Infrastructures for alcohol policy

BACKGROUND

This is a snapshot of alcohol policies in twenty five member states[1] 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 infrastructures for alcohol policy and considers six issues:

1. The evidence base for infrastructures
2. Presence of a written national policy on alcohol
3. Year of adoption and revision of policy
4. Policy characteristics
5. Jurisdictional level of policy
6. Developing and implementing an action plan

[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

At country level, it is ultimately a government's responsibility to define and be accountable for a clear alcohol policy for the whole country and for regions within a country. Many different decision-making authorities are involved in the formulation and implementation of alcohol policy, including the health ministry, the transportation authority and the taxation agency. Governments need to establish effective and permanent coordination machinery, such as a national alcohol council, comprising senior representatives of many ministries and other partners, to ensure that a coherent approach is taken to alcohol policies and that policy objectives are properly balanced in both their political and technical aspects.

Targets make policy objectives more specific, allow progress towards them to be monitored and inspire many partners actively to support alcohol policy developments. Targets require an assessment of the present situation and help to determine priorities. They can focus discussion on what it had been hoped to achieve and why, and whether or not this was successful and why. They provide a powerful communication tool, taking policy-making out of bureaucratic confines and making it a clearly understood public issue; they give all partners a clearer understanding of the scope of the policy; they strengthen accountability for health; and they motivate people for action.

Accountability for the health impact of alcohol policies and programmes rests with all sectors of society, as well as government officials who create policy, allocate resources and initiate legislation. Mechanisms such as alcohol policy audits, litigation for damage to health and public access to reports on impact assessments can ensure that both the public sector and private industry are publicly accountable for the health effects of their alcohol policies and activities. Accountability can be achieved through mechanisms for coordinating, monitoring and evaluating progress in policy implementation and through procedures for reporting to elected bodies, as well as through the mass media.

One method of financing programmes to reduce the harm done by alcohol is an earmarked tax. This means that a proportion of tax revenue collected from alcohol is devoted to a specific activity, such as policy implementation or health care.

But the presence of an alcohol policy, although important, is not enough. Policy needs to be sensitive to cultural values and historical experience and to engage the many different sectors that have an impact on alcohol-related harm. Policy needs to be comprehensive, minimizing any negative consequences due to perverse incentives. A lack of transparency and information, poor organization and preparation for the introduction of new policies and laws, poor public health infrastructures, vertically as opposed to horizontally organized government, a lack of financing, the presence of corruption, and public distrust of authority are all impediments to the implementation of effective policy.

Research

A firm research base is a pre-requisite for alcohol policies and actions. A clear finding is that Europe, and particularly southern and eastern Europe, lags behind other parts of the world in carrying out and publishing research on alcohol and alcohol policy. The scientific community should be involved in developing scientifically sound, socially relevant and feasible bases for decisions relating to alcohol policy. Research is not value-free, in the sense that the framing and choice of topics inevitably reflects judgments and choices between competing priorities. The duty of the scientific

community is to be faithful to the research evidence, which means that the findings of research may contradict current policies and programmes. There is good reason, then, for there to be some distance between the public health scientific community and both governments and the alcohol beverage industry.

However, there must be a much better match between the needs for alcohol policy research as perceived by decision-makers and planners on the one hand, and the research priorities set by the research community on the other. To be useful, research evidence has to be communicated simply and given meaning by making it relevant to current issues. Such sustained contributions may only be possible in the context of a long-term, publicly-funded research programme designed to engage members of the scientific community in each country in the collection, evaluation and interpretation of research data relevant to a country's alcohol policy needs.

Research and development efforts cannot be implemented without building the appropriate capacity. Effective alcohol policy needs competent and well-informed personnel working in settings supportive of their efforts. Investments must, therefore, be made in both institutional and human capacity for the development of research.

The responsibility for translating scientific research into effective policy is distributed across a wide variety of government agencies and public interest groups. In addition, there need to be systematic mechanisms for ensuring that new evidence from research is actually introduced into policy and programme practice. If all existing knowledge about which alcohol policy approaches work and which do not were fully applied, there could be a major impact on improving public health.

