
European Region

Albania

Sociodemographic characteristics

POPULATION	1980	1990	1995
Total	2 671 000	3 289 000	3 441 000
Adult (15+)	1 715 000	2 213 000	2 362 000
% Urban	33.8	35.8	37.3
% Rural	66.2	64.3	62.7

Health status

Life expectancy at birth, 1990-1995 : 69.2 (males), 75.0 (females)

Infant mortality rate in 1990-1995 : 30 per 1000 live births

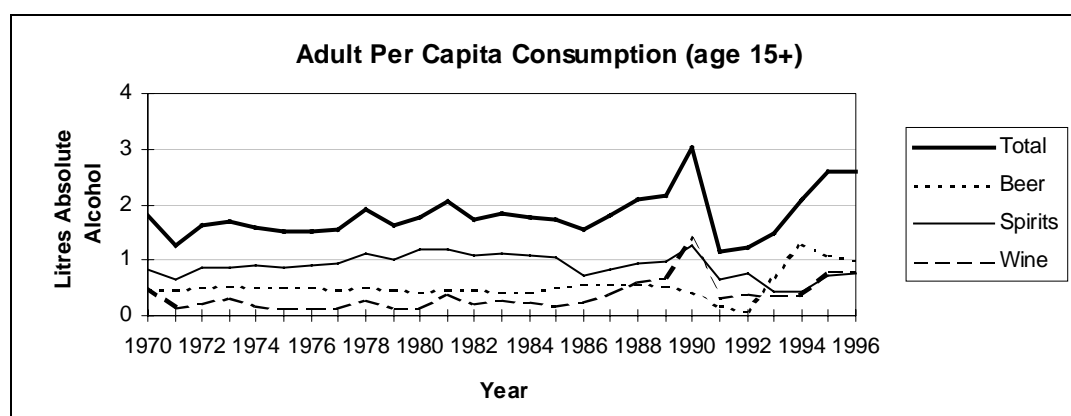
Socioeconomic situation

Average distribution of labour force by sector, 1990-1992 : agriculture 56%; industry 19%; services 25%

Alcohol production, trade and industry

Albania produces modest amounts of wine and beer. Wine production has fallen in the 1990s. Beer production in the early 1990s was in the range of 100 000 hectolitres.

Alcohol consumption and prevalence



Consumption

Since 1990/1992 there has been a marked shift away from wine and spirits and towards beer in recorded consumption. This may be an indication of increased illegal or informal spirits and wine production and consumption.

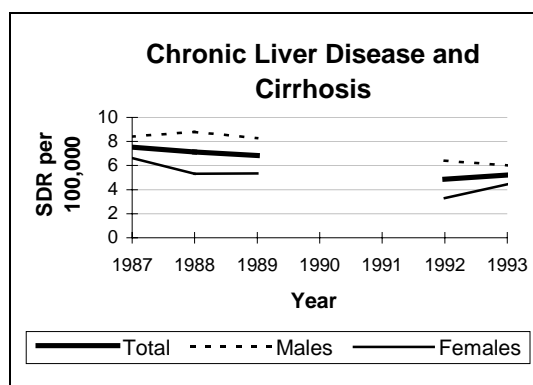
Mortality, morbidity, health and social problems from alcohol use

Alcohol dependence and related disorders

The number of alcohol dependent patients in Tirana Hospital ranged between 30 and 40 annually between 1985 and 1994. Of these, women constituted less than one per cent of all inpatient admissions.

Mortality

The SDR for chronic liver disease and cirrhosis was about five per 100 000 population in the 1990s.



Alcohol policies

Control of alcohol problems

The BAC limit for drivers is 0.01 g%.

Armenia

Sociodemographic characteristics

POPULATION	1980	1990	1995
Total	3 072 000	3 352 000	3 599 000
Adult (15+)	2 137 000	2 332 000	2 533 000
% Urban	65.7	67.5	68.7
% Rural	34.3	32.5	31.3

Health status

Life expectancy at birth, 1990-1995 : 69.5 (males), 75.5 (females)

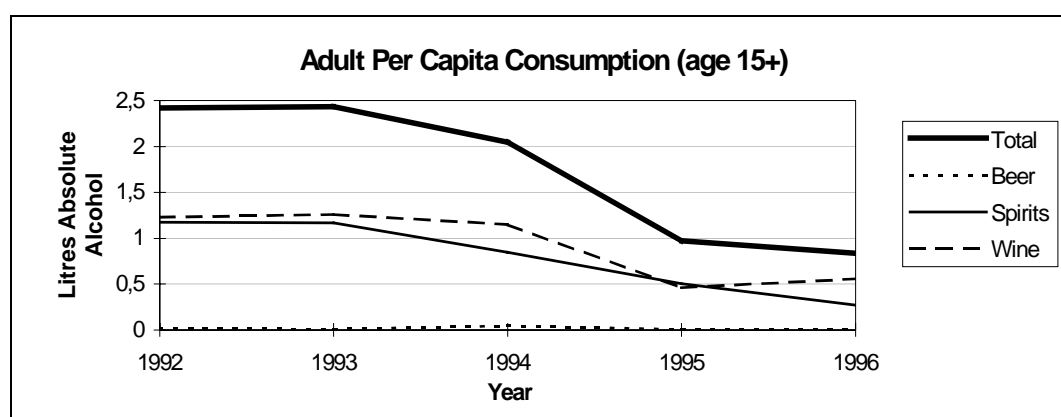
Infant mortality rate in 1990-1995 : 21 per 1000 live births

Socioeconomic situation

GNP per capita (US\$), 1995: 730, PPP estimates of GNP per capita (current int'l \$), 1995: 2260

Average distribution of labour force by sector, 1990-1992 : agriculture 11%; industry 32%; services 57%

Alcohol consumption and prevalence



Consumption

Beer statistics take an inexplicable plunge after 1991. WHO's European office estimated recorded consumption at 2.8 litres of pure alcohol per person in 1993, a figure slightly higher than that shown above. There is no information available for consumption of smuggled or home- or informally-produced alcohol.

Prevalence

An analysis of heavy drinkers showed that 57.2 per cent were manual workers, 18.9 per cent were peasants, 14.9 per cent were unemployed, 9.1 per cent were white collar workers and 0.1 per cent were retired.

Economic impact of alcohol

Consumer expenditure on alcoholic drinks, as a percentage of general expenditure on purchase of goods and payments for services, fell from 4 in 1990 to 1.7 in 1995.

Mortality, morbidity, health and social problems from alcohol use

Alcohol dependence and related disorders

The rate of admission to inpatient for alcoholic psychosis treatment was 2.3 per 100 000 population in 1993, a decrease from the 1991 and 1980 rates of about 5 per 100 000. These rates were calculated using the 1992 population statistics since population figures for earlier years were unavailable. The number of patients with alcoholic addiction registered at hospitals and other clinics at the end of the year was 4.5 per 100 000 population in 1991, down from 5.2 in 1990.

Mortality

The SDR for chronic liver disease was 15.3 per 100 000 population (all ages) in 1992, very similar to the 1991 rate.

Alcohol policies

Control of alcohol products

The real prices of all three types of alcoholic beverage i.e. beer, spirits and wine, have been increasing during the early 1990s. There is no maximum legal limit for the alcohol content of beverages. Labels for alcohol content are required by law.

Control of alcohol problems

There is no information available on the exact BAC limit permissible by law, but suspension of a driving licence is usual on conviction for an offence of exceeding the limit, and random alcohol breath testing is conducted frequently.

Alcohol data collection, research and treatment

There are no institutes that specialize in, or have major responsibility for, research on alcohol issues.

In the early 1990s developing specialized treatment for alcohol dependence and other alcohol problems became a high priority. The Republican Narcological Dispensary (RND) in Solerudnik is the national agency dealing with alcohol-related problems. Its activities include prevention, inpatient and outpatient treatment and follow-up, and provision of professional expertise in the area of intoxication and toxicological facilities. Apart from the RND, there is also a City Narcological Dispensary in Gyumri.

As a result of economic problems, the high cost of living, economic blockade, unemployment, geographical remoteness, and transport problems, alcohol dependent persons visit a physician or narcologist (a psychologist or psychiatrist who specializes in the treatment of addiction to alcohol or other drugs) only when suffering from such severe sequelae as psychosis, encephalopathy or polyneuritis. However, there has been an upward trend in the numbers presenting since the beginning of 1995 (twice the rate in 1994). Compared to other CIS countries, alcohol dependence is less of a major problem - there are no recorded examples of alcohol dependence among women or adolescents and there have not been, nor are there, any "sobering up" stations found elsewhere in the region.

Austria

Sociodemographic characteristics

POPULATION	1980	1990	1995
Total	7 549 000	7 705 000	7 968 000
Adult (15+)	6 007 000	6 364 000	6 549 000
% Urban	54.8	55.4	55.5
% Rural	45.2	44.6	44.5

Health status

Life expectancy at birth, 1990-1995 : 73.0 (males), 79.2 (females)

Infant mortality rate in 1990-1995 : 7 per 1000 live births

Socioeconomic situation

GNP per capita (US\$), 1995 : 26 890, PPP estimate of GNP per capita (current int'l \$) : \$21 250

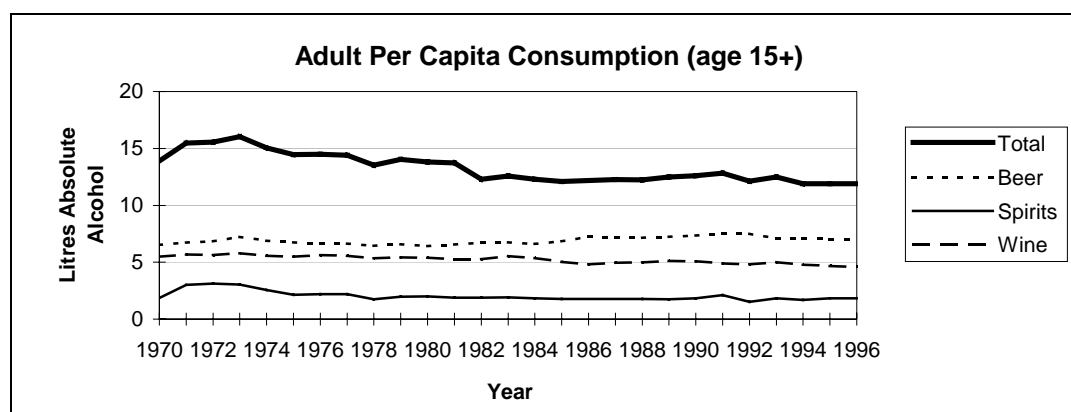
Average distribution of labour force by sector, 1990-1992 : agriculture 7%; industry 37%; services 56%

Adult literacy rate (per cent), 1995 : more than 95

Alcohol production, trade and industry

Austria produces beer, distilled spirits and wine. The country's leading brands include Stock Brandy, Spitz Brandy and Eristoff Vodka. Just three spirits types i.e. brandy (non-cognac), rum and liqueurs currently account for nearly two-thirds of Austrian consumption.

Alcohol consumption and prevalence



Consumption

The alcoholic beverages of choice are beer and wine. Pear, apple and grape ciders reportedly account for six per cent of all absolute alcohol consumed, and are not reflected in the graph above.

Prevalence

A 1994 survey of a representative sample of 2000 Austrians aged 16 to 99 years showed that 16.2 per cent of the entire population (28.8 per cent of males and 4.3 per cent of females) consume an average of 60 grams alcohol per day or more, and 24.3 per cent (41 per cent of males and 8.5 per cent of females) consume an average of 40 grams per day. A study carried out in 1985 among a representative sample of 2044 people aged 15 to 40 years found that 11.5 per cent drank daily, 33 per cent drank more than 60 grams pure alcohol daily, and 16 per cent abstained completely from alcohol.

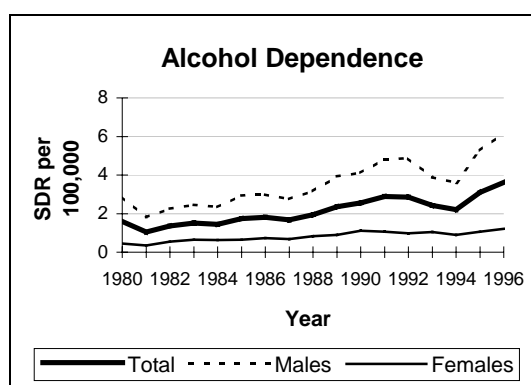
Age Patterns

In 1994 a survey of more than 3000 15 year old students found that of boys, 79.3 per cent had tried alcoholic beverages and 52.4 per cent had drunk alcoholic beverages more than 10 times in ninth grade. Of girls, 78.6 per cent had tried alcoholic beverages, and 43.1 per cent had drunk alcoholic beverages more than 10 times in ninth grade. A 1993/1994 WHO study among 15 year old boys and girls showed that 96.2 per cent of boys had tried alcoholic beverages, 40.2 per cent drank alcoholic beverages at least weekly and 45.6 per cent had been drunk at least twice. Of girls, 94.6 per cent had tried alcoholic beverages, 24.9 per cent drank alcoholic beverages at least weekly and 30.4 per cent had been drunk at least twice.

Mortality, morbidity, health and social problems from alcohol use

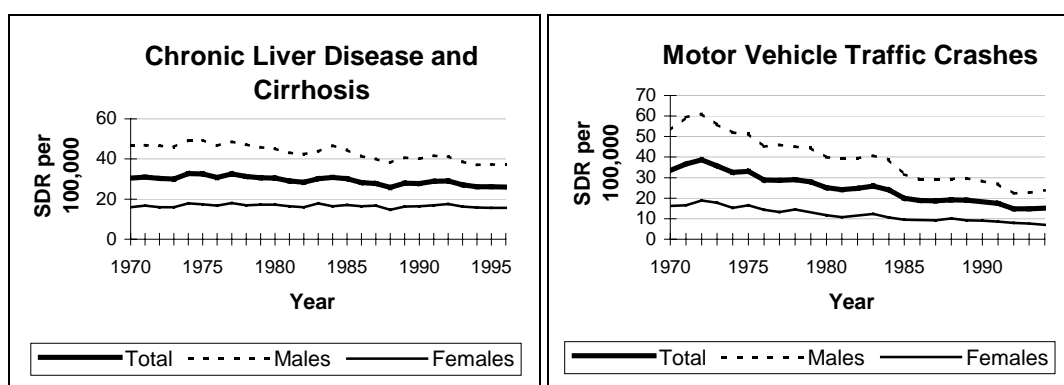
Alcohol dependence and related disorders

The number of people per 100 000 population treated in hospitals for alcoholic psychosis decreased from 29.7 to 24.2 between 1990 and 1993. However, the SDR per 100 000 population for alcohol dependence has been rising during the late 1990s.



Mortality

The SDR per 100 000 population for chronic liver disease decreased from 29.2 to 25.9 between 1980 and 1993.



Social problems

The number of people killed in motor vehicle accidents related to alcohol was 118 in 1993, compared to 245 in 1980, giving death rates per 100 000 population of 1.5 and 3.2 respectively. The total rate per 100 000 population of road traffic accidents involving alcohol was 38.9 in 1992, a marginal decrease on the 1990 figure, but a more substantial decrease on the 49.7 recorded in 1985.

Alcohol policies***Control of alcohol products***

Table wines are taxed US\$ 0.12 per litre, sparkling wine is taxed US\$ 1.60 or US\$ 3.20 per litre, beer (four to six per cent alcohol) is taxed US\$ 0.22 per litre and spirits (over 35 per cent alcohol) are taxed US\$ 4.90 per litre of pure alcohol. Farmers are allowed to produce quite a high amount for private consumption tax free. Small farmers selling their products themselves pay a 10 per cent value added tax (VAT) while all others pay a 20 per cent VAT. If a product is sold in a restaurant or shop, there is a special drink tax amounting to 10 per cent. The real price of wine has decreased by about five per cent and the prices of spirits and beer have increased by about five per cent during the early 1990s.

There are no special restrictions on hours, days of sale, type or location of alcohol outlets. State authorities must be informed and a licence must be procured giving permission to produce alcohol as well as indicating how much may be produced. For the production, sale and trade of any alcohol product a license is required.

Restrictions on the advertising of beer, spirits and wine are implemented by means of a voluntary code. General and specific health warnings are not required by law. There is no maximum legal limit for alcohol content but there are regulations governing the maximum limit for different types of beverages. Rum of up to 80 per cent proof may be bought, but the sale of whiskey of 80 per cent is not allowed. However, alcoholic beverages may be sold mixed with pure alcohol amounting to more than 80 per cent proof, provided it is marketed under a specific name, such as "hard" whiskey. Labels for alcohol content are required by law.

There is no minimum legal age limit for buying or drinking alcohol, but in all nine federal states the age limit for drinking spirits in public (and for visiting bars) is 18 years.

Control of alcohol problems

In eight federal states the minimum legal age limit for drinking wine and beer in public (which includes drinking in a restaurant) is 16 years; in one federal state (Lower Austria) it is 15 years. For motor vehicle drivers, a BAC limit of 0.05 g% was introduced in Austria on 1 January, 1998. A driver with a BAC of between 0.05 g% and 0.08 g% may receive a fine of between £140 (US\$ 11.18) and £2400 (US\$ 191.75). A repeat offence at this level within a year results in a confiscation of a driver's licence for three weeks. Imprisonment is usually considered only in cases of accidents where people have been injured or killed. Random alcohol breath testing was introduced in early 1995.

There are no national agencies specifically responsible for the prevention of alcohol problems, but it is included in the work of the Department of Sport and Consumer Protection within the Ministry of Health and in the Medical Service within the Ministry of Education and Arts. The Ministry of Interior (police) is also active in providing school-based information. All local inpatient and outpatient treatment centres for alcohol and drugs devote some of their time to informing teachers, students, and parents as well as the interested public about alcohol and drugs. A ten hour curriculum on alcohol, tobacco, medical and illicit drugs has been developed for schools.

Alcohol data collection, research and treatment

The Department of Public Health has an Advisory Council on Combating Addiction to Alcohol and Other Drugs which advises the Minister of Health, and a Co-ordination Agency for Addiction Problems. There is no national agency responsible for collecting all alcohol data, but the Ludwig-Boltzmann Institute for Addiction Research will be commissioned by the Ministry of Health to collect all alcohol-relevant statistics and survey results in a brochure.

Courses on alcohol dependence are provided in the framework of undergraduate training in medicine and psychology and within the education for social workers. Students of psychology and social work are given the opportunity to do several weeks of practical work in appropriate institutions. Lectures

and seminars are organized by professional organizations, such as the Medical Society, for the continuing training of the professions concerned.

The number of treatment facilities and specialized staff has grown nationwide since 1980, as have the temperance movement and organizations such as Blue Cross, Good Templars, and Alcoholics Anonymous. A broad network of outpatient services provides a full range of treatment and rehabilitation services. Help is available through treatment centres, family and youth counselling centres and self-help groups, but this is not organized nationally.

Azerbaijan

Sociodemographic characteristics

POPULATION	1980	1990	1995
Total	6 157 000	7 117 000	7 558 000
Adult (15+)	4 029 000	4 759 000	5 151 000
% Urban	52.8	54.4	55.8
% Rural	47.2	45.6	44.2

Health status

Life expectancy at birth, 1990-1995 : 66.5 (males), 74.5 (females)

Infant mortality rate in 1990-1995 : 28 per 1000 live births

Socioeconomic situation

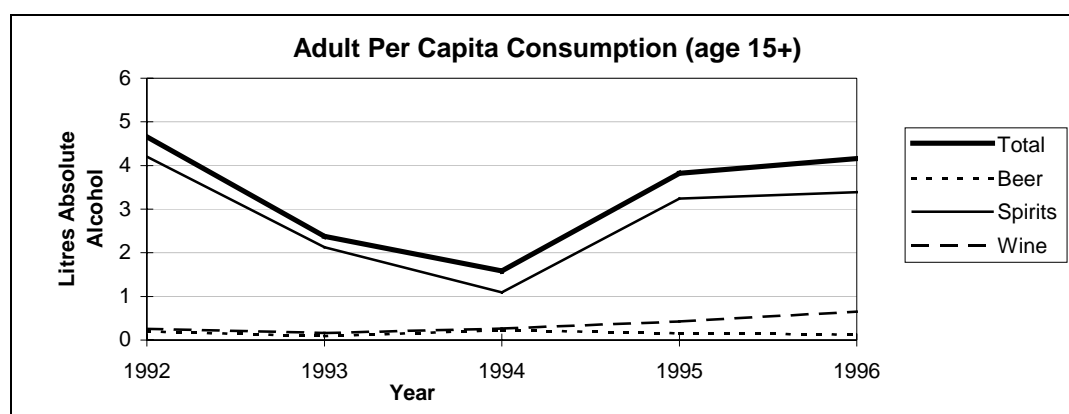
GNP per capita (US\$), 1995: 480, PPP estimates of GNP per capita (current int'l \$), 1995: 1460

Average distribution of labour force by sector, 1990-1992 : agriculture 15%; industry 21%; services 64%

Alcohol production, trade and industry

A new plant for production of pure alcohol was to be launched in December, 1997. The new enterprise will be capable of manufacturing 20 million litres of alcohol per year. Currently, the leading wine manufacturer in Baku is capable of manufacturing 22 million litres of vodka annually. In 1996, 16 million litres of alcohol was imported from Ukraine to cover the existing demand. With the creation of the new enterprise, alcohol imports will be postponed and Azerbaijan will completely service the demand of the domestic market.

Alcohol consumption and prevalence



Consumption

Figures obtained directly from Azerbaijan indicate that alcohol availability was declining until 1994. Immediately after Azerbaijan became independent, alcohol availability diminished more slowly than the overall decline in retail trade, but has expanded again at a lower rate when compared to retail trade since 1994.



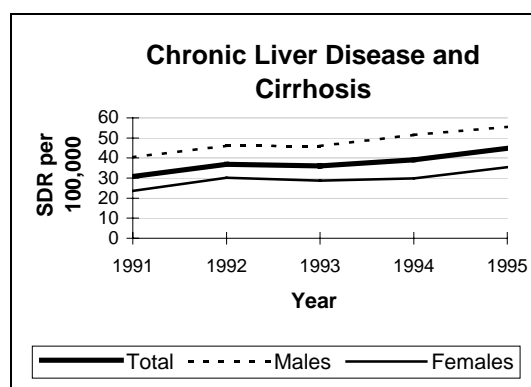
Economic impact of alcohol

Consumer expenditure on alcoholic beverages as a percentage of total expenditure decreased from 1.3 in 1990 to 0.9 in 1995.

Mortality, morbidity, health and social problems from alcohol use

Alcohol dependence and related disorders

The rate of admission per 100 000 population to inpatient treatment for alcoholic psychosis was 8.2 in 1993, an increase from the 3.2 recorded in 1990. The number per 100 000 population of patients with alcoholic dependence registered at hospitals and other clinics (at the end of the year) rose from 16.4 in 1990 to 16.7 in 1995.



Mortality

The SDR per 100 000 population for chronic liver disease was 33 in 1993, and 33.1 in 1992.

Social problems

The number of persons committing crimes under the influence of alcohol rose from 1000 in 1990 to 1200 in 1995.

Alcohol policies

Control of alcohol products

Real prices of beer, spirits and wine have been increasing during the last five years. There is a tax on spirits. There are no restrictions on the sale of alcoholic beverages. There is no state monopoly and no licence is required for the production and distribution of alcoholic beverages. There is no minimum legal age limit for buying alcohol, and there are no restrictions on advertising of alcoholic

beverages. General or specific health warnings are not required by law. Labels for alcohol content are not required by law, and there is no maximum legal limit for the alcohol content of beverages.

Control of alcohol problems

Priorities of the early 1990s have been reducing availability and using price policy to reduce demand. Religious leaders are involved in spreading messages on reducing substance use. There is no national agency for the prevention of alcohol problems.

The BAC limit is 0.0 g% for drivers. Random alcohol breath testing is not carried out.

Belarus

Sociodemographic characteristics

POPULATION	1980	1990	1995
Total	9 627 000	10 212 000	10 141 000
Adult (15+)	7 425 000	7 856 000	7 948 000
% Urban	56.5	66.8	71.2
% Rural	43.5	33.2	28.9

Health status

Life expectancy at birth, 1990-1995 : 64.5 (males), 75.1 (females)

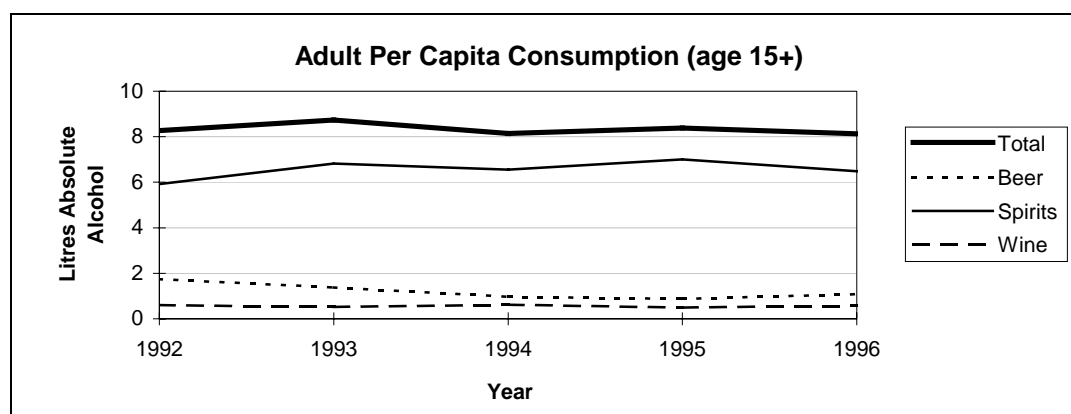
Infant mortality rate in 1990-1995 : 17 per 1000 live births

Socioeconomic situation

GNP per capita (US\$), 1995: 2070, PPP estimates of GNP per capita (current int'l \$), 1995: 4220.

Average distribution of labour force by sector, 1990 : agriculture 20%, industry 40%

Alcohol consumption and prevalence



Consumption

Spirits is the alcoholic beverage of choice by a wide margin. There are no data available on consumption of smuggled or home- or informally-produced alcoholic beverages.

Prevalence

It is estimated that approximately 10 per cent of the population drinks heavily.

Economic impact of alcohol

Consumer expenditure on alcoholic beverages, as a percentage of general expenditure on purchase of goods and payments for services, decreased from 7.4 in 1990 to 3.3 in 1995.

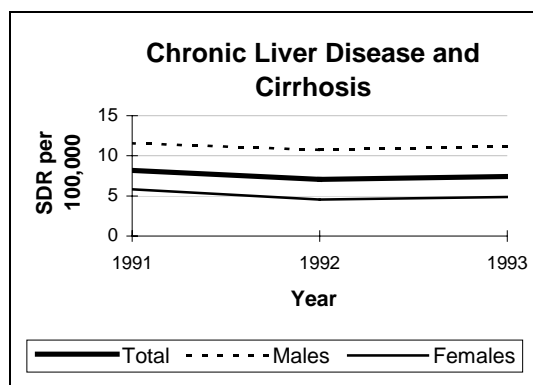
Mortality, morbidity, health and social problems from alcohol use

Alcohol dependence and related disorders

The number (per 100 000 population) of patients registered during the year with alcoholic dependence at hospitals and other clinics increased from 11 in 1990 to 13.5 in 1995.

Mortality

The SDR per 100 000 population for chronic liver disease was 7.7 in 1994, compared to 8 in 1980 and about 6 in 1987.



Social problems

The number of persons committing crimes under the influence of alcohol (thousands) rose from 15 in 1990 to 22.1 in 1995.

Alcohol policies

Control of alcohol products

The real price of all three types of alcoholic beverage, i.e. beer, spirits and wine has remained stable during the past five years. In 1995 a law of the Republic of Belarus imposed the following taxes on alcoholic beverages: spirits and vodka, 75 per cent; sparkling wine, 45 per cent; beer, 40 per cent.

There are no restrictions on hours or days of sale of alcoholic beverages. There is a state monopoly for the production of beer, wine and spirits. There is no state monopoly for distribution but a licence is required for all three types of alcoholic beverage.

The advertising of all three types of alcoholic beverages has been restricted since 1993, though alcohol advertising can be widely seen on foreign television channels. Labels for alcohol content are required by law. There is no maximum legal limit for the alcohol content of beverages. General and specific health warnings are not required.

Control of alcohol problems

The use of alcohol is forbidden in work places. There is a minimum legal age limit of 21 for buying alcoholic beverages. The BAC limit is 0.04 g% for drivers. Suspension of driving licence is usual upon conviction for a first offence of driving above the permitted BAC. Upon conviction for a second or subsequent offence, suspension or imprisonment is usual. Random alcohol breath testing is carried out frequently.

There is no government agency devoted specifically to alcohol issues, but it is included in the work of the Belorussian Republican Centre of Health in Minsk. There are seven regional Centres of Health in Belarus.

Alcohol data collection, research and treatment

The Narcology Laboratory of the Medical Institute is a research institute which specializes in, and has major responsibility for, research on alcohol issues. The Ministry of Statistics and Analysis is responsible for collating, analysing, and disseminating data, and using it as a basis for national policies.

Priorities in the 1990s have been to develop specialized treatment for alcohol dependence and other alcohol problems. Alcoholics Anonymous is also available. Alcohol dependence treatment expanded in the 1980s, but has contracted during the 1990s when measured both by numbers of persons in treatment, and by numbers of physicians working in the field, as the chart below shows:

	1980	1985	1990	1993
Persons in inpatient treatment	91 575	135 675	108 450	90 150
Persons in outpatient treatment	20 732	36 523	26 406	20 632
Physicians offering treatment services	106	217	312	248

Belgium

Sociodemographic characteristics

POPULATION	1980	1990	1995
Total	9 852 000	9 951 000	10 113 000
Adult (15+)	7 867 000	8 145 000	8 306 000
% Urban	95.4	96.5	97.0
% Rural	4.6	3.5	3.0

Health status

Life expectancy at birth, 1990-1995 : 73.1 (males), 79.8 (females)

Infant mortality rate in 1990-1995 : 6 per 1000 live births

Socioeconomic situation

GNP per capita (US\$), 1995: 24 170, PPP estimates of GNP per capita (current int'l \$), 1995: 21 660

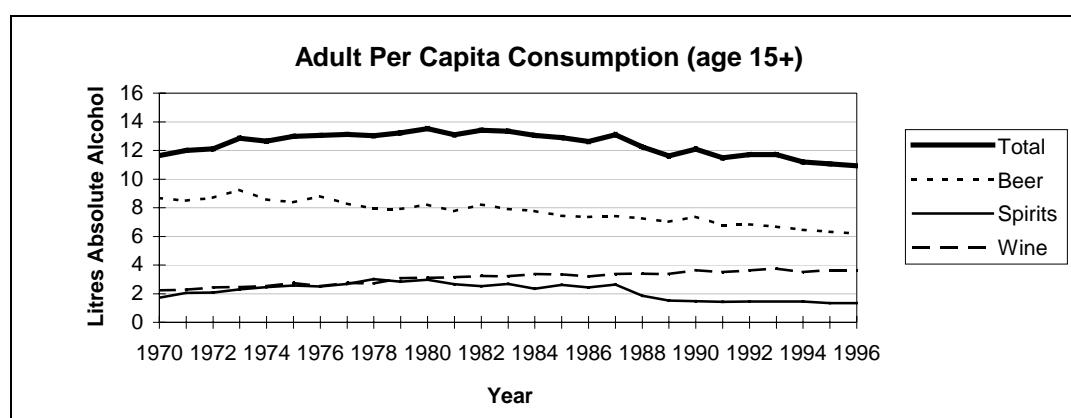
Average distribution of labour force by sector, 1990-1992 : agriculture 3%; industry 28%; services 69%

Adult literacy rate (per cent), 1995 : more than 95

Alcohol production, trade and industry

Belgium produces beer, wine and spirits. Belgium's Interbrew NV was the world's fourth largest brewer in 1996. Interbrew's share of the Belgian market remained steady at 56 per cent.

Alcohol consumption and prevalence



Consumption

There is no quantified information available on unrecorded consumption. Beer is the beverage of choice, although wine consumption has been rising in recent years.

Prevalence

A 1990 survey of a sample of those over 15 years of age found that 19 per cent were frequent consumers of alcohol (at least three days a week), 36 per cent were moderate consumers and 45 per cent were infrequent consumers (less than weekly or never).

Age patterns

A survey among a representative sample of 1820 students, aged 14 to 24, in Limburg found that 19 per cent never drank alcoholic beverages, 28.2 per cent drank at least weekly, 7 per cent drank three or more glasses a day, 36 per cent had been drunk several times and 10 per cent became drunk regularly.

A dozen epidemiological studies of drinking patterns were carried out between 1961 and 1984. It was found that the age at which young people first come in contact with alcohol has sharply declined over the years. Working youths consume more alcohol than students of the same age group. There are also notable regional and sub-regional differences in drinking patterns (linked, for example, with the degree of urbanization).

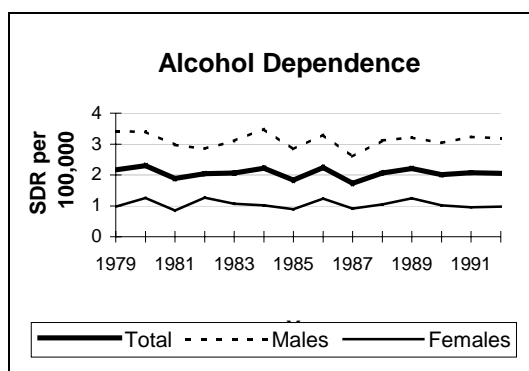
Economic impact of alcohol

About three per cent of household expenditure was used for alcoholic beverages in the 1980s. Approximately 8000 people were employed in the alcohol industry in 1978 and about 3.4 per cent of the employed population were engaged in production and distribution of alcoholic beverages in 1977.

Mortality, morbidity, health and social problems from alcohol use

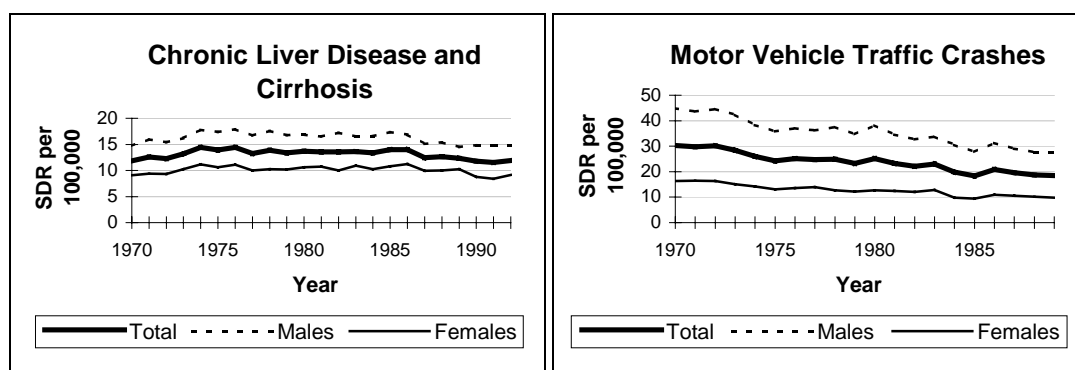
Alcohol dependence and related disorders

The Institute of Hygiene and Epidemiology in Brussels requested a national sample of general practitioners to record, in 1983-1984, the number of contacts for alcohol problems during a period of 15 months. It was found that 1267 contacts (1.3 per 1000 total contacts or 10.2 per practitioner) were for alcohol problems. The Ministry of Health conducted a one-day prevalence study of alcohol-related and drug-related problems in all the health services in June 1986. Of all inpatients, 12 per cent of those in psychiatric hospitals, eight per cent in psychiatric units of general hospitals, and three per cent of those in general hospitals had problems related to psychoactive substances.



Mortality

SDR for chronic liver disease and cirrhosis per 100 000 population in 1992 was 11.84. Rates are approximately 50 per cent higher for men than for women.



Social problems

The number of alcohol-related motor vehicle traffic crashes per 100 000 population decreased from 18.3 to 10.9 between 1985 and 1992. Criminal offences connected with drunkenness comprised 8 per cent to nearly 14 per cent of all criminal offences between 1970 and 1978, with a peak in 1977.

Alcohol policies***Control of alcohol products***

The trends in real prices of wine and spirits have been stable and the real price of beer has been increasing during the early 1990s. Taxation as a percentage of price is not available. Non-sparkling wines are taxed 1471 Bfr/hl (US\$ 40.10/hl) and sparkling wines are taxed 5149 Bfr/hl (US\$ 140.40/hl). Wines with less than 8.5 per cent alcohol are not taxed. Ethyl alcohol (spirits) are subject to pure alcohol taxes adjusted to the alcohol percentage of the liquor.

Under the General Regulations on Labour Protection there is a ban on bringing distilled alcoholic beverages and fermented drinks with an alcohol content of more than six per cent into workplaces and associated locations. There is no state monopoly for production or distribution of alcohol, and a licence is not required.

General and specific health warnings are not required. There is a voluntary code restricting advertising of spirits and beer on TV, in print, on the radio or on billboards. The code does not include table wine. Labels for alcohol content are required by law. There is no maximum legal limit for the alcohol content of beverages.

Control of alcohol problems

There is a minimum legal age limit of 16 years for buying alcohol. The BAC limit is 0.05 g% for drivers, being reduced from 0.08 g% in December 1994. On conviction for a first offence of driving above the permitted BAC, suspension of driving licence, generally for a few hours, is a usual penalty. In the case of subsequent offences, suspension for a longer period is usual with the eventual possibility of imprisonment.

A comprehensive action plan for information, education and action on alcohol problems has been established by two regional organizations. Special emphasis is given to young people and health education. Annual education weeks are also organized. There are national school-based and workplace programmes that deal with alcohol and other substances.

Alcohol data collection, research and treatment

The Vereniging voor Alcohol- en andere Drugproblemen (VAD) collects and analyses data for the Flemish community through the Ministry of Economic Affairs, the National Institute for Statistics and the Confederation of Belgian Breweries. These data are used as a basis for national policies. The VAD makes an annual review of relevant surveys and an inventory of prevention activities.

Each linguistic community (Flemish, French and German) has an agency for the prevention of alcohol problems. The agencies are involved in the coordination of local prevention workers, development of programmes and strategies, organizing training programmes for key-figures and operating a drug hot-line. The centres also have a documentation function.

The Flemish community has 10 mental health centres, each of which employs a prevention worker who has a regional coordination function. In each of the nine provinces, at least one specialized residential service (mostly a specialized unit of a psychiatric hospital) is available as well as one or two specialized outpatient services (generally in the context of a community mental health centre). More than 100 specific self-help groups are in operation in the whole country. There are a number of active voluntary organizations such as Alcoholics Anonymous, Blue Cross, Gold Cross and the International Organization of Good Templars. Several of these bodies have a religious affiliation. They provide assistance of various kinds, including some advisory services and clinics. Self-help groups like Al-Anon, Al-a-teen and Trefpunt Zelfhulp are also active. Some treatment centres have family groups. Alcoholics Anonymous groups arrange information evenings for the public and professionals.

Bosnia and Herzegovina

Sociodemographic characteristics

POPULATION	1980	1990	1995
Total	3 914 000	4 308 000	3 459 000
Adult (15+)	2 847 000	3 280 000	2 691 000
% Urban	35.5	44.6	49.0
% Rural	64.5	55.4	51.0

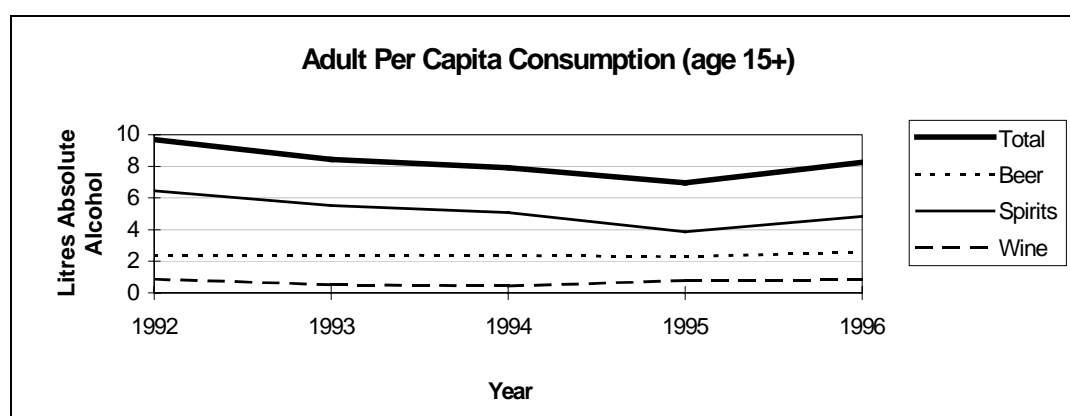
Health status

Life expectancy at birth, 1990-1995 : 69.6 (males), 75.1 (females)

Infant mortality rate in 1990-1995 : 15 per 1000 live births

Alcohol production, trade and industry

Bosnia and Herzegovina produce beer, distilled spirits and wine.



Alcohol consumption and prevalence

Consumption

Distilled spirits are the alcoholic beverage of choice among adults. There are no data available regarding consumption of smuggled or home- or informally-produced alcohol.

Bulgaria

Sociodemographic characteristics

POPULATION	1980	1990	1995
Total	8 862 000	8 891 000	8 769 000
Adult (15+)	6 901 000	7 153 000	7 160 000
% Urban	61.2	67.7	70.7
% Rural	38.8	32.3	29.3

Health status

Life expectancy at birth, 1990-1995 : 67.8 (males), 74.9 (females)

Infant mortality rate in 1990-1995 : 14 per 1000 live births

Socioeconomic situation

GNP per capita (US\$), 1995: 1330, PPP estimates of GNP per capita (current int'l \$), 1995: 4480

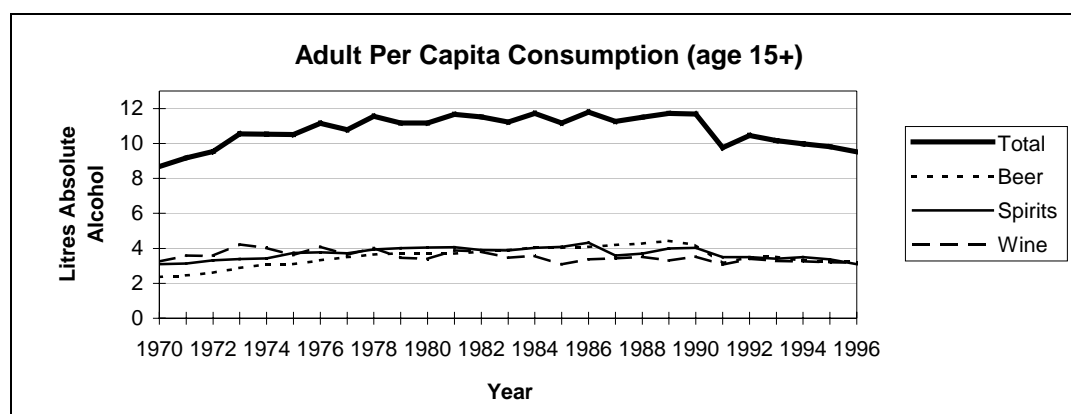
Average distribution of labour force by sector, 1990-1992 : agriculture 17%; industry 38%; services 45%

Adult literacy rate (per cent), 1995 : N/A

Alcohol production, trade and industry

Privatization of formerly state-owned breweries is proceeding. The state-owned Zagorka Brewery, which produces about 80 million litres of beer per year, was bought by Heineken's Athenian Brewery SA and Leventis Group's Hellenic Bottling group (who together created Brewinvest SA) in 1994. In 1995, Belgium-based Interbrew acquired 70 per cent of Bulgaria's Kamenitsa Brewery.

Alcohol consumption and prevalence



Consumption

In the early 1990s unrecorded imports, untaxed sales and other illegal sales of alcohol increased greatly and became a significant part of total alcohol consumption. Traditionally home-produced alcohol has also accounted for a sizeable percentage of consumption. An important new trend is the illegal production of highly toxic alcohol using well-known Bulgarian and import trade marks.

Prevalence

In a 1992 study carried out in Burgas County among adults aged up to 30 years, 50 per cent were found to be abstinent, 14 per cent were abusers and 2 per cent were alcohol dependents.

Age patterns

In a 1993 survey in four cities of 14 to 18 year olds, 77 per cent were alcohol drinkers and 6 to 7 per cent drank often. One per cent drank daily and 1.2 per cent were dependent on alcohol. The average age of first use ranged from 13 to 16 years old. In the same year, a WHO sponsored pilot study of 99 students aged 14 to 18 years in Sofia found that two-thirds drank alcohol and one-fifth drank regularly. Another one-fifth had increased their consumption recently. One-third disapproved of drinking alcohol.

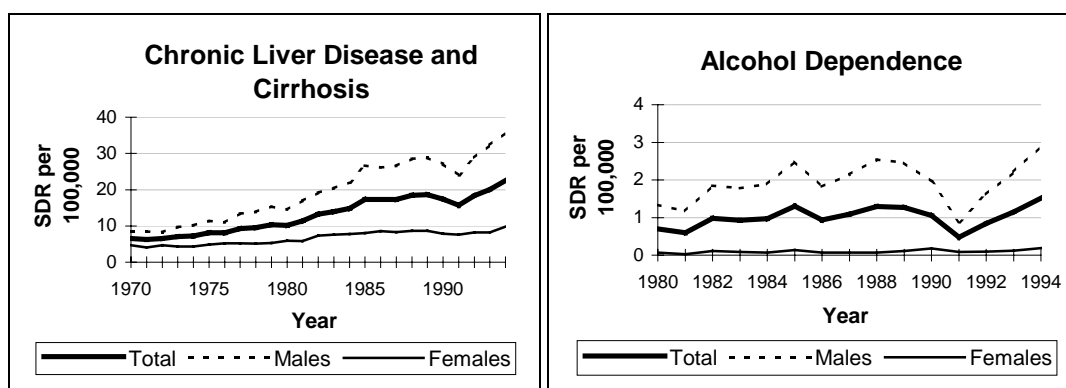
Mortality, morbidity, health and social problems from alcohol use

Alcohol dependence and related disorders

In a 1986 survey, 31 per cent of males and 3 per cent of females showed signs of alcohol abuse. The rate (per 100 000 population) of inpatient admissions for alcoholic psychosis increased from 12 in 1980 to 18.2 in 1985, then decreased to 8.8 in 1991 and rose again to 12.9 in 1992.

Mortality

The SDR per 100 000 for both chronic liver disease and cirrhosis and for alcohol dependence rose sharply in the early 1990s.



Social Problems

In 1986, 30 per cent of traffic crashes were alcohol-related.

Alcohol policies

Control of alcohol products

The real price of beer, spirits and wine increased during the early 1990s. Table wines are taxed 18 per cent, beer (four to six per cent proof) is taxed 18 per cent, spirits (over 35 per cent proof) are taxed 18 per cent. The former state monopoly on alcohol production and trade has been relaxed. There is a ban on sales to minors (under 18 years of age), people in a state of intoxication, and automobile drivers on the road. The use of alcoholic beverages is forbidden on public transport and in discos and clubs for teenagers.

The advertising of alcoholic beverages is banned on television and radio, in newspapers and magazines and in cinemas. However these bans are not effectively enforced. There are no advertising restrictions on billboards. Labels for alcohol content are required by law.

Control of alcohol problems

The National Centre for Addictions in Sofia, Suhodol, is the national agency dealing with the prevention and treatment of alcohol problems. There is a regional centre in Varna. The main activities of Suhodol are prevention, including provision of information and education programmes, public relations and research. There are also school-based programmes that deal with alcohol and other substances. The highest coordinating body is the State Council, and other agencies such as the National Temperance Committee and the Ministry of Public Health analyze available information and develop norms. The BAC limit is 0.02 g%. A conviction for driving above the BAC limit does not usually lead to imprisonment or suspension from driving. Random alcohol breath testing is carried out infrequently.

A 1976 Order of the Medical Academy prescribed the organization of postgraduate courses and the inclusion of alcohol-related topics in undergraduate training. Postgraduate courses of two weeks to six months are being given for general practitioners and other medical and non-medical personnel in dealing with alcohol problems. The subject of abuse of psychoactive substances is taught in a 60-hour course at the University of Sofia.

Alcohol data collection, research and treatment

In the 1980s attention was given to groups considered to be at high risk for alcohol-related problems. In each of the districts in the country there is a psychiatric dispensary with an outpatient service whose task is registration, follow-up, monitoring and help for alcohol and drug abusers. Case finding is carried out with the assistance of primary health services. There are four specialized substance dependence hospitals, one being the University Department for Alcoholism in Sudohol. They have a total of 470 beds, and there are an additional 250 beds in alcohol dependence wards in six specialized psychiatric hospitals. There is emphasis on early diagnosis and treatment at the primary health care level, with the provision of advice and monitoring. The family is involved to some extent, but this is better developed in the outpatient alcohol clinics.

Research into alcohol problems is initiated by the state. However, there is no stable coordination of efforts, activities and action. The National Statistical Institute and the National Centre for Addictions collect, analyze and utilize data for national policies.

Croatia

Sociodemographic characteristics

POPULATION	1980	1990	1995
Total	4 377 000	4 517 000	4 495 000
Adult (15+)	3 454 000	3 591 000	3 638 000
% Urban	50.1	59.8	64.4
% Rural	49.9	40.2	35.6

Health status

Life expectancy at birth, 1990-1995 : 67.1 (males), 75.7 (females)

Infant mortality rate in 1990-1995 : 9 per 1000 live births

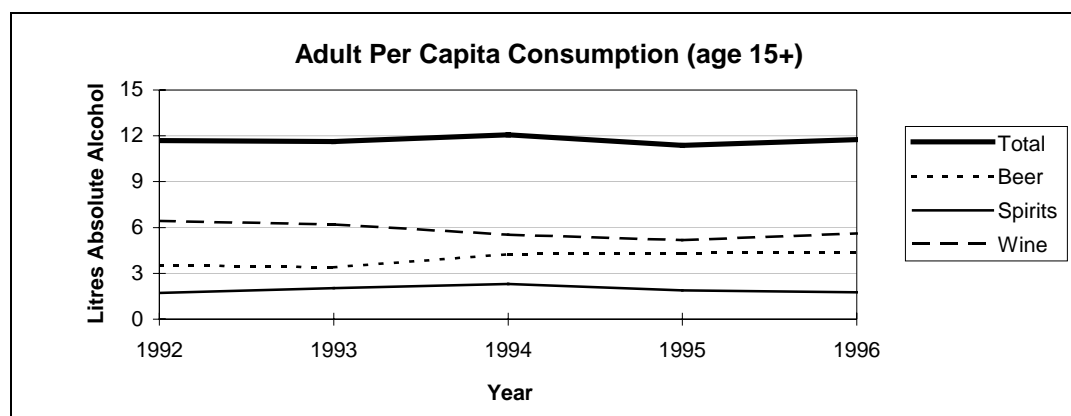
Socioeconomic situation

GNP per capita (US\$), 1995: 3250

Alcohol production, trade and industry

Croatia produces, imports and exports beer, wine and distilled spirits.

Alcohol consumption and prevalence



Consumption

Croatia reports substantial consumption of all three categories of alcoholic beverages. It is estimated that in regions where there is home production of alcohol, consumption may be as much as two to three times the recorded amount.

Age patterns

A study of 2815 15 to 16 year olds (1518 boys and 1297 girls) was carried out in 1995. The response rate was 92 per cent (91 per cent for boys and 92 per cent for girls). Seventy per cent of the respondents had drunk an alcoholic beverage in the last 12 months, and 33 per cent had drunk to intoxication in the last 12 months. Lifetime prevalence of alcohol use was 82 per cent (85 per cent for boys and 79 per cent for girls).

