

Availability regulations

This is a snapshot of alcohol policies in twenty five member states¹ of the European Union as at 31 December 2007. The data were collected as a joint initiative between the World Health Organization and the European Union as part of the World Health Organization's global alcohol database. Further information was taken from and is available in two publications of the World Health Organization: Evidence for effectiveness and cost-effectiveness of interventions to reduce alcohol-related harm [<http://www.euro.who.int/document/E92823.pdf>], and handbook for action to reduce alcohol-related harm [<http://www.euro.who.int/Document/E92820.pdf>].

The Alcohol Policy Series includes the following ten fact sheets documenting the state of the European Union's member state alcohol policy:

1. Infrastructures for alcohol policy
2. Price and tax measures
3. Awareness raising activities
4. Counselling and treatment
5. Availability regulations
6. Drink driving legislation
7. Health warning labels
8. Alcohol advertising
9. Alcohol sponsorship
10. Monitoring and evaluation.

The present fact sheet deals with availability regulations and considers seven issues:

1. The evidence for managing the availability of alcohol
2. Monopolies
3. License systems
4. Age limits for purchase
5. Restrictions on drinking in public domains
6. Sales restrictions
7. Considerations and next steps

¹ Austria; Belgium; Bulgaria; Cyprus; Czech Republic; Denmark; Estonia; Finland; France; Germany; Hungary; Ireland; Italy; Latvia; Lithuania; Malta; Netherlands; Poland; Portugal; Romania; Slovakia; Slovenia; Spain; Sweden; and United Kingdom

1. EVIDENCE BASE

While total bans on the sale of alcohol are not present in any European countries, there do exist bans in widely dispersed parts of the European Region on the use of alcohol in particular locations (such as parks, streets, hospitals and workplaces) and circumstances (such as during football matches). Government monopolies on alcohol sales are another way to reduce availability and hence alcohol-related harm. These monopolies tend to have fewer stores and shorter opening hours than are found in countries with private sales. Alcohol licensing is another way that a government can restrict availability, since it allows the government to restrict the number of licences and require licensees to meet certain standards, revoking the licence of any licensee that infringes the laws. On the other hand, the income generated by licence fees may tempt some jurisdictions to allow licensed establishments to proliferate. While strictly limiting the availability of alcohol may encourage the development of a parallel market in illicit alcohol, it can usually be controlled through enforcement.

Where a government monopoly for the retail sale of alcohol exists, there is a strong argument for preserving it, since such monopolies effectively limit the availability of alcohol and reduce alcohol-related harm. Where such a monopoly does not exist, and where it is not feasible to introduce one, then a licensing system for alcohol sales should be introduced or maintained. Licence renewals should be issued only to establishments that adhere to laws restricting sales to under-age drinkers and intoxicated people, and that discourage patrons from being a public nuisance or engaging in violence. It can be difficult for on-trade establishments to maintain order when drinkers arrive already intoxicated, often on cut-price off-trade alcohol. Steps should be taken to ensure that local communities and municipalities do not use licensing systems merely as a source of revenue, a practice that can lead to excessive distribution of licences. Licensing authorities should be charged with maintaining and improving public health, rather than simply with responding to market forces. Similarly, national licensing regulation should permit local bodies to act to reduce alcohol-related incidents of violence, crime, public disturbance and harm to health.

Governments should regulate the density of alcohol outlets and limit it in the presence of undue harm. It is advisable to avoid extending the days and hours of alcohol sales, and to curtail them further when given neighbourhoods or communities experience excessive alcohol-related harm. Minimum purchase ages for alcohol enjoy broad public support in the European Region. Where they are less than 18 years, it would be advantageous to increase it to 18 for all beverage products in both off-trade and on-trade establishments. "Mystery shoppers" – in this case, under-age purchasers – can be used to ensure that establishments enforce minimum purchase ages.

2. MONOPOLIES

No countries had a monopoly on producing beer, wine and spirits. Two countries had a monopoly for off-premise sales of higher strength beers, wines and spirits.

3. LICENSE SYSTEMS

Fifteen countries (60%) required a license for beer and wine production, and 18 (72%) for spirits production; sixteen countries (64%) required a license for the on-premise sale of beer and wine and

18 (72%) for spirits; and sixteen countries (64%) required a license for the off-premise sale of beer and wine and 19 (76%) for spirits.

