



COMPARING ALCOHOL POLICIES –
A CASE STUDY OF ALCOHOL POLICY STRATEGIES IN FOUR
EUROPEAN COUNTRIES

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ABSTRACT

PURPOSE: The purpose of this study is to better understand differences, similarities and trends of national-level alcohol policies in different parts of Europe as viewed in their contexts and with a focus on the policy-making process and influencing factors.

METHOD: This case study included a combination of document and interview data and considered four European countries with different traditions concerning drinking culture, geographical location and policy approach. The countries were selected through purposive sampling. National-level official policy documents were collected using an openly accessible database. Four interviews with a national expert from each of the study countries were conducted by telephone, recorded and transcribed. Data analysis centred on a variety of alcohol policy strategies and factors influencing the policy-making process.

RESULTS: The data show that all four countries have implemented a variety of complementary alcohol policy strategies including both preventive and regulatory strategies. However, alcohol policies are complex and the findings show differences across the four countries in priorities, type and number of preventive versus regulatory strategies, their implementation and enforcement, and their strictness. The results furthermore illustrate the variety of actors and their level of influence in the policy process.

CONCLUSION: Alcohol consumption and policies are embedded into complex social, cultural, historical and political circumstances and are greatly influenced by these contexts. Despite existing differences, a combination of a variety of

alcohol policy strategies, which are in accordance with the five health promotion strategies, is applied in all four countries. European recommendations or regulations provide guidance for national level alcohol policies on the one hand, but might also hinder advances for alcohol policies from a public health perspective. It is necessary to consider all policy sectors at all levels in order to build healthy public policy. The policy-making process involves many actors with competing interests, which makes it necessary to advocate for alcohol policy from a public health perspective.

1 INTRODUCTION

Alcohol is one of the most important risk factors for ill-health and premature death. Responses to this health threat are multifaceted. Health promotion acknowledges that “the major influences on health status are outside the immediate control of individuals [and] has focussed attention on the role of the environment and healthy public policy” (Tones & Green, 2004, p.175). Thus, political action must be an essential part of efforts to reduce alcohol-related harm.

Every country in the European Union (EU) has implemented some kind of policies and strategies to counteract the adverse effects of alcohol on health. Alcohol policies can include a variety of areas comprising of policies reducing drinking and driving; policies that support education, communication, training and public awareness; policies that regulate the alcohol market; policies that support the change of drinking and surrounding environments; restriction of the volume and content of commercial communications of alcohol products; and interventions to reduce hazardous and harmful alcohol consumption and alcohol dependence (Anderson & Baumberg, 2006). Strategies to reduce alcohol-related harm are well studied and the findings show the effectiveness and cost-effectiveness of policy strategies (Österberg, 2004) as well as mechanisms and processes that relate policies to outcomes (Babor, et al., 2003). However despite research evidence, alcohol policies vary considerably throughout Europe, for example regarding priorities of the implemented strategies and their strictness, and do not always focus on strategies proven to be most effective.

“There is a gap between the possible and the practical, which is linked by the process of alcohol policy-making” (Babor, et al., 2003, p.225). The policy-

making process is not only informed by the scientific community but also by a variety of other aspects and groups such as commercial interests, the media, public interest groups and non-governmental organisations, and the general public (Babor, et al., 2003). Furthermore, the country-specific national context such as drinking culture (e.g. alcohol consumption, drinking patterns), political framework and historical background build a foundation for policy-making. “The social and political environment within a country both shapes and is shaped by national alcohol policies” (Anderson & Baumberg, 2006, p.374).

Influences from international and European level are increasingly important. Trade law or economic issues on international or EU level may restrict alcohol policies. Nevertheless, one of the aims of the EU is to protect and promote the health of its citizens together with the Member States. There exist several initiatives and recommendations seeking to guide alcohol policy and action on national level. A European level alcohol strategy has been developed additionally to national-level alcohol policies.

Various studies have been carried out to investigate the use of alcohol as well as policy responses in a European perspective. Anderson and Baumberg (2006) have delivered a comprehensive report on this topic including health matters, the economic role of alcohol as well as alcohol policies. The European Comparative Alcohol Study (ECAS) concerns alcohol policies, alcohol consumption, and alcohol-related harm in 15 European countries within a comparative and longitudinal approach (Norström, 2002). A study by Rehn, Room and Edwards (2001) covers alcohol consumption, alcohol-related harm and alcohol policy measures. Another study provides a collection of country reports

for EU Member States and Norway, illustrating similarities, differences and trends in alcohol policies (Österberg & Karlsson, 2002). The Global Status Report: Alcohol Policies presents an overview of existing alcohol policies in WHO Member States (World Health Organization, 2004b). Those studies are extensive and comprehensive overviews of the situation and trends in the whole of Europe. Other studies develop a scale to analyse and compare the strength of alcohol policies (Karlsson & Österberg, 2007).

The purpose of this study is to better understand differences, similarities and trends of national-level alcohol policies in different parts of Europe as viewed in their contexts. This comparative analysis seeks to explore contents of alcohol policies in four European countries with different traditions, compare them and examine them with consideration of their historical, social, cultural and political circumstances and with a focus on policy processes and influences of scientific evidence and recommendations, European level initiatives as well as the concept of healthy public policy.

1.1 THE RESEARCH QUESTIONS

The following research questions evolve from the aims and the purpose of the study.

- What are the contents of national-level alcohol policies in the four European countries and how do alcohol policies differ in these countries?
 - Which policy areas are addressed and which strategies are highlighted (e.g. taxation, availability restrictions, education, treatment)?
 - Is research evidence used in alcohol policy decision-making (processes) and the implementation thereof?

- Do international or European level processes and particularly EU recommendations influence alcohol policy and its development process in various European countries?
- How do alcohol policies meet the requirements of healthy public policies?

2 BACKGROUND

2.1 THE SOCIAL AND CULTURAL CONTEXT – AN OVERVIEW OF ALCOHOL USE, MEANINGS AND POLICIES IN EUROPEAN COUNTRIES

2.1.1 A BRIEF HISTORY OF ALCOHOL IN EUROPE

Alcohol has a long history in Europe. It has been produced and drunk for thousands of years. Until the early nineteenth century, beer and other weak alcoholic drinks were common beverages in everyday life and drunkenness was generally accepted. When distilled alcohol was discovered, it was also used for medical purposes (Room, Babor, & Rehm, 2005).

From the industrial revolution, alcoholic drinks became more available, stronger and cheaper (Anderson & Baumberg, 2006). Growing markets for commercial production, trade, and improved transportation were accompanied by increased consumption of alcohol across Europe and increasing visible problems resulting from alcohol use (Anderson & Baumberg, 2006). As a result, in the beginning of the nineteenth century, the so-called ‘temperance movement’ led to prohibitions, partly prohibitions or other policies such as taxes or state monopolies seeking to minimize the harms from drinking (Anderson & Baumberg, 2006). Earlier, policies on alcohol concerned public order or market regulations rather than public health.

The medical recognition of alcohol addiction accompanied by the development of treatment facilities took place during the nineteenth century (Room, et al., 2005). Nowadays, within the ‘new public health movement’ the

view on alcohol covers besides the concept of alcoholism, also social harms such as productivity loss, crime, poverty (Room, et al., 2005).

2.1.2 THE ECONOMIC IMPACT OF ALCOHOL

PRODUCTION

Europe produces a quarter of the world's alcohol production (Anderson & Baumberg, 2006). Anderson and Baumberg (2006) calculated the importance of the different beverages on the global alcohol market. Thereby, **wine** is the most important alcoholic product in Europe. Over half of the world's wine production is coming from Europe with the greatest total wine-producing areas in France, Italy and Spain¹. With over 20% of the global alcohol production, **beer** is another important product on the world's alcohol market. Germany is the largest producer of beer in Europe, followed by the UK, Poland, Spain, the Netherlands, Czech Republic, France and Belgium. Although **spirit** production mostly takes place outside the EU, the UK, France and Germany are among the 10 highest-producing countries for spirits in the world.

TRADE

More than 70% of all exports of alcohol in the world come from European countries, although over half of the exports go elsewhere within the European Union (EU) rather than the rest of the world (Anderson & Baumberg, 2006). France, the UK, Italy, Spain, the Netherlands and Germany are the countries exporting the most alcohol (combined over 60% of the world's total) (Anderson & Baumberg, 2006).

¹ <http://ec.europa.eu/agriculture/markets/wine/prod/inv.pdf> - Inventory of wine-growing potential of the European Commission

TAXES AND TAX LOSSES

Alcohol-specific taxes constitute between 0.5 – 3% of the total tax income in EU15² countries (Anderson & Baumberg, 2006). They are thus an important income for many national governments. Besides, general taxes are related to alcoholic products including general sale taxes, income tax, and corporation taxes.

Tax losses arise through illegal trade. The European High Level Group on Fraud in the Tobacco and Alcohol Sectors (1998) estimated that €1.5bn was lost due to fraud within the EU15 in 1996. Legal cross-border shopping, associated with a legal avoidance of taxes, has increased and is important, especially in areas with large price difference across small distances (Anderson & Baumberg, 2006).

EMPLOYMENT

Besides, alcohol is associated with employment. The industry-founded Amsterdam Group (TAG) estimated that nearly 850,000 people work in alcohol producing industry in the EU (Naert, Naert, & Maex, 2001). A larger amount of employment is indirectly related to alcohol. Retail, wholesale and the Hotels, Restaurants and Catering sector (HoReCa) account for an estimate of 2,723,000 jobs (Naert, et al., 2001). However, there is evidence that a decrease in alcohol consumption may not necessary lead to job losses in the economy as a whole (Lehto, 1997).

SOCIAL COSTS AND SOCIAL BENEFITS

Alcohol is associated with a number of costs to the society including costs for alcohol-related problems as well as for productivity losses due to absenteeism, unemployment and premature mortality. “The social cost of alcohol is the cost to

² 15 countries of the European Union, i.e. Austria, Belgium, Denmark, France, Finland, Germany, Greece, Ireland, Italy, Luxembourg, Netherlands, Portugal, Spain, Sweden, United Kingdom

society of everything that happens in Europe in 2003 which would not happen in a world without alcohol” (Anderson & Baumberg, 2006, p.60). Anderson and Baumberg (2006) undertook a review and estimated the total tangible costs of alcohol to the EU society in 2003 to be €125bn, equivalent to 1.3% of the gross domestic product (GDP). The intangible costs, which describe the value people place on pain, suffering and life itself due to crime and lost healthy life due to alcohol, were estimated to be €270bn (Anderson & Baumberg, 2006). These costs take into account some health benefits, while other social benefits of alcohol have not been evaluated yet (e.g. ‘cost savings’ in healthcare as people’s early deaths prevent them from getting a disease that is more costly to treat; benefits from the pleasure that people get from drinking alcohol) (Anderson & Baumberg, 2006).

2.1.3 THE USE OF ALCOHOL IN EUROPE

ALCOHOL CONSUMPTION

The European Region has the highest alcohol consumption in the world with an average consumption of each adult above 15 years drinking 11 litres of pure alcohol each year (World Health Organization, 2004a). Alcohol consumption is slightly lower in the EU10³ (10½ litres) than in the EU15 (11½ litres) and noticeable lower in three of the Nordic countries (Anderson & Baumberg, 2006). Considering unrecorded consumption and abstention rate, the total amount of alcohol consumption is higher (15 litres), differing from country to country so that in Norway and Iceland, for example, alcohol drinkers consume less than 10 litres whereas Bulgaria, Hungary, Latvia, Lithuania, and Turkey have an average consumption per drinker of more than 20 litres (Anderson & Baumberg, 2006).

³ 10 Member States of the European Union which joined in 2004, i.e. Cyprus, Czech Republic, Estonia, Hungary, Latvia, Lithuania, Malta, Poland, Slovakia, Slovenia

WAYS OF DRINKING

Looking at drinking patterns in the European region, most alcohol is consumed in the form of beer (44%), followed by wine (34%) and spirits (23%) (Anderson & Baumberg, 2006). In the EU15, drinking patterns often show a north-south gradient concerning preferred drinking beverage, drinking frequency and drinking occasion. Central and northern European countries prefer beer, while in southern Europe wine is the preferred beverage (Anderson & Baumberg, 2006). Drinking with meals and more frequent or daily drinking is more common in the south of the EU15, while binge-drinking⁴ and drunkenness has the highest occurrence in the north of Europe (Hemström, Leifman, & Ramstedt, 2002). However, it is worth stressing that there exist several exceptions in this (historical) pattern (Anderson & Baumberg, 2006). There is limited evidence about drinking patterns in the EU10. However, the consumption of spirits seems to be higher in many countries of the EU10 than in the EU15. Besides, the drinking frequency is lower while binge-drinking is as common as in the EU15 (Anderson & Baumberg, 2006).

2.1.4 THE IMPACT OF ALCOHOL

Besides a few social and health benefits for the individual, alcohol increases the risk of a great number of health and social harms.

Peele and Brodsky (2000) found evidence for psychosocial benefits of moderate drinking in the areas of subjective health, mood enhancement, stress reduction, sociability, social integration, mental health, long-term cognitive functioning, and work income/disability. Besides, a small amount of alcohol

⁴ which is defined as drinking above a certain number of drinks at one drinking occasion

reduces the risk of coronary heart diseases, although further research is needed (Corrao, Rubbiati, Bagnardi, Zambon, & Poikolainen, 2000).

On the other hand, alcohol is also associated with more than 60 health harms including injuries, neuropsychiatric conditions, gastrointestinal conditions, cancers, cardiovascular diseases, immunological disorders, lung diseases, post-operative complications, skeletal conditions, reproductive disorders, and an increased risk of mortality (Rehm, et al., 2003; World Health Organization, 2004a). Furthermore, alcohol consumption increases the individual's risk of negative social consequences such as getting into a fight, harming home life, marriage, work, studies, friendship or social life (Hemström, et al., 2002).

Other people than the drinker are affected as well through being kept awake at night by drunk people, being harassed in public places or private parties, being scolded at, being afraid of drunk people in public areas as well as more serious consequences such as being physically hurt or property damaged (Rossow & Hauge, 2004). Moreover, alcohol does not only have an impact on individuals but also on the European society as a whole with health and social harms associated with considerable economic costs.

For many negative consequences, there is an increasing risk with increasing levels of alcohol consumption, with no evidence of the threshold effect (Anderson & Baumberg, 2006; Rehm, et al., 2003).

2.1.5 ALCOHOL POLICY IN EUROPEAN COUNTRIES

Alcohol policies are a response to alcohol-related problems. Barbor (2003, p.95) defines alcohol policy broadly "... as any purposeful effort or authoritative decision on part of governments or non-governmental groups to minimise or

prevent alcohol-related consequences”. Often alcohol policies are categorised into several alcohol policy strategies differing in their overall objectives (e.g. to reduce the harm done by alcohol or to directly control and influence behaviour) and their specific measures (e.g. education, availability restrictions) (Babor, et al., 2003). Some important strategies and interventions concern alcohol pricing and taxation, regulating the physical availability, regulating alcohol promotion, drunk-driving countermeasures, modifying the drinking context, education and persuasion, and early identification and treatment (Babor, et al., 2003). From a public health perspective, alcohol policies have the central intention “to serve the interests of public health and social well-being through their impact on health and social determinants” (Babor, et al., 2003, p.7).