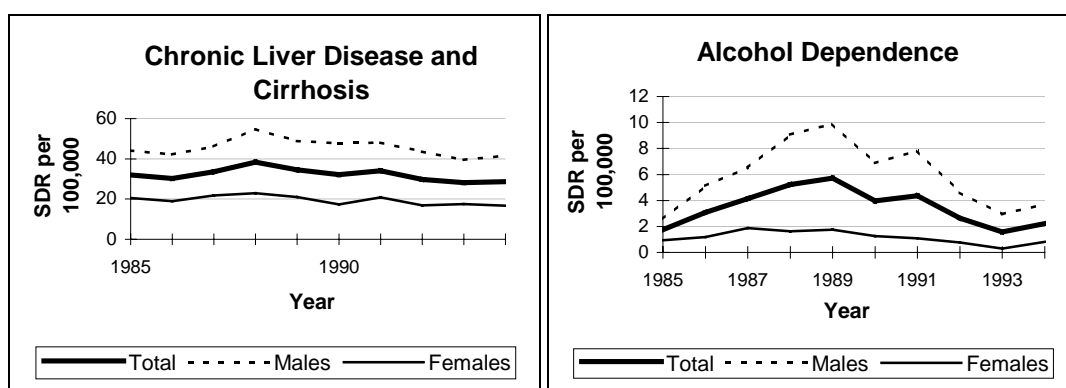
Mortality, morbidity, health and social problems from alcohol use

Alcohol dependence and related disorders

The rate of discharges from inpatient treatment for alcoholic psychosis decreased from 53.7 to 24.4 per 100 000 population between 1981 and 1991.

Mortality

The SDR per 100 000 population for chronic liver disease decreased from 38.8 to 21 between 1980 and 1990, then increased in the 1990s to approach the level of 30 per 100 000 population. Rates of death from chronic liver disease and cirrhosis continue to be among the world's highest.



Alcohol policies

Control of alcohol products

Table wines are taxed 22 per cent, beer (4 to 6 per cent) is taxed 35 per cent and spirits (over 35 per cent proof) are taxed 39 per cent. The real prices of all three types of alcohol i.e. beer, spirits and wine have remained stable during the early 1990s.

There is no state monopoly and no licence is required for the distribution or production of beer, spirits or wine. There are restrictions on location of outlets, but there are no restrictions on hours and days of sale. The sale of alcohol is banned in canteens belonging to health and social institutions, schools, public services, companies, special non-alcoholic restaurants and confectioneries.

General and specific health warnings are not required by law. The advertising of all three types of alcohol is banned on television, radio, newspapers/magazines and billboards. Labels for alcohol content are mandated by law, and there is a maximum limit of 40 to 52 per cent volume for the alcohol content of a special type of brandy.

Control of alcohol problems

There is a minimum legal age limit of 18 years for buying alcohol. The BAC limit is 0.05 g% for drivers in general and 0.0 g% for professional drivers. On conviction for driving above the permitted BAC, a person's driving licence is usually suspended for a limited period of time. Random alcohol breath testing is carried out infrequently.

Alcohol data collection, research and treatment

There is no national agency devoted specifically to alcohol, but alcohol problems are included in the work of the clinic concerned with psychiatry and alcohol and drug dependence in Zagreb. A national programme for the prevention of alcohol dependence is being prepared.

At the regional level, there are Clubs of Treated Alcoholics based on the Zagreb Alcoholic School model. There are also self-help groups with trained leaders who are either treated alcohol dependents or volunteer medical or social professionals. The activities of the groups include therapeutic work, with both the patient and the patient's family; joint social activities; the prevention of alcohol dependence through the adoption of healthier habits; and the creation of alcohol-free environments. The development of outpatient care paralleled the reversal in what had been a rising trend in admissions for inpatient treatment of alcohol dependent persons in the early 1980s.

Czech Republic (the)

Sociodemographic characteristics

POPULATION	1980	1990	1995
Total	10 283 000	10 306 000	10 296 000
Adult (15+)	7 870 000	8 096 000	8 298 000
% Urban	63.6	64.9	65.4
% Rural	36.4	35.1	34.6

Health status

Life expectancy at birth, 1990-1995 : 67.8 (males), 74.9 (females)

Infant mortality rate in 1990-1995 : 9 per 1000 live births

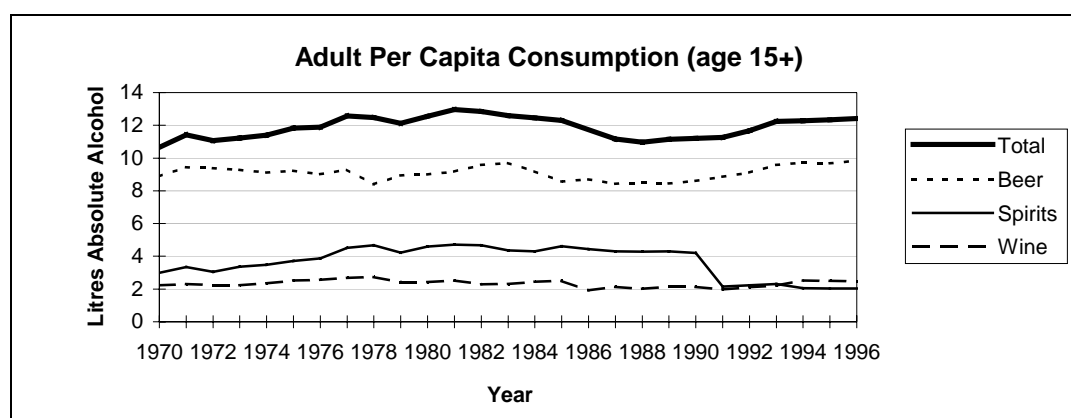
Socioeconomic situation

GNP per capita (US\$), 1995: 3870 , PPP estimates of GNP per capita (current int'l \$), 1995: 9770 .

Alcohol production, trade and industry

In 1995, there were 72 breweries in the Czech Republic. Ninety per cent of them have been privatised. The country's brewers are now looking to export markets, particularly into Western Europe, to fuel growth. Plzensky Prazdroj is the largest brewery in the Czech Republic, and the country's second largest exporter. The Czech Republic also produces and exports distilled spirits and wine.

Alcohol consumption and prevalence



Consumption

The Czech Republic is one of the world's highest consumers of beer. Spirits consumption fell dramatically as a result of political changes of the early 1990s, but an increase in beer consumption compensated for this.

Prevalence

A 1993 representative sample of males between the ages of 20 and 49 in Prague showed that 28 per cent averaged 50 grams or more of pure alcohol per day, up from 23 per cent in 1988. A 1992 survey showed that 24 per cent of males between the ages of 27 and 38 consumed more than 50 grams of pure alcohol a day, while 8 per cent of females between the ages of 20 and 49 consumed more than 20 grams a day. A survey of a probability sample of 718 Prague women aged 20 to 49 found that 47 per cent averaged a daily intake of 5 grams or more of pure alcohol, while 8 per cent averaged 20 grams or more daily.

Age patterns

A study of 2962 15 to 16 year olds (1626 boys and 1336 girls) was conducted in 1995. The response rate was 92 per cent (91 per cent for boys and 93 per cent for girls). Ninety-one per cent of the respondents had drunk an alcoholic beverage in the last 12 months, and 54 per cent had drunk to intoxication in the last 12 months. Lifetime prevalence of alcohol use was 97 per cent for both boys and girls.

In a 1993 school survey of 14 and 16 year olds, 87 per cent and 88 per cent, respectively, had used alcohol in the past year. The majority first used alcohol before the age of 12. This represents an increase in consumption since the 1978 survey.

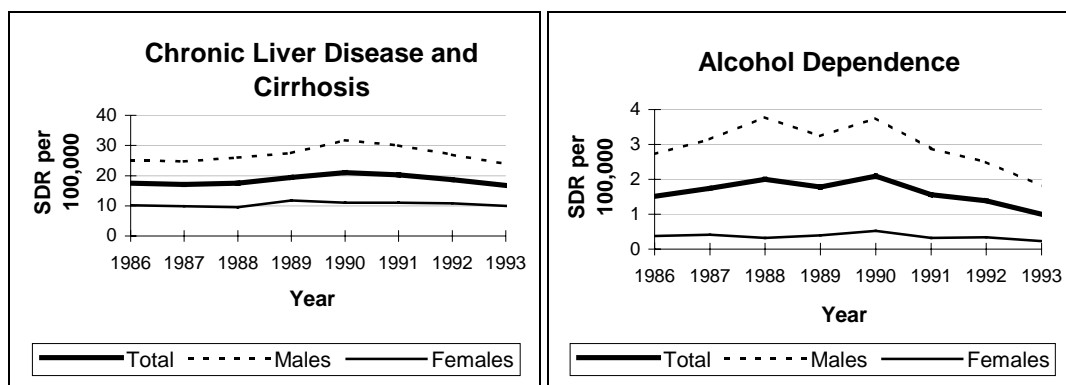
An earlier study carried out in 1993 among school children aged 15 years found that 95.4 per cent of boys had tried alcoholic beverages, 38.3 per cent were drinking alcoholic beverages at least once a week and 35.6 per cent had been drunk at least twice. Among girls, 96.6 per cent had tried alcoholic beverages, 18.5 per cent drank at least weekly, and 19.1 per cent had been drunk two or more times.

Mortality, morbidity, health and social problems from alcohol use**Alcohol dependence and related disorders**

The rate per 100 000 population of discharge from treatment for alcoholic psychosis among men rose from 39 to 48 between 1980 and 1990, then decreased to 16 in 1995. Female discharge rates mirrored this pattern, rising from 4.1 in 1980 to 7.5 in 1990, then receding to 3.3 in 1995. In 1994, 40 per cent of all psychiatric hospital admissions of males were due to substance-related disorders (mostly alcohol dependence).

Mortality

In 1993, the SDR per 100 000 population for chronic liver disease was 16.75, down from 17.5 in 1986. Both male and female liver disease rates experienced a rise around 1990, with the increase being more pronounced among males, whose rates rose from 25 to 31.7 between 1986 and 1990, then fell to 23.9 in 1993.

**Alcohol policies****Control of alcohol products**

The price of alcoholic beverages is equal to the basic price, plus the consumer tax, plus the value added tax. The value added tax is equal to 22 per cent of basic price and consumer tax. Spirits are taxed a consumer tax of 195Kč (US\$ 6.30) per litre of 100 per cent alcohol, beer of more than six per cent pure alcohol is taxed 430Kč (US\$ 14.00) per 100 litres, and beer which is five per cent absolute alcohol and less is taxed 157Kč (US\$ 5.10) per 100 litres. The real prices of beer and wine have remained stable during the early 1990s, but the real price of spirits has decreased.

It is not permitted to drink alcoholic beverages on health service premises, and there are some restrictions on drinking alcohol at sporting events. There are no restrictions on hours or days of sale or types of outlets. There is no state monopoly but a licence is required for the production and distribution of beer, wine and spirits, and there are restrictions on where outlets may be located. There is a voluntary code restricting advertising of alcoholic beverages. General and specific health

warnings are not required and there is no maximum legal limit for the alcohol content of beverages. Labels are required regarding alcohol content.

Control of alcohol problems

There is a minimum legal age limit of 18 years for buying alcohol. The BAC limit is 0.0 g%. On conviction for a first offence of driving above the BAC limit, suspension of driving licence is usual if the BAC is high. Imprisonment can be imposed in the case of a crash. Random alcohol breath testing is carried out infrequently.

There are mass media and school-based programmes which deal with alcohol in relation to tobacco and/or illicit drugs. A number of books relative to prevention have been published as part of a programme called Fit In. In 1993, the Czech Ministry of Education, Youth and Sport funded the development of a model preventive programme based on peer leadership. This was piloted in four Prague schools in 1994.

Alcohol data collection, research and treatment

Priorities of the early 1990s have been to address particular alcohol problems such as drinking and driving, and the consumption of alcohol by young people. There is a movement towards having a joint approach to issues related to alcohol, drugs and tobacco. The National Centre for Health Promotion in Prague was the national agency for prevention, but was abolished in 1995. The National Institute for Public Health now has responsibility for coordination of preventive activities, but is concerned mainly with prevention of drug use among youth.

The Prague Psychiatric Centre (Addiction Studies Unit) is a research institute that specializes in alcohol issues. There is no specific agency in charge of data collection but, in practice, alcohol-related data are regularly monitored by the Prague Psychiatric Centre's Addiction Studies Unit. The Society on Drugs and Alcohol is a nongovernmental organization that collects bibliographical data on medico-social aspects and demand reduction, legal provisions and strategies, international co-operation and trafficking. The intended audience includes researchers, scientists, policy makers, service providers and the general public. A full-time professional staff of 80 people is employed. There are 170 full-time workers employed, and a review of overall results is published annually. The Czech Medical Society's Section for Alcohol and Drugs focuses primarily on statistical data (treatment demand, emergency admissions, etc.) in registered patients.

The number of inpatient psychiatric treatment facilities changed very slightly during the period 1970-1990. Independent of alcohol treatment centres, there are acute detoxification units (usual stay of 24 hours) whose clients are generally from lower socioeconomic groups. Very severe alcohol intoxication and patients in states of delirium are treated in emergency units of general hospitals. Admissions to detoxification centres decreased sharply between 1988 and 1990, at a time when other objective indicators of alcohol problems such as traffic crashes and criminal offences under the influence of alcohol showed exactly the opposite trend.

Denmark

Sociodemographic characteristics

POPULATION	1980	1990	1995
Total	5 123 000	5 140 000	5 181 000
Adult (15+)	4 056 000	4 264 000	4 293 000
% Urban	83.7	84.8	85.2
% Rural	16.3	15.2	14.8

Health status

Life expectancy at birth, 1990-1995 : 72.5 (males), 78.2 (females)

Infant mortality rate in 1990-1995 : 7 per 1000 live births

Socioeconomic situation

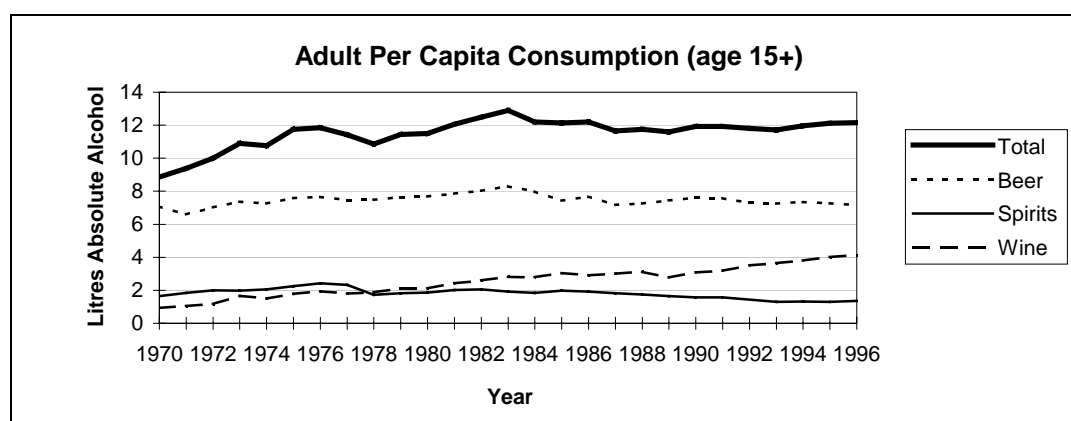
GNP per capita (US\$), 1995: 29 890, PPP estimates of GNP per capita (current int'l \$), 1995: 21 230. Average distribution of labour force by sector, 1990-1992 : agriculture 6%; industry 28%; services 66%

Adult literacy rate (per cent), 1995 : more than 95

Alcohol production, trade and industry

Denmark produces beer and distilled spirits, but is primarily a wine importer. Denmark's largest brewer is Carlsberg A/S. More than 80 per cent of Carlsberg's sales are outside of Denmark.

Alcohol consumption and prevalence



Consumption

Home brewing of beer and wine is legal, but home distilling is illegal. A sharp decline in spirits consumption followed the imposition of high taxation in the early twentieth century, but much of the reduction in consumption, in terms of pure alcohol, was counteracted by increased beer consumption, which now comprises about 60 per cent of total alcohol consumption. Although there is no quantified information available on unrecorded consumption, it is estimated to be about one fifth of recorded consumption. This would mean that total consumption of absolute alcohol in 1996 was 15.2 litres per adult.

Prevalence

A 1990 survey of people aged 15 years and over found that 39 per cent were infrequent consumers of alcohol (less than weekly or never), 44 per cent were moderate consumers and 16 per cent were frequent consumers (three or four days a week). A representative sample of the population (1542) was surveyed in August 1984 and January 1985. The results were similar to those of an earlier study done in 1977, i.e. women drank considerably less than men, the younger age groups drank more than the older and elderly, and those in the higher socioeconomic groups drank more than those in the lower.

Age patterns

A study of 2439 15 to 16 year olds (1189 boys and 1250 girls) was conducted in 1995. The response rate was 90 per cent (90 per cent for boys and 91 per cent for girls). Ninety-four per cent of the respondents had drunk an alcoholic beverage in the last 12 months, and 82 per cent had drunk to intoxication in the last 12 months. Lifetime prevalence of alcohol use was 96 per cent (97 per cent for boys and 95 per cent for girls).

A WHO study of schoolchildren in 1993/1994 found that 94.9 per cent of boys aged 15 years had tried alcoholic beverages, 40.1 per cent drank at least once a week and 64.7 per cent had been drunk at least twice. Of girls aged 15 years, 95.6 per cent had tried alcoholic beverages, 33.4 per cent drank at least once a week and 66.7 per cent had been drunk at least twice. A decade earlier, in 1983, a survey of 4700 young people aged 13 to 19 years found that practically all had had experience with alcohol. Boys consumed approximately twice as much as girls. Children from higher-income families consumed the most.

Economic impact of alcohol

In 1994 more than 13 million kroner (US\$ 1.9 million), 2.44 per cent of total private consumer expenditure, was spent on alcoholic beverages in Denmark.

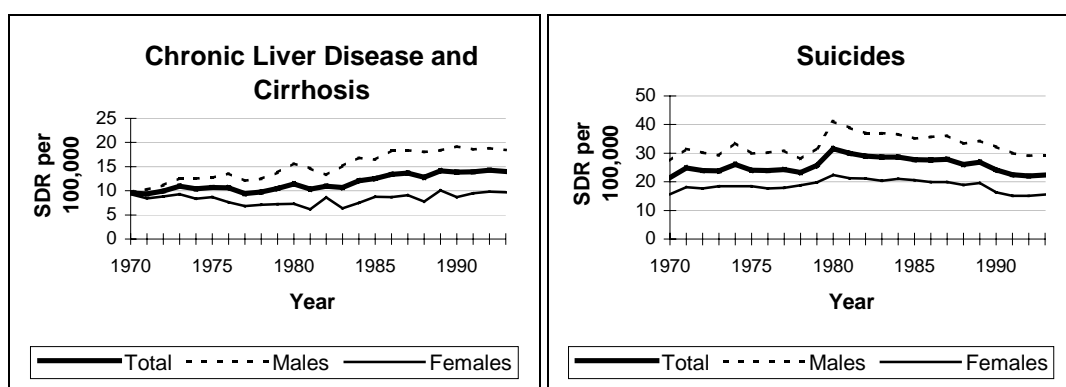
Mortality, morbidity, health and social problems from alcohol use

Alcohol dependence and related disorders

The number of people receiving somatic treatment for alcohol dependence rose from 7092 to 7943 between 1989 and 1993, while the number of people receiving psychiatric treatment for alcohol dependence fell from 6320 to 4460 during the same period. Persons with alcohol-related problems (alcohol dependence, alcohol psychosis and alcohol poisoning) as the main diagnosis admitted to psychiatric hospitals, departments and treatment homes totalled 14.1 per cent of all admissions in 1978, and rose to 16.6 per cent in 1987.

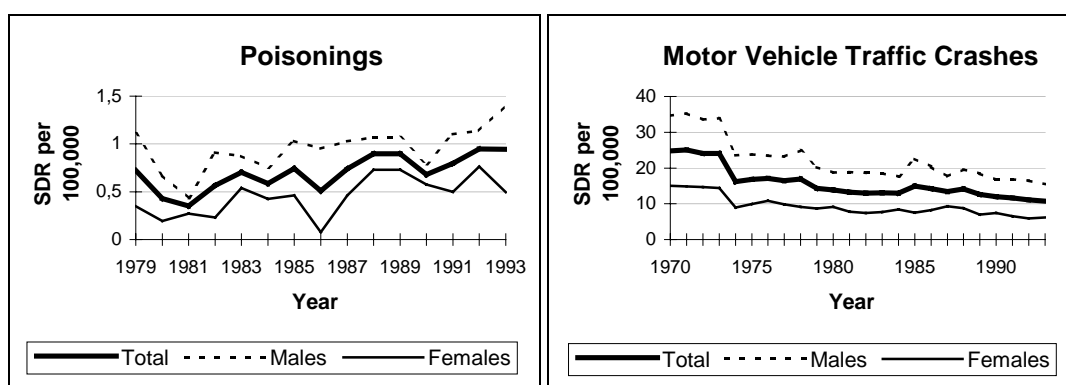
Mortality

Between 1911 and 1924, a period where the per capita consumption of absolute alcohol among people over the age of 15 decreased from 11 litres to 4.2 litres, the number of suicides amongst alcohol abusers fell from 164 to 83. The number of total suicides decreased from 524 in 1911 to 466 in 1924. The SDR per 100 000 population for chronic liver disease rose from 11.4 to 13.5 between 1980 and 1993.



Morbidity

The number of people receiving somatic treatment for alcohol poisoning decreased from 791 to 605 between 1989 and 1993.



Social problems

The rate per 100 000 population of alcohol-related motor vehicle traffic crashes decreased from 47 to 29.7 between 1970 and 1987. The rate (per 1000 population over age 15) of cautions and arrests for public drunkenness fell from 2.7 to 2.2 between 1990 and 1994.

Alcohol policies

Control of alcohol products

Table wines are taxed approximately 20 per cent, beer is taxed approximately 18 per cent and spirits (over 35 per cent proof) are taxed approximately 60 per cent. The real prices of beer and wine has been decreased and the real price of spirits has been stable during the early 1990s.

There is no state monopoly but a licence is required for the production and distribution of all types of alcoholic beverages. There are restrictions on hours and days of sale. Alcoholic beverages can be sold only during normal opening hours: Monday to Friday from 06:00 to 17:30 hours and Saturday from 06:00 to 12:00 hours. There are no restrictions on types and location of outlets. Serving minors (those aged under 18 years) is illegal.

General and specific health warnings are not required by law. The advertising of alcoholic beverages is banned on radio and television and is restricted by means of a voluntary code in other media such as newspapers/magazines, billboards and cinemas. There is no maximum legal limit for the alcohol content of beverages. Labels for alcohol content are required.

Control of alcohol problems

The BAC limit is 0.08 g% for drivers. If a driver's BAC is 0.12 g% or lower, suspension of driving licence is not usual. However, the driver's licence can be suspended for a first offence when the BAC limit is above 0.12 g%. Imprisonment can be imposed for second and subsequent offences. Random alcohol breath testing of motor vehicle drivers is carried out frequently.

There is no agency devoted specifically to the prevention of alcohol-related problems, but it is included in the work of the National Board of Health. An adviser on alcohol matters is attached to the Ministry of Education and, since 1975, information on alcohol and its damaging effects has been part of health education in primary schools. The objective is to prepare pupils to take responsibility for decisions regarding drinking. Temperance societies issue informative material through their national federation. Public information campaigns are also carried out, and the Road Safety Council has concentrated on education concerning alcohol and traffic. The Committee of Health Education, the Crime Prevention Council and the National Board of Social Welfare are also involved in educational and other preventive work. The National Board of Health organizes mass media campaigns. Some deal with alcohol only and others with alcohol and other substances, e.g. tobacco and/or other drugs.

Professional training courses have been organized through the Ministry of Education and local districts, 14 out of 15 of which have special advisers on alcohol and narcotics, some teacher training colleges and some medical faculties. Private temperance societies train instructors in collaboration with the Ministry of Health adviser.

Alcohol data collection, research and treatment

A Government Commission on Alcohol and Narcotics was mandated to institute and carry out sociological and socio-psychological research into alcohol and narcotics problems and to cooperate with Danish and foreign research bodies in this work. After 1988, the research section was transferred to the Danish National Institute for Social Research.

Following legislation in 1960, emphasis has increasingly been placed on outpatient treatment of alcohol dependent people. There is a move towards greater interest in early diagnosis and care of alcohol problems through primary health care services.

The A-Ring is affiliated with the Young Men's Christian Association (YMCA) and functions in a clinical capacity. Some clinics are in psychiatric hospitals or departments, but most are in flats or houses in shopping areas or residential quarters and are open usually only twice a week for four to five hours in the evening. About 15 000 people a year are admitted to outpatient clinics. The number of treatment homes increased from four (118 beds) in 1960 to seven (250 beds) in 1985 with approximately 3000 people admitted annually. All, but one, are run by two private organizations, the Blue Cross and the YMCA. Alcoholics Anonymous has never really gained a footing in Denmark. The number of outpatient clinics for alcohol dependents rose from 10 in 1960 to 61 in 1986.

Estonia

Sociodemographic characteristics

POPULATION	1980	1990	1995
Total	1 480 000	1 575 000	1 530 000
Adult (15+)	1 161 000	1 227 000	1 214 000
% Urban	69.7	71.8	73.1
% Rural	30.3	28.2	26.9

Health status

Life expectancy at birth, 1990-1995 : 63.8 (males), 74.8 (females)

Infant mortality rate in 1990-1995 : 16 per 1000 live births

Socioeconomic situation

Average distribution of labour force by sector, 1990-1992 : agriculture 9%; industry 33%; services 58%

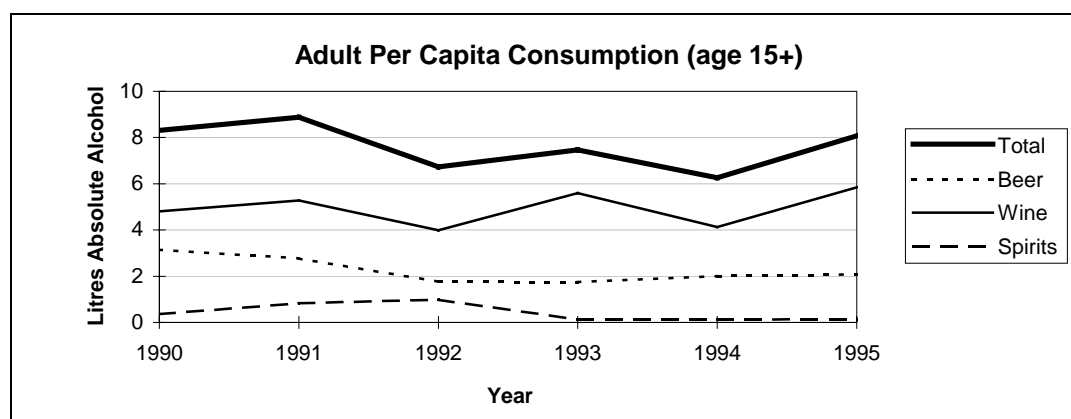
Alcohol production, trade and industry

Legal alcohol production is dominated by Liviko, the state distilled spirits monopoly, which in 1995 claimed its products comprised 60 per cent of the nation's vodka sales. An import-export joint venture between Liviko and the Finnish alcohol monopoly, ALKO, has expanded to include a shared retail outlet, the company's second retail store in Tallinn. As of 1997, Liviko was slated for privatization. The Finnish alcohol production monopoly ALKO has purchased control of Ofelia, the country's second largest distiller.

As of 1994, Estonia had seven industrial breweries, the largest of which are Saku Brewery and Tartu Brewery. After Baltic Beverages Holdings (a joint venture of the largest Finnish, Swedish and Norwegian brewers) purchased control of Saku Brewery, Saku's sales shot up to 57 per cent of the market's volume. In 1996, Tartu's share of the beer market was 22 per cent and later, the Finnish brewer, Olvi, purchased control of Tartu Brewery.

Since independence in 1991, rapid economic liberalization and deregulation have been accompanied by an explosion in the number of outlets selling alcohol, as well as increased visibility of major brands. According to the Estonian Shops Directory, in 1993 (the first year for which records are available) there were 1517 shops in the country licensed to sell alcohol. Even as the population has fallen, this number has grown: by 1995, 2685 shops were selling liquor - an average of one outlet for every 553 Estonians.

Alcohol consumption and prevalence



Consumption

Distilled spirits account for the majority of recorded alcohol consumption. Recorded consumption rose slightly 1990 to 1991, and then fell off in 1992, rose again in 1993 and fell again in 1994. The economy and taxes, and their impact on vodka prices, explain these fluctuations almost entirely. At the end of 1992, the consumer price index was more than 10 times that of the previous year, reducing the rise in legal alcohol sales. Towards the end of 1993, inflation had slowed but the government raised alcohol taxes by 30 per cent, and consumption of legal vodka plummeted.

Although there is no dispute that illegal production and sales of vodka are substantial, estimates vary. Spokespersons for the National Economic Police put the illegal market at 25 per cent of the total market. In addition to this internal illegal production, customs officials estimate that a million litres of spirits enter the country illegally each year. A spokesperson for Liviko estimated that illegal alcohol production varied between 20 and 50 per cent of the total market, depending on the time and the region. Representatives from the International Order of Good Templars estimated unrecorded consumption of alcohol much higher, in the region of five to seven litres per capita in 1993.

Prevalence

According to EMOR, a Gallup market research subsidiary operating in Estonia, there was a 50 per cent increase in "almost weekly" drinking between 1993 and 1996, and a rise in every category of drinking except "over six months ago" and abstainers. Seven per cent of vodka drinkers drink weekly.

A survey by a group of Nordic researchers in 1994 found that 53 per cent of men and 31 per cent of women drank at least weekly, 20 per cent of both genders drank at least once a month, and only 10 per cent of men and five per cent of women had not had a drink in the past year.

A study carried out in 1991 randomly selected 538 urban and rural families and also interviewed adolescents aged 14 to 16 years. Five per cent of the families consumed no alcohol, 54 per cent drank a few times a year, 37 per cent drank at least a few times a month, and four per cent drank more frequently. Three per cent of fathers consumed no alcohol, 23 per cent drank a few times a year, 50 per cent drank at least a few times a month, and 24 per cent drank more frequently. Fourteen per cent of mothers consumed no alcohol, 54 per cent drank a few times a year, 29 per cent drank at least a few times a month, and 3 per cent drank more frequently.

Age patterns

A study of 3118 15 to 16 year olds (1438 boys and 1680 girls) was conducted in 1995. The response rate was 83 per cent (82 per cent for boys and 84 per cent for girls). Eighty per cent of the respondents had drunk any alcoholic beverage in the last 12 months, and 46 per cent had been drunk in the last 12 months. Lifetime prevalence of alcohol use was 95 per cent (95 per cent for boys and 94 per cent for girls).

The 1991 survey of families found that the proportion of alcohol users, as well as of heavy drinkers, increased significantly with age and that girls consumed alcohol less frequently and less heavily than did boys. EMOR confirms the age pattern finding: according to its market research, the largest proportion of heavy vodka drinkers are adults between the ages of 35 and 49. Their ethnicities parallel those of the general population.

A WHO study for 1993/1994 showed that 92.5 per cent of boys aged 15 had tried alcoholic beverages, 13.2 per cent drank alcoholic beverages at least once a week, and 25.8 per cent had been drunk at least twice. Of girls aged 15, 91.9 per cent had tried alcoholic beverages, 3.3 per cent drank alcoholic beverages at least once a week, and 9.6 per cent had been drunk at least twice. Another study of young people ages 11 to 15, conducted between 1992 and 1994, found that 15 per cent of 15 year old boys and 8 per cent of girls had been drunk, and 5 and 1 per cent, respectively, had been drunk between 4 and 10 times in the past month. According to another study of young people in ninth and tenth grades (roughly ages 14 and 15), daily and weekly drinkers were most likely to drink beer and "long drinks" (sweet flavoured gins, vodkas and rums containing approximately five per cent alcohol).

Economic impact of alcohol

Excise and sales tax revenues from alcohol totalled approximately 10 per cent of the national budget in 1995.

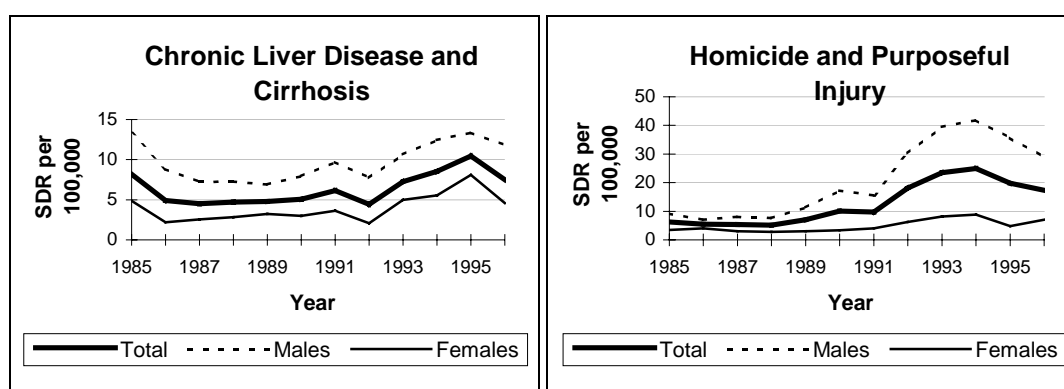
Mortality, morbidity, health and social problems from alcohol use

Alcohol dependence and related disorders

The rate per 100 000 population of inpatient treatment admissions for alcoholic psychosis decreased from 66.5 to 29 between 1980 and 1990, and then rose to 53.2 in 1993. The number of treated inpatient cases of alcohol dependence decreased from 2035 to 1696 between 1980 and 1993, while the number of outpatient consultations diminished from 13 514 to 7394 during the same period. The decline in inpatient admissions due to alcohol dependence can be attributed to the decreased availability of treatment.

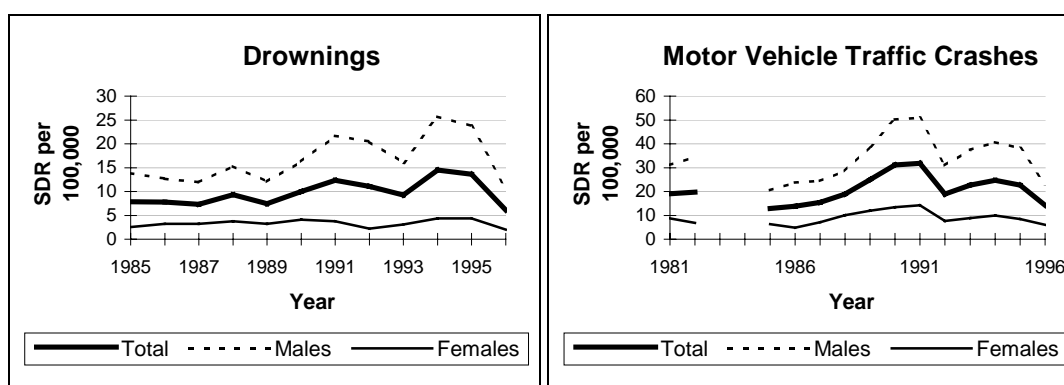
Mortality

The rate per 100 000 population of acute alcohol deaths doubled between 1990 and 1993, from 10 to 20, and the number of deaths from alcohol poisoning nearly tripled for both men and women between 1989 and 1993. The SDR per 100 000 population of mortality from alcoholic cirrhosis of liver was 1.1 in 1990, remained constant at 1.2 during 1991 and 1992, and then rose to 1.6 in 1993. The SDR per 100 000 population for chronic liver disease rose from 5.7 to 9.2 between 1990 and 1993, then to 11 in 1994.



More than 70 per cent of apprehended adult offenders and 69 per cent of juvenile offenders in homicides and attempted murders were drunk at the time of the crime.

Alcohol was involved in 72 per cent of drowning deaths in 1995.



Social Problems

In 1985, the number of alcohol-related motor vehicle crashes per 100 000 population was 15.5. This figure rose to 32.2 in 1993, and then to 39.3 in 1994. In 1994, 1995 and the first half of 1996, the percentage of motor vehicle crashes involving drunk drivers hovered between 28 and 30.

In 1995, 43 per cent of apprehended adult criminals were drunk at the time of the crime. The more violent the crime, the more likely the perpetrator was drunk. More than 70 per cent of apprehended offenders in assaults involving grievous bodily harm and rapes and attempted rapes were drunk. The percentage of drunken offenders arrested for robbery and hooliganism also exceeded 70 per cent. Juvenile crime figures mirror the adult rates. Juvenile drinking offences are also on the rise, with

more than two and a half times as many juveniles arrested for drunkenness in 1995 than in 1992. Apprehended young offenders in 79 per cent of rapes were drunk at the time of the crime.

Alcohol policies

Control of alcohol products

The real prices of beer and wine have been increasing and the price of spirits has been stable during the early 1990s. There is an 18 per cent value added tax on wine, beer and spirits.

Excise taxes are up to US\$ 1.31 per litre of wine, US\$ 0.12 - 0.75 per litre of beer, and US\$ 0.09 per 1 per cent volume absolute alcohol per litre. In December, 1996, the state reduced the excise tax on imported beer from more than three times the levy on domestic beer to the same level.

The sale of alcoholic beverages is forbidden in, or close to, medical and children's institutions. There are no restrictions on hours and days of sale. Restrictions on type and location of outlets are left to the discretion of the cities and towns. A licence is required for the production and distribution of all three types of alcoholic beverages, i.e. beer, spirits and wine. Wholesalers and retailers are required to have working capital of at least US\$ 8800 in order to acquire a licence.

The advertising of beer, wine and spirits on radio and television is banned, but as of late 1996 there was no law defining alcohol, so the country's largest brewer, Saku, advertised its alcoholic beers on television. As of 1995, alcohol advertisements in the streets and in newspapers were not yet regulated by law.

Labels for alcohol content of beverages are required by law. There is no maximum legal limit for the alcohol content of beverages. As of late 1996, a law which provides directives for the production, import, export, sale, taxation, licensing, quality, labelling and advertising of alcohol was under consideration by the Government.

Control of alcohol problems

There is a minimum legal age limit of 18 years for buying alcohol. The BAC limit is 0.0 g%. Conviction for a first or second offence will generally result in a penalty or fine of up to 200 DEM (US\$ 14.10), or a loss of driving licence for up to 36 months, but there is also the possibility of imprisonment for up to 30 days. Random alcohol breath testing is carried out, but infrequently. There are school-based programmes which deal with alcohol, tobacco and other drugs.

Alcohol data collection, research and treatment

There is no agency devoted specifically to alcohol, but it is included in the work of the Public Health Department within the Ministry of Social Affairs. In 1995, a foundation for health protection and promotion was created at the Ministry of Social Affairs. It has started a project developing preventive materials.

The Estonian Medical Statistical Bureau was founded in 1990 as a governmental organization that concentrates on data relating to psychiatric and narcological diseases by region, and particularly data concerning drug and alcohol dependent patients (admissions, treatment, etc.). A full-time professional staff of ten people is employed, and a review of overall results is published annually. At the national level, the Department of Public Health dedicates one civil servant to alcohol and drug-related issues.

The number of government beds for alcohol dependence treatment fell from 773 during Soviet rule to 80 as of 1995. Treatment is now increasingly in the hands of private or voluntary groups. There are approximately 10 Alcoholics Anonymous groups in the country.

Finland

Sociodemographic characteristics

POPULATION	1980	1990	1995
Total	4 780 000	4 986 000	5 107 000
Adult (15+)	3 810 000	4 024 000	4 132 000
% Urban	59.8	61.4	63.2
% Rural	40.2	38.6	36.8

Health status

Life expectancy at birth, 1990-1995 : 71.7 (males), 79.6 (females)

Infant mortality rate in 1990-1995 : 5 per 1000 live births

Socioeconomic situation

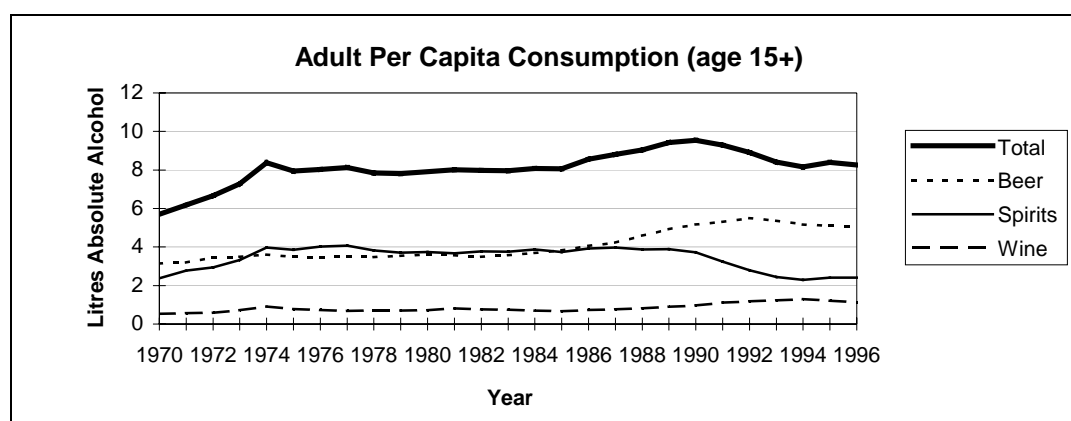
GNP per capita (US\$), 1995: 20 580, PPP estimates of GNP per capita (current int'l \$), 1995: 17 760
Average distribution of labour force by sector, 1990-1992 : agriculture 9%; industry 29%; services 62%

Adult literacy rate (per cent), 1995 : more than 95

Alcohol production, trade and industry

Finland produces, imports and exports beer, distilled spirits and wine. As a result of joining the European Union, Finland has separated its retail and production monopolies. ALKO, the former spirits and wine production and importing monopoly, continues to dominate spirits production although its retail monopoly of 255 stores has been preserved. Oy Hartwall AB (of which Denmark's Carlsberg owns 10 per cent) and Oy Sinebrychoff AB are the two largest brewers.

Alcohol consumption and prevalence



Consumption

Estimated unrecorded consumption was 20 per cent of recorded consumption in 1994. Using 1996 figures, this would bring total adult per capita consumption to approximately 10.3 litres of absolute alcohol.

Prevalence

Two survey samples representing the population between 15 and 69 years of age were conducted in 1984 and 1992. The number of respondents was 3624 in 1984 and 3446 in 1992. Technically, the two studies were almost identical. Results showed a downward trend in abstinence among women in all age groups since 1984. Among men, the changes were smaller and hardly significant. An increase in drinking frequency was shown in all gender and age groups. Frequent drinking taking place daily, or

almost daily, was however rare. Only one per cent of women and three per cent of men drank daily in 1992.

A sample of 985 women and 863 men was drawn from the population register in the four monitoring areas (the provinces of North Karelia and Kuopio in eastern Finland, the city of Turku and its rural municipalities in southwest Finland, and the southern cities of Helsinki and Vantaa). All subjects were 25 to 64 years of age. Eight per cent of men were abstainers, compared with 18 per cent of women, and 8 per cent of men were heavy drinkers compared with 3 per cent of women (heavy drinking was defined as at least 280 grams per week for men and at least 190 grams per week for women).

In 1968, Finnish women very seldom drank, but by 1984 they drank about 20 per cent of all alcohol consumed in Finland and intoxication among women had become more common, particularly among the youngest age group (15 to 19 years). Women with upper-grade clerical jobs had the highest drinking frequencies and annual alcohol consumption.

Heavy drinking is common: for men, two-thirds of alcohol consumption occurs during occasions leading to intoxication; for women, 41 per cent of alcohol consumption occurs during occasions leading to intoxication.

Age patterns

A 1995 representative sample of 2300 comprehensive school children born in 1979 found that nearly 90 per cent of all 15 year old students had drunk alcohol in their lifetime, and almost all of those had drunk in the past 12 months. In the past 30 days, 61 per cent of girls and 55 per cent of boys had consumed alcohol. Furthermore, 21 per cent of the respondents had drunk weekly. About one quarter of the respondents had drunk one to three drinks the last time they had a drink (one drink = 1.5 cl of pure alcohol). More than half of the boys and a just less than half of the girls had consumed at least seven drinks the last time they drank. Approximately 16 per cent of boys had consumed 13 drinks or more, compared to 5 per cent of girls. About 12 per cent of girls and 42 per cent of boys who drank alcohol usually took at least seven drinks at a time.

Drinking among young people increased markedly between the early 1960s and the early 1970s, but in 1984 their average consumption was less than in 1976, though still higher than in the 1960s. Over the 16-year period, boys of all ages became far more likely to drink until they reached a stage of intoxication.

Economic impact of alcohol

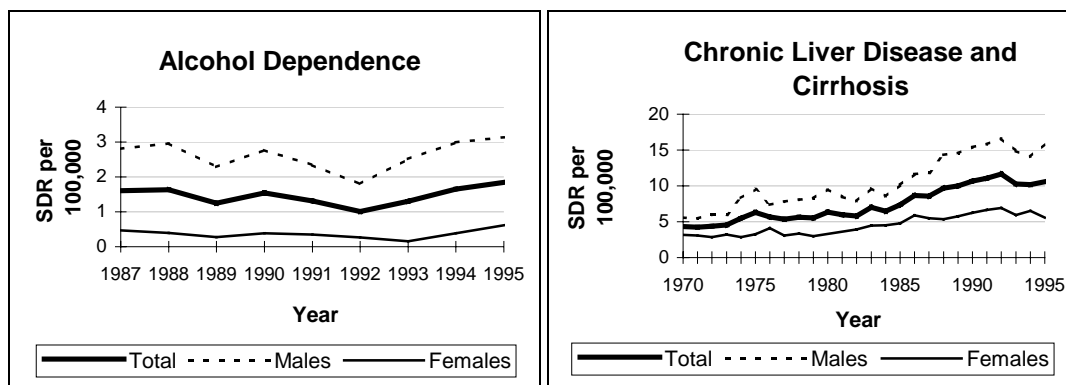
In 1994, expenditure on alcoholic beverages constituted 6.2 per cent of the total consumer expenditure, down slightly from 6.9 per cent in 1990. In 1987, an estimated two per cent of the country's labour force participated in the production and trade of alcoholic beverages.

Mortality, morbidity, health and social problems from alcohol use

Alcohol dependence and related disorders

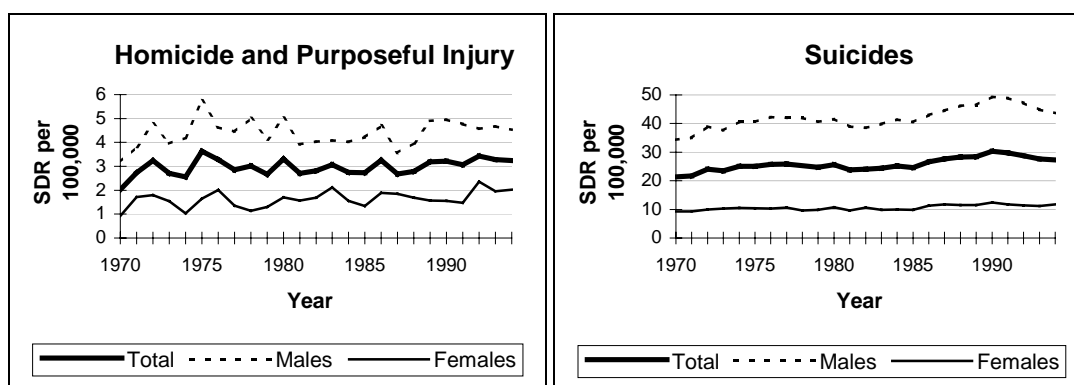
The rate per 100 000 population of alcohol-related admissions to general hospitals rose from 83.3 to 95.5 between 1970 and 1985. The rate per 100 000 population of treatment admissions for alcoholic psychosis was 79.3 in 1994, compared with 77.1 in 1989. The rate of treatment admissions for alcohol dependence was 263.2 in 1994, up from 199 in 1989.

In 1993, 337 327 days of outpatient treatment were given in A-clinics and centres for young people with alcohol problems, and alcohol treatment cases occupied 237 000 bed days in detoxification centres, treatment homes, and hospitals.



Mortality

A total of 1067 suicides (824 males, 243 females) between April 1987 and March 1988 were investigated through face-to-face interviews with next of kin, the attending health care and medical personnel, and from psychiatric, medical and social agency records. Alcohol misuse was found in 44.5 per cent of the men and in 18.4 per cent of the women. In an analysis of forensic psychiatric examinations conducted on persons charged with homicide during several years, it was discovered that the odds ratio for alcohol dependence was about 16 among men and about 50 among women, when compared to the general population. The SDR per 100 000 population for chronic liver disease rose from 6.8 to 9.9 between 1980 and 1993.

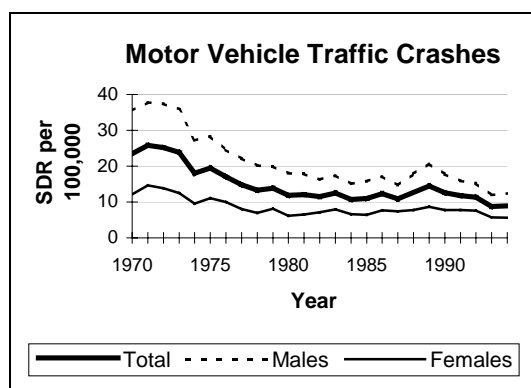


Morbidity

The rate per 100 000 population of treatment admissions for alcohol poisoning fell from 16.6 to 15.5 between 1989 and 1994.

Social problems

The rate per 100 000 population of alcohol-related motor vehicle traffic crashes rose from 17.1 to 23.9 between 1980 and 1993, in a period when overall deaths from motor vehicle crashes were falling (see chart below). The rate, per 100 000 population aged 15 years or older, of cautions and arrests for public drunkenness fell from 35.6 in 1990 to 22.5 in 1994. Arrests for drunkenness, per 1 000 litres of alcohol consumed, declined from 16 in 1960 to about 7 in 1980.



Alcohol policies

Control of alcohol products

From 1980 to 1987, the consumer prices of alcoholic beverages increased by 7.3 per cent in relation to the prices of other commodities. Taxation depends on the alcohol content of alcoholic beverages. The level of taxation is prescribed to be relatively high by law and the rates are approximately as follows: table wine, 56 per cent; beer (four to six per cent alcohol), 60 per cent; spirits, 87 per cent. The real price of alcohol is now decreasing.

Finland put an end to its production, import and export monopolies in 1995, following which the National Product Control Agency for Welfare and Health, under the Ministry of Social Affairs and Health, has been in charge of alcohol administration. The Agency is the authority for control of marketed products and monitors all production and distribution as well as issuing all required licences. Finland has a retail monopoly for alcoholic beverages (except fermented products under 4.7 per cent alcohol by volume) which functions under the control of the Ministry of Social Affairs and Health. A licence is required for wholesale, on-premises retailing of alcohol. A licence is also required for retailing beer and fermented alcoholic beverages under 4.7 per cent alcohol by volume. There are restrictions on hours and days of sale and on types of outlets (a state retail monopoly) and these are fairly effectively enforced.

It is prohibited to advertise, indirectly advertise or otherwise promote the sale of strong alcoholic beverages containing 22 per cent by volume of alcohol or higher. Advertising of alcoholic beverages containing less than 22 per cent alcohol is allowed under restrictive rules. General or specific health warnings are not required. Labels for alcohol content are required by official statute, and there is a maximum legal limit of 60 per cent for the alcohol content of beverage. There is legislation to create and support alcohol-free environments.

Control of alcohol problems

Priorities of the early 1990s have been: reducing availability; mass media campaigns to encourage safer drinking and to encourage lighter drinking in work settings; increasing the role of primary health care teams in the prevention and early detection of alcohol problems; using price policy to reduce demand; addressing particular alcohol problems; and carrying out surveys on drinking habits to develop statistical and information services on alcohol and drug problems.

There is a minimum legal age limit of 18 years for buying alcoholic beverages. Consumption during working hours is not permitted, and the Wage Agreement Act states that the worker may be dismissed if consumption interferes with work. The BAC limit is 0.05 g% for drivers, and this is quite effectively enforced. Random alcohol breath testing is frequently carried out (1 700 000 recorded in 1993). When a person is convicted of driving above the BAC limit suspension of drivers licence is common practice for a first offence. Imprisonment for second and subsequent offences is a possibility, but not usual. Some mass media, school-based and work place programmes deal with alcohol only while others deal also with tobacco and/or illicit drugs.