4. AGE LIMITS FOR PURCHASE

Sixty eight per cent of countries had an age limit of 18 years and 24% of 16 years for on-premise sales of beer and wine, and 84% of 18 years and 12% of 16 years for spirits. Two countries had no age limit for the off-premise purchase of beer and wine and one no limit for spirits. 64% of countries had an age limit of 18 years and 20% of 16 years for the off-premise purchase of beer and wine, and 80% of 18 years and 12% of 16 years for spirits. The age limits are summarized in Figures 1-6.

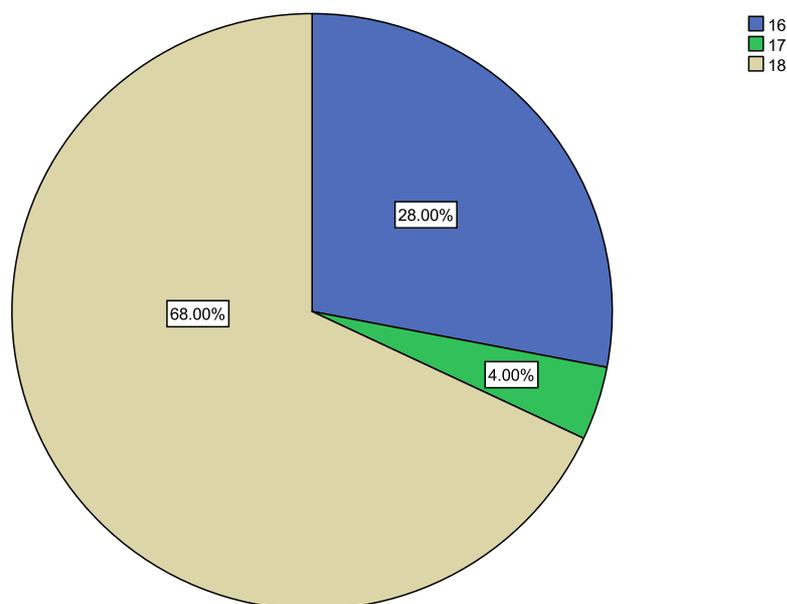


Figure 1 Age limits for on-premise purchase of beer.

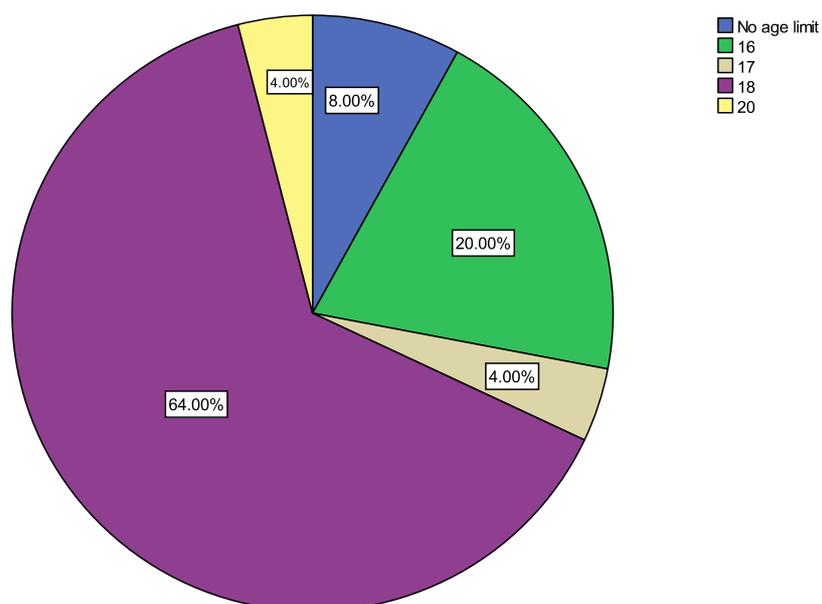


Figure 2 Age limits for off-premise purchase of beer.