Every country in the European Union has implemented a number of alcohol-specific policies, however with varying priorities and approaches across the countries. The strictness of alcohol policies in European countries can be illustrated on a single scale from 0 (no restrictions) to 40 (all restrictions) and ranges within Europe from 4.5 in Luxembourg to 37.5 in Norway, with an average of 14.5 (Karlsson & Österberg, 2007). Generally, policies are most strict in northern European countries, least strict in southern Europe and in parts of central and eastern Europe including wine-producing countries (that do not have a positive excise duty on wine) and medium in beer-preferring countries in central and eastern Europe (Karlsson & Österberg, 2007).

Anderson and Baumberg (2006) provide a summary of alcohol policies in the countries of Europe based on data from the Global Status Report on Alcohol

Policy (World Health Organization, 2004b) which are updated by members of a alcohol policy network. This information is the basis of the following overview.

The existence of a national alcohol action plan forms a concrete framework for alcohol policies. Still, under half the EU countries do not have an action plan and/or coordinating body for alcohol.

The average effective tax rate⁵ is lowest in southern Europe and in parts of central Europe, whereas northern Europe, the Baltic countries, the UK, Ireland and Poland have the highest tax rates.

Only a few (northern European) countries have retail monopolies but the majority require licences to sell alcohol. In addition, many countries restrict places or hours of alcohol sale. Some countries limit days of sales or density of alcohol retailers. Again, some of the northern European countries have all types of restrictions, while some central, eastern and southern European countries have none. However, there exist exceptions and there is no consistent north-south gradient visible. Furthermore, drinking restrictions in inappropriate situations such as while driving, at workplaces or in public spaces are common throughout Europe. All countries prohibit sales to young people beneath a certain age in bars and pubs and almost all countries (except four countries) restrict shop sales. The age limits for these restrictions vary throughout Europe from 16 to 20 years.

Alcohol marketing through television adverts is banned completely in five countries only, while just over half of Europe has partially legislation (beyond content restrictions). Voluntary agreements are relatively common in EU15,

⁵ The effective tax rate considers if policy implementations account for specific drinking patterns such as the preferred beverage.

whereas the EU10 are more likely to have no control. Regulations for billboard and print media advertisements as well as sponsorships are even less common.

School-based education programmes are well developed throughout Europe.

2.2 THE SCIENTIFIC CONTEXT – RESEARCH EVIDENCE ON ALCOHOL POLICY

2.2.1 POLICY OPTIONS & THEIR EFFECTIVENESS

Above, several groups of alcohol policy strategies have been introduced. Findings from research and other evidence show the effectiveness of various alcohol policy strategies.

Effective policies that regulate the alcohol market include taxation and restrictions on the availability of alcohol. There is strong evidence that an increase in prices leads to a decrease in alcohol consumption and the other way around (Anderson & Baumberg, 2006; Babor, et al., 2003; Österberg, 2004). Besides, taxes create revenue for the government and are easy to establish and easy to enforce (Babor, et al., 2003). The sensitivity and way of reaction to price change, however, varies between countries stemming from different social, cultural and economic contexts (Babor, et al., 2003; Österberg, 2004). An increase in prices is nevertheless effective in reducing alcohol consumption, hazardous and harmful alcohol consumption, alcohol dependence, and the harm done by alcohol to the individual drinker and to others than the drinker (Anderson & Baumberg, 2006). However, the possibilities for circumventing taxes through smuggling or illegal production have to be considered (Babor, et al., 2003).

Restrictions on availability of alcohol such as a minimum drinking age, government retail outlets, restrictions on the number and density of outlets and on hours and days of sale are also effective in reducing harm done by alcohol (Anderson & Baumberg, 2006). This is not culturally specific (Österberg, 2004).

There is limited evidence on the effectiveness of restrictions on alcohol advertising and great controversy in this area (Babor, et al., 2003). Nevertheless, Anderson and Baumberg (2006) conclude that restricting the volume and contents of commercial communications are likely to reduce harm. Self-regulations on the other hand have shown to be “fragile and largely ineffective” (Babor, et al., 2003).

There is evidence that the drunk-driving legislation including lowered blood alcohol concentration (BAC) levels, random breath testing, administrative licence suspension, and lower BAC levels and graduated licences for young drivers, when adequately enforced and having public support and awareness, are highly effective (Anderson & Baumberg, 2006; Österberg, 2004).

Strategies that are directed at the individual, such as educational programmes and public education campaigns, are expensive and seem to have little effect on alcohol consumption and alcohol-related problems (Anderson & Baumberg, 2006; Babor, et al., 2003).

There is growing evidence for the impact of strategies that change the drinking and surrounding environments in reducing harm done by alcohol (Anderson & Baumberg, 2006). This concerns mainly on-premise drinking in bars and restaurants and depends on adequate enforcement (Anderson & Baumberg, 2006; Babor, et al., 2003). Community-based prevention programmes can increase the effectiveness of such strategies.

Interventions to reduce hazardous and harmful alcohol consumption and alcohol dependence targeting the individual are, for example, brief advice in primary care, in accident and emergency departments as well as in work-based programmes. Although these interventions are cost intensive, they are an effective strategy in reducing harmful alcohol consumption (Anderson & Baumberg, 2006). Generally, early intervention strategies and treatment are not shown to be very effective in reducing consumption at population level, but are necessary and benefit a small proportion of the population (Österberg, 2004).

2.3 THE POLITICAL CONTEXT – THE POLICY-MAKING PROCESS AND INFLUENCING FACTORS

2.3.1 THE POLICY-MAKING PROCESS

The previous sections provide an overview of existing alcohol policies in European countries as well as of research evidence of the effectiveness of various alcohol policy strategies. However, evidence is not necessarily guiding the development and implementation of alcohol policies in practice. As de Leeuw (1993, p.49) states, “epidemiologists have often witnessed how their research findings have not been translated into effective policies, policy-makers complain that they cannot find appropriate data to base their plans on”. Thus, “there is no simple relation between scientific findings and policy-making” (Babor, et al., 2003, p.248). This points to the relevance of the policy-making processes and brings up several questions: How are policies developed? Who is involved in the process and who/ what affects policy development?

Tones and Green (2004) identify four main stages of policy making, i.e. problem identification, policy formulation, implementation and evaluation.

However, in reality the process is very complex and neither simple nor straightforward. De Leeuw (1993, p.50) argues, that it is not a rational process based on objective information: “The essential perspective is that the making of policy is intimately connected with implicit assumptions, interests, and power positions.” Milio (1987) remarks that policy development is influenced by the social climate and the interests of key participants.

[...] policy development – initiation, adoption, implementation, evaluation and reformulation – is seen as a continuous, but not necessarily linear, social and political process. Policy substance (content) changes under the influence of both changing social, political and economic conditions (social climate) and the changing perceptions of interested parties (Milio, 1987, p.266).

Governments play a substantial role in the development of policy, but many more actors are involved into the process. Tones and Green (2004) provide an overview of such groups. ‘Policy actors’ are directly involved in policy-making and may be individuals, groups or organisations, while ‘stakeholders’ include all who are affected by a policy. The ‘policy keeper’ is the agency holding the policy. While ‘interest or pressure groups’, which are organised groups, attempt to influence the direction of the policy, influences may also come from individuals who engage directly in the policy process. Besides, ‘policy networks’ or ‘coalitions’ may develop to engage within a policy arena. Barbor et al. (2003) consider commercial interests, the mass media, the scientific community, public interest groups and non-governmental organisations, the general public, national governments, and community coalitions as actors involved in alcohol policy formation. Since a policy-making process involves a great variety of actors, not all of them can be successful in achieving their objectives.

Depending on their priorities, the groups deploy their resources to influence the shape, pace, or direction of policy-making in ways that will either enhance or at least not harm their interests. The effectiveness of their efforts depends on their influence, status, resources, and skill relative to competing groups that have different interests (Milio, 1987, p.268).

Therefore Ham & Hill (1993) argue that many policies are products of negotiation and compromises between conflicting values or key interest and may be formed without consideration of other underlying powerful influence (e.g. economic ones) which might weaken them. In this process of negotiations and compromises, the actors with most power and resources to pursue their interests are more successful. Consequently, sectors other than the health sector might be prioritised.

Health policy priorities are dependent on broader priorities and aims of governments and it is in this context that politics of implementation are of importance. [...] This has lead to a situation where, rather than articulating how economics, industrial and trade policies could contribute to the health and well-being of European citizens, health policies and especially the organization and financing of health services provision are scrutinized themselves in terms if their compliance with and contribution to industrial, trade and economic policies. (Ståhl, Wismar, Ollila, Lahtinen, & Leppo, 2006, p.10)

2.3.2 HEALTHY PUBLIC POLICY – PUBLIC POLICY FROM A HEALTH PROMOTION PERSPECTIVE

Upon reflection, an ecological view of health leads to an awareness that the many contexts in which people live and the ways people relate to them are profoundly influenced by the most powerful collective means to shape human living: public policy. [...] Public policy then becomes a prime approach to creating the conditions and relations that can nurture health (Milio, 1987, p.8-9).

Healthy public policy has become a crucial theme in health promotion.

The Ottawa Charter, result of the First International Conference on Health Promotion, identifies five health promotion strategies: ‘Build Healthy Public Policy’, ‘Create Supportive Environments’, ‘Strengthen Community Action’,

‘Develop Personal Skills’ and ‘Reorient Health Services’ (World Health Organization, 1986). Healthy public policy is thus one of the priority areas of health promotion, characterised by an involvement of all sectors at all levels and an application of various strategies.

Health promotion [...] puts health on the agenda of all policy makers in all sectors and at all levels, directing them to be aware of the health consequences of their decisions and to accept their responsibilities for health. Health promotion policy combines diverse but complementary approaches including legislation, fiscal measures, taxation and organisational change. [...] Health promotion policy requires the identification of obstacles to the adoption of healthy public policies in non-health sectors, and ways of removing them. The aim must be to make the healthier choice the easier choice for policy makers as well (World Health Organization, 1986).

The Second International Conference on Health Promotion, held in Adelaide in 1988 had a particular focus on healthy public policy (World Health Organization, 1988). It is stressed that health issues have to become more present within the policy arena since all sectors of government, not only the health sector, have an impact and therefore a responsibility for health. The Adelaide Recommendations on Healthy Public Policy furthermore emphasise that many government sectors, and other organisations, have a great influence on health.

In the pursuit of healthy public policy, government sectors concerned with agriculture, trade, education, industry, and communications need to take into account health as an essential factor when formulating policy. These sectors should be accountable for the health consequences of their policy decisions. They should pay as much attention to health as to economic considerations. [...] Government plays an important role in health, but health is also influenced greatly by corporate and business interests, nongovernmental bodies and community organisations (World Health Organization, 1988).

Since then the focus on the development of healthy public policy addressing all levels and sectors has continuously been confirmed as vital for the promotion of health. The Jakarta Declaration confirmed the five strategies of the

Ottawa Charter including 'build healthy public policy' (World Health Organization, 1997). The Fifth Global Conference on Health Promotion in 2000 established the Mexico Ministerial Statement signed by 87 countries. Among other aspects, the statement "acknowledges that the promotion of health and social development is a central duty and responsibility of governments, that all sectors of society share" and aims to "position the promotion of health as a fundamental priority in local, national and international policies and programmes" (World Health Organization, 2000b). The Bangkok Charter builds upon the values, principles and action strategies set up by the Ottawa Charter for Health Promotion. One of the key commitments addresses the responsibility of the government in the promotion of health: "Local, regional and national governments must give priority to investments in health, within and outside the health sector and provide sustainable financing for health promotion" (World Health Organization, 2005b).

'Tobacco and alcohol' are among the four key action areas for healthy public policy that have been identified in the Adelaide Recommendations. They are recognised as "two major hazards that deserve immediate action through the development of healthy public policy" (World Health Organization, 1988).

The production and marketing of tobacco and alcohol are highly profitable activities – especially to governments through taxation. Governments often consider that the economic consequences of reducing the production and consumption of tobacco and alcohol by altering policy would be too heavy price to pay for the health gains involved. This Conference calls on all governments to consider the price they are paying in lost human potential by abetting the loss of life and illness that tobacco smoking and alcohol abuse cause. Governments should commit themselves to the development of healthy public policy by setting nationally-determined targets to reduce tobacco growing and alcohol production, marketing and consumption significantly by the year 2000 (World Health Organization, 1988).

Crucial for health promotion and specifically healthy public policy is advocating, one of the three action areas of health promotion as identified by the Ottawa Charter. The aim is to raise the attention that is given to health aspects: “The commitment to healthy public policy demands an approach that emphasizes consultation and negotiation. Healthy public policy requires strong advocates who put health high on the agenda of policy-makers” (World Health Organization, 1988).

Other concepts such as ‘Health in All Policies (HiAP)’ are closely related to ‘Healthy Public Policy’ and stress the necessity to consider health in all policy sectors and at all levels.

HiAP is a horizontal, complementary policy-related strategy with a high potential for contributing to population health. The core of HiAP is to examine determinants of health, which can be influenced to improve health but are mainly controlled by policies of sectors other than health. [...] In addition to the recognition that HiAP is about population health and health determinants, it also concerns addressing policies in the context of policy-making at all levels of governance, including European, national, regional and local levels of policies and governance (Ståhl, et al., 2006, p.4).

2.4 THE INTERNATIONAL CONTEXT – GLOBAL AND EUROPEAN FACTORS INFLUENCING ALCOHOL POLICY

Health policies cannot be considered in a national context only but need to take into consideration international and European legal obligations. “Policy-making in European countries occurs in the framework of a multilevel system. Many national policies are co-determined by European policies. Therefore Health in All Policies will often require changes in the policies on various levels” (Ståhl, et al., 2006, p.xxvii). Ståhl (2006) describes the challenges of different action levels of policy-making within the context of HiAP.

Integrating HiAP has become complex due to the changing structure of decision-making and the existence of different levels of decision-making on health from global to local levels. While in many countries responsibilities, such as health and social service provision, are being delegated to local levels, other issues such as crucial decisions on financial, trade, industrial and agricultural policies have been shifted to international level. This has implied that responsibilities of health outcomes have remained at local level, while crucial decisions influencing the determinants of health are made at European Union (EU) or even global level (Ståhl, et al., 2006, p.9).

Consequently, other fields such as trade law or economics on international or EU level may restrict alcohol policies. Health policies must not contravene international regulations such as the General Agreement on Traffics and Trade (GATT) and the General Agreement on Trade in Services (GATS), although the World Trade Organization (WTO) acknowledges exceptions where health needs to be prioritised over trade interests (Anderson & Baumberg, 2006). The WHO suggests that

Greater interaction is needed between policy-makers and practitioners in the trade and health sectors in order to improve the coherence of domestic and international policy. In view of current and emerging international trade rules, ministries of health need to become more aware of trade issues under consideration within WTO and other international organizations, and need to help colleagues in the ministries concerned with international trade to understand relevant aspects of public health at both national and international levels (World Health Organization, 2005a, p.5).

European trade law includes a prohibition of favouring domestic products, e.g. higher taxation on goods from elsewhere in the EU. Besides, the EU forbids monopolies, which concerns the alcohol market as well. However, exceptions have been made for off-premise retail monopolies. Restrictions on advertising are mostly accepted if they aim to protect health (Anderson & Baumberg, 2006).