There are a number of national agencies dealing with the formulation and application of alcohol policies including the Department of Promotion and Prevention in the Ministry of Social Affairs and Health and several nongovernmental organizations. ALKO Ltd has an Alcohol Policy Planning and

Information Unit. The Ministry of Social Affairs and Health is responsible for coordination and monitoring of alcohol policies.

Alcohol data collection, research and treatment

The Social Research Institute for Alcohol Studies, the Finnish Foundation for Alcohol studies, The ALKO Biomedical Research Centre and the Research Unit on Alcohol Diseases at the University of Helsinki specialize in research on alcohol issues.

The psychiatric services have a limited role of long-term treatment and management of more complex alcohol-related cases with prominent psychiatric aspects, but the primary health care services are increasingly taking over both short-term intensive treatment, including detoxification, and longer term follow-up, often in collaboration with the social services. By the early 1980s, active Alcohol Anonymous groups had been established in 179 districts.

Residential alcohol services in Finland are estimated to consult approximately 20 000 clients each year with non-residential services consulting about 40 000. There are 63 non-residential alcohol clinics and eight clinics for young people with alcohol problems.

France

Sociodemographic characteristics

POPULATION	1980	1990	1995
Total	53 880 000	56 718 000	57 981 000
Adult (15+)	41 876 000	45 235 000	46 623 000
% Urban	73.3	72.7	72.8
% Rural	26.7	27.3	27.2

Health status

Life expectancy at birth, 1990-1995 : 73.0 (males), 80.8 (females)

Infant mortality rate in 1990-1995 : 7 per 1000 live births

Socioeconomic situation

GNP per capita (US\$), 1995: 24 990, PPP estimates of GNP per capita (current int'l \$), 1995: 21 030

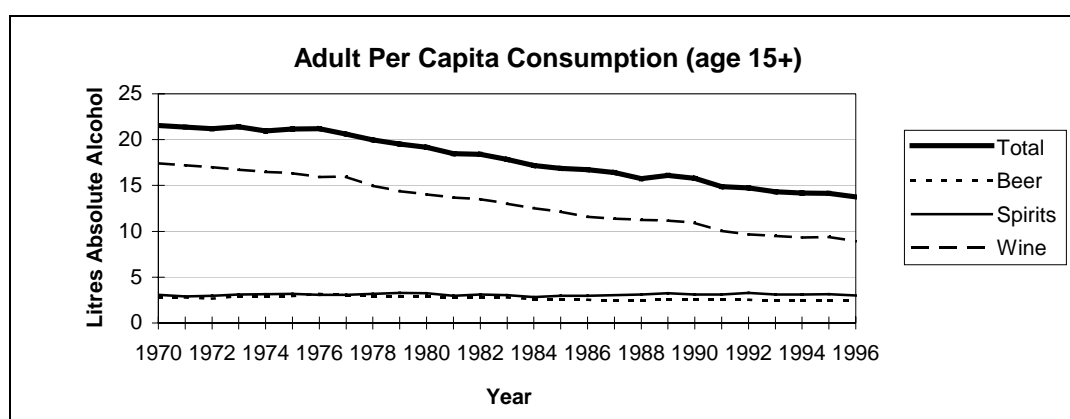
Average distribution of labour force by sector, 1990-1992 : agriculture 6%; industry 29%; services 65%

Adult literacy rate (per cent), 1995 : more than 95

Alcohol production, trade and industry

France produces beer, distilled spirits and wine. The producer, Groupe Danone, dominates the beer market, followed by Heineken, and the top three producers sell more than two-thirds of the beer. In distilled spirits, the conglomerate Louis Vuitton Moët Hennessy (LVMH) dominates the world cognac trade. France's wine industry is not highly centralized. The largest is family-owned Castel Frères.

Alcohol consumption and prevalence



Consumption

Consumption of wine, the alcoholic beverage of choice, has declined steadily since the mid-1970s, while beer and spirits consumption have remained constant. Declared home production was 53 million litres of pure alcohol during 1974-1975, and 42 million litres of pure alcohol during 1975-1976. If these levels remained constant through 1996, this would be the equivalent of an additional 0.9 litres of absolute alcohol per adult, bringing total adult consumption to 14.63 litres.

Prevalence

A national survey of a representative sample of the population over 18 in November 1992 found that 7 per cent were lifetime abstainers, an additional 6.6 per cent abstained currently, 56 per cent drank once or twice a week at the weekend or less often, and 30.4 per cent drank every day or three to five times per week. Four times as many women abstain as men. On average, men drink twice as many drinks as women. Regarding drunkenness, 46.2 per cent say they have never been drunk, 44.6 have rarely been drunk, and 0.9 per cent get drunk frequently. In the past year, women on average had been drunk once, men 1.7 times, those aged 18 to 24 years 3.8 times, and those aged 25 to 34 years 1.5 times.

A 1988 study in Languedoc-Roussillon of a sample of the population aged over 15 years showed that 8.9 per cent of the sample had high levels of consumption (especially working class males aged 45 to 54 years), and 4.7 per cent seldom or never consumed alcoholic beverages.

Age patterns

In 1995, 65 per cent of young people between the ages of 12 and 18 drank alcohol, compared with 47 per cent in 1991. A WHO study in 1993/1994 of boys and girls aged 15 in the regions of Nancy and Toulouse showed that of boys, 88.9 per cent had tried alcohol, 38 per cent drank alcohol at least once a week, and 23.8 per cent had been drunk at least twice. Of girls, 89.9 per cent had tried alcohol, 17.5 per cent drank alcohol at least once a week, and 12.9 per cent had been drunk at least twice.

Alcohol use among population subgroups

In 1982, a survey was carried out in the region of Aquitaine among 4953 men aged 40 to 75 years. Representative urban and rural samples in each of the five sub-regions of Aquitaine were interviewed. The average daily consumption (mostly wine) was 95 grams. Of heavy drinkers (more than 150 grams pure alcohol), 25 per cent were agricultural workers (highest percentage), and five per cent were liberal professions (lowest percentage).

Economic impact of alcohol

Between 1991 and 1995, it is estimated that 1.5 per cent of the national Prevention Fund's annual contribution went to the prevention of alcohol dependence. In 1970 three per cent of the annual household expenditure was devoted to alcoholic beverages. This figure fell to 2.2 per cent in 1980, then to 2 per cent in 1984. In 1980, the estimated costs of alcohol-related problems in the workplace were FF 21 thousand million (US\$ 3.5 thousand million). In 1977, the estimated costs of alcohol-related traffic crashes were FF 73 thousand million (US\$ 12.1 thousand million).

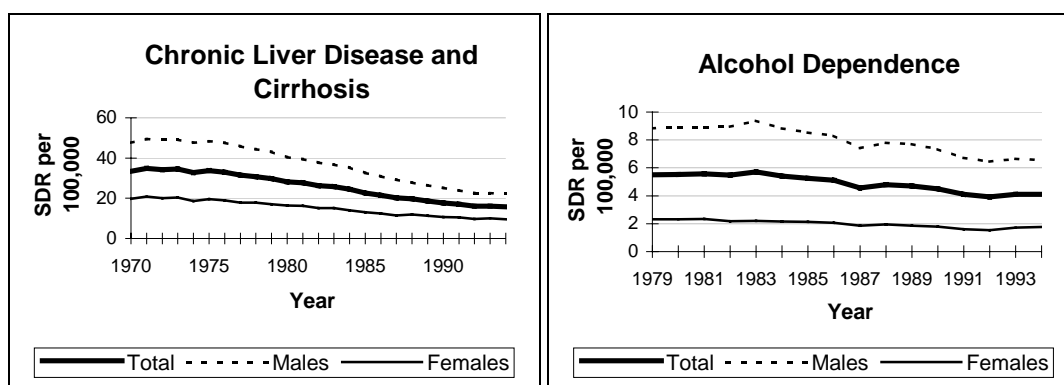
Mortality, morbidity, health and social problems from alcohol use

Alcohol dependence and related disorders

France ranks among the top quarter of countries reporting death rates from alcohol dependence. It is estimated that two million people are dependent on alcohol, and that five million experience difficulties of a medical, psychological and social nature because of their alcohol consumption. In 1980, alcoholic psychosis accounted for 34 per cent of all male admissions to psychiatric hospitals, and 8 per cent of all female admissions. There are no data available on admission rates per 100 000 population as France does not routinely collect morbidity statistics.

Mortality

The SDR per 100 000 population of all ages for chronic liver disease and cirrhosis fell from 33.4 (47.7 for males, 19.8 for females) in 1980 to 15.8 (22.3 for males and 9.6 for females) in 1994. Although the death rate has fallen, in 1991, 11 910 French people died as a direct result of excessive alcohol consumption, with diagnoses of alcohol dependence, alcoholic psychosis and cirrhosis. An additional 10 233 died from cancers of the upper digestive system linked to alcohol. An estimated one third of all motor vehicle crash deaths are attributable to alcohol. The excess mortality in French people under the age of 65, particularly males, is largely linked to alcohol consumption.

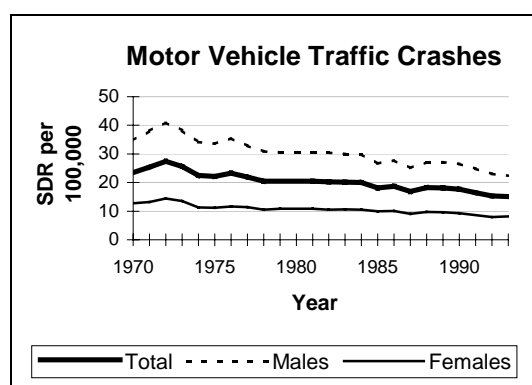


Health problems

In 1980, between 25 and 30 per cent of all male admissions to general hospitals, and between five and ten per cent of all female general hospital admissions were alcohol-related.

Social problems

The rate per 100 000 population of alcohol-related motor vehicle crashes fell from 303.8 to 297.3 between 1989 and 1992. Deaths from motor vehicle crashes have been falling as well during the 1990s.



Alcohol policies

Control of alcohol products

The real price of beer has been stable, with that of wine decreasing and of spirits increasing during the early 1990s. Table wines are taxed 22FF/hl (US\$ 3.68/hl), sparkling wines are taxed 54.8FF/hl (US\$

9.18/hl), beer (with alcohol content not exceeding 2.8 per cent alcohol by volume) is taxed 6.25FF (US\$ 1.04) /degree of alcohol/hl, other beer (with alcohol content more than 2.8 per cent alcohol by volume) is taxed 12.5FF (US \$2.09) /per degree of alcohol/hl and spirits (with a pure alcohol content greater than or equal to 40 per cent) is taxed 5125FF (US\$ 859.10) /hl pure alcohol.

Since 1987, no alcoholic beverage may be served to pupils in primary or secondary schools or at recreational facilities for children. Consumption at workplaces is limited to fermented beverages, the maximum quantity being specified by workshop regulations. Restrictions on hours of sale are determined by local authorities. There are no restrictions on days of sale or on location of outlets. It is forbidden to sell alcoholic beverages between 22:00 and 06:00 hours at petrol stations. There is a restriction on the establishment of new License IV outlets, i.e. those licensed to sell all types of alcoholic drinks. There is no state monopoly for the distribution and production of beer, wine and spirits but a declaration for taxation purposes is obligatory and a licence is required for distribution.

The advertising of beer, spirits and wine is banned on television and in cinemas and is restricted on radio, in newspapers, billboards and magazines (allowed in adult press only). Restriction generally means that the content of the advertising is regulated and that a health warning is obligatory. The maximum legal alcohol content limit is 18 per cent for wine-based aperitifs and 45 per cent for spirits. Labels for alcohol content are required by law.

Control of alcohol problems

There is a minimum legal age limit of 16 years for buying alcohol. The BAC limit is 0.08 g% for drivers, and anything over this limit is considered an offence. A level above 0.07 g% is considered a contravention and incurs a fine. On conviction for a first offence of driving above the permitted BAC it is usual to suspend a person's driving licence and/or to imprison him. Random alcohol breath testing is carried out, but infrequently.

The Alcohol and Public Health Committee of the High Committee of Public Health makes recommendations to the Ministry of Health in relation to alcohol issues. A special unit within the Ministry of Health develops policy and programmes in cooperation with the French Committee on Education for Health (CFES) and the National Association for Prevention of Alcoholism. The High Committee for Study and Information on Alcoholism (HCEIA) and Comité National de Defense Contre Alcoolisme (CNDCA) have the main responsibility for informing and educating the public on alcohol problems, with the assistance of other bodies such as the Pharmaceutical and Social Education Councils and the Scientific Nutritional Health Society. Priorities of the early 1990s included mass media campaigns to encourage safer drinking and addressing particular alcohol problems such as drinking and driving. The French Society of Alcoholology (FRA) develops contacts between members and organizations of various disciplines in the study of alcohol matters.

Alcohol data collection, research and treatment

HCEIA and the National Institute of Health and Medical Research (INSERM) together carry out biological, epidemiological and statistical research on alcohol use and problems. This joint programme includes a longitudinal study over many years of the development of alcohol consumption among young people. INSERM also collects national and regional data on mortality and morbidity from alcohol-related disorders. CNDCA collates and publishes information in its review "*Alcool ou santé*". The FRA contributes to the development of information and coordinates some multidisciplinary research. The Institute for Research on Beverages groups 12 producing societies that subsidise studies on alcohol and alcohol problems. Every ten years, the Statistics, Studies and Information Systems Service (INSEE) and the Research Centre for the Study and Monitoring of Living Conditions (CREDOC) make inquiries on health and medical consumption. INSERM and HCEIA are both involved in the collection of various types of data pertaining to alcohol.

The HCEIA has played an important role in developing education on alcohol in medical, paramedical and sociology courses. Some universities also have alcohol programmes. Since 1978, CNDCA has had a national training centre that provides courses for national and regional groups, hospital centres and social workers. In 1970, nutritional hygiene centres were established. Their number has since increased, and their field of activity has developed considerably.

Alcohol units are available in general hospitals, and other health centres and general services, but these are developing very slowly. Outpatient and inpatient units of psychiatric hospitals are often

poorly adapted to the treatment of alcohol dependent patients. There are some inpatient homes (cure establishments). Post-cure (rehabilitation) is carried out in post-cure centres, sometimes with the help of associations of treated alcohol dependents, of which there are 15, that work with a network of regional and local delegations. Legal provisions exist for the protection of the families of heavy drinkers, and alcohol dependents may be placed in institutions under a legal order as an extreme measure.

Georgia

Sociodemographic characteristics

POPULATION	1980	1990	1995
Total	5 048 000	5 418 000	5 457 000
Adult (15+)	3 747 000	4 085 000	4 161 000
% Urban	51.7	56.0	58.5
% Rural	48.3	44.0	41.5

Health status

Life expectancy at birth, 1990-1995 : 68.5 (males), 76.7 (females)

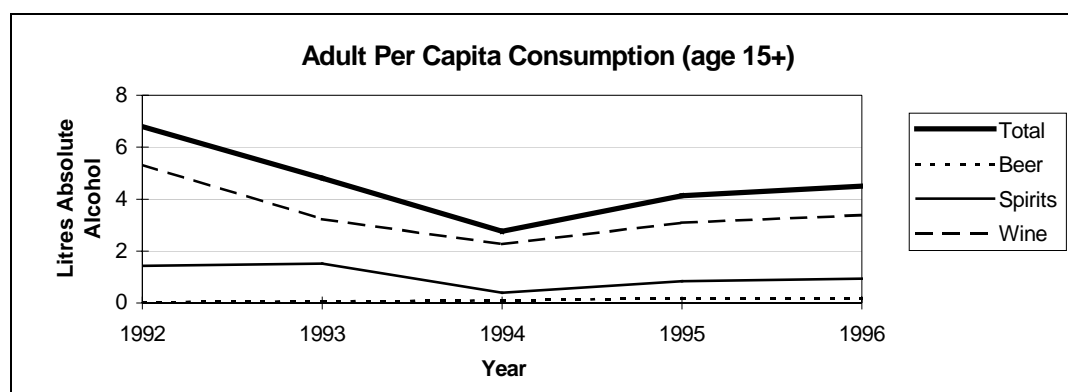
Infant mortality rate in 1990-1995 : 19 per 1000 live births

Socioeconomic situation

GNP per capita (US\$), 1995: 440, PPP estimates of GNP per capita (current int'l \$), 1995: 1470

Average distribution of labour force by sector, 1990-1992 : agriculture 14%; industry 30%, services 56%

Alcohol consumption and prevalence



Consumption

Historically, Georgia is a country of Mediterranean culture. Wine grapes are grown in all regions and almost every person in rural areas makes wine and grape vodka for personal consumption, and sometimes for sale. There is a special ceremony with toasts for drinking wine even when only two people are present. Drunkenness is considered shameful, and therefore rare. This custom is credited with keeping the prevalence of alcohol dependence low, and progression of the disease slow when it occurs. The other important factor is the pace at which alcohol is drunk and the quality of wine, which usually contains about 10 to 12 per cent alcohol. According to WHO's European office, adult per capita consumption of pure alcohol has fallen from its 1980 level of 9.5 litres. There are no data available on consumption of smuggled or home- or informally-produced or sold alcohol.

Economic impact of alcohol

Consumer expenditure on alcoholic drinks, as a percentage of general expenditure on purchase of goods and payments for services was 1.1 in 1991, compared to 1.3 the previous year.

Mortality, morbidity, health and social problems from alcohol use

Alcohol dependence and related disorders

Georgia provides a good example of the influence of different drinking cultures on alcohol-related harm. There were about 33 alcohol dependent patients registered per 10 000 population in Georgia in 1984-1989 whereas there were about 190 registered in the former USSR. There were about 21 alcohol dependent patients registered per 10 000 of the native Georgian population during the period. Georgian alcohol rituals influence the non-native population; thus there are 28 alcohol dependents per 10 000 of the Armenians in Georgia compared to less than 20 among Armenians in Armenia. Among the Russian population in Georgia, there are about 120 alcohol dependents per 10 000, significantly less than in Russia. On the other hand, Georgian national peculiarities have almost no influence on the Azerbaijan population in Georgia which is Moslem, and has only four alcohol dependent patients per 10 000.

The rate of admission to inpatient treatment per 100 000 population for alcoholic psychosis was 1.4 in 1993, compared to 13.3 in 1980, 13.1 in 1985 and 10.5 in 1990.

Mortality

The SDR per 100 000 population (all ages) for chronic liver disease was at 25.2 in 1991 and 25.1 in 1992. Figures for earlier years are not available.

Social problems

The number of persons committing crimes under the influence of alcohol (thousands) decreased slightly from 1.5 in 1990 to 1.1 in 1993.

Alcohol policies

Control of alcohol products

The real prices of beer and wine have remained stable and the real price of spirits decreased during the early 1990s. There are no restrictions on the sale of alcohol. General and specific health warnings are not required by law. Restrictions on advertising of all three types of alcohol, i.e. beer, spirits and wine are implemented by means of a voluntary code. Labels for alcohol content are required by law. There is no maximum legal limit for the alcohol content of beverages.

Control of alcohol problems

There is no agency involved in prevention work at a national level. The BAC limit is 0.0 g% for drivers. A person's driving licence can be suspended for exceeding this. Random alcohol breath testing is frequently carried out.

Alcohol data collection, research and treatment

There are no research institutes which specialize in or have major responsibility for research on alcohol issues.

Georgia largely operates the treatment system it inherited from the Soviet administrative days: the treatment of alcohol and drug addicts in a system of narcological dispensaries and hospitals. In official statistics, the number of alcohol dependent patients has decreased from approximately 15 000 in 1987-1989 to about 12 000 in 1990-1992. It is considered by experts that this does not represent the real trend but is a result of the destruction of the treatment and medical systems. The absence of medicines and other important conditions for treatment of alcohol dependence have significantly reduced the number seeking medical treatment. There is some unofficial evidence that the situation in relation to alcohol use is worsening. According to private doctors and the police, alcohol-related morbidity is growing among young native people (under 30 years).

Germany

Sociodemographic characteristics

POPULATION	1980	1990	1995
Total	78 304 000	79 365 000	81 591 000
Adult (15+)	63 827 000	66 603 000	68 465 000
% Urban	82.6	85.3	86.6
% Rural	17.4	14.7	13.4

Health status

Life expectancy at birth, 1990-1995 : 72.7 (males), 79.0 (females)

Infant mortality rate in 1990-1995 : 6 per 1000 live births

Adult literacy rate (per cent), 1995 : more than 95

Socioeconomic situation

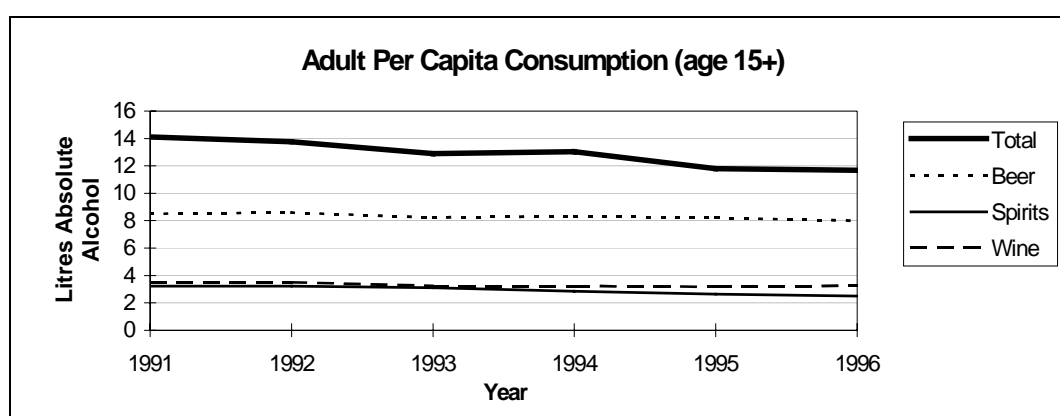
GNP per capita (US\$), 1995: 27 510, PPP estimates of GNP per capita (current int'l \$), 1995: 20 070. Average distribution of labour force by sector, 1990-1992 : agriculture 3%; industry 39%; services 58%

Adult literacy rate (per cent), 1995 : more than 95

Alcohol production, trade and industry

As of the late 1990s, Germany's 1278 breweries face growing competition as national beer consumption and income begins to decline. Brewers in Western, in particular, face declining sales as former East German breweries begin to modernize and to produce their own high-quality beer. Brewers are coping with these changes by laying off employees and increasing advertising expenditures. Importers find that it is hard to obtain a sizeable share of the German market because access is limited, profit margins are small, and Reinheitsgebot (purity laws which state that beer can only contain yeast, water, malt, and hops) are strict. In addition, per-capita consumption of beer remains at about 140 litres a year. While Reinheitsgebot is no longer enforceable by law, Germans have come to expect it of their beer.

Alcohol consumption and prevalence



Consumption

Alcohol consumption in Germany declined nine per cent from 1991 to 1995, according to the German Health Ministry. No quantified information is available on unrecorded consumption.

Prevalence

In 1995, a mail survey of 7833 respondents aged 18 to 59 years (response rate 65 per cent) found that, in West Germany, 16.3 per cent of males and 30 per cent of females consumed no alcohol. More than

19 per cent of males and 10.8 per cent of females consumed 11 to 20 grams of pure alcohol per day, 17.8 per cent of males and 6.5 per cent of females consumed 21 to 40 grams per day, and 7.4 per cent of males and 1.4 per cent of females drank more than 61 grams per day. In East Germany, 12.8 per cent of males and 20.8 per cent of females drank no alcohol. About 20.1 per cent of males and 14.7 per cent of females drank 11 to 20 grams of pure alcohol per day, 23.1 per cent of males and 7.2 per cent of females drank 21 to 40 grams per day, and 9.2 per cent of males and 1.3 per cent of female drank more than 61 grams per day. Wine was the preferred drink for lighter drinkers, whereas the more frequent drinkers preferred beer in both regions.

Age patterns

A 1993 study in the region of Nordrhein Westfalen found that 90.6 per cent of boys had tried alcohol by the age of 15. More than 25 per cent drank beer at least weekly and 33.7 per cent had been drunk at least twice. Of girls, 93.8 per cent had tried alcohol by the age of 15, 17.9 per cent drank beer at least weekly and 26.4 per cent had been drunk at least twice.

Economic impact of alcohol

The percentage of per capita income that was used for alcoholic beverages in the Federal Republic of Germany went from 5.5 in 1960 to 4.2 in 1970, and down to 2.2 in 1986.

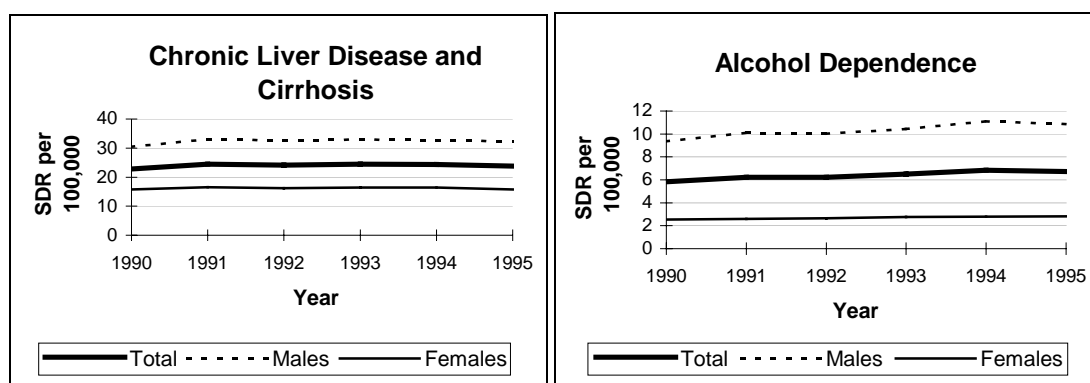
Mortality, morbidity, health and social problems from alcohol use

Alcohol dependence and related disorders

In 1995, a mail survey of 7833 respondents aged 18 to 59 years (response rate 65 per cent) found that 15.1 per cent of males and 10 per cent of females in West Germany, compared with 20.5 per cent of males and 10.5 per cent of females in East Germany abused alcoholic beverages. A study conducted immediately after the opening of the Berlin wall found that four per cent of males aged 15 to 17 years, and 10 per cent of males aged 18 to 24 years were "at risk" from their drinking.

Mortality

In 1992 the SDR per 100 000 population for chronic liver disease was 31.5 in West Germany and 13 in East Germany. The SDR per 100 000 inhabitants from alcohol-related motor vehicle crashes in united Germany was 2.6 in 1992 and 2.5 in 1993.



Health problems

Persons with alcohol problems dominate admissions for alcohol and other drug treatment. Data from 86 facilities in the East Germany and 357 in West Germany became available in 1994. The data covers a total of 100 000 persons, 60 per cent of whom started treatment in 1994. In West Germany, 68.8 per cent of males and 44.5 per cent of females were treated for alcohol problems, compared to 93.3 per cent of males and 70.1 per cent of females in East Germany. The Stationäre einrichtungsbezogene Dokumentationssystem (SEDOS) report refers to 12 psychiatric hospitals, 41 special clinics for alcohol and medicament users, 18 special clinics for drug abusers and 11 centres for aftercare. In 78 per cent of the total numbers of clients, the most prominent cause of admission in 1994 was alcohol problems.

Social problems

The number of road traffic crashes involving alcohol per 100 000 population was 41 in 1991 and 50.7 in 1992.

Alcohol policies***Control of alcohol products***

The tax rate is calculated according to the alcohol content of the drink in question and not according to the price. In the case of beer, DM 3.18 (US\$ 1.78) in tax has to be paid per litre of pure alcohol independent of the price charged. The real prices of beer, wine and spirits remained stable during the early 1990s. There are no restrictions on hours or days of sale or on type or location of outlets. There is no state monopoly nor is a licence required for the production or distribution of beer, wine or spirits.

Advertising is governed by the Rules of Conduct of the German Advertising Standards Authority for Advertising of Alcoholic Beverages. General and specific health warnings are not required by law. There is no maximum legal limit for the alcohol content of beverages but labels for alcohol content are required by law.

Control of alcohol problems

There is a minimum legal age limit of 16 for buying beer and wine and an age limit of 18 for buying spirits. The BAC limit is 0.08 g% for drivers. The penalty for driving above the BAC limit depends upon the degree to which the limit is exceeded and on the consequences of the driver's intoxication (e.g. crashes). Random alcohol breath testing is carried out frequently. Regulations exist for professional drivers and for security reasons in workplace.

The Federal Centre for Health Education holds regular meetings on drug prevention with the regional agencies in order to coordinate national and regional prevention activities. The main coordinating body for government action in FDR was the Permanent Working Group on Drug Problems in the Federal Ministry for Youth, Family, Women and Health. This ministry also subsidized a nongovernmental body - the German Central Office against Addiction - whose membership included most of the non-profit organizations. The Federal Centre for Health Education within the Federal Ministry of Health also carries out mass media campaigns.

The German Association against Addiction is an umbrella organization for a number of associations against alcohol dependence and drug addiction. Health Insurance Offices are also involved in the prevention of alcohol problems. Programmes for the control of alcohol abuse were established in various regions of the German Democratic Republic and in large cities, under the responsibility of regional medical officers. An example is the programme adopted in Berlin in 1980, which developed a treatment and rehabilitation network.

Today, there are national alcohol programmes in the mass media and in schools which deal with substance use in general. There are no national alcohol education programmes in workplaces, but some companies organise education programmes themselves. In the FDR, special courses on alcohol problems were available for social workers, and many of those employed in treatment facilities have now undergone such training as "addiction therapists". Clinical psychologists received training on addictions, and alcohol problems figured in specialty training curricula for physicians (as part of psychiatry) and in their continuing education programmes.

Alcohol data collection, research and treatment

There were formerly two large documentation and information systems in FDR: EBIS (Einrichtungs Bezogenes Informations System: Provision of relevant information system), which was concerned mainly with outpatient settings, and DOSY for follow-up studies of inpatients. EBIS was developed in 1980 from the Tobacco Dependence Project Group of the Max Planck Institute of Psychiatry in Munich in collaboration with the EBIS - Working Group with the Financial Assistance of the National Ministry of Health for help concerning addictions. Since 1988 the EBIS-A System has covered about 500 consultant and treatment centres in the whole of Germany and in 1994 the documentation system became entirely computerised. Members of EBIS include representatives of the NGO, Caritas, the German Addiction Department, the Union for Addiction Help of the Evangelical Church and the

Institute for Therapy Research. Annual reports of EBIS are produced by the German Addiction Centre.

SEDOS (a system to collect data on inpatient facilities for substance abusers) was developed in 1992 on the basis of the DOSY + EBIS systems. A SEDOS working group, with assistance from the Ministry of Health brought together various organizations such as the nongovernmental organization, Caritas, the Evangelical Church and the IFT Institute for Therapy Research. Discussions held in 1993 led to the development of a programme in 1994 and a first annual report for that year.

In the FDR, withdrawal and detoxification were carried out mainly through medical wards of general hospitals and sometimes in specialized addiction treatment centres, of which there were more than 220. The stabilization of those under treatment for alcohol dependence took place in addiction treatment centres and in alcohol units of psychiatric hospitals. Psycho-social services were available in almost all cities and counties. Many large firms developed special programmes to help employees with alcohol problems. The German Council on Addictions had 910 outpatient counselling and treatment centres, 183 inpatient treatment facilities with about 7175 places (clinics and therapeutic communities), 209 transitional facilities with 2516 places, and 6550 self-help and temperance groups. These were fairly evenly distributed throughout the country.

Greece

Sociodemographic characteristics

POPULATION	1980	1990	1995
Total	9 643 000	10 238 000	10 451 000
Adult (15+)	7 443 000	8 295 000	8 702 000
% Urban	57.7	62.6	65.2
% Rural	42.3	37.4	34.8

Health status

Life expectancy at birth, 1990-1995 : 75.0 (males), 80.1 (females)

Infant mortality rate in 1990-1995 : 10 per 1000 live births

Socioeconomic situation

GNP per capita (US\$), 1995: 8210, PPP estimates of GNP per capita (current int'l \$), 1995: 11 710

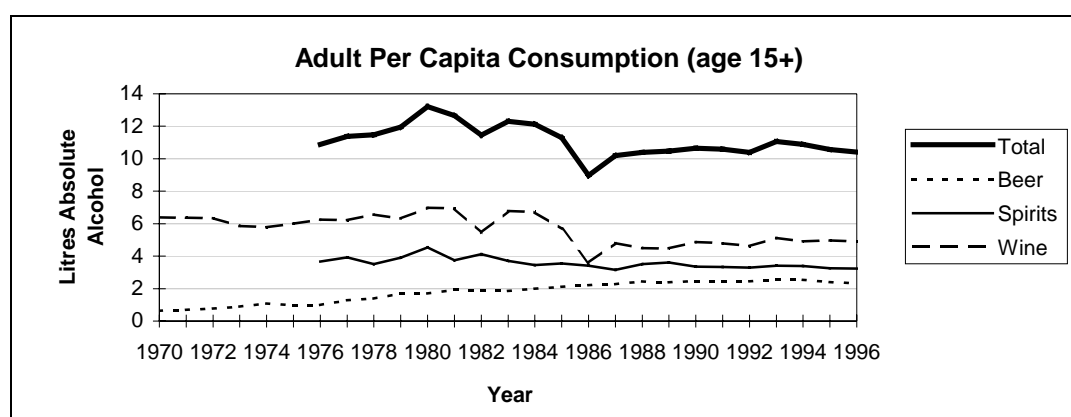
Average distribution of labour force by sector, 1990-1992 : agriculture 23%; industry 27%; services 50%

Adult literacy rate (per cent), 1995 : N/A

Alcohol production, trade and industry

In 1993 the Greek market followed a pattern of domestic volume declines and import gains. Traditionally, Greece has been primarily a wine-drinking country. Imported liquors, a very small portion of the spirits market before Greece joined the European Union in 1987, account for 48 per cent of the spirits market and seven of the country's top ten brands.

Alcohol consumption and prevalence



Consumption

Unrecorded consumption was an estimated 1.8 litres per capita in 1990, bringing total adult per capita consumption for that year to approximately 12.5 litres of absolute alcohol.

Prevalence

A 1984 nationwide general population survey of 4292 persons aged 12 to 64 years showed the prevalence of alcohol use ranged from 91 per cent to 97 per cent among males. The highest male prevalence rate was 97.6 per cent in the 25 to 64 years age group. Systematic drinkers, those who had been drinking more than 10 times in the previous 30 days, comprised 15 per cent and 8.4 per cent of males and females aged 12 to 17 years respectively, 42.2 per cent and 16.8 per cent of men and women aged 18 to 24 years respectively, and 53.7 per cent and 18.5 per cent of males and females between 25 and 64 years of age respectively.

Age patterns

Results of a 1993/1994 study show that 83.1 per cent of boys had tried alcohol by age 15, 8.3 per cent drank alcoholic beverages at least weekly and 46.3 per cent had been drunk at least twice. Of girls, 87.1 per cent had tried alcohol by age 15, 7.5 per cent drank alcoholic beverage at least weekly and 46.4 per cent had been drunk at least twice.

Economic impact of alcohol

A 1984 survey estimated that about 1.6 per cent of household monthly expenditure was for alcohol consumption, the percentage being higher in rural areas where much more drinking takes place outside the home in comparison to in urban areas.

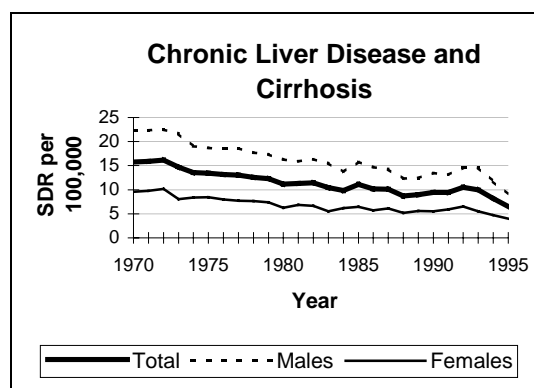
Mortality, morbidity, health and social problems from alcohol use

Alcohol dependence and related disorders

The SDR per 100 000 population for alcoholic psychosis decreased from 20.1 to 13.3 between 1980 and 1991.

Mortality

The SDR per 100 000 population for chronic liver disease decreased from 10.6 to 8.2 between 1980 and 1993.



Morbidity

In 1981, there were 10.7 cases of treated alcohol-related disability per 100 000 population. A 1984 nationwide survey found untreated severe alcohol-related problems among 12.9 per cent of men aged 18 to 64 years and 2.1 per cent of women. A similar study conducted three years later, however, found 2.7 per cent and 0.4 per cent, respectively.

Social problems

A 1984 nationwide general population alcohol survey of 4292 persons aged 12 to 64 years showed that 14 per cent of those between 18 and 24 had experienced two or more alcohol-related psycho-social problems. Twice as many males as females in the 12 to 17 year age group had experienced two or more such problems (10.7 per cent and 5.1 per cent, respectively). Among 18 to 24 year olds, the difference increased to nearly four times as many males as females (24.5 per cent and 6.2 per cent, respectively), while among 25 to 64 year olds, nearly six times as many males as females had experienced two or more alcohol-related psycho-social problems.

Alcohol policies

Control of alcohol products

Table wines are taxed at a rate of 30 per cent, beer (four to six per cent pure alcohol) is taxed 15 per cent and spirits (over 35 per cent proof) are taxed 54 per cent and four per cent of the value as stamp duty. The real prices of all types of alcoholic beverage have been increasing during the early 1990s.

There are no restrictions on hours or days of sale or on type or location of outlets. There is no state monopoly and no licence is required for production or distribution of alcohol.

There are no restrictions on advertising in the media. Labels for alcohol content are required by law. The maximum legal limit for the alcohol content of beer is five to seven per cent. The maximum legal limit for wine is 11.5 to 12 per cent, and the limit for spirits is 40 to 42 per cent.

Control of alcohol problems

There is a minimum legal age limit of 18 years for buying alcoholic beverages in public drinking places such as bars and discos. There is no statutory public age for drinking. The BAC limit is 0.08 g% for drivers. On conviction for a second offence of driving above the permitted BAC, it is usual for a person's driving licence to be suspended. Random alcohol breath testing is carried out infrequently.

Some developments in policy were introduced in the early 1990s as a result of an increasing number of surveys on drugs which usually included alcohol, as well as increased awareness of drug problems which also often involve alcohol. There is no national agency devoted specifically to prevention of alcohol problems, but it is included in the work of the Organization Against Drugs. This organization is responsible for the formulation of policies on prevention, treatment, rehabilitation and research on alcohol, drugs and tobacco. Scientists and representatives of seven ministries are members of this organization.

In the early 1990s, the priorities of the Organization Against Drugs had been to encourage lighter drinking in work settings; develop specialized treatment for alcohol dependence and other alcohol problems and address particular alcohol problems such as drinking and driving. There is a movement towards having a joint approach to issues related to alcohol, drugs and tobacco.

Alcohol data collection, research and treatment

Since 1980, nine Therapeutic Community settings and three specialized outpatient clinics for dependencies (including alcohol) have been established, mainly in Athens and Thessaloniki, and 45 outpatient clinics have been operating in general hospitals.

Hungary

Sociodemographic characteristics

POPULATION	1980	1990	1995
Total	10 707 000	10 365 000	10 115 000
Adult (15+)	8 358 000	8 268 000	8 281 000
% Urban	56.9	62.0	64.7
% Rural	43.1	38.0	35.3

Health status

Life expectancy at birth, 1990-1995 : 64.5 (males), 73.8 (females)

Infant mortality rate in 1990-1995 : 15 per 1000 live births

Socioeconomic situation

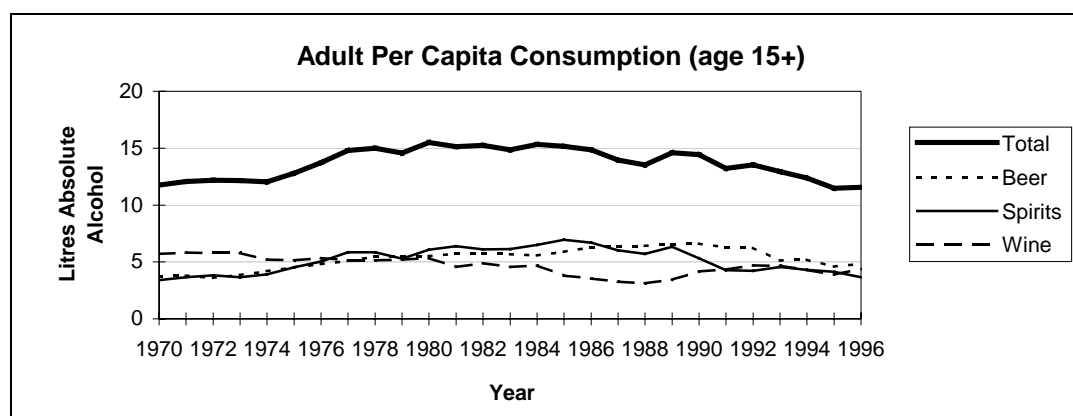
GNP per capita (US\$), 1995: 4120, PPP estimates of GNP per capita (current int'l \$), 1995: 6410.

Average distribution of labour force by sector, 1990-1992 : agriculture 15%; industry 31%; services 54%

Alcohol production, trade and industry

Hungary produces beer, distilled spirits and wine. Zwack Unicum, producer of a unique Hungarian distilled beverage, has a 54 per cent share of Hungary's legal spirits market.

By acquiring two local brewers, Kobanya and Kanizsa, and combining them into one company, called Dreher Sorgyarak. South African Breweries became the country's largest brewer, controlling 38 per cent of the Hungarian market. In 1994, the International Finance Corporation announced plans to loan US\$ 6.8 million to Hungarian brewer Albadomu Malatermelo Es Kereskedelmi BT to build a malt production factory and to buy a silo complex. In 1996, Hungary's Borsod Brewery, owned by Belgium-based Interbrew, became the first brewery to brew an American beer (Rolling Rock).

Alcohol consumption and prevalence**Consumption**

Beer has narrowly surpassed spirits to become Hungary's alcoholic beverage of choice in recorded consumption. Widespread illegal home brewing throughout the 1970s and 1980s led to increased

control and punishment in the mid-1980s. During the late 1990s, political changes and border openings have been followed by a decline in home brewing and a sharp increase in spirit smuggling from Romania and Serbia. In 1980, the estimated unrecorded consumption, in terms of litres of pure alcohol per capita (total population), was 1.5. This figure dropped to 1 in 1985 and then rose to 2.5 by 1995.

Prevalence

The first national survey of drinking among a representative sample of 6000 adults took place in 1985-1986. The survey found that over the preceding six months, 6.6 per cent of men never drank, 12.2 per cent drank occasionally, 19.8 per cent drank moderately, 18.8 per cent drank regularly, 10.6 per cent were problem drinkers and 14.1 per cent were heavy drinkers. Of women, 21.4 per cent never drank, 35.7 per cent drank occasionally, 14.1 per cent were moderate drinkers, 3.5 per cent were regular drinkers, 1.6 per cent were problem drinkers and 0.8 per cent were heavy drinkers (no definition provided).

Age patterns

A study of 2571 15 to 16 year olds (1199 boys and 1372 girls) was carried out in 1995. The response rate was 89 per cent (88 per cent for boys and 89 per cent for girls). Eighty per cent of the respondents had drunk an alcoholic beverage in the last 12 months, and 40 per cent had drunk to intoxication in the last 12 months.

A 1993/1994 sample of 15 year olds showed that 93.3 per cent of boys and 93.6 per cent of girls had tried alcoholic beverages, 22.8 per cent of boys and 13.4 per cent of girls drank at least once a week, and 35.5 per cent of boys and 19.7 per cent of girls had been drunk at least twice. Based on a sample of 17 055 secondary school students, most of whom were age 16, a 1995 survey concluded that 21.4 per cent of boys and 7.4 per cent of girls had had five or more drinks on three or more occasions during the past 30 days. Approximately 44.3 per cent of boys and 54.5 per cent of girls had had no alcoholic drinks during the past 30 days.

Alcohol use among population subgroups

A study was conducted in 1995 among 615 Palocs, an ethnic minority in Hungary. Data were collected through interviews and questionnaires. About 9.1 per cent of males and 30.8 per cent of females were abstinent at the time of the study. Four to five times more females than males were light drinkers (one or two times per week). More than 90 per cent of the Paloc males drank daily. Females tended to drink brandy while males drank more beer. The total alcohol consumption of males was 2.8 times higher than that of females, and 53 per cent of males were heavy drinkers (no definition).

Economic impact of alcohol

In 1984, approximately 11.3 per cent of the population's income was spent on alcoholic beverages, compared with 10.8 per cent in 1970.

The mean value of economic losses due to alcohol dependence grew approximately tenfold, from US\$ 15 million in 1970 to US\$ 151 million in 1989. It is estimated that about US\$ 35.4 million was spent in 1989 on alcoholic-handicap allowance.

Mortality, morbidity, health and social problems from alcohol use

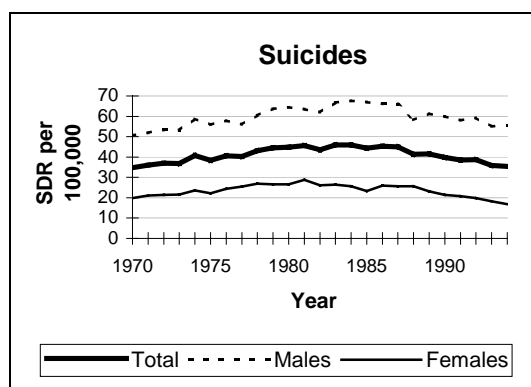
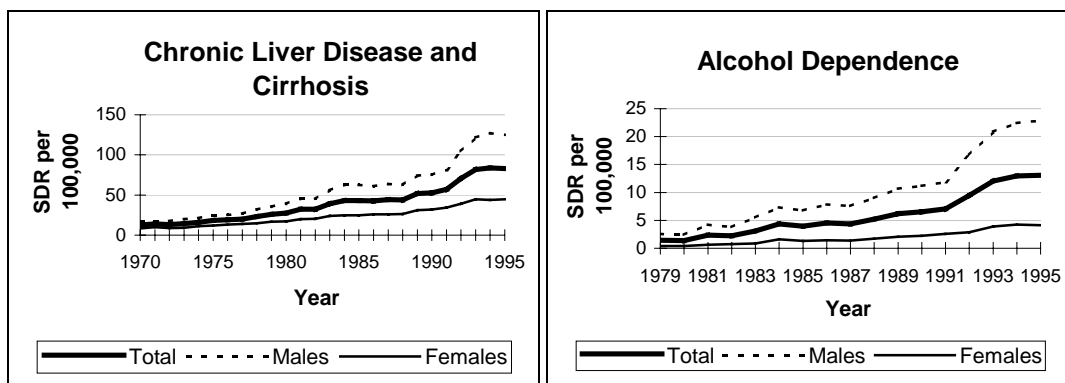
Alcohol dependence and related disorders

Death rates per 100 000 population for alcohol dependence have risen very rapidly during the 1990s, to the point where Hungary now reports the world's second highest death rate from alcohol dependence. Death rates per 100 000 population for alcoholic psychosis rose from 0.2 to 0.5 between 1980 and 1993, while the number of registered patients per 100 000 population with alcoholic psychosis in psychiatric dispensaries increased from 1089 in 1970 to 2610 in 1994.

Mortality

The mortality rate per 100 000 population of alcohol-related causes of death rose from 14.5 to 67.2 between 1980 and 1993. The SDR per 100 000 population for chronic liver disease rose from 27.4 to 78.9 during the same period. Liver cirrhosis rates have doubled over the past ten years, to become the

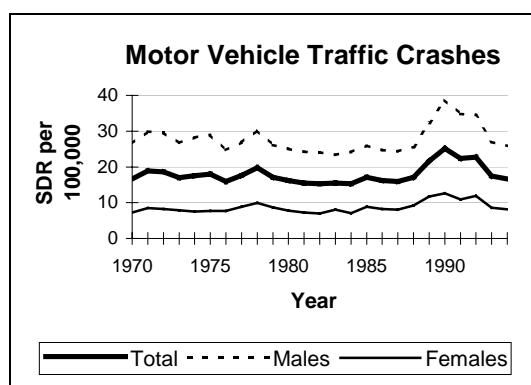
most common cause of death for men aged 15 to 64. This increase is due primarily to alcoholic cirrhosis.



Trends in per capita consumption and the overall suicide rate in Hungary during the period 1950 to 1990 are very highly correlated. From about 1955 to 1980 there was a steady and almost linear growth in both variables, both increasing almost threefold. During the first half of the 1980s both alcohol consumption and suicide rates stabilized, and during the second half of the 1980s there was a slight recession, the decrease being most significant for suicide.

Social problems

The number of people fined for "scandalous drunkenness" fell from 21 475 in 1965 to 19 299 in 1975, to 17 251 in 1985 and down to 6971 in 1994. The number of persons fined for drunken driving remained fairly constant between 1965 and 1975, falling from 7999 to 7708, then rising to 12 187 in 1985, and falling again to 8385 in 1994.



Alcohol policies

Control of alcohol products

The anti-alcohol policy of the mid-1980s in the former Soviet Union influenced policy in satellite states such as Hungary. The government introduced several measures to limit alcohol consumption in public places and to limit availability of alcoholic beverages generally. A committee on alcohol dependence was upgraded as a State Committee and granted significantly more operational funds. Since the political changes of 1989, the limitations and restrictions have been gradually abolished and the committee and the regional network of anti-alcohol organizations have been re-arranged as structures and local units of health promotion. In the meantime the national sales monopoly on alcohol has ceased to be an active force, partly because private and local sales units can operate without control and partly because large amounts of alcohol are reportedly being smuggled into the country.

Control of alcohol problems

Measures to limit consumption in streets and public places were introduced in the mid-1980s but are no longer enforced. The BAC limit is 0.0 g%. A few schools include consideration of alcohol in school health promotion programmes. There have been one or two experimental programmes in workplaces.

Alcohol data collection, research and treatment

The Sober Life Association and the Central Statistical Office, as well as the Institute of Sociology in Budapest, have done much to compile data on trends and consequences of alcohol consumption in Hungary. In addition, the Central Statistical Office has carried out mortality studies concerning alcohol dependence and investigated various indices of alcohol problems on a statistical level and within the comprehensive framework of health status and mortality, as well as performing economic investigations and making computer simulations of programmes designed to reduce the availability of alcohol. Individual health professionals have made great efforts to develop research and information services and most of the materials of the European Alcohol Action Plan have been translated into Hungarian.

There were about 50 000 people under outpatient care for alcohol problems in 1982. In 1995, nearly 18 000 alcohol dependents were under care in Budapest outpatient services. By 1985, there were independent alcohol departments in 17 of the 19 counties in Hungary within departments of psychiatry. There were closed and open facilities, and treatment included biological, social and psychological care. There were some departments for work therapy rehabilitation, with 2000 beds. The 106 outpatient dispensaries for alcohol dependents collaborated with the alcohol departments and with the anti-alcoholic clubs, which were started in the late 1950s. By 1980, there were 20 such clubs and 100 in 1988.

After 1989, the compulsory treatment system began to disintegrate, the special work therapy institute was closed down, and a new mental health law was drafted to end compulsory alcohol withdrawal treatment. Only about ten per cent of the country's chronic drinkers are currently registered in state-run rehabilitation centres according to the Central Statistics Office. Treatment and care are carried out mainly in outpatient services.

The Sober Life Association and Blue Cross are both involved in aid to alcohol dependent persons within the community. In 1985, the National Club Committee and the first Alcoholics Anonymous club for young people were started. Alcoholics Anonymous currently has more than 150 clubs.

