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POLICY AND PRACTICE

Improving monitoring of implementation of alcohol policy: a case study from Estonia

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ABSTRACT

Background: Alcohol consumption is an increasingly important contributor to the global burden of noncommunicable diseases (NCDs). Goal 3 of the Sustainable Development Goals provides concrete targets for tackling the NCD burden, and Goal 10 highlights the importance of sound policies for reducing inequalities. Alcohol control policy, for one, has a critical role to play in mitigating the harmful effects of alcohol consumption, reducing inequalities in the distribution of alcohol-related harm and thus reducing the incidence and prevalence of NCDs.

Regional and Local Contexts: While the WHO European Region is on track to meet the agreed global premature mortality goal, alcohol consumption is not decreasing at a sufficient pace to achieve the overall agreed targets in the global monitoring framework for the prevention and control of NCDs. Here, we use the evolution of alcohol control policy in Estonia in the past decade as a case study

of successful policy formulation and implementation. We also highlight the European action plan to reduce the harmful use of alcohol 2012–2020 (EAPA) composite indicators for monitoring policy implementation.

Ways forward: The Estonian case study shows that successful policy responses in the reduction of alcohol consumption are likely to be multipronged, covering a wide range of policy areas, to have gathered support across society, from policy-makers to researchers and including parents and advocates, and to anticipate and address pressures from vested interests. The EAPA composite indicators can help countries to map the policy tools at their disposal and to track their progress both across time and relative to other countries. Future iterations of these indicators will build on the current baseline and establish a comprehensive picture of alcohol control progress in the WHO European Region.

Keywords: ALCOHOL CONSUMPTION, ESTONIA, EUROPEAN ALCOHOL ACTION PLAN, SUSTAINABLE DEVELOPMENT GOALS, NONCOMMUNICABLE DISEASES

BACKGROUND

Alcohol consumption is an increasingly important contributor to the global burden of noncommunicable diseases (NCDs) – alcohol use went from eighth place in the rank of contributors to global disability-adjusted life years in 1990, to fifth in 2010 and on to fourth in 2016 (1). Within the WHO European Region, alcohol use is the leading risk factor for disease burden in eastern Europe (2). The Sustainable Development Goals (SDGs) include several targets relevant to improving health through

reductions in the harmful use of alcohol. Two of the targets in Goal 3 are “by 2030, reduce by one third premature mortality from non-communicable diseases through prevention and treatment and promote mental health and well-being” and “strengthen the prevention and treatment of substance abuse, including narcotic drug abuse and harmful use of alcohol”, and one of the targets of Goal 10 is “ensure equal opportunity and reduce inequalities of outcome, including by eliminating discriminatory laws, policies and practices and promoting appropriate legislation, policies and action in this regard”.

While Goal 3 provides a concrete benchmark against which to track the reduction of alcohol consumption and related harm, Goal 10 speaks to the importance of sound policies in the equitable achievement of those goals.

Alcohol control policy has a critical role to play in mitigating the harmful effects of alcohol consumption as well as inequalities in the distribution of this harm. Inequalities in harmful drinking and its consequences are found both between and within countries. There is wide variation in the levels of alcohol consumption among WHO European Region Member States, and, within countries, the burden of alcohol-related harm is distributed according to socioeconomic status, education level, sex, ethnicity and place of residence (3). For example, in most countries in the WHO European Region, inequities in alcohol-related deaths and health problems are more pronounced in the lower strata of the social gradient. In general, lower socioeconomic groups experience higher levels of alcohol-related harm than wealthier groups with the same level of consumption. Similarly, drinkers in low socioeconomic groups are more likely to binge drink (3, 4). The alcohol policies outlined in European action plan to reduce the harmful use of alcohol 2012–2020 (EAPA) are universal in their approach – especially those within the areas of availability of alcohol, marketing of alcoholic beverages, and pricing policies. They are thus powerful means for reducing health inequalities by enhancing improvements both in overall trends and across socioeconomic groups, genders, and the life-course (5).

Reducing alcohol consumption also contributes to other NCD-related goals, such as reducing blood pressure and promoting mental health and well-being (2). The prevalence of tobacco use is also likely to be affected, as drinking and smoking often go hand in hand, and measures to curb one are likely to limit the other (6).

While the WHO European Region is on track to meet the agreed global premature mortality goal, alcohol consumption is not decreasing at a sufficient pace to achieve the overall agreed targets in the global monitoring framework for the prevention and control of NCDs (7). The NCD progress-monitoring indicators include measures such as comprehensive restrictions or bans on alcohol advertising and promotion, and excise tax increases on alcoholic beverages. A more detailed description of the progress-monitoring indicators can be found elsewhere (7). Between 2015 and 2017, while the proportion of countries with full implementation of progress-monitoring indicators of targets to reduce NCDs increased for 12 of the 18 progress-monitoring indicators, it decreased for five of them. Among the indicators where there have been

setbacks are the implementation of regulations controlling the availability of alcohol, and alcohol pricing policies.

