I'm more like cutting it back… for now. I don't (I don't limit) cigarettes because I have to have them.*" It does not necessarily imply that consumers do not respond to the price signals or costs of smoking. Rather it can illustrate that for some respondent tobacco smoking is very strongly associated with relaxation or response to stress with little awareness about alternative ways of addressing these needs. It may also indicate that for respondents it is harder to imagine quitting or replacing smoking with less harmful and potentially less costly alternatives.

There are two main findings regarding the perceptions of the possibilities and available substations that can reduce the health and social risks associated with harmful, or addictive, behaviour. First, the respondents

expressed a relatively high level of mistrust in novel products or substitution alternatives both in the case of alcohol use and tobacco smoking. Although only a part of the respondents based their view on these alternatives on personal experience with them, the restrained attitudes were not necessarily influenced by experience only. At least three main reasons, why individuals with vulnerable backgrounds consider alternatives to alcohol drinking and tobacco smoking not particularly attractive, could be identified and possibly further explored in future research. Firstly, taste plays a role. A number of respondents who tested alternatives, such as non-alcoholic drinks or e-cigarettes, complained about the taste of these products and compared it with the taste of alcoholic drinks of classical cigarettes. Second, some expressed that these alternatives are often more expensive. Lastly, the attitudes of a number of respondents were informed by shared opinions rather than accessing and assessing relevant information about these products or consultations with experts as one respondent illustrated in the following statement: "*These are even worse! My brother, who is a year older than me, goes to the same doctor. And he switched to an electronic cigarette with nicotine, and when he took a puff, it was cherry flavoured. And believe me, because he had been smoking since he was 14 years old, his lungs were more clogged in a month than when he smoked normal cigarettes. So, I don't know which moron came up with it, if it damages a person's lungs even more*."

4. CONCLUSIONS AND RECOMMENDATIONS

The European Union is increasingly aware of the consequences of serious illnesses for European society. Europe's Beating Cancer Plan, as well as the attention paid to mental health at the EU level, are certainly going in the right direction. However, if the EU's ambitious targets are to be achievable and improve the state of health of the European population, it is essential to conduct an evidence-based political and public debate of both the causes of serious illnesses, the multitude of factors that need to be taken into account in addressing these problems, as well as influence of social and economic environment, all playing a crucial role in the development of serious physical illnesses or in the development of mental health problems. This study focuses on some of the key factors with serious impact on the alcohol use and tobacco smoking-related risks of increased health problems among groups with vulnerable socio-economic backgrounds in order to improve our knowledge about complexities that influence the increased health-related risks for the European population. At the same time, it highlights a number of factors that should be addressed in a more comprehensive way in order to enable the EU to deliver on its objectives and to improve the health of Europeans. It addresses two key levels where a holistic approach and sets of mutually complementary interventions and measures are needed: the macro-level (socio-economic level) and the level of individuals.

First, the study identifies a two-way relationship between socio-economic factors and the harmful use of tobacco and alcohol products. In particular, it tries to demonstrate the link between increased stress caused by inequalities, including poverty, marginalisation, or lack of access to public services, on the one hand, and alcohol and tobacco addictions on the other hand with mutually reinforcing effects. For example, increased stress and uncertainty caused by the vulnerable socio-economic situations of individuals, households, and communities contribute to increased risks of harmful use of alcohol and tobacco. While stress can be among the triggers of addictions, alcoholism or smoking can retroactively negatively influence socio-economic situation of vulnerable groups. In order to address this relationship, macro-level policies, including social policies and access to public services, need to take these factors into account in a more comprehensive way. At the moment, the linking of strategies aiming to improve the situation, especially regarding the health conditions of Europeans, and broader plans to tackle inequalities and social problems have not been mainstreamed and the connection of these two areas is relatively underdeveloped.