Iceland

Sociodemographic characteristics

POPULATION	1980	1990	1995
Total	228 000	255 000	269 000
Adult (15+)	165 000	191 000	204 000
% Urban	88.2	90.6	91.6
% Rural	11.8	9.4	8.4

Health status

Life expectancy at birth, 1990-1995 : 75.8 (males), 80.8 (females)

Infant mortality rate in 1990-1995 : 5 per 1000 live births

Socioeconomic situation

GNP per capita (US\$), 1995: 24 950, PPP estimates of GNP per capita (current int'l \$), 1995: 20 460

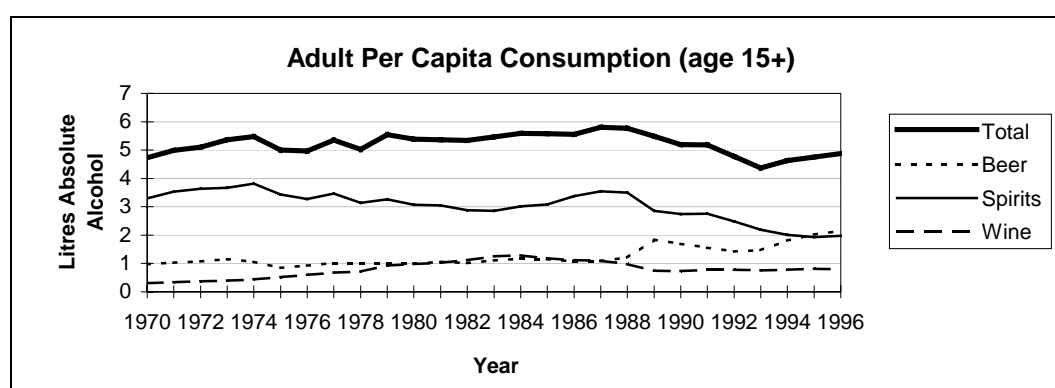
Average distribution of labour force by sector, 1990-1992 : agriculture 11%; industry 26%; services 63

Adult literacy rate (per cent), 1995 : N/A

Alcohol production, trade and industry

Iceland produces beer and spirits, and imports wine.

Alcohol consumption and prevalence



Consumption

Estimated unrecorded consumption is about 1.05 litres of pure alcohol per capita if beverages with a lower alcohol content than 2.25 per cent are included: excluding these gives an unrecorded consumption of 0.67 litres (estimates of tax free alcohol sales, home production and smuggled alcoholic beverages). This would imply that total consumption of alcohol above 2.25 per cent was 5.55 litres per adult in 1996. Beer consumption has risen notably since the repeal of the prohibition on sale of strong beer in 1989. A concomitant decrease in recorded spirits consumption is discernible.

Prevalence

A 1992 mail survey of a random sample of 1000 Icelanders found that 8.1 per cent of men and 1.6 per cent of women drank five or more litres of pure alcohol during the previous six months. A survey of a representative sample of the population aged 20 to 49 in 1984 found that approximately 30-50 per cent drank less than once a month or two to four times per month, and 3.3 per cent drank more than four times per month. On average, males used 8.7 units per occasion, while females drank 4.5 units.

Age patterns

A study of 3814 15 to 16 year olds (1931 boys and 1878 girls) was carried out in 1995. The response rate was 87 per cent (86 per cent for boys and 88 per cent for girls). Seventy-two per cent of the respondents had drunk an alcoholic beverage in the last 12 months, and 60 per cent had drunk to intoxication in the last 12 months. Lifetime prevalence of alcohol use was 79 per cent (78 per cent for boys and 80 per cent for girls).

Questionnaires were sent to random samples of school pupils aged 15-16, 17-18, and 19-20 in 1984 and 1986 (nearly 2000 responses each time). Alcoholic beverages were used by 85 per cent and 87 per cent of students in the respective years. Each time about 90 per cent of the drinkers said they had often been intoxicated and a majority had experienced a loss of consciousness in connection with drinking.

Economic impact of alcohol

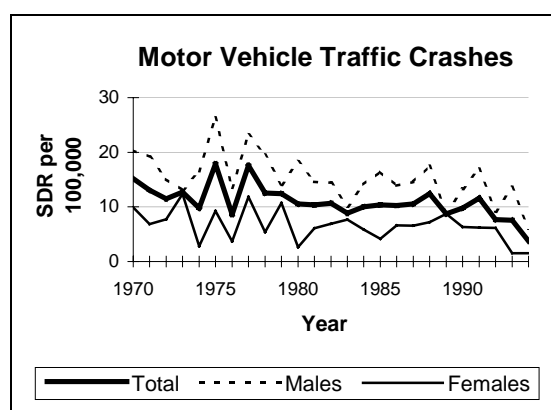
In 1993, 3.1 per cent of private consumer expenditure went towards alcoholic beverages. In 1986 the mental hospital spent US\$ 2.1 million on the treatment of alcohol dependents and their families. Other centres spent US\$ 3.4 million.

Mortality, morbidity, health and social problems from alcohol use**Alcohol dependence and related disorders**

The rate of admission to inpatient treatment for alcoholic psychosis was 8.8 in 1989. There has been an increase in persons seeking inpatient treatment of alcohol dependence since 1980, while utilization of outpatient treatment has been relatively stable.

Social Problems

The rate per 100 000 population (15 years and older) of cautions and arrests for driving under the influence of alcohol steadily decreased between 1990 and 1994, from 12.8 to 9.7. The number of road traffic accidents involving alcohol per 100 000 population was 20.3 in 1992, less than half the 43.5 recorded in 1985.

**Alcohol policies****Control of alcohol products**

The real price of beer has been decreasing and the real prices of wine and spirits have been increasing during the past five years. A resolution of the Icelandic Parliament in 1991 stated that the price of alcoholic beverages should be gradually increased over the next five years in excess of general price increases and that the price of strong liquor should be increased to a greater extent than the price of wine and beer. Table wines are taxed 45 per cent, beer (four to six per cent alcohol) is taxed 70 per cent, and spirits (over 35 per cent proof) are taxed 90 per cent.

Prohibition, with the general consent of the population, came into effect in Iceland in 1915, but was repealed in the 1930s. A government monopoly over production and distribution of alcoholic beverages was established in the 1920s. Today, there are restrictions on hours and days of sale and on

types and location of outlets. The number of outlets run by the monopoly doubled between 1979 and 1992 (growing from nine to 21) and the number of licensed restaurants increased sevenfold during the same period (from 34 to 253). Prior to March 1989, the sale of strong beer (over 2.25 per cent by volume) was illegal.

The advertising of beer, wine and spirits on television, radio, newspapers/magazines, billboards and in cinemas is banned. Labels for alcohol content or health warnings are not required by law, and there is no maximum legal limit for the alcohol content of beverages.

Control of alcohol problems

There is a minimum legal age limit of 20 years for buying alcoholic beverages. Intoxication in public places is illegal under the Alcohol Act. The BAC limit is 0.05 g% for drivers. It is usual to suspend a person's driving licence upon conviction for a first offence of driving above the limit. Random alcohol breath testing is not carried out. The Liquor Prevention Council distributes educational programmes, and there are school-based programmes that deal with alcohol and other substances. Some mass media programmes deal with alcohol only while others also deal with other substances.

Alcohol data collection, research and treatment

The Committee on Alcohol Problems (CAP), comprising 17 members, was appointed by the government following a 1980 resolution demanding an official policy on alcohol-related matters. The Alcohol Committee's proposals have included a draft law aimed at reducing alcohol consumption and more general preventive measures under the control of a coordinating alcohol prevention board, with alcohol prevention committees in towns and cooperative committees in communities. Priorities of the early 1990s have been mass media campaigns to encourage safer drinking; using price policy to reduce demand; developing specialized treatment for alcohol dependence and other alcohol problems; and addressing particular alcohol problems. There is a movement towards having a joint approach to issues related to alcohol, drugs and tobacco.

The Department of Psychiatry at the National University Hospital, and the Icelandic Institute for Educational Research have the primary responsibility for research on alcohol issues. Professional training in alcohol problems prevention and treatment is undertaken at all levels, at home and abroad, but heads of programmes are legally required to have diplomas from valid schools.

In the mid 1980s there was a considerable emphasis on the treatment of alcohol dependents through hospitals and agencies: there were 400 beds, i.e. one bed per 500 population. Outpatient facilities were also available as well as treatment through Alcoholics Anonymous and similar groups. An interest has been shown in developing earlier diagnosis and treatment of alcohol problems at the primary health care level. The National Psychiatric Hospital and the Laymen's Council on Alcoholism have detoxification and rehabilitation facilities, and the former has a long-term treatment farm. For chronic alcohol dependents, there are shelters, half-way houses and a resident institution. "Blue Ribbon" has a combined rehabilitation house and a home for senior citizens. Alcoholics Anonymous runs about 200 groups and Al-anon 30 groups. There are services for the counselling and treatment of relatives of people with alcohol problems.

Ireland

Sociodemographic characteristics

POPULATION	1980	1990	1995
Total	3 401 000	3 503 000	3 553 000
Adult (15+)	2 360 000	2 546 000	2 684 000
% Urban	55.3	56.9	57.5
% Rural	44.7	43.1	42.5

Health status

Life expectancy at birth, 1990-1995 : 72.6 (males), 78.1 (females)

Infant mortality rate in 1990-1995 : 7 per 1000 live births

Socioeconomic situation

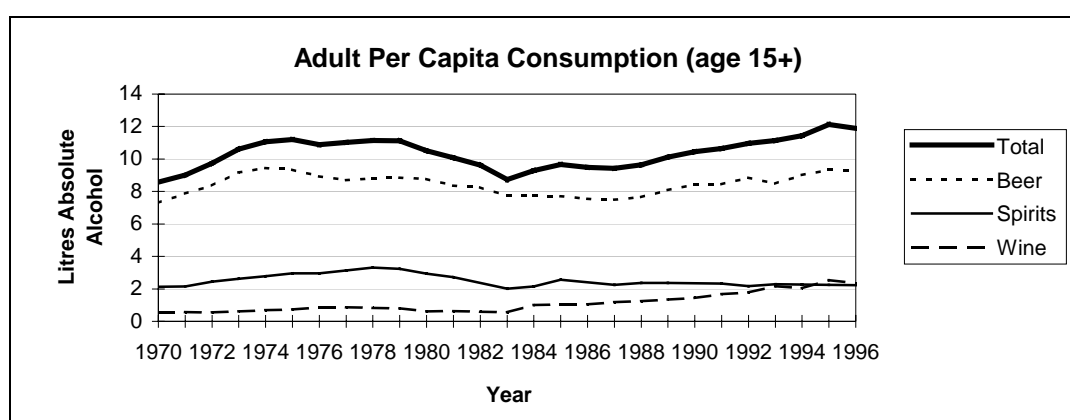
GNP per capita (US\$), 1995: 14 710, PPP estimates of GNP per capita (current int'l \$), 1995: 15 680
Average distribution of labour force by sector, 1990-1992 : agriculture 14%; industry 29%; services 57%

Adult literacy rate (per cent), 1995 : more than 95

Alcohol production, trade and industry

Ireland produces beer and spirits, and imports wine. The major brewer, Guinness, is the world's 14th largest and also dominates the spirits trade through its subsidiary, United Distillers. Guinness recently announced plans to merge with Grand Metropolitan to form the world's largest drinks conglomerate, Diageo.

Alcohol consumption and prevalence



Consumption

Little is known about the extent of illegal production. Beer is the alcoholic beverage of choice, and total consumption tends to follow trends in beer consumption. The wine category above includes cider and perry (fermented beverages popular in Ireland and made from apples and pears respectively) from 1984 onwards.

Prevalence

A 1990 survey of people aged 15 years and over found that five per cent of the sample drank alcohol at least three to four days per week, 40 per cent were moderate consumers and 54 per cent drank less than weekly or not at all. No detailed national survey of the drinking habits of adults has been carried out since 1980. At that time 11 per cent of males were classified as heavy drinkers (drinking more than 50 units of alcohol a week), while one per cent of females were classified as heavy drinkers (drinking more than 35 units of alcohol a week).

Age patterns

A study of 1849 15 to 16 year olds (907 boys and 942 girls) was carried out in 1995. The response rate was 96 per cent. Eighty-six per cent of the respondents had drunk an alcoholic beverage in the last 12 months, and 66 per cent had drunk to intoxication in the last 12 months. Lifetime prevalence of alcohol use was 91 per cent for both boys and girls.

A 1990 survey showed that zero per cent of boys aged 11 to 12 years drank alcohol weekly, compared with one per cent of girls. In the 13 to 15 year age bracket, the percentage of girls drinking weekly remained at one per cent, while the percentage of boys rose to two per cent. Surveys of comparable samples of 2000 post-primary students in Dublin in 1984 and 1991 indicate that, among boys, the percentage who have ever drunk alcoholic beverages rose from 74 per cent to 83 per cent, while girls remained stable at 57 per cent. In 1991 the percentage of boys who were regular drinkers by the age

of 15 was 36, compared with 22 per cent of girls. By age 17, 63 per cent of boys and 40 per cent of girls were regular drinkers.

Economic impact of alcohol

Personal expenditure on alcohol amounted to IR£ 2.08 billion (US\$ 2 900 000 000) in 1993 and IR£ 2.34 billion (US\$ 3 300 000 000) in 1994. Excise duty on alcohol is still a substantial source of revenue, though in real terms it has declined somewhat since the early 1980s. It totalled more than IR£ 495.5 million (US\$ 699.75 million) in 1994.

About 33 000 full time and about 48 000 part time jobs are attributable to the entire alcohol industry and drinks trade.

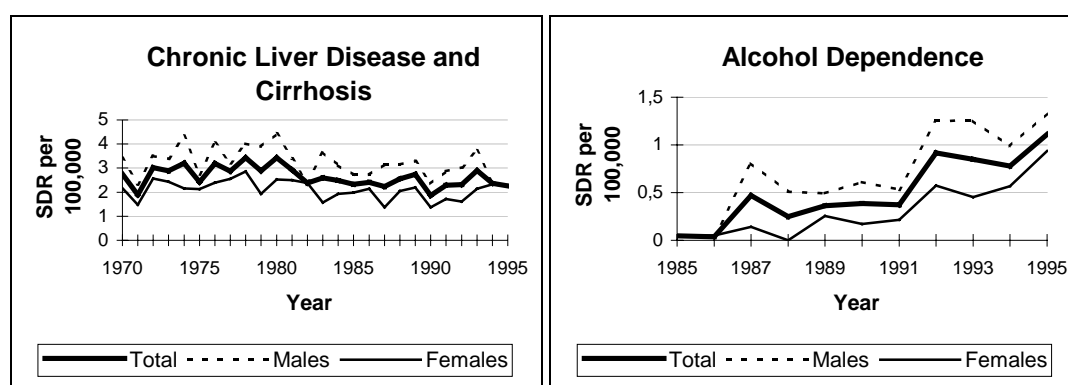
Mortality, morbidity, health and social problems from alcohol use

Alcohol dependence and related disorders

In 1993 the rate of admission to inpatient treatment per 100 000 population for alcoholic psychosis was 12.9, fairly similar to the 1990 and 1992 rates, but a decrease from the rate of about 17 recorded in 1980, 1985 and 1991. However, these figures do not cover some private treatment centres. Death rates per 100 000 population from alcohol dependence have risen in recent years for both men and women.

Mortality

The SDR per 100 000 population of chronic liver disease went from 4.7 to 3.1 between 1980 and 1992.



Alcohol policies

Control of alcohol products

About half the price of beer and spirits is taxation, mostly an excise tax that is adjusted in the annual budget to keep par with inflation. The real price of all three types of alcohol, i.e. beer, spirits and wine has remained stable during the past five years. Table wine is taxed 48.1 per cent per bottle; beer (four to six per cent alcohol) is taxed 37.9 per cent per pint; spirits (over 35 per cent proof) are taxed 38.7 per cent per glass, 66 per cent per bottle of whiskey and 65 per cent per bottle of other spirits.

There are restrictions on hours and days of sale and on type and location of outlets. There is no state monopoly but a licence is required for the production and distribution of all types of alcohol (except home-made wine and beer).

Restrictions on advertising are currently implemented by means of a voluntary code operated by the alcohol and advertising industries. All media are covered by the code. General or specific health warnings are not required by law, nor are labels for alcohol content. There is no maximum legal limit for the alcohol content of beverages.

Control of alcohol problems

There is a minimum legal age limit of 18 years for buying alcohol. Drunkenness is prohibited in public places. The BAC limit is 0.08 g% for drivers. It is usual to suspend a person's driving licence upon conviction for a first offence of exceeding the permitted limit. Subsequent offences are

frequently dealt with in the same way but imprisonment is also an option at the discretion of the judge. Random alcohol breath testing is not carried out.

A national policy is under preparation in the late 1990s which will include historical, cultural, economic and legal factors relevant to availability and consumption of alcohol, and matters such as prevention, education, advertising, diagnosis and treatment strategies and particularly the issues of youth and alcohol and the role of parents and family. Priorities over the early 1990s have included encouraging lighter drinking; the issue of drinking and driving; alcohol and young people, and developing the role of the criminal justice system in the prevention and management of drinking problems.

There is no specific national coordinating mechanism for investigating, preventing and dealing with alcohol problems, but the Irish National Council on Alcoholism (INCA), a voluntary organization, is supported by eight health boards with the approval of the Department of Health. All undergraduate medical, psychological and social work training includes courses in mental health and alcohol dependence. Psychiatric training includes courses on alcohol problems, as does postgraduate social work training. The INCA provides courses for various groups and has been undertaking a concentrated programme in industry.

Work on the prevention of alcohol-related problems is also included in the mandate of the National Health Promotion Unit in the Ministry of Health. The Health Promotion Unit is involved in developing educational materials on the subject of alcohol for specific target audiences and for the general public. These include a national school-based programme which also addresses tobacco and other drugs, and an out-of-school programme for young people. The Health Promotion Unit is involved in training programmes and addresses a variety of educational settings where alcohol is the subject of discussion. In addition, it seeks to influence policy which will facilitate the responsible use of alcohol in society.

At the regional level, Health Education Officers within eight regional health boards provide life skills programmes which include modules on the use and misuse of alcohol. Addiction counsellors, in addition to their work in counselling services, provide advice and information to a wide range of community groups and schools via seminars, public lectures, and the like.

Alcohol data collection, research and treatment

The Medico-Social Research Board, inaugurated in 1969, has carried out some epidemiological research into alcohol consumption and alcohol problems. Some reliable basic information on alcohol consumption covering the past 200 years is available from the excise data. Regular market surveys are carried out by the major brewers and distillers, but they are not made available for scientific purposes. Hospital admission data on alcohol dependence are augmented by psychiatric case register data in some areas of the country. The National Psychiatric Reporting System reports on summary diagnostic groupings, including "Alcohol Disorders"

For a long time, treatment focused on inpatient medical services. More recently, however, efforts have been made to provide counselling and treatment at an earlier stage through general practitioners working closely with psychiatrists. Many alcohol dependents are admitted to private psychiatric hospitals, and some public mental hospitals have specialized alcohol units. Some of the health boards have alcohol counsellors to deal with the family and personal problems caused by heavy drinking. Counselling of families of alcohol dependent people is available from both statutory and non-statutory agencies who provide treatment services.

Israel

Sociodemographic characteristics

POPULATION	1980	1990	1995
Total	3 879 000	4 660 000	5 629 000
Adult (15+)	2 592 000	3 201 000	3 991 000
% Urban	88.6	90.3	90.6
% Rural	11.4	9.7	9.4

Health status

Life expectancy at birth, 1990-1995 : 74.6 (males), 78.4 (females)

Infant mortality rate in 1990-1995 : 9 per 1000 live births

Socioeconomic situation

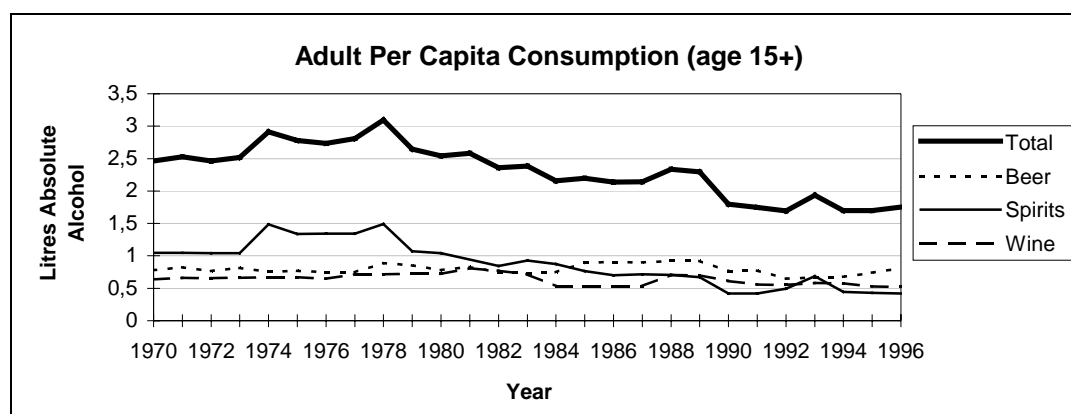
GNP per capita (US\$), 1995: 15 920, PPP estimates of GNP per capita (current int'l \$), 1995: 16 490
Average distribution of labour force by sector, 1990-1992 : agriculture 4%; industry 22%; services 74%

Adult literacy rate (per cent), 1995 : N/A

Alcohol production, trade and industry

Israel produces beer, distilled spirits and wine. Carlsberg AS now owns 20 per cent of Tel-Aviv-based Israel Breweries Ltd., built in cooperation with Central Bottling Co. Wente Brothers has formed a joint venture with Israel's Segal Winery to produce kosher wines.

Alcohol consumption and prevalence



Consumption

Recorded spirits consumption has fallen off since its peak in 1978. Beer consumption has remained steady over the past 25 years. There is no quantified information available on unrecorded consumption.

Prevalence

In both 1982 and 1992, surveys of a representative sample of over 1000 people aged 20 years and over showed that two per cent drank heavily. Heavy drinking was defined in this instance as drinking every day during the previous year.

Age patterns

A cohort of 1276 male and female undergraduate students was surveyed at a major university. Among the study participants, 21 per cent reported regular, weekly use of alcohol. Men were much more

inclined to drink on a weekly basis than women, and seven per cent of the students who used alcohol regularly did so on a daily basis.

Results of a WHO study of schoolchildren in 1993-1994 indicate that 68.2 per cent of boys had tried alcoholic beverages, 22.8 per cent drank alcoholic beverages at least weekly and 8.1 per cent had been drunk at least twice. Of girls, 52.6 per cent had tried alcoholic beverages, 10.4 per cent drank alcoholic beverages at least weekly and 5.6 per cent had been drunk at least twice.

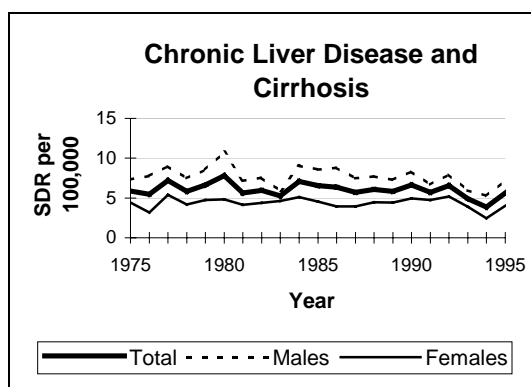
Mortality, morbidity, health and social problems from alcohol use

Alcohol dependence and related disorders

The admission rate per 100 000 population for inpatient treatment for alcoholic psychosis remained nearly constant from 1988 to 1993, dropping slightly from 1.4 to 1.3.

Mortality

The SDR per 100 000 population of chronic liver disease fell from 11 to 8.3 between 1980 and 1992.



Alcohol policies

Control of alcohol products

The real prices of beer and wine have been decreasing, and the real price of spirits has been stable during the past five years. There are no restrictions on times or days of sale nor on type or location of outlets. There is no state monopoly and no licence is required for production or distribution of alcohol. General and specific health warnings are not required by law, and there is no maximum legal limit for the alcohol content of beverages. There are no restrictions on alcohol advertising. Labels of alcohol content are required by law.

Control of alcohol problems

There is a minimum legal age limit of 18 years for buying alcohol. The BAC limit is 0.05 g% for drivers. Random alcohol breath testing is not carried out.

Priorities of the early 1990s have been: working in the school system to encourage lighter drinking; developing the role of the social welfare system in the prevention and management of alcohol problems; developing specialized treatment for alcohol dependence and other alcohol problems and addressing particular alcohol problems such as drinking and driving. The Israel Society for the Prevention of Alcoholism (ISPA) offers interdisciplinary educational prevention programmes for schools and provides training services to teachers, parents and students. ISPA also provides training services to professionals.

Alcohol data collection, research and treatment

The Israel Society for the Prevention of Alcoholism is a research institute specializing in alcohol issues. They also distribute prevention materials such as pamphlets, posters and stickers, operate a 24 hour hot-line, offer consultation in legal and legislative matters, offer advice to parliament and police, and initiate and support research in the preventive domain. In 1994 there were one inpatient and 11 outpatient treatment centres.

Italy

Sociodemographic characteristics

POPULATION	1980	1990	1995
Total	56 434 000	57 023 000	57 187 000
Adult (15+)	43 865 000	47 496 000	48 563 000
% Urban	66.6	66.7	66.6
% Rural	33.4	33.3	33.4

Health status

Life expectancy at birth, 1990-1995 : 74.2 (males), 80.6 (females)

Infant mortality rate in 1990-1995 : 8 per 1000 live births

Socioeconomic situation

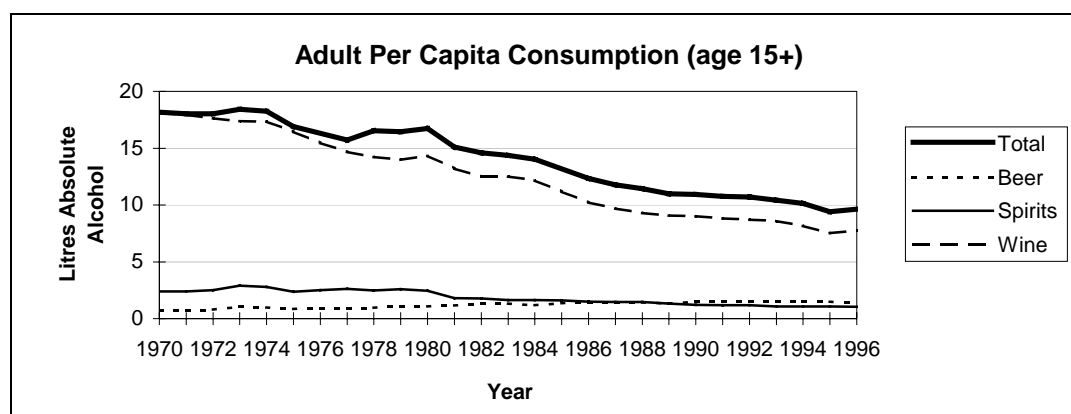
GNP per capita (US\$), 1995: 19 020, PPP estimates of GNP per capita (current int'l \$), 1995: 19 870
Average distribution of labour force by sector, 1990-1992 : agriculture 9%; industry 32%; services 59%

Adult literacy rate (per cent), 1995 : more than 95

Alcohol production, trade and industry

Heineken Italia's 1996 acquisition of Birra Moretti, currently Italy's third largest brewery, will make Heineken Italy's largest brewer with a market share of 38 per cent. The Italian spirits market continued its long-term contraction in 1993, with total volume down 2.9 per cent to 19.3 million cases. In 1980, annual volume stood at nearly 29 million cases.

Alcohol consumption and prevalence



Consumption

There is no quantified information available on unrecorded consumption. However, home production of wine and other alcohol plays an important role in the alcohol market. Total adult per capita consumption in Italy has fallen in the last 25 years along with the decrease in wine consumption. Spirits consumption has decreased more gradually, while consumption of beer has risen slightly.

Prevalence

A 1990 survey among adults aged 15 years and over found that 53 per cent were frequent consumers (drank alcohol at least three or four days a week), 16 per cent were moderate (weekly) consumers and 31 per cent were infrequent consumers (drank alcohol less than weekly or never). A similar survey in 1988 indicated an increase in the frequent consumption of wine and beer among Italian women between 1988 (28 per cent) and 1990 (40 per cent). However, the 1988 question specified "wine not mixed with water" while the 1990 question related just to wine.

Age patterns

A study of 1555 15 to 16 year olds (943 boys and 582 girls) was carried out in 1995. The response rate was 95 per cent (92 per cent for boys and 94 per cent for girls). Eighty-three per cent of the respondents had drunk an alcoholic beverage in the last 12 months, and 35 per cent had drunk to intoxication in the last 12 months. Lifetime prevalence of alcohol use was 89 per cent (89 per cent for boys and 86 per cent for girls).

Data from a 1990 survey showed that at age 11 to 12 years, 34 per cent of boys and 18 per cent of girls drank alcohol weekly. At age 13 to 15 years, 39 per cent of boys and 21 per cent of girls drank alcohol weekly.

Economic impact of alcohol

Annual household expenditure devoted to alcoholic beverages, as a percentage of total expenditure, went from 1.6 to 1 between 1980 and 1994.

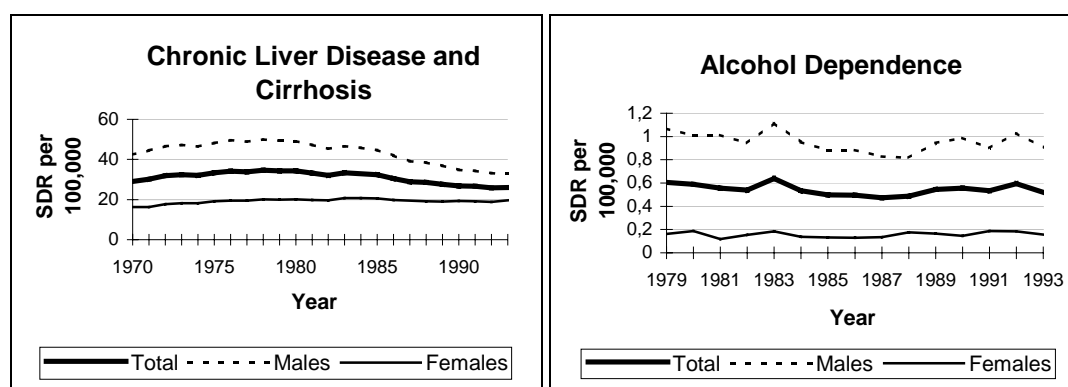
In 1994 primary direct costs concerning treatment of alcohol dependents (including: hospital care, rehabilitation, reinsertion, other health costs and disability payments) amounted to 2 609 822 million lire (US\$ 1490 million); primary indirect costs (including morbidity of alcohol dependents, including lack of work following incidents or illness, loss of work through permanent invalidity, death of alcohol dependents and loss of production) amounted to 5 613 741 million lire (US\$ 3190 million); secondary direct costs (including costs associated with incidents caused by alcohol dependents, health treatment, administrative arrangements and destruction of property) amounted to 4 009 825 million lire (US\$ 2280 million) and indirect secondary costs (including morbidity of victims of alcohol dependents loss of their production and mortality of victims plus loss of production) amounted to 868 086 million lire (US\$ 494 million), for a total 1994 loss of 13 101 474 million lire (US\$ 7460 million).

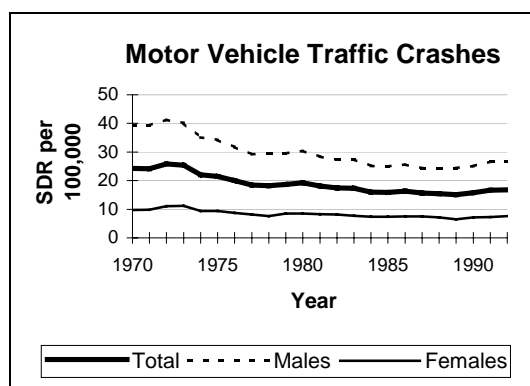
Mortality, morbidity, health and social problems from alcohol use**Alcohol dependence and related disorders**

The rate per 100 000 population of alcoholic psychosis rose from 1.7 to 2.5 between 1980 and 1990. Rates of death from alcohol dependence are low and have remained steady. However, this may reflect under-reporting.

Mortality

The SDR per 100 000 population for chronic liver disease went from 32.9 to 22 between 1980 to 1993.





Social problems

The number of alcohol-related motor vehicle crashes per 100 000 population went from 0.35 to 0.4 between 1980 and 1991.

Alcohol policies

Control of alcohol products

Table wines are not taxed. Beer (four to six per cent alcohol) is taxed 2170 lire per 100 litres and spirits (over 35 per cent proof) are taxed 1 146 600 lire (US\$ 653) per 100 litres. The real prices of beer and wine have been stable, and the real price of spirits has been increasing during the past five years.

The sale of drinks with an alcohol content of 21 per cent or more is not allowed at sporting venues, or at fairs, entertainment complexes, amusement parks (including temporary events), meeting places, during sports gatherings, music sessions or open air concerts. There are no restrictions on hours or days of sale or on location of outlets, but restrictions do exist on types of outlets. There is no state monopoly but a licence is required for the production and distribution of beer, wine and spirits. Vendors who sell alcohol to minors under 16 years of age may be arrested and may be given a higher penalty if a case of underage drunkenness is involved.

The advertising of beer, wine and spirits on television is restricted. These restrictions were imposed by the Ministry of Communications (Posts) in 1991. Labels for alcohol content are required by law. There is no maximum legal limit for the alcohol content of beverages.

Control of alcohol problems

The sale of alcohol to those under 16 years of age is prohibited. The BAC limit is 0.08 g% for drivers. Suspension of driving licence or imprisonment is a usual penalty when a person is convicted for a first offence. Random alcohol breath testing is not carried out.

There is no agency devoted specifically to prevention of alcohol-related problems but it is included in the work of the Central Service for Alcohol and Drug Addiction (CSADA) established in 1990 to provide guidelines for all preventive activities. The actual organization of preventive activities is carried out by the Regions themselves under the supervision of the CSADA. The Ministry of Public Education promotes and coordinates health education activities and provides information on harm caused by the use of alcohol, tobacco and drugs. It also approves annual programmes proposed by the national technical and scientific committee. The implementation of activities is coordinated at the provincial level by the Education Board.

Priorities of the early 1990s have been: mass media campaigns to encourage safer drinking; developing specialized treatment for alcohol dependence and other alcohol problems and addressing particular alcohol problems. There are school-based programmes which deal with alcohol, tobacco and illicit drugs. With the collaboration of public social and health services for assisting persons dependent on alcohol and drugs, the Education Board establishes centres in second level schools for information and counselling in relation to substance use problems. The Education Board promotes training courses for teachers.

Alcohol data collection, research and treatment

The Permanent Study on Children and Alcohol in Rome and the Society on Alcoholology are research institutes which specialize in alcohol issues. The Central Service for Alcohol and Drug Addiction oversees the collection and dissemination of data from the Regions. It provides information for the Drug and Alcohol Addiction Bulletin published by the Ministry of Health.

The Ministry of Health has the competence to determine measures for the prevention, treatment and rehabilitation of pathological states arising from the abuse of alcohol. Integrated treatment of alcohol dependence, including medical, psychological and social aspects often in collaboration with self-help groups, has started in some regions with the Department for Social Solidarity being responsible for organizing such services.

An important recent development is the Health Ministerial Decree which directs that in every Local Health Unit (Health Services at the municipality level) there should be a working group for prevention, treatment and rehabilitation of alcohol dependency, with a global approach taking into consideration medical, psychological and social aspects of the problem. This has brought about an increase in the treatment of alcohol dependence in hospitals and surgeries as well as an increase in the number of personnel involved.

Kazakhstan

Sociodemographic characteristics

POPULATION	1980	1990	1995
Total	14 907 000	16 670 000	17 111 000
Adult (15+)	10 077 000	11 413 000	12 016 000
% Urban	54.0	57.6	59.7
% Rural	46.0	42.4	40.3

Health status

Life expectancy at birth, 1990-1995 : 65.0 (males), 74.0 (females)

Infant mortality rate in 1990-1995 : 30 per 1000 live births

Socioeconomic situation

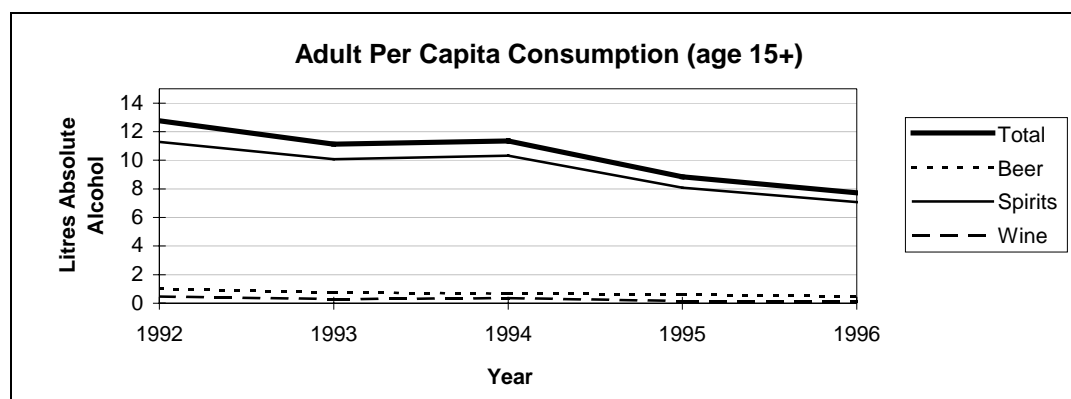
GNP per capita (US\$), 1995: 2717, PPP estimates of GNP per capita (current int'l \$), 1995: 3010

Average distribution of labour force by sector, 1990-1992 : agriculture 20%; industry 22%; services 58%

Alcohol production, trade and industry

Kazakhstan produces beer, distilled spirits and wine.

Alcohol consumption and prevalence



Consumption

Recorded alcohol consumption has been falling since 1992, driven mainly by the drop in consumption of distilled spirits. There are no data available on consumption of home or informally-produced alcoholic beverages.

Prevalence

A survey in the South Kazakhstan region of 217 women aged 30 to 60 years, most of them living in towns and many of them employees of state enterprises or public organizations, showed that 73 per cent had used alcohol at some time. Statistics show that the proportion of women involved in drunkenness is increasing, with the male-female ratio fluctuating from 1:10 in 1990 to 1:8 in 1993.

Economic impact of alcohol

Consumer expenditure on alcoholic beverages, as a percentage of general expenditure on purchase of goods and payments for services, fell from 5 in 1990 to 2.5 in 1995.

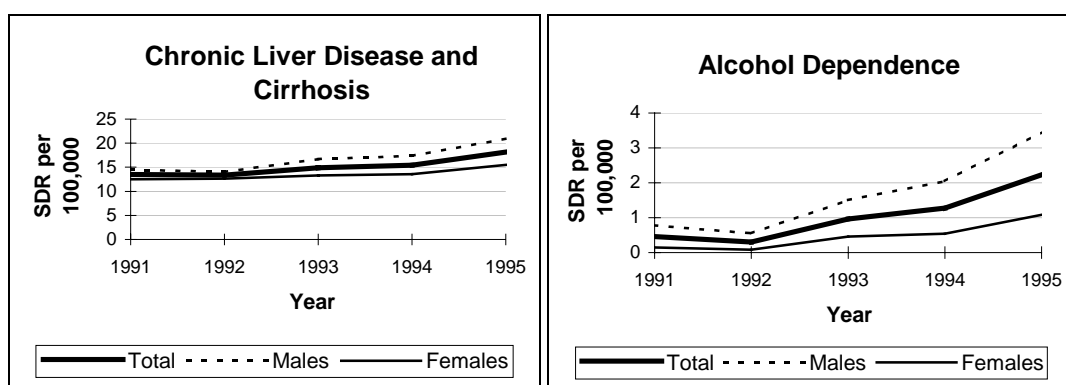
Mortality, morbidity, health and social problems from alcohol use

Alcohol dependence and related disorders

The rate per 100 000 population of treatment admissions for alcohol dependence decreased from 87.9 to 54.9 between 1988 and 1991. The number per 100 000 population of patients with alcohol dependence registered at hospitals and other clinics during the year decreased from 16.8 in 1990 to 12.9 in 1995. However, death rates per 100 000 population from alcohol dependence have been rising rapidly in recent years.

Mortality

The SDR per 100 000 population (all ages) for chronic liver disease was 24.9 in 1994, compared to 20.8 in 1995.



Social problems

The number of persons committing crimes under the influence of alcohol (thousands) increased from 22.7 in 1990 to 25.2 in 1995.

Alcohol policies

Control of alcohol products

In 1993 Parliament imposed a 50 per cent tax on vodka. The government announced restrictions on trade of alcohol products with alcohol-by-volume of over 12 per cent, which became effective 1 December, 1997. The ban applies to movable trade outlets such as kiosks and stalls, and also to markets and street cafes. Alcoholic beverages are now only available in licensed shops, cafes, bars and restaurants.

Control of alcohol problems

The Ministry of Health's Department of Psychiatry and Narcology is responsible for formulating, applying, coordinating and monitoring national policies. A national policy and programme on alcohol, drugs and other psychoactive substances has been drawn up covering the area of prevention,

legislation and treatment/rehabilitation. There have been some mass media campaigns in relation to alcohol, particularly in 1992.

Alcohol data collection, research and treatment

The Department of Psychiatry and Neurology in the Ministry of Health is responsible for collating, analyzing, and disseminating data, and using it as a basis for national policies.

Involuntary treatment was abolished at the beginning of 1990. From 1988 to 1993, two of three narcological hospitals and 19 of 26 polyclinics were closed and beds were reduced by half. The number of narcological beds in special medical institutions for rehabilitation and work therapy in both enterprises and agriculture was reduced from 4370 to 965. In the same period, 419 physicians, more than half of all the narcologists in Kazakhstan in 1988, left their narcological establishments because of a reduction in workplaces and changes in their occupation. These reductions are reflected in a decline in the rates of persons registered with the narcological services with a diagnosis of alcohol dependence.

The State Addiction Service has a regional centre in Chimkent in the South Kazakhstan Region which provides services to people with drug or alcohol dependence. In all the districts and towns of the region there are units where persons with drug or alcohol problems may receive qualified medical help from a psychiatrist and a nurse. There are both inpatient and outpatient services. There were 18 alcohol and other drug treatment units located at factories and construction sites in Chimkent. People with alcohol or other drug dependence could be diagnosed, observed and if necessary, treated at these units. However, most of these treatment units were closed in the 1990-1993 period as employers were terminating employment of people who were dependent on drugs or alcohol.

Kyrgyzstan

Sociodemographic characteristics

POPULATION	1980	1990	1995
Total	3 617 000	4 362 000	4 745 000
Adult (15+)	2 277 000	2 724 000	2 982 000
% Urban	38.3	38.2	38.9
% Rural	61.7	61.8	61.1

Health status

Life expectancy at birth, 1990-1995 : 65.0 (males), 72.8 (females)

Infant mortality rate in 1990-1995 : 35 per 1000 live births

Socioeconomic situation

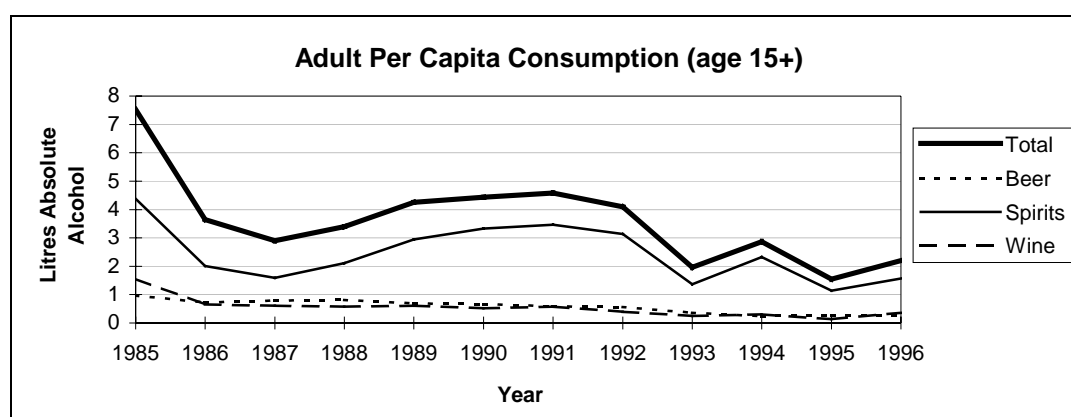
GNP per capita (US\$), 1995: 700, PPP estimates of GNP per capita (current int'l \$), 1995: 1800

Average distribution of labour force by sector, 1990-1992 : agriculture 16%; industry 24%; services 60%

Alcohol production, trade and industry

Kyrgyzstan produces beer, distilled spirits and wine.

Alcohol consumption and prevalence



Consumption

In recorded consumption, adults consumed just over 2 litres of pure alcohol in 1994, down from a high of 7.5 litres in 1985. However, there are no quantified data available regarding unrecorded consumption, and experts consider that the actual trend in consumption has been upwards during the mid-1990s rather than downwards.

Age patterns

While no studies of prevalence of use among adults are available, research shows that alcohol is used by 14 per cent of school children, 30 per cent of students at vocational training colleges and 32 per cent of students at technical colleges.

Economic impact of alcohol

Consumer expenditure on alcoholic drinks as a percentage of general expenditure on purchase of goods and payments for services decreased from 3.9 to 1.9 between 1990 and 1995.

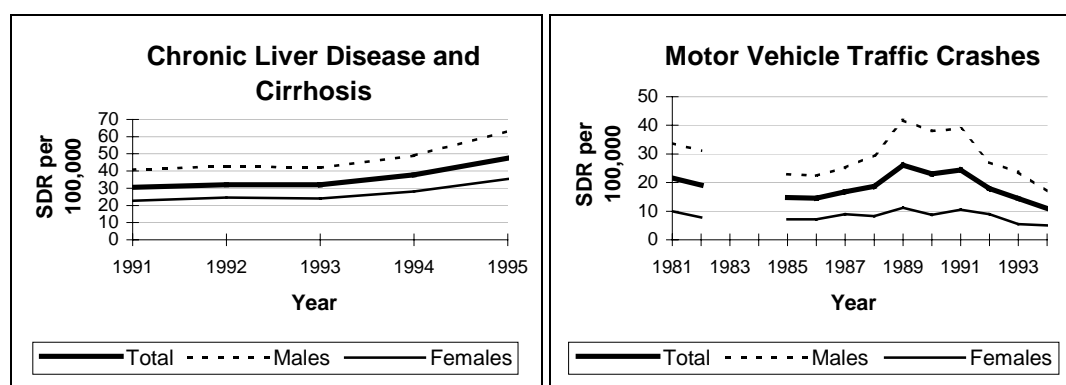
Mortality, morbidity, health and social problems from alcohol use

Alcohol dependence and related disorders

In 1993, more than 28 000 people were officially registered as suffering from chronic alcohol dependence. Each year between 3000 and 4000 people including 100 adolescents are registered as occasional users of alcohol in a problematic way. Women account for between 10 and 12 per cent of those recorded as suffering from chronic alcohol dependence. Authorities estimate the true figures to be much higher.

Mortality

The SDR per 100 000 population for chronic liver disease was 30.5 in 1991 and 32.1 in 1995.



Social problems

The number of motor vehicle crashes involving alcohol per 100 000 population increased from 9 in 1986 to 16.8 in 1989, then dropped to 7 in 1993. The number of persons committing crimes under the influence of alcohol (thousands) rose from 3.7 in 1990 to 4.1 in 1995.

Alcohol policies***Control of alcohol products***

Although alcohol has become expensive during the 1990s, its real price has fallen relative to the big increases in food prices. The situation varies for different types of alcohol. For example, Kyrgyzstan's own alcohol is not expensive. There are no restrictions on days of sale or on location of outlets. Previously, there were restrictions on hours of sale and on type of outlets but these are not so strongly enforced now as many small businesses have started.

Control of alcohol problems

In the early 1990s, priorities have been: developing specialized treatment; addressing problems such as drinking and driving, and drinking among young people; and increasing the role of primary health care in the prevention and early detection of alcohol problems. In early 1994 the government decided on a major alcohol control programme.

It is not permitted to drink alcoholic beverages in cars or transport generally, in public parks, workplaces, discos or in clubs (except in special alcohol clubs). The minimum legal age limit is 16 years for buying alcohol, although young people now buy alcohol in the many newly-opened small shops.

The BAC limit is 0.0 g% for drivers. A first offence in this area frequently incurs a suspension of driving licence for one or two years. Police have the power to take those suspected of driving above the permitted BAC to a doctor for confirmatory tests.

General and specific health warnings are not required by law. The narcological dispensaries carry out some educational work. Some mass media programmes dealing with alcohol only and others dealing with alcohol, tobacco and other drugs have been used but this aspect is not yet well developed. An education programme dealing jointly with alcohol, tobacco and other drugs is being developed in the Medical Institute in Bishkek.

Alcohol data collection, research and treatment

There is no special institute for research on alcohol but some such research is carried out in the Faculty of Psychiatry in the Medical Institute in Bishkek. The role of private treatment is being developed and efforts are being made to develop the role of the social welfare system in the prevention and management of alcohol problems. In 1980 most alcohol dependent persons were treated in psychiatric hospitals. In the mid-1980s, with the establishment of narcological dispensaries, many alcohol dependents worked by day and stayed in the dispensary at night. At the end of the 1980s, a greater emphasis was placed on outpatient treatment and this trend is increasing.

The Medical Institute deals with adolescent behavioural problems relating to substance use. Narcological dispensaries located in Bishkek, in every regional centre and in some small towns provide substance abuse treatment. The Centre for Postgraduate Training provides psychotherapeutic and client psychological training.

Latvia**Sociodemographic characteristics**

POPULATION	1980	1990	1995
Total	2 534 000	2 671 000	2 557 000
Adult (15+)	2 016 000	2 096 000	2 031 000
% Urban	68.3	71.2	72.8
% Rural	31.8	28.8	27.1

Health status

Life expectancy at birth, 1990-1995 : 63.3 (males), 74.9 (females)

Infant mortality rate in 1990-1995 : 14 per 1000 live births

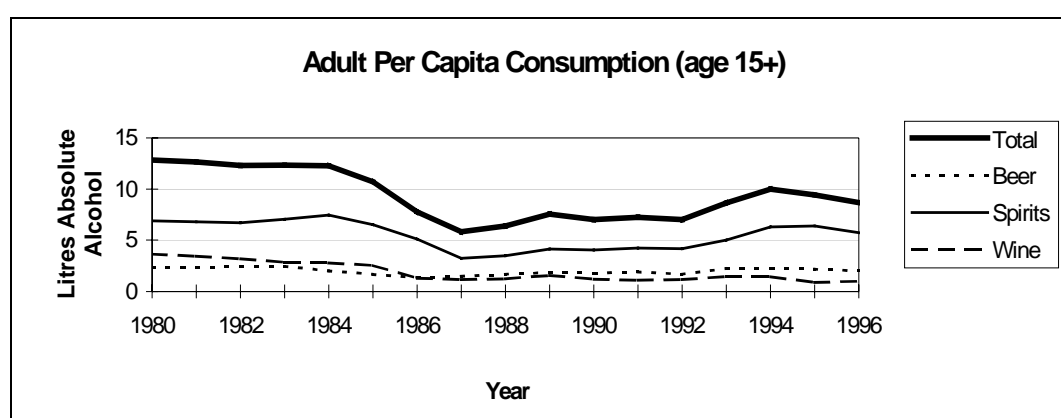
Socioeconomic situation

Average distribution of labour force by sector, 1990-1992 : agriculture 9%; industry 33%; services 58%

Alcohol production, trade and industry

Latvia produces, imports and exports beer, distilled spirits and wine. Aldaris Brewery, owned by a joint venture between the largest brewers in Norway, Finland and Sweden, sells 54 per cent of the country's beer.

Alcohol consumption and prevalence



Consumption

Recorded per capita consumption has fallen off considerably since the early 1980s, according to estimates by the European Regional Office of WHO. Spirits account for more than half of total alcohol consumption. Unrecorded consumption is estimated to be very high, bringing total consumption up to a range of between 16 and 20 litres per capita in 1993.

Prevalence

A survey published in 1993 found that 85 per cent of men and 53.8 per cent of women drank alcoholic beverages. About 2.5 per cent of men and 0.7 per cent of women drank several times a week.

Age patterns

A study of 2179 15 to 16 year olds was conducted in 1995. Eighty-seven per cent of the respondents had drunk an alcoholic beverage in the last 12 months, and 43 per cent had drunk to intoxication in the last 12 months.