Alcohol control policy indices that rank the performance of individual countries are valuable tools for comparing rates of progress in alcohol policy (8, 9). They have, nonetheless, been criticized in the past because there can actually be important policy shortcomings in countries that appear to be performing relatively well on the basis of such indices (10, 11). In these instances, case studies are valuable complements to composite measures, as they can shed light on the processes underpinning the policies. On the other hand, case studies of processes of policy formulation and implementation are subject to greater levels of subjectivity than more systematic approaches to compare policies. A case can thus be made for using both case studies and more systemic approaches, such as policy indices, simultaneously when monitoring progress towards international commitments. By describing recent developments in Estonia, this article provides a concrete case study illustrating the mechanisms through which better alcohol policies may be adopted and implemented, and consumption reduced. At the same time, it highlights the importance of the EAPA composite indicators in providing a tool for monitoring policy formulation and implementation, one which can help countries to track their progress towards adopting a suite of policies to tackle the negative consequences of alcohol consumption across society.

LOCAL CONTEXT

Estonia provides a good example of how a country can take steps to improve key indicators through large-scale implementation of cost-effective public health interventions to reduce alcohol consumption and related harm. Alcohol consumption in Estonia has historically been similar to that in northern Europe and post-Soviet countries, with patterns of high consumption and heavy episodic drinking that often start at a young age (the latest European School Survey Project on Alcohol and Other Drugs showed that 58% of pupils reported having tried alcohol before the age of 13, and 15% reported having been intoxicated before the age of 13 (12). Ten years ago, the country had one of the highest levels of alcohol consumption in the world, with alcohol affordability playing an important role. In 2008, the average annual salary could buy 62 litres of strong spirits, compared with 28 litres in 2000; the increase of affordability was one of the highest in the European Union (EU) (13). Since then, the progressive adoption of measures that rely heavily, but not exclusively, on increasing excise taxes has caused the alcohol consumption per capita in Estonia to be reduced by

a third. In 2016, Estonians drank five litres less alcohol per adult annually than in 2007. The reduction in consumption has also led to a reduction in problems associated with alcohol consumption. The number of deaths from alcohol-related illnesses has fallen by 40%, meaning that measures to reduce alcohol consumption may have saved as many as 300 lives per year since 2007 (14).

ALCOHOL POLICY REFORMS IN ESTONIA SINCE 2008

In 2003–2004, attempts to introduce stricter alcohol control policies failed, partially due to lack of public support and political interest. However, that experience provided information that was used for the most recent approach, which focused on creating and gathering knowledge and expertise, raising public awareness and creating societal demand for a stronger alcohol policy. A comprehensive alcohol strategy was finalized in 2014–2015; however, dialogue among stakeholders had begun during the policy developing stage in 2007, with regular intersectoral meetings to coordinate different alcohol policy measures.

In 2008, the new Advertising Act came into effect, to reduce the display and attractiveness of alcohol advertising as well as prohibit the off-premise sales of alcohol from 22:00 until 10:00. Regular media campaigns to prevent drink-driving, led by the Road Administration, were timed to support random breath testing enforced by the police. In 2009, the first programme to introduce early identification of alcohol abuse, and brief interventions in primary health care, was initiated, and guidelines on low-risk drinking were made available online for the general public. Simultaneously, the National Institute for Health Development (NIHD) started a media campaign warning of alcohol-related risks and harms. Since then, NIHD has launched one to two campaigns every year, focusing on different aspects of alcohol-related harm.

The process leading to the drafting of the Green Paper on Alcohol Policy was started in 2011 by the Ministry of Social Affairs and focused on all 10 action areas of the EAPA. Working groups consisted of representatives from different ministries, government institutions, nongovernmental organizations and the alcohol industry.

WHO also supported Estonia throughout the alcohol control policy-making process. The WHO Regional Office for Europe was involved in ad hoc consultations, presented in the Estonian Ministry of Health yearly alcohol policy

conference and brought in experts to assist the Ministry in highly technical tasks that required specialized input. The Regional Office also compiled short overviews of the evidence that informed the policy decisions and, through WHO-led EVIPNet seminars, built scientific and technical capacity within the Ministry. Furthermore, the WHO European Office for Investment for Health and Development organized seminars during which alcohol was discussed as an entry point to an exploration of health inequalities in general.