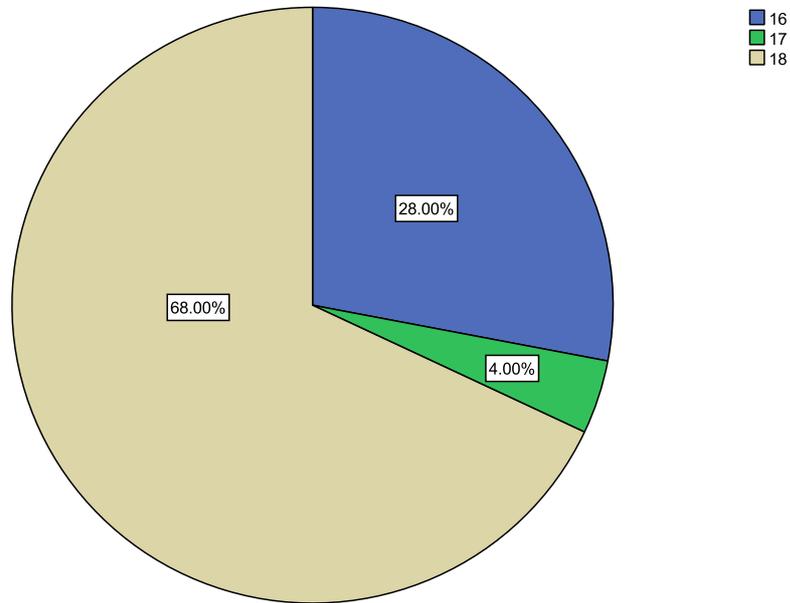


Figure 3 Age limits for on-premise purchase of wine.

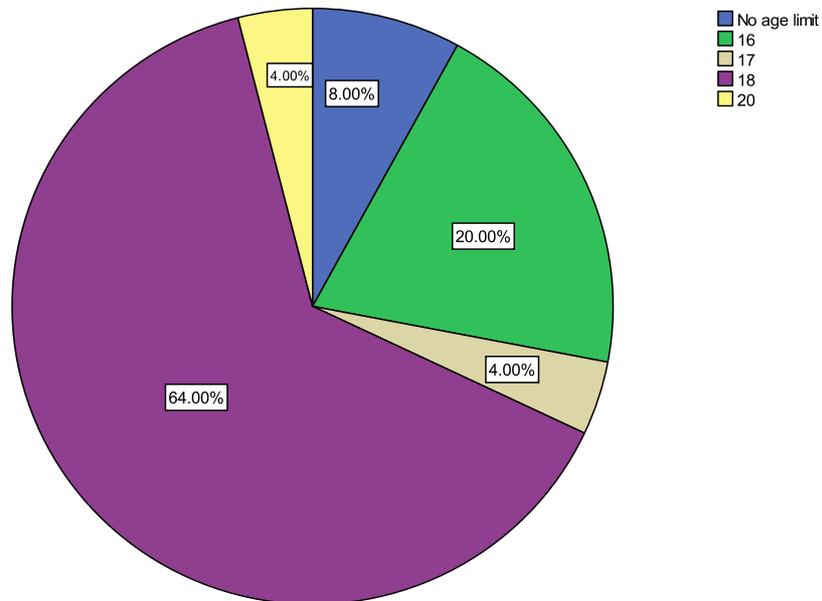


Figure 4 Age limits for off-premise purchase of wine.

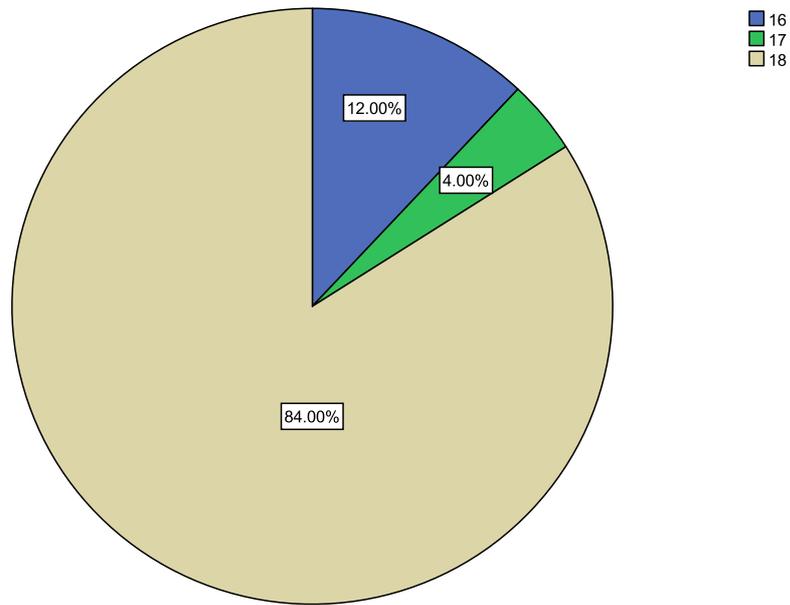


Figure 5 Age limits for on-premise purchase of spirits.