A 1993/1994 study among 15 year old boys and girls showed that 93.2 per cent of boys and 93.1 per cent of girls had tried alcoholic beverages. Approximately 16 per cent of boys and 3.2 per cent of girls drank alcohol at least weekly.

Economic impact of alcohol

On average, two per cent of annual household expenditures were spent on alcoholic beverages in 1994.

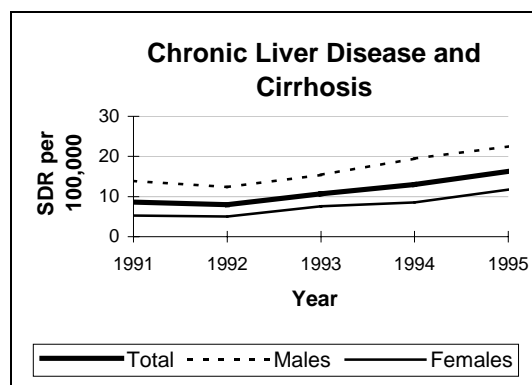
Mortality, morbidity, health and social problems from alcohol use

Alcohol dependence and related disorders

The rate per 100 000 population of hospital admissions for alcoholic psychosis fell from 46 in 1980 to 10 in 1987, then rose to 17 in 1990 and to 66 in 1993.

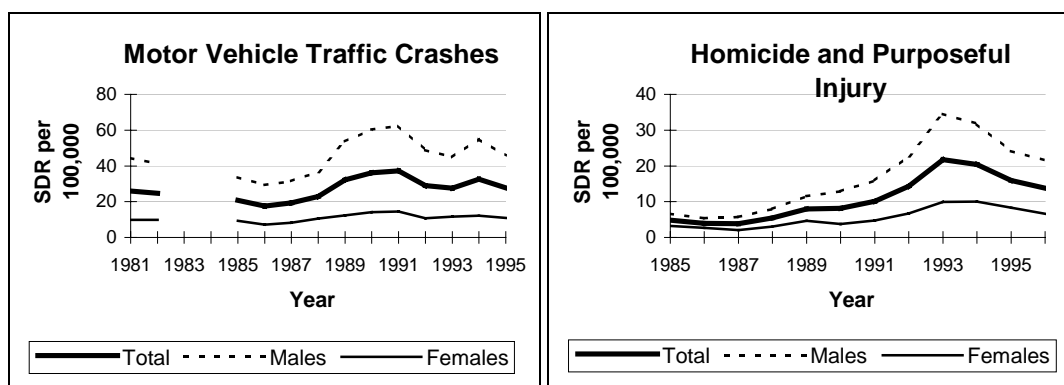
Mortality

The SDR from chronic liver disease and cirrhosis per 100 000 population for men rose from 13.9 in 1991 (5.2 for women) to 22.5 in 1995 (11.7 for women).



Social problems

In 1988, 25 per cent of motor vehicle traffic crashes were alcohol-related. In 1990 the figure rose slightly to 27 per cent and then fell to approximately 20 per cent in 1992 and 1993. In 1984, 53 per cent of all crime offenders were under the influence of alcohol at the time of the crime.



Alcohol policies

Control of alcohol products

The trend in the real price for all three types of alcohol has been decreasing during the early 1990s. Table wines are taxed 30 to 40 per cent, beer (four to six per cent alcohol) is taxed 20 per cent, and spirits (over 35 per cent proof) are taxed 70 to 80 per cent.

There is a state production monopoly and a licence is required for the production and distribution of wine and spirits. There are no restrictions on hours or days of sale, or on types or location of outlets. There are no restrictions on the advertising of beer, wine and spirits in the media except in the city of Riga. Neither general or specific health warnings nor labels for alcohol content are required by law, and there is no maximum legal limit for the alcohol content of beverages.

Control of alcohol problems

The Decree of the Board of the Supreme Soviet of the Latvian Soviet Socialist Republic on Provisions Regarding Strengthening of Controls on Alcohol Abuse and Illicit Production of Alcoholic Beverages of 1985 is still in force. There is a minimum legal age limit of 18 years for buying alcohol but it is not effectively enforced. There are mass media, school-based and workplace programmes which deal

with substance use in general. The BAC limit is 0.05 g% for drivers and is fairly effectively enforced. On conviction for a second offence of driving above the permitted BAC, suspension of driving licence or imprisonment is usual. Random alcohol breath testing is carried out, but infrequently.

Alcohol data collection, research and treatment

The Latvia State Drug Abuse Prevention and Health Care Centre is the national agency dealing with prevention of alcohol problems. A Unit within the Ministry of Welfare finances and organizes treatment for alcohol and drug dependent persons, collects data, deals with training for professionals and is also involved in the prevention of alcohol-related problems. There are several regional agencies dealing with alcohol-related issues, but their work is mainly in the area of therapy and rehabilitation.

On 14 June, 1990 the Board of Health Protection Ministers adopted and issued Decision No. 7 on Strengthening the Medical and Social Support for Alcohol, Drug and Toxic Substances Dependent Patients, calling for monitoring of inpatient and outpatient care, rehabilitation and social care, and registration procedures for substance dependent persons.

Lithuania

Socio-demographic characteristics

POPULATION	1980	1990	1995
Total	3 433 000	3 711 000	3 700 000
Adult (15+)	2 624 000	2 871 000	2 892 000
% Urban	61.2	68.8	72.1
% Rural	38.8	31.2	27.9

Health Status

Life expectancy at birth, 1990-1995 : 64.9 (males), 76.0 (females)

Infant mortality rate in 1990-1995 : 13 per 1000 live births

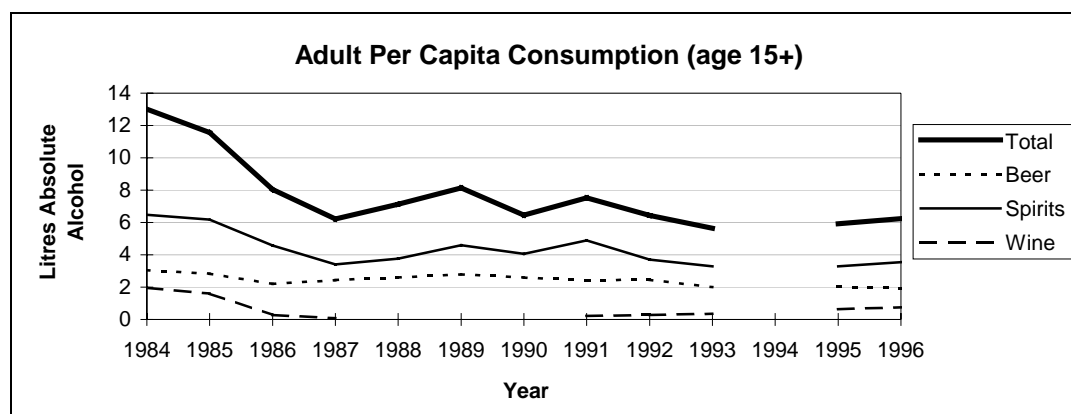
Socio-Economic situation

Average distribution of labour force by sector, 1990-1992 : agriculture 10%; industry 33%; services 57%

Alcohol production, trade and industry

Kalnapolis Brewery, owned by a joint venture between the largest Norwegian, Swedish and Finnish brewers, has 15 per cent of the beer market.

Alcohol consumption and prevalence



Consumption

Figures used to calculate consumption are not reliable. It was estimated that in 1994, 20 per cent of the alcoholic beverage market consisted of alcohol legally produced in Lithuania, 10 to 15 per cent was legally imported and 60 to 65 per cent was illegally imported or illegally produced. This suggests a figure of about 12 litres for total per capita consumption of pure alcohol. According to alcohol industry sources, nearly all of the spirits consumed in Lithuania are vodkas.

Prevalence

A survey of workers between the ages of 18 and 70, conducted between 1983 and 1987, found that 10.6 per cent (23.3 per cent males, 2.4 per cent females) were regular drinkers. There is no more recent prevalence data available for adults.

Age patterns

A study of 3196 15 to 16 year olds (1502 boys and 1694 girls) was conducted in 1995. The response rate was 89 per cent (88 per cent for boys and 90 per cent for girls). Eighty-seven per cent of the respondents had drunk an alcoholic beverage in the last 12 months, and 57 per cent had drunk to intoxication in the last 12 months. Lifetime prevalence of alcohol use was 95 per cent (94 per cent for boys and 95 per cent for girls).

A 1993/1994 study among boys and girls aged 15 years showed that 95.3 per cent of boys and 95.1 per cent of girls have tried alcoholic beverages, while 13.8 per cent of boys and 5.7 per cent of girls drink alcohol at least weekly. In a 1984 higher school survey of two cities, 11 per cent of males and 6.4 per cent of females drank twice or more weekly, while a 1985 school survey of 15 to 16 year olds showed that 80 per cent had ever used alcohol, 20 per cent had drunk alcohol in the previous month and 3.3 per cent had drunk in the previous week.

Economic impact of alcohol

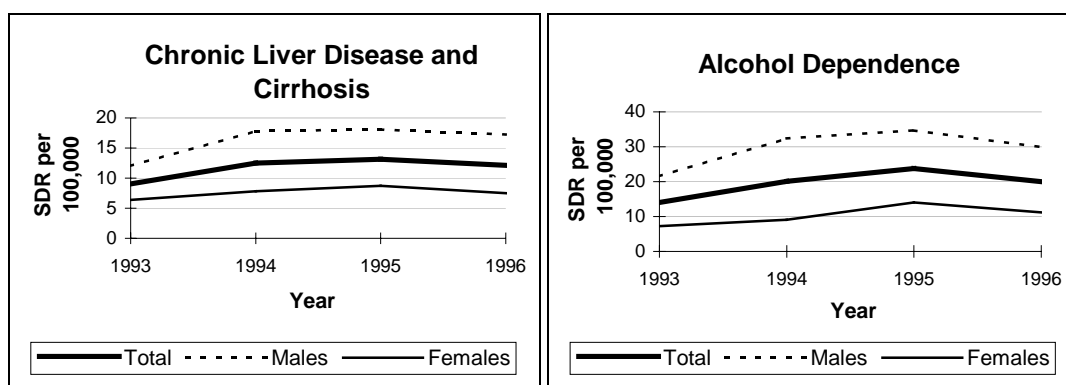
Two per cent of household expenditures on average were spent on alcoholic beverages in 1993, down from 6.1 per cent in 1990.

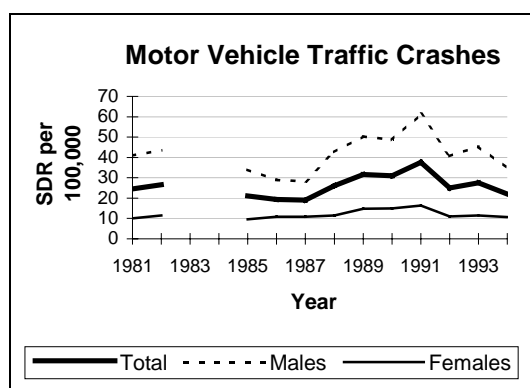
Mortality, morbidity, health and social problems from alcohol use**Alcohol dependence and related disorders**

The rate per 100 000 population of hospital admissions for alcohol psychosis fell from 25.8 in 1980 to 3.5 in 1987, and then climbed steadily back up to 20.5 in 1993. The rate of inpatient admissions due to alcoholic psychosis increased from 6.9 to 33 per 100 000 population between 1990 and 1995. The rate per 100 000 population of hospital admissions for alcohol dependence decreased from 97 in 1989 to 48 in 1993.

Mortality

The SDR per 100 000 population for alcohol dependence is the highest reported in the world. The SDR for acute alcohol deaths fell from 15.8 in 1980 to 6.8 in 1990, and then rose to 13 in 1993. The SDR for chronic liver disease and cirrhosis showed a gradual rise during the first half of the 1990s, going from 14.3 to 20.4 between 1991 and 1995 for men, and from 5.6 to 8.5 for women during the same period.





Morbidity

In 1985 13.3 per cent of motor vehicle traffic crashes were alcohol-related. This figure dropped to 11.6 per cent in 1991, rose slightly to 12.6 per cent in 1993, and remained constant in 1994 at 12.7 per cent.

Alcohol policies

Control of alcohol products

The trend in real price of all three types of alcoholic beverages has been increasing during the early 1990s. Beer (four to six per cent alcohol) is taxed 28 per cent, and spirits (over 35 per cent proof) are taxed 76 per cent.

The sale of alcohol is forbidden near churches, schools, kindergartens and youth hostels. Industrial enterprises and health care institutions are alcohol-free. Sale of alcoholic beverages is permitted from 11:00 to 22:00 hours. For sale at other hours and on Sundays, a special licence is required. There is no state monopoly for the distribution of alcoholic beverages or for the production of beer, but a licence is required. There is a state monopoly for production of wine and spirits.

The advertising of beer is not restricted, but advertising spirits and wine in the media is banned and the ban is quite effectively enforced. General or specific health warnings are not required by law and there is no maximum legal limit for the alcohol content of beverages. Labels for alcohol content are not required by law.

Control of alcohol problems

There is a minimum legal age limit of 18 for buying alcohol but it is not effectively enforced. BAC limit is 0.04 g% for drivers and is quite effectively enforced. Convictions of driving above the BAC limit usually result in licence suspension or a fine of US\$ 500. Random alcohol breath testing is frequently carried out. A new lower BAC limit of 0.02 %g is under consideration. In 1994 educational programmes on healthy lifestyles including alcohol, tobacco and drug issues were adopted in second level schools. According to the new Alcohol Control Law, the Ministry of Education and Science is responsible for developing educational programmes on alcohol for secondary schools and other educational institutions. Youth sobriety movements are also involved in the promotion of healthy lifestyles.

There is no agency devoted specifically to prevention of alcohol-related problems but it is included in the work of the National Health Promotion Agency. The Vilnius Narcology Centre provides annual reports on alcohol problems, disseminates information to the mass media, contributes to legislation, prepares publications such as brochures and manuals for primary health care workers and cooperates with nongovernmental organizations and self-help groups at the national and local level.

Alcohol data collection, research and treatment

The Lithuanian Health Information Centre was created in 1991, and collects medical-statistical information from all medical institutions of Lithuania (demography, mortality, morbidity, hospital activities and medical personnel). The Centre introduces health information systems in medical institutions and analyzes health status in Lithuania. Annual reports are prepared on health situation, mortality and medical personnel.

There is no information available on treatment facilities.

Luxembourg

Sociodemographic characteristics

POPULATION	1980	1990	1995
Total	364 000	381 000	406 000
Adult (15+)	295 000	315 000	338 000
% Urban	78.9	86.3	89.1
% Rural	21.1	13.7	10.9

Health status

Life expectancy at birth, 1990-1995 : 72.0 (males), 79.3 (females)

Infant mortality rate in 1990-1995 : 7 per 1000 live births

Socioeconomic situation

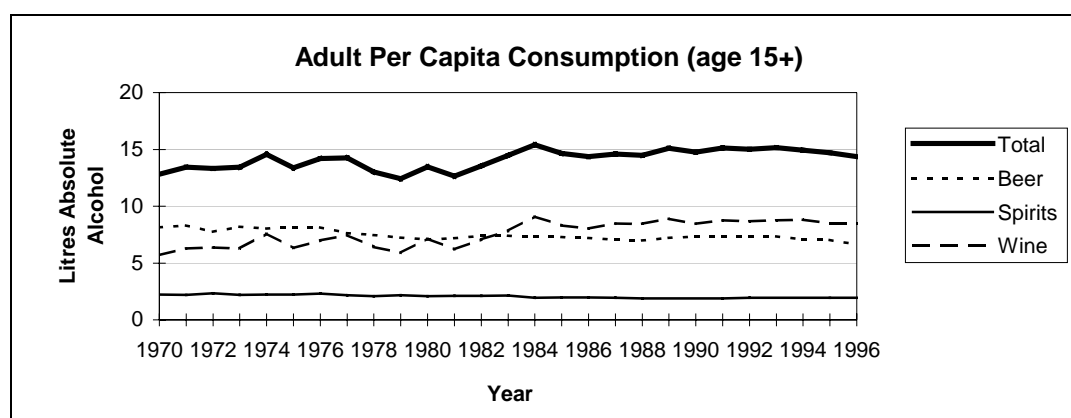
GNP per capita (US\$), 1995: 41 210, PPP estimates of GNP per capita (current int'l \$), 1995: 37 930. Average distribution of labour force by sector, 1990-1992 : agriculture 3%; industry 31%; services 66%

Adult literacy rate (per cent), 1995 : more than 95

Alcohol production, trade and industry

Luxembourg produces beer, distilled spirits and wine. It is also a major trans-shipment point for alcoholic beverages in Southern Europe.

Alcohol consumption and prevalence



Consumption

According to data from Luxembourg's own Central Statistical and Economic Studies Office, adult per capita consumption has remained fairly steady since 1970, rising in the early 1980s, mainly as a result of increased wine consumption.

Prevalence

A study conducted in 1990 found that among persons aged 15 years and over, 20 per cent drank alcohol at least three to four days per week (frequent consumers), 31 per cent were moderate consumers (drinking at least weekly) and 45 per cent drank less than weekly or never (infrequent consumers). A 1980 survey of 1227 adults indicated that 28 per cent consumed alcoholic beverages daily, 52 per cent consumed alcoholic beverages several times a week and 1.6 per cent never consumed alcoholic beverages.

Age patterns

A 1990 survey found that 5 per cent of 11 to 12 year old boys and 16 per cent of 13 to 15 year old boys drank alcohol weekly. None of the 11 to 12 year old girls and four per cent of 13 to 15 year old girls drank alcohol weekly.

Economic impact of alcohol

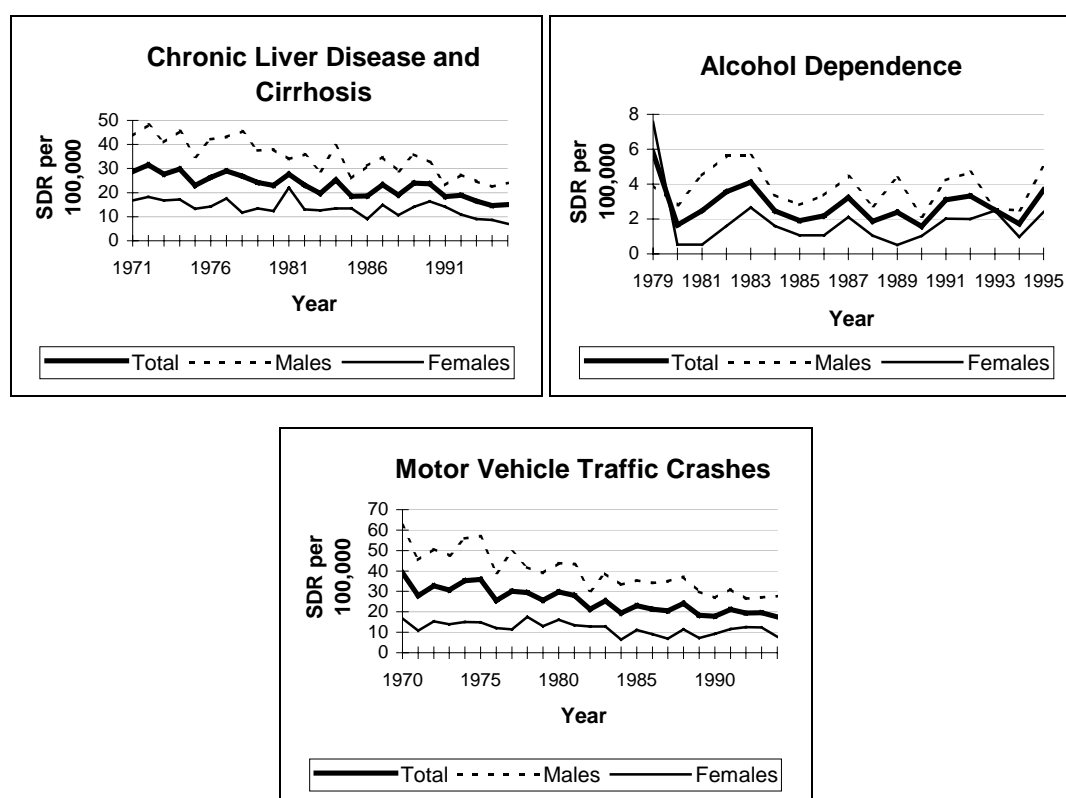
In 1985, Luxembourg families spent an average of 1.4 per cent of their budget on alcoholic beverages. Taxes on alcoholic beverages, domestic and imported, amounted to luxF 1884 million (US\$ 51.3 million) in 1985, or about 2.5 per cent of the total budget.

Mortality, morbidity, health and social problems from alcohol use**Alcohol dependence and related disorders**

The SDR from alcohol dependence syndrome has fluctuated since the 1980s between two and four per 100 000 population, with the 1995 rate placing Luxembourg just behind France in international rankings. In 1988, alcohol-related admissions to psychiatric hospitals constituted 45.3 per cent of total admissions, down from 49.2 in 1981.

Mortality

The SDR per 100 000 population for chronic liver disease decreased from 28.7 to 15 between 1971 and 1995.

**Social problems**

The number of alcohol-related motor vehicle crashes per 100 000 population fell from 57.9 to 45.9 between 1985 and 1993. In 1985, the Diekirch Courts found that of 65 sentences passed, 31 per cent were for alcohol abuse or drunkenness. In 1980 the Ministry of Transport estimated that alcohol abuse played a part in about 80 per cent of withdrawals of driving licences and judicial prohibitions of driving.

Alcohol policies

Control of alcohol products

There are restrictions on hours of sale, but there are no restrictions on days of sale or on type or location of outlets. There are only very few controls on the production and trade of alcoholic beverages. General but not specific health warnings are required by law, as are labels for alcohol content. There are no restrictions on the advertising of alcohol, and there is no maximum legal limit for the alcohol content of beverages.

Control of alcohol problems

There is a minimum legal age limit of 16 years for buying alcohol. The BAC limit is 0.08 g% for drivers. On conviction for a second or subsequent offence of driving above the limit, suspension of driving licence is usual. Random alcohol breath testing is carried out, but infrequently.

In 1980 the National Council against Alcoholism (CNLA) organized public information and provided short courses to army recruits three times a year. That same year, the Ministry of Health launched a major campaign, including educational courses in secondary schools, courses for teachers in primary schools and distribution to all families of health education materials on alcohol problems.

Priorities of the early 1990s have been: mass media campaigns to encourage safer drinking; encouraging lighter drinking in work settings; increasing the role of primary health care teams in the prevention and early detection of alcohol problems; developing the role of the social welfare system in the prevention and management of alcohol problems; developing specialized treatment for alcohol dependence and other alcohol problems; and addressing particular alcohol problems. CNLA provides an information service, and collaborates with Alcoholics Anonymous and SOS Distress. The section Prevention of Drug Dependencies in the Ministry of Justice is the national agency responsible for prevention of alcohol-related problems. There are national school-based programmes on substance use in general.

Alcohol data collection, research and treatment

Since 1978, there has been a specialized centre in Useldange where a number of scientific methods have been tried out. The system used is based on community therapy where the patient is expected to take a large part of the responsibility for the outcome of the treatment. Major multi-national enterprises generally have employee assistance programmes offering treatment options to their employees.

Malta

Sociodemographic characteristics

POPULATION	1980	1990	1995
Total	324 000	354 000	366 000
Adult (15+)	248 000	272 000	284 000
% Urban	83.1	87.6	89.3
% Rural	16.9	12.4	10.7

Health status

Life expectancy at birth, 1990-1995 : 73.8 (males), 78.3 (females)

Infant mortality rate in 1990-1995 : 9 per 1000 live births

Socioeconomic situation

GNP per capita (US\$), 1991: 7300 , PPP estimates of GNP per capita (current int'l \$), 1991: 7575 .

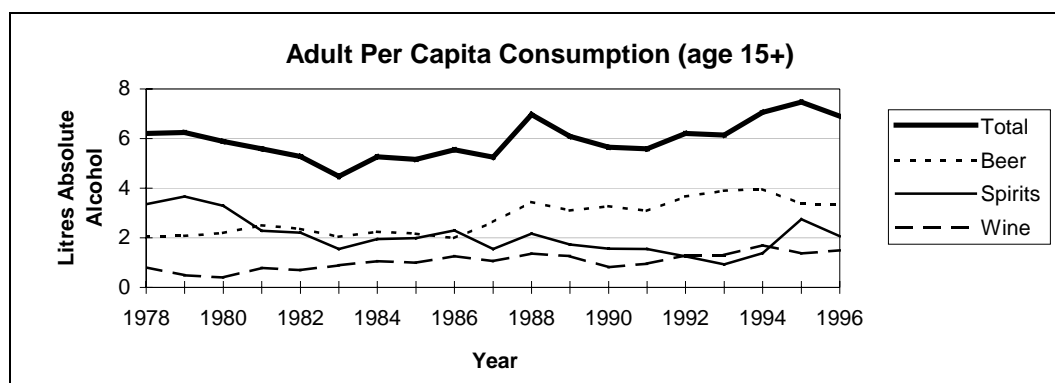
Average distribution of labour force by sector, 1990-1992 : agriculture 3%; industry 28%; services 69%

Adult literacy rate (per cent), 1995 : N/A

Alcohol production, trade and industry

Malta produces beer and wine, and imports distilled spirits.

Alcohol consumption and prevalence



Consumption

Beer has superseded distilled spirits as the alcoholic beverage of choice in recorded production. There are no data available on unrecorded consumption.

Prevalence

A 1992 survey of 1000 people over 15 years old found that 39 per cent drink alcoholic beverages. Alcohol consumption was higher in males than in females, and excessive drinking (defined as five or more bottles of beer, four or more glasses of wine, or four or more units of distilled spirits during one day) was low (between one and four per cent of those surveyed). The higher the level of education, the lower the consumption of wine, and the higher the consumption of beer and spirits.

Age patterns

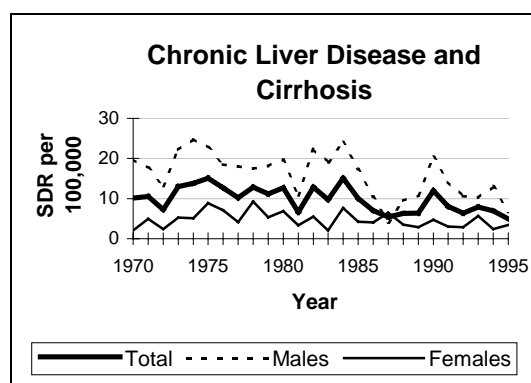
The same 1992 survey found that 43 per cent of people between the ages of 15 and 19 drank alcoholic beverages, compared with 54 per cent of those between 20 and 24.

A study of 2832 15 to 16 year olds (1269 boys and 1563 girls) was conducted in 1995. The response rate was 53 per cent (47 per cent for boys and 60 per cent for girls). Eighty-nine per cent of the respondents had drunk an alcoholic beverage in the last 12 months, and 35 per cent had drunk to intoxication in the last 12 months. Lifetime prevalence of alcohol use was 92 per cent for both boys and girls.

Mortality, morbidity, health and social problems from alcohol use

Mortality

The SDR per 100 000 population for chronic liver disease dropped from 12.9 to 7.9 between 1980 and 1993.

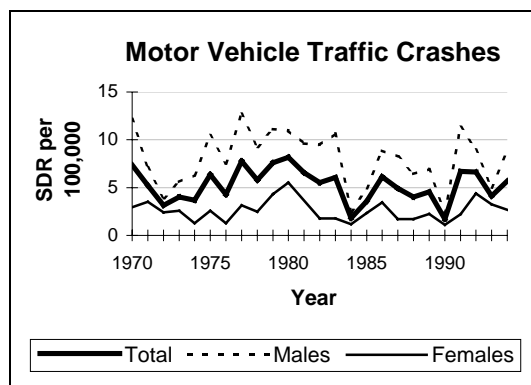


Health problems

The number of alcohol-related hospital admissions fluctuated from 173 in 1992, to 180 in 1993, and to 175 in 1994. Psychiatric hospital admissions for alcohol dependence increased by 50 per cent between 1980 and 1993, and for males by 79 per cent. Male hospital admissions for alcohol dependence were 26 per cent of total male hospital admissions and 18 per cent of total psychiatric hospital admissions.

Social Problems

The number of alcohol-related motor vehicle crashes per 100 000 population rose from 1.2 to 1.8 between 1983 and 1994.

**Alcohol policies****Control of alcohol products**

The trend in the real price of all three types of alcoholic beverage, i.e. beer, spirits and wine has been stable during the early 1990s. The percentage of the price of alcoholic beverages which is tax is approximately as follows: table wines 20 to 25 per cent; whiskies 40 to 45 per cent; beer (local) 15 per cent; beer (imported) 20 to 25 per cent.

There are restrictions on hours of sale and on types of outlets. There are no restrictions on days of sale or location of outlets. A licence is required for the distribution and production of all three types of alcoholic beverage except for home produced wine, which is quite popular in Malta.

General and specific health warnings are not required by law. There are no restrictions on the advertising of beer, wine and spirits. The maximum legal limit for the alcohol content of wine is 24 per cent, 40 per cent for whiskey, brandy, rum and gin, and 20 per cent for other alcoholic drinks, except wine and beer. Labels for alcohol content are required by law.

Control of alcohol problems

There is a minimum legal age limit of 16 years for buying alcohol. There is no specific legislation on the maximum blood alcohol content permitted while driving. If a person has a severe traffic crash and is admitted to the hospital, BAC will be tested there and the result may be used as evidence for insurance purposes. The legal offence is most likely to be one of careless driving.

The Agency Against Drug and Alcohol Abuse (SEDQA) coordinates the efforts of other relevant agencies and collaborates with them in the preparation and execution of programmes. Priorities of the early 1990s have been mass media campaigns to encourage safer drinking; encouraging lighter drinking in work settings especially in schools; developing specialized treatment for alcohol dependence and other alcohol problems; addressing particular alcohol problems such as drinking and driving; and assisting relevant nongovernmental organizations.

Priority is given to prevention through demand reduction. SEDQA's aim is to promote attitudes that contribute to a healthy lifestyle and therefore reduce the demand for alcohol and other drugs. OASI is an autonomous philanthropic organization established in 1991 that works on a national level to increase awareness of the health hazards of substance abuse and to provide alternative treatment and rehabilitation facilities for persons dependent on alcohol and drugs. The issue of substance use in general is included in a life skills programme for 14 and 15 year olds.

Alcohol data collection, research and treatment

Collection of alcohol-related data falls within the brief of SEDQA. Gozo has two main centres that deal with individuals who have a drug and alcohol problem: the Drug Detoxification Centre in the Gozo General Hospital, and the OASI Out-Patient Programme. KADA (Commission Against Drug and Alcohol Abuse) is a policy-formulating body that brings together more than forty experts and operators from voluntary organizations, government departments, professions and related organizations to discuss policy issues, make recommendations and also oversee the quality of services.

Netherlands (the)**Sociodemographic characteristics**

POPULATION	1980	1990	1995
Total	14 144 000	14 952 000	15 503 000
Adult (15+)	10 987 000	12 226 000	12 650 000
% Urban	88.4	88.7	89.0
% Rural	11.6	11.3	11.0

Health status

Life expectancy at birth, 1990-1995 : 74.4 (males), 80.4 (females)

Infant mortality rate in 1990-1995 : 7 per 1000 live births

Socioeconomic situation

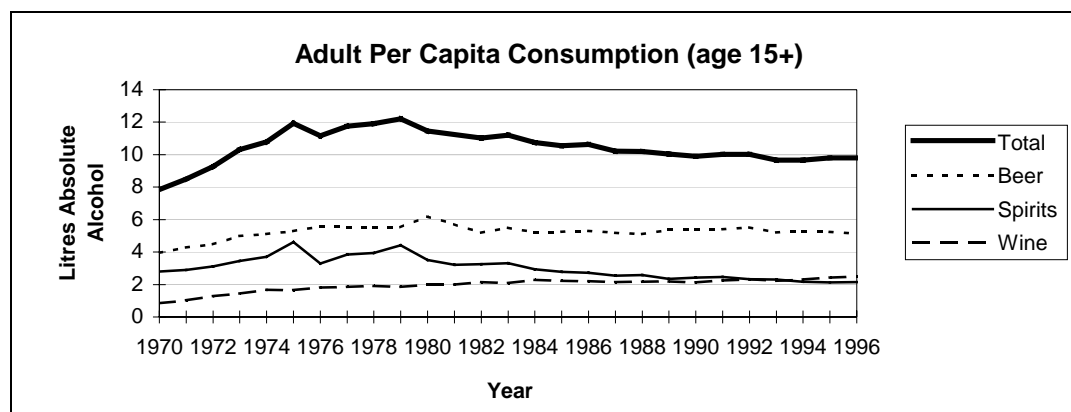
GNP per capita (US\$), 1995: 24 000, PPP estimates of GNP per capita (current int'l \$), 1995: 19 950

Average distribution of labour force by sector, 1990-1992 : agriculture 5%; industry 25%; services 70%

Adult literacy rate (per cent), 1995 : more than 95

Alcohol production, trade and industry

The Netherlands is predominantly a beer-drinking country. The country is home to Heineken NV, the number two brewer in the world, and the leading beer exporter. About two-thirds of Dutch spirits volume comes from such localized products as genever, vieux, advocaat and fruit-flavoured specialty drinks. While these traditional tastes are gradually ceding ground to more international-style spirits, the Dutch spirit market as a whole is shrinking.

Alcohol consumption and prevalence

Consumption

There is no quantified information on unrecorded consumption but it is not considered to be significant. There is almost no illegal production of alcohol. However, in recent years because of fiscal harmonization in the European Union there appears to be a growing importation of wine and spirits by Dutch tourists returning home. No accurate data on this phenomenon are yet available.

Prevalence

A 1990 survey among a sample aged 15 years and over, found that 20 per cent were frequent consumers (drank alcohol at least three to four days per week), 34 per cent were moderate consumers (drinking at least weekly) and 46 per cent drank infrequently (less than weekly or never). A survey carried out in 1986 indicated that 15 per cent of the total sample drank daily (26 per cent of those over 35 years old). Almost half the sample aged 15 years and older had 6 or fewer standard glasses of alcohol during the week before the interview, while 27 per cent had greater than 10 glasses.

Age patterns

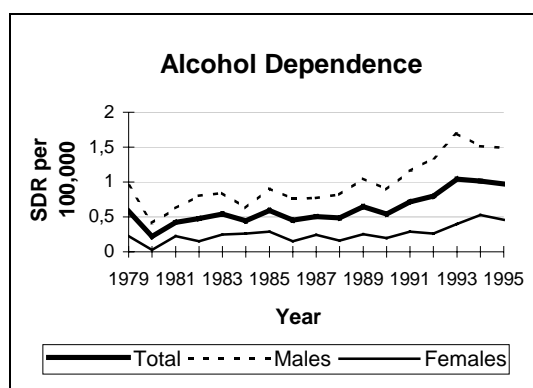
In a 1992 survey of more than 10 000 school pupils aged 10 years and over, 64 per cent had drunk alcohol by the age of 12, down from 69 per cent in 1988. In 1992, 28 per cent had consumed at least five glasses of alcohol on their last drinking occasion, up from 12 per cent in 1984. In all age groups boys drank a much larger amount of alcohol than girls. Data from a 1990 survey showed that 11 per cent of boys aged 13 to 15 drank alcohol weekly, compared with 7 per cent of girls in the same age group.

Economic impact of alcohol

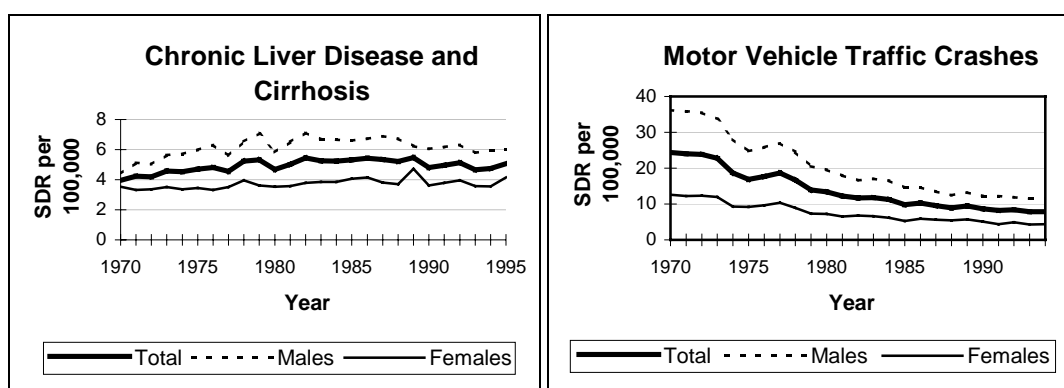
Consumer expenditure on alcoholic beverages in 1989 was almost 600 guilders per capita (US\$ 295.70), and 880 guilders (US\$ 433.70) per average drinker, equalling more than 3.5 per cent of total consumer expenditure. In 1982, 1600 people were employed in distilling, an additional 4000 in the wholesale trade and 4500 in liquor stores. In 1989, around 8500 people were employed in brewing.

Mortality, morbidity, health and social problems from alcohol use**Alcohol dependence and related disorders**

Admission rates per 100 000 population to general hospitals for alcoholic psychosis went from 4.5 to 3.6 between 1980 and 1990, then dropped to 2.8 in 1992. However, the SDR per 100 000 population from alcohol dependence has been rising in recent years.

**Mortality**

Between 1980 and 1992 the SDR per 100 000 population of chronic liver disease remained constant at 5.1.



Social problems

The number of road traffic crashes involving alcohol per 100 000 population was 16.2 in 1992 compared to 25.6 in 1985. Alcohol consumption was observed in 8.4 per cent of fatal crashes in 1992, compared to 14.7 per cent in 1980.

Alcohol policies

Control of alcohol products

Between 1960 and 1980, alcoholic beverages on the average became 36 per cent cheaper. The real price of spirits has been increasing, but the real price of beer and wine has been decreasing over the past five years. Table wines are taxed 16 per cent, beer (4 to 6 per cent alcohol) is taxed 34 per cent, spirits (over 35 per cent proof) is taxed 69 per cent and sherry is taxed 41 per cent.

Drinking is banned in workplaces (except for special occasions), in transport and in the parks of some municipalities. There are restrictions on hours and days of sale and on types of outlets, and liquor shops and supermarkets are closed on Sundays and during evening hours. Opening hours of bars/discos are restricted locally by the mayor, and no liquor is sold in supermarkets. There is no state monopoly for production or distribution of alcoholic beverages but a licence is required for distribution for on-premises consumption of all alcoholic beverages. No licence is required for off-premises consumption of beer and wine. Licence conditions are judged beforehand by local police/municipalities. A licence is required not for the production *per se*, but because of excise duties.

Restrictions on advertising of alcoholic beverages are currently implemented by means of a voluntary code operated by the alcohol and advertising industries. All media are covered by the code, which specifies that alcohol may have no relation with sports, traffic, youth, psycho-active effects, work, health or encouragement to excess consumption. Labels with general or specific health warnings are not required by law. Labels for alcohol content have been required since January 1993 in conformity with the regulations for harmonization of the internal market in the European Union. There is no maximum legal limit for the alcohol content of beverages.

Control of alcohol problems

There is a minimum legal age limit of 16 years for buying beer and wine and an age limit of 18 years for buying spirits. The BAC limit is 0.05 g% for drivers. On conviction for a second and subsequent offences of driving above the permitted BAC, suspension of driving licence is usual and imprisonment is also an option depending on the circumstances. Random alcohol breath testing is frequently carried out.

Because of the sharp rise in alcohol consumption between 1960 and 1980, the Government decided to develop and implement an alcohol control policy aimed at preventing the risks of alcohol use. A memorandum was drawn up by the Interministerial Steering Committee for Alcohol and Drug Policies. In 1987, the memorandum was debated in Parliament, which supported most of the proposals. The Bureau Alcohol Education Plan is involved in mass media campaigns, prevention projects, public relations and information for consumers. Priorities of the early 1990s have been: reducing availability; mass media campaigns to encourage safer drinking; encouraging lighter drinking in work settings; increasing the role of primary health care teams in the prevention and early detection of alcohol problems; using price policy to reduce demand; developing the role of the criminal justice

system in the prevention and management of alcohol problems, especially drunken driving; developing specialized treatment for alcohol dependence and other alcohol problems; and addressing particular alcohol problems.

There are a variety of alcohol education programmes in the mass media, schools and workplace and some school-based programmes which address the issue of substance use in general. Regional agencies such as addiction clinics and outpatient counselling centres for alcohol and drugs also have a prevention and education role at the local level. Several professional courses have been established. Short courses have also been organized for the police, prison personnel, welfare departments of the army, social workers, medical students, local welfare institutions, teachers, etc.

Alcohol data collection, research and treatment

The Netherlands Institute for Alcohol and Drugs is involved in the documentation and monitoring of research, as well as providing information on alcohol issues. The Central Bureau of Statistics produces alcohol consumption statistics.

Much of the treatment of people with an alcohol dependence is carried out through community facilities. There are also extensive social welfare and subsidized facilities that can be used to deal with alcohol problems. Apart from the psychiatric hospitals and specialized addiction clinics, there are many consultation bureaux (80 branches) that deal with alcohol clients (from nearly 11 000 in 1970 to more than 18 000 in 1987).

Norway

Sociodemographic characteristics

POPULATION	1980	1990	1995
Total	4 086 000	4 241 000	4 337 000
Adult (15+)	3 181 000	3 437 000	3 492 000
% Urban	70.6	72.3	73.2
% Rural	29.5	27.7	26.8

Health status

Life expectancy at birth, 1990-1995 : 73.6 (males), 80.3 (females)

Infant mortality rate in 1990-1995 : 8 per 1000 live births

Socioeconomic situation

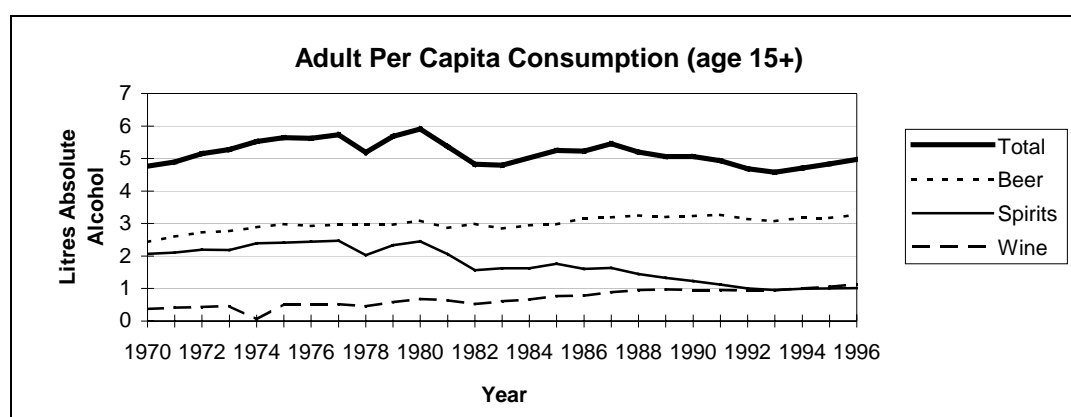
GNP per capita (US\$), 1995: 31 250, PPP estimates of GNP per capita (current int'l \$), 1995: 21 940
Average distribution of labour force by sector, 1990-1992 : agriculture 6%; industry 24%; services 70%

Adult literacy rate (per cent), 1995 : more than 95

Alcohol production, trade and industry

Norway's beer industry is dominated by the foods conglomerate Orkla which controls Ringnes, the country's largest brewer. As a result of negotiations with the European Economic Area (EEA), the state alcohol retailing monopoly is being retained, as is the state monopoly for the production of spirits, but the retail and the production divisions of the monopoly will be separated into two companies. Alcohol wholesaling, import and export are being opened up to competition.

Alcohol consumption and prevalence



Consumption

Three interview surveys were carried out in 1985, 1991 and 1994 on representative samples of about 2000 persons aged 15 years and over. In 1994, 9 per cent of all interviewees had bought home distilled alcohol in the past year, and 17 per cent had bought or smuggled spirits into the country illicitly. Thirty-four per cent of men and 87 per cent of women had drunk home distilled alcohol over the past year. In 1994 it was estimated that unrecorded consumption added up to at least one-third of total recorded consumption. This would suggest that total consumption of alcohol was 7.05 litres of absolute alcohol per adult in 1994.

Prevalence

In the 1994 interview survey described above, 86 per cent of men and 76 per cent of women drank beer over the past year, 81 per cent of men and 82 per cent of women drank wine and 84 per cent of both men and women drank spirits. The average quantity of beer consumed per occasion was 4.2 cl of pure alcohol, the average quantity of wine consumed per occasion was 3.9 cl of pure alcohol and the average quantity of spirits consumed per occasion was 5.8 cl of pure alcohol. The annual average pure alcohol consumption for all interviewees was 0.31 cl of beer, 1.64 cl of wine and 1.07 cl of beer.

According to Eurodata figures from 1990, one per cent of the population aged 18 years and over drank daily or almost daily, 23 per cent drank once or twice a week, 23 per cent drank twice a month and 38 per cent drank once a month or less.

Age patterns

A study of 3910 15 to 16 year olds (1979 boys and 1931 girls) was conducted in 1995. The response rate was 91 per cent. Seventy-two per cent of the respondents had drunk an alcoholic beverage in the last 12 months, and 50 per cent had drunk to intoxication in the last 12 months. Lifetime prevalence of alcohol use was 79 per cent (79 per cent for boys and 80 per cent for girls).

A 1993 study among 15 year old boys and girls found that 80.1 per cent of boys had tried alcohol, 9.5 per cent drank alcohol at least weekly and 30.4 per cent had been drunk at least twice. Of girls, 79.3 per cent had tried alcohol, 6.8 per cent drank alcohol at least weekly and 29.1 per cent had been drunk at least twice.

Economic impact of alcohol

The percentage of annual household expenditure devoted to alcoholic beverages was 4.9 in 1994, up from 4.4 in 1990

Mortality, morbidity, health and social problems from alcohol use

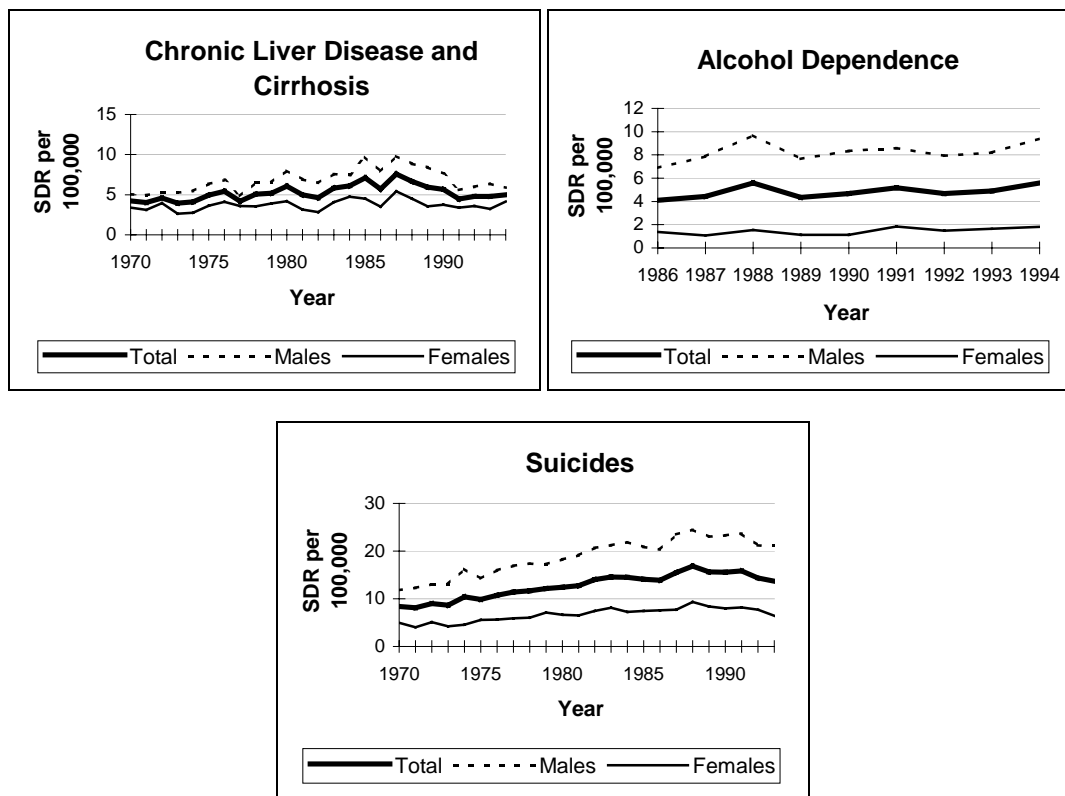
Alcohol dependence and related disorders

The rate per 100 000 population of persons discharged from hospital with alcoholic psychosis as either the primary or secondary diagnosis at admission was 9.1 in 1990 and 10.2 in 1991. The SDR per 100

000 population from alcohol dependence has slowly been rising in recent years, and is the world's sixth highest.

Mortality

In a 40-year follow-up study of 40 000 military conscripts, it was estimated that the relative risk of suicide among alcohol abusers was 6.9. The SDR per 100 000 population of chronic liver disease and cirrhosis was 4.5 (5.7 for men and 3 for women) in 1992 which represents a slight decrease from the 1980 rate of 5.8. The SDR reached its highest for the period at 7.4 in 1987.



Social problems

According to police reports in the 1980s, 50 per cent of all sexual crimes towards children were committed while under the influence of alcohol. Police estimate that alcohol is the background for every fifth divorce, involving about 2000 children in those families every year.

The number of cautions and arrests for public drunkenness per 100 000 population decreased from 2.2 to 1.9 between 1990 and 1993. According to police reports, 80 per cent of all crimes of violence, 60 per cent of all occurrences of rape, arson and vandalism, and 40 per cent of all burglaries and thefts are committed while under the influence of alcohol.

Alcohol policies

Control of alcohol products

The real price of all three types of alcohol, i.e. beer, spirits and wine has increased during the early 1990s. Table wines are taxed 65 per cent, beer (4 to 6 per cent alcohol) is taxed 61.5 per cent and spirits (over 35 per cent proof) are taxed 89.7 per cent.

There are restrictions on hours and days of sale and on type and location of outlets. Owing to the EEA (European Economic Area) agreement, in the summer of 1995 the Norwegian Government abolished the state monopoly on import, export and wholesale of alcoholic beverages. Private interests will be permitted to act in these sectors of the alcohol market along with the former state company, but licences are required. Drinking is banned in public places.

All advertising of alcohol in the media is prohibited. Moreover, alcoholic beverage products must not be included in advertisements for other goods or services. General or specific health warnings on

alcohol products are not required by law. There is a maximum legal limit of 60 per cent of pure alcohol per beverage, and labels giving alcohol content are required by law.

Control of alcohol problems

There is a minimum legal age limit of 18 for buying beer or wine and a minimum legal age limit of 20 for buying spirits. The BAC limit is 0.05 g% for drivers. On conviction for a first offence of driving above the permitted BAC, suspension of driving licence and/or imprisonment is usual. Random alcohol breath testing is carried out frequently.

The main objective of alcohol policies in the 1980s was to minimize medical and social problems caused by alcohol. This aim was expected to be reached by reducing average per capita consumption of alcoholic beverages by 25 per cent between 1975 and 2000. Means of achieving this objective were considered in a white paper presented to Parliament in 1988, when it received general approval. It is generally considered that the strong application of a number of alcohol policy measures has contributed to keeping consumption low. The main measures in this regard are the limited availability of alcohol and its high price. The Ministry of Health and Social Affairs is responsible for national alcohol policy (except for taxation which comes under the Ministry of Finance) and has general responsibility for alcohol and drug issues concerning secondary prevention and treatment. The National Directorate for the Prevention of Alcohol and Drug Problems is concerned with coordination of governmental work on alcohol and drug matters, promotion of education and information activities, linkage between government and private bodies and advisory activities to public authorities.

