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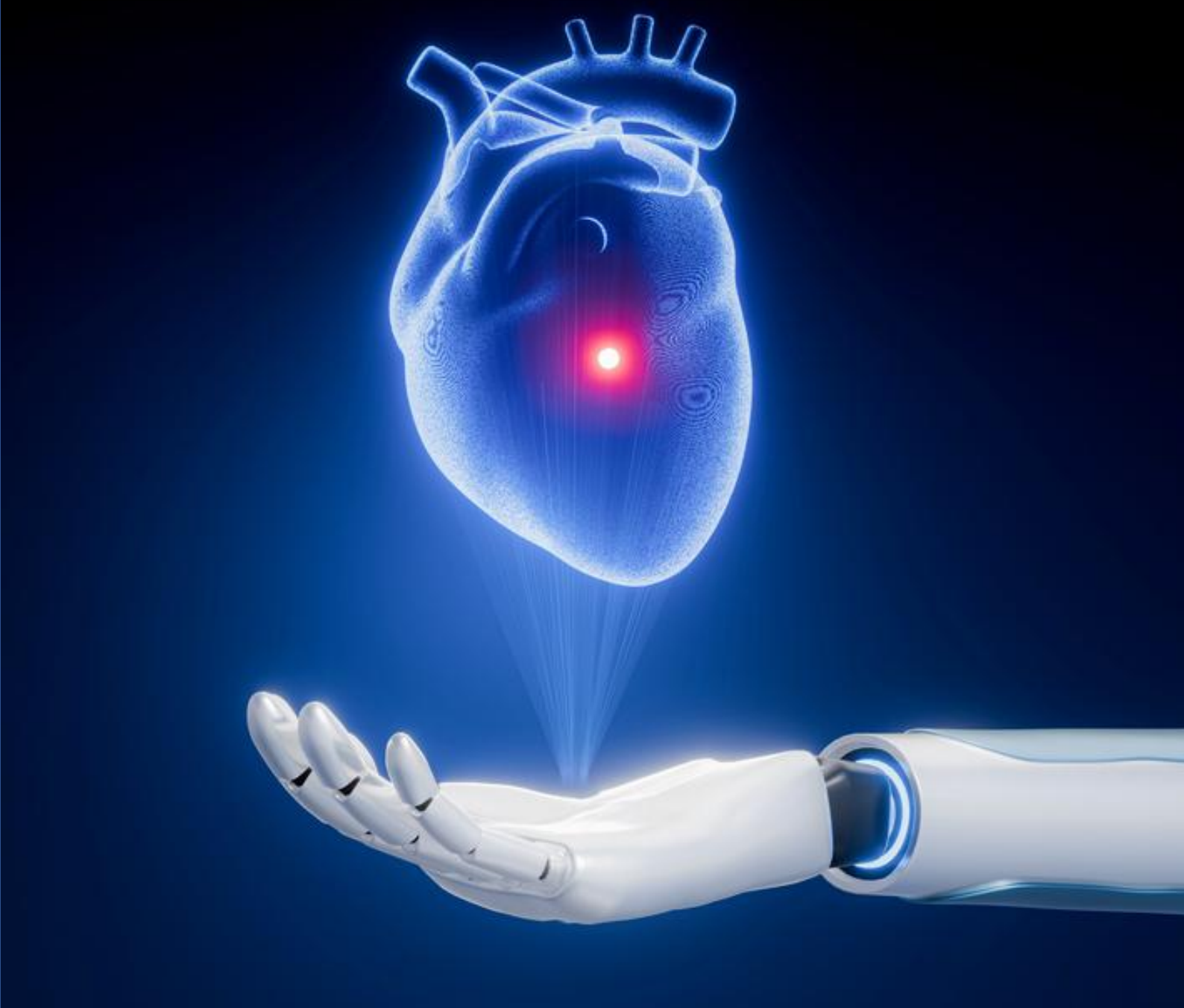
MAGAZINE SPRING 2025

Artificial intelligence in healthcare



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Global co-operation on health more important than ever

For over 65 years, our association's work has been based on the principle that collaboration between countries on health is overwhelmingly beneficial for everyone involved.

In an increasingly turbulent geopolitical landscape, the value of global solidarity in health is questioned. Political instability, wars, and conflicts are testing the resilience of our collaboration. At a time when health should be a unifying force, it is instead becoming victim of political division and conflict.

Now is a decisive moment for health policy at both European and global levels. As stakeholders, we must advocate for solidarity in public health.

As a profession, we stand together with the healthcare professionals who put their lives at risk to serve patients in warzones. We support those who provide evidence-based medicine at a time when misinformation is proliferating. We reach out for cooperation and finding solutions together at a time when division and self-interests are becoming more prevalent.

