HOW DO PUBLIC HEALTH POLICIES TACKLE ALCOHOL-RELATED HARM: A REVIEW OF 12 DEVELOPED COUNTRIES

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Abstract — Aims: To identify how current public health policies of 12 developed countries assess alcohol-related problems, the goals and targets that are set and the strategic directives proposed. Methods: Policy documents on alcohol and on general public health were obtained through repeated searches of government websites. Documents were reviewed by two independent observers. Results: All the countries studied state that alcohol causes substantial harm to individual health and family well-being, increases crime and social disruption, and results in economic loss through lost productivity. All are concerned about consumption of alcohol by young adults and by heavy and problem drinkers. Few aim to reduce total consumption. Only five of the countries set specific targets for changes in drinking behaviour. Countries vary in their commitment to intervene, particularly on taxation, drink-driving, the drinking environment and for high-risk groups. Australia and New Zealand stand out as having coordinated intervention programmes in most areas. Conclusions: Policies differ markedly in their organization, the goals and targets that are set, the strategic approaches proposed and areas identified for intervention. Most countries could improve their policies by following the recommendations in the World Health Organization’s European Alcohol Action Plan.

INTRODUCTION

Alcohol-related health problems have for many years been recognized as a major public health problem. In 1983, the World Health Assembly declared that problems related to alcohol consumption were among the world’s major public health challenges. In 2000, alcohol use was estimated to be responsible for 4% of the global burden of disease (WHO, 2002) and responsible for 9.2% of all disability-adjusted life-years (DALYs) lost in developed countries. Alcohol misuse increases the risk of contracting many diseases including several types of cancers, hypertension, stroke, epilepsy and cirrhosis of the liver, as well as injuries and accidents (WHO, 2002; Rehm et al., 2003). The overall effects of alcohol-related harm, however, extend beyond the detrimental health effects on the individual to include the social and economic cost of harm to families, communities and the wider society (WHO, 2002). The global patterns of alcohol use and its health consequences are documented in the World Health Organization Global Alcohol Database (WHO Department of Mental Health and Substance Abuse, 2004).

Trends in alcohol consumption, the resulting harm and policy responses of governments have been reviewed by several groups. The WHO sponsored the seminal monograph on alcohol control policies by Bruun and colleagues, published in 1975 (Bruun et al., 1975). This restricted the remit of policy to direct government action and excluded health education and attitude change. A subsequent report in 1994 expanded the remit to a broader public health approach which included education campaigns (Edwards et al., 1994). The most recent monograph in this series provided an authoritative review of the literature and makes recommendations for policy (Babor et al., 2003). In a separate development, the comprehensive European Comparative Alcohol Study (ECAS) (Norstrom, 2003) reviewed alcohol policy in 15 countries, which demonstrated that all have alcohol controls although these vary in the degree of strictness (Karlsson and Osterberg, 2001). The Nordic countries had the strictest policies, although restrictions had weakened a little by 2000. The other countries had increased the strength of their policies but not to the level of the Nordic countries. Despite these controls, alcohol was seen to be a substantial contributor to disability and death in all the countries studied and tackling alcohol-related problems was a public health imperative need (Room, 2002).

In response to the problems posed by alcohol, the WHO launched the European Alcohol Action Plan in 2000 which outlined 10 broad areas for action (WHO Regional Office for Europe, 2000). This was followed by a declaration aimed at reducing alcohol misuse by young people (WHO Regional Office for Europe, 2001; WHO Department of Mental Health and Substance Abuse, 2004). In 2005, the World Health Assembly reaffirmed its commitment to tackle the harm caused by alcohol-related problems, requesting governments to develop, implement and evaluate programmes to reduce alcohol-related harm (WHO, 2005a). More recently, the WHO Framework for Alcohol Policy in the European Region reinforced the guidance on policy options and strategic approaches (WHO, 2005b). Despite these developments, there are concerns that policies on alcohol are inadequate (Room et al., 2005). Three recent commentaries on England’s new alcohol strategy have concluded that current proposals were unlikely to address existing alcohol problems (Drummond, 2004; Marmot, 2004; Plant, 2004; Room, 2004). The important question is whether current public health policies on alcohol recognize the scale of the problem, and propose strategies to address it. This study presents an analysis of public health policy documents on alcohol in 12 developed countries to identify how countries currently assess alcohol-related...
problems. It also reviews the goals and targets that are set and the strategic directions proposed.