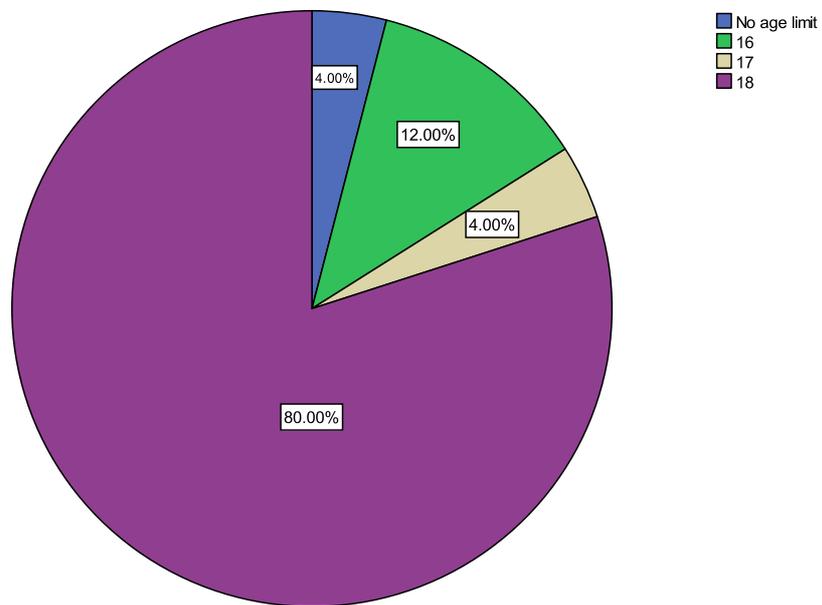


Figure 6 Age limits for off-premise purchase of spirits.

5. RESTRICTIONS ON ALCOHOL CONSUMPTION IN DIFFERENT PUBLIC DOMAINS

Countries varied in their restrictions on alcohol consumption in different domains, Table 1. Twenty two countries (48%) had a total restriction on drinking alcohol in health care establishments and 14 countries (30%) at the workplace.

Table 1 Numbers of countries with specified restrictions on alcohol consumption in different public domains

	Total ban	Partial statutory restriction	Voluntary agreement / self-regulation	No restriction
Health care establishments	8	5	7	5
Educational buildings	13	2	7	3
Government offices	9	4	7	5
Public transport	7	8	4	5
Parks, streets etc	4	7	7	7
Sporting events	6	7	7	4
Leisure events (concerts etc.)	1	5	6	11
Workplaces	9	3	9	4
Religious places of worship	4	2	9	7

6. SALES RESTRICTIONS

Some four out of ten countries restricted the on- and off--premise hours of sale, but less than one in six the days of sale of alcoholic beverages, Table 2. Although some one half to two-thirds of countries restricted the location of on- and off-premise sales, less than one in eight restricted the density of outlets.

Table 2 Numbers of countries with specified restrictions for on premise and off premise sales of alcohol.

	Beer	Wine	Spirits
On premises			
Hours restricted	10	10	10
Days restricted	3	3	3
Places restricted	14	14	16
Density restricted	2	3	3
Specific event sales restricted	14	15	16
Sales restricted to intoxicated persons	19	19	18

Off premises			
	Beer	Wine	Spirits
Hours restricted	8	8	9
Days restricted	4	5	5
Places restricted	14	13	14
Density restricted	1	2	2
Specific event sales restricted	14	14	14
Petrol stations restricted	7	6	7

The mean (sem) level of enforcement on a scale of 0 (not enforced) to 10 (fully enforced) was estimated at 5.4 (sem 0.4) for on-premise sales and 5.6 (0.6) for off-premise sales. In only three countries was the level of enforcement based on statistical information for on-premise and in two for off-premise sales.

7. CONSIDERATIONS AND NEXT STEPS

Monopolies for the sale of alcohol are a rarity in the countries of the European Union. Between one quarter and one third of countries do not require a license for the sale of alcohol. In about one-third of countries, the age limit for purchasing alcohol is less than 18 years, and in some countries, there is even no age limit. Restrictions on the sale of alcohol are limited, and the most effective option, limiting the density of alcohol outlets is rare indeed. All of this suggests that there are considerable opportunities for strengthening the regulations of the availability of alcohol across the countries of the European Union.