The bottom line is that the benefits of European cooperation far outweigh any costs, and failing to collaborate only makes future crises worse. The real question isn't "Should we collaborate?" but "How can we do it more effectively?". Now is a time to elevate health above politics, to achieve a consensus around cooperation on health that can outlast political volatilities.

Dr Ole Johan Bakke
CPME President


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Advancing European doctors' voice in European health policy-making

Dr Ole Johan Bakke
CPME President

In January, I was honoured to take office as CPME President, chairing a new Board of Directors for the next three years.

We are lucky to have a diverse and experienced team to express European doctors' voices at a time of challenges to both the medical profession and Europe as a whole.

I am honoured by the confidence shown in me by being elected President of CPME. I promise that I will give time, energy and dedication to our mission of contributing the medical profession's point of view to European policy-making.

The Board of Directors 2025-27 from left to right: Dr Andreas Botzlar (Germany), Dr Kitty Mohan (United Kingdom), Prof. Dr Ray Walley (Ireland), Dr Ole Johan Bakke (Norway), Dr Péter Álmos (Hungary), Dr Jacqueline Rossant-Lumbroso (France), Dr Christiaan Keijzer (Netherlands)

Last year, we published our Health Check 2024-2029, which outlines European doctors' five ambitions to build a coherent long-term vision for health in Europe and beyond for equitable access to healthcare for patients.

As a Norwegian, I am keen to stress that our vision is not only confined to the European Union. Our membership encompasses associations from Iceland to Turkey, and we are united by the shared challenges of the medical profession.

The health sector benefits from European cooperation, from equal rights for health personnel across the continent, and as we have witnessed during the pandemic, health crises recognise no borders.

Our mandate starts at a critical moment; doctors' working conditions and autonomy are threatened in several, and different, ways across our continent.

Healthcare systems, both in hospitals, private practice and primary care are facing challenges in the form of inadequate financing, poorly organised services and dysfunctional electronic systems. These create unnecessary obstacles for both doctors and patients.

The healthcare sector does not recruit as needed, neither to serve our populations, nor to give proper working conditions to healthcare professionals.

If we do not have the necessary staff, our work to ensure proper working conditions for physicians will have little effect.

We have to stand up for our colleagues and member organisations.

From left to right: Dr Ole Johan Bakke (CPME President), Olivér Várhelyi (European Commissioner for Health and Animal Welfare) and Sarada Das (CPME Secretary General)

In February, I met the new European Commissioner for Health and Animal Welfare, Olivér Várhelyi. I presented our ambitions for the new EU mandate and reaffirmed the medical profession as a committed partner in achieving them.

I was pleased to note that many of our priorities are present in the agenda of the incoming European Commission.

We welcome the mission to continue building the European Health Union and the inclusion of priorities such as antimicrobial resistance,, mental health and the European Health Data Space.

However, the absence of any mention of the health workforce is a glaring omission. Doctors across Europe are still recovering from a global pandemic which left them stressed, strained and overstretched as well as being exposed to pre-existing problems with working conditions.

We must prioritise the health workforce when setting our political agenda.

In addition, tobacco regulation, alcohol labeling and the environmental impact on human health, and more action on prevention are incredibly important. CPME must continue to be a clear voice in health policy, from medical associations across the continent.

Our political work with the European institutions, our member organisations and fellow European medical organisations is more important than ever, to ensure health is given top priority.

In a time when political focus is often elsewhere, we must do our job to bring focus on the heath sector. Our population needs it, they deserve it, as well as our fellow doctors.