METHODS

Public health policy documents which address alcohol were obtained from Australia, Canada, Denmark, England, Ireland, Japan, New Zealand, Northern Ireland, Scotland, Sweden, USA and Wales (Table 1). These countries were selected because they have a long tradition of public health and publish their policy documents in English. Government websites were searched using the key terms alcohol and policy. Independent searches were carried out with an Internet search engine (Google) using key terms of country name, alcohol and policy. Repeated searches were carried out up to May 2004 for an initial report (Crombie et al., 2005) and the searches were updated to February 2006 for the present analyses. Most documents were obtained from departments of health or their equivalent, although that for England was from the Prime Minister’s Strategy Unit of the Cabinet Office. When the most up-to-date policy documents referred to periods that had

<table>
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<tr>
<th>Table 1. Current policies on alcohol</th>
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<td><strong>Policy documents</strong></td>
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<tr>
<td>Australia</td>
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<tr>
<td>National alcohol strategy, 2001 to 2003–2004 (National Expert Advisory Committee on Alcohol (NEACA), 2001a)</td>
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<tr>
<td>Alcohol in Australia: issues and strategies (National Expert Advisory Committee on Alcohol (NEACA), 2001b)</td>
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<tr>
<td>Canada</td>
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<tr>
<td>National framework for alcohol and other drugs (Drug Strategy and Controlled Substances Programme, Canadian Centre on Substance Abuse, 2005)</td>
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<td>Canada’s drug strategy (Interdepartmental Working Group on Substance Abuse, 1998)</td>
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<td>Denmark</td>
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<tr>
<td>The Danish Government Programme on Public Health and Health Promotion 1999–2008 (Ministry of Health, 1999)</td>
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<tr>
<td>England</td>
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<td>Delivering choosing health: making healthier choices easier (Department of Health, 2005)</td>
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<td>Alcohol harm reduction strategy for England (Prime Minister’s Strategy Unit, 2004)</td>
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<td>Interim analytical report (Strategy Unit Alcohol Harm Reduction Project, 2003)</td>
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<tr>
<td>Ireland</td>
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<td>Strategic task force on alcohol. Second report (Strategic Task Force on Alcohol, 2004)</td>
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<td>Strategic task force on alcohol. Interim report (Department of Health and Children, 2002)</td>
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<td>National alcohol policy (Minister for Health, 1996)</td>
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<td>Japan</td>
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<td>New Zealand</td>
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<td>Northern Ireland</td>
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<tr>
<td>Strategy for reducing alcohol-related harm (Department of Health, Social Services and Public Safety, 2000)</td>
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<td>Scotland</td>
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<td>Plan for action on alcohol problems (Scottish Executive, 2002)</td>
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<td>Sweden</td>
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<tr>
<td>Preventing alcohol-related harm. A Comprehensive policy for public health in Sweden (Ministry of Health and Social Affairs, 2001)</td>
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<tr>
<td>USA</td>
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<tr>
<td>Healthy people 2010 (US Department of Health and Human Services, 2000)</td>
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<tr>
<td>Wales</td>
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<td>Tackling substance misuse in Wales (Ministry for Health and Social Services, 2000)</td>
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elapsed by February 2006 (e.g. New Zealand’s policy was dated 1998–2003) the departments of health were approached to determine if a new policy had been developed. No new policies were obtained.

Two independent reviewers (LI and IC) assessed the alcohol policies. The key themes explored were the description of the impact of alcohol use on society, the groups at high risk of harm, the goals and targets set, and the areas within which interventions were proposed. Summaries of the individual countries outlining their coverage of the key themes were produced by LI and were checked against the policy documents by IC. Differences of interpretation were resolved by discussion. For the nature of alcohol-related problems, and for the areas of intervention, scoring systems were developed, as will be described, to assess the extent of coverage in individual countries.