Other European policies deal with alcohol as an economic commodity. This concerns, for example, the discussion of standardised excise duties in the

EU, alcohol advertising on television and the support of wine production in the EU15 through the Common Agriculture Policy (CAP).

On the other side, the WHO Regional Office for Europe has for several years been active in facilitating and promoting the development of alcohol policy in the Member States and has passed several resolutions related to alcohol.

The European Charter on Alcohol (World Health Organization, 1995), adopted by Member States in 1995, establishes five ethical principles and goals as guidance for the European Region and calls for the development of comprehensive alcohol policies and the implementation of programmes as appropriate in their differing cultures and social, legal and economic environments. Furthermore, ten strategies for action on alcohol are developed, providing guidelines for implementation and covering the following topics:

- Information and education
- Public, private and working environments
- Drink-driving
- Availability of alcohol products
- Promotion of alcohol products
- Treatment
- Responsibility of the alcohol beverage industry and the hospitality sector
- Society's capacity to respond to alcohol-related harm
- Nongovernmental organizations
- Formulation, implementation and monitoring of policy (World Health Organization, 1995).

The second European Alcohol Action Plan (EAAP) (World Health Organization, 2000a) aims to “prevent and reduce the harm that can be done by alcohol throughout the European region” (World Health Organization, 2000a, p.5). Based on the ten strategies of the European Charter on Alcohol, the EAAP specifies what should be achieved (outcomes) and how (actions). The EAAP concludes that ways of meeting the challenge to reduce the harm done by alcohol

are well known and calls “to exercise political will, to mobilise civil society and carry out systematic programmes in every Member State” (World Health Organization, 2000a, p.18).

In 2006, a framework for alcohol policy in the European Region was published, representing a broad vision for alcohol policy developments, reaffirming existing international alcohol policy initiatives and documents (e.g. the European Charter on Alcohol, EAAP), and aiming to provide guiding principles and goals as well as guidance for policy development on local, national and international level (World Health Organization, 2006). The document calls upon Member States to establish their own national strategies and action plans building upon the framework and considering the EAAP.

The EU on the other hand is not primarily concerned with health issues, and trade and industry interests occasionally conflict with health interests. Nevertheless, the EU has become more active in efforts to prevent the harm done by alcohol. The EU cannot pass laws to protect human health, but might influence through ‘soft-law’ in form of non-binding resolutions and recommendations as well as research and information function (Anderson & Baumberg, 2006). An example is the recommendation on the maximum blood alcohol concentration for drivers. An important recent document is the Council Communication establishing an EU strategy to support Member States in reducing alcohol related harm (Commission of the European Communities, 2006). The Commission has identified the following five priority themes, which are relevant for national policies as well as on EU level:

- *Protect young people, children and the unborn child;*
- *Reduce injuries and death from alcohol-related road accidents;*

- *Prevent alcohol-related harm among adults and reduce the negative impact on the workplace;*
- *Inform, educate and raise awareness on the impact of harmful and hazardous alcohol consumption, and on appropriate consumption patterns;*
- *Develop and maintain a common evidence base at EU level (Commission of the European Communities, 2006, p.7).*

In 2007, the European Commission (EC) established the European Alcohol and Health Forum with the overall objective to provide a common platform for action for all interested stakeholders at EU level (European Commission, 2007).

Moreover, other initiatives operate on a European level. Eurocare, for example, is a European alliance of non-governmental organisations (NGOs) advocating for the prevention of alcohol-related harm in Europe. Besides, a number of European-wide projects have been running active for several years and established an alcohol policy network including over 30 European countries.

As indicated above, a number of international agreements, regulations and recommendations have an impact on alcohol policies, also on national level. Ståhl et al. stressed the necessity to recognise European influences.

Therefore moving health higher up the European agenda is important so that we can be sure that European policies and processes do not hinder the scope of national policy space for healthy public policies within the Member States (Ståhl, et al., 2006, p.21).

3 THE CASE – ALCOHOL POLICIES IN FOUR EUROPEAN COUNTRIES

This chapter provides an overview of alcohol consumption and alcohol policy in four European countries and aims to address the social and cultural background (drinking patterns), the overall political arena as well as alcohol policy strategies that are currently in place. Basic knowledge as necessary to understand the context of the present study and implications for further developments in the field is presented rather than a complete picture, which would exceed the scope of this paper and is available elsewhere.

3.1 GERMANY

Germany, officially the Federal Republic of Germany, is situated in the centre of Europe. The federal parliamentary republic consisting of 16 states (Länder) is a member of the European Union. It has a high-developed and comprehensive social security system (mandatory insurance system). The Federal Ministry of Health has its central responsibilities in the preparation of legislation and regulations and thereby providing a legal frame for health matters. Drug prevention is an important area for the Ministry of Health and a drug commissioner is appointed for all related issues. However, regional governments of the 16 federal states (Länder) have considerable authority concerning health aspects.

Alcohol consumption in Germany is in 2002 10.2 litres pure alcohol per capita and is thus still relatively high, although it has slightly decreased since the second half of the 1970s (Kraus, Kümmler, Jünger, Karlson, & Österberg, 2002) revised by Walter Farke, www.ias.org.uk/btg/countryreports/germany/index.html,

access: 07.11.2008). Unrecorded consumption is estimated to be 1.0 litre pure alcohol per capita for population older than 15 years (World Health Organization, 2004a). Germany can traditionally be grouped into the category of medium consumption countries similar to other countries in this category concerning post-war consumption levels, beverage preferences, alcohol policy regimes, alcohol prices and possibly drinking patterns such as binge drinking (Leifman, 2002b). Germany was one of the traditionally beer-drinking countries (Leifman, 2002b). Beer still accounts for 55% of the total alcohol intake (Allamani, Voller, Kubicka, & Bloomfield, 2000). Drinking frequency is relatively high with e.g. 24% of German men and 13% of women drink 2-3 days a week and 12% men and 5% of women drink daily (based on the beverage that has the highest frequency for the respondent) (Leifman, 2002a). However, drinking is more concentrated on weekends and the drinking volume per occasion ranges somewhat between amounts of Northern and Southern European countries (Leifman, 2002a). Approximately one out of ten drinking occasions result in heavy drinking (Leifman, 2002a). Binge drinking in the last 12 month accounted for 14% for men and 7% for women of all drinking occasions (World Health Organization, 2004a).

Three social subsystems deal with alcohol issues: the legal system with the police, legislation and regulating authorities, the health and social system with general practitioners, counsellors and other health professionals, and the educational system with an intermediate position between regulating and helping authorities (Kraus, et al., 2002).

In terms of legislation, Germany has a rather liberal alcohol policy approach with few restrictive policies. In a scale of alcohol control policies,

Germany was identified as a country with low alcohol control (Karlsson & Österberg, 2007). An overview of alcohol policy in Germany is provided in Appendix 1.

3.2 ITALY

Italy is situated in Southern Europe. It has been a democratic republic since 1946. Italy is divided into 20 regions. The regional governments have considerable authority. The Ministry of Health has the responsibility to enact laws and approve specific guidelines, while other competences for health issues such as the implementation of laws or other regulations lie within the regional health departments. Local health agencies carry out treatment and preventive activities. Funding is provided by the government and distributed to regional and local level (Allamani, et al., 2002).

Alcohol consumption in Italy has shown a substantial decrease since the 1970s. In 2000, the Italian per capita alcohol consumption was with 7.5 litres (Allamani, et al., 2002) relatively low, this means a decrease by almost 50 per cent in about two decades. Traditionally, Italy was categorised as a high consumption country, characterised through Mediterranean drinking patterns. With about 80% of the alcohol intake, wine accounts by far for the largest proportion of alcoholic beverages (Allamani, et al., 2000). Italians show a high frequency of regular drinking and daily drinking is most common, for 42% of Italian men and 26% of Italian women (based on the beverage that has the highest frequency for the respondent) (Leifman, 2002a). Most drinking occasions (80%) are connected with lunch and dinner and account for small quantities of alcohol

consumed per drinking occasion (Leifman, 2002a). One out of ten drinking occasions result in heavy drinking (Leifman, 2002a).

In 2001, the Italian parliament approved a law on alcohol and alcohol-related problems. Nevertheless, Italy is a country with low alcohol control (Karlsson & Österberg, 2007). An overview of alcohol policy in Italy is provided in Appendix 1.

3.3 NORWAY

Norway, situated in northern Europe, is a country with one of the highest standards of living in the world. Norway is a hereditary, constitutional and parliamentary monarchy. The Council of State headed by the Prime Minister carries out administrative duties while the king has nominal powers only. The parliament, called 'Storting', has legislative power. Norway is not a member of the European Union, but has joined the European Economic Area (EEA) agreement in 1994. The responsibility for alcohol and drug issues concerning secondary prevention and treatment and the coordination of the national alcohol policies lies at the Ministry of Social Affairs. The Norwegian Directorate for Health and Social Affairs implements parts of the government's policy such as licensing, coordinates and implements activities for the prevention of alcohol and drug problems, and initiates information measures and campaigns (Karlsson & Österberg, 2002).

Norway represents a low-consumption country with 4.3 litres alcohol per capita of recorded consumption (Karlsson & Österberg, 2002). Unrecorded consumption is with an estimate of about two litres relatively high (World Health Organization, 2004a). Drinking patterns of Northern European countries with high

abstinence rates and low frequency of consumption but heavy drinking are characteristic (Karlsson & Österberg, 2002). Although this pattern has begun to change, drinking is still most common on weekends or specific occasions (Karlsson & Österberg, 2002). Spirits have traditionally been the preferred beverage with a shift taking place nowadays with about 55% of the recorded consumption accounting for beer (Karlsson & Österberg, 2002). The annual frequency of heavy drinking occasions was 8.8% for men and 2.9% for women (World Health Organization, 2004a).

Norway is among the countries with the strictest alcohol control policies (Karlsson & Österberg, 2007). An overview of alcohol policy in Norway is provided in Appendix 1.

3.4 SLOVENIA

Slovenia is a small eastern European country, which declared its independence in 1991 and became an EU member in 2004. The Ministry of Health deals with public health, health care service and health insurance and has the tasks to prepare legislation and assure its implementation, to monitor the health status, prepare and implement health policies, including alcohol policies. The National Public Health Institute and the Health Inspectorate support this work. The State budget and the National Insurance Fund provide funding for the implementation of legislation and policies, for treatment as well as preventive activities (Petric, 2005).

In Slovenia, alcohol is an important aspect of culture and alcohol consumption is high and even has increased by 24% in the last years from 9.4 litres of pure alcohol per capita in 1991 to 11.7 litres in 2004 (Cebasek-Travnik, 2007). Besides, there is a high level of unrecorded consumption, estimated to be

5-7 litres (Cebasek-Travnik, 2007). Traditionally and until 1994, Slovenia could be positioned as a wine-drinking country, with wine accounting for more than 50%, while later on beer became popular and consumption thereof has risen substantially (Šešok, 2004). Drinking frequency is high in Slovenia with 48% of the population drink regularly at least 1-2 times per week and 13% of the population drink daily (Petric, 2005).

In 2003, a law on alcohol was accepted, also providing a basis for the establishment of a coordinating body for the preparation and implementation of alcohol policy, the Council for Alcohol Policy. Concerning alcohol policies, Slovenia has been grouped as a country with low alcohol control policy (Karlsson & Österberg, 2007). An overview of alcohol policy in Slovenia is provided in Appendix 1.

4 METHODOLOGY

4.1 CASE STUDY METHOD

This study uses a qualitative case study approach to answer the research questions. Case studies enable the researcher to explore in depth a program, an event, an activity, a process or individuals (Creswell, 2003). This is an appropriate strategy of inquiry to explore national alcohol policies in detail and under consideration of the contexts from which they emerge and in which they are embedded. Alcohol policy strategies and the policy formation processes are complex, requiring an in-depth analysis to understand existing variations. Qualitative research is emergent (Creswell, 2003) and may unfold background information that is not generally known or visible. Thus, the researcher can obtain new insights into alcohol policies within different contexts and on factors that inform and influence alcohol policy development and thereby broaden the knowledge base.

In qualitative studies, researchers often use multiple forms of data collection procedures such as observations, interviews, documents, and audio and visual material (Creswell, 2003). This study involves the collection of documents as well as expert interviews by telephone.

4.2 DATA COLLECTION

4.2.1 SAMPLING

Purposive sampling allows the researcher to choose cases with characteristics of interest for the study (Silverman, 2005). Four European countries are included in this study. Purposive sampling was used to determine the country selection. In order to answer the research questions and considering the aim to include diverse

countries in Europe, the following criteria guided the choice: drinking culture (e.g. drinking patterns, preferred beverages, etc), geographical location, and existing policies (e.g. strictness). This study thus includes countries with different backgrounds as described in Chapter 3, i.e. Norway, Germany, Italy and Slovenia.

4.2.2 DOCUMENTS

Official public documents were used to gather data on national alcohol policies in four European countries. Document data was available through HP-Source.net (www.hp-source.net), which includes databases on health promotion generally but also on specific subject areas such as European alcohol policy.

HP-Source.net is described as a system for mapping health promotion capacity “that would produce country profiles with both qualitative and quantitative data, permitting country comparisons, useful to inform policy processes and as an applied research tool” (Mittelmark, Fosse, Jones, Davies, & Davies, 2005, p.35). Considering this, HP-Source.net is an excellent tool for gathering comprehensive and comparable data material on alcohol policies in European countries and is suitable for this study. Besides, the researcher is familiar with the database from former research, ensuring the best possible utilisation of this tool.

National researchers, who are invited by HP-Source.net based on their known interest in the field, enter data directly. “The completeness, validity and reliability of the data are all dependent on the national researchers’ ability to identify all the correct data and to enter them correctly” (Mittelmark, et al., 2005, p.36). Threats to validity or biases might occur when national researchers have limited resources to enter data, when they seek to enter data favourably to their

country or when they are biased through their profession. Comparability of data might be limited when the national researchers' knowledge or resources differ across countries or when researchers have different professional background. Also, experience shows that it is difficult to motivate respondents to keep data up-to-date. Information entered might therefore be out-dated.

On the other hand, the respondents of HP-Source.net present documentation for verification either through links or through directly accessible documents. The documents available determined the findings. The documents differ in their type, which was considered in analysis and interpretation of the data. Furthermore, the study took place in a European context. In a few cases only, the document analysis required language skills, which the researcher was unable to cover.

The document data supplied the researcher with official information (laws and regulations) on national-level alcohol policy strategies. These data served additionally as background information necessary for informed interviews and as basis for the development of the interview guide.

4.2.3 INTERVIEWS

The interview data were collected through semi-structured interviews of national experts from each of the study countries. The conversations could validate the accuracy of the document data, expand the knowledge and reveal background information on policy processes and its influencing factors, which are not content of official documents. The expert interviews have supplemented the document data and served as triangulation. Limitations occurring through data collection via

HP-Source.net, i.e. missing or out-dated information, have been addressed through the interviews.

The quality and results of the interviews depended on the knowledge and position of the interviewee. The participants have been identified using the Module Director of the alcohol-related databases in HP-Source as a gatekeeper. This procedure ensured information-rich interviewees. Even though interviews provide indirect information filtered through the views of the interviewees (Creswell, 2003), it was paid attention that the interviewee is a knowledgeable person who can provide basic as well as background information on alcohol policies in the respective country.