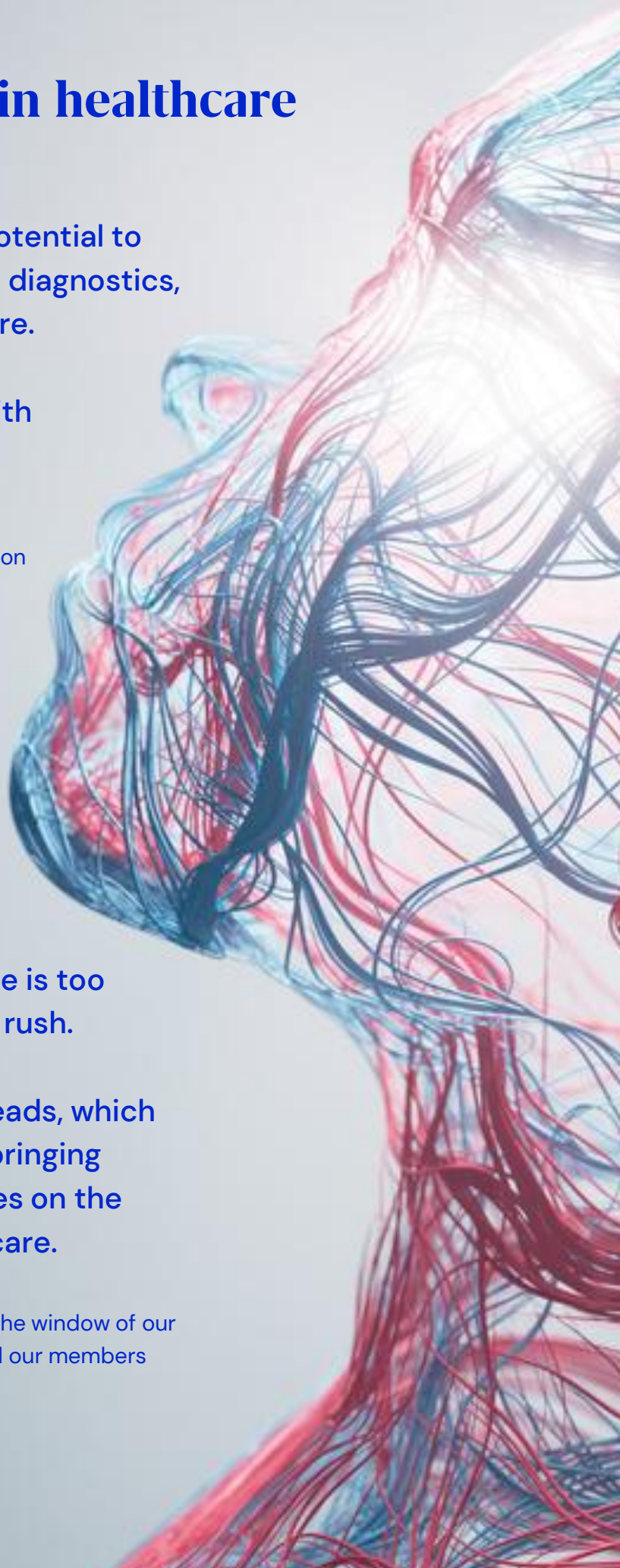
Artificial intelligence in healthcare

Artificial Intelligence (AI) has the potential to transform healthcare by improving diagnostics, treatment planning, and patient care.

However, its deployment comes with challenges.

Addressing these challenges requires collaboration between technology developers, healthcare professionals, and policymakers to ensure AI enhances, rather than hinders, patient care.

The regulatory challenge is not whether AI should be integrated into medicine—it is how to balance patient safety with the breakneck speed of innovation.



A paradox emerges: AI in healthcare is too powerful to ignore, but too risky to rush.

The result is a tangled mesh of threads, which we start to unravel in this edition, bringing recommendations and perspectives on the further deployment of AI in healthcare.

We take a deep dive in AI in healthcare through the window of our recently published policy paper on the topic and our members conference at our recent General Assembly.

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Recommendations for artificial intelligence to meet the needs of clinical practice

Sara Roda
EU Senior Policy Adviser

In November 2024, the CPME General Assembly adopted a policy paper presenting the European doctors' views on the deployment of artificial intelligence (AI) in healthcare.

This policy addresses sector-specific challenges for the low uptake of AI in healthcare and key recommendations to accelerate its uptake.

European doctors see the use of AI and digital tools with high hopes, as a way to improve the quality of care and clinical practice, not innovation *per se*.

AI aimed at reducing administrative burden is very much welcomed, to alleviate healthcare professionals from other working pressures, allowing more time to be spent with patients.

CPME policy distinguishes two main categories of AI:

1. Those aimed at optimising administrative or workflow processes, such as speech-to-text systems or scheduling algorithms; and

2. Those designed to support clinical decision-making processes, including tools used for diagnosis and the development of treatment plans. Predictive AI also fits under this category.

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The low uptake of AI is the result of a complex and fragmented healthcare environment, making it very difficult to spread technology across organisations and specialties.

Then there is a wide offer available on the market, where most systems are not certified by a third party.

This does not ensure a safe and trustworthy system for healthcare professionals.

Moreover, doctors do not feel confident in using a system from unknown data sources, or unknown data collection processes, and where the data quality can be questionable.

Doctors are also reluctant to provide access to health data for AI training purposes if it could be easily related to a patient.

Finally, the amount of time it can consume (where the transitioning period can be very resource-intensive), the poor design not adapted to healthcare professional needs, and the high-level investment it requires (e.g. specialised staff, training, licence cost and renewal, among other).

AI which supports clinical decision-making is the main focus of the paper's recommendations.