Information systems are key components in making knowledge more widely available *(9)*. Intelligence is broader than information. It implies idetifying and interpreting essential knowledge for making decisions from a range of formal and informal sources. Intelligence should include: current and future trends and system performance (e.g. levels, trends and inequalities in areas of alcohol consumption and alcohol-related harm); risk factors for harm; vulnerable groups; organizational or institutional challenges in implementing policy; governance; important contextual factors and actors (the political, economic and institutional context); the roles and motivation of different actors; users' and consumers' preferences; opportunities and constraints for change; and events and reforms in other sectors with implications for alcohol policy. This information should be available on electronic media and be published regularly in a publicly accessible form, so as to promote an informed and open debate among politicians, professionals and the public concerning outcomes and determinants, and future priorities for action and investment.

2. PRESENCE OF WRITTEN NATIONAL ALCOHOL POLICY

Seventeen countries (68%) stated that they had a written national alcohol policy, Figure 1 and Table 1. Five countries (20%) did not have a written policy. One country had a policy in draft form, and two countries had written sub-national policies.

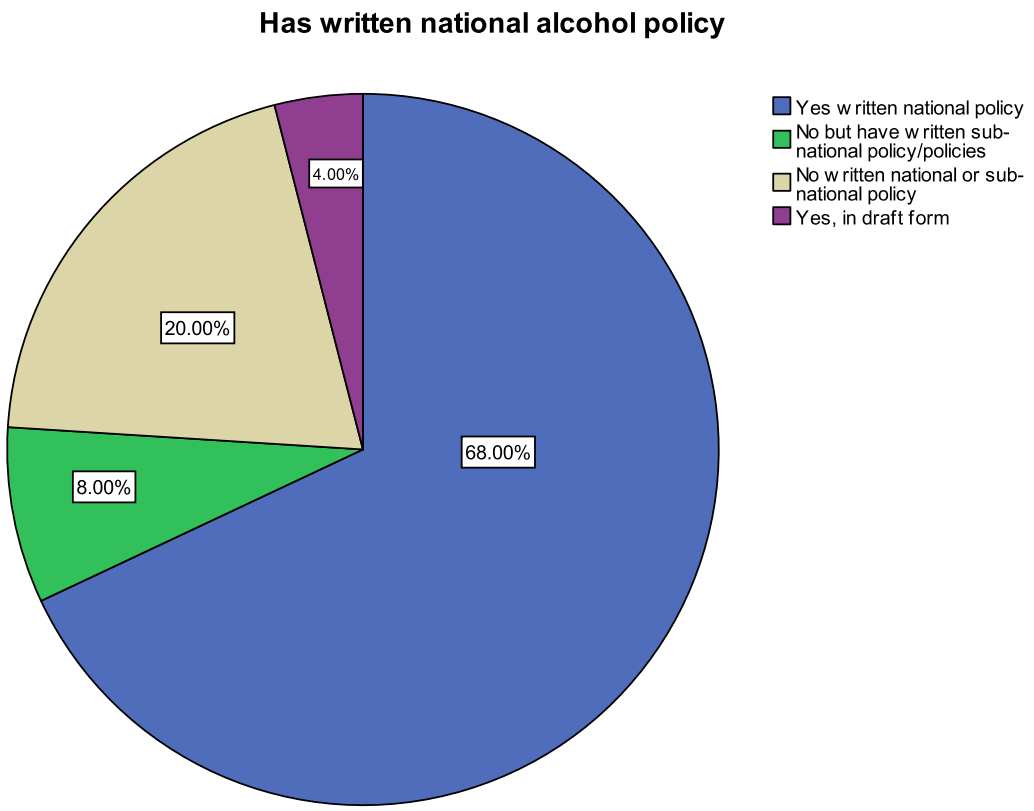

Figure 1 Countries (%) with written national alcohol policy

3. YEAR OF ADOPTION AND REVISION OF POLICY

Of the 17 countries with national policies, seven out of ten were first adopted since the year 2000, Figure 2. Seven out of ten countries had revised their policies since 2005.

Table 1 Written national alcohol policy by country

	Yes written national policy	No but have written sub-national policy/policies	No written national or sub-national policy	Yes, in draft form
Austria		√		
Belgium			√	
Bulgaria				√
Cyprus	√			
Czech Republic	√			
Denmark		√		
Estonia			√	
Finland	√			
France			√	
Germany	√			
Hungary			√	
Ireland	√			
Italy	√			
Latvia	√			
Lithuania	√			
Malta			√	
Netherlands	√			
Poland	√			
Portugal	√			
Romania	√			
Slovenia	√			
Spain	√			
Sweden	√			
United Kingdom	√			