A semi-structured interview guide was developed for data collection. Prior to data collection, a pilot interview was undertaken in order to test and adjust the interview guide. The interview guide focussed on the following themes:

- Drinking culture
- Alcohol policy strategies
- Policy-making process and influencing factors

Even though the interview guide provided themes to be covered and suggested questions, the sequence and forms of questions were adjusted openly to follow up the answers given by the respondents (Kvale, 1996).

All four interviews were conducted by telephone. To schedule the interviews, the participants were contacted by email and appointments were made at their convenience. All respondents were informed about the general purpose of the study. The interviews, which lasted between 60 and 90 minutes, were recorded using a minidisk recorder and all respondents gave their consent for recording.

4.3 DATA ANALYSIS AND INTERPRETATION

Initial reviewing of the documents started the data analysis process and was followed by a more detailed content analysis of the policy documents. Alcohol policies were categorised according to policy strategies in HP-Source.net. HP-Source.net differentiates between two main topics and specifies sub-areas (alcohol policy strategies) as follows.

<ul style="list-style-type: none">- Alcohol policy<ul style="list-style-type: none">• Definition of an alcoholic beverage• Taxes and prices• Trade and cross border shopping• Licensing• Availability• Age of purchase• Commercial communications	<ul style="list-style-type: none">- Reducing the harm done by alcohol<ul style="list-style-type: none">• Drinking and driving• Consumer labelling• Education• Public education campaigns• Drinking environments• Advice and treatment
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Those areas built a framework for data analysis of document data and to a certain extent for interview data. Other topics around the themes ‘policy-making process and influencing factors’ additionally emerged from the interviews. The researcher firstly transcribed the recorded interviews into written words making them appropriate for closer analysis (Kvale, 1996).

Secondly, the data were analysed across countries. The comparative analysis of national-level alcohol policies once more followed the established categorisation, i.e. the alcohol policy strategies.

Finally, data analysis involved interpretation of the data by comparing the findings with the literature or theories (Creswell, 2003). The results were compared and contrasted across countries under consideration of country-specific cultural and political contexts and with regard to research evidence on alcohol policy effectiveness, EU recommendations and the concept ‘healthy public policies’.

4.4 THE RESEARCHER'S ROLE

Qualitative research is primarily interpretive and the researcher approaches data through a personal lens (Creswell, 2003). Throughout the processes of sampling as well as data collection, analysis and interpretation, the researcher naturally had an impact on the research findings.

In this study, purposive sampling determined the countries selection. Alongside theory-based criteria, personal considerations such as language knowledge and accessibility of data, guided the sampling process as well. The utilisation of HP-Source.net has been justified for scientific reasons but personal considerations supported this choice additionally (see above). Furthermore, qualitative research is shaped by values and interest (Creswell, 2003). The researchers' professional background and interests in health promotion influenced the research questions, the approach to the analysis and interpretation of the data and thereby the findings.

4.5 ETHICAL CONSIDERATIONS

Ethical issues arise during many stages of the research process, e.g. data collection, data analysis and interpretation (Creswell, 2003).

During data collection the respect of the participant and the sites are crucial (Creswell, 2003). This study involves official public documents, collected through HP-Source.net, an openly accessible database. The identity of the national contact persons, who entered the data, is visible through HP-Source.net. The respondents of HP-Source are aware of this and have agreed that their contact details are available. Moreover, the study includes expert interviews. All participants were informed carefully about the purpose and procedures of the

study and were aware that participation is voluntary and that they have the right to withdraw at any time. The interviews were recorded with the consent of the participants. The identity of all interviewees was protected, even though it was unlikely to reveal sensitive information.

Another ethical issue was to consider whether the study needed to be reviewed by the Institutional Review Board (IRB) of the University. This was not necessary since data collection included publicly available information and documents and the direct contact with participants involve experts within their professional expertise and knowledge.

5 RESULTS

Firstly, key alcohol policy documents, which build the basis for the present study, are identified and their overall aims and the meaning to the general alcohol policy approach in the various countries are introduced. Secondly, the contents of the identified key documents along with the expert interviews are revealed in detail, categorised according to alcohol policy strategies as outlined in Section 4.3.

Thirdly, there is an emphasis on the policy process and national and international influences.

5.1 KEY DOCUMENTS ON ALCOHOL POLICY

The data revealed different kinds of documents from different authorities.

Generally, two kinds of key policy documents exist: firstly, national level official documents such as an alcohol law or other alcohol-related laws and secondly, national alcohol action plans or closely related documents.

LAWS AND REGULATIONS

Laws are one type of the key policy documents, which exist in each of the four countries. Laws are rules of a government, applying for all citizens and being enforced by a responsible agency. Two different types of laws have been identified amongst the key documents: firstly, specific alcohol laws and secondly, laws which have a different focus but include alcohol related issues.

Italy, Norway and Slovenia have a national level law addressing alcohol specifically, i.e. in Italy, the Law on Alcohol and Alcohol-Related Problems (2001), in Norway, the Act on the Sale of Alcoholic Beverages (1989), and in Slovenia, the Law on Reduction of Alcohol Consumption (2003). Other laws additionally deal with aspects concerning alcohol. The existence of a

comprehensive alcohol law, which builds an overarching frame, points to the general position of alcohol and alcohol related problems in the country's political arena. It suggests the recognition that alcohol is no ordinary commodity and that it is necessary to address and prevent arising health problems through regulations. This might be implied in other laws as well, although not mentioned explicitly. The interviewees from Italy and Slovenia acknowledge the recent progress made through the establishment of an alcohol law.

The alcohol policy in Italy as a formal one started just after the endorsement of the WHO European Alcohol Action Plan. ... previously there were a number of laws and regulations that were in a sense not included into a framework ... In 2001, Italy endorsed the law 125 that is the frame-law on alcohol now including a lot of arguments (Italy, p.3).

... alcohol is still not in general population recognised as a problem ... it is of course recognised by experts, not as much by politicians although they admit that we should do something about for instance driving and drinking, young people drinking. But there is not much political will for serious action at the moment. Nevertheless, we have accepted legislation in 2003, which I believe is quite progressive (Slovenia, p.2).

Germany's alcohol policy in contrast is not reflected in a single law, lacking this kind of framework. On the other hand, the German expert confirms that there do exist "good laws" (Germany, p.10). Such laws deal with alcohol as a topic besides other matters, as for example in the laws on taxation of specific alcoholic beverages, the Licensing Act and the Protection of Young Persons Act.

From a public health perspective, an important question is if the laws are related to health matters or if other topics prevail. The alcohol laws in Italy, Norway and Slovenia specifically aim to prevent the harm done by alcohol. Thus concrete political action was taken to address the topic from a health perspective.

This law deals with regulations aimed at prevention, treatment and social rehabilitation of alcohol dependent people (Italy, Law, Article 1, 1.).

The purpose of regulating the importation and sale and serving of alcoholic beverages pursuant to this Act is to curb to the greatest possible extent the harm to society and the individual that may result from the consumption of alcoholic beverages. To this end the Act aims at limiting the consumption of alcoholic beverages (Norway, Act, Section 1-1).

This Act defines ways and means of limiting the consumption of alcohol and of the prevention of the harmful effects of the consumption of alcohol (Slovenia, Law, Article 1).

Although not specifically stated in the laws themselves, the titles of two laws in Germany reveal that their main aims concern health aspects in relation young people: “Protection of Young Persons Act” and the “Alcopop Tax Law for the protection of young people”.

NATIONAL ACTION PLANS

The second types of key documents are action plans or closely related documents. In all four countries, recent national action plans on alcohol are either available, or by the time of writing in preparation. Action plans are usually established for a specific period and aim to achieve a certain goal. They comprise of a set of specific objectives, strategies and actions, persons or agencies responsible for implementation and enforcement, and a budget. Such a strategic document has the ability to indicate future policy trends or directions.

All interviewees mention the national action plan throughout the interviews and three of them particularly refer to its importance and meaning. While the Slovenian expert outlines possible positive effects of an alcohol action plan, i.e. establishing strategies and priorities as well as allocating resources for particular actions, the German expert points to the fact that an alcohol action plan can point into certain directions but does not necessarily assure progress.

Additionally, there is the need for commitment and political will to implement and foster changes.

... the most important ... [policy documents are] the National Action Plan 'Alcohol and Health' ... , the programme, ... 'Gaining Health' and ... the law 125/2001 (Italy, p.10).

... we are waiting now that we will accept ... an action plan and then ... adapt a national budget accordingly. Because if you have an action plan – which will be of course a bit more strategic – ... this also means that there are resources available for particular actions, that there are priorities (Slovenia, p.8).

I think there should be an alcohol action plan and the political will to fulfil this ... and yes, the political will and the image of alcohol must be changed ... I think the new action plan will be a signal in itself to focus more on alcohol (Germany, p.10).

The quotes indicate the different statuses regarding the development of an alcohol action plan across the four countries. Two countries, Italy and Norway, have an action plan addressing alcohol, while the other two, Germany and Slovenia, do not yet have a current action plan but are by the time of writing in the process of preparing one.

Italy has presented the National Plan Alcohol and Health in 2007. Ten objectives shall be achieved through eight strategic areas. The document has a strong connection to the European Alcohol Action Plan (EAAP).

The recent National Action Plan on Alcohol and Drugs of the Norwegian government has a considerable focus on alcohol and presents aims, strategies and actors. Its name “escalation plan” suggests a focus on upgrading of existing structures rather than fundamental changes in alcohol policy.

In Germany, two documents, which are closely connected to the development of a new alcohol action plan, are available and include recommendations for necessary or desirable future policy developments. The

documents might have substantial influence on the development as well as the contents of the coming national action plan. A NGO developed one of the documents (DHS Alcohol Action Plan), while a task force commissioned by the council of drugs and addiction establishes the other (Recommendations for a National Action Programmes for Alcohol Prevention (NAA)).

5.2 CONTENTS OF ALCOHOL POLICIES

5.2.1 APPROACHES AND PRIORITIES

The laws of the four European countries have diverse focuses concerning their content. Italy combines some regulatory measures to restrict alcohol consumption with measures for preventing the harm done by alcohol, mainly through information and education. Slovenia's law similarly devotes attention to various alcohol policy strategies ranging from restrictive measures to educational measures. On the contrary, the Norwegian national law is directed at regulatory alcohol policy measures only, such as licensing and hours and days of sale. The German laws address regulatory measures such as age of purchase, requirements to obtain a licence to operate a restaurant (and thereby sell alcohol) and taxation. None of the preventive alcohol policy strategies are included in laws in Germany or Norway.

The focuses of the alcohol action plans are different. The overall goal of Italy's alcohol action plan is the prevention and reduction of alcohol related mortality and morbidity. The eight strategic areas are situated mostly on the preventive side of alcohol policy strategies. They include information/education, drinking and driving, drinking environments and workplaces, treatment, responsibilities of the alcohol industry, capacity to cope with the risk arising from

alcohol, the potential of NGOs, and monitoring. Those strategies are adopted from the EAAP, while two regulatory strategies, i.e. availability and promotion of alcoholic products, which are included in the EAAP, are not addressed in the Italian alcohol action plan. Preventive measures outweigh regulatory measures.

Regulatory measures are hardly addressed in Norway's national action plan itself, while it aims to maintain the comprehensive alcohol policy approach, including its regulatory measures and the enforcement thereof: "a holistic approach in alcohol policy shall be maintained and the regulative strategies be continued" (p.15). In addition, it centres on information/ education, improvement of international cooperation, enhancement of quality and availability of services and treatment and intersectoral collaboration, and increased user influence and participation. This indicates a comprehensive alcohol policy approach.

In Germany, the two action plan related documents both stress the importance of the combination of a package of different measures: "Therefore, the interplay of various measures in an alcohol action plan involving all social and political players is needed" (DHS, p.3, translated by the author) and "Overall, a bundle of differentiating evidence-based strategies with proven effectiveness is needed. These should be combined in terms of a policy mix and implemented in a long term perspective" (NAA, p.1-2, translated by the author). Having a closer look at the recommended strategies, the DHS names stricter strategies including both regulative and preventive measures, while NAA has a stronger focus on educational measures.

In summary, the documents indicate a comprehensive approach for all countries including both regulatory and preventive strategies, although with

differing weight. Regulatory strategies are highlighted especially in Norway, while preventive measures get a legal ground in the Slovenia and Italy. Preventive measures also prevail in the Italian action plan and the German NAA.

5.2.2 ALCOHOL POLICY STRATEGIES

DEFINITION OF AN ALCOHOLIC BEVERAGE

The three countries with an alcohol law define an alcoholic beverage, while Germany's documents do not provide a definition. An alcoholic beverage in Italy and Slovenia is defined as a beverage containing 1.2 percent alcohol by volume. In Norway's law alcoholic beverages contain more than 2.5 percent alcohol by volume; when it comes to the minimum age of purchase however, alcoholic beverages are those with 0.7 percent by volume.

TAXES AND PRICES

All four countries levy taxes on alcoholic beverages, such as value added taxes (VAT) as well as excise duties. The level of taxes and prices of alcoholic beverages differs between the four countries as well as for various alcoholic beverages. Generally, taxes increase with the alcoholic strength of the beverage although there are some exceptions and special handling of certain beverages. Three countries, i.e. Germany, Italy, and Slovenia, have a zero tax on wine, which is highlighted by all interviewees.

We have ... a zero wine tax and this should be changed (Germany, p.3).

... as in most countries wine is not taxed ... (Slovenia, p.2).

There is no taxation on wine in Italy as ... in many other ... wine producing countries ... And this is interesting, also because 80% of the alcoholic intake is related to wine in Italy (Italy, p.4-5).

Both Italy and Slovenia are historically wine drinking countries. Also wine growing is in the three countries to some extent an important branch in production, employment and trade. On the other side, taxes are important revenues for the government. Still, wine is an exception. As the Italian interviewee points out, despite the fact that wine accounts for the great majority of consumed alcoholic beverages.

In Germany, another exception is the extraordinary tax that is charged for alcopops (drinks mixed with spirit) and presents the highest tax. The aim of the Alcopop Tax Law is the protection of young people (§1 (1)).

As already indicated above, taxes on alcoholic beverages are important revenues for the government, as the Norwegian and Italian interviewee stress.

[Taxation is] a way to increase the level of income of the state ... So it is not unusual to see increasing taxation of spirits but also of beer and the other alcoholic beverages according also to ... the alcoholic strength, but not for wine... (Italy, p.5).

In general terms ... most excise duty systems that we have and most countries have, were established not as much for health or social reasons as for provenue reasons from the government ... But already quite early ... it has been looked upon mainly as or at least been argued for in relation to ... the importance of the prevention element of it (Norway, p.3).

A missing focus on health issues and prevention may be explained by the fact that governmental sectors other than the health sector are responsible for taxation, particularly if intersectoral cooperation is not well developed.

The responsibility on taxation does not lie within the ... Ministry of Health but it lies with the authorities of the Ministry of Finance. And therefore one would see that over the years for many times proposals for change and the construction of the different elements of the taxation has often only been taken by the Ministry of Finance and not been brought to discuss with the other Ministries (Norway, p.3).

Nevertheless, in Norway cooperation between the Ministries has improved and economists might even argue for a higher tax rate because of high social costs caused by alcohol.

