

Monitoring and evaluation

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 monitoring and evaluation and considers six issues:

1. The evidence for monitoring and evaluation
2. Per capita consumption
3. Survey data
4. Health indicators
5. Monitoring reports
6. 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. THE EVIDENCE FOR MONITORING AND EVALUATION

To be effective, national alcohol action plans and strategies should include objectives and targets that are publicized and worked towards. Process and outcome indicators and targets need to be developed, used and monitored, with annual reports to keep stakeholders informed. Regular evaluation allows tracking of progress in implementing the national action plan or strategy, helps identify what is working and what is not and enables regular revision of the plan or strategy. The national instrument and the monitoring reports should be made public, and civil society and other stakeholders should be invited to provide comments and feedback on them at regular intervals.

The European Commission's Committee on Data Collection, Indicators and Definitions has recommended three key indicators for monitoring changes in alcohol consumption and alcohol-related harm. These indicators measure:

1. *volume of consumption* (total recorded and unrecorded per capita consumption of pure alcohol in litres by adults (15 years and older), with subindicators for beer, wine, and spirits);
2. *consumption pattern* (intake of at least 60 grams of alcohol on a single occasion at least once per month during the previous 12 months); and
3. *alcohol-related health harm* (years of life lost (YLL) attributable to alcohol, with subindicators for alcohol-attributable YLL from chronic disease and from injury) (2008).

There are many potential sources of data for monitoring the impact of alcohol policies and strategies, including the following.

Affordability data. The *alcohol price index* shows how much the average price of alcohol has changed compared to a given base price. The *retail price index* (RPI) is a measurement of inflation that shows how much the composite price of common retail items have changed compared with their base price. The *relative alcohol price index* is then calculated thus:

$$(\text{alcohol price index}/\text{retail price index}) * 100$$

The resulting number shows how the average price of alcohol has changed relative to the prices of other goods. A value of less than 100 indicates that the price of alcohol has risen less than inflation during the period examined. The *real household disposable income index* measures total household income – minus taxes, pensions and other similar payments – converted to real terms (i.e. after dividing by a general price index to remove the effect of inflation). The *affordability of alcohol* indicates its relative affordability by comparing changes in its price relative to other goods, to changes in disposable income during the same period. It is calculated thus:

$$(\text{real household disposable income index}/\text{relative alcohol price index}) * 100$$

If the affordability is above 100, then alcohol is more affordable than in the base year.

Availability of alcohol. The availability of alcohol, shown as the volume of alcohol released for home consumption per capita, can usually be obtained from revenue and customs data.

Crime data. Population-based surveys and police records can provide data on patterns and trends in alcohol-related crime.

Expenditure and food surveys. Expenditure and food surveys, typically based on individual diaries, can provide data on spending and food consumption, which in this case includes alcoholic beverages. The diaries record expenditures and quantities of purchased food and drink, rather than of consumed food and drink.

General household surveys. General household surveys are usually continuing surveys that collect information on a range of topics from private households. Questions about drinking can be included, to estimate for example changes in the prevalence of heavy episodic drinking.

Hospital episode statistics. Hospital episode statistics record hospital admissions, which are classified using the ICD (WHO, 2006). The ICD is the standard international diagnostic classification for all general epidemiological purposes and many health management purposes. It is used to classify diseases and other health problems listed in many types of health and vital records, including hospital records and death certificates. WHO publishes the ICD, currently in its tenth revision (the ICD-10). Admissions for conditions that are wholly attributable to alcohol (for example alcoholic psychosis) can be supplemented with estimated admissions for conditions that are partially attributable to alcohol (for example hypertension) to provide a more complete picture of alcohol's role in ill health.

ICD-10. The tenth revision of the ICD (WHO, 2006), the latest in a series of disease classifications, incorporates a major reorganization of the structure and groupings in the ninth revision. An alphanumeric coding scheme replaces the numeric one, e.g. alcohol dependence syndrome has been changed from 303 in ICD-9 to F10.2 in ICD-10. The regrouping of classifications means that they do not always map precisely between the two revisions; for instance, the nearest equivalent to the ICD-9 code 571.1 (acute alcoholic hepatitis) are the ICD-10 codes K70.1 (alcoholic hepatitis) and K70.9 (alcoholic liver disease, unspecified). Deaths can also be classified by ICD-10 codes, supplemented by alcohol-attributable fractions for deaths from alcohol-related conditions.