The Green Paper was adopted in 2014, and, in October 2015, the Health Minister introduced an alcohol policy bill to change the Alcohol Act and Advertising Act (the bill was subsequently adopted by Parliament in December 2017). This changed provisions in the Alcohol Act concerning the regulation of alcohol sales, the presentation of alcoholic products, and age verification for purchasing alcoholic beverages. The Act stipulates control transactions to improve surveillance to ensure better adherence to the ban on alcohol sales to minors and energizes the fight against illegal alcohol sales. The law also changes the provisions of the Advertising Act to restrict the content of alcohol advertisements, amends the list of locations where alcohol advertising is banned, and clarifies provisions that restrict the use of low pricing to market alcoholic beverages, as well as the advertising requirements set for health warnings. Provisions concerning advertising restrictions are to enter into force on 1 June 2018.¹

With regards to pricing, in 2015, the government adopted a policy to fix excise tax increases for alcohol from 2016 (15%) to 2020 (yearly 10% increases), a move that built on successive tax increases that have taken place since 2010. Subsequently, in February 2017, taxes on beer and spirits were increased by 10%. In July 2017, the beer tax was increased by an additional 70%, and a further 18% increase was planned for February 2018 (15), although it was later halved because of growing cross-border trade from Latvia.

Table 1 shows the chronology of alcohol policy developments in Estonia. This process has not always been seamless, however. Challenges to developing effective alcohol policies included prejudice and misconceptions about alcohol that were deeply rooted in Estonian culture, as well as strong opposition from the alcohol industry – including the introduction of self-regulatory measures, personal attacks against the Minister of Health, and the claim that policy-makers had a prohibitionist

¹ Stores, meanwhile, will be given a year and a half for the reorganization of their premises, and the provisions affecting them are to enter into force on 1 June 2019.

TABLE 1. CHRONOLOGY OF ALCOHOL POLICY DEVELOPMENTS IN ESTONIA

Year	Policy
2007	Dialogue and intersectoral meetings in preparation for the national alcohol strategy
2008	The New Advertising Act comes into force
2009	A programme for early identification of alcohol abuse and brief interventions in primary health care is introduced National Institute for Health Development launches a media campaign warning of alcohol-related risks
2011	Start of the process leading to the creation of the Green Paper on Alcohol Policy
2014–2015	The Estonian alcohol strategy is finalized and adopted
2015	An alcohol policy bill to change the Alcohol Act and the Advertising Act is introduced The government adopts a policy to fix excise tax increases for alcohol from 2016 onwards
2017	The alcohol policy bill is approved by Parliament Alcohol control is made one of the health priorities of the Estonian Presidency of the Council of the European Union

agenda (16, 17) – and a lack of support from the media in establishing the role of alcohol as a vector for disease burden in the country.

Although it is too early to draw definitive conclusions about the impact of the changes to alcohol policy in Estonia, as the majority of the measures from the recent law change have not yet entered into force, there are three key lessons that other countries may draw upon. The first one pertains to political leadership. The Health Minister has shown personal commitment to the strategy, both nationally and at the EU level, as he raised the control of alcohol consumption as one of the health priorities during the Estonian Presidency of the Council of the European Union in 2017. This resulted in the adoption of the Council conclusions on cross-border aspects in alcohol policy (18).

The second lesson relates to the decreases in alcohol consumption, and factors influencing this. In Estonia, alcohol consumption has declined by almost a third since 2008 (14), in a period during which little policy action was underway. The consumption decrease started with quite a sharp drop right after the economic crisis started in 2008. While it could be argued that one of the effects of the economic crisis was to reduce personal income, so there was less money available to be spent on alcohol, it is important to note that the momentum in consumption decline was sustained with

ensuing policy action. Since 2008, the NIHD has organized several awareness campaigns. From 2014 to 2016, civil society organizations ran larger campaigns funded by international grants, and the Ministry of Internal Affairs and the NIHD organized education programmes for parents. In addition, training programmes to rehabilitate people charged with drink-driving were introduced, and a programme to develop a comprehensive system to prevent and treat alcohol-use disorders in Estonia – “Sober and healthy Estonia” – was initiated in 2015. Surrounding these developments was an extensive public discussion about alcohol-related harm and alcohol policy in the media. Annual surveys by the Institute of Economic Research show that the population supports stronger and more restrictive alcohol policies, with 80% of respondents repeatedly saying that they wanted stronger bans on alcohol advertising.