... now we have a close cooperation with the Ministry of Finance ... Some people ... are even interested in going further than ... the proposal from the Ministry of Health ... They ... are economist and ... say that the revenue income is not covering the social costs and it should be higher. Whereas we are arguing that we have to be modest in the development to not loose the support of the population and not to stimulate too much the cross border trade (Norway, p.3).

Problems indicated here are price differences between countries. The Norwegian interviewee therefore calls for increases in taxes and prices in other countries: “I would like to see some developments on taxation in Europe” (Norway, p.12). Taxes in Germany, Italy and Slovenia are relatively low and also the national experts call to increase them. The German interviewee additionally, mentions that price levels are stable or decrease compared to other prices suggesting that alcoholic beverages have a special status.

Especially the beer tax is very low and ... wasn't increased for a very long time. This is the problem that all the taxes should be adjusted with other price indexes and that has not happened ... The spirit tax ... could be higher as well. Because we know that ... price increase ... is one of the main means to reduce consumption. So this should be a measure adopted by the government (Germany, p.3).

Definitely we should aim for higher taxes. We are also very much defending the idea that taxes should be unified in a way through Europe. And also prices of alcoholic beverages in Slovenia are relatively low. So in this regard, we would consider first of all of course taxation of all beverages but then also higher prices of alcoholic beverages as a good instrument to limit availability (Slovenia, p.3).

The German interviewee sees a barrier against the raise of tax rates in the divided responsibility for beer and spirit taxation.

There is one problem, the spirit tax goes to the central government and the beer tax goes to the regions (Länder) ... So the government doesn't want to increase its taxes because they assume the people will drink more beer

and they have less earning and the other way around. So it should be an increase ... in taxes for all beverages (Germany, p.3).

Despite the experts' assessments that changes concerning taxation are needed, taxation is not a topic of high priority in key policy documents such as action plans. In Germany, the DHS action plan calls for an increased and standardised tax rate on all alcoholic beverages (15€ per litre alcohol) arguing that no alcoholic beverage should be represented as being hazardous to a greater or lesser extent than another. The NAA on the other hand acknowledge and suggest tax increases as medium-term strategies but do not include them into measures to be implemented in near future. A study on the effects of a tax increase plus the examination of the possibility to earmark taxes to alcohol prevention is however scheduled for the short-term. The plan also calls for a harmonisation of tax levels on EU level.

In Italy, the strategic areas of the alcohol action plan were mainly adopted from the EAAP with the exception of two areas, one of which addresses availability including taxation.

TRADE AND CROSS-BORDER SHOPPING

Tax and price differences between countries may result in increased smuggling or cross-border shopping since trade is sensitive to prices. Unlike the Northern countries, cross-border trade plays a minor role in Germany, Italy and Slovenia. In Norway, it accounts for a growing proportion of unrecorded consumption although there exists a limit for private import of alcoholic products.

We are there facing a problem that the taxation in other countries are lower, partly significantly lower ... Previously the majority of that unregistered consumption of alcohol was ... through illegal production and smuggling. Now [it is]... through travel because people travel very much ... So there is a worry that this would even increase (Norway, p.4).

LICENSING, AVAILABILITY AND AGE OF PURCHASE

Besides taxation, several instruments are used to limit the physical availability of alcoholic beverages including licensing, age of purchase and other restrictions on the availability.

Norway has, as the only country, implemented a licensing system for the sale, serving, wholesale and production of alcohol. The establishment of this policy dates long back in history and the interviewee explains its background.

It has been wanted to have a situation where the sales and production of alcohol was disconnected with profit ... accepting that it is not an ordinary commodity and accepting that having profit interest could pursue attitudes on the sellers' sides that is not supporting public health interests (Norway, p.5).

The Norwegian interviewee points furthermore to changes and limitations of licensing regulations that came with the entry into the EEA. The monopoly system on production and import of alcoholic beverages had to be opened up, while the monopoly system and licensing for sale and serving could be maintained.

There was one important change that came with the European Economical Area and that was that the state monopoly on the import of alcohol and also on production of alcohol, ... on spirits and wine, were taken out. So then it was opened for companies to import and also to produce spirits and also wine (Norway, p.5).

Italy as well has a licensing system, which however does not have any effects on the markets. Density and numbers of outlets selling alcoholic beverages are not restricted but follow the market.

There is a licensing system ... bars, markets and many others need to be licensed by regional authority ... there is not a limit of licences ..., the licences is mainly governed by the market ... There are some competences ..., some particular characteristics that are requested to [those who] sell alcoholic beverages, but ... that's all (Italy, p.5).

The German Licensing Act also includes some requirements in order to obtain a licence to open a restaurant. Exclusion criteria are for example addiction to alcohol or suspicion that the applicant will not comply with the Young Persons Act. Nevertheless, this being the only restrictions and neither density nor number of outlets being addressed, the German interviewee suggests an introduction of a licensing system.

The Licensing Act now doesn't say anything about the density or the capacity of the restaurants and we think there should not be more than a certain amount of restaurants or bars in special areas (Germany, p.4).

Also the Slovenian interviewee expresses shortcomings of current regulations and efforts to strengthen them.

Unfortunately [there is no licensing system] ..., this has been discussed at several occasions, even there was a proposal ... but up to now this is not the case (Slovenia, p.3).

On the other hand, all four countries have some restrictions on the availability of alcoholic beverages although variations between the countries are visible. Norway's alcohol law includes besides restrictions on density and number of outlets, also restrictions on hours and days for on- and off-premise sales of alcoholic beverages. Slovenia as well has some restrictions on the hours of sales, while Germany and Italy do not restrict hours or days of sale. For all countries, some restrictions for selling alcoholic beverages at specific events (e.g. sporting events) or at certain places (e.g. educational buildings, along the highways) are established. Besides, all countries restrict the availability of alcoholic beverages to young people. The age of purchase varies between 16 and 20. The age limit in Italy is lowest (16 years), followed by Germany (16/18 years for spirits), Slovenia (18 years) and Norway with the highest age limitations (18/20 years for spirits).

However, according to the German interviewee, availability of alcoholic beverages needs to be restricted more strongly.

[The DHS is] ... at the moment preparing an alcohol action plan and ... focus on this problem of availability. The government also says that there has to happen something in this area ... but that's more ... a strategy but not with concrete elements that shall be realised in a short time ... this is ... one of the difficult points to really implement (Germany, p.5).

This is confirmed by the documents. The NAA refers e.g. to the reduction of outlets selling alcoholic beverages, bans of the sale in specific places such as petrol stations for at least certain periods, and improvements of controls, but is not addressing the issue concretely in short term. The DHS Action Plan goes a step further with its demands and calls for restrictions on times and days of sale.

The interviewee furthermore suggests that too many exceptions in the laws can hinder adequate enforcement concerning the age of purchase. Nevertheless, awareness with regard to underage drinking is increasing, discussions relating to this topics and political will to strengthen regulations is growing. However, similarly as described above, changes are not likely to happen in near future.

The main problem is there are ... too many age limits ... it is in discussion ... to harmonise this to the age of 18. But this is also I think a strategic goal and will not be accomplished very soon. But I think it is perhaps one of the measures or interventions that ... are easier to change because the political will is greater in this area of young people and also ... awareness is growing (Germany, p.5).

Other difficulties are caused through high costs: "... enforcement is very difficult because it is very personnel intensive and that means also cost-intensive ... generally the resources are too low" (Germany, p.6).

Both documents confirm the necessity to strengthen controls and enforcement of those regulations. The German DHS Alcohol Action Plan recommends increasing the age of purchase up to 18 years for all alcoholic

beverages. Although the interviewee was positive about the preparedness of the government to increase the age, the governmental recommendations (NAA) suggest hesitation rather than confirming this. The document postpones this decision to the time when results on the effect of the increased age of purchase for tobacco are evaluated.

Also the Italian expert refers to an increase of age limits and better enforcement as a necessary improvement of Italian alcohol policy: “First of all, increase of legal age from 16 to 18, ... the second is of course the prohibition of ... selling alcoholic beverages to young people below the legal age” (Italy, p.10). The Italian alcohol action plan however does not address availability. Nevertheless, according to the Italian expert, awareness has increased, followed by actions such as increased controls and enforcement of regulations on availability, again with a special focus on the minimum age of purchase.

There is an evidence that something is changing. There are much more controls than before, also because of the social alarm on the binge drinking and on the episodes of drink driving during ... the night for young people. ... we are trying ... to control that ... alcoholic beverages are not served to young people below the limit of 16 ... This kind of enforcement is higher than before, but not the maximum as we should like (Italy, p.6).

In Slovenia, the law regulates the availability of alcohol. The interviewee considers the law as a good basis, which is respected and controlled by appointed authorities. However, there is room for improvement of the enforcement of the law, particularly in terms of minimum age of purchase.

In particular this law I think is quite well respected, maybe not that much in regard to selling alcohol to younger people ... We have monitored this and ... people who are serving in the shops or in the bars ... don't ask very often, but if they consider there are young people, they do. But they don't check regularly. ... [But] there are checks and inspections ... and they do find cases where legislation is not respected (Slovenia, p.6).

The enforcement of regulations such as restrictions on the minimum age of purchase can be supported by the existence of specific shops selling alcoholic beverages, as the Norwegian interviewee suggests.

... in wine monopoly shops ... there is quite a strong social control because they [are] only selling that commodity. So they are of course conscious about whom they sell to and so on (Norway, p.6).

In spite of this, there is room for improvements and the interviewee names stronger enforcement on the local level, particularly in terms of availability and controls of the regulations. The drug action plan supports this view and calls for enforcement of the law, monitoring of the strategies and if necessary adjustments, more effective controls of licences and stronger reactions on violations.

The Slovenian expert points to obstacles against the implementation of restrictive measures such as availability.

There is quite a lot of pressure of alcohol industry in terms of influencing ... politicians not to really go on with some stronger activities or to decide on for instance on limit alcohol availability ..., with licensing or with some other serious measures or highering the price of alcohol or something which we know that works (Slovenia, p.9).

In Germany, obstacles might occur through the possibility of variations from state to state since responsibility lies at regional level.

This is also under the responsibility of the Länder and the communities and this is handled very differently. If you are in a big city of Berlin or Hamburg or in special areas and there are also exemption regulations and this is not very helpful to really strengthen the idea that alcohol should not be drunk all day long (Germany, p.4).

COMMERCIAL COMMUNICATIONS

All four countries are concerned with restricting commercial communications for alcoholic beverages. Some regulations concerning commercial communications are made through laws, others through self-regulations.

The most straightforward restrictions exist in Norway and have been in place for many years. The Alcohol Act prohibits all advertisements of alcoholic beverages. “The ban on tobacco and the ban on alcohol came about the same time in the beginning of the 70s. And since then we had a full ban on advertising alcohol” (Norway, p.8).

In Slovenia, the Law on Sanitary Suitability of Foodstuff, Products and Materials Coming into Contact with Foodstuffs regulates advertising of alcoholic beverages including labelling. Advertising for spirits is forbidden completely, while alcoholic beverages containing 15% or less alcohol by volume may be advertised with some restrictions on time and content.

Germany and Italy include few restrictions on advertising in laws. Germany’s Protection of Young Persons Act sets up a ban on commercials and advertising programmes for alcoholic drinks at movie performances before 6 p.m. The Italian alcohol law aims to restrict advertisements in time and content, also mainly in order to protect young people. Mostly however, voluntary self-regulation codes are in place to regulate advertising. Both interviewees stress the ineffectiveness and difficulties concerning self-regulations. Several aspects are touched upon. Firstly, the contents of the self-regulations codes are assessed as not being sufficient.

... on the other hand we only have this self regulation and this is ... not effective ... they are only referring to the content but it’s not the quantity that is regulated ... On the first sight the regulations sound very good but if you look a little bit closer you see that the most effective methods of advertising are not banned, for young people for example, and so they are useless (Germany, p.6).

Secondly, self-regulation codes are not implemented adequately. They are easy to violate and hard to enforce.

We have self regulation ... such as many other countries, but many times we have the feeling that this self code is broken. Also because self regulation is ... linked to the activity of an autonomous panel, that apparently is not so independent (Italy, p.6).

... you can interpret [the regulations] ... and you have no really chance to complain and the chance to have a restriction on a certain advertising is very low. So nobody really uses this and I think they have only 15 complains a year or so ... They say this shows the high quality of the regulations but I think it's the other way around ... (Germany, p.6).

Thirdly, the industry, which itself sets up the codes, is a strong actor and hard to counteract.

Of course alcohol industry and the advertising industry is not keen to admit that they do not follow exactly the rules. And they are engaged also with the Ministry of Health where a panel was constituted to ask them to work together on the self regulations code. But a self regulation code is a self regulation code, so only the partners of the self regulations code, that are representatives of the industry, ... can ask ... for a revision (Italy, p.7).

But ... this association is very important and they are lobbying very strongly and as they have good contacts to the media and good contacts to the policy and they are really strong and it's really hard to do something against it (Germany, p.6).

Thus, voluntary self-regulation codes have according to experts in the field limited effects and are not seen as an effective public health response to alcohol advertising, as the Italian interviewee confirms: “From a public health perspective it is really far from being adequate to reply to the health need and social need to decrease the risk of alcohol among young people as an example” (Italy, p.7).

Therefore, stricter regulative rules or complete bans are recommended or in discussion, as for example in Italy.

There is a battle actually in Italy, because a proposal of law has been advanced to ban the spots on the TV such as in France according to the 'loi vin'. But ... the proposal law is dropped. But we hope ... to produce this kind of proposal to the next government ... And we hope that at least some of the requested modifications from one side of the self-regulations, from the other side on much more strict adherence on what these self-regulations impose will be applied in the next future ... there is a strong support on this from the scientific society (Italy, p.6).

In Germany, this aspect is taken up by the two documents concerning an action plan. Stricter regulations on alcohol advertising and sponsorship are required from both sides. However, while the DHS calls for a ban on advertising plus legal restrictions for marketing and sponsorship, the NAA recommends restricting only advertising times, places and types (before 8pm in cinemas, related to sports). NAA calls for pan-European regulations and an advertisement and sponsorship ban in the long run.

Also the Slovenian interviewee suggests a complete ban on alcohol advertising: “advertising should perhaps be also banned completely”. The expert also points to the problem concerning the reach of media. Advertising can reach beyond borders, which makes the problem not only relevant on national level. A European approach seems necessary.

Well the problem with advertising is that advertising has no border and we are bordering Croatia and they ... have had so far very attractive advertisements on their beer, which of course can be seen easily by anyone here in Slovenia. This is why we consider this broader problem not just a problem of Slovenia (Slovenia, p.6).

DRINKING AND DRIVING

All four countries address drinking and driving in their policies mostly through a set maximum of blood alcohol concentration (BAC) for drivers. Norway has a BAC limit of 0.2‰, while the BAC level for the other three countries is 0.5‰. Slovenia and Germany additionally restrict young people and novice and professional drivers to stick to a zero BAC level. As the experts explain, changes have been made recently and even lower BAC levels are discussed. This is an area, which has receiving some attention and where awareness has risen over the recent years and actions could be implemented.

There have been good advancements in this area. The general alcohol level has been reduced to 0.5 BAC and for young [and novice] drivers it is 0 ... The alcohol level reduce for young people was a good starting point because now many people say, why not reduce it to 0 for everybody. And the awareness of the problem of alcohol-related accidents ... is helpful (Germany, p.6-7).