Omnibus surveys. Omnibus surveys are multipurpose surveys carried out by national statistics offices in most months of the year on behalf of a range of government departments and other bodies. Questions on drinking can be included on an ad-hoc basis.

Road casualty reports. Road casualty reports can provide detailed information about accident circumstances (including drink-driving), vehicle involvement and any resulting casualties, along with contributory causes and key trends.

School and adolescent surveys. Many countries participate in the Health Behaviour in School-aged Children (HBSC) survey (hbcs.org) and the European School Survey Project on Alcohol and Other Drugs, which provide regular data on young people's alcohol consumption.

Annual reports on alcohol. Based on the above data sources, annual reports on alcohol can be prepared each year that cover at a minimum the following four topics:

1. *drinking among adults*, including trends in alcohol consumption, types of alcohol consumed, socioeconomic variables, demographic characteristics, drinking and pregnancy, adults'

drinking behaviour and knowledge of alcohol, and geographical patterns of alcohol consumption;

2. *under-age drinking*, including trends in alcohol consumption, types of alcohol consumed, drinking among different ethnic groups, drinking and mental health, and minors' drinking behaviour and knowledge of alcohol;
3. *drinking-related ill health*, including hazardous, harmful and dependent drinking, consultations about drinking with health professionals, alcohol-related hospital admissions and alcohol-related mortality; and
4. *costs to society*, including expenditures on alcohol, availability and affordability of alcohol, alcohol-related crime and alcohol-related traffic accidents.

2. PER CAPITA CONSUMPTION DATA

Only 16 countries (64%) were able to provide the recorded adult (15+ years) per capita consumption of alcohol at the national level, for the last five years. Eleven countries (44%) could provide unrecorded consumption data, which included legal home brew in 5 countries, illegal home brew in 7, smuggled in 7 and border trade in 7. Three countries had consumption data for tourists.

3. SURVEY DATA

Twenty two countries (88%) had data from national surveys on alcohol consumers in the general population dating from the last five years, although in four of the 22 countries this was more than two years out of date. Twenty five countries (80%) could provide data on the proportion of abstainers, although this was only available in nine countries for the past two years. Twenty three countries (92%) could provide data on underage drinking, although there was limited common ground in the definition of underage drinking, Figure 1. Fourteen countries (56%) had survey data for young adults, defined in 11 as those between 18 and 25 years.

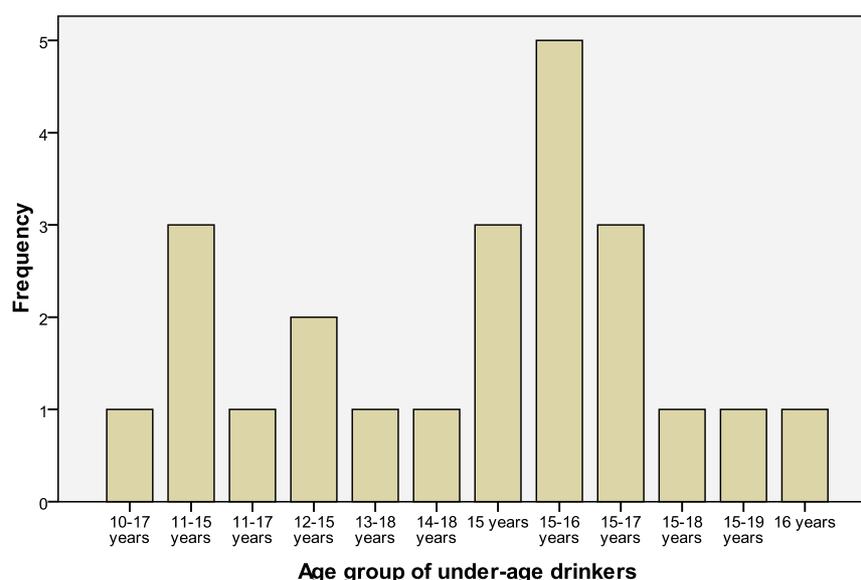


Figure 1 Age groups used in surveys of underage drinkers.