The nature of the problem
The problem was categorized into four broad topics: consumption, individual health, social and economic costs and benefits. Within each of the following, specific factors were highlighted:

Consumption. Total consumption, patterns of consumption, risky consumption

Individual health. Total mortality, total morbidity, road traffic injuries, specific diseases (cirrhosis, cancer, mental disorders, foetal alcohol syndrome) and other (risk of drowning, fire, falls, industrial accidents and suicide)

Social and economic harms. Violence, domestic abuse, family disruption, employment (absence when sick, lost production), unsafe sex

Benefits. Health benefits of moderate consumption, economic (employment and export earnings), government tax raising (excise duty), social benefits

The extent of the coverage within each topic was graded using the following scoring system:

++ + review of all or most of the categories, giving data
+ + review of most of the categories, with limited detail
+ review of a few of the categories, with limited detail
- topic not mentioned

Interventions
The problems were categorized into eight broad areas (Table 3) using groupings developed from three recent overviews of the evidence on effectiveness of interventions to tackle alcohol-related problems (Babor et al., 2003; Ladbrook, 2004; Mulvihill et al., 2005). Comparison with the organization of interventions within policy documents showed that the classification provided a workable system for identifying the range of interventions.

The eight areas covered the following types of interventions:

Taxation and pricing. Excise duty; price of low-alcohol content drinks; price promotions

Legislation and enforcement. Minimum drinking age; opening hours; outlet density; sales to persons who are intoxicated; server liability; restrictions on sales at social and sports events

Drink-driving. Blood-alcohol level; zero tolerance for young drivers; increased enforcement, e.g. random breath testing; repeat offences

Marketing. Monitoring of voluntary codes; legislative controls; penalties for breaching codes; restrictions on sponsorship by the industry; promotion of low-alcohol drinks

Drinking environment. Server training voluntary and statutory; provision of food; training of door staff; in-house drinks promotion

High-risk groups. Indigenous peoples; pregnant women; prisoners and offenders; people with mental health problems

Problem drinkers. Screening in primary care; brief interventions; increased provision of early treatment facilities; training of professional staff; promote awareness of treatment services

Education. Mass media campaigns on harm; warning labels on drink containers; alcohol policies in schools, colleges and workplaces; education on responsibilities of adults; parenting programmes

Policies were graded by the scale of interventions proposed in each area using the following scoring system:

++ + substantial coverage with a wide range of proposed interventions
++ moderate range of proposals
+ few proposals
- no proposals

RESULTS

The diversity in the ways in which public health policies on alcohol are organized is shown in Table 1. Eight countries have free-standing policy documents on alcohol, although these vary in length and detail. Australia and England have background papers as well as policy documents. Ireland has a policy from 1996, which has been superseded by Task Force reports in 2002 and 2004. Two countries (Denmark and Japan) address alcohol use as a section or chapter within an overall public health policy. Three other countries have free-standing policy documents that deal with drugs and alcohol together, and these give much more attention to drugs than to alcohol. One of these, Canada, has recently published a Framework for Action on Alcohol and Drugs, which gives much more attention to alcohol than to drugs (Drug Strategy and Controlled Substances Programme and Canadian Centre on Substance Abuse, 2005). Finally, the United States tackles alcohol-related problems within its general public health policy in a chapter on substance abuse, but this gives as much attention to alcohol as drugs.

The extent to which countries review the nature of alcohol-related problems in society, and the dangers and benefits from its consumption, were assessed using the scoring system described in the Methods section (Table 2). There are marked differences between the countries, with Australia, England, Ireland and Scotland giving most detail and Canada, Northern Ireland, Sweden and Wales giving least. All countries describe trends in levels of consumption and changes in drinking patterns, particularly the increased consumption by young people and by women. Only four of the twelve countries
All the countries are concerned about drinking by young people and by heavy drinkers, but differ in the other groups identified as being at high risk. The United States mentions ethnic groups and those with co-occurring substance abuse and mental illness (US Department of Health and Human Services, 2000). Sweden draws attention to pregnancy, the risks of alcohol on transport and the workplace and to the excess harm among socially disadvantaged groups (Ministry of Health and Social Affairs, 2001). Scotland points out that men in the most deprived areas are seven times more likely to die of alcohol-related deaths (Scottish Executive, 2002). It also points out that many groups (e.g. disabled people, ethnic groups, the homeless) have difficulty accessing services. New Zealand is concerned with ethnic groups, those with mental health problems, prisoners and the unborn child (Ministry of Health, & Alcohol Advisory Council of New Zealand, 2001).

England identifies ex-prisoners, and those with other problems such as mental illness, drug use and homelessness (Prime Minister’s Strategy Unit, 2004). Australia, which gives most coverage of the issue, mentions ethnic minorities, pregnant women, those with mental health disorders, homelessness and risks at the workplace (National Expert Advisory Committee on Alcohol (NEACA), 2001b). Sweden is unusual in setting a goal that children should grow up in an alcohol-free environment (Ministry of Health and Social Affairs, 2001).