There are several mass media, school-based and workplace programmes which deal with alcohol only and also some programmes which deal with substance use in general. To promote an alcohol-free lifestyle, the authorities give considerable financial support to temperance and anti-drug organizations. A fund for alcohol-free hotels and serving places gives loans at low interest.

Alcohol data collection, research and treatment

The National Institute for Alcohol and Drug Research specializes in research on alcohol issues. It carries out annual postal surveys in Oslo on young people's alcohol, tobacco and drug habits (biannually on a national sample), and every sixth year a detailed survey is made on a representative sample of the total population. Statistics in Norway publishes numbers of persons in institutions for people with alcohol and drug problems but the groups are not reported out separately.

Efforts are being made to integrate services dealing with alcohol problems into the more general services for health and social care. SIFA (National Institute for Alcohol and Drug Research) has been given the responsibility of developing a National Documentation System to provide an overview of treatment facilities for alcohol and drug abusers. Types of institutions providing care for people with alcohol problems include detoxification clinics, clinics for alcohol dependents, health resorts, supervision homes and protection homes. The majority are privately owned but receive funds from the country for running costs. There are also about 25 Evangelical Centres run by the Pentecostal Church. Health and Social Welfare officers are responsible for organizing services for families.

Treatment policy has turned towards increasing the responsibility for care at community and country levels, with a reduction in the number of institutions and an increase in outpatient facilities. In 1985, there were about 70 institutions altogether, 68 per cent being owned and run by private organizations. The majority were religious temperance organizations such as Blue Cross. Since early 1985, the administrative responsibility for these institutions has been in the hands of the 19 county administrations. As far back as the early 1900s, special institutions for inpatient care of people with alcohol problems were the main form of treatment and care, so nearly every county has at least one such institution.

Poland

Sociodemographic characteristics

POPULATION	1980	1990	1995
Total	35 574 000	38 119 000	38 388 000
Adult (15+)	26 945 000	28 544 000	29 614 000
% Urban	58.2	62.5	64.7
% Rural	41.8	37.5	35.3

Health status

Life expectancy at birth, 1990-1995 : 66.7 (males), 75.7 (females)

Infant mortality rate in 1990-1995 : 15 per 1000 live births

Socioeconomic situation

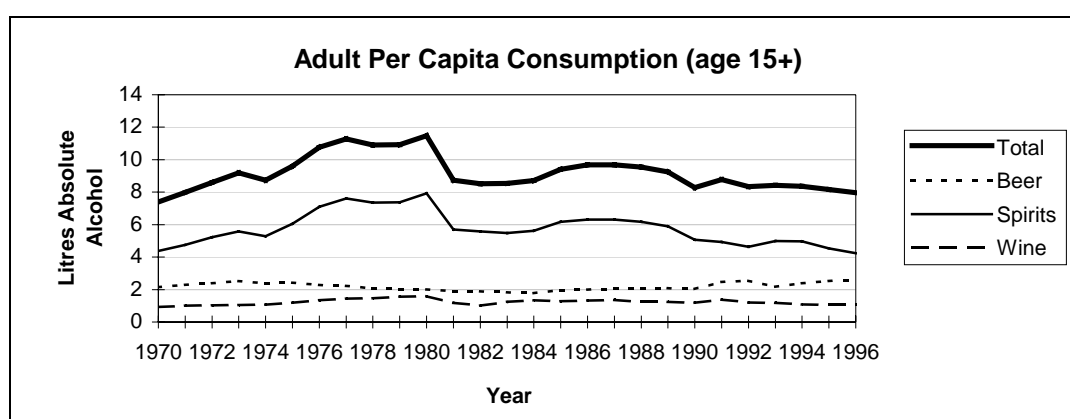
GNP per capita (US\$), 1995: 2790, PPP estimates of GNP per capita (current int'l \$), 1995: 5400.

Average distribution of labour force by sector, 1990-1992 : agriculture 27%; industry 37%; services 36%

Alcohol production, trade and industry

Poland produces beer, distilled spirits and wine. In 1985, the percentage of people employed in the alcohol industry was 0.83 per cent of total industrial employment. The top five brewers, each of which has signed on a foreign strategic partner, have a combined 55 per cent market share. Elbrewery Company Ltd, which is controlled by the Australian Brewpole Group, has the largest share of the Polish beer market. The controlling interest in Browary Tyskie, the country's second largest brewer, is owned by Kompania Piwna, whose leading shareholders include Euro Agro Centrum and South African Breweries, which plan a major investment in the brewer over the next five years. These two are also majority shareholders in fourth-ranking Lech Browary Wiepolsky. Heineken NV owns 32 per cent of the shares in Ywiec, the third largest brewer. Rounding out the top five is Okocim, of which Carlsberg owns nearly 32 per cent. All of these breweries have ambitious expansion plans, hoping that per capita beer consumption will rise.

Alcohol consumption and prevalence



Consumption

Local experts estimate that unrecorded consumption in 1994 was 3.7 to 4.2 litres of pure alcohol. The State Agency for Prevention of Alcohol Problems estimated that illegal production and smuggling totalled between 20 and 25 per cent of the legal trade. These combine to suggest that actual per capita consumption in 1994 was between 14.47 and 15.7 litres of absolute alcohol per adult, as opposed to 8.36 litres per adult recorded consumption.

Prevalence

A national sample survey of drinking habits among people 15 years or older in 1984 found that more than one quarter had not drunk alcohol during the previous 12 months. About 64 per cent were moderate drinkers, and 10.4 per cent were classified as abusers. A 1993 nationwide sample of 2000 adults found that 23.7 per cent of males age 18 or over drank more than 150 grams of alcohol per week, while only 3.6 per cent of females drank greater than 115 grams per week. Eleven per cent of adults abstained completely from alcohol.

Age patterns

A study of 8940 15 to 16 year olds (4494 boys and 4349 girls) was conducted in 1995. The response rate was 84 per cent (81 per cent for boys and 85 per cent for girls). Eighty per cent of the respondents had drunk an alcoholic beverage in the last 12 months, and 44 per cent had drunk to intoxication in the last 12 months. Lifetime prevalence of alcohol use was 92 per cent (93 per cent for boys and 90 per cent for girls).

Studies of young people in the early 1980s showed that, by the age of 14 years, 50 per cent drank periodically and by the age of 15 to 19 years, the number of boys who drink had increased by 100 per cent. A 1993/1994 survey among 15 year old boys and girls revealed that almost 90 per cent of boys and 87 per cent of girls have tried alcoholic beverages. Twenty-two per cent of boys and 9.2 per cent of girls drink at least weekly, and 33 per cent of boys have been drunk at least twice, compared with 18 per cent of girls.

Economic impact of alcohol

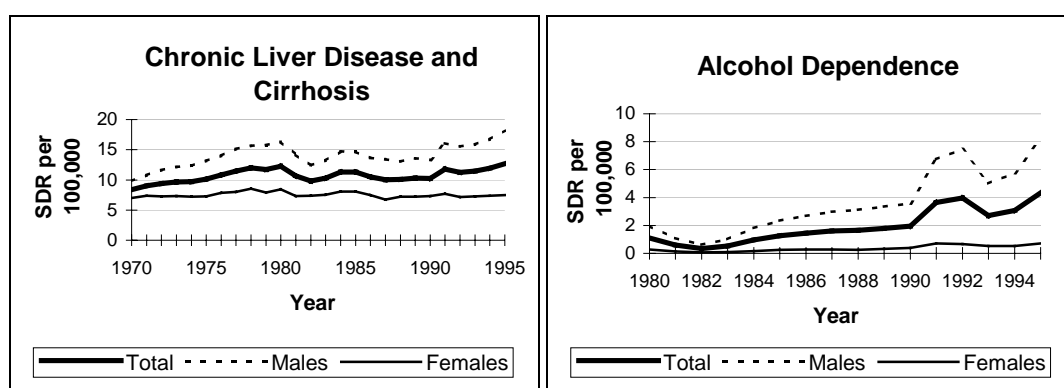
The per capita expenditure on alcoholic beverages as a per cent of the total per capita expenditure went from 9.9 per cent in 1960, up to 13.6 per cent in 1985, and fell to 6.8 per cent in 1993.

In 1995, the estimated costs of alcohol-related health and social problems were US\$ 2500 million, and alcohol revenue was 4.9 per cent of total government revenue. Of the total taxes collected from alcohol (excise, VAT and trade tax), 0.25 per cent is earmarked for the treatment of alcohol related problems. The estimated cost of alcohol programmes in 1996 was US\$ 5 million.

Mortality, morbidity, health and social problems from alcohol use

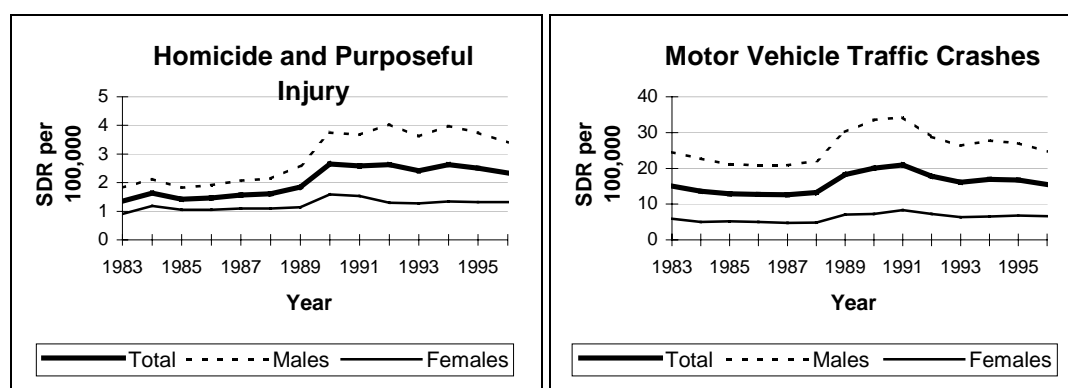
Alcohol dependence and related disorders

The SDR from alcohol dependence has risen steadily in recent years, from 1.1 to 4.3 per 100 000 population between 1980 and 1995. The rate of admission to inpatient care per 100 000 population for alcoholic psychosis rose from 23 in 1980 to 30.2 in 1991, before falling back to 27.4 in 1991.



Mortality

The percentage of homicides committed while intoxicated rose from 53.9 per cent to 75 per cent between 1970 and 1985. The number of alcohol-related fatal motor vehicle crashes fell from 453 in 1960 to 2199 in 1991.



Social Problems

Among people detained in sobering-up stations in 1985, 2169 were less than 18 years old, and 95 470 were between the ages of 19 and 24. In the 1980s about 25 per cent of all divorces were considered to result from excessive drinking, and it was estimated that about one million children were being brought up in families with alcohol problems. The percentage of rapes committed while intoxicated rose from 53.2 per cent in 1970 to 81.9 per cent in 1985.

Alcohol policies

Control of alcohol products

Between 1990 and 1994, the real prices of beer and wine increased while the real price of spirits fell.

A licence is required for the production of spirits and the distribution of all three types of alcohol, i.e. beer, spirits and wine. Control of the alcohol market weakened significantly as a result of the decentralization of decision making on the number and location of liquor stores. There are restrictions on type of outlets, but these restrictions are not effectively enforced. Specific restrictions are developed at a local community level.

The advertising of wine and spirits is prohibited, and penalties now range from US\$ 3300 to US\$ 167 000. In 1998 the House of Parliament voted to allow beer advertising. The advertising of alcohol-free beer is still permitted as well. Labels for alcohol content are required by law, and there is no maximum legal limit for the alcohol content of beverages.

Poland has some legislation to support environments free from alcohol.

Control of alcohol problems

There is a minimum legal age limit of 18 for buying alcohol but it is not effectively enforced. The BAC limit is 0.03 g% for drivers. Upon conviction for a first offence of driving above the BAC limit, suspension of driving licence is usual (and imprisonment for a second offence). Random alcohol breath testing is also carried out infrequently.

The State Agency for Prevention of Alcohol-Related Problems supports the educational initiatives of several nongovernmental organizations, and there are national school-based programmes which deal with substance use. A new prevention programme developed by the State Agency for school children was designed to reach 250 000 school children and 3000 teachers in 1994. The Church and the denominational organizations are engaged in various activities concerning prevention, support and information.

The First Permanent Commission for Counteracting Alcoholism was established at the Council of Ministers as early as 1956. During 1983-1987, it was headed by the Deputy Prime Minister, although, in 1987 leadership was transferred from the Council of Ministers to the Ministry of Health. Its position as the central agency for alcohol prevention has slowly been usurped by the State Agency for Prevention of Alcohol-Related Problems, which works in cooperation with regional agencies.

Alcohol data collection, research and treatment

The Central Statistical Office, the Central Bureau of Statistics and the Institute of Psychiatry and Neurology all collect data regarding alcohol.

Since November 1987, the Commission for Counteracting Alcoholism has functioned in the Ministry of Health and Social Welfare. The Commission brings together representatives of ministries and voluntary organizations. In 1981, an interdisciplinary research programme on "health and social problems associated with alcohol" was set up. The programme was initiated and coordinated by the Institute of Psychiatry and Neurology. More than 50 scientific research units joined in the programme between 1981 and 1985, and approximately 70 themes and studies were carried out in various institutions of the Polish Academy of Sciences, at six universities, eight medical schools and many other centres all over the country.

Beginning in 1982, "other dependence-producing substances" were included in the programme. During 1986-1990 the programme was further expanded. In the beginning of the 1990s, alcohol research lost priority and funds, but in 1995 the State Agency for Prevention of Alcohol-Related Problems and the Institute of Psychiatry and Neurology established the Council for Alcohol Research to make decisions regarding grants for alcohol research. Currently 13 projects are funded by the council.

Alcohol problems are considered in the undergraduate medical courses on psychiatry for physicians and nurses, and a wide range of courses are run by the Institute of Social Prevention and Re-socialization, University of Warsaw, and by the Institute of Psychiatry and Neurology. The Ministry of Justice is responsible for training personnel in prisons and detention homes. Other groups receiving training in dealing with alcohol problems include the police, lawyers, teachers, sociologists, employees in trade and catering, activists in youth organizations, reporters and others working in the mass media.

Starting in the 1950s, long-term inpatient treatment was used regularly, but this system began to change following the 1982 law and the new programmes of the Ministry of Health and Welfare, which emphasize the involvement of both primary and specialized care services in the prevention and treatment of alcohol problems. Certain voluntary organizations run alcohol clinics and rehabilitation units and organize psycho-social activities, with some providing counselling not only for people with alcohol problems, but also for their families. In 1995, there were approximately 400 outpatient alcohol clinics, 16 day care centres and several hostels. Poland also provides more than 60 major residential treatment services. Many of these are located in psychiatric hospitals, and are generally set up to treat large numbers of people (46 psychiatric hospitals with 2300 beds). A further 11 wards are available in general medical facilities and these provide 339 beds. The Government Council for Family Problems has proposed to incorporate family protection programmes for families with alcohol problems into the more general programmes which serve to aid families in poor economic circumstances, and socially neglected children.

Portugal

Sociodemographic characteristics

POPULATION	1980	1990	1995
Total	9 766 000	9 868 000	9 823 000
Adult (15+)	7 232 000	7 807 000	7 970 000
% Urban	29.4	33.5	35.6
% Rural	70.6	66.5	64.4

Health status

Life expectancy at birth, 1990-1995 : 71.1 (males), 78.0 (females)

Infant mortality rate in 1990-1995 : 10 per 000 live births

Socioeconomic situation

GNP per capita (US\$), 1995: 9470, PPP estimates of GNP per capita (current int'l \$), 1995: 12 760.

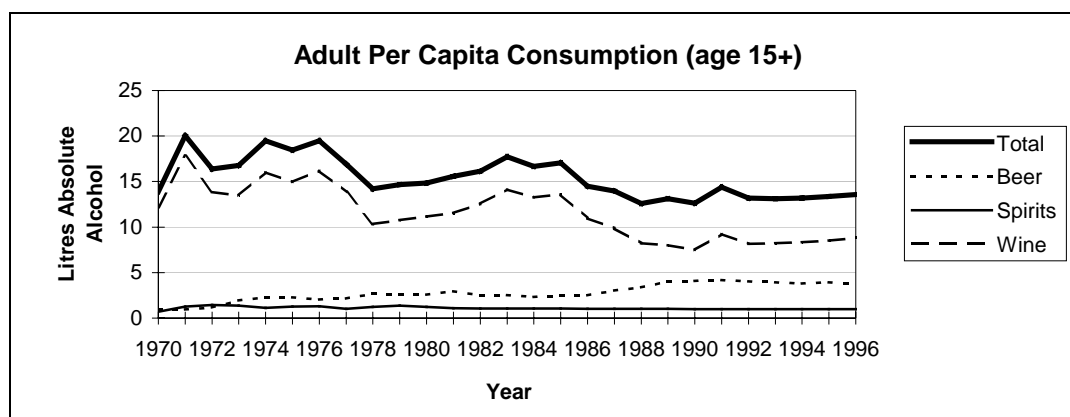
Average distribution of labour force by sector, 1990-1992 : agriculture 17%; industry 34%; services 49%

Adult literacy rate (per cent), 1995 : more than 95

Alcohol production, trade and industry

Portugal produces beer, distilled spirits and wine. It is a major exporter of wine.

Alcohol consumption and prevalence



Consumption

Production of wine, Portugal's chief alcoholic product, has led to a decrease in adult per capita alcohol consumption in the past 25 years, which has been slightly counterbalanced by a modest increase in beer consumption. There is no information available on unrecorded consumption.

Prevalence

A 1990 survey of a sample of the population aged 15 years and over showed that 39 per cent drank alcohol at least three to four days per week, 24 per cent were moderate consumers (drinking at least weekly) and 37 per cent drank less than weekly or never.

Age patterns

A study of 2033 15 to 16 year olds (852 boys and 1181 girls) was conducted in 1995. The response rate was 92 per cent. Seventy-four per cent of the respondents had drunk an alcoholic beverage in the last 12 months, and 28 per cent had drunk to intoxication in the last 12 months. Lifetime prevalence of alcohol use was 79 per cent (80 per cent for boys and 78 per cent for girls).

In a series of surveys in public schools in various regions between 1987 and 1993, lifetime prevalence of alcohol use among 12 to 18 year olds was shown to be about 60 per cent. Prevalence of use in the previous 30 days varied between 27 per cent and 42 per cent. A 1990 survey showed that 7 per cent of boys aged 11 or 12 years, and 19 per cent of boys between the ages of 13 and 15 drank alcohol weekly. Of girls, three per cent of those aged 11 or 12 and seven per cent of those between the ages of 13 and 15 drank alcohol weekly.

Alcohol use among population subgroups

Prison surveys of male prisoners in Portugal have shown a before-prison prevalence of 86.3 per cent for alcohol use and a use-in-prison prevalence of 63.8 per cent.

Economic impact of alcohol

About five per cent of the active population (20 per cent of active agricultural workers) are employed in viticulture (240 000 workers). More than a tenth of the population (1.2 million) are directly economically dependent on wine production and trade.

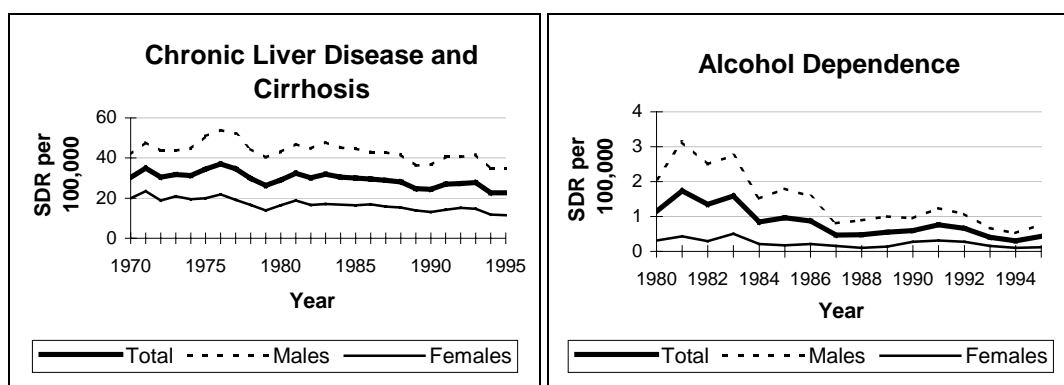
Mortality, morbidity, health and social problems from alcohol use

Alcohol dependence and related disorders

The SDR for alcohol dependence fell from 1.14 to 0.43 per 100 000 population between 1980 and 1995.

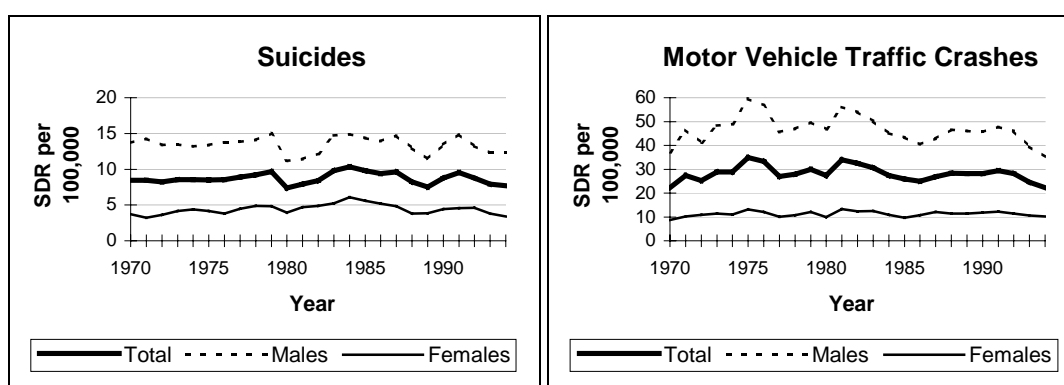
Mortality

An analysis of regional and temporal co-variation of suicide rates and indicators of alcohol use and abuse in Portugal revealed that an increase in per capita consumption of alcohol is accompanied by a simultaneous increase in the male suicide rate of 1.9 per cent. The SDR per 100 000 population for chronic liver disease fell from 30.3 to 22.7 between 1970 and 1995.



Social problems

The number of alcohol-related motor vehicle crashes per 100 000 population rose from 18 to 23.2 between 1988 and 1992.



Alcohol policies

Control of alcohol products

The real prices of beer, wine and spirits have been increasing during the early 1990s. There are no restrictions on hours or days of sale or on type of location of outlets. A licence is required for the production and distribution of beer, wine and spirits.

The advertising of all three types of alcoholic beverages, i.e. beer, spirits and wine is restricted on radio and television, and the advertising of beer and spirits is banned on billboards and in cinemas. There are no restrictions on the advertising of alcohol in the print media. Alcohol advertising is not allowed inside schools or in any publication addressed to young people under 18 years of age, and the advertisement cannot connect the product to people under 18 years of age or present them drinking alcoholic beverages. Advertisements are not allowed to encourage excessive drinking or to intimidate non-drinkers, and they cannot suggest that alcohol will lead to social success or provide increased ability, or that alcohol has therapeutic properties, is a stimulant or a sedative. Advertisements cannot associate alcohol with positive properties, with driving or with physical exercise, or with sporting activities.

The advertising restrictions are enforced through the application of the "Publicity Code", a national law created in 1990 and revised in 1995. Enforcement occurs after a breach and is the responsibility of the General Direction of Social Communication and the National Institute of Consumers Defence. There have been many breaches, and little action has been taken to enforce the ban.

Labels for alcohol content are required by law, and the maximum legal limit for alcohol content of "green wine" is 12 per cent. General and specific health warnings are not required by law.

Control of alcohol problems

There is a minimum legal age limit of 16 years for buying alcohol, but it is infrequently enforced. BAC limit is 0.05 g% for drivers. On conviction for a first offence of driving above the permitted BAC, suspension of driving licence or imprisonment is usual. Random alcohol breath testing is frequently carried out.

The National Committee against Alcoholism (NCA) is the national agency dealing with the prevention of alcohol problems. Until November 1988, there was no explicit policy statement concerning alcohol. However at the end of 1986 the NCA presented to the Minister of Health the following proposals: recommendations for legislation on measures to prevent alcohol problems; a draft comprehensive national programme on alcohol defining priorities; suggestions for establishing an inter-ministerial coordinating committee on alcohol problems, comprising personnel from various ministries and other bodies.

A 1988 government decree established Regional Alcoholology Centres in Coimbra, Lisbon and Oporto. Their main objectives are prevention and treatment of alcohol-related problems in their respective zones, in collaboration with the regional health and welfare administrations and centres. These three regional alcohol agencies play a significant role in the treatment and prevention of alcohol problems.

There are national mass media programmes dealing with drinking and driving. Other alcohol education programmes are undertaken by various agencies and individuals. Some pilot training is now being given to general practitioners, and there are some courses on alcohol problems within public health training.

Alcohol data collection, research and treatment

The National Institute of Statistics and the International Wine Bureau both collect some data on alcohol but there is no specific national agency responsible for all relevant data collection.

Treatment until recently was mainly confined to inpatient treatment in the three zone centres attached to large psychiatric hospitals. Greater attention is now being given to small units for the treatment of alcohol dependents in local health centres and mental health centres. Training for decentralized treatment is being stimulated by the zone centres.

In 1998 the Portuguese Government created three Regional Alcohol Centres to prevent alcohol abuse and coordinate alcohol-related activities as well as to treat people with alcohol-related problems. The Centres cover the northern, central and southern regions of Portugal.

Republic of Moldova (the)

Sociodemographic characteristics

POPULATION	1980	1990	1995
Total	4 011 000	4 362 000	4 432 000
Adult (15+)	2 938 000	3 145 000	3 263 000
% Urban	39.9	47.8	51.7
% Rural	60.1	52.2	48.3

Health status

Life expectancy at birth, 1990-1995 : 63.5 (males), 71.6 (females)

Infant mortality rate in 1990-1995 : 25 per 1000 live births

Socioeconomic situation

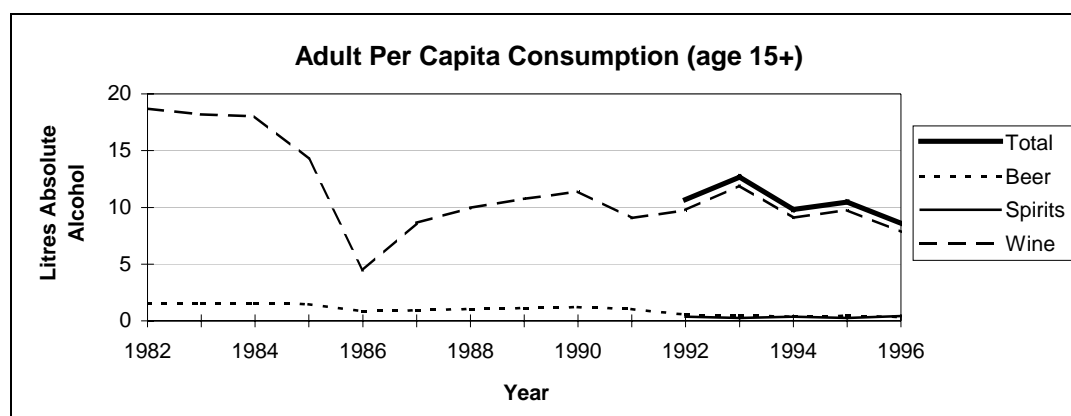
GNP per capita (US\$), 1995: 920

Average distribution of labour force by sector, 1990-1992 : agriculture 21%; industry 26%; services 53%

Alcohol production, trade and industry

The Republic of Moldova produces beer, distilled spirits and wine.

Alcohol consumption and prevalence



Consumption

There is no quantified information available on unrecorded consumption. However, it is known that domestic alcohol production is about 40 to 70 per cent of state production. At present there is a large amount of unrecorded alcohol imports which is distributed illegally in the Republic of Moldova, and there is also diversion of spirits intended for other use into beverage making. It is estimated that, in all, unregistered consumption accounts for about 70 per cent of total consumption. Recorded consumption in 1996 was approximately 8.6 litres of absolute alcohol per adult. Taking the midpoint of estimated unrecorded consumption, total consumption, including unregistered, would then be approximately 15.6 litres of absolute alcohol per adult.

Prevalence

It is estimated that 15 per 1000 people drink heavily and that about 20 per cent of these are women.

Economic impact of alcohol

Consumer expenditure on alcoholic drinks, as a percentage of general expenditure on purchase of goods and payments for services, dropped from 2.6 to 1.9 between 1990 and 1995. Wine accounts for between 35 and 40 per cent of the Republic of Moldova's gross domestic product.

Mortality, morbidity, health and social problems from alcohol use

Alcohol dependence and related disorders

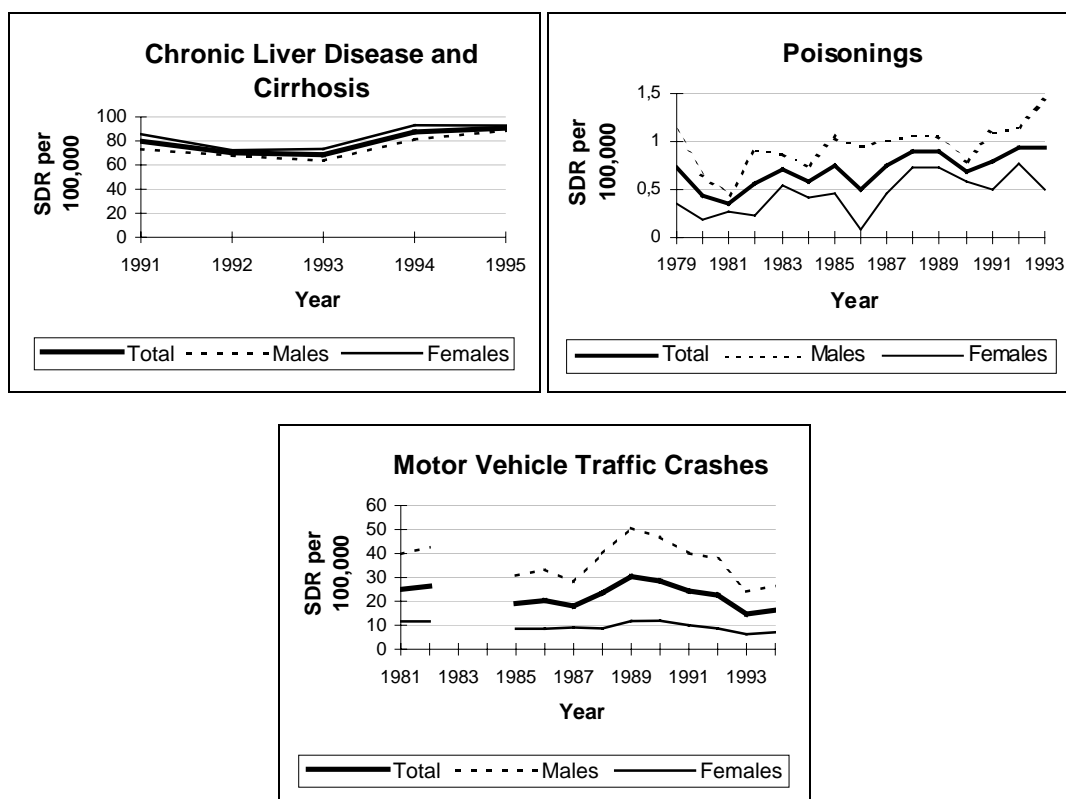
The SDR per 100 000 population has risen rapidly in recent years, placing the country among the top ten countries most heavily affected by alcohol dependence.

The recorded morbidity rate for alcohol dependence (per 100 000 population) fell by 4.4 per cent between 1990 and 1991 (1598.8 and 1529.9, respectively), while the morbidity indicators for alcoholic psychosis rose by 47.1 per cent (from 10 to 14.7) during the same period. The rate of admission to inpatient care (per 100 000 population) for alcoholic psychosis was 9.4 in 1993, compared to 25.5 in 1985 and 14.7 in 1991. The number of patients (per 100 000 population) with alcohol dependence registered at hospitals and other treatment centres during the year fell from 5.5 in 1990 to 3.4 in 1992, then increased to 5 in 1990.

The number of people treated for alcohol dependence in outpatient centres has recently decreased. This decrease in treatment is explained by the lack of medicines for treatment and the high prices of those medicines which are available.

Mortality

The SDR per 100 000 population (all ages) for chronic liver disease and cirrhosis was 90.7 in 1995. This represents an increase from the 79.3 per 100 000 reported in 1980, being the highest rate in the world.



Social problems

The SDR from alcohol-related motor vehicle traffic crashes per 100 000 inhabitants was 0.4 in 1993. The number of motor vehicle traffic crashes involving alcohol was 11 per 100 000 population in 1992. The number of persons committing crimes under the influence of alcohol (thousands) increased from 5.5 in 1990 to 6.4 in 1994, then fell to 4.9 in 1995.

Alcohol policies

Control of alcohol products

The trend in the real prices of wine and spirits has been stable but the trend in the real price of beer has been increasing during the early 1990s. Table wines are taxed at between 5 and 8 per cent, beer (containing 4 to 6 per cent alcohol) is taxed 18 per cent and spirits (over 35 per cent proof) are taxed 18 per cent.

The draft National Alcohol Plan proposes restrictions on the sale of alcoholic beverages including the introduction of an age limit. However, public concern has already led to the introduction of some control measures, such as regulation of the retail trade in alcohol, restrictions on hours and days of sale and on number of outlets, a licensing system for distribution of alcoholic beverages, and taxation. During the anti-alcohol campaign in the mid 1980s in the former USSR, the State in Moldova completely controlled production and distribution of hard liquor and about 85 per cent of wine. The political, economic and social changes of 1990-1992 led to the disappearance of the state monopoly but there has been some discussion about its re-establishment.

There are no restrictions on the advertising of alcohol. Labels for alcohol content are required by law. There is a maximum legal limit of 42 per cent for the alcohol content of vodka/cognac, 16 per cent for wine and 4 to 6 per cent for beer.

Control of alcohol problems

There is a minimum legal age limit of 18 years for the purchase of alcohol. The BAC limit is 0.03 g%. Breath testing is obligatory after motor vehicle crashes or if a person is suspected of using alcohol at work. Otherwise current law only requires establishment of BAC in cases of unconsciousness or severe poisoning. Priorities of the early 1990s have been reducing availability; increasing the role of primary health care teams in the prevention and early detection of alcohol problems; developing the role of the social welfare and criminal justice system in the prevention and management of alcohol problems; developing specialized treatment for alcohol dependence and other alcohol problems and addressing particular alcohol problems such as drinking and driving.

Some substantial changes took place in alcohol and drug policy during 1993 and 1994. National programmes on alcohol and drugs were prepared. While the drug programme was adopted by parliament, the alcohol programme was still under discussion as of late 1995. The proposed strategy and approaches of the draft National Alcohol Programme are in line with the European Alcohol Action Plan. The draft plan is multi-sectoral in perspective and proposes a range of health, social, economic and legislative measures.

The Republican Dispensary of Narcology (RDN) is the national agency dealing with the prevention of alcohol problems. It coordinates all prevention activities of other relevant agencies in the Republic of Moldova. The RDN prepares information for the mass media. There are no national alcohol education programmes in schools or workplaces.

Alcohol data collection, research and treatment

The RDN has a network of two specialized hospitals, three specialized dispensaries and 40 consulting rooms. It is also responsible for about between 70 and 80 per cent of outpatient treatment services for heavy drinkers.

Romania

Sociodemographic characteristics

POPULATION	1980	1990	1995
Total	22 201 000	23 207 000	22 835 000
Adult (15+)	16 278 000	17 736 000	18 166 000
% Urban	49.0	53.3	55.4
% Rural	51.0	46.7	44.6

Health status

Life expectancy at birth, 1990-1995 : 66.6 (males), 73.3 (females)

Infant mortality rate in 1990-1995 : 23 per 1000 live births

Socioeconomic situation

GNP per capita (US\$), 1995: 1480, PPP estimates of GNP per capita (current int'l \$), 1995: 4360.

Average distribution of labour force, 1990-1992: agriculture 29%; industry 43%; services 28%

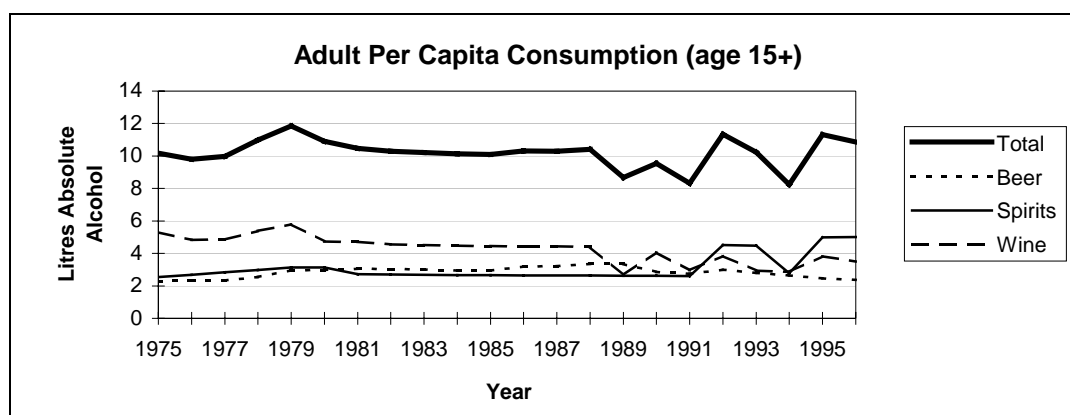
Alcohol production, trade and industry

Romania produces beer, distilled spirits and wine. South African Breweries owns the largest brewery. Belgium-based Interbrew has also bought interests in breweries in Romania.

New taxes levied in 1993 on distilled spirits all but eradicated imports and contributed to widespread smuggling. Lobbying from the industry succeeded in lowering the taxes on brandy and vodka to 100 per cent, and on whisky to 150 per cent. At least two distillers – Diageo (formerly IDV) and Fenshaw

International - eliminated these costs by forming joint ventures and producing their products within Romania.

Alcohol consumption and prevalence



Consumption

Recorded alcohol consumption has fluctuated considerably since the late 1980s. Increases in spirits consumption have come primarily from imports. Information on unrecorded consumption is not available.

Prevalence

A 1992 population survey of people 20 years and older found 77 per cent of males to be drinkers, with 16 per cent drinking daily. Among women, 47 per cent were drinkers, and two per cent drank daily. This represents an increase over 1989, particularly among females. Consumption was higher in rural areas, among males aged 30 to 59, among females aged 20 to 29, and among qualified workers.

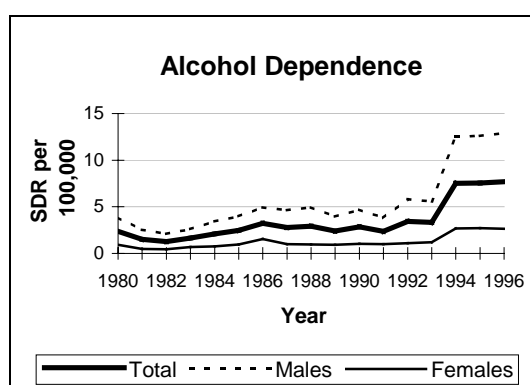
Economic impact of alcohol

On average, 11 per cent of household expenditures were spent on alcohol in 1991.

Mortality, morbidity, health and social problems from alcohol use

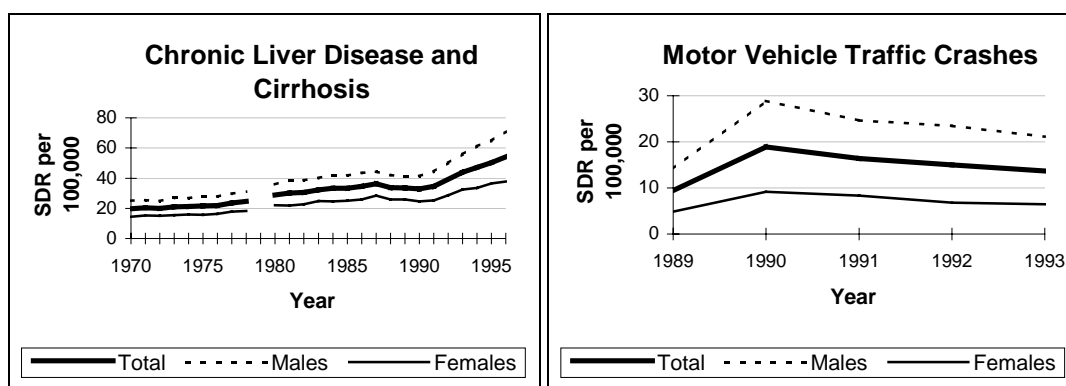
Alcohol dependence and related disorders

As a result of a sharp increase in the mid-1990s, Romania has the one of the highest SDR per 100 000 population from alcohol dependence in the world. The rate per 100 000 population of inpatient treatment for alcoholic psychosis dropped from 37.1 to 29.1 between 1980 and 1991, then rose to 47.7 in 1993.



Mortality

The SDR for chronic liver disease rose from 32.7 to 44.7 between 1980 and 1993.



Social problems

The number of alcohol-related motor vehicle crashes per 100 000 population was 2.5 in 1985, 1.7 in 1989 and 2.3 in 1992. In 1993 four per cent of all traffic crashes were alcohol-related.

Alcohol policies

Control of alcohol products

Prior to 1993, there were no excise taxes, and the import duty on spirits was 25 per cent. In 1993 the government instituted a tax of 300 per cent on imported whisky, 200 per cent on vodka, and similar amounts on other types of alcohol. In June of 1995, customs duties were increased to 269.5 per cent. After heavy lobbying from the industry, the taxes on brandy and vodka were decreased to 100 per cent, and on whisky to 150 per cent. The real prices of all three types of alcohol i.e. beer, spirits and wine have been increasing during the past five years.

The advertising of all three types of alcoholic beverages is restricted on television and radio, and the advertising of spirits is restricted in newspapers and magazines. Labels for alcohol content on alcohol products are required by law.

Control of alcohol problems

There is a minimum legal age limit of 18 for buying alcohol, and this restriction is fairly effectively enforced. The BAC limit is 0.0 g% for drivers. A conviction for a first offence of driving above this limit will usually result in the suspension of the driver's licence. Random alcohol breath testing is frequently carried out. Alcohol consumption is forbidden in educational institutions and in workplaces which are considered hazardous. There are some mass media programmes which deal with substance abuse.

Alcohol data collection, research and treatment

There is no national agency for the prevention of alcohol problems. The Centre for Health Statistics and Medical Documentation in Bucharest is involved in alcohol-related data collection.

Russian Federation (the)

Sociodemographic characteristics

POPULATION	1980	1990	1995
Total	138 483 000	147 913 000	147 000 000
Adult (15+)	108 505 000	113 952 000	116 050 000
% Urban	69.8	74.0	76.0
% Rural	30.3	26.0	24.0

Health status

Life expectancy at birth, 1990-1995 : 61.7 (males), 73.6 (females)

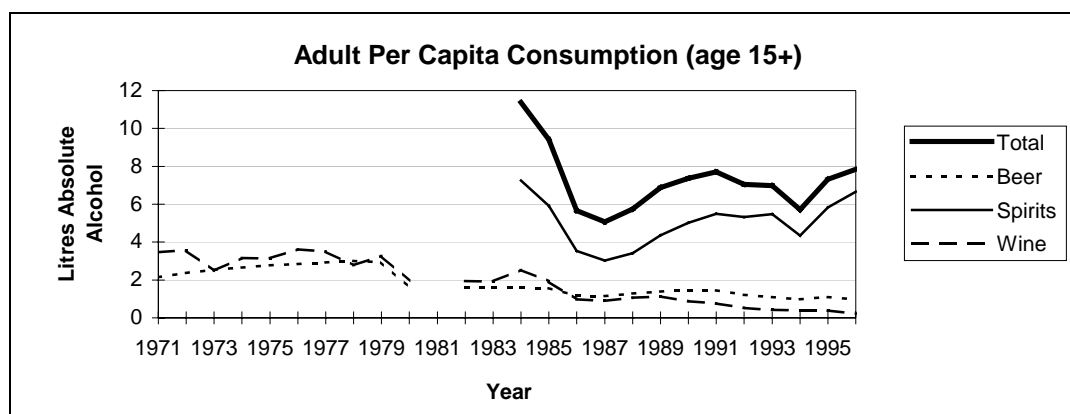
Infant mortality rate in 1990-1995 : 21 per 1000 live births

Socioeconomic situation

GNP per capita (US\$), 1995: 2240, PPP estimates of GNP per capita (current int'l \$), 1995: 4480
Average distribution of labour force by sector, 1990-1992 : agriculture 20%; industry 46%; services 34%

In 1996, Russian President Boris Yeltsin announced the government take-over of all alcohol production and marketing to finance massive governmental debt, to take effect in January 1997. There are numerous joint ventures between Russian manufacturers and foreign alcohol corporations. There is also reportedly widespread illegal production of alcohol, particularly vodka.

Alcohol consumption and prevalence



Consumption

In 1993 unrecorded consumption was estimated at 4.5 litres per capita in 1985 and 7.5 litres per capita. This implies that total adult per capita consumption in 1993 was 14.5 litres of pure alcohol. (Note: Figures prior to 1990 are for the former USSR.)

Age patterns

Results of a study on 15 year old boys and girls in the region of St. Petersburg for 1993/1994 showed that 80 per cent of boys had tried alcoholic beverages, 17.3 per cent drank alcoholic beverages at least once a week and 20.8 per cent had been drunk at least twice. Of girls, 83.5 per cent had ever tried alcoholic beverages, 6.2 per cent drank alcoholic beverages at least once a week and 12.3 per cent had been drunk at least twice.

Economic impact of alcohol

In 1995, alcoholic beverages constituted 2.5 per cent of total consumer expenditure, down from 5 per cent in 1990. Illicit production costs the government an estimated US\$ 360 million annually in lost tax revenues.

Mortality, morbidity, health and social problems from alcohol use

Alcohol dependence and related disorders

The number of patients suffering from alcoholic psychosis registered at outpatient departments (per 10 000 population, all ages) fell from 3.5 to 1.8 between 1984 and 1990, while the rate of admission to inpatient care for alcoholic psychosis (per 100 000 population) rose from 74.6 to 83.3 between 1980 and 1993. The number of alcohol dependent patients registered at outpatient departments (per 10 000 population, all ages) decreased from 183.9 to 177.3 between 1984 and 1990, while the number of persons admitted to inpatient treatment suffering from alcohol dependence (per 10 000 population) decreased from 31.2 to 26.4 during the same period.

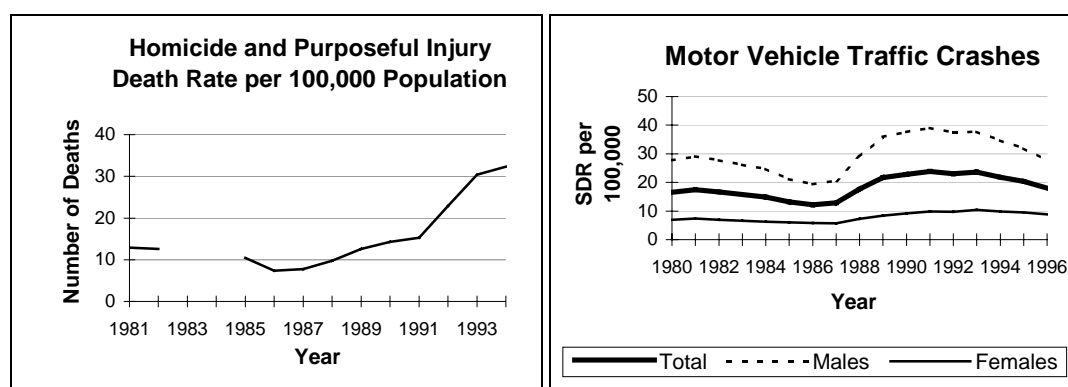
Mortality

Mortality from alcohol-related disease in general dropped during the mid-1980s, and then rose sharply in the early 1990s. The main factor for this was a sharp fall, then increase in death by alcohol

poisoning, which accounted for 80 per cent of male and 70 per cent of female alcohol-related deaths under age 45 in 1987.

AGE-STANDARDISED MORTALITY RATES PER 100 000 POPULATION FROM ALCOHOL-RELATED DISEASE		
Year	Male	Female
1984	455	123
1987	210	59
1994	863	230

The rate per 100 000 population of chronic liver disease and cirrhosis rose from 12.4 to 18.6 between 1981 and 1993. Male rates went from 20.3 to 25.8, while female rates increased from 7.8 to 13.9 during the same period. In 1994, 71 per cent of all murders were committed in a drunken state.



Health problems

A study carried out in one Moscow city district, one district centre and a township in Moscow Oblast examined all calls answered by emergency ambulance teams for the first quarter of 1994. Emergencies connected with alcohol use accounted for 6.8 to 7.7 per cent of all calls (not including psychotic disturbances due to alcohol abuse). Those in a state of intoxication are hospitalized twice as often as all other patients attending emergency care centres (29.5 per cent as against 14.1 per cent). The most frequent reasons given for hospitalization among cases connected with alcohol use were injuries or other accidents, which accounted for 27.8 per cent of all "alcohol" calls and for between 50 and 55 per cent of all hospital admissions in connection with alcohol use. Women made up 17.5 per cent of all patients calling in emergency assistance in connection with intoxication in Moscow Oblast and 16.7 per cent in Moscow City. Of them, 32 per cent were hospitalized.

Social problems

The percentage of crimes committed in a state of alcohol intoxication, compared with all crimes, rose from 18.2 to 34.9 between 1990 and 1994. In 1994, 68.4 per cent of all rapes, 47.2 per cent of all robberies and 62.2 per cent of all attacks were committed in a state of alcohol intoxication. The rate of motor vehicle traffic crashes involving alcohol was 45.1 per 100 000 population in 1991 and 31.6 in 1992.

Alcohol policies

Control of alcohol products

The real prices of beer and wine have been increasing, and that of spirits has been decreasing during the early 1990s. Prior to 1997, table wines were taxed not less than 31 per cent, beer (four to six per cent alcohol) was taxed not less than 26 per cent and spirits (over 35 per cent proof) were taxed not less than 37 per cent. An excise rate of 80 per cent was levied on vodka and other hard liquors with an alcohol content ranging from 28 per cent to 85 per cent. A new alcohol tax system was effected in January 1997, requiring a tax stamp on all bottles sold in the country. At the same time, the Russian Economics Ministry declared beer a non-alcoholic beverage for the purposes of taxation.

There are some restrictions on the hours of sale for alcoholic beverages. The sale of spirits which have been additionally distilled is banned, as is the sale of raw and hydrolysed and fruit-derived spirits. Drinking pure spirits is prohibited except in the far eastern regions of the Russian Federation. The sale of alcoholic beverages is forbidden within 500 metres of educational institutions and child care establishments, and on the grounds of addiction prevention/treatment institutions and industrial enterprises during working hours.

A licensing system for production and distribution currently exists alongside the traditional state monopoly. In January 1997 President Yeltsin announced plans to reinstate the state monopoly, but also noted that recently privatized distilleries and liquor stores would not be renationalized.

Since the ban on advertising of alcoholic beverages was not being effectively enforced, the President of the Russian Federation issued a decree in 1995 prohibiting advertising of alcoholic beverages and tobacco. There are provisions for any profits made by companies breaking this law to be confiscated and allocated to the Public Health budget. Advertising of alcohol is no longer shown on state-controlled television but indirect advertising continues. Labels for alcohol content are required by law. There is no maximum legal limit for the alcohol content of beverages.

Control of alcohol problems

There is a minimum legal age limit of 18 years for buying alcohol. The BAC limit is 0.01 g% for drivers. Conviction for a first offence of driving above the BAC limit carries a penalty of suspension of driving licence for one year, or a fine. A second offence carries a penalty of suspension of licence of one to three years or a fine. Random breath testing is carried out. There are national school-based programmes which deal with substance use.

Priorities of the early 1990s have been mass media campaigns to encourage safer drinking; encouraging lighter drinking in work settings; and using price policy to reduce demand and developing the role of the social welfare system in the prevention and management of alcohol problems.

Alcohol data collection, research and treatment

The Interdepartmental Scientific Council for Narcology plans and coordinates relevant investigations, makes suggestions for improvement in population health indices and participates in professional training. The State Centre for Research in Narcology of the Ministry of Health, the Institute for Preventive Narcology, the Department of Social and Legal Problems or Prevention of Narcological Diseases and the Department of Epidemiology are research institutes which specialize in, and have a major responsibility for research on alcohol issues.