Our policy explored different angles of action. In this article, we summarise three main areas:

(i) **Recommendations related to the autonomy and independence of the medical profession**, such as a) the right to freely decide to use or not to use an AI system, without repercussions, bearing in mind the best interests of the patient; b) the right to disagree with an AI system, also without repercussion; and c) not to deploy AI to replace or compete with health professionals, nor to diminish patient autonomy and shared decision-making;

(ii) **Recommendations related to technical aspects**, such as a) design AI on actual healthcare demands, ensuring meaningful engagement of healthcare professionals, where results are fed into the system in a dynamic loop to improve it; b) evaluate AI efficiency and efficacy, where cost-benefit analysis criteria was proposed; b) certify AI-driven software to increase trust; and c) promote reliability of data sets in healthcare and transparency from manufacturers about the underlying training data.

(iii) **Recommendations related to educational aspects**, such as a) demystify AI by improving AI literacy and foster competence development; b) mitigate deskilling risks and ensure critical thinking, while also avoiding 'automation bias' by the medical profession; c) establish knowledge environments of sufficient scale and clinical expertise within national settings, coordinating AI research collaboration at national and EU level.

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In conclusion, the deployment of AI cannot mean a disinvestment in other areas of healthcare systems.

Retention and recruitment of health professionals needs to be a priority as well as safe staffing levels and good working conditions to enable time and capacity for training clinical practice.

Patients' awareness and consent of AI system usage is an ethical requirement to be upheld in the patient-doctor relationship.

Three take-home messages on the use of technology in healthcare

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During the CPME General Assembly in Amsterdam in November 2024, the Royal Dutch Medical Association (RDMA) celebrated its 175th anniversary, with a conference where experts exchanged views on the European doctor and digital health.

The speakers addressed the conditions and opportunities of technology for healthcare. We summarise three key conclusions.

In his opening address, Dr. René Héman, (Outgoing RDMA President) outlined a vision for the future of the medical profession in 2040, including urging doctors to nurture critical thinking and challenge established norms. He noted that not every innovation is an improvement and not everything new is good. A balance was needed between 'high tech' and 'high touch'. He called for unity and international cooperation to build resilience and address future challenges together.

Abigail Norville (Deputy Secretary General of the Dutch Ministry of Health, Welfare, and Sports) highlighted Dutch advances in healthcare digitalisation, including the European Health Data Space (EHDS). She stressed the importance of securely sharing medical data, the trade-offs towards data solidarity, and ensuring interoperability to maximise the benefits of digital tools.

1. Technology must improve healthcare

Abigail Norville underscored the importance of steering AI development toward enhancing healthcare and improving lives. She highlighted a key benefit for doctors: the potential to reduce administrative burdens, allowing more time to focus on patient care.

Corette Ploem (Professor of Law, Care Technology and Medicine at the University of Amsterdam) emphasised how AI can revolutionise patient care by advancing personalised medicine. She pointed out that, unlike humans, AI is not affected by fatigue, stress, or impatience—factors that often influence healthcare outcomes.

However, Ploem also acknowledged challenges in leveraging AI to improve care. For instance, AI's ability to detect medical abnormalities can sometimes create unintended burdens, such as identifying conditions for which no treatment is available, potentially adding to a patient's mental distress.

Henk Marquering (Professor of translational AI at Amsterdam UMC) recognised the growing number of success stories, showcasing the use of AI tools in healthcare. However, he cautioned against overlooking significant challenges.

Marquering pointed out the current lack of robust evidence proving the value of AI in clinical practice and the unresolved liability issues that could emerge. Additionally, he emphasised the high costs associated with implementing AI in healthcare, compounded by the absence of reimbursement systems to support its adoption.

Abigail Norville, Deputy Secretary General of the Dutch Ministry of Health, Welfare, and Sports

2. AI should support doctors, not replace them

Corette Ploem advocated for AI to serve as a supportive tool, enhancing doctors' work and ensuring that doctors retain responsibility for medical treatment.

The panel collectively agreed that being a good doctor means ensuring AI remains a tool to support, not substitute, their role.

While AI can streamline processes and improve efficiency, human contact and empathy remain irreplaceable elements of the patient-doctor relationship.

From left to right: Dr Christiaan Keijzer, Tomar Sharon, Henk Marquering, Corette Ploem and Dr. René Heman

3. Address Big Tech and AI risks in healthcare

Corette Ploem emphasised that existing regulations, such as the GDPR and AI Act, do not specifically address AI in healthcare. She highlighted the risks AI poses to data protection, as it relies heavily on patient data to function effectively.

To mitigate these risks, Ploem called for professional guidelines to ensure doctors understand their duties and responsibilities when using AI. She stressed that AI in healthcare must comply with strict safety standards, maintain high healthcare quality, and ensure doctors retain oversight of its use.