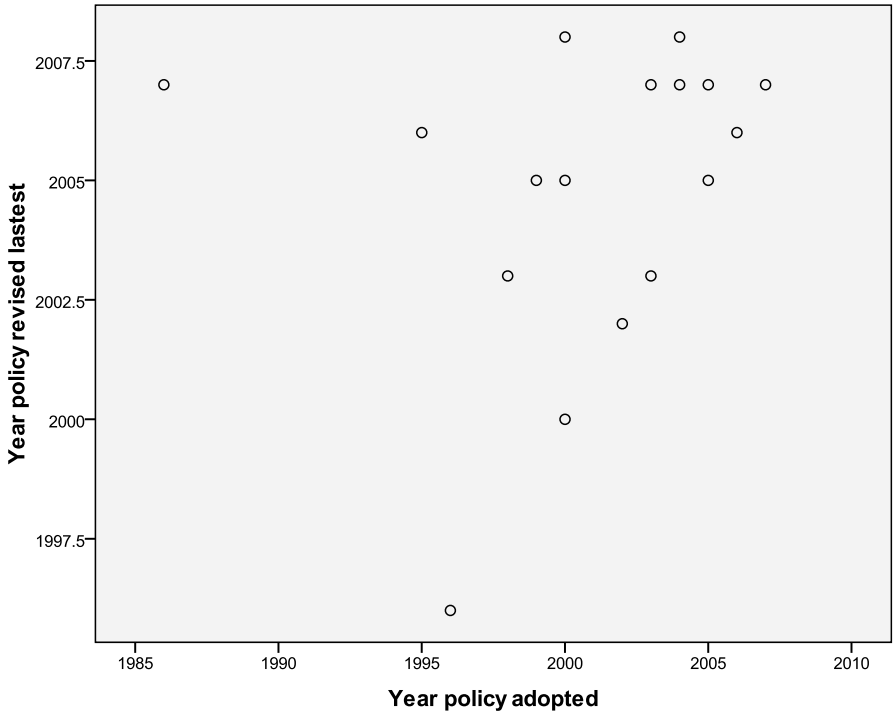

Figure 2 Year policy first adopted and latest year of revision

4. POLICY CHARACTERISTICS

Five policies had been adopted by the national parliament, 12 by the national government and one by another national body. Eleven policies comprised a comprehensive strategy, 11 had set policy measures and 13 included a national action plan. Twelve were alcohol specific policies; six were set in the framework of a substance abuse policy, two a mental health policy, one a non-communicable disease policy, and four a general public health policy. Fifteen policies (88%) were stated as multisectoral, Table 2. Fourteen policies were coordinated by health, two by social affairs, one by trade and one by criminal justice. Fifteen had a central coordinating entity for implementation.

Table 2 Sectors represented in national alcohol policy

Sector represented	Number of countries
Health	15
Social	14
Justice	14
Road safety	14
Education	15
Employment	11
Law enforcement	15
Finance / taxation	12

5. JURISDICTIONAL LEVEL

In most countries, alcohol policies were formulated at the national level only, Table 3. The exceptions were sales and treatment policies, which were formulated in a mixture of national, sub-national and municipal levels in about one-quarter of countries. With implementation, there was greater devolvement to a mixture of national, sub-national and municipal levels and sub-national and municipal levels alone, particularly for sales and treatment. Nevertheless, policies were implemented at the national level only in between one half and three-quarters of countries, depending on the specific policy.

Table 3 Formulation and implementation of policies by jurisdictional level

	National only	National, sub-national and municipal	Sub-national only	Municipal only
Formulation				
Production	23	1		
Imports	23	1		
Exports	24			
On-premise sales	16	8		1
Off-premise sales	18	6		1
On-premise age limits	22	2	1	
Off-premise age limits	22	2	1	
Broadcast advertising	22	2	1	
Print media advertising	22	2	1	
Billboard advertising	22	1		1
Internet advertising	19		1	
Sponsorships	18	1	1	1
Product placement	19		1	
Taxation	23	1		
Drink driving	22	2		
Treatment	17	5		1

Implementation				
Production	21	3		
Imports	22	1		
Exports	22	1		
On-premise sales	10	10		4
Off-premise sales	12	9		3
On-premise age limits	14	6	2	2
Off-premise age limits	16	6	2	
Broadcast advertising	21	2	1	
Print media advertising	18	2	1	
Billboard advertising	15	4	1	1
Internet advertising	17	1	1	
Sponsorships	17	2	1	
Product placement	18	1	1	
Taxation	22			
Drink driving	15	4	1	2
Treatment	12	9	1	1

6. Developing and implementing an action plan[2]

Five countries still have to prepare a national policy on alcohol, and in a further five countries, policies are likely to be due for revision.