**Goals and targets**

All the countries aim to reduce the harm caused by alcohol misuse, particularly by reducing consumption among heavy drinkers and among young people. Only Sweden, Ireland and the USA explicitly state the goal of reducing total consumption. Australia recognizes that the higher the overall consumption the higher the levels of alcohol-related problems (National Expert Advisory Committee on Alcohol (NEACA), 2001b), but has moved the emphasis of its policy from average consumption to a focus on patterns of drinking (National Expert Advisory Committee on Alcohol (NEACA), 2001a). England contends that ‘there is no direct relationship between the amounts or patterns of consumption and types or levels of harm caused’, but is concerned about binge drinking and frequent heavy drinking (Prime Minister’s Strategy Unit, 2004).

Only five countries cite numeric targets to identify the amount of improvement intended. The United States is unusual in having many specific targets covering road traffic injuries, cirrhosis deaths, violence, emergency hospital visits as well as drinking patterns (US Department of Health and Human Services, 2000). It is also notable that the United States sets many targets for young people and students, including perceptions of harm, disapproval of excessive drinking, and travelling with a driver who has been drinking. Japan, Scotland, New Zealand and Denmark have numeric targets for heavy drinking and underage drinking. New Zealand also sets other targets for topics such as drink-driving, alcohol-related crime, and alcohol-related drowning. Australia, although it does not have specific targets, carefully reviews approaches to evaluating progress and identifies six key indicators of harm taken from the WHO guide for monitoring alcohol consumption and harm (WHO, 2000). England acknowledges that it has no target and that at present it is difficult to monitor progress on managing alcohol misuse. However, it makes a commitment to monitor progress and identifies sources of data on topics such as crime, lost

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### Table 2. Assessing the extent to which countries review the nature of alcohol in society

<table>
<thead>
<tr>
<th>Country</th>
<th>Consumption patterns</th>
<th>Harm to individual health</th>
<th>Social and economic harm</th>
<th>Benefits</th>
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<td>USA</td>
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<td>Wales</td>
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++ + Review of all or most of the categories, giving data.
++ Review most of the categories, with limited detail.
+ Review of a few of the categories, with limited detail.
− Topic not mentioned.
productivity, drinking patterns and underage drinking (Prime Minister’s Strategy Unit, 2004).

Strategic approaches
The strategic approaches to tackling alcohol-related problems differ markedly across countries. For example, New Zealand structures policy interventions around controlling the supply, reducing demand and dealing with problem drinkers (Ministry of Health, & Alcohol Advisory Council of New Zealand, 2001). Sweden also aims to control supply and reduce demand, but structures much of its policy around high-risk groups, opinion moulding, and management of problem drinkers (Ministry of Health and Social Affairs, 2001). Northern Ireland aims to encourage a responsible approach to drinking, to promote treatment services and to protect individuals and communities from harm (Department of Health, Social Services and Public Safety, 2000). England identifies four approaches: education, identification and treatment of problem drinking, using existing powers to tackle crime and promoting the contribution of the alcohol industry to harm reduction (Prime Minister’s Strategy Unit, 2004). Scotland also organizes its policy in four areas, but identifies them as culture change, prevention and education, service provision and protection (Scottish Executive, 2002). Australia organizes its action plan across eleven strategic areas covering law enforcement, education, training and a series of measures to encourage responsible drinking (National Expert Advisory Committee on Alcohol (NEACA), 2001a).

All the countries identify a wide range of areas for intervention, which can be conveniently classified into eight broad categories (Table 3). This analysis was restricted to those countries, which have substantial alcohol policies in English. The US policy only identifies opportunities for action but does not commit to intervening in specific areas. Thus it has been omitted from this analysis. The table needs to be interpreted with care as it describes current proposals. When countries already have well developed strategies in place, they might be expected to have a few proposals for further action. This does not seem to be the case. For example, Sweden and Australia already have some of the strictest rules on drink-driving, including random breath testing, but have proposals for additional measures. Similarly Sweden has strict controls on marketing, including a complete ban on marketing of drinks with >2.5% alcohol, but is developing proposals for further restrictions such as sponsorship of sport, marketing to young people and the use of soft drinks as an indirect means of promoting alcoholic drinks. The interpretation of taxation and pricing interventions is more problematic. The component countries of the UK cannot change levels of taxation as this is under the overall control of the UK government. In addition, the countries in the European Union (EU) are affected by EU rules on free trade (Ministry of Health and Social Affairs, 2001). However, these countries can make commitment to keep the taxes as high as possible. This is the approach adopted by Ireland and Denmark. In contrast, England makes a clear commitment not to increase price as a means to reduce alcohol-related harm (Prime Minister’s Strategy Unit, 2004).