Tomar Sharon (Professor of Philosophical ethics and political philosophy at Radboud University) warned of the growing 'Googlisation of healthcare' where companies like Apple and Amazon increasingly provide privatised healthcare services.

While some companies comply with privacy and data protection rules, others do not, raising significant concerns.

Sharon highlighted the implications of this trend, including non-equitable returns to the public sector. For example, paying twice for both for the funding development of datasets and buying models developed by the company, as well as clashes between tech and healthcare expertise and increased societal dependence on these companies for basic services.

To address these challenges, Sharon stressed the need to look beyond privacy risks, into Big Tech risks in healthcare.

She urged healthcare professionals to critically evaluate whether technology is the appropriate solution and, if so, to prioritise non-commercial, non-U.S based alternatives. She concluded that digital sovereignty and autonomy for the digital healthcare sector in Europe need to become a core priority.

Keep standards high for quality of basic medical education

In November, European doctors adopted a policy on the quality of basic medical education, calling for authorities at the national and European level to take action to safeguard the high standards of medical education.

Against the background of an ongoing health workforce crisis, we underline the central importance of high-quality medical education and training to maintain functioning health systems. National, European and international responsibilities to assure and continuously improve quality must be translated into action. It was reaffirmed that a lack of adequate number of health professionals is not a justified reason to lower qualifications and training standards.


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European doctors oppose any reduction of the minimum training requirements set out in the EU Professional Qualifications Directive and underline that these represent minimum standards.

CPME encourages regular reviews of curricula and enforcement of legislation.

Topics such as prevention, sustainability, well-being, and the use of artificial intelligence are essential areas for curriculum updates. Medical students should understand the benefits and limitations of digital health for patients, telemedicine and mobile health as well as understand the ethical and legal implications of digital health tools.

Dr Martin Balzan said "High quality basic medical education is a cornerstone in attracting students to medicine as well as for preparing them to become competent, and practice-ready doctors who are adaptable to real-world challenges."

Strengthening disease prevention through clean air: A unified call to action from health groups

The EUHAC brings together non-profit health expert voices in the EU to advocate for better health for all through clean air. CPME is a founding member.

More info: https://healthyaircoalition.eu/

On 28 January, CPME and the other members of the EU Healthy Air Coalition (EUHAC) organised a high-level policy outlook at the European Parliament, hosted by MEP Javi López, a Vice-President of the European Parliament, to emphasise the critical role of strengthening disease prevention through clean air action.

The evidence is clear – air pollution remains the top environmental risk to health in Europe, resulting in hundreds of thousands of premature deaths, avoidable ill-health, and hundreds of billions of euros in costs annually.

With speakers from various EUHAC founding members as well as key clean air action leaders like Veronica Manfredi (Director for Zero Pollution and Green Cities at the European Commission, Directorate General for Environment) and WHO air quality representatives Dr Maria Neira (Director of Environment, Climate Change and Health) and Miriam Weber (city of Utrecht, WHO Healthy cities network), the event brought to the fore the urgent need for coherent action to reduce air pollution's devastating health and economic impacts.

In his introductory remarks in a fully packed room, MEP Javi Lopez – the lead negotiator of the revision of the Ambient Air Quality Directive (AAQD) – recognised the critical and unique contribution of EU civil society in the shaping of EU policies that answer the vital needs of people. In her intervention, Veronica Manfredi highlighted the Commission's commitment to the Zero Pollution Ambition and the range of EU funding opportunities available to support clean air initiatives at national and local levels.

Diverse health voices, united in purpose

During the event chaired by Anne Stauffer from HEAL as host of the EUHAC Secretariat, Coalition members shared powerful insights from their unique perspectives, painting a comprehensive picture of the health and economic burden resulting from air pollution.

First and foremost, patient's voices were brought to the fore, highlighting the very real effects of air pollution on people's lives. The European Lung Foundation (ELF) showed a video featuring Mary, a young patient with severe asthma from Greece, and her mother Mata. Their story is a reminder that behind the statistics are real people whose lives and wellbeing depend on bold and immediate action to realise the right to clean air. Christine Strous from the European Federation of Allergy and Airways Diseases Patients' Associations (EFA) clearly conveyed:

"Breathing without fear is a right, not a privilege – clean air is like providing health care for patients with respiratory conditions and allergies."

Elaborating on the economic dimension of the problem, Ludo Vandenthoren from the Independent Health Insurance Funds (MLOZ) stated: "Reducing air pollution means protecting the financial sustainability of the social security system."