Infrastructure for alcohol policy

For an action plan to reduce alcohol-related harm to be effective, it is necessary to ensure that the requisite infrastructure for policy development, priority-setting, monitoring and surveillance, research and evaluation, workforce development and programme delivery is all in place. Despite some advances in building core infrastructure for action on alcohol, it can be argued that there continues to be insufficient political will and investment by both the private and the public sector in many Member States, and ensuring that this infrastructure is sufficiently large and capable remains a challenge. There is also evidence that good infrastructure can facilitate the effective implementation of an alcohol action plan, while its absence can be an obstacle. Although vested interests – whether from the political, business, health care or academic sector – can also be barriers to action, they can be overcome by effectively utilizing existing infrastructure or developing new infrastructure.

[2] This section draws on "Do infrastructures impact on alcohol policy making?" by Claudia König and Lidia Segura (2009).

Goals and targets

A national alcohol action plan or strategy is needed to establish priorities and guide action. National health goals can set priorities, express commitment to new action and allocate resources. Such goals and priorities should be based on epidemiological evidence, while the choice of strategies and interventions should be evidence-based. Targets make policy objectives more specific, allowing progress to be monitored and often inspiring partners to support policy initiatives. Targets require assessing the present situation, and they help determine priorities; they can focus discussion on what is to be achieved and why, and on whether an effort is successful and why; they provide a powerful communication tool, freeing policy-making from bureaucratic confines and making it a readily understood public matter; they give all partners a clearer understanding of the scope of a policy; they strengthen all stakeholders' accountability for public health; and they motivate people to act. A target can be outcome-oriented, such reducing alcohol consumption or alcohol-related harm by a given amount, or process-oriented, such as identifying and advising a given proportion of the population that engages in hazardous or harmful alcohol consumption.[3]

Accountability

Accountability for the health impact of alcohol actions and programmes rests with all sectors of society, as well as the government officials who prepare action plans, allocate resources and initiate legislation. Mechanisms such as alcohol policy audits, litigation for health damages and publicly accessible health impact assessments can ensure that both the public sector and private industry are held accountable for the health effects of their actions relating to alcohol. Accountability can be achieved through mechanisms to coordinate, monitor and evaluate progress in implementing action plans, through procedures for reporting to elected bodies and through use of the mass media.

Laws and regulations

National laws and regulations form the legislative basis for action on alcohol. Every Member State has implemented some alcohol-specific laws and regulations, albeit with differing priorities and approaches. The gap between alcohol-related evidence and action in a particular country, as well as its particular choice of action, is determined by its mix of actors and how it resolves policy conflicts. Ultimately, legislation can only be successful when the underlying governmental structures support its implementation.

Barriers to an effective alcohol action plan

The responsibility of the national government for developing and implementing an action plan on alcohol is usually split among several governmental departments and levels. The departments involved can include those devoted to industry and trade, agriculture, employment, finance and health. The interests and priorities of these different sectors are often in conflict on alcohol policy, and they may also wield power unequally. From a public health perspective, common barriers to effective action on alcohol include the economic and political priorities of free trade, unfettered marketing, unrestricted access to alcohol, governmental perceptions about the economic importance of the alcohol industry, and the potential unpopularity of certain actions. In several of the European countries in economic and political transition, a lack of political support for public health issues and a deference to financial concerns have been identified as obstacles to action on alcohol.

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[3] *Hazardous use* refers to patterns of alcohol consumption that increase the risk of harm to the user, while *harmful use* refers to patterns that are actually damaging the user's physical health (e.g. through cirrhosis of the liver) or mental health (e.g. through depressive episodes).

A coordinating body
Coordination is needed to ensure that all levels of government and all affected sectors and stakeholders are considered in making alcohol policy decisions. A coordinating body, such as a national alcohol council, should include senior representatives from the ministries and partners involved.

Politicians
National politicians have the authority to regulate and influence the environment in which alcohol is marketed. Politicians often have particular interests in alcohol issues, interests that vary according to their official roles as well as their personal views. Contacts with outside government players such as the alcohol industry or health groups can shape politicians' views on specific alcohol policies and influence the forming or refining of policy proposals. Since politicians are influential players in the policy arena, their political support for the content of alcohol action plans is crucial.