Since 1993/1994 the practice of compulsory treatment of persons addicted to alcohol and other drugs in preventive clinics has been abolished. Decree 959 of the Russian Federation Council of Ministers and Government in 1993 provided for the establishment of rehabilitation centres, social refuges, night shelters and other public institutions for persons addicted to alcohol or other drugs.

The Russian Federation provides more than 58 000 beds in government (municipal) alcohol treatment units. The majority of these beds are in 247 clinics (43 000 beds) and the remainder are in psychiatric hospitals. In addition, there is a large nationwide network of about 2000 non-residential alcohol services based in government health service clinics. Russian alcohol treatment services are set up to treat comparatively large numbers of people. Typically a residential alcohol treatment service is located in a psychiatric hospital and has 50 to 60 beds.

Slovakia

Sociodemographic characteristics

POPULATION	1980	1990	1995
Total	4 976 000	5 256 000	5 353 000
Adult (15+)	3 675 000	3 930 000	4 128 000
% Urban	51.6	56.5	58.8
% Rural	48.4	43.5	41.2

Health status

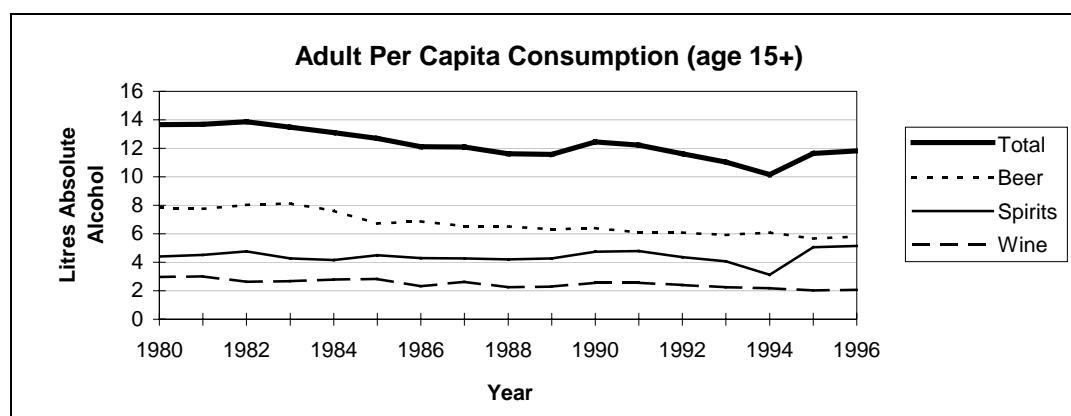
Life expectancy at birth, 1990-1995 : 66.5 (males), 75.4 (females)

Infant mortality rate in 1990-1995 : 12 per 1000 live births

Alcohol production, trade and industry

Slovakia produces beer, distilled spirits and wine. Heineken owns 66 per cent of Zlaty Bazant, Slovakia's largest brewer.

Alcohol consumption and prevalence



Consumption

The alcoholic beverage of choice is beer, consumption of which has fallen steadily since 1980. There is no information available on unrecorded consumption. Between 1994 and 1996, there was an increase in overall consumption driven by an increase in recorded spirits consumption.

Prevalence

There is no information available regarding the prevalence of drinking in the adult population.

Age patterns

According to a 1995/1996 survey, the percentage of secondary school students in Bratislava who had drunk alcohol during the 30 days preceding the interview increased from 60.7 to 61.8 among boys and from 59.2 to 65.1 among girls between 1995 and 1996. In a 1993 survey of primary school students aged 8, 10 and 12 years, 51 per cent, 61 per cent and 73 per cent respectively had tried wine. About 71 per cent of both age groups had tried beer.

A study of 2376 15 to 16 year olds (1262 boys and 1114 girls) was conducted in 1995. The response rate was 96 per cent (94 per cent for boys and 97 per cent for girls). Eighty-five per cent of the respondents had drunk any alcoholic beverage in the last 12 months, and 41 per cent had drunk to intoxication in the last 12 months. Lifetime prevalence of alcohol use was 96 per cent (96 per cent for boys and 94 per cent for girls).

A 1993/1994 study of 15-year-old boys and girls found that 95.4 per cent of boys had tried alcohol, 33 per cent drank alcohol at least weekly and 46.3 per cent had been drunk at least twice. Of girls, 93 per cent had tried alcohol, 10.3 per cent drank alcohol at least weekly and 0.2 per cent had been drunk at least twice.

Economic impact of alcohol

In 1994 the estimated cost of alcohol-related health and social problems was US\$ 570 million, while the estimated cost of all alcohol programmes was US\$ 62.3 million.

Mortality, morbidity, health and social problems from alcohol use

Alcohol dependence and related disorders

The rate of admissions to inpatient treatment for alcoholic psychosis (per 100 000 population) dropped from 50.2 to 35.4 between 1990 and 1993.

A survey between 1983 and 1987 of 12 759 inhabitants in the Slovak population and using the Michigan Alcohol Screening Test (MAST) found the drinking behaviour of 32.5 per cent of the sample problematic to some degree.

Mortality

The SDR per 100 000 population for chronic liver disease rose from 36.4 to 44.3 between 1980 and 1990, and then dropped to 37.5 in 1993.

Health problems

Between 1981 and 1989 the incidence of oesophageal cancer in males increased from 4.8 to 6.6 per 100 000 population.

Social problems

The number of alcohol-related motor vehicle crashes per 100 000 population dropped from 59.2 to 30.2 between 1990 and 1992.

Alcohol policies

Control of alcohol products

The real prices of all three types of alcohol, i.e. beer, spirits and wine increased during the early 1990s. Table wines are taxed 40 per cent, beer (four to six per cent alcohol) is taxed 35 per cent and spirits (over 35 per cent alcohol) are taxed 55 per cent.

There are no restrictions on hours or days of sale or type or location of outlets. State owned enterprises still produce alcohol but there is no longer a state monopoly for production or distribution. In 1995 most beer production was privatized. A licence is required for the distribution of all three types of alcohol.

Restrictions on advertising of alcoholic beverages are currently implemented by means of a voluntary code operated by the alcohol and advertising industries. General and specific health warnings are not required by law, and there is no maximum legal limit for the alcohol content of beverages. Labels for alcohol content on alcohol products are required by law.

Control of alcohol problems

There is a minimum legal age limit of 18 years for buying alcohol but it is not effectively enforced. The BAC limit is 0.0 g% for drivers and is quite effectively enforced. A conviction for a subsequent offence of driving above the permitted BAC will usually result in the suspension of the driver's licence. Random alcohol breath testing is carried out infrequently. Under local and municipal regulations, drinking in public places, other than those licensed, is prohibited in parts of Bratislava City.

There are no government agencies devoted specifically to alcohol, but it is included in the work of the National Health Promotion Centre in Bratislava. The centre coordinates the implementation of national health promotion policy in conjunction with the CINDI programme and with regional agencies and nongovernmental organizations. According to the National Drug Bureau Act passed by the Government of the Slovak Republic, a National Drug Bureau was to be established in 1995.

Alcohol data collection, research and treatment

The Institute of Health Information at the National Health Promotion Centre, the Statistical Office of the Slovak Republic and the State Health Institute of the Slovak Republic in Bratislava are all involved in the collecting of alcohol consumption data.

Since 1989, five centres for Drug Addiction Treatment have been established, and nongovernmental organizations are involved in the prevention of alcohol-related problems. The State Health Institute has a network of regional institutes throughout the country, and is involved in the implementation of prevention activities. The Institute of Health Education in Bratislava carries out primary prevention

programmes in relation to alcohol and other drugs. Since 1980, there has been more emphasis on outpatient care in combination with long-term psychotherapy and aftercare treatment in the A-Club network.

Slovenia

Sociodemographic characteristics

POPULATION	1980	1990	1995
Total	1 832 000	1 918 000	1 946 000
Adult (15+)	1 405 000	1 518 000	1 589 000
% Urban	48.0	59.0	63.5
% Rural	52.0	41.0	36.5

Health status

Life expectancy at birth, 1990-1995 : 67.7 (males), 77.6 (females)

Infant mortality rate in 1990-1995 : 8 per 1000 live births

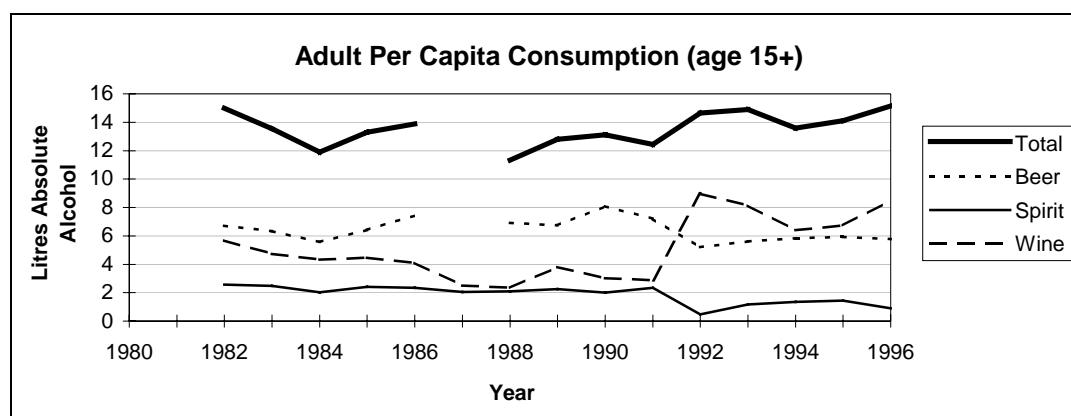
Socioeconomic situation

GNP per capita (US\$), 1995: 8200.

Alcohol production, trade and industry

Slovenia produces beer, distilled spirits and wine.

Alcohol consumption and prevalence



Consumption

In addition to the amounts charted above, unrecorded consumption of alcohol has been estimated at between seven and eight litres of pure alcohol per capita (or approximately 8.7 to 10 litres per adult).

Prevalence

In Slovenia 74 per cent of adults drink wine at least a few times a year, 42 per cent of adults think that it is wise to drink wine every day, and only 5.1 per cent object in general to the drinking of wine.

Age patterns

A study of 3306 15 to 16 year olds (1543 boys and 1763 girls) was conducted in 1995. The response rate was 92 per cent (91 per cent for boys and 92 per cent for girls). Seventy-three per cent of the respondents had drunk an alcoholic beverage in the last 12 months, and 43 per cent had drunk to intoxication in the last 12 months. Lifetime prevalence of alcohol use was 87 per cent (88 per cent for boys and 86 per cent for girls).

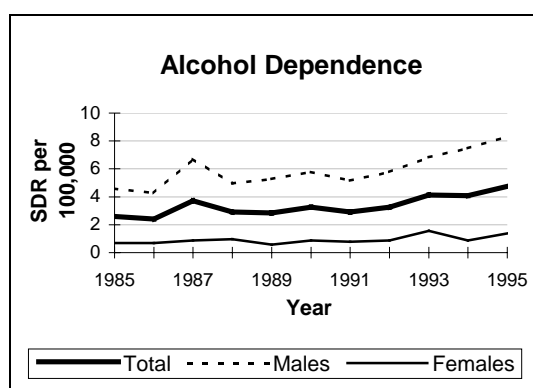
A study, published in 1994, was carried out on the drinking habits of 941 students aged 12 to 15 years in the community of Litija. The results showed that 51.3 per cent of the sample drank alcohol more than once a year, 24.6 per cent drank more than once a month, 14.6 per cent drank more than once a week, 3.5 per cent drank every day, and 6 per cent did not drink alcohol. There were no statistically significant differences in alcohol use by sex or by age.

A 1990 school survey found that 5.5 per cent of 16 year olds and 9.5 per cent of 18 year olds drink several times a week.

Mortality, morbidity, health and social problems from alcohol use

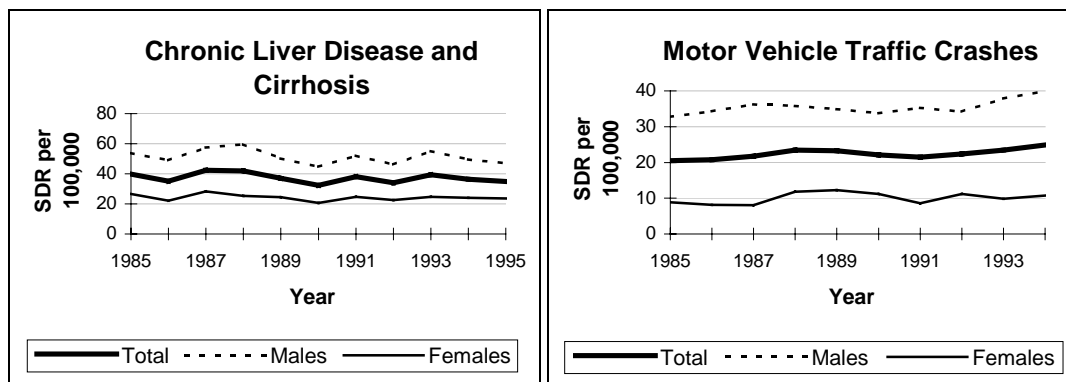
Alcohol dependence and related disorders

The SDR per 100 000 population for alcohol dependence has risen steadily particularly for males, placing the country among the highest reporting countries. The rate per 100 000 population of inpatient treatment for alcoholic psychosis dropped from 47.6 to 38.8 between 1985 and 1991, and then rose to 49.7 in 1993.



Mortality

The SDR from chronic liver disease dropped from 45.8 to 36.1 per 100 000 population between 1987 and 1994.



Social problems

The number of alcohol-related motor vehicle crashes per 100 000 population has fluctuated during the past 15 years. Between 1980 and 1984, the rate rose from 30.6 to 54.8, and then dropped to 34.1 in 1990. In 1992 the rate rose to 41.6, and then to 50 in 1993.

Alcohol policies

Control of alcohol products

The real prices of beer, wine and spirits increased in the early 1990s.

There are restrictions on hours of sale and these are fairly effectively enforced, but there are no restrictions on days of sale or on type or location of outlets. There is no state monopoly and no licence is required for the production or distribution of alcohol.

The advertising of beer, wine and spirits is quite effectively restricted on television, radio, newspapers, magazines, billboards and cinemas. Neither health warnings nor labels for alcohol content are required by law, and there is no maximum legal limit for the alcohol content of beverages.

Control of alcohol problems

There is a minimum legal age limit of 18 years for drinking alcoholic beverages in restaurants and bars, but this restriction is not enforced effectively. There is no legal age limit for buying alcohol in shops, grocery stores or gasoline stations. BAC limit is 0.05 g% for the general public and 0.0 g% for professional drivers. A first offence conviction of driving above the permitted BAC will usually result in the suspension of the driver's licence. Random alcohol breath testing is carried out, but infrequently. There are school-based programmes, some of which deal with alcohol only and others which deal with substance use in general. There is no national agency for the prevention of alcohol problems.

Alcohol data collection, research and treatment

The Institute of Public Health of Slovenia has been involved in drug-related activities since 1982. They employ approximately 100 people full-time. Their focus is on statistical data pertaining to epidemiology and law enforcement, as well as bibliographical data on medico-social aspects and demand reduction. The Institute of Public Health in Ljubljana collects data on patients admitted or discharged from hospitals and on first admission to the 1542 outpatient clinics. There is also a psychiatric case register which includes records of contacts of patients with alcohol disorders at the psychiatric hospitals.

The institutional treatment of alcohol problems became part of the public health system only after World War Two. Treatment is continued in clubs of abstainers and therapeutic communities. There is a tendency towards emphasising community-based approaches to treatment.

Spain

Sociodemographic characteristics

POPULATION	1980	1990	1995
Total	37 542 000	39 272 000	39 621 000
Adult (15+)	27 566 000	31 531 000	33 088 000
% Urban	72.8	75.3	76.4
% Rural	27.2	24.6	23.5

Health status

Life expectancy at birth, 1990-1995 : 74.6 (males), 80.5 (females)

Infant mortality rate in 1990-1995 : 7 per 1000 live births

Socioeconomic situation

GNP per capita (US\$), 1995: 13 580, PPP estimates of GNP per capita (current int'l \$), 1995: 14 520

Average distribution of labour force by sector, 1990-1992 : agriculture 11%; industry 33%; services 56%

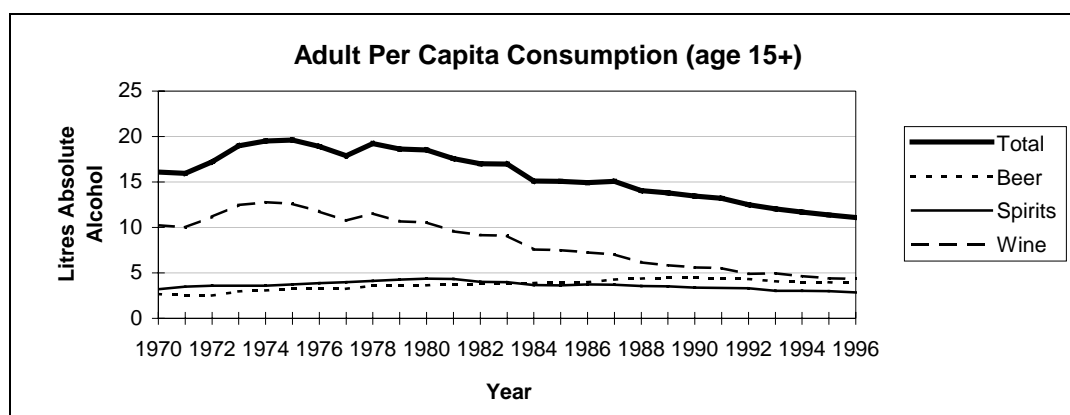
Adult literacy rate (per cent), 1995 : more than 95

Alcohol production, trade and industry

Spain is largely a wine-drinking country. Freixenet is a leading winery with market ventures in Great Britain, Germany and the US, among others. In 1994, there was a huge oversupply of wine, prompting the European Union to consider legislating a curb on wine production. The Spanish beer market is expected to grow about two per cent a year. Sociedad Ansnima Damm brews and packages Budweiser for the Spanish market. In 1993 Coors Brewing Company purchased El Aguila SA, a

Spanish brewery with a capacity of 500 000 barrels. A 1995 study revealed that Spain had more liquor outlets per capita than any other western European country.

Alcohol consumption and prevalence



Consumption

Although spirits consumption has dropped slightly and beer has risen slightly, Spain is primarily a wine-drinking country, and the decline in wine consumption has fuelled a decrease in overall adult per capita consumption of absolute alcohol since its high point in 1975.

Prevalence

A national survey found that in 1993, two per cent of adults were high consumers (drinking between 415 and 553 grams of pure alcohol per week), and two per cent were classified as excessive consumers of alcoholic beverages (drinking more than 553 grams of pure alcohol per week), a decrease from three per cent in 1980. A 1990 survey found that 32 per cent of persons aged 15 years and over drank at least three or four days a week, while 44 per cent drank less than weekly or never. A representative nationwide sample of 2495 adults aged 18 years and over, was selected by a multi-staged random strategy during 1989. Total lifetime prevalence was 55.7 per cent (70.1 per cent for men and 42.6 per cent for women). The average age of first use was 16.7 (16.1 for men and 17.8 for women).

Patterns of drinking vary considerably from one part of the country to another. Population sample surveys in Cantabria and Seville showed that in Cantabria (population of about half a million), a serious problem of excessive drinking (defined as greater than 100 ml of pure alcohol a day on average) was found among men between the ages of 16 and 65. Prevalence of excessive drinking among women was very low. In rural areas, about twice as many men of the above age group were found to be excessive drinkers as in urban areas. In Seville, two-thirds of men and one-third of women reported drinking daily or nearly every day.

Age patterns

An EC survey in 1990 found that 3 per cent of boys and 1 per cent of girls aged 11 or 12, and 22 per cent of boys and 17 per cent of girls aged 13 to 15 drank alcohol weekly. A WHO study of schoolchildren in 1993/1994 found that more than 90 per cent of 15 year old boys and girls drank alcohol at least once a week, and that 22.8 per cent of boys and 19.1 per cent of girls had been drunk at least once.

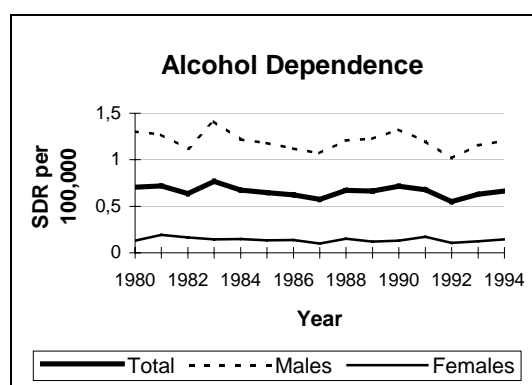
Economic impact of alcohol

In 1984 the health costs of alcohol totalled 15 017 million pesetas (US\$ 99.3 million), up from 13 145 million pesetas (US\$ 86.9 million) in 1981. Between 1970 and 1992 the total expenditure on alcoholic beverages as a percentage of private consumption expenditure dropped from 1.7 to 1.3.

Mortality, morbidity, health and social problems from alcohol use

Alcohol dependence and related disorders

The rate of discharges per 100 000 population for alcohol dependence syndrome fell from 36 to 19 between 1980 and 1992.

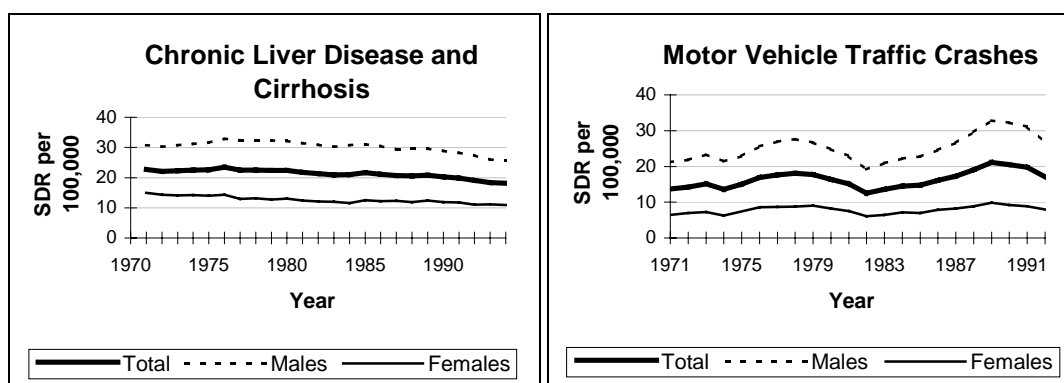


Mortality

The SDR per 100 000 population for chronic liver disease fell from 24.2 in 1980 to 18.7 in 1991, while the rates for alcohol-related burns, falls, drowning and poisoning rose from 42.9 to 44.4 over the same period.

Health problems

The total number of reported alcohol-related admissions to all hospitals fell from 15 990 in 1978 to 13 267 in 1984.



Social Problems

Alcohol-related motor vehicle crashes per 100 000 population rose from 6.9 in 1985 to 10.6 in 1992.

Alcohol policies

Control of alcohol products

The real prices of all three types of alcohol, i.e. beer, spirits and wine increased between 1990 and 1995. In 1994, taxation rates were: 13 per cent on table wines, 18.4 per cent on beer and 43.4 per cent on spirits.

There are restrictions on hours of sale, but there are no restrictions on days of sale, or on type or location of outlets. A licence is required for the production and distribution of beer, wine and spirits.

Advertising of alcoholic beverages in schools, sport centres and health care institutions is prohibited. The General Advertising Law prohibits the advertising of alcoholic beverages with an alcohol content greater than 20 per cent on television and radio. Advertising of other alcoholic beverages on television and radio is permitted only after 21:30 hours. A voluntary code governs the content of advertisements in newspapers/magazines and on billboards. In general, private media employ a more liberal policy than public media.

General or specific health warnings on alcohol containers are not required, although a label is required to display the alcohol content of beverages.

Control of alcohol problems

There is a minimum legal age limit of 16 years for buying alcohol in most regions of Spain, otherwise the age limit is 18. The BAC limit is 0.08 g% for car drivers, 0.05 g% for drivers of vehicles of more than of 3500 kg and 0.03 g% for public service drivers and drivers of dangerous merchandise, emergency service vehicles, schoolchildren and minors, and special service vehicles. On conviction for a first offence, suspension of driving licence is usual, and random alcohol breath testing is frequently carried out.

There is no national agency devoted specifically to prevention of alcohol-related problems but it is included in the work of the Section on Epidemiology, Health Promotion and Health Education in the Directorate General of Public Health within the Ministry of Health and Consumer Affairs (MHCA). The MHCA has organized intersectoral meetings between various ministries, autonomous communities, professionals, organizations and volunteers, etc. in order to reconcile the diverse legislation on alcohol and coordinate the intervention policies on supply and demand.

There are mass media and school-based programmes at a national level which deal with substance use in general. The number of alcohol-related initiatives directed at young people is increasing at national, regional and local levels.

Alcohol data collection, research and treatment

New programmes in the study of alcohol abuse have been established in the Basque country to provide training for future members of teams who will work with alcohol and drug abusers.

The most widespread system of specialized treatment is organized on an outpatient basis through 70 dedicated dispensaries or mental health centres for alcoholic and drug-dependent people. Some outpatient consultations have been established in mental hospitals. The social security system provides treatment for alcoholics through about 500 neuropsychiatric consultations in the medically specialized outpatient departments or in "zone consultations", which are held for two hours a day, on referral by a general practitioner. There are a few specialized inpatient services for alcoholics in university general hospitals, but most inpatient care occurs in mental hospitals where between four and five per cent of beds are occupied by alcohol dependent patients who also constitute 25 per cent of psychiatric admissions.

An important role in treatment and rehabilitation is played by the self-help organizations, such as Alcoholics Anonymous (20 units available working in 15 autonomous communities in 1996) and rehabilitated ex-alcohol dependent persons associations. Some attention is paid to the families of excessive drinkers through certain outpatient alcoholism services, the social services and voluntary organizations, but these problems do not appear to have received priority attention.

Sweden

Sociodemographic characteristics

POPULATION	1980	1990	1995
Total	8 310 000	8 559 000	8 780 000
Adult (15+)	6 682 000	7 024 000	7 113 000
% Urban	83.1	83.1	83.1
% Rural	16.9	16.9	16.9

Health status

Life expectancy at birth, 1990-1995 : 75.4 (males), 81.1 (females)

Infant mortality rate in 1990-1995 : 5 per 1000 live births

Socioeconomic situation

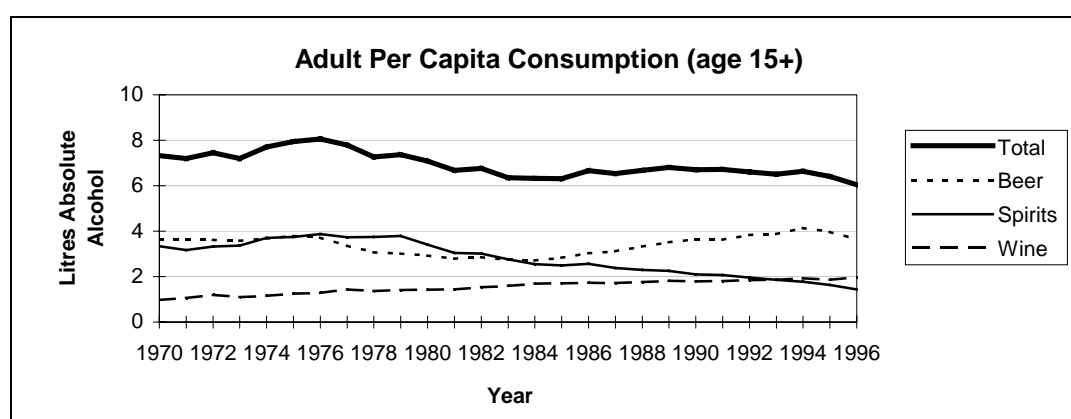
GNP per capita (US\$), 1995: 23 750, PPP estimates of GNP per capita (current int'l \$), 1995: 18 540
Average distribution of labour force by sector, 1990-1992 : agriculture 3%; industry 28%; services 69%

Adult literacy rate (per cent), 1992 : 95

Alcohol production, trade and industry

Despite joining the European Union, the state production monopoly on wine and spirits production has not been privatized, nor have new wine or spirits production companies been established. Nine import licences were issued to private firms. The nine licensees are unable to sell alcohol at the retail level, instead, they have the right to sell alcohol to the state-run Systembolaget stores. The leading brewer, Pripps, is owned by the Norwegian food and drink conglomerate Orkla. Domestic and imported marketers of beer spent US\$ 12 million marketing brands in Sweden in 1993. Imports continue to dominate Sweden's wine consumption, although since 1986 the contribution of domestic producers has been substantial.

Alcohol consumption and prevalence



Consumption

Unrecorded consumption was estimated at 1.8 litres of pure alcohol per capita in 1991. This would make total adult per capita consumption in 1991 approximately 8.5 litres of absolute alcohol. Reduction in total recorded consumption has been fuelled by reductions in recorded spirit consumption. However, much of the decrease has been offset by increases in beer and wine consumption.

Prevalence

A consumer survey in 1990 found that one per cent of adults were drinking almost every day, 23 per cent were drinking once or twice a week, 27 per cent were drinking twice a month, 36 per cent were drinking once a month or less often, and 14 per cent were abstainers.

Age patterns

A study of 3472 15 to 16 year olds (1746 boys and 1725 girls) was conducted in 1995. The response rate was 86 per cent (84 per cent for boys and 87 per cent for girls). Eighty-two per cent of the respondents had drunk an alcoholic beverage in the last 12 months, and 63 per cent had drunk to intoxication in the last 12 months. Lifetime prevalence of alcohol use was 89 per cent for both boys and girls.

A 1993/1994 survey of fifteen year olds showed that 94 per cent had tried alcoholic beverages. Nineteen per cent of boys and 11.3 per cent of girls drank weekly, and 27.4 per cent of boys and 22.4 per cent of girls had been drunk at least twice.

Economic impact of alcohol

The cost of lost output because of alcohol during the 1980's is estimated at Skr 5 000 million annually. The Medical Advisory Committee at the Ministry of Health and Social Welfare reports alcohol as one of the major causes of production losses, illness and premature death, and of high costs of social and medical resources.

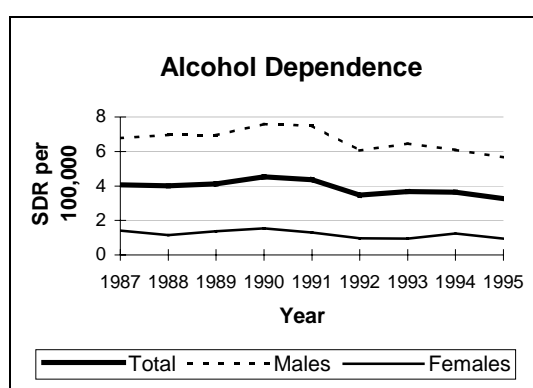
In 1992 Sweden spent SEK 29 million (US\$ 3.6 million) on alcohol, equivalent to 3.7 per cent of private consumer expenditure. Over 60 per cent of this went as income to the State.

In the 1980s approximately six out of 1000 employed people were engaged in the production or trade of alcoholic beverages.

Mortality, morbidity, health and social problems from alcohol use

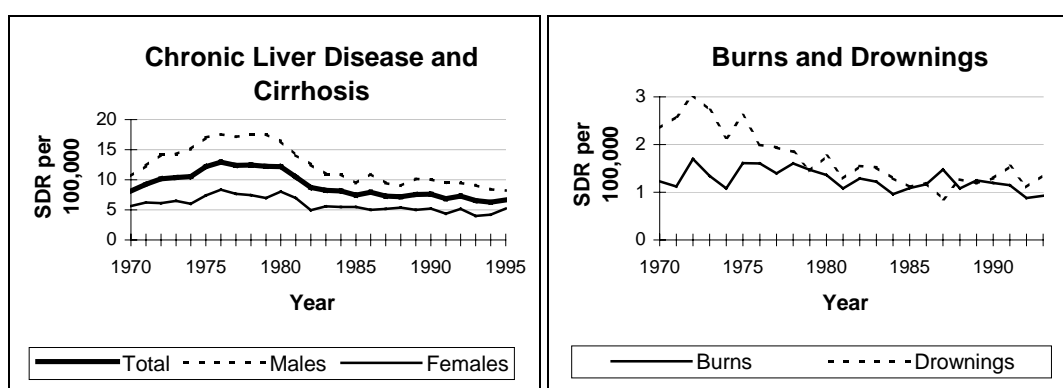
Alcohol dependence and related disorders

Hovering between 3 and 4 per 100 000 population, Sweden's SDR from alcohol dependence is relatively high by global standards. The rate per 100 000 population of reported alcohol-related admissions to psychiatric hospitals increased by more than six times between 1960 and 1990, rising from 83 to 562.



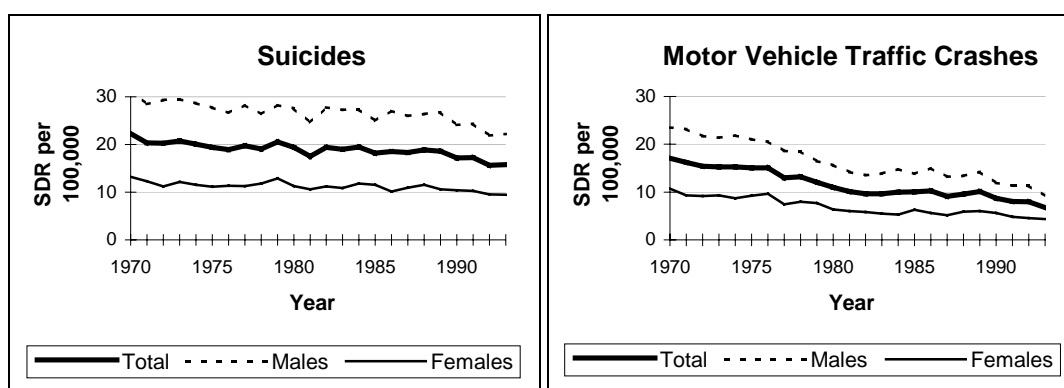
Mortality

The SDR per 100 000 population for alcohol-related burns, falls, drowning and poisonings fell from 62.7 to 44.2 between 1980 and 1992. Chronic liver disease rates fell from 11.2 to 6.4 during the same time period.



Morbidity

A 1992 study of psychiatric patients showed that 87 per cent of the attempted suicides were performed after drinking, and 86 per cent of total violent episodes took place when the assailant was drunk.



Social problems

The number of road traffic crashes involving alcohol per 100 000 inhabitants was 12 in 1992, similar to the 12.5 recorded in 1985 and a decrease from the 15.4 recorded in 1990. The number of drunken drivers detected decreased from 24 563 in 1992 to 24 298 in 1993.

Alcohol policies

Control of alcohol products

The real price of beer increased in the 1985-1990 period but has been decreasing since 1990. The real prices of wine and spirits have been decreasing since 1987. The 1994 taxation rates were: 59 per cent on table wines, 55 per cent on strong beer (alcohol content greater than 3.5 per cent), and 84 per cent on spirits.

The state has a monopoly on the retail sale of wine, spirits and strong beer. All the stores are closed on Saturdays and Sundays and outlets are not allowed in areas where they could be perceived as contributing to social problems. They are also prohibited in the immediate neighbourhood of schools. One or more state monopoly stores (Systembolaget) exist in most municipalities of Sweden. Strong beer may only be purchased in Systembolaget stores. Sale of beer with a medium alcohol content (between 2.5 and 3.5 per cent alcohol) is permitted in ordinary grocery stores. The state monopoly on import, export, wholesale and production of spirits was abolished on 1 January 1995, following Sweden's accession to the EU. Private interests are now permitted to act in these sectors of the alcohol market, but licences, issued by a new governmental board (the Alcohol Inspection Authority) are required.

General and specific health warnings on alcohol containers are not required by law. The advertising of beer, wine and spirits is banned, although the advertising of low-alcohol beer (less than 2.5 per cent alcohol) is allowed, and advertising is permitted in trade magazines. In some municipalities local regulations prohibit alcohol consumption in public places such as parks and streets. Labels for alcohol content are required by law, but there is no maximum legal limit for the alcohol content of beverages.

Control of alcohol problems

There is a minimum legal age limit of 18 years for buying alcohol in restaurants, and an age limit of 20 years for buying alcohol in liquor stores. There is a legal age limit of 18 for buying medium strength beer sold in ordinary grocery stores. The BAC limit is 0.02 g% for drivers and this restriction is quite effectively enforced. First offence conviction for driving above the BAC limit usually results in suspension of driving licence. Imprisonment is often, but not always, used on conviction for a second or subsequent offence of driving above a BAC of 0.10 g%. General and specific health warnings on alcohol containers are not required by law. There are local school-based and workplace alcohol education programmes.

The retail monopoly offers point-of-purchase information on alcohol-related harm and on the risks related to the use of alcohol in situations such as pregnancy, adolescence and driving. In many counties, representatives of the county council, the county municipalities, police, schools and nongovernmental offices collaborate for the prevention of alcohol problems.

At the national level, priorities of the 1990s have been reducing availability; mass media campaigns to encourage safer drinking; encouraging lighter drinking in work settings; increasing the role of

primary health care teams in the prevention and early detection of alcohol problems; using price policy to reduce demand; developing the roles of the social welfare system and the criminal justice system in the prevention and management of alcohol problems; developing specialized treatment for alcohol dependence and other alcohol problems; and addressing particular alcohol problems.

The high price of alcohol has been considered to be probably the single most effective element of the Sweden's national alcohol policy. Membership in the EU effective January 1995, with higher permitted levels of import of alcoholic beverages and abolition of State monopolies (except for retailing) is expected to require greater effort to influence the demand for alcohol. The main objective of an explicitly formulated national policy, as stated by Parliament in 1985, was to reduce alcohol consumption by 25 per cent by the year 2000. The National Institute of Public Health has been given the leadership role at national level for the prevention of alcohol problems and had a mandate to form a National Executive Group for Prevention of Alcohol and Drug-Related Problems. In June 1995 this group presented a National Action Plan to the Government. The General Directors of various National Boards and organizations (National Board of Health and Welfare, National Alcohol Inspection Board, National Police Board, central organizations for the county councils and the municipalities, Customs Departments, etc.) are represented in the executive group. There are local school-based and workplace alcohol education programmes.

Alcohol data collection, research and treatment

The National Institute of Public Health, Systembolaget and various university departments sponsor both alcohol research and data collection of various kinds. In 1987 there were 250 institutions for alcohol and drug abusers with 4200 beds, and 1700 beds in boarding homes/half-way homes. Sweden's temperance movement, supported by the nation's most successful lottery, sponsors alcohol education and treatment programmes throughout the country.

The goals of the social services laid down in Section 1 of the Social Services Act constitute guidelines for all treatment designed to help individuals to discontinue the abuse of alcohol, and other drugs. These goals are that care must be based on respect for the self-determination and privacy of the individual and must as far as possible be designed and conducted in partnership with the individual abuser. Care within the framework of social services must be provided in agreement with the abuser in accordance with the provisions of the Act. However, care must be provided for an abuser regardless of his or her consent, subject to the conditions stated in the Act (compulsory care). Compulsory care is provided through residential institutions run by county councils or municipalities. Hospital care is mandated to be provided for those who require it.

Switzerland

Sociodemographic characteristics

POPULATION	1980	1990	1995
Total	6 319 000	6 834 000	7 202 000
Adult (15+)	5 072 000	5 680 000	5 929 000
% Urban	57.0	59.5	60.8
% Rural	43.0	40.5	39.2

Health status

Life expectancy at birth, 1990-1995 : 74.7 (males), 81.2 (females)
 Infant mortality rate in 1990-1995 : 6 per 1000 live births

Socioeconomic situation

GNP per capita (US\$), 1995: 40 630, PPP estimates of GNP per capita (current int'l \$), 1995: 25 860
 Average distribution of labour force by sector, 1990-1992 : agriculture 6%; industry 34%; services 60%.
 Adult literacy rate (per cent), 1995 : more than 95

Alcohol production, trade and industry

Switzerland produces beer, distilled spirits and wine. Two large brewers produce two-thirds of the nation's beer, and the number of brewers has fallen by half since 1970 to 28, employing 3250 people. Wine production is largely a craft activity, with 33 003 registered vintners, and only 941 of these cultivating more than three hectares. Spirits production also occurs widely on a very small scale, with 170 000 producers, approximately 700 of which do so professionally.

Alcohol consumption and prevalence

Consumption

In 1985 unrecorded consumption of alcohol was estimated at about five per cent of recorded consumption. No estimate of unrecorded consumption is available in the late 1990s. If unrecorded consumption had stayed at this level, total adult consumption for 1995 would have been 11.8 litres of absolute alcohol.

Prevalence

The Swiss Institute for Prevention of Alcoholism and Other Drug Problems (ISPA) carried out four surveys on representative samples of the population aged 15 to 74 years, in 1975, 1981, 1987 and 1992. The 1992 survey found that, in the category of "consuming alcohol one or several times daily", the highest percentage was among those in the 45 to 54 year age group (32 per cent). Only 5 per cent of those in the 15 to 24 year age group consumed alcohol one or several times daily, and the rest of the age groups ranged from 15 per cent to 24 per cent. Thirty per cent of those in the 25 to 34 year age group consumed alcohol between one and two times a week, while the percentage of those who "seldom" consumed alcohol ranged from 25 per cent to 34 per cent among all age groups. About 25 per cent of 15 to 24 year olds reported never drinking alcohol, compared with 8 per cent of 45 to 54 year olds. The most frequent and highest consumption occurred among the Italian Swiss, followed by the French Swiss and, lastly, the German Swiss.

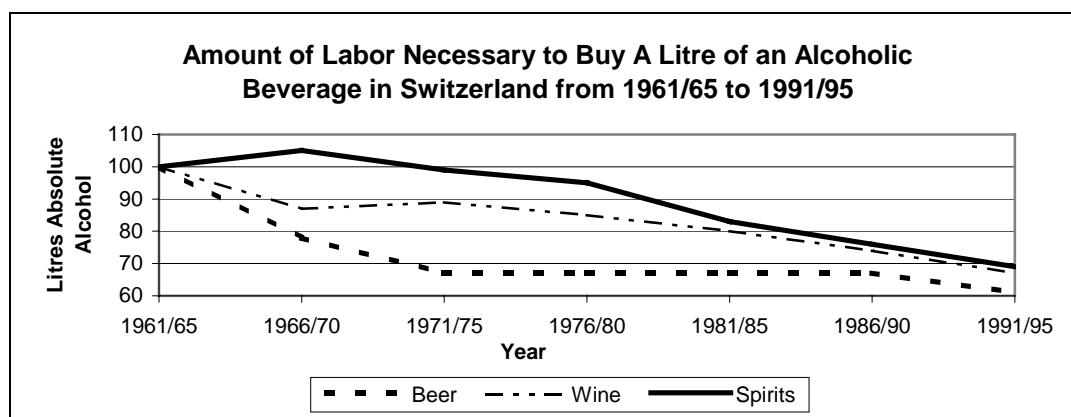
Age patterns

Surveys of young people in 1994 showed that 60 per cent of those between the ages of 11 and 12 and 90 per cent of those between 15 and 16 had had some experience of alcohol. About 25 per cent of 10 year old boys and more than 40 per cent of 15 to 19 year old boys were drinking alcohol at least weekly. Seven per cent of 10 year old girls and 25 per cent of girls aged 15 to 19 years drank at least weekly. Five per cent of boys aged 15 to 19 reported having at least one drink per day.

Economic impact of alcohol

In 1972 it was estimated that alcohol consumption cost the Swiss economy Sfr 1 300 000 (US\$ 862 500 000). The extrapolation for 1975 was Sfr 1 500 000 000 (US\$ 995 190 000) and Sfr 2 000 000 000 (US\$1 326 900 000) for 1987. Ten per cent of the profits made by the Alcohol Board on distilled beverages is allocated for prevention (three per cent) and treatment (seven per cent) of problems relating to use of alcohol, drugs and medicaments. In the fiscal year 1993/1994 this amounted to Sfr 18 million (US\$ 12 million).

Industries concerned with alcoholic beverages employed 5494 people in 1985 - about 0.6 per cent of industrial employees. That same year, purely viticultural enterprises employed 4256 people full-time - about five per cent of agricultural employees - as well as 27 913 occasional workers. In the fiscal year 1993/1994, Sfr 18.8 million were distributed to cantons from excise on distilled spirits for prevention and treatment of alcohol problems, drug problems and abuse of medicaments.



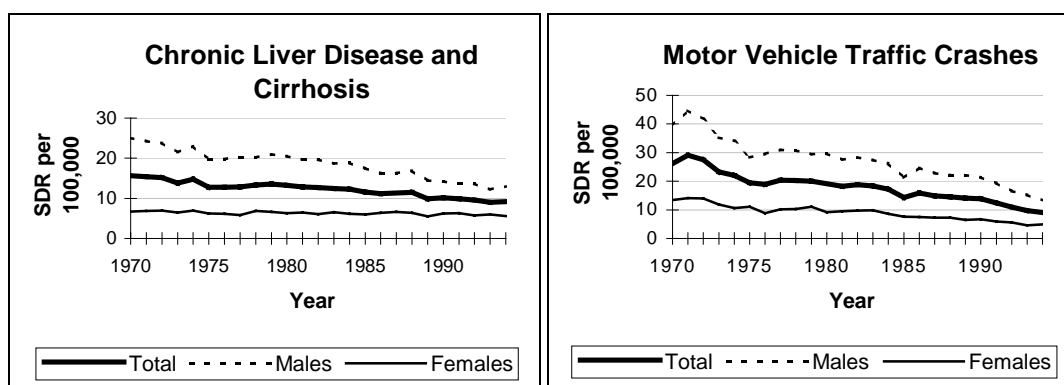
Mortality, morbidity, health and social problems from alcohol use

Alcohol dependence and related disorders

There are no data available for at the last 10 years on the treatment of alcoholic psychosis, but a comprehensive report is in preparation. The number of alcohol dependent persons is estimated to be about 150 000. Among male hospital patients of working age, those with a primary or secondary diagnosis of alcohol dependence constitute the largest group (8 to 13 per cent of those between 30 and 59 years of age). At the end of 1983, specialized and medico-social services for alcohol dependence had more than 20 000 alcohol dependent patients on their books. The ratio of newly admitted patients was twelve men to one woman in the 1950s, but four to one in 1987.

Mortality

The SDR per 100 000 population for chronic liver disease dropped from 12.6 to 8.3 between 1980 and 1993.



Social problems

The number of road traffic crashes involving alcohol per 100 000 inhabitants was 40.2 in 1992 compared to 43.8 in 1985 and 34.2 in 1991. Alcohol-related traffic crashes constitute approximately 10 per cent of the total number of traffic crashes. Alcohol-related injuries, as a percentage of total motor vehicle crashes, rose from 6.2 per cent in the period from 1963 to 1965 to 12.2 per cent in the period from 1981 to 1985. Between 1963 and 1981, 30 to 49 per cent of sentences for road offences were for drunkenness. This rate rose to above 50 per cent in the period from 1983 to 1985. Over these years, more than 40 per cent of all withdrawals of driving licences were for drunk driving.

Alcohol policies

Control of alcohol products

The real prices of beer and spirits have been decreasing during the last five years while the real price of wine has been stable. Table wines are taxed five per cent. The tax on beer is fixed by the Constitution at 18 per cent of the price of draft lager beer. Different rates apply to spirits depending on the type.

The Constitution states that "Legislation should reduce the consumption of potable spirits and, accordingly, their importation and production..." and that trade in alcoholic beverages and the cantonal licensing laws must take public health needs into account. The cantons are largely responsible for controlling the sale of alcoholic beverages, and they collaborate with the confederation on the implementation of the Federal law on wholesale and retail trade beyond the cantonal borders. There is a state monopoly for the production of spirits, but not of wine, beer and cider made by fermentation.

The Federal Government, while having the exclusive right to produce spirits, in practice grants licences to third parties. The monopoly grants concessions for the importation of spirits, and it buys up home-made spirits legally distilled from fruit with pips to reduce consumption after abundant harvests. No spirits may be produced from potatoes, grain or molasses. A licence is required for the distribution of distilled beverages, beer and wine. There are strict controls to ensure that spirit alcohol designated for industrial use is not diverted for use in beverages. Farmers are permitted to distil tax free for their own use. The Swiss Alcohol Board has tried to decrease the number of such distillers by purchasing their stills. However, about 72 000 tax-exempt producers remained in the early 1990s, and their production amounted to nearly one third of the whole production. Whereas spirits production is controlled, wine production is encouraged and receives subsidies and protection from imports.

General and specific health warnings are not required by law. Labels for alcohol content are required by law on distilled beverages only. There is a maximum legal limit of 55 per cent by volume for the alcohol content of spirits. In two-thirds of the cantons, a regulation requires on-premises establishments to offer a choice of non-alcoholic beverages at a price no higher than the least expensive alcoholic beverage. There is no legislation to create or support environments free from alcohol.

Control of alcohol problems

There is a minimum legal age limit of 16 years for buying fermented beverages and an age limit of 18 years for buying distilled beverages. Since the mid-1980s the Federal Law prohibits advertising of spirits in or on places for public usage, sporting fields and events, events for young people and price lists, etc. The BAC limit is 0.08 g% for drivers. Random alcohol breath testing is not carried out. Penalties for driving above the permitted limit vary from canton to canton.

Priorities of the early 1990s have been: mass media campaigns to encourage safer drinking; using price policy to reduce demand; developing the role of the criminal justice system in the prevention and management of alcohol problems; and addressing particular alcohol problems. A section on alcohol and tobacco matters of the Division of Health Promotion in the Federal Office of Public Health advises the Ministry and Government on policies and programmes. It deals mainly with educational measures, while the Federal Alcohol Board deals (for distilled spirits) with political measures. National school-based programmes focusing on alcohol and tobacco are provided.

ISPA is a private body subsidised by the State, which collaborates with the above bodies in promoting national priorities on the prevention of alcohol problems.

Alcohol data collection, research and treatment

Institutes such as ISPA in Lausanne and various university institutes specialize in research on alcohol issues. The Swiss Research Foundation on Alcohol was appointed by the Federal Commission to encourage and coordinate alcohol research related to public health. The ISPA initiated a reporting system and data bank at the end of 1987. Data on inpatient and outpatient treatment were collected only until 1981. Data from German-speaking Switzerland have been collected since 1984, and discussions are under way to include institutions in French-speaking Switzerland as well.

Considered part of health care, treatment of alcohol problems comes under the jurisdiction of the cantons. The involvement of general practitioners is tending to increase. The most widespread type of

institutional treatment is given in outpatient centres, run by persons with professional training. There are about 300 such counselling centres, some also involved with drug dependence. Further outpatient care is provided by social services, psychiatrists, volunteer groups and Alcoholics Anonymous. Inpatient care is provided mainly by mental hospitals, but also by general hospitals and specialized institutions, generally under medical and psychiatric management.