The aspect of health equity was brought to the discussion by Raymond Gemen from the European Public Health Alliance (EPHA): "For a stronger Europe, we need to work together to reduce air pollution and tackle the health inequities it fuels."

These perspectives reinforced the broader call for inclusive and equitable clean air policies that protect the most vulnerable and address the systemic disparities exacerbated by air pollution.


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Urgent health imperative

Interventions at the event effectively underscored the urgent health imperative presented by air pollution. Presenting the scientific perspective, Dr Ulrike Gehring from the European Respiratory Society (ERS) explained that: "With every breath we inhale millions of particles that can penetrate deeply into our lungs, there is no safe threshold below which no health effects occur."

Cancer is one of the most severe outcomes of air pollution. Nico Latteur of the Association of European Cancer Leagues (ECL) remains hopeful: "Every nine seconds, a new case of cancer is diagnosed in the European Union. The good news? 4 in 10 of these cases are preventable. Strengthening EU's clean air standards is a unique opportunity to intensify the fight against cancer by preventing premature deaths and protecting those most vulnerable."

Miriam Weber (city of Utrecht, WHO Healthy cities network) emphasised the importance of meeting the WHO guidelines of 2021, acknowledging that while change is not going to be easy, it is vital for the wellbeing of communities. The urgency to act for the health and well-being of the population was also brought to the front by Dr Ian Marnane from the European Environment Agency (EEA), who reminded participants of the major combined impacts of heat and air pollution, drawing from the landmark first European Climate Risk Assessment (EUCRA).

Dr Maria Neira from the World Health Organization underscored the necessity of policy measures targeting the combustion of fossil fuels.

She argued that this issue is not only a major driver of climate change but also a direct threat to human health, contributing to respiratory diseases, cardiovascular conditions, and premature death.

Dr Ina Kelly of CPME asserted that air pollution and climate change are inseparable issues.

The revised EU Ambient Air Quality Directive (AAQD), which entered into force in December 2024, marks a critical step forward. Its implementation can reduce air pollution's burden on health; however, Coalition members stressed that the AAQD is just one piece of the puzzle. Achieving clean air requires coherent action across policy fields, adequate financing, and integration with EU climate efforts.

Call to firm political action

The EUHAC event showcased a collective call to tackle air pollution as a public health emergency. By bringing together diverse voices, high-level policymakers, and global health leaders, the Coalition has laid the groundwork for meaningful progress.

Clean air is a health imperative, a social justice issue, and an economic sustainability driver. Hundreds of thousands of premature deaths and billions of euros in health costs each year can be saved with decisive action.

The EUHAC call to policymakers is unequivocal: they must prioritise swift and effective implementation of the AAQD and ensure that clean air measures are adequately funded and seamlessly integrated into broader climate and health strategies.

As Anne Stauffer from the Health and Environment Alliance (HEAL) aptly stated, "The case for strengthened EU clean air action is clear: from the science, the voices we heard today, and the call of people across the EU for clean air."

Research Ethics: Carrying the Principles of the Declaration of Helsinki into the Virtual World – The Declaration of Taipei

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For the last six decades, the World Medical Association (WMA) Declaration of Helsinki (DoH) has established ethical principles for research involving human beings.

The DoH requires major safeguards for patients and volunteers in medical research as internationally accepted standards.

Among those are 'informed consent', the requirement of approval by an ethics committee, the obligation to scientific standards, the obligation to publish, rules on how and when to use placebo controls, requirements for post-trial access to care, and many others.

The most recent review of the DoH examined questions raised by new technologies, a greater involvement of patients and communities, and experiences from the COVID-19 pandemic.

Though it was determined that new technologies and methods did not necessitate any modifications to the ethical principles, the inclusion of patients and lessons from the pandemic required a refinement of those principles.

Among several significant changes, detailed in an article by Dr Jack Resnek Jr, at least two of the changes represent a paradigmatic shift:

- Research is increasingly viewed as a matter of co-creation. Patients and communities are no longer regarded merely as subjects on whom research is conducted, but rather as partners in defining, planning, and executing research, including sharing in the successes and outcomes.

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- Furthermore, the perception of vulnerability has changed fundamentally. Previously, being vulnerable was often a reason for exclusion from research; however, we have finally recognised that conducting research solely on young male participants does not address the health needs of women, children, older patients, or other groups deemed vulnerable for various reasons.

Vulnerability itself may necessitate research, or exclusion from research may worsen an existing vulnerability or even create a new one.

With new technologies, the availability of large sets of health data, and a growing number of biobanks collecting human specimens, the landscape of research opportunities is shifting to in-vitro and even more in-silico research.

The Declaration of Taipei (DoT) aims to extend the protections of the DoH in this new research landscape.

Health research is increasingly conducted outside the classical clinical environment.