Second, the individual level needs to be also taken into account when designing effective policies to address risks related to addictions. When it comes to harmful alcohol use or tobacco smoking it concerns issues such as individual perceptions of health and social risks, misconceptions about possible less harmful alternatives, reactions to price incentives, or capacity of significant behavioural change. In the case of socially vulnerable groups, the influence of social context and socio-economic situation of individuals, both have an impact on these factors that can seriously jeopardize the effectiveness of measures introduced by public authorities across the European Union. It is also the gap between awareness and action that makes especially smokers less capable to opt for less harmful behaviour or to attempt cessation. More evidence will be needed to improve our understanding of the effects of these factors, however, a better balance between possible measures for prevention, treatment, and harm reduction should be seriously considered by the European Union and member states.

KEY RECOMMENDATIONS

1. *given the relevance of the interrelationship between addictions and socio-economic factors, mainstream addiction-related concerns into social policies of MSs and into measures targeting social and economic inequalities at the level of the European Union;*
2. *explore different tools at the EU level to better understand the link between socio-economic situation of individuals and households on the one hand and addiction on the other hand in order to improve evidence-based decision-making of both EU institutions and MSs;*
3. *integrate comprehensive socio-economic perspective into national strategies addressing harmful alcohol use and tobacco smoking;*
4. *improve access, especially through removing barriers and increasing availability, to public services, especially health care, education, counselling, for socially vulnerable groups;*
5. *given the announcement of the EU initiative on mental health, work to improve evidence-based policy-making and public awareness about the link between addictions and mental health as part of a comprehensive approach to mental health;*
6. *improve access to mental health services for most vulnerable social groups through targeted programmes and support to providers and to civil society organizations;*
7. *continue to work at the EU level at the implementation of the European Parliament´s recommendations proposed in its BECA report;*
8. *increase the scientific evidence about possible benefits and risks of harm reduction strategies;*
9. *address information deficit regarding harm reduction alternatives among the vulnerable groups prone to misconceptions and misinformation;*
10. *given the ongoing work on a revised EU tobacco regulatory framework and other initiatives within the European Health Union, it should be ensured that users are able to access harm reduction alternatives to alcohol and tobacco smoking in order to reduce risks and better protect the health of EU citizens.*

APPENDIX

ALCOHOL

TABLE 1. FACTORS IN THE SOCIOECONOMIC CONTEXT THAT SHAPE INEQUITIES AND INTERVENTIONS TO CONSIDER

Sources/drivers for inequities	Interventions to consider
Levels and distribution of poverty	• Social protection - increased spending on social welfare policies can mitigate the impacts of economic recession and unemployment on increased alcohol-related harm. • Early childhood investment - ensure every child gets the best start (high-quality early childhood education, parenting support, generous social protection).
Availability and affordability of alcohol	• Introduce pricing policies to raise price of alcohol, for example setting a minimum price per unit of alcohol (23) (Box 1). • Restrict new licences in areas of high licence density.
Effects of economic crisis and unemployment	• Set up active wokforce programmes and promotion of lifelong opportunities for education and skills training.
Drinking culture and gender norms *E.g. compared to women, men in Europe are likely to abstain, but they drink more frequently and in larger quantities and they expirence more alcohol-related harm.*	• Introduce measures to change harmful drinking cultures among certain groups (e.g. men, young people). • Build on strenghts (e.g. evidence from Roma populations suggets that higher levels of parental monitoring in a minority population living in high-poverty neighbourhoods can lead to less substance use).
Social exclusion/marginalization	• Implement community empowerment and skill development programmes to address broader issues of hopelessness and exclusion affecting groups with higher prevalence of harmful alcohol use. • Involve people from excluded groups in development and implementation of policies that allow them to fulfil their rights (e.g. to education, health, housing).