The third and last lesson pertains to cross-border trade. The twofold alcohol price difference between Estonia and Latvia, resulting from the price increases described above, caused an unintended increase in cross-border trade between the two countries. This, in turn, caused a new wave of public discussion around pricing policies, and a loss of popular support for tax increases. As a first step towards addressing the problem, the government halved the tax increase planned for February 2018, thus increasing the beer tax by 9% and the spirits tax by 5%. Different ministers have suggested that tax increases scheduled for 2019 and 2020 should be cancelled.

WAYS FORWARD

Case studies of policy formulation and implementation, such as this one, provide useful lessons for policy-makers. There are, however, some limitations to this approach, among which is the fact that the reflections in case studies are speculative and do not lend themselves to systematic evaluations of the factors influencing policy outcomes. Case studies tend to focus on one or two countries as examples; hence, there is a need to study the factors affecting the formulation and implementation of alcohol policies across multiple countries in the WHO European Region.

Composite indicators can facilitate a more systematic way to monitor and evaluate alcohol policy formulation and implementation. Therefore, mapping the strictness and comprehensiveness of national alcohol policies, using composite indicators tied to the EAPA, is a necessary step in tackling alcohol consumption, for four reasons. First, evidence-based policies form the cornerstone of any strategy

to reduce consumption at the population level. Second, by introducing comparability of the suite of policies adopted by Member States, we provide a benchmark by which countries can measure their progress and identify gaps in their package of adopted policies. Third, the quality of the policies and their implementation may be used to explain variations in the reduction in alcohol consumption and answer questions such as “Do countries with stricter and more comprehensive policies achieve larger reductions in alcohol consumption?” Fourth, by keeping track of the evolution of policy adoption and implementation, the Regional Office can help countries monitor and evaluate their own progress against the policies in the action areas outlined in the EAPA.

The EAPA outlines 10 action areas for the reduction of the harmful use of alcohol (19). The Regional Office used these 10 action areas to construct novel composite indicators, each of which includes a recommended portfolio of evidence-based interventions. They assess the extent to which a Member State has implemented a policy measure and take into account the level of empirical support for the measure’s effectiveness, as well as the level of strictness and comprehensiveness of each action. As such, the composite indicators allow monitoring to go beyond solely tracking whether a Member State has a national alcohol policy, to a more fine-grained approach of evaluating the individual components. Future iterations of these indicators can be generated at regular intervals throughout the lifespan of the EAPA, to quantitatively monitor the progress of individual countries. These periodic evaluations will accord recognition to role models while motivating countries that are lagging behind to make good on their commitment. The EAPA composite indicators give guidance for politicians to identify areas of alcohol policy where a Member State has low scores. Furthermore, they offer an important sense of regional solidarity, as countries across the world are seen to move in step. That is perhaps the greatest reassurance that politicians can have when adopting potentially unpopular policies (20).

In their current formulation, the EAPA composite indicators offer a baseline against which scores produced by future iterations can be measured. The lowest score obtained was zero for all but two action areas: health services’ response, and drink-driving policies and countermeasures. None of the countries obtained the maximum possible points for health services’ response or the availability of alcohol. In general, Member States performed relatively well in the domain of drink-driving policies and countermeasures. Many countries fared poorly in the areas of pricing policies and reducing the negative consequences of drinking and alcohol intoxication. There is clearly room for improvement, both in the WHO

European Region at large and in Estonia, despite its remarkable success. Estonia obtained the highest score, which was above the EU mean, in the action area “Leadership, awareness and commitment”, a quantitative expression of the policy process described in this article. It also obtained the highest score in the action areas “Reduction of the public health impact of illicit alcohol and informally produced alcohol” and “Monitoring and surveillance”. The composite indicators also highlighted areas that need improvement as, for all the indicators for the remaining seven areas, Estonia’s score was below the EU mean. Most notably, Estonia scored 25 out of 100 points in the indicator for the action area “Marketing of alcoholic beverages”.²

CONCLUSION

The Estonian case study shows that successful policy responses to reduce alcohol consumption and associated harm are likely to be multipronged, covering a wide range of policy areas, and to have gathered support across society – from policy-makers to researchers and including parents and advocates. Valuable as case studies are in illustrating contexts and policy processes, they are not standardized measures of policy and therefore benefit from being analysed in conjunction with composite indicators. Composite indicators help countries to map the policy tools at their disposal and track their progress both across time and relative to other countries. Future iterations of the EAPA composite indicators will build on the current baseline and establish a comprehensive picture of alcohol control progress in Europe.

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² The scores for Estonia are derived from our own tool and will be published in Madureira Lima L, Brummer J, Schölin L, Täht T, Beekmann L, Ferreira-Borges C. Alcohol consumption, alcohol attributable harm and alcohol control policies in the EU, Norway and Switzerland, Country Profiles (forthcoming).

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³ All references were accessed on 6 August 2018.