Questions to consider

1. ***If there is a government retail monopoly on the retail sale of alcohol, are there any threats of its disestablishment? How much public and political support does it enjoy?*** There is no doubt that a governmental retail monopoly reduces alcohol-related harm. Many studies have modelled the impact of changing from a public to a private retail system, which they show increases alcohol's health and economic burden.
1. ***Where there is no such monopoly, is there any government or public discussion of introducing one?*** In many countries, such a change may not seem politically feasible or possible within the frame of international trade agreements, but the presence of an unacceptably high level of alcohol-related harm can provide a good opening to discuss the possibility.
2. ***Is there an alcohol licensing system? Are local parts of the system granted sufficient power to decide the density of retail sales and opening hours in response to local issues and potential problems?*** In some countries, it is possible to sell alcohol without a specific licence. They accordingly lack the ability to suspend a licence for failing to adhere to alcohol sales laws, as well as the ability to use licences to manage alcohol availability.
3. ***Are there any opportunities for reviewing the days and hours of sale so that they can be adjusted to reduce alcohol-related harm?*** Although the trend in most countries has been towards liberalizing the days and hours of sale, some countries are actively considering restricting them.

4. **What are the present minimum purchase ages for the various beverage categories? For off-trade and for on-trade? How much public and political sentiment is there for increasing the minimum age?** Public support is generally in favour of increasing the minimum purchase ages for alcohol. Some countries have harmonized the minimum age for all categories of alcoholic beverage (e.g. it is 18 in France).
5. **How is the minimum purchase age enforced?** Minimum age laws are only effective if enforced, and evidence suggests that they are frequently unenforced in the European Region. One method of monitoring adherence is to use mystery shoppers, under-age customers who are legally allowed to enter stores to undertake test purchases. A licence system is not necessary to enforce minimum age laws, since violations can still incur penalties.

Options for action

- **Maintain the status quo**, making no changes in current availability laws and regulations. Fortunately, most jurisdictions still provide opportunities to control the sale of alcohol in ways that can reduce alcohol-related harm, notably through better enforcement. Enforcement appears to be a major deficiency in European alcohol efforts, particularly enforcement of minimum age laws and laws against selling alcohol to already intoxicated customers. It is also worthwhile to review ways to control the density and sale hours of alcohol sales outlets by using existing laws and regulations.
- **If the minimum purchase age is less than 18, consider raising it to 18 years for all beverage categories**, including beer and wine, at all sales outlets, including supermarkets, bars and cafes. Any such change in the purchase age should be supported by increased enforcement.
- **Weigh the political and public support for strengthening existing laws and regulations** to reduce the density and opening hours for alcohol sales outlets, and for introducing a government retail monopoly.

Stakeholders for action

- The health ministry's main partner in this policy area is the ministry responsible for licensing regulation. The two ministries can undertake joint actions to review or introduce licensing regulation and to analyse how changes might affect levels of alcohol-related harm and public nuisance.
- Other important partners are the government ministries and departments responsible for enforcing alcohol sales laws and regulations, as well as the police departments that are responsible for actual enforcement. Together they can discuss how to better monitor and implement enforcement.
- It is normal to consult alcohol producers and retailers when changes in availability or enforcement are contemplated, although the record shows that the industry does not support measures to reduce availability or increase minimum purchase ages.

Bibliography

Anderson P (2009). *Evidence for the effectiveness and cost-effectiveness of interventions to reduce alcohol-related harm*. Copenhagen, WHO Regional Office for Europe.

This report, a companion document to the present handbook, details the available evidence for the impact of availability changes on alcohol consumption and related harm.

Holder H et al. (2008). *Alcohol monopoly and public health: potential effects of privatization of the Swedish alcohol retail monopoly*. Stockholm, Swedish National Institute of Public Health (http://www.fhi.se/PageFiles/4006/R200827_Alkoholmonopol_eng_0809.pdf, accessed 12 August 2009).

WHO (2009. WHO-CHOICE interventions: hazardous alcohol use [web page]. Geneva, WHO (http://www.who.int/choice/interventions/rf_alcohol, accessed 11 August 2009).

The WHO-CHOICE project has modelled the cost, impact and cost-effectiveness of a range of alcohol policy measures in reducing alcohol-related harm, including changes in availability. Several publications discuss the results.

This fact sheet was prepared by Peter Anderson on behalf of the German Centre for Addiction Issues (DHS) as part of the Building Capacity project managed by the Institute of Public Health of the Republic of Slovenia, co-financed by the European Commission. Unless otherwise stated all data is sourced from the WHO Global Information System on Alcohol and Health (GISAH). The data was collected in the framework of the Global Survey on Alcohol and Health implemented by the WHO Department of Mental Health and Substance Abuse (Management of Substance Abuse team) in collaboration with WHO Regional Office for Europe and the European Commission.

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