Furthermore, health data and specimens may be collected without the frame of a research question but rather as a repository for developing questions and answers in the future.

This is important to note as it makes the idea of a 'primary use' (treatment-related) and 'secondary use' scenario obsolete.

Data and specimens are already collected for multiple uses in the future, with or without a primary use scenario.

In such scenarios, some of the crucial means of protection for those subjected to research are difficult or impossible to apply.

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The impossibility of obtaining regular 'informed consent' for each use of data or specimens necessitates alternative protection through an initial consent process, an established governance and custodianship framework, and a review by an ethics or access committee.

For initial consent, the data or specimen collector must inform the donor, among other things, about the purpose of the databank, the risks and burdens associated with the collection, the procedures for whether and how findings are being returned, the security and privacy of the process, the general governance of the database or biobank, ownership and commercial aspects and the sharing of results, and the possibilities and options for a later withdrawal of data and specimens.

When it comes to using the collected data or specimens, each use scenario must be reviewed by an ethics or access committee.

The committee will have to check whether the intended use is in line with the governance principles of the collection and the conditions that have been informed to the donor of the data or specimen. Special attention will have to be paid to whether the use scenario and its results may pose any risks for the donor and how findings can or must be shared.

While one may assume that for most use scenarios, any repercussions to the donors can be excluded, there may be use scenarios with intrinsic dangers to the donor.

In such cases, the committee may ask for additional protection, which could be by technical means such as pseudonymisation, anonymisation and aggregation or, if serious consequences cannot be excluded, the recourse to an obligatory 'informed consent'.

The DoT provides more details about protecting donors and regulates deviations from those principle protections where they are warranted by emergencies (e.g., public health emergencies) or law.

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First and foremost the 'informed consent' is at question. This core tool for self-determination enables the dignity of a person to decide whether or not to participate in research, which is in question when data is being used in high frequency or long after its collection.

Those who have given the data may not be interested in being bothered multiple times to give their consent after being informed or they may not be reachable or even deceased.

However, a so-called 'broad consent' alone is insufficient to provide the protection of 'informed consent', as it cannot detail the risks or benefits of potential research that may be designed and conducted in the future. Therefore, "broad consent" cannot replace "informed consent."

It can be argued that research without physical and invasive intervention does not present the risks typically associated with standard clinical research.

However, research involving data and specimens may still pose risks to the donors. It could result in findings that might lead to stigma, as well as loss of health or life insurance, or psychological distress, such as the unintended discovery of an incurable disease that could be fatal in the future. Conversely, while this knowledge may be embraced by some donors, the risks are undeniably present.

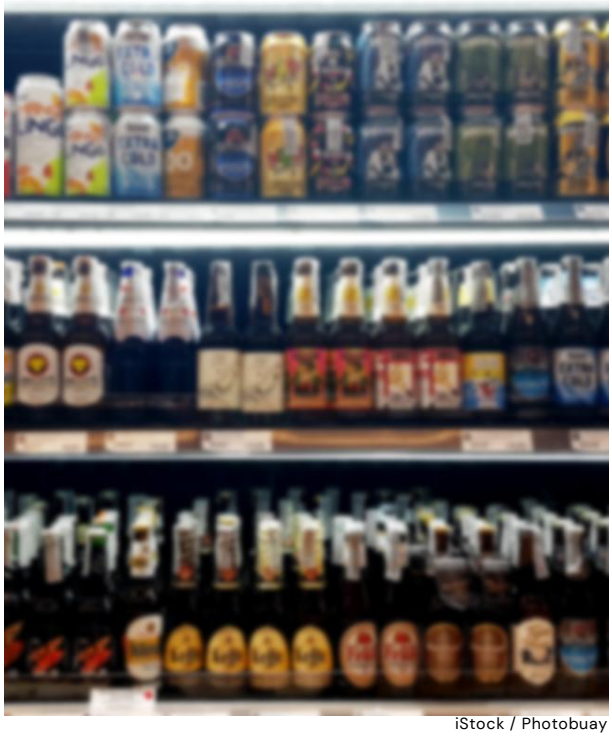
While research enjoys high degrees of freedom in democratic societies, the right to conduct experiments may be restricted to various degrees, for instance, because of their intrinsic dangers. In data- or biobank research, such dangers may not exist or be difficult to recognise. Furthermore, the definition of research is open to broad interpretation, allowing studies with no scientific but rather political or commercial motivations to be called research.

For these reasons, the DoT pertains to all databases or biobanks that provide health data or specimens for studies, without distinguishing between first or secondary use. It does not define any scientific or moral classification of research but rather addresses all uses of the data or specimens equally.