The BAC level is 0.5. We are discussing that it should be 0 or 0.2 ... but I wouldn't say that we are already there. The problem is huge... what is well done is cooperation with the police sector and with other sectors that are important here. This is done through a national board, which handles prevention of traffic accidents, where the Ministry of Health has a strong role but is only one among the partners ... activity is high (Slovenia, p.6).

[The BAC limit] was 5g of alcohol in the blood and more than 5g and now has been reduced to 2g or 0.2‰ and at the same time one changed ... the penal legislation ... [and introduced] income related fining (Norway, p.9).

Nevertheless, there is space for improvements with regard to BAC levels, particularly in terms of controls and enforcement. The German NAA recommendations, for example, acknowledges advancements in this area, but also call for more controls and further tightening of the law (lowering BAC level to 0.2 and 0 in long-term). As the interviewee points out, there are usually controls but control activities are restricted through the German constitution.

Our constitution does not permit random alcohol controls and so you can only make a control ... if you suppose that this person has drunken alcohol ... But nevertheless the police itself say that it is very important to control on weekends and in the areas where discotheques are (Germany, p.7).

The Italian interviewee mentions a reduction of BAC levels for novice and young drivers as a desired improvement. Control activities have improved lately and also the penalty system has been strengthened through the implementation of the Italian alcohol law.

... controls in Italy with breath testing ... has been more than double respect to the previous years ... And actually there is a system of penalties that increases by the increasing of the blood alcohol contents ... you may pay only a penalty, but you can also ... be in prison (Italy, p.7).

In Slovenia, the interviewee explains that fines should be higher and enforcement concerning proceedings in the court is a problem.

... what we do believe is that perhaps the fines for those who drink and drive are not high enough. Or even if they get higher, they are not enforced because of ... the proceedings in the court ... in many cases this does not even come to a proper end because of ... weak approach problems in court (Slovenia, p.6).

WARNING LABELS

None of the four countries have regulations concerning health warning label on the containers or bottles of alcoholic beverages. The German interviewee describes the situation as being exceptional since more labelling regulations exist for other products.

This is a problem as overall, because in Germany we have no labels up to now on alcoholic beverages ... but we have other regulations that consumers must be informed on some ingredients of food ... and so on. But on alcohol you have only to write the percentage of the alcohol volume and nothing about the ingredients and no warning labels (Germany, p.7).

The Italian interviewee points to producers' statements that warning labels are not necessary and refers to a lack of regulations from EU level.

There are no warning labels, also because the producers say that we don't need the warning labels – and this was a formal reply on a formal table of the Ministry of Health. They say that we wait for the European Union approach of this (Italy, p.7).

The interviewee also expresses the wish for developments in this direction although he indicates that it would not have direct effects on drinking behaviour, but nevertheless should be embedded into a complex alcohol policy strategy.

We hope that in the next future we will [introduce health warning labels] ... we don't think that according to the Italian culture ... warning labels can produce ... strong effects on the ... habits of the Italian population. But as a part of a programme ... that can improve the capacity for the people ... to produce much more healthy..., informal choices (Italy, p.7).

EDUCATION AND PUBLIC EDUCATION CAMPAIGNS

Prevention and education are prevalent strategies, which are implemented in all four countries. Generally, the interviewees report some efforts to improve those programmes and to implement evidence based programmes.

The German interviewee refers to an evaluation study, which could be used in order to implement effective educational programmes.

We have different programmes and projects and we have ... this very good ... evaluation ... There are ... so many projects and only some of them really are effective. ... many people in the communities or at regional level they are of good will, they want to do prevention in schools and with young people but they don't look really if this is effective or not. So I think it is very good to have this book where you can see if a programme is good or not (Germany, p.7).

Also the Norwegian interviewee points to efforts to apply evidence based programmes.

[There are many] ... prevention programmes run by non-governmental organisations and also some by the Directorate of Health and Social Services. And the schools themselves decide which programme would be undertaken. There has been over the years now many attempt to make these programmes better, ... to increase their credibility or their evidence base (Norway, p.10).

The Slovenian expert points to the fact that projects now have a holistic approach instead of focussing on alcohol issues alone.

... we have all these usual programmes in ... school, ... many also oriented towards healthy life-style, more than just alcohol ... These programmes are definitely complex because they involve not just teachers, parents and children, they also involve doctors. ... they are planned for the whole education. ... we try to be more holistic ... So I do believe that in a couple of years we'll be able to prove that there is some success (Slovenia p.5).

In Italy, there are attempts to provide more consistency in programme implementation.

It is not formalised, ... mainly based ... on personal capacity of teachers to implement some programme of education ... Actually there is also an agreement between Ministry of Education and the Ministry of Health to

introduce one hour per week on health education formally, just to give much more coherence to a solid programme that last during the year and to give continuity to these health promotion activities (Italy, p.8).

The Norwegian interviewee additionally points to educational programmes with a new focus on approaches through peers and on programmes that raise awareness and acceptance for alcohol control policies.

I think what has lately been very interesting is the educational programmes, ... which was focussing on ... arguments of alcohol control policy ... it was quite effective apparently that people started to understand the reasons for having prices, ... control on accessibility and so on ... that's probably an approach that is quite important. The other thing is ... the only area where we have internationally ... some support is this peering message (Norway, p.10).

The laws in Italy and Slovenia establish a legal ground for educational activities, which might support the implementation of effective, evidence-based programmes, which are monitored and evaluated. Italy's law aims to "promote information and education on the negative consequences of alcohol consumption and abuse". Part of the yearly budget, i.e. 1.000.000 Euro, is devoted to education and prevention activities. The Slovenian law also includes measures on the prevention of the harm done by alcohol including e.g.

informing, educating and raising the awareness of the general public and of specific population groups about the harmful effects of alcohol consumption; coordination, monitoring and evaluation of preventative programmes aimed at specific population groups; creation and implementation of programmes encouraging a healthy lifestyle among different age groups and social groups, and their evaluation.

In addition, the Italian action plan focuses on education and prevention. Since the Slovenian law as well as the Italian law and alcohol action plan provide a specific focus as well as a budget for preventive and educational measures, it is expected that there also will be a future focus on this topic.

Prevention and education is also a main focus in Germans' NAA and is dominating for medium-term as well as for the short-term measures. Mainly preventive measures are suggested to achieve five out of six short-term objectives, while only one objective includes structural regulatory measures. The DHS action plan on the other hand aims to balance both kind of strategies and specifically calls for a strengthened regulative approach. A big challenge thus is to complement educational strategies with non-behavioural approaches. The German interviewee calls for a general change in attitude – from a focus on behavioural strategies towards a comprehensive approach including more regulatory strategies. The Norwegian interviewee confirms this and criticizes that educational measures are so prevalent despite their ineffectiveness.

... the problem in Germany is more that many people believe ... in behavioural approaches ... for many years this was the only approach and people did not think so much about ... structural approaches. And so ... it is hard to motivate them to rethink ... because they think 'we are doing so much' ... and they don't like the idea that other approaches are more effective. And it is hard to change this belief (Germany, p.8).

... we have to accept that it is not the easy way out. It is the famous quotation of the Australian sociologist Robin Room that ... popular measures are ineffective and effective measures are unpopular. ... for many areas in politics but particularly here I think it is very easy to say, we should particularly focus on education (Norway, p.10).

DRINKING ENVIRONMENTS

Little data is available concerning the design of drinking environments, server trainings or the like. The German interviewee refers to a campaign of the Ministry of Family Affairs, Senior Citizens, Women and Youth in cooperation with the Association of the Hotels and Gastronomy (DEHOGA), retailers and an association for youth protection. The industry used the campaign however for creating a positive image.

... the alcohol industry and the DEHOGA ... show off saying, we are doing all this training programmes ... but it is their duty (Germany, p.8).

The Italian interviewee states that server trainings are only carried out on voluntary basis.

... it [training of the personnel] is mainly based on voluntary basis ... and apparently does not work as we should like ... no one can say anything ... the autonomy is full in this field (Italy, p. 9).

Some additional aspects concerning the enforcement of selling and serving laws have already been mentioned in the section on availability.

ADVICE AND TREATMENT

All experts acknowledge early identification, brief intervention and treatment as areas of importance. The Italian interviewee suggests, for example, that

... early identification and brief intervention should be one of the main topics for the next future ... that could be used ... by the health and social professionals ... to identify the problematic drinkers, the risk drinkers (Italy, p.8).

The Italian expert also mentions the introduction of a mandatory training for general practitioners as central.

This is one of the main topics that is actually ongoing also because it is solicited by the resolution of the European Parliament and also by the framework on alcohol policy by WHO. So my ... feeling is that the future of the prevention is mainly based on ... early identification of risky drinkers and also the possibility to implement brief intervention ... So this is basic but a lot of things have to be done (Italy, p.9)

The German interviewee points to the importance of prevention within the care system as one of three main streams within prevention. Little payment for general practitioners are obstacles against appropriate implementation of early interventions.

I think there are ... [three] important lines of prevention. One is to start really early, in the kindergarten the other focus is prevention in schools. And the third is ... early intervention and this has shown very

effective. But it is also problematic ... for physicians or medical staff to integrate in their work. They really have to believe in this because ... it is time-costly and you don't get so much money for that ... You have possibilities but they are restricted (Germany, p.9).

The NAA in Germany do not address this issue, but nevertheless include short-term measures to educate health professionals.

On the contrary, the Slovenian expert states that prevention in the health care system in Slovenia has an important role.

In the care system ... in Slovenia we are organised in primary health care in a way that also incorporates prevention activities. So we have ... assessment of risk factors..., counselling ...[and] treatment as a part of something that is covered by national insurance ... In terms of prevention ... alcohol is a risk factor which is seriously taken care of in primary health care. And also doctors they get financial incentives to handle prevention (Slovenia, p.7).

The Norwegian action plan addresses treatment very intensively and includes quality and competency improvements, better accessibility of services, better intersectoral cooperation and participation of service users in four out of five objectives in the action plan.

[In the] ... escalation plan for alcohol policy ... these [care] systems are being more thoroughly developed. But as a ... general system for all general practitioners ... it has not come very far. There is also ... the area of increasing the knowledge of the people working in the health and ... treatment [field] and their lack of knowledge of the ... reasons for the alcohol control policies ... (Norway, p.11).

In Italy, there are a number of projects taking place in the area of early identification and brief intervention.

... according to WHO Phase 4 Collaborative Project [on early identification and brief intervention], we did a demonstration project in four towns here in Italy ... Now we are starting a project ... 'alcohol free hospital', that is also a project from WHO ... We have also created a network of 100 general practitioners, that validated in Italy the short audit instrument, ... a first tool to identify people who should be submitted to the full audit question ... And we are going ahead also with ... the PHEPA

Project ... on the implementation of the European standard of the brief intervention (Italy, p.8-9).

The implementation for training programmes for health professionals is also an important strategy in Italy.

This is basic for us ... the Ministry of Health set out some rules for the general practitioners, a training programme that they set as mandatory ... this two/three training course per year ... is devoted to train the people to use all those instruments that is not so well known by the general practitioners in Italy and ... to integrate this kind of activities in the daily activity (Italy p.8-9).

5.3 INFLUENCES ON POLICY PROCESSES

Policy-making is a complex process with numerous factors interacting and influencing its development. In the arena of alcohol policy, such factors include the alcohol producing industry, the media, European and international regulations and initiatives, national level or local interest groups, and the cultural context of alcohol consumption in the society.

The experts from all countries stress that the alcohol industry has a strong influence.

The alcohol and the marketing industry ... are very strong lobbyists, they finance political parties and their conferences and so on – so they have really influence (Germany, p.10).

... we have a very strong industry, wine-producing ... and beer-producing industry. They are both very strong with a lot of political influence, influence on media and so on. This is definitely influencing political will to change (Slovenia, p.9).

... when there are lobbies, of course there are lobbies that are related to the alcohol industry ... so even if a law is adopted you have to be careful because something can change, also in brief time, because [of] a counter proposal ... so the influence there is a strong influence (Italy, p.11).

The Norwegian interviewee calls attention to the changing weight of the influence of the alcohol industry over time and from different industry branches.

... it varies with the time ... When the alcohol policy is functioning well and the consumption is going down, the influence of the industry is going up, because then the people don't see the problems but they see the hindrances. But when the problems are going up and the people see the problems, then of course the alcohol influence is going down because then the sentiments know we have to do something ... Secondly, ... there has been a rather different approach between the different industries over the years ... (Norway, p.12).

On the other side, important influences come from NGOs advocating for health interests. The strength of these influences varies across the countries. While Norway's and Germany's experts describe activities, Italy and Slovenia report no or only modest power of such interest groups.

... the NGOs ... have been working quite actively over the years ... [and] have been very able ... in setting agendas, ... were very active both in parliament and in the Ministries, ... and they are active towards the political parties (Norway, p.13).

[The DHS] ... try to influence as well, have contacts to the political parties, ... inform them about developments and discussion and research and so on ... This is very important to cooperate and to have good information policy and public relations ... But there is no or little organisation that have money to do political work (Germany, p.11).

[The influence of NGO's] ... is not so high, not so wide spread ... (Italy, p.12).

... there is no coalition in Slovenia, there is no NGO movement with a common goal and even no activity that would point to the government to go for stronger legislation ... (Slovenia, p.9).

Other influencing factors mentioned by the interviewees are the media and its approach to the topic as well as the society with peoples' perception and opinions.

Scientific knowledge on the other hand is not necessarily a basis for policy development, as confirmed by experts in the field. This is clearly stated by the Slovenian interviewee.

Scientific studies unfortunately don't influence political process (Slovenia, p.8).

Also in Germany, the interviewee expresses that influence of research is limited to persons or institutions that are already aware of the problem.

... the research community has influence within the professionals and some politicians who are really sensitised for the problem and they have influence really in some institutions (Germany, p.10).

Consequently, there is a need to increase awareness among policy makers by presenting scientific evidence in a clear and precise way and to advocate for change, as the Norwegian interviewee pointed out. The interviewee from Slovenia supports that advocacy is crucial and names health professionals as important actors.

... they are very knowledgeable, ... very useful, ... there is a very good ... knowledge base for policies, but they are not as ... visible in the public discussion as you would see in some other fields (Norway, p.14).

We should better use health professionals as advocates. ... They are not well enough aware of their role as advocates in this field (Slovenia, p.9).

5.4 INTERNATIONAL INFLUENCES

Global or European level influence is often mentioned throughout all expert interviews. It is also a theme within several official documents and thereby acknowledged as an area of importance.

On the one hand, there might emerge the need for pan-European regulations when international activities or alcohol policy strategies of other European countries influence national alcohol consumption as well as alcohol policy. The Norwegian expert stresses the importance of a stronger international approach and calls for stricter regulations on taxation and availability in Europe, mentioning harmonisation of consumption patterns and alcohol policies throughout Europe.

I want to see a strengthening international approach ... We very much affiliate with the accessibility ... in other countries with longer opening hours and less taxation ... but at the same time we have not affiliated with the Mediterranean way of using alcohol ... and that's a big problem ... at the same time you see that some of the Mediterranean countries tend to develop more into Northern consumptions ... But we see that some of the countries are developing ... more strong ... [regulations] (Norway, p.12).