4. HEALTH INDICATORS

Twenty three countries (92%) had one or more health indicator data, Table 1.

Table 1 Number of countries with availability of data for specified health indicator.

Health indicator	Number of countries
Alcohol liver cirrhosis	20
Alcohol related traffic injury	17
Ethanol poisoning	17
Methanol poisoning	12
Alcohol use disorders	17
Liver cirrhosis	21
Road traffic injury	21
Alcohol related crime	10

5. MONITORING REPORTS

Seventeen countries (68%) stated that they produced regular monitoring reports, reporting on a wide range of un-standardized indicators. Twelve of the 17 countries stated that they monitored consumption patterns, six motor vehicle accidents, five alcohol-related deaths, three treatment data, and four crime data.

6. CONSIDERATIONS AND NEXT STEPS

Questions to consider

1. ***Are routine data on alcohol readily available within a reasonable timeframe?*** That is the key prerequisite for compiling a summary annual report on alcohol. There are many different alcohol data sources, often scattered throughout different government departments and bodies. These disparate sources need to be brought together to prepare an overview of alcohol consumption and alcohol-related harm and describe trends, thereby making it possible to monitor the impact of existing policies and programmes.
2. ***Do existing surveys incorporate the alcohol questions needed to obtain the data needed for an annual report on alcohol?*** If not, there are often a variety of periodic surveys, whether conducted by the national statistics office or other government departments, to which relevant questions about alcohol can easily be added.

Options for action

- ***Maintain the status quo.*** Although a number of countries produce annual reports on alcohol that collect all the relevant data, it is likely that every country can find ways to improve these data and strengthen its reporting systems. Moreover, it is difficult to

improve existing action plans and strategies in the absence of extensive monitoring and evaluation.

- **Assemble all the available data on alcohol each year in one report** covering consumption, harm and social costs, and publicize the report widely. This annual report could also include on a rotating basis more detailed information on a given topic.
- **Refine the analytical methods used in generating data on alcohol.** Morbidity and mortality data should include the calculation of alcohol-attributable fractions. It is also important to estimate social costs, particularly the avoidable social costs that result from implementing specific alcohol policy measures.

Stakeholders for action

- Since many government departments are responsible for gathering the data and conducting the various surveys that could contribute to an annual report on alcohol, it may be appropriate to create an alcohol information task force to support the collection and availability of these data. Internationally, European countries are also obligated to report certain data regularly to WHO and (if EU members) the European Commission.

Bibliography

Committee on Data Collection, Indicators and Definitions (2008). *1st meeting: Luxembourg, 4 December 2008: summary report*. Luxembourg, European Communities (http://ec.europa.eu/health/ph_determinants/life_style/alcohol/Forum/docs/ev_20081204_mi_en.pdf, accessed 12 July 2009).

The Committee is developing indicators to monitor the implementation of the European Commission's 2006 communication on alcohol.

National Health Service (NHS) Information Centre for Health and Social Care (2008). *Statistics on alcohol: England, 2008*. London, NHS Information Centre for Health and Social Care (<http://www.ic.nhs.uk/pubs/alcohol08>, accessed 23 August 2009).

An example of an annual report on alcohol from the United Kingdom.

WHO (2006). International Statistical Classification of Diseases and Related Health Problems: 10th revision: version for 2007 [online database]. Geneva, WHO (<http://apps.who.int/classifications/apps/icd/icd10online>, accessed 16 August 2009).

WHO (2009b). Global Information System on Alcohol and Health (GISAH) [web site]. Geneva, WHO (<http://apps.who.int/globalatlas>, accessed 23 August 2009).

GISAH provides rapid, easy access to a wide range of alcohol-related health indicators. It is an essential tool for assessing and monitoring the health situation and trends relating to alcohol consumption, alcohol-related harm, and policy responses in individual countries.

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