Tajikistan

Sociodemographic characteristics

POPULATION	1980	1990	1995
Total	3 954 000	5 287 000	6 101 000
Adult (15+)	2 258 000	3 006 000	3 472 000
% Urban	34.3	32.2	32.2
% Rural	65.7	67.8	67.8

Health status

Life expectancy at birth, 1990-1995 : 67.3 (males), 73.0 (females)

Infant mortality rate in 1990-1995 : 48 per 1000 live births

Socioeconomic situation

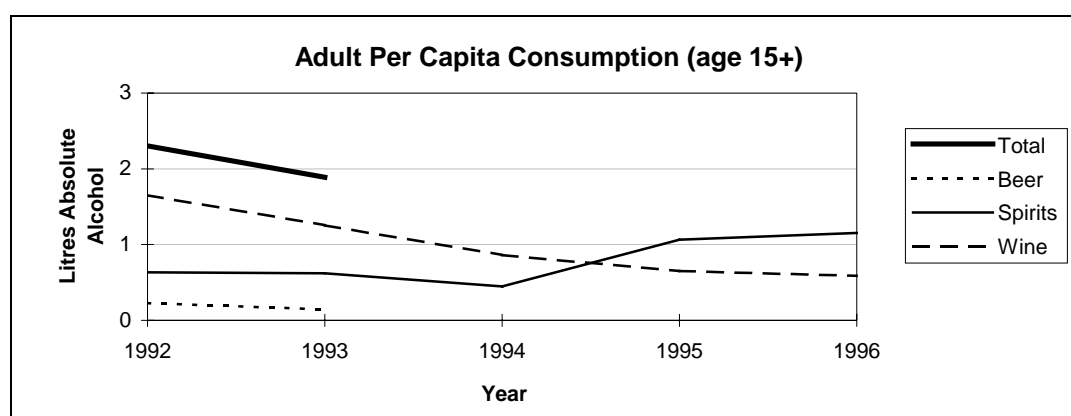
GNP per capita (US\$), 1995: 340, PPP estimates of GNP per capita (current int'l \$), 1995: 920

Average distribution of labour force by sector, 1990-1992 : agriculture 14%; industry 19%; services 67%

Alcohol production, trade and industry

Tajikistan reports production of beer and wine.

Alcohol consumption and prevalence



Consumption

In 1993, the last year for which beer production figures are available, total adult consumption of pure alcohol was 1.75 litres.

Economic impact of alcohol

Consumer expenditure on alcoholic beverages, as a percentage of general expenditure on purchase of goods and payments for services, was 1.8 in 1990, rising to 2.2 in 1993.

Mortality, morbidity, health and social problems from alcohol use

Alcohol dependence and related disorders

The number of patients (per 100 000 population) with alcoholic dependence registered at hospitals and other treatment centres during 1990 was 1.7, and 1.2 in 1991.

Social problems

The number of persons committing crimes under the influence of alcohol (thousands) decreased from 1.1 to 0.7 between 1990 and 1994.

The Former Yugoslav Republic of Macedonia

Sociodemographic characteristics

POPULATION	1980	1990	1995
Total	N/A	2 046 000	2 163 000
Adult (15+)	N/A	1 506 000	1 635 000
% Urban	N/A	57.8	59.9
% Rural	N/A	42.2	40.1

Health status

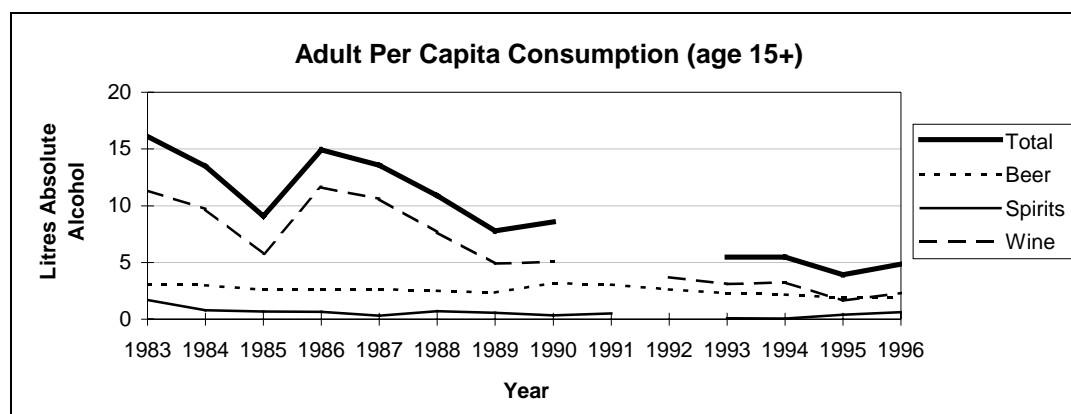
Life expectancy at birth, 1990-1995 : 68.8 (males), 75.0 (females)

Infant mortality rate in 1990-1995 : 27 per 1000 live births

Alcohol production, trade and industry

The former Yugoslav Republic of Macedonia produces beer, distilled spirits and wine.

Alcohol consumption and prevalence



Consumption

Wine was the alcoholic beverage of choice for recorded consumption until very recently, when it fell to the level of beer consumption. It was estimated in 1992 that about 50 per cent of total production was home-made and that unrecorded per capita consumption was about four litres of pure alcohol. This would put total adult per capita consumption at around 10 litres of pure alcohol. A 1994 survey of second level school children found that 83 per cent of families were involved in the production of alcohol at home.

Prevalence

Surveys carried out in the early 1990s showed that 15 per cent of males were heavy drinkers (no definition).

Age patterns

Surveys in second level schools in Skopje, Bitola, Kavadarci and other towns in 1994 found that 54 per cent of adolescents between the ages of 14 and 18 used alcoholic beverages periodically, while a 1993 survey indicated that most Macedonians have their first contact with alcohol at the age of seven.

Mortality, morbidity, health and social problems from alcohol use***Alcohol dependence and related disorders***

Surveys in the early 1990s estimated that approximately two per cent of the population was dependent on alcohol. Surveys in Skopje during the early 1980s found that approximately 12 000 people were dependent on alcohol, with a male-female ratio of 1:14. The rate per 100 000 population of admission to inpatient treatment centres for alcoholic psychosis rose from 10.2 to 14.3 between 1985 and 1990, and then dropped to 12.1 in 1993. Between 1980 and the early 1990s, the number of inpatients under treatment for alcohol dependence increased by 5 to 10 per cent and the number of outpatients by 50 per cent.

Mortality

The autopsy reports of 3138 patients who died in the Institute for Lung Diseases and Tuberculosis, Sremska Kamenica, between 1981 and 1990 were examined. Of these, 50 patients, ranging in age from 19 to 72 (median age 51), died as a result of tuberculosis. Of these 42 per cent were alcohol abusers.

Alcohol policies***Control of alcohol products***

The real prices of beer, spirits and wine have been increasing during the early 1990s. Table wines are taxed 18 per cent, beer (four to six per cent alcohol) is taxed 60 per cent and spirits (over 35 per cent alcohol) are taxed 90 per cent.

There are restrictions on hours of sale and on location of outlets and these are enforced quite effectively. There are no restrictions on days of sale or types of outlets. Under laws passed in 1993-1994, the sale of alcoholic beverages to minors is prohibited and the sale of alcoholic beverages is prohibited in close proximity to schools and workplaces. There is a state monopoly for the production and distribution of all the three types of alcoholic beverages i.e. beer, spirits and wine, and part of the monopoly's profits are allocated for the prevention of alcohol-related problems.

There are restrictions on the advertising of wine and spirits, but none on the advertising of beer. General or specific health warnings are not required by law, and there is no legal requirement for labels carrying alcohol content. The maximum legal limit for the alcohol content of beverages is 50 per cent.

Control of alcohol problems

There is a minimum legal age limit of 16 years for buying alcoholic beverages and it is effectively enforced. The BAC limit is 0.05 g% for the general public and 0.0 g% for professional drivers and these limits are fairly effectively enforced. A conviction for a first offence of driving above the permitted BAC will usually result in the suspension of the driver's licence. Random alcohol breath testing is carried out, but infrequently. There are mass media, school-based and workplace programmes at the national level dealing with substance use in general. The Republican Association organizes lectures and seminars for parents, teachers and other concerned persons. There is also a City Association for Prevention of Problems related to Alcohol, Drugs and Tobacco, which engages in similar work at a more local level.

Alcohol data collection, research and treatment

There is no agency devoted specifically to the prevention of alcohol-related problems, but it is included in the work of the Republican Association for Prevention of Problems related to Alcohol, Drugs and Tobacco. The State Commission against Alcohol, Drugs and Tobacco, and the Association of the Clubs of Treated Alcoholics of the Republic of Macedonia are also involved in prevention of alcohol-related problems. Both inpatient and outpatient treatment are available, and use of these

resources has been rising since 1980. After treatment, patients are followed-up in a network of clubs for treated alcohol dependents.

Turkey

Sociodemographic characteristics

POPULATION	1980	1990	1995
Total	44 438 000	56 098 000	61 945 000
Adult (15+)	27 003 000	36 617 000	40 938 000
% Urban	43.8	60.9	68.8
% Rural	56.2	39.1	31.2

Health status

Life expectancy at birth, 1990-1995 : 64.5 (males), 68.6 (females)

Infant mortality rate in 1990-1995 : 65 per 1000 live births

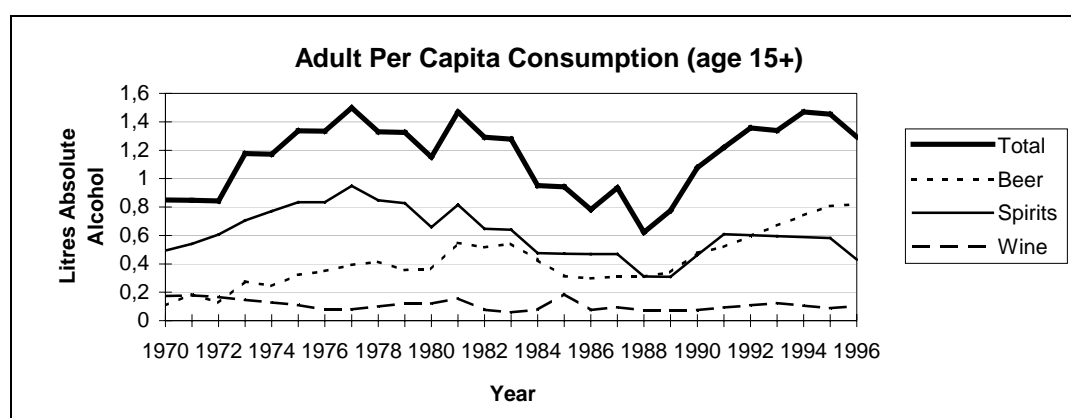
Socioeconomic situation

GNP per capita (US\$), 1995: 2780, PPP estimates of GNP per capita (current int'l \$), 1995: 5580

Average distribution of labour force by sector, 1990-1992 : agriculture 47%; industry 20%; services 33%

Adult literacy rate (per cent), 1995 : total 82; male 92; female 72

Alcohol consumption and prevalence



Consumption

There is no information available on unrecorded consumption. An increase in adult per capita consumption since 1988 has been fuelled by rising beer consumption since that time.

Age patterns

A study of 2636 15 to 16 year olds (1502 boys and 1134 girls) was conducted in 1995. Fifty-one per cent of the respondents had drunk an alcoholic beverage in the last 12 months, and 24 per cent had drunk to intoxication in the last 12 months. Lifetime prevalence of alcohol use was 61 per cent (62 per cent for boys and 60 per cent for girls).

Mortality, morbidity, health and social problems from alcohol use

Alcohol dependence and related disorders

In 1992, 8305 people were discharged from inpatient treatment for alcoholic psychosis which gives an unstandardized rate of 14.1 per 100 000 population.

Mortality

In 1992 the unstandardized death rate per 100 000 population of chronic liver disease was 1.2.

Alcohol policies***Control of alcohol products***

The real prices of beer, wine and spirits increased during the early 1990s. Table wines are taxed 17 per cent, beer (four to six per cent alcohol) is taxed 18.5 per cent and spirits (over 35 per cent proof) are taxed 110 per cent.

There are no restrictions on hours or days of sale, but there are restrictions on types and location of outlets. Special permission is required to sell alcoholic beverages in shops, supermarkets and Tekel agencies. There is a state monopoly for the production and distribution of spirits. A licence is required for the production and distribution of beer and wine, and the sale of alcoholic beverages in parks, cafes and restaurants is prohibited.

General and specific health warnings are not required by law. The advertising of alcohol is totally banned in national broadcasting, although beer advertisements are permitted in private broadcasting. Alcohol advertising is banned on radio and restricted either legally or through the use of a voluntary code in all other media. The maximum legal limit for the alcohol content of beer is 5 to 8 per cent; for wine 11 to 12 per cent; and for spirits, 35 to 45 per cent. Labels specifying alcohol content are required by law.

Control of alcohol problems

There is a minimum legal age limit of 18 years for buying alcohol and it is fairly effectively enforced. BAC limit is 0.05 g% for drivers, but it is not effectively enforced. A conviction of driving above the permitted BAC will usually result in a suspended driving licence. Random alcohol breath testing is carried out, but infrequently. There are national mass media programmes which deal with substance use.

The Department of Prevention of Harmful Habits, the Directorate of Mental Health and the General Directorate of Primary Health Care within the Ministry of Health all carry out training activities and determine national policies. The Green Crescent Society carries out preventive activities related to alcohol dependence and other harmful habits and provides public training in these areas.

Alcohol data collection, research and treatment

The Directorate of the Research Institute in TEKEL Enterprises (the state monopoly) is a research institute which specializes in, and has major responsibility for, research on alcohol issues.

The main centre for research and treatment of alcohol and other drug problems is located in Bakirköy, Istanbul and has a capacity of 360 beds. Treatment in the centre is carried out in two phases: cure of physical addiction, which may last for two to four weeks, and cure of psychological dependence, which may last up to one year, using methods of group therapy and individual therapy. Treatment is also carried out a small scale at state hospitals in Manisa, Elazig and Samsun. Private clinics are also involved in the treatment of alcohol dependent persons.

AMATEM, an organization attached to the Bakirköy Mental Health Hospital, specializes in treating persons dependent on alcohol or drugs. The "Adsiz Alkolikler", a voluntary association established by people who have stopped drinking, works to rehabilitate those who are dependent on alcohol.

Turkmenistan

Sociodemographic characteristics

POPULATION	1980	1990	1995
Total	2 864 000	3 657 000	4 099 000
Adult (15+)	1 681 000	2 178 000	2 481 000
% Urban	47.1	44.9	44.9
% Rural	52.9	55.1	55.1

Health status

Life expectancy at birth, 1990-1995 : 61.5 (males), 68.5 (females)

Infant mortality rate in 1990-1995 : 58 per 1000 live births

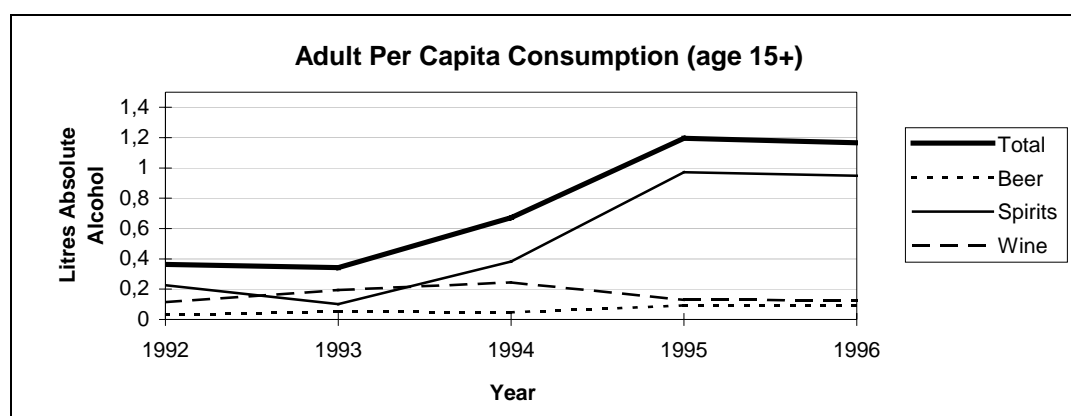
Socioeconomic situation

GNP per capita (US\$), 1995: 920

Alcohol production, trade and industry

Turkmenistan reports production of very low levels of beer and wine.

Alcohol consumption and prevalence



Consumption

WHO/EURO reports recorded per capita consumption of 1.9 litres in 1994. This translates to 3.1 litres per adult, a figure higher than that shown above. As beer production figures are not available after 1993, the above chart reflects consumption from imported beer only after that year. While there is no quantified information on unrecorded consumption, it is not considered to be very significant.

Economic impact of alcohol

Consumer expenditure on alcoholic beverages as a percentage of general expenditure on purchase of goods and payments for services increased from 3.4 in 1990 to 4 in 1994.

Mortality, morbidity, health and social problems from alcohol use

Alcohol dependence and related disorders

Data from an annual report on persons on clinic treatment registers for alcohol dependence on 1 January 1995 show the following:

	INCIDENCE (NEW CASES REGISTERED DURING 1994)		PREVALENCE (ALL CASES REGISTERED UP TO 1/1/95)	
	Number	per 100 000	Number	per 100 000
Alcohol dependence Without psychosis	1 191	27.31	16 699	382.89
Urban men	302	30.86	12 921	1 320.2
Urban women	70	6.98	1 144	114.12
Rural men	213	18.12	2 324	197.66
Rural women	3	0.25	310	25.74
Alcoholic psychosis	93	2.13	95	2.18

The highest morbidity (i.e. rate of new cases of alcohol dependence registered in medical establishments during one year) and prevalence are to be found in men and women in Ashkabad and in

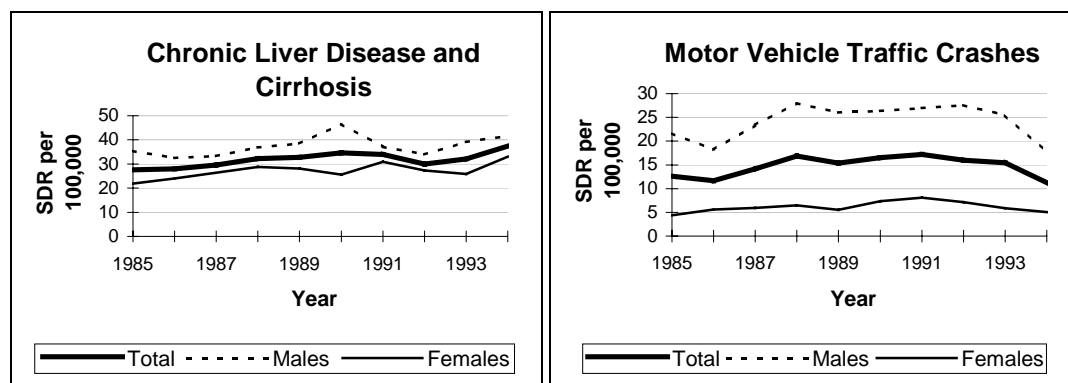
the Balkan Velayat (where the population is predominantly urban). Rates of morbidity and prevalence among women in Ashkabad are about 19.7 and 276.5 per 100 000 population, respectively. The lowest estimates, especially among women, are found in the north (Dashkhovuz) and the south-east (Mary), where the population is 70 per cent rural. These statistics have been relatively stable for the period from 1986-1992. Almost all patients being treated for alcohol dependence (97.7 per cent) are between 20 and 60 years of age. No people below the age of 18 are on the treatment register (although six per cent of the group registered for preventive surveillance are between the ages of 15 and 19). The proportion of women among all registered alcohol dependants has remained between 8 and 10 per cent over the last ten years.

The number of patients (per 100 000 population) with alcohol dependence registered at hospitals and other treatment centres at the end of the year increased slightly from 14.9 to 15.7 between 1990 and 1994.

The rate per 100 000 population of persons receiving inpatient treatment for alcoholic psychosis was 2.1 in 1993 and 1994, similar to the 1990 and 1985 rates but a decrease on the 4.8 recorded in 1980. In 1993, the morbidity (incidence) and prevalence rates per 100 000 population were 0.5 and 1.6, respectively.

Mortality

The SDR per 100 000 population for chronic liver disease was 17.7 in 1994, a decrease on the 19.7 recorded in 1990 and the 20.9 recorded in 1980, but slightly higher than the 16.3 recorded in 1985.



Social problems

The SDR per 100 000 population for motor vehicle traffic crashes involving alcohol was 0.8 in 1994, a decrease on the 2.1 in 1991 and the 2.2 in 1981. The number of persons committing crimes under the influence of alcohol (thousands) fell from 2.4 in 1990 to 1.6 in 1994.

Alcohol policies

Control of alcohol products

The real prices of all three types of alcohol, i.e. beer, spirits and wine have been increasing during the early 1990s. Table wines are taxed 60 per cent, beer (between four and six per cent alcohol) is taxed 10 per cent and spirits (over 35 per cent proof) are taxed 30 per cent. Since August, 1996, new excise taxes on imported alcoholic beverages have been implemented (beer: US\$ 0.5 per litre; all kinds of wine: US\$ 1.5 per litre; strong alcohol beverages: US\$ 1.5 per litre). This will increase the retail price of alcohol beverages.

Restrictions on types and location of outlets were introduced in 1965. Alcohol retail sale near schools, kindergartens, hospitals and in working places is prohibited. There is a state monopoly for the production of all three types of alcohol. A licence is required for distribution.

The draft of a Presidential Decree banning advertising of alcoholic beverages, tobacco and narcotic drugs was prepared and expected to come into effect late in 1995. General and specific health warnings are not required by law. Labels giving alcohol content are required by law, and the maximum legal limit for the alcohol content of beverages is 95 per cent.

Control of alcohol problems

There is a minimum legal age limit of 18 for the distribution of vodka, which is rationed. In June 1995 a minimum legal age limit of 18 years was introduced for buying alcohol of any type in any kind of outlet. The BAC limit is 0.03 g% for drivers. On conviction for a second or subsequent offence of driving above the permitted BAC, suspension of driving licence is usual. The routine method of detecting alcohol intoxication is by breath testing. Random alcohol breath testing is carried out, but infrequently. Blood alcohol content is measured only for special reasons, e.g. forensic cases.

The Department of Psychiatry Services and Prevention of Substance Abuse of the Ministry of Health and Medical Industry of Turkmenistan and the Department for Substance Abuse in the Research Institute of Preventive and Clinical Medicine are involved in the formulation, application, coordination and monitoring of national alcohol policies. Priorities of the early 1990s have been: reducing availability; developing specialized treatment for alcohol dependence and other alcohol problems; and working in schools.

Prevention of substance use/abuse is a significant part of work of the system of narcological dispensaries which provide inpatient and outpatient treatment in the area of substance (including alcohol) use. Each province has not less than one narcological dispensary or psychoneurological dispensary and in rural regions there are outpatient narcological units within general hospitals. These dispensaries are responsible for prevention and treatment of substance abuse on their administrative territory. Narcologists in the dispensaries provide the mass media with information and organize meetings and discussions with various groups of the population.

Five Centres for Health Promotion deal with health education, and the prevention of alcohol-related problems. These centres engage the help of specialists, generally medical doctors with expertise in the area of substance abuse. The centres also publish leaflets, brochures and posters on the issue. Pilot implementation of a school-based programme dealing with all psychoactive substances was carried out in Ashgabat in 1995. The programme was scheduled to be implemented in all schools in Turkmenistan on a phased basis from 1995 to 2000.

Alcohol data collection, research and treatment

The Department of Statistics, in the Ministry of Health and Medical Industry of Turkmenistan, the Department of Psychiatry Services and Prevention of Substance Abuse and the Department for Substance Abuse in the Research Institute of Preventive and Clinical Medicine are all involved in the gathering of alcohol consumption data for the entire population.

Persons dependent on alcohol are registered only with medical establishments, unless sentenced to compulsory treatment in establishments run by the Minister of the Interior. In the period from 1986 to 1992 no more than six per cent of all registered cases of alcohol dependence were treated on a compulsory basis.

Ukraine

Sociodemographic characteristics

POPULATION	1980	1990	1995
Total	49 961 000	51 637 000	51 380 000
Adult (15+)	39 266 000	40 569 000	41 051 000
% Urban	61.7	67.5	70.3
% Rural	38.3	32.5	29.7

Health status

Life expectancy at birth, 1990-1995 : 64.3 (males), 74.2 (females)

Infant mortality rate in 1990-1995 : 16 per 1000 live births

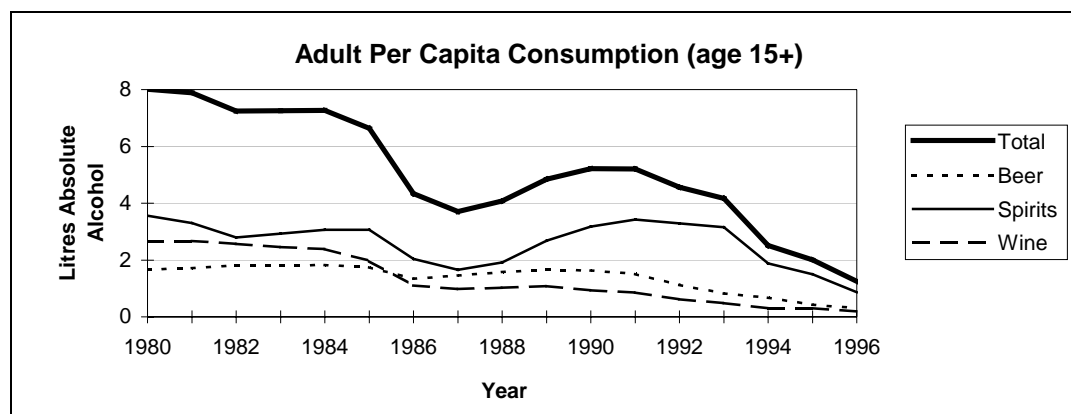
Socioeconomic situation

GNP per capita (US\$), 1995: 1630, PPP estimates of GNP per capita (current int'l \$), 1995: 2400
Average distribution of labour force by sector, 1990 : agriculture 20%, industry 40%

Alcohol production, trade and industry

Ukraine produces beer, distilled spirits and wine. The Seagram Company has formed Seagram Ukraine Ltd. in an effort to produce, distribute, and market new and existing spirits in the Ukraine. Illegal imports of spirits have gained in significance in Ukraine in the late 1990s.

Alcohol consumption and prevalence



Consumption

Recorded consumption of absolute alcohol was approximately 3.4 litres per adult in 1993. It is estimated that unrecorded consumption of pure alcohol was seven litres per capita in 1980, four in 1985 and seven in 1993. This suggests that total adult per capita consumption of alcohol in 1993 was 11.2 litres of absolute alcohol.

Age patterns

A study of 7193 15 to 16 year olds (3332 boys and 3861 girls) was conducted in 1995. The response rate was 93 per cent. Seventy-nine per cent of the respondents had drunk any alcoholic beverage in the last 12 months, and 30 per cent had been drunk in the last 12 months. Lifetime prevalence of alcohol use was 87 per cent (86 per cent for boys and 88 per cent for girls).

In 1978, 16 per cent of 562 rural secondary school students drank alcohol, compared with 66 per cent of 622 vocational-technical school students.

Economic impact of alcohol

Consumer expenditure on alcoholic drinks as a percentage of general expenditure on purchase of goods and payments for services was 3.7 in 1990, and 2.8 in 1991.

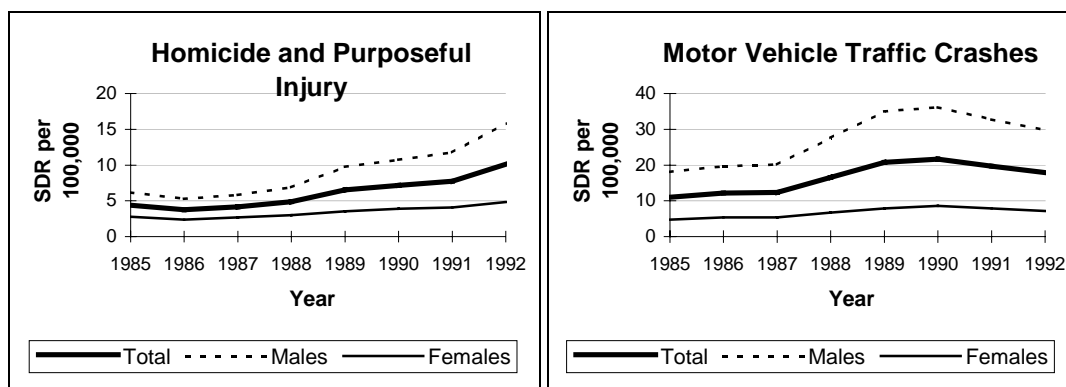
Mortality, morbidity, health and social problems from alcohol use

Alcohol dependence and related disorders

The rate per 100 000 population of persons treated in hospitals and psychiatric units for alcoholic psychosis was 16 in 1993, compared to 22.8 in 1980 and 8.5 in 1990. The number of patients (per 100 000 population) with alcohol dependence registered at hospitals and other treatment centres during the year decreased from 71.4 in 1990 to 63.9 in 1995.

Mortality

The number of alcohol-related homicides rose from 1102 to 2101 between 1980 and 1993. This number as a percentage of all homicides went from 53.7 to 69.4 during the same period. The SDR per 100 000 population for chronic liver disease and cirrhosis was 16.1 (25.2 for men and 9.6 for women) in 1992.



Social problems

The number of motor vehicle traffic crashes involving alcohol per 100 000 inhabitants was 13.1 in 1992, a decrease from the 16.1 recorded in 1990. The number of arrests for public drunkenness (thousands) increased from 1134 to 1802 between 1980 and 1985, then dropped to 839 in 1990 and rose again to 1359 in 1994. Alcohol-related crimes (as a percentage of all crimes) fell from 29.8 to 22.7 between 1980 and 1985. The number of persons committing crimes under the influence of alcohol (thousands) was 66.8 in 1994, compared with the 54.4 recorded in 1990.

Alcohol policies

Control of alcohol products

The real prices of beer, wine and especially of spirits have been decreasing during the early 1990s. Table wines are taxed 30 per cent, beer (between four and six per cent alcohol) is taxed 20 per cent and spirits (over 35 per cent proof) are taxed 85 per cent.

There are restrictions on hours of sale and location of outlets, but there are no restrictions on days of sale or on types of outlets. Sales have been banned in shops less than 20 square meters, to eliminate kiosk sales. However, the law defines alcoholic beverages as only beverages with over 8.5 per cent alcohol. According to legislation, workplaces and public transport must be alcohol-free.

There is a state monopoly for the production of spirits and fortified wine. A licence is required for the production of beer and table wine and for the distribution of all three types of alcohol, i.e. beer, spirits and wine.

According to Article 32 of the Health Promotion Law (adopted by Parliament in 1992), all advertising of alcoholic beverages is banned in Ukraine. However, no regulations have been issued to enforce this law. Alcohol advertising is therefore widely seen in the mass media but some television stations voluntarily restrict alcohol advertising. In July 1996 a law was passed banning the advertising of alcohol (and tobacco) in the context of media (TV, radio and the press) aimed at young people. Ukraine requires warnings on print advertisements stating: "Excessive alcohol use is harmful to your health." General and specific health warnings are not required by law to appear on alcoholic beverage containers. Labels carrying alcohol content are required by law, but there is no maximum legal limit for the alcohol content of beverages. Spirits with up to 95 per cent alcohol can be purchased in shops.

Control of alcohol problems

There is a minimum legal age limit of 21 for buying alcohol. The Ministry of Interior focuses on drinking and driving. The BAC limit is 0.0 g% for drivers. On conviction for a first offence for driving above the permitted BAC, suspension of driving licence is usual. Random alcohol breath testing is not carried out.

There is no national agency for the prevention of alcohol problems. A programme has been established by the Ministries of Health, Internal Affairs, Education and Justice concerning organizing and legal work, demand reduction for alcohol and tobacco, and treatment and social and medical rehabilitation of patients with signs of alcohol and tobacco dependence. A priority of the early 1990s has been to develop the role of the criminal justice system in the prevention and management of alcohol problems. In 1992 a law on health promotion was passed in Parliament, stating that the policy

was to decrease alcohol consumption and an advertising. Some education programmes exist but none at the national level. The Independent Sobriety Association aims at decreasing total consumption of alcohol and other drugs and advocates the choice of alcohol and other drug-free lifestyles. The Alcohol and Drug Information Centre (ADIC) documents the nature and extent of alcohol problems, advocates adequate responses and trains voluntary and professional staff for preventive work.

Alcohol data collection, research and treatment

The Ministry of Statistics and the Ministry of Health are responsible for analyzing, disseminating and utilizing data for the formulation of national policies.

The Decree of the Supreme Soviet of Ukraine, dated 17 August 1966, as amended, provides for “the compulsory treatment of chronic alcoholics.”

From 1980 to 1988 treatment facilities for alcohol dependence increased as did staff numbers. Places for the treatment of alcohol dependence in special hospitals increased from 2.2 per 100 000 inhabitants to 3.8 over the same period. However, since 1988 the number of places and staff has decreased by up to 50 per cent in some regions of Ukraine.

United Kingdom of Great Britain and Northern Ireland (the)

Sociodemographic characteristics

POPULATION	1980	1990	1995
Total	56 330 000	57 411 000	58 258 000
Adult (15+)	44 561 000	46 491 000	46 856 000
per cent Urban	88.8	89.1	89.5
per cent Rural	11.2	10.9	10.5

Health status

Life expectancy at birth, 1990-1995 : 73.6 (males), 78.7 (females)

Infant mortality rate in 1990-1995 : 7 per 1000 live births

Socioeconomic situation

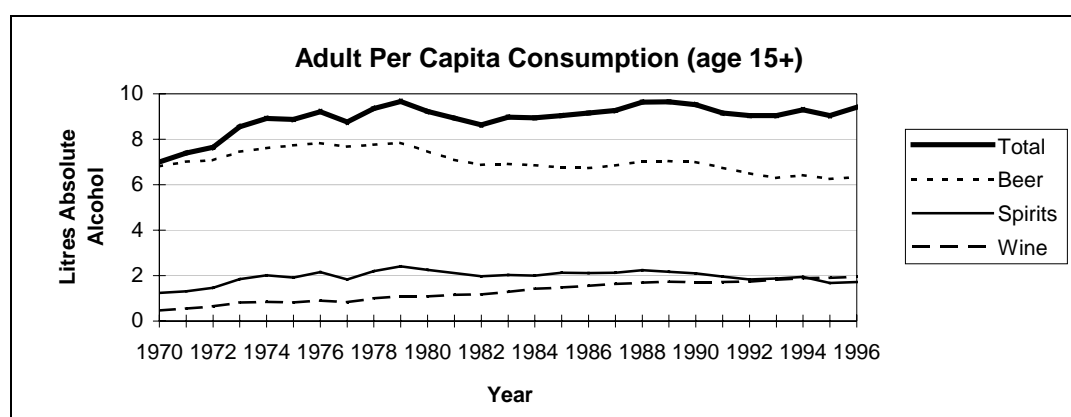
GNP per capita (US\$), 1995: 18 700, PPP estimates of GNP per capita (current int'l \$), 1995: 19 260
Average distribution of labour force by sector, 1990-1992 : agriculture 2%; industry 28%; services 70%

Adult literacy rate (per cent), 1995 : more than 95

Alcohol production, trade and industry

The United Kingdom's (UK) brewing industry saw a wave of consolidation until the decision by the United Kingdom's Board of Trade to block the proposed merger Bass and Carlsberg-Tetley. The decision leaves the country's largest brewer, Scottish Courage, with an approximately 31 per cent share of the domestic market for beer. In regard to spirits, the world's largest marketer of distilled spirits, UK-based Grand Metropolitan, announced that it would merge with the number two global spirits purveyor, Guinness, to form a new company to be called Diageo, from the Latin word for day and the Greek word for world. Guinness' strength in whisky distilling, concentrated in Scotland, will complement Grand Metropolitan's global dominance in vodka (Smirnoff), gin (Gilbey's) and brandy (Dreher).

Alcohol consumption and prevalence



Consumption

Figures obtained directly from the country itself (by *World Drink Trends*) yield the graph above. Illicit distilling is thought to be a small problem in the UK. It is not illegal to produce beer and wines at home, and an increasing number of people make their own with the raw materials widely available. There is however no specific estimate available that quantifies illicit and home production.

Prevalence

The 1992 annual General Household Survey found that men aged 16 years and over were drinking an average of 15.9 units of alcohol a week - about three times as much as women. (N.B. In the U.K., a unit is defined as eight grams of absolute alcohol.) About 27 per cent of men and 11 per cent of women aged 18 years and over were drinking more than 21 and 14 units a week, respectively, and 6 per cent of men and 2 per cent of women were drinking more than 50 and 35 units, respectively. The proportion of men whose consumption is above 21 units has remained steady since 1980, but there is some suggestion of a slight increase among men over the age of 45.

As in surveys carried out in previous years, the association between alcohol consumption and socioeconomic group in 1992 was much more pronounced for women than for men. The proportion of women who drank more than 14 units was higher among those in non-manual groups than among those in manual labour groups. Approximately 15 per cent of women in the professional group usually drank more than 14 units a week, compared with eight per cent of women in the unskilled manual group. Among men, those in the employers and managers group and the unskilled manual group were slightly more likely than others to have drunk more than 21 units weekly.

A 1990 survey among persons aged 15 years and over found that 16 per cent were frequent consumers (drinking alcohol three or four days per week), 36 per cent were moderate consumers and 48 per cent drank infrequently (weekly or never).

Age patterns

According to a decade-long survey of more than 8000 boys and girls published in 1997, four children in five started drinking alcohol at home by the ages of 14 or 15. By the tenth year of compulsory schooling, boy drinkers average more than 10 units of alcohol a week - equivalent to 5 pints of beer or 10 measures of spirits - and girls average 10 units. Three per cent of boys aged 12 or 13 years and more than seven per cent of boys aged 14 or 15 years reported drinking more than 21 units of alcohol per week. Beer and lager were the most common alcoholic beverages for boys, while wine was the most popular among girls. Alcopops were the second most common for both sexes. Among 14 to 15 year olds, 76 per cent of boys and 79 per cent of girls said they drank "to get drunk."

A study of 7722 15 to 16 year olds (3630 boys and 4092 girls) was conducted in 1995. The response rate was 84 per cent. Ninety per cent of the respondents had drunk any alcoholic beverage in the last 12 months, and 70 per cent had been drunk in the last 12 months.

Economic impact of alcohol

Total expenditure on alcoholic beverages as a percentage of total consumer expenditure rose from 5.7 in 1960 to 7.5 in 1980, dropping to 7.4 in 1984.

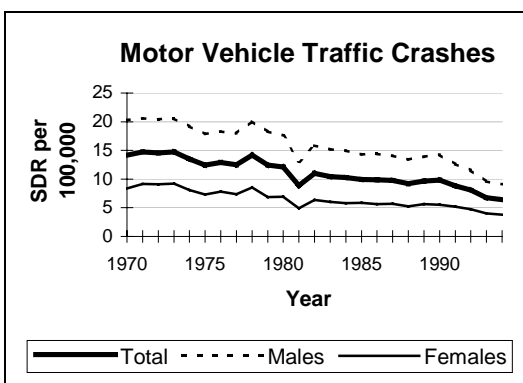
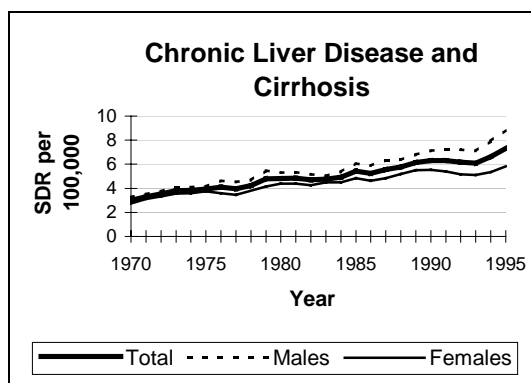
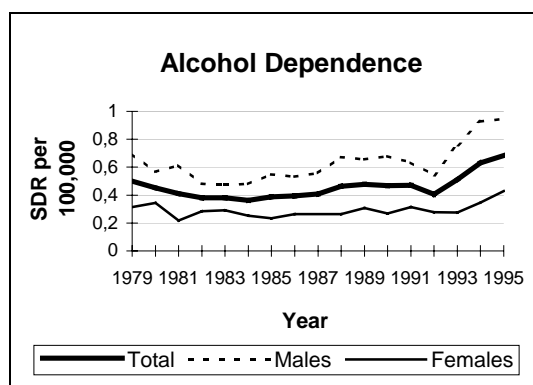
Mortality, morbidity, health and social problems from alcohol use

Alcohol dependence and related disorders

The SDR per 100 000 population from alcohol dependence has risen fairly rapidly since 1991, but remains at a relatively low level by global standards.

Mortality

The SDR for chronic liver disease and cirrhosis rose from 3.0 to 7.3 per 100 000 population between 1970 and 1995.



Social problems

It is estimated that alcohol is a factor in up to 30 per cent of child abuse cases. In a survey of more than 8000 boys and girls, close to four per cent had experienced physical violence associated with drinking in the home within the previous week. The number of road traffic crashes per 100 000 population involving alcohol was 21.9 in 1992, fairly similar to the 1985 figure. The number has fluctuated since then, being at its highest in 1989 at 25.5 and its lowest in 1990 at 17.5.

Alcohol policies

Control of alcohol products

In response to EEC rules, it was necessary to reduce taxes levied on wines. Price indices of alcoholic beverages have shown enormous increases over the past 20 years. Beer prices increased 808 per cent between 1963 and 1984, but relative to personal disposable income the cost per litre, in terms of pure alcohol, fell by 33 per cent between 1960 and 1983. The hours of work required to pay for a pint of beer diminished for manual workers by 14 per cent for men and 26 per cent for women, and for non-manual workers by 26 per cent and 21 per cent respectively. The respective reductions in hours of work required to pay for a bottle of whisky were 61 per cent and 70 per cent and 63 per cent and 70

per cent. The real prices of beer and spirits have been stable, and that of wine decreasing, over the last five years.

Table wines are taxed 51.1 per cent, beer (four to six per cent alcohol) is taxed 31 per cent and spirits (over 35 per cent proof) are taxed 66.5 per cent. Duties are rising in line with inflation, adding £0.19 (US\$ 31.03) to a bottle of spirits, £0.01 (US\$ 1.63) to a pint of beer, £0.04 (US\$ 6.53) to a bottle of table wine and £0.01 (US\$ 1.63) to high strength alcohol, including alcopops. In 1997, the Chancellor of the Exchequer announced that the rise of duty for wine, beer and spirits would rise in line with inflation, or three per cent. This will mean a US\$ 0.31 rise in the price of a bottle of whisky, a US\$ 1.63 rise for a pint of beer, and a US\$ 0.065 rise for a bottle of wine. The Chancellor also announced a review of excise duties on alcoholic drinks in light of the distortions of trade caused by cross-border shopping.

There are restrictions on hours and days of sale and on type and location of outlets. Some local authorities have introduced local By-laws restricting alcohol consumption in certain public places, particularly outdoors. A licence is required for the production or distribution of beer, wine or spirits.

A voluntary code governs the advertising of all three types of alcohol, i.e. beer, spirits and wine, and in 1997 the Advertising Standards Authority found that 98 per cent of alcohol advertisements in the UK follow standards set by the industry. General and specific health warnings are not required by law. Television transmission of alcohol advertising is banned between 16.00 and 18.00 hours (excluding weekends and bank holidays), between religious programmes, and immediately before, during or after children's programmes. Complaints made against advertisements are considered by the Advertising Standards Authority. Labels for alcohol content are required by law. Discussions are being held with the beverage alcohol industry about labelling the number of units contained in each alcoholic beverage container. There is no maximum legal limit for the alcohol content of beverages.

Control of alcohol problems

There is a minimum legal age limit of 18 for purchasing alcoholic beverages. However it is possible to consume some alcoholic beverages in bars or restaurants at 16 or 17 years of age. BAC limit is 0.08 g% for drivers. On conviction for a first or subsequent offence of driving above the BAC limit, suspension of driving licence is usual. Random alcohol breath testing is not carried out.

A recent strategy document set a target of reducing the proportion of men drinking more than 21 units of alcohol per week from 28 per cent in 1990 to 18 per cent by 2005, and the proportion of men drinking more than 14 units of alcohol per week from 11 per cent in 1990 to seven per cent by 2005. Other priorities of the early 1990s have been: mass media campaigns to encourage safer drinking; encouraging lighter drinking in work settings; increasing the role of primary health care teams in the prevention and early detection of alcohol problems; developing the role of the social welfare system and of the criminal justice system in the prevention and management of alcohol problems; developing specialized treatment for alcohol dependence and other alcohol problems and addressing particular alcohol problems.

The Health Education Authority in England has been the major organization carrying out Government alcohol prevention policies at the national level. It engages in education programmes and campaigns. The Ministerial Group on Alcohol Misuse of the Department of Health and Social Security has launched a number of initiatives, in cooperation with the alcohol industry where appropriate.

The Health Education Authority concentrates on education and prevention. It collaborates with other bodies in producing materials for use in schools and youth clubs on alcohol problems. The Scottish Health Education Group has produced alcohol education films for use in schools. There are mass media, school-based and workplace programmes, some of which deal with alcohol alone and some with substance use in general. This latter approach is particularly a feature of school-based programmes.

Each Health District or Health Board in the UK has a health education/health promotion department which carries out alcohol prevention work in that community/district. There are more than 120 such districts in the country. Alcohol Concern, the leading national voluntary organization, is also involved in preventive work at the national level. It is a national umbrella organization for the voluntary sector. It engages in information, education and prevention initiatives and in improvement of voluntary sector

services for alcohol abusers. In addition, many local "councils on alcoholism" are involved in prevention work.

Alcohol data collection, research and treatment

Several universities have research and training units concerned with alcohol problems, such as the Addiction Research Unit at the Institute of Psychiatry, University of London; the Addiction Research Centre at Hull and York; the Alcohol Research Group and Alcohol Problems Clinic at the University of Edinburgh; and the Alcohol Studies Centre at Paisley. Training on alcohol problems is now included in all medical and social work education.

According to a report on the pattern and range of services for problem drinkers, produced by the Advisory Committee on Alcoholism established in 1975, the provision of specialized services was inadequate and primary health personnel were ill equipped and lacking in sufficient time to deal with the variety and volume of problems arising. There has therefore been a considerable increase in interest in improving skills in the recognition and management of alcohol problems at various levels and studying methods of providing simple advice, encouraging self-monitoring and extending outpatient intervention.

In 1988 the Ministerial Group on Alcohol Abuse was established in recognition of the need to coordinate various types of treatment provision to suit the requirements of the widely differing subgroups of people with alcohol problems. Treatment for alcohol problems is available within the National Health Service through general practitioners, hospital care (detoxification, specialized alcohol dependence units, outpatient and day patient treatment), through the social services, and through voluntary agencies (councils on alcohol dependence, Alcoholics Anonymous, Al Anon, churches and the Salvation Army).

Uzbekistan

Sociodemographic characteristics

POPULATION	1980	1990	1995
Total	15 936 000	20 420 000	22 843 000
Adult (15+)	9 415 000	12 067 000	13 723 000
% Urban	40.8	40.6	41.3
% Rural	59.2	59.4	58.7

Health status

Life expectancy at birth, 1990-1995 : 66.0 (males), 72.2 (females)

Infant mortality rate in 1990-1995 : 41 per 1000 live births

Socioeconomic situation

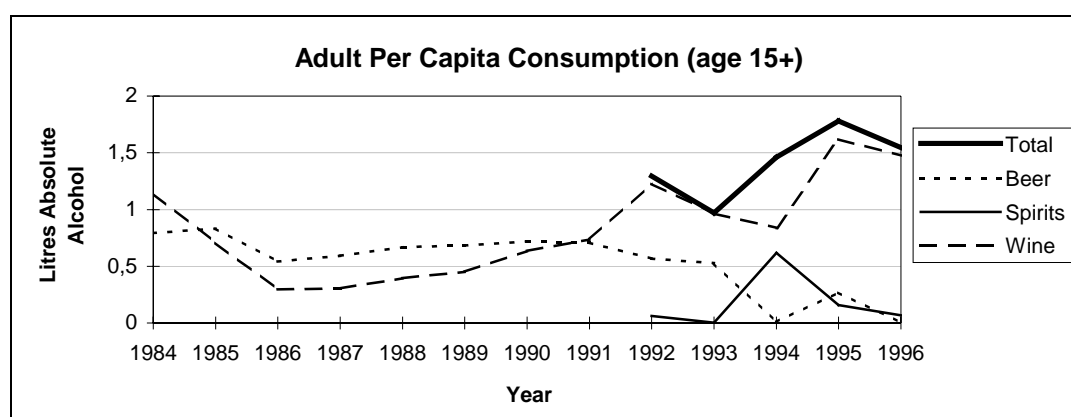
GNP per capita (US\$), 1995: 970, PPP estimates of GNP per capita (current int'l \$), 1995: 2370

Average distribution of labour force by sector, 1990-1992 : agriculture 17%; industry 20%; services 63%

Alcohol production, trade and industry

Uzbekistan reports production of beer and wine.

Alcohol consumption and prevalence



Consumption

Due to gaps in the data available, the best estimate of recorded consumption is in 1995, when adults drank 1.78 litres of pure alcohol per capita. There are no data available on the extent of unrecorded consumption.

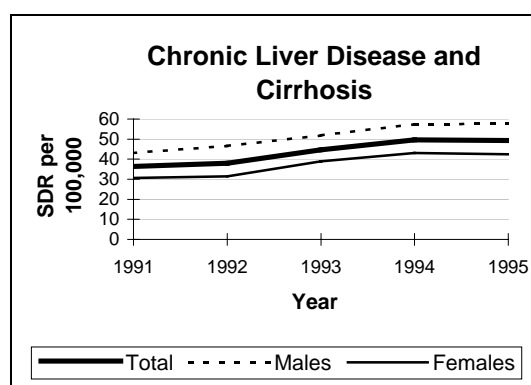
Economic impact of alcohol

Consumer expenditure on alcoholic drinks as a percentage of general expenditure on purchase of goods and payments for services decreased from 2.9 to 1.9 between 1990 and 1995.

Mortality, morbidity, health and social problems from alcohol use

Alcohol dependence and related disorders

The number of patients per 100 000 population with alcohol dependence registered at hospitals and other treatment centres during the year fell from 8.4 in 1990 to 4.7 in 1995.



Health problems

A cross sectional study was conducted among 1569 men. All subjects in the study had an oral examination, and oesophagoscopy was performed in 1344 men. Alcohol intake was not found to be independently associated in any way with the presence of oral and oesophageal precancerous lesions.

Social problems

The number of persons committing crimes under the influence of alcohol (thousands) decreased from 8.2 to 6.7 between 1990 and 1994.

Yugoslavia

Sociodemographic characteristics

POPULATION	1980	1990	1995
Total	9 522 000	10 156 000	10 849 000
Adult (15+)	7 230 000	7 782 000	8 459 000
% Urban	46.3	53.1	56.5
% Rural	53.7	46.9	43.5

Health status

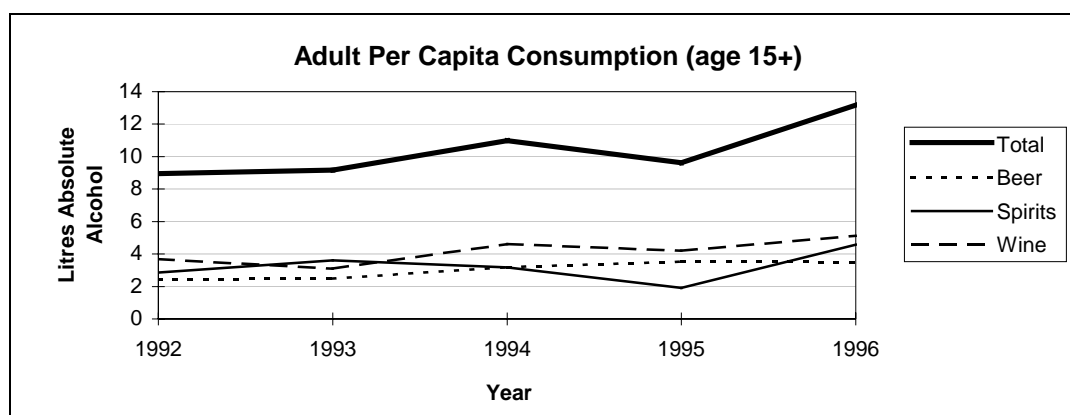
Life expectancy at birth, 1990-1995 : 69.5 (males), 74.5 (females)

Infant mortality rate in 1990-1995 : 20 per 1000 live births

Alcohol production, trade and industry

Yugoslavia produces beer, distilled spirits and wine.

Alcohol consumption and prevalence



Consumption

Consumption has risen recently as a result of an increase in spirits consumption. There is no information available regarding unrecorded consumption.

Mortality, morbidity, health and social problems from alcohol use

Mortality

The SDR per 100 000 population from chronic liver disease and cirrhosis peaked at 24.4 in 1983, and had fallen to 16.7 by 1990, the last year for which data are available.