The international perspective is also part of the Norwegian Action Plan on Drugs and Alcohol. The sub-objective 1.5 addresses the topic “strengthen the international work” in detail. Aims of the action plan include being an active participant, collaborating partner and a driving force in international processes and ensuring that alcohol is set up high on the agenda of international agencies. The action plan stresses the need for international collaboration on various topics, particularly in the reduction of availability, monitoring, exchange of experiences, research, and policy formulation.

On the other hand, discussions, agreements or regulations on international or EU level, influence and guide national developments or policies. International influences like trade regulations and the WTO are, according to the Norwegian interviewee, of importance. International trade regulations might violate regulations on national policies on e.g. alcohol distribution.

I think ... the World Trade Organisation ... has to be cautious about. ... regulations on trade with services... could be violating some of the regulations that we have on domestic policies on alcohol distribution and so on. ... we are aware of and try to follow but ... the trade field is a big field and has traditional not been as open in discussions, not as transparent as many other politic fields (Norway, p.15).

Also the Norwegian drug action plan, addresses this topic in the sub-objective 1.5 “strengthen the international work” and includes measures related to consideration of public health aspects within trade agreements (p.23).

While Norway seeks to be active in guiding European policies, the other three country experts refer to enhanced possibilities to argue for developments in national alcohol policy resulting from EU processes.

For Germany, discussions on EU level bring attention to the topic and provide the possibility for national agencies to react and comment on international changes and argue for national development.

... important also is the discussion at the EU level ... it puts the topic on the table. And for example the alcohol strategy of DC SANCO or the Alcohol and Health Forum ... gives also the possibility ... to focus on this topic because then it is in the media and then ... [the DHS] can also say something and then the media asks ... what do you think and how should this be done in Germany and so on. ... this helps a lot (Germany, p.11).

The Slovenian interviewee highlights that the EU Communication and other EU actions are taken up by Slovenia and may influence further developments, for example concerning a new alcohol action plan. The Communication is used as a tool for professionals in the field.

... [the EU communication] has been taken seriously and this is also perhaps the reason why again we have started to discuss that we need an action plan ... Slovenia is quite eager to follow the initiative coming from European Union ... and I do believe, it will have some impact. How far it will go, it is difficult to say, but in terms of using it for professionals for public health, it is definitely a valuable tool (Slovenia, p.9).

Italy's national level policy documents reflect a strong connection to European resolutions, activities and recommendations. The law is in accordance with European resolutions, international guidelines, and particularly the EAAP and the European Charter on Alcohol. The interviewee points out that European action influenced and guided national developments like the law and the National Plan Alcohol and Health. In fact, five out of ten objectives of the plan and all eight strategic areas are adopted from the EAAP.

The Italian law on alcohol ... endorsed the principles of ... WHO Charta on Alcohol ... [which] have become rights in the Article 2 of the law ... This was considered very important, also to change the culture of the policy makers ... Then we have also produced a national plan on ... alcohol and health, PNAS, ... and a program that is 'Gaining Health' that is inspired to the European one (Italy, p.3).

The Norwegian interviewee describes formal EU influence as well as discussions and cooperation at EU level which have been taken up and can stimulate developments in the national context.

There is ... the discussions and the cooperation that we participate within the EU on developing the alcohol policy strategy ... in general terms we feel that there is ... the long-term tendency of that the differences are being smaller, that there is more emphasis on alcohol control policies ... At the same time there would be ... working messages and standings and so on that are influences. But the main influence of the EU countries are of course through the formal systems (Norway, p.15).

Another aspect of activities on European level is the active involvement in projects or other activities. Slovenia is for example at the moment leader of a European-wide project and the interviewee acknowledges the importance of international cooperation.

Slovenia I think is very active in the moment at international level because most often, as it was the case with tobacco, the international circumstance influence a lot what is going on in Slovenia ... But international pressure or activities going on ... in Slovenia and this is also why we decided to lead a project ... 'Building Capacity for Alcohol Policy' involving I think more than 40 partners from all over Europe (Slovenia, p.8).

In fact, all of the four countries are participants in European-wide projects and therefore are aware of European developments and influences.

6 DISCUSSION

6.1 ALCOHOL POLICY STRATEGIES

“... alcohol policy is broadly defined as any purposeful effort or authoritative decision on part of governments or non-governmental groups to minimise or prevent alcohol-related consequences” (Babor, et al., 2003, p.95). This definition covers both structural policy strategies such as increasing alcohol taxes as well as preventive strategies such as education. Longest (1998) in (Babor, et al., 2003) differs between “allocative” and “regulatory” alcohol policies according to their nature and purpose. While allocative policies are directed at specific groups or organisations and seek to reduce the harm done by alcohol or to provide services, regulatory policies aim for direct control and influence actions, behaviours, and decisions of individuals or organisations (Babor, et al., 2003). The database HP-Source.net, which was used for data collection in the present study, distinguishes between a variety of alcohol policy strategies by using a similar structure called ‘alcohol policy’ (regulative strategies) and ‘prevention of the harm done by alcohol’ (allocative strategies).

The results show that all four countries have implemented a variety of complementary alcohol policy strategies including both allocative (e.g. education, treatment) and regulatory (e.g. taxes and prices, availability) strategies. This points to the understanding that alcohol is a key health determinant and the awareness that a response to alcohol-related problems cannot be covered by the treatment sector only.

Nevertheless, alcohol policies are complex and vary across countries. The results show those varieties – differences in priorities, types and numbers of

allocative versus regulatory strategies, their implementation and enforcement, and their strictness across the four countries. The results furthermore confirm alcohol policy pattern as known from previous research and show some recent developments and possible directions for the future.

Norway clearly stands out with its strict regulatory alcohol policy strategies. Taxes and prices are highest in Norway. The experts from the other three countries confirm that taxes and prices are low. However, it is not possible to further group the countries on basis of the present data. Findings from research show the effectiveness of increased prices, leading to a decrease in consumption and related problems (Anderson & Baumberg, 2006; Babor, et al., 2003; Österberg, 2004). It is not obvious if, for example, taxes are raised on the basis of health considerations in addition to revenue considerations. Health matters are not explicitly mentioned in the laws, but the existence of specific taxes suggests a special position of this commodity. Nevertheless, taxes are mainly considered being revenue for the government. Tax raise may lead to higher revenue, but may on the other hand lead to a decrease in consumption and thereby a decrease in revenue. However, an increase in alcohol taxes and prices could lead to a reduction of alcohol-related harm and thereby lower costs related to alcohol. Besides, alcohol policy strategies concerning taxes are easy to establish and to enforce (Babor, et al., 2003). Despite this, the results from the expert interviews confirm the existence of low taxes and prices in three of the four countries and a lack of adjustments of prices in Germany and Slovenia. The experts consider adjustment and increase of taxes necessary for health reasons. What is the reason that taxes are not increased or adjusted although evidence and expertise point to

the advantages of this strategy? Possible explanations can be found when considering the complex context around alcohol consumption and policy-making. The relationship between alcohol consumption and prices is obviously multifaceted and other potential effects of price increases need to be considered when designing alcohol tax policies. From a health perspective, this could include consideration of the effects on cross-border trade or home-production of alcohol. Furthermore, health considerations are not necessarily prevailing in all sectors of government. Taxes are usually the responsibility of the Ministry of Finances and cooperation between sectors (e.g. with the Ministry of Health) needs to be ensured or improved to highlight health impacts. Other sectors concerned with production and trade may have a strong position, especially in countries such as Italy and Slovenia where wine production is an important trade branch. Governmental support for agriculture can conflict with decisions for health related issues. It is remarkable that three of the four countries do not levy any taxes on wine. Furthermore, other influencing factors may prevail. Players outside the government, such as a strong lobby of the alcohol industry, argue for their own interests and might succeed. This contextual influence, which differs from country to country, may include economical, political but also cultural circumstances to guide alcohol consumption and alcohol policy decision-making. An example for cultural influences is the close integration of alcohol into traditions of a country, such as wine in Mediterranean countries like Italy. This dual value of alcohol is even acknowledged and considered in the alcohol action plan, which does not include regulatory measures like tax increases. An integration of alcohol consumption into everyday life furthermore suggests that an increase in wine

prices in Italy would not have the same effect than, for example, in Norway. When wine consumption is closely linked to cultural traditions, it is not so responsive to changes (Babor, et al., 2003).

Besides taxation, other alcohol policy strategies are in place and have its influence on alcohol consumption and alcohol-related harm. When it comes to availability restriction, Norway again stands out with the strictest limitations. The country has, as the only of the four countries, a system of monopolies for off-premise sales in place, which gives the government formal control, for example over the number of outlet. The interviewee pointed out that this system supports public health interests by removing competition and showing acknowledgement of alcohol not being an ordinary commodity. The evidence supports that monopoly systems are effective in reducing alcohol consumption and related harm (Babor, et al., 2003). The monopoly system has been in place for a long time but was threatened by Norway's entry in the European Economic Area. Nevertheless, most parts could be maintained with exception of the monopoly on import and production. This shows on the one hand a strong influence of the EU, and on the other hand recognition of national historically established existing structures and public health considerations from EU level.

Other restrictions on the physical availability of alcoholic beverages include licensing, restrictions on hours, days and locations of sales and minimum age of purchase. The German interviewee stresses the necessity for more restrictions on availability of alcohol in Germany. This is also confirmed in the NAA, although only included into the general strategy and not as a short-term measure. In Italy, further strengthened regulatory strategies on availability do not

seem to be considered for future implementation. The Italian Alcohol Action Plan, which is strongly based on the European one, excludes those areas from being adopted. Nevertheless, in the alcohol laws in Italy as well as slightly more so in Slovenia, some regulatory measures have been implemented or strengthened recently. This indicates a trend towards more and stricter regulatory measures. In Norway on the other hand, the objectives are to keep the existing strict regulations and suggest and further support the implementations of stricter strategies in other parts of Europe.

Generally, restrictions on the physical availability are proven to be effective in lowering alcohol consumption and related problems (Anderson & Baumberg, 2006; Österberg, 2004). As mentioned above, in the three countries, there is a trend towards some stricter regulations recognisable, although no dramatic changes occurred. Reasons for hesitation towards a structural approach may lie in the different histories of the countries' welfare states and political systems. State intervening is more tolerated in Norway than in the other countries since acceptance has grown historically over many years. Public support and compliance are important preconditions for successful implementation and enforcement of policies and will be considered when designing policies. Many of the aspects on taxation addressed above are also relevant for policies on the physical availability of alcohol. Other policy sectors may for example advance own interests, which interfere with public health interests. In Germany, for example, the interviewee suggests that the alcohol industry uses the argument of personal freedom to gain public opposition against stricter regulations and to counter public compliance. Further obstacles to the implementation of regulation

on availability may be competences on different levels (regional vs. national) as in Germany, where strong regional competences lead to variations across the regions. This has shown to be a hesitant factor for the implementation of regulations, for example concerning tobacco and the establishment of smoking bans in restaurants and bars. Slovenia's recent engagement and the implementation of more regulatory strategies, indicates commitment to the topic and may be a result of the new EU Membership and the current EU presidency and thus strong orientation on EU recommendations.

A complete ban of commercial communication is in place in Norway, while the other three countries only ban a few aspects of advertisements and leave other restrictions to the self-regulations of the industry. Self-regulations are however shown to be ineffective (Babor, et al., 2003), which is confirmed by the experts. Changes seem to be necessary, but again evidence does not automatically influence policy developments and factors such as conflicting interests, especially from a strong alcohol industry lobby, counteract efforts to strengthen regulations.

For all regulatory approaches as discussed above, Norway is – and has been historically – the country with the strictest measures while the other countries have more recently developed some regulatory and/or stricter policy approaches. The existence of an alcohol law in Norway for a long time and the recent development of alcohol laws in Italy and Slovenia support this statement. The Norwegian alcohol law mainly addresses regulative alcohol policy approaches concerning the monopoly system, sales times, advertising, etc, while the Slovenian and Italian alcohol laws also restrict those aspects but additionally

set the foundation for behavioural strategies in the law, showing the continuous importance of allocative strategies.

Several allocative strategies are applied in all four countries. Drink-driving measures such as a legal limit on the BAC level, aimed at reducing the harm through behavioural changes, are in place in all four countries. The results show that recent advances have been made. The topic has received attention in policy-making as well as in public, leading to increased awareness and possibly increased public support. Still, stricter regulations and further improvements regarding controls and enforcement are desirable. Drink-driving legislation such as a BAC limit together with vigorous enforcement and a penalty system are highly effective in preventing harm (Österberg, 2004). However, as shown in some examples above, evidence alone does not necessarily lead to action. A difference in this area is increased awareness, public support and possibly the absence of strong opponents (e.g. the alcohol industry) that allows for success. Moreover, cultural differences seem to be less strong influencing factors, but are visible as well. In Germany, for example, random breath testing is not allowed and this sort of intervening is not highly accepted.

The results furthermore show the popularity of educational strategies and public education campaigns and the future trend to keep up this approach. While in Norway regulatory strategies are prioritised, the other countries seem to centre more on educational measures. Especially the NAA in Germany and the Alcohol Action Plan in Italy are dominated by educational and preventive measures. The laws in Italy and Slovenia comprise this topic. The evidence however suggests that those strategies, including mass media campaigns, warning labels and school-

based programmes as compared to other regulatory strategies are expensive and have little potential for reducing alcohol consumption and related problems (Babor, et al., 2003; Österberg, 2004). So why are strategies with limited effectiveness continuously prioritised and why are resources provided for them? Why is not more emphasis directed at regulatory measures since those are shown to be more effective and cost-effective? Political, economic and cultural conditions are some of the influencing factors. The political systems vary across the countries and so does the acceptance of political intervening. A focus on the behavioural approach also has a long tradition, as the regulatory approach has in Norway, which might be one reason for its continuously strong centre of attention. Nevertheless, there is a shift towards more regulatory approaches visible.

Treatment, early identification and prevention in the care sector are areas that are addressed in all countries. They are important themes in the action plans as well. Topics for suggested improvements include quality raise, the promotion of early intervention, adequate professional training and the supply of sufficient resources.

The findings support the evidence, suggesting a stronger regulatory approach instead of an allocative approach. But although evidence points towards these strategies, it is important to consider the contexts and national differences in terms of drinking patterns, political systems and other factors. Not all influences on alcohol consumption have been studied extensively. Complex contexts do not allow for a simple and similar conclusion for all countries. A good example is the decline of alcohol consumption in Italy that occurred over the last decades

(Allamani, et al., 2002) despite of the lack of regulatory or preventive alcohol policies. Recent research seeks to find explanations, among others, in changes of lifestyle conditions such as urbanisation, work conditions, changes in family structure, de-structuring meals, health consciousness (Cipriani & Prina, 2007). It is thus important to consider a comprehensive approach. Health impacts of policies have to be considered in all sectors (e.g. trade, transport or education), as also the concept ‘build healthy public policy’ suggests.

From a health promotion perspective, a comprehensive approach is supported and would not only focus on behavioural strategies directed at the individual, but also stress structural determinants of health and thus support strategies altering environmental conditions (create supportive environments) and policies (build healthy public policies). A comprehensive approach including both kinds of strategies has been advanced in all countries. The various alcohol policy strategies match the five health promotion strategies, i.e. efforts to ‘build healthy public policy’ through a comprehensive policy approach including all sectors (e.g. finance, trade, agriculture), ‘create supportive (drinking) environments’ (e.g. physical and economical availability of alcohol), ‘develop personal skills’ (e.g. drinking behaviour), and ‘reorient health services’ (e.g. prevention, advice and treatment in primary health care). Nevertheless, it has to be kept in mind that not only measures and policies directed at alcohol specifically will have an impact on alcohol consumption and alcohol-related harm.