TABLE 2. HOW DIFFERENTIAL VULNERABILITIES COULD OCCUR AND INTERVENTIONS TO CONSIDER

Less resilience/support to cope with stressors *E.g. poor people, socially excluded groups and people who are homeless have fewer coping mechanisms.*	• Review how vulnerable groups are identified for brief alcohol interventions in the health care system. Ensure that those groups with excess vulnerability to alcohol-related harm are offered interventions (even if they are not in the groups with the highest levels of alcohol consumption).
Biological vulnerabilities *E.g. women are at greater risk of harm from the same level of consumption*	

TABLE 3. HOW DIFFERENTIAL HEALTH OUTCOMES COULD OCCUR AND INTERVENTIONS TO CONSIDER

Sources/drivers for inequities	**Interventions to consider**
Cost of access to care	• Provide universal health services. • Remove financial barriers for those who cannot pay (user charges, transport costs).
Non-financial barriers to accessing care *E.g. the United Kingdom National Institute for Health and Clinical Excellence (NICE) guideline on alcohol use disorders identifies a number of specific groups that require special consideration because their needs are not well met with mainstream services (e.g. young people, homeless people, ethnic minorities)*	• Simplify eligibility requirements and support provided to those without documentation. • Improve acceptability of services for high-risk groups (staff training, recruitment policies, gender and cultural sensitivity, opening hours, location of services). • Review the continuum of care pathway to ensure better links between health and social services for people at risk of poorer outcomes upon discharge from health care (e.g. homeless people; see for example Box 4). • Provide supported housing to people discharged from care.
Different treatment within the health care system *E.g. females with hazardous drinking pattern in Sweden are less likely than male drinkers with similar drinking patterns to be asked about alcohol use by their physician (34)*	• Train health professionals to ask more frequently about alcohol use and provide screening, early identification and brief advice interventions in primary care, including to groups with excess exposure to vulnerability. Review the equity in provision of this advice. • Change attitudes of staff, and create greater awareness of the distribution of alcohol related harm according to socioeconomic factors. • Accompany this with targeted measures to ensure that groups of the population are reached that would ordinarily be less likely to access primary care (e.g. homeless people, individuals without a general practitioner, and prisoners).

TABLE 4. TOBACCO PRODUCT HARMS

To users	• Product-specific mortality • Product-related mortality • Product-specific morbidity • Product-related morbidity • Dependence • Loss of tangibles • Loss of relationship
To others	• Injury • Crime • Environmental damage • Family adversities • International damage • Economic cost • Community

TABLE 5. DEFINITIONS OF THE EVALUATION CRITERIA FOR THE NICOTINE PRODUCTS

Name	Description
Product-specific mortality	Deaths directly attributed to product misuse or abuse as in the case of accidental and deliberate poisoning.
Product-related mortality	Deaths indirectly attributed to the product, e.g. death due to cancer, respiratory illness, cardiovascular disease and fire.
Product-specific morbidity	Damage (morbidity, chronic ill health) to physical health directly attributed to product misuse or abuse, e.g. ulcers, lung disease, heart disease.
Product-related morbidity	Damage to physical health indirectly attributed to product misuse or abuse, e.g. burns, allergies.
Dependence	Extent to which the product creates a propensity or urge to continue use despite adverse consequences and causes withdrawal symptoms on cessation.
Loss of tangibles	Extent of loss of tangible things (e.g. income, housing, job).
Loss of relationship	Extent of loss of relationship with family and friends.
Injury	The extent to which the product increases chances of injuries to others both directly and indirectly, e.g. traffic accident, fetal harm, second-hand smoke, accidental poisoning, burns.
Crime	The extent to which the use of the product increases criminal behaviour (e.g. smuggling) directly or indirectly (at the population level, not the individual).
Environmental damage	The extent to which the use and production of this product causes environmental damage locally, e.g. fires, competition for arable land, cigarette stub pollution.
Family adversities	The extent to which the use of the product causes family adversities, e.g. economic well-being, future prospects of children.
International damage	The extent to which the use of the product contributes to damage at an international level, e.g. deforestation, contraband as criminal activity, conterfeiting.
Economic cost	The extent to which the use of the product results in effects that create direct costs to countries (e.g. health-care costs, customs) and indirect costs (e.g. loss of productivity, absenteeism).
Community	The extent to which the use of the product creates decline in social cohesion and decline in the reputation of the community.

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