European doctors urge policy-makers to ensure commercial influence does not harm public health

European doctors published a policy highlighting the negative impact of commercial determinants on health and urging policy-making to be evidence-based and ethical for the benefit of public health.

Annually, 2.7 million premature deaths as well as increasing rates of illness are caused in the WHO European Region by four major commercial sectors: alcohol, tobacco, ultra-processed foods and beverages, and fossil fuels.



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Commercial actors also influence health policy, for example through lobbying, incentivising policymakers to align decisions with commercial agendas and preventing or weakening regulation of their products and services. In addition, marketing of unhealthy products enhances their desirability and acceptability.

Dr Christiaan Keijzer said "The EU and national governments need to recognise the scale of the impact that commercial practices have on health. Public health and wellbeing must be prioritised in policy decisions. This requires coordinated efforts, political will and courage.

Policy-makers need to be transparent regarding their contacts with stakeholders and consider scientific evidence from objective and ethical research when introducing new legislation."

CPME Chair of Healthy Living Dr Ina Kelly added "The European Commission must act on the unfulfilled commitments it made in 2021 as part of the Europe's Beating Cancer Plan. This includes introducing mandatory alcohol labelling and the revision of key tobacco control directives. The EU must also regulate advertising particularly towards children and adolescents, and protect them from exposure to unhealthy products."

Alcohol Labelling: The Right to Know European Awareness Week on Alcohol Related Harm 2024

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Did you know that alcoholic beverages in the EU are not required to list their ingredients or nutritional content, unlike soft drinks or bottled water?

This surprising omission denies consumers their basic right to know what they are drinking.

The 2024 European Awareness Week on Alcohol Related Harm (AWARH24) addressed this critical issue, asking: what's being hidden?

Why Alcohol Labelling Matters

Citizens across the EU are largely kept in the dark regarding the content of their alcoholic drinks. Unlike other beverages, those with over 1.2% alcohol by volume are exempt from providing mandatory ingredient and nutrition information on their labels. This lack of transparency compromises people's ability to make informed health choices, especially given alcohol's proven role in causing over 200 diseases and almost one million deaths annually across Europe.

As a carcinogen and contributor to cardiovascular diseases, even low levels of alcohol consumption pose significant risks. Consumers deserve the basic facts to make informed decisions about their health and well-being.

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There is strong consensus among civil society organisations on the necessity of including health and nutritional information on alcohol labels.

From 2 to 6 December 2024, the campaign themed "Alcohol Labelling: The Right to Know" ran as a highly visible and successful exhibition in the European Parliament in Brussels, advocating for mandatory ingredient and nutrition information on alcoholic drinks in the EU.

The inauguration of AWARH24 brought together a distinguished panel of speakers and experts who contributed valuable insights to the discussions

Hosted by MEP Vytenis Povilas Andriukaitis, former European Commissioner for Health and Food Safety, the campaign was organised by the European Alcohol Policy Alliance (Eurocare), EuroHealthNet, the European Association for the Study of the Liver (EASL), United European Gastroenterology (UEG), IOGT-NTO, and Green Crescent, in partnership with the World Health Organisation Regional Office for Europe.

The campaign primarily targeted MEPs and EU policymakers, aiming to raise awareness and promote dialogue on the need for EU-wide preventive measures to combat alcohol-related harm, such as mandatory labelling.

Key insights from the event revealed that alcohol labelling is a systemic issue, driven by a lack of public awareness about the risks.

Clear and transparent communication is essential, with health information being managed by health experts.

There is strong consensus among civil society organisations on the necessity of including health and nutritional information on alcohol labels.

Consistent, collaborative efforts are crucial to protecting future generations and promoting healthier societies.

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With over 100 policymakers and stakeholders engaging directly with the exhibition stand, the campaign succeeded in introducing and raising awareness about an issue that is largely unknown.

Beyond raising awareness, the event built stronger collaboration among stakeholders, reinforcing calls for comprehensive policy changes, such as mandatory labelling, marketing restrictions, and pricing policies.

Each day, hundreds of people observed the booth and its visual materials, with dozens taking the time to read at least one of the key messages.

Introducing our work through such a powerful campaign, if widely recognised, will greatly enhance our reputation, credibility, and expertise.

The message from AWARH24 is clear: consumers demand transparency, and the EU has a responsibility to deliver.

A European Commission consultation revealed that over two-thirds of participants believe alcoholic beverages should have ingredient and nutritional labels.

Current voluntary self-regulation by the alcohol industry has failed to address this need, leaving consumers without the essential information required to make informed choices about their health and well-being.

It is time for policymakers to act, and ensure that every citizen knows what is in their drink. Consumers have been kept in the dark for far too long.

CONTACT

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