Table 3 indicates substantial differences between countries in the areas in which interventions are proposed. Some countries, such as Australia, New Zealand and Ireland, feature strongly in almost all the categories whereas the UK countries have a much more mixed pattern. Two intervention areas, education and problem drinkers, have a wide range of proposals in almost all the countries. In contrast, taxation, drink-driving, the drinking environment and high-risk groups show most variation across countries. The lack of commitment to tackle drink-driving in some countries is disappointing. For example, England points out that drink-driving results in 530 deaths per year at a cost of £500 million, but only proposes to ‘closely monitor the trends to assess whether additional action is needed’ (Prime Minister’s Strategy Unit, 2004).

One feature that is not well captured in Table 3 is the extent to which interventions are coordinated to ensure multifaceted approaches to tackling problems. Australia stands out as having the most well developed set of integrated interventions, although New Zealand, England and Ireland also have many coordinated programmes. For example, Australia plans to accompany a community education programme on responsible service provisions with new legislation to enable consumers to complain about irresponsible serving and advertising (National Expert Advisory Committee on Alcohol (NEACA), 2001a). This will be supported by a further education campaign on the processes for lodging a complaint about...
These practices. Similarly to tackle underage drinking, England plans to review the enforcement of rules on advertising to ensure the under-18s are not being targeted, to enforce the laws on the sale of alcohol to under-18s and to support the industry-led proof-of-age scheme.

**DISCUSSION**

This study has reviewed current public health policies on alcohol-related problems in 12 developed countries. It complements previous work in Europe which established alcohol controls that were in place from 1950 to 2000 (Norstrom, 2002). The focus of the present study was on commitment to new actions in current policy. All the countries studied acknowledge that alcohol-related problems still present a major public health challenge, and review the harm to individual health, family well-being, crime and social disruption and lost productivity. There may be differences in the exact level of harm, but the countries identify the same sets of harm and these are substantial. This indicates that existing alcohol controls, as the World Health Assembly (WHO, 2005a) and others (Room et al., 2005) have suggested, are not sufficient to control the problem. The recognition of this by governments gives hope that new effective measures will be implemented.

The main finding of this study is one of diversity: of policy organization, goals and targets, strategic approaches and areas for intervention. This is consistent with the previous finding of marked differences in controls of countries across Europe from 1950 to 2000 (Österberg and Karlsson, 2002). The explanation for the diversity may lie in the nature of the policy-making process. Policy making has been defined as the process by which governments translate their political vision into programmes and actions to deliver outcomes (Prime Minister and the Minister for the Cabinet Office, 1999). Policy is influenced by many factors including social, electoral, ethical, cultural and economic factors (Black, 2001). It is also suggested that the alcohol industry influences the design of alcohol policy, particularly in opposing actions such as price increases, reduced access to alcohol and controls on marketing (Giesbrecht, 2000; Babor et al., 2003; Room et al., 2005). Finally, international trade agreements also constrain alcohol control measures (Grieshaber-Otto et al., 2000; Babor et al., 2003). Sweden is notable in pointing out that EU regulations have resulted in a weakening of its restrictions on alcohol. The other countries’ public health policies do not discuss the impact of European or World Trade Organization regulations on their policies. The way in which individual countries resolve the many conflicting factors leads to the diversity of their policies.

Designing alcohol policy is particularly problematic because alcohol use is long established and it can play an important role in social activities (Babor et al., 2003). Because of this, it is natural that policy makers may be reluctant to risk political unpopularity through aggressive alcohol control measures. Sweden, which also has a long tradition of restrictive alcohol policies, acknowledges the measures proposed need to be acceptable to the general population (Ministry of Health and Social Affairs, 2001). The success of the United States in raising the minimum drinking age to 21 years, shows that potentially unpopular measures can be implemented (Wagenaar, 1993). Further, Ireland has included the results of a survey of public opinion in a policy document (Department of Health and Children, 2004), which shows that there are high levels of support for measures such as random breath testing and restrictions on marketing. Possibly, other countries might find that there is also general support for alcohol control measures.