6.2 GLOBAL AND EUROPEAN INFLUENCES

The connections within Europe are getting closer. This has an influence on national level as well, as the results confirm. We see this e.g. in harmonisation of

drinking patterns, increased European cooperation and the development of European-wide guidelines for alcohol policies. However, European initiatives always stress national individuality and the respect of national differences. Still, there have been several initiatives providing input, principles and a framework for national level policies. But how does that influence national policies? The results show that global and European developments and initiatives play a major role in influencing national policies. European processes have an impact in each of the four countries, however the impact is different.

European influences or regulations have the potential to further national alcohol policy strategies through providing a reference point or pressure from ‘above’ to develop a national strategy. Particularly alcohol policies in Italy, Slovenia and Germany experience European level influence. Firstly, as confirmed by the interviewees, European discussions and initiatives put the topic on the political agenda and serve as a tool for professionals to argue that alcohol, as a public health issue, is a topic of importance. Italy’s and Slovenia’s alcohol policy has developed more recently and has taken European initiatives as a starting point. Secondly, recommendations on priority areas were taken up, addressed and developed further in laws and action plans. In Italy, for example, the alcohol law has a strong connection to European initiatives and the EAAP was to a great extent adopted to form a national action plan. On the other hand, a given European strategy might comprise the risk to adopt this strategy without considering national differences or needs. Priorities set on European level are not necessarily in accordance with national needs. There is a threat to draw attention from other national priority areas or response needs. Given different cultural

backgrounds in drinking patterns or expectance of political intervening, policy responses need to match national particularities.

While European level processes may have too much impact on some countries on the one side, they do not directly affect countries on the other side, since their policies have already been developed further. An adoption of such suggestions would mean a drawback. Therefore, such countries are not necessarily satisfied with the provided European suggestions since their goals are different. This includes the potential for further development with those actors arguing for strengthened approaches. Norway does not base national alcohol policies on European documents, but rather seeks to advice European initiatives. The drug action plan, for example, confirms that Norway aims to be a driving force in international processes to ensure alcohol is a priority area for international agencies. The Norwegian expert supports the importance to focus on international processes. The differences in the countries reactions is linked to different historical contexts of alcohol policy in the countries. Norway has had a strict alcohol policy already for many years and is not very much affected by European suggestions, while for example Italy's and Slovenia's and possibly Germany's alcohol policies have been influenced more strongly. Norway's concerns are to keep up existing strict regulations, and acts to further develop, strengthen and advocate for alcohol policy in other European countries rather than European initiatives directing their national alcohol policy. Harmonisations of European drinking patterns and policy responses might threaten Norway's regulatory approach, suggesting a weaker approach in Norway as well. Norway's entry into the European Economic Area, for example, was capable to pressurise

existing purchase systems such as the monopoly system. Furthermore, Norway's interest in strengthening other national alcohol policies might also be caused by influences on Norwegians alcohol consumption, through growing cross-border trade of alcoholic beverages caused by low prices in other countries and increased travel patterns of the population.

This shows interactions into both directions from the European Union level to the national level for some countries and from national level to European level on the other hand.

It is stressed in European level documents that countries have to consider cultural aspects in the implementation of recommendations. Is it possible at all to provide recommendations if countries' starting points are so different? The interviews all point into the direction that EU recommendations are positive and support national policy development. This still leaves the question of how similar policy responses should be. Should they become more similar, considering harmonisation of the context or should they stay different considering constant variations and differing contexts?

6.3 THE POLITICAL CONTEXT

Alcohol policies and their developments are imbedded in a context of the political arena. Research can give rational guidance when it comes to the effectiveness of alcohol policy strategies. A variety of studies exist pointing out which strategies are effective and cost-effective in reducing alcohol consumption and the harm done by alcohol. But why is research hardly guiding practice or informing policies? The policy process is neither a simple nor straightforward process

building on a research rational, but influenced and informed by a variety of actors having specific interests, which may conflict with the interest of public health.

This is also and especially true for the arena of alcohol policy. Actors like governments, NGOs and the alcohol industry are involved in the process and try to stand up for and defend their interests. Health issues are only one out of many interests and may not seem as profitable to most actors. A stronger lobby, having more resources and thus more power, might for example support economic or trade interests. The power structure of different actors will lead to different policy results. If the alcohol industry has a strong lobby, as in Germany for example, the development of health-related alcohol policies will be more slowly, more restricted or more hesitant concerning the implementation of changes than in other countries, such as Norway, where strict regulatory alcohol policy is completely respected and alcohol is not seen an ordinary economic commodity.

This points to the need for stronger involvement of health professionals in the policy-making process to argue for, become more visible and provide a stronger forum for alcohol and health related policies.

6.4 CONCLUSIONS

Alcohol consumption and policies are embedded into complex social, cultural, historical and political circumstances and are greatly influenced by these contexts. Therefore the alcohol policies do not and cannot have the same approach in every European country. Despite existing differences, a combination of a great variety of alcohol policy strategies is applied in all four countries, which is in accordance with the five health promotion strategies.

European recommendations are despite the complex and differing contexts seen as a good guidance and framework for national level policies and do influence the countries' policies in diverse ways. Other global or European regulations, particularly from sectors other than the health sector, might hinder advances for alcohol policies. The same applies to national level influences from other policy sectors. It is necessary to consider all policy sectors at all levels in order to build healthy public policy, one of the main health promotion strategies.

Advocating for health is an important health promotion action area. The policy-making process involves many actors with competing interests, which makes it necessary to advocate for alcohol policy from a public health perspective. Research results have to be communicated more clearly in order to provide a scientific basis for arguments, which can be implemented into practice. The alcohol industry seems to be a strong, powerful actor in many countries. Health professionals need to become more active in advocating for health interests within policy processes.

The historical development and approach to alcohol policy form policy processes through shaping public acceptance of certain policy strategies. Public opinion and the acceptance of a policy measure are important factors in the policy-making process. It is crucial to increase public acceptance of effective policy measures, which might contribute to increased political will to implement such measures.

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APPENDIX

Germany		Beverage categories		
		Beer	Wine	Spirits
Control of retail sale and production	Monopoly on production of	NO	NO	NO
	Monopoly on sales of	NO	NO	NO
	Licence for production of	NO	NO	NO
	Licence for sale of	NO	NO	NO
Off-premise sales restrictions and level of enforcement	Hours of sale	NO	NO	NO
	Days of sale	NO	NO	NO
	Places of sale	NO	NO	NO
	Density of outlets	NO	NO	NO
	Level of enforcement	N.A.		
Age limit for purchasing alcoholic beverages	On-premise:	16	16	18
	Off-premise:	16	16	18
Taxation of alcoholic beverages	Sales TAX/VAT exists?	YES		
	% sales TAX/VAT	16		
	Tax as % of retail price ¹	6.6	0	13.78
	Excise stamps exist?	NO		
Restrictions on advertising	National television	VOLUNT	VOLUNT	VOLUNT
	National radio	VOLUNT	VOLUNT	VOLUNT
	Print media	VOLUNT	VOLUNT	VOLUNT
	Billboards	VOLUNT	VOLUNT	VOLUNT
	Health warning on advertisements	NO		
	Enforcement of advertising and sponsorship restrictions	N.A.		
Restrictions on sponsorship of	Sports events	VOLUNT	VOLUNT	VOLUNT
	Youth events	VOLUNT	VOLUNT	VOLUNT
Restrictions on alcoholic beverage consumption in public domains	Health care establishments	BAN		
	Educational buildings	BAN		
	Government offices	VOLUNTARY		
	Public transport	PARTIALLY		
	Parks, streets, etc.	NO		
	Sporting events	PARTIALLY		
	Leisure events (concerts, etc.)	NO		
Workplaces	PARTIALLY			
Definition of alcohol, BAC level and RBT	Definition of alcohol (vol. %)	1.2		
	Maximum Blood Alcohol Concentration (BAC) level	0.5		
	Use of Random Breath Testing (RBT)	NO		

¹ Since 1 July 2004, there has also been a special tax on spirits-based alcopops of EUR 0.83 per 275ml bottle

Figure 1 Basic information on alcohol policy in Germany

Source: World Health Organization (2004b), reviewed and updated by APN member July <http://www.ias.org.uk/btg/countryreports/germany/basic.html>, access: 07.11.2008.

Italy		Beverage categories		
		Beer	Wine	Spirits
Control of retail sale and production	Monopoly on production of	NO	NO	NO
	Monopoly on sales of	NO	NO	NO
	Licence for production of	YES	YES	YES
	Licence for sale of	YES	YES	YES
Off-premise sales restrictions and level of enforcement	Hours of sale	NO	NO	NO
	Days of sale	NO	NO	NO
	Places of sale	NO	NO	NO
	Density of outlets	NO	NO	NO
	Level of enforcement	N.A.		
Age limit for purchasing alcoholic beverages	On-premise:	16	16	16
	Off-premise:	16	16	16
Taxation of alcoholic beverages	Sales TAX/VAT exists?	YES		
	% sales TAX/VAT	20		
	Tax as % of retail price ¹⁰¹	11	0	20
	Excise stamps exist?	YES		
Restrictions on advertising	National television	PARTIAL	VOLUNT	PARTIAL
	National radio	PARTIAL	VOLUNT	PARTIAL
	Print media	PARTIAL	VOLUNT	PARTIAL
	Billboards	PARTIAL	VOLUNT	PARTIAL
	Health warning on advertisements	NO		
	Enforcement of advertising and sponsorship restrictions	PARTIALLY		
Restrictions on sponsorship of	Sports events	VOLUNT	VOLUNT	VOLUNT
	Youth events	VOLUNT	VOLUNT	VOLUNT
Restrictions on alcoholic beverage consumption in public domains	Health care establishments	VOLUNTARY		
	Educational buildings	VOLUNTARY		
	Government offices	VOLUNTARY		
	Public transport ¹⁰²	VOLUNTARY		
	Parks, streets, etc.	VOLUNTARY		
	Sporting events	VOLUNTARY		
	Leisure events (concerts, etc.)	VOLUNTARY		
	Workplaces	VOLUNTARY		
Definition of alcohol, BAC level and RBT	Definition of alcohol (vol. %)	0.1		
	Maximum Blood Alcohol Concentration (BAC) level	0.5		
	Use of Random Breath Testing (RBT)	SOMETIMES		

¹⁰¹ When including VAT the tax rates are 31% on beer, 0% on wine, and 40% on spirits.

¹⁰² Alcohol consumption forbidden on buses, but not on trains.

Figure 2 Basic information on alcohol policy in Italy

Source: World Health Organization (2004b).

Norway		Beverage categories		
		Beer	Wine	Spirits
Control of retail sale and production	Monopoly on production of	NO	NO	YES
	Monopoly on sales of	NO	YES	YES
	Licence for production of	YES	YES	YES
	Licence for sale of	YES	YES	YES
Off-premise sales restrictions and level of enforcement	Hours of sale	YES	YES	YES
	Days of sale	YES	YES	YES
	Places of sale	YES	YES	YES
	Density of outlets	NO	YES	YES
	Level of enforcement	FULLY		
Age limit for purchasing alcoholic beverages	On-premise:	18	18	20
	Off-premise:	18	18	20
Taxation of alcoholic beverages	Sales TAX/VAT exists?	YES		
	% sales TAX/VAT	24		
	Tax as % of retail price ¹⁰⁷	-	-	-
	Excise stamps exist?	NO		
Restrictions on advertising ¹⁰⁸	National television	BAN	BAN	BAN
	National radio	BAN	BAN	BAN
	Print media	BAN	BAN	BAN
	Billboards	BAN	BAN	BAN
	Health warning on advertisements	-		
	Enforcement of advertising and sponsorship restrictions	FULLY		
Restrictions on sponsorship of	Sports events	BAN	BAN	BAN
	Youth events	BAN	BAN	BAN
Restrictions on alcoholic beverage consumption in public domains	Health care establishments	PARTIALLY		
	Educational buildings	PARTIALLY		
	Government offices	PARTIALLY		
	Public transport	PARTIALLY		
	Parks, streets, etc. ¹⁰⁹	PARTIALLY		
	Sporting events	PARTIALLY		
	Leisure events (concerts, etc.)	PARTIALLY		
Workplaces	PARTIALLY			
Definition of alcohol, BAC level and RBT	Definition of alcohol (vol. %)	2.5		
	Maximum Blood Alcohol Concentration (BAC) level	0.2		
	Use of Random Breath Testing (RBT)	OFTEN		

¹⁰⁷ Tax rates 15.55/litre on beer, 3.47 per vol%/litre on wine and 5.98 vol%/litre on spirits.

¹⁰⁸ Advertising in business to business magazines is allowed. Advertising for products with less alcohol than 2.51 vol% is allowed and is used to circumvent the advertising ban.

¹⁰⁹ Drinking in public places is prohibited, but you can get a local licence to serve alcohol e.g. in a park.

Figure 3 Basic information on alcohol policy in Norway

Source: World Health Organization (2004b).

Slovenia		Beverage categories		
		Beer	Wine	Spirits
Control of retail sale and production	Monopoly on production of	NO	NO	NO
	Monopoly on sales of	NO	NO	NO
	Licence for production of	NO	NO	NO
	Licence for sale of	NO	NO	NO
Off-premise sales restrictions and level of enforcement	Hours of sale	YES	YES	YES
	Days of sale	NO	NO	NO
	Places of sale	YES	YES	YES
	Density of outlets	NO	NO	NO
	Level of enforcement	HIGH		
Age limit for purchasing alcoholic beverages	On-premise:	18	18	18
	Off-premise:	18	18	18
Taxation of alcoholic beverages	Sales TAX/VAT exists?	YES		
	% sales TAX/VAT	20		
	Tax as % of retail price	25.1	0	40.1
	Excise stamps exist?	NO		
Restrictions on advertising	National television	PARTIAL	PARTIAL	BAN
	National radio	PARTIAL	PARTIAL	BAN
	Print media	PARTIAL	PARTIAL	BAN
	Billboards	BAN	BAN	BAN
	Health warning on advertisements	YES		
	Enforcement of advertising and sponsorship restrictions	PARTIALLY		
Restrictions on sponsorship of	Sports events	YES	YES	YES
	Youth events	YES	YES	YES
Restrictions on alcoholic beverage consumption in public domains	Health care establishments	BAN		
	Educational buildings	BAN		
	Government offices	BAN		
	Public transport	PARTIALLY		
	Parks, streets, etc.	NO		
	Sporting events	BAN		
	Leisure events (concerts, etc.)	PARTIALLY		
Workplaces	BAN			
Definition of alcohol, BAC level and RBT	Definition of alcohol (vol. %)	1.2		
	Maximum Blood Alcohol Concentration (BAC) level	0.5		
	Use of Random Breath Testing (RBT)	YES		

Figure 4 Basic information on alcohol policy in Slovenia

Source: World Health Organization (2004b), reviewed and updated by APN member July 2005, <http://www.ias.org.uk/btg/countryreports/slovenia/basic.html>, access: 07.11.2008.