Hazardous drinkers

153 million

Annual alcohol-related health costs:

81% of 15 year-olds have already tried alcoholic beverages

956 deaths due to alcohol per year

3876 annual alcohol-related hospitalizations

ALCOHOL POLICY IN SLOVENIA
OPPORTUNITIES FOR REDUCING HARM AND COST

Annual estimated health costs related to alcohol use between 2011 and 2014 amounted to €153 million.

Slovenia lagging behind European countries with strictest alcohol policies

Public support of stricter alcohol-related measures, such as alcohol licensing, minimal alcohol pricing and total ban on alcohol advertising

Two out of five adolescents have engaged in binge drinking at least twice in their lives despite the ban on the sale of alcohol to people under 18 years of age.

10 people are hospitalized every day as a result of alcohol use.

Increase in percentage of young female binge drinkers

Increase in alcohol prices

Ban on alcohol advertising

512 700 hazardous drinkers

0.0 blood alcohol content

Increase in percentage of young female binge drinkers

Increase in alcohol prices

Ban on alcohol advertising

Slovenia lagging behind European countries with strictest alcohol policies

Annual alcohol-related health costs:

€ 153 million

Public support of stricter alcohol-related measures, such as alcohol licensing, minimal alcohol pricing and total ban on alcohol advertising

Limiting alcohol availability

Recognizing hazardous drinkers

77% of the public support a blood alcohol concentration limit of 0.0 for all drivers
The aim of the publication is to equip policy-makers in different sectors at the national and local community levels, and others working to reduce alcohol-related harm in Slovenia, with credible data on the extent of the alcohol problem in the country and information on effective, evidence-based alcohol-related policy measures. The publication was prepared by alcohol experts working at the National Institute of Public Health and the Ministry of Health of Slovenia, colleagues from the MOSA network, Mobilizacija skupnosti za odgovornejši odnos do alkohola (Mobilizing society for more responsible attitudes towards alcohol), and the Alcohol Policy Youth Network. The contents of the publication are based on data and sources included in the monograph, Alkohol v Sloveniji. Trendi v načinu pitja, zdravstvene posledice škodljivega pitja, mjenja akterjev in predlogi ukrepov za učinkovitejšo alkoholno politiko (Alcohol in Slovenia. Trends in the way of drinking, health consequences of harmful drinking, stakeholders’ opinions and suggested measures for an effective alcohol policy), published in 2014 by the National Institute of Public Health, as well as on other national and international sources.
ALCOHOL IS A SERIOUS PROBLEM

The harmful effects of alcohol use are many. In Slovenia:

- despite the ban on selling alcohol to persons under 18 years of age, most 15 year-olds have tried or drunk alcoholic beverages and two out of five have engaged in binge drinking at least twice in their lives;
- there has been an increasing trend in binge drinking among young women over the past ten years;
- among young adults (25–35 years), 28% of men and 16% of women engage in binge drinking at least once and up to three times per month;
- ten people are admitted to hospitals every day for reasons exclusively related to alcohol;
- every year, an average of 956 people die as a result of the harmful effects of alcohol use on health and traffic accidents caused by drunk drivers.

GOVERNMENT FUNDS ARE STRONGLY AFFECTED BY COSTS RELATED TO ALCOHOL USE

For the period 2011–2014, health costs related to alcohol use in Slovenia were estimated on average at €153 million per year; adding the costs resulting, for example, from traffic accidents, crime, domestic violence and theft, brings the amount to €234 million. Reduced productivity and the anguish felt by close family members, especially children, are also costs that need to be taken into account.

WHO RECOMMENDS EVIDENCE-BASED MEASURES

To reduce alcohol-related harm, WHO recommends taking evidence-based action to:

- prevent drunk driving;
- limit alcohol availability, for example, by introducing alcohol licensing, restricting sales to certain days/hours, and decreasing the age limit for the purchase and use of alcohol;
- reduce the affordability of alcohol, for example, by increasing minimal alcohol tax rates and introducing minimal alcohol prices, bans on happy hours and promotional pricing, and additional taxation on mixed carbonated alcoholic beverages [alcopops];
- limit the marketing and advertising of alcoholic beverages;
- increase the responsibility of serving personnel;
- ensure the early identification and treatment of hazardous drinkers;
- provide treatment for alcohol-related mental and behavioural disorders, as well as other alcohol-related diseases and conditions.2
EFFECTIVE MEASURES NOT YET IN PLACE IN SLOVENIA

Slovenia is lagging behind the countries in Europe that are most advanced in introducing effective measures of alcohol policy. While being in top place among 29 European countries with respect to the consequences of alcohol-related harm, Slovenia is in 16th place concerning the introduction of effective measures to reduce it.

BENEFITS OF REDUCING ALCOHOL-RELATED HARM

Investment in the prevention of hazardous and harmful alcohol use leads to better population health and well-being, lower morbidity and mortality rates (also among youth and the working population), fewer traffic and other accidents, less violence, fewer unhappy families, less absenteeism, higher work efficiency, and better economy for the individual and the country.

EFFECTIVE ALCOHOL POLICY DEPENDS ON COOPERATION AMONG KEY STAKEHOLDERS

To facilitate the coordination of interventions and the mobilization of all key stakeholders, WHO recommends adopting alcohol strategies at the national and local-community levels, including action plans with clear goals, priority areas and activities.1,4

PUBLIC SUPPORT OF ALCOHOL-POLICY MEASURES

The Slovenian population strongly supports introducing measures to limit alcohol use, such as alcohol licensing (79%), minimal prices for alcohol (62%), and a total ban on alcohol advertising (57%).
Research in recent decades has identified a variety of adverse outcomes of harmful alcohol use.\textsuperscript{3,5–7}

- Numerous diseases, including cancer
- Suicides
- Murders
- Premature deaths
- Traffic and other accidents
- Disturbance of the peace
- Conflicts at the workplace
- Absenteeism
- Family-relationship problems
- Reduced productivity
- Physical and mental consequences among family members
- Poorer decision-making and problem-solving skills, memory lapses
- Higher risk to the health of newborns
- Higher risk of illicit drug use
- Hazardous sexual behaviour
- Alcohol addiction
- Financial consequences at individual, family and society levels
- €
The consequences of hazardous and harmful alcohol use are seen at the following levels:3,6

**INDIVIDUAL**
- poor health; illness; relationship problems at home and at work;
- involvement in traffic and other accidents; worsening financial status

**FAMILY**
- relationship problems; episodes of violence; emotional problems in family members, including children

**ENVIRONMENT**
- problems