The lack of commitment to reduce average consumption is disappointing because the evidence shows that harm arises from total consumption as well as from hazardous drinking patterns (Room et al., 2003). The concern about total consumption led the European Region of WHO to set a target of 25% reduction in consumption between 1984 and 2000 (WHO, 1993). The current WHO target is to reduce total consumption to six litres per person per year (WHO, 1999): currently all of the countries in this study exceed that figure and most do so by more than 25% (WHO Department of Mental Health and Substance Abuse, 2004). The lack of commitment may well reflect what Babor has described as the economic and political values of free trade, unfettered marketing and open access to alcohol (Babor, 2002).

The strategic approaches to tackling alcohol-related problems differ markedly across countries. This analysis was based on an assessment of what was proposed, although we cannot comment on the effectiveness of the overall strategies. The areas in which all countries make strong commitments to change are problem drinkers and education. There is strong evidence to support the benefit of early identification and management for problem drinkers (Babor et al., 2003; Ludbrook, 2004; Mulvihill et al., 2005). However this will have only a limited impact on the burden of alcohol on society (Room et al., 2005). Educational initiatives such as mass media campaigns could have a much wider impact, but by themselves have little impact on alcohol-related problems (Babor et al., 2003; Ludbrook, 2004; Mulvihill et al., 2005). These approaches can be effective when combined with other interventions (such as education on the harm of drink-driving, combined with measures to enforce legislation) (Task Force on Community Preventive Services, 2005). Unfortunately many of the information-giving proposals in policies are not linked to other types of intervention.

It is disappointing that many countries have only limited proposals for new interventions in areas such as price, restricting availability (such as reducing outlet density and opening hours), and drink-driving. These are the areas in which several recent overviews have found most evidence for effectiveness (Babor et al., 2003; Ludbrook, 2004; Mulvihill et al., 2005). One explanation for this could be the influence of the alcohol industry (Giesbrecht, 2000; Babor et al., 2003; Room et al., 2005). However, it seems possible that other factors could also be influential, such as, concerns about the contribution of alcohol to the economy, or the possible political unpopularity of certain actions.

One limitation of this study is that it is restricted to policy documents from 12 developed countries so that the findings cannot be extrapolated to all developed countries. However, the countries that were studied have long traditions of public health actions (Powles, 2002; Crombie et al., 2003; Irvine et al., 2006), and might be expected to have well developed
alcohol policies. A second limitation is that the policy documents do not describe actions to implement the strategies at regional and municipal levels. For example, the Australian state of Victoria has recently conducted a comprehensive review of strategies to reduce the harm of alcohol consumption (Drugs and Crime Prevention Committee, 2006). A final limitation of the study is that we cannot tell the extent to which the proposed strategies are implemented in practice. It is possible that intentions in policy, even if strongly voiced, may not be picked for full implementation. For example, all countries have a minimum drinking age, but there is strong evidence that this is often poorly enforced and thus, regularly flouted (Wagenaar and Wolfson, 1994; Willner et al., 2000; Huckle et al., 2005). Thus, the proposals in policy may only represent the most optimistic view of the strength of the intervention strategies, while in practice, much less may be intended. It is also difficult to assess from policy whether there is earmarked funding to support all the proposed strategies.

In summary, this study has found that although policies display marked heterogeneity, together they identify desirable goals, challenging targets, and the key areas for intervention. To this extent, the policies are consistent with the recommendations of experts and expert groups. However, most policies give much more emphasis to problem drinkers and education than to measures designed to reduce supply or demand, although Australia and also New Zealand, Sweden, emphasize the need for strategies aimed at reducing supply and demand. The WHO can play a leading role in the development of alcohol policies (Jernigan et al., 2000). The WHO European Alcohol Plan, first introduced in 1992 (WHO, 1993) and updated in 2000 (WHO Regional Office for Europe, 2000), could provide a blueprint for alcohol policy. The WHO has also produced a set of recommendations to tackle alcohol-related problems in young people (WHO Regional Office for Europe, 2001). The political challenge lies in the effective implementation of these recommendations for policy development.

CONFLICT OF INTEREST

There are no conflicts of interest.

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REFERENCES


TACKLING ALCOHOL-RELATED HARM IN 12 DEVELOPED COUNTRIES—A REVIEW