The alcohol industry
The alcoholic beverage industry is a pressure group that enters the policy arena to protect its commercial interests. Pressure groups have a varying ability to influence alcohol policy action, and some are more powerful than others. The alcohol industry generally wields a great deal of economic, political and organizational power in the policy arena, particularly in some of the European countries in transition. The various parts of the industry often form lobbies and coalitions to foster their common interests, although these interests do not always agree on policy options. The stark discrepancy between research findings on effective alcohol policy options on the one hand, and the form alcohol policies actually take on the other, is often attributed to the central and even dominant role of commercial interests in the policy-making process. The involvement of the alcohol industry can thus be a major barrier to a public health-oriented action plan on alcohol.

Nongovernmental organizations (NGOs)
One source of response to the power of the alcohol industry is opposing pressure groups, including health-based nongovernmental organizations (NGOs). In comparison to the industry, however, such NGOs usually have less access to policy-makers and fewer political and financial resources. In many countries, public health advocacy is weak or altogether lacking. In several of the European countries in transition, the feebleness of civil society and of public opinion have been identified as obstacles to alcohol policy reform. Institutions that support public health-oriented alcohol policy include independent, publicly funded institutions, insurance industry programmes, issue-based organizations and networks, and professional associations.

Science and research
Other important infrastructural elements supporting a robust alcohol policy include science and research systems, which help expand the knowledge base for effective action on alcohol. Research can identify problems, evaluate and analyse programmes and policies, and recommend strategies. Unfortunately, there is often a stark discrepancy between scientific evidence on the effectiveness of alcohol policy measures, and the actual policy options that governments consider. Research appears to be most influential in setting a policy agenda and considering policy alternatives, less influential when amending draft laws and least influential in decision-making.

Knowledge base
Nevertheless, a good knowledge base remains a prerequisite for an effective action plan on alcohol. It should include data on alcohol consumption, alcohol-related harms and the effectiveness of alcohol policies and action, providing a basis for rational decision-making. The lack of such data can

pose difficulties for health advocates arguing for comprehensive alcohol policies, as has been seen in several European countries in transition. Appropriate human as well as institutional capacity should accordingly be supported as a precondition for research undertakings.

Monitoring and surveillance

Monitoring and surveillance data comprise an important basis for each step in policy development and implementation, for example in setting priorities. Alcohol monitoring and surveillance systems are necessary to identify and publicize information about current and future trends, the effectiveness of policy actions, risk factors for alcohol-related harm, vulnerable groups, organizational and institutional challenges in implementing policies, governance, key contextual factors, the role and motivation of key actors, user and consumer preferences, opportunities for and constraints on change, and events and reforms in other sectors that have implications for alcohol policy. Information systems are a critical element in disseminating knowledge on alcohol and must be accessible to a wide range of actors, including researchers, health professionals, decision-makers and policy advocates.

The professional workforce

The professional workforce engaged in alcohol policy and implementation includes public health practitioners, policy advocates and researchers. Alcohol policy work requires an appropriately trained workforce with a wide variety of knowledge and skills. Its training needs include higher education, as well as postgraduate training that develops knowledge and skills relevant to public health and alcohol policy.

Capacity-building

In some of the European countries in transition, effective action on alcohol has been hampered by a poor understanding and lack of information about modern epidemiology, public health, health promotion, evidence-based medicine and the application of social science research, due in part to a lack of public health education and training opportunities. In addition, to negotiate effectively with the alcohol industry, other stakeholders need to understand it better and develop media and policy advocacy skills. Better training needs to be developed to address these deficits.

Financing action

Finally, effective alcohol policies cannot be developed and implemented without sufficient funds, which are critical to all aspects of alcohol policy. Funding sources can include governmental budgets, donations from charitable organizations and earmarked taxes.

Bibliography

König C, Segura L (2009). *Do infrastructures impact on alcohol policy making?* Barcelona, Alcohol Public Health Research Alliance (AMPHORA).
This paper may be obtained by contacting the AMPHORA project at amphoraproject.net.

FACT SHEET
Alcohol Policy Series June 2010

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.

With the support of

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INŠTITUT ZA VAROVANJE ZDRAVJA REPUBLIKE SLOVENIJE

DHS
Deutsche Hauptstelle für Suchtfragen e.V.

Generalitat de Catalunya
Departament de Salut

Co-financed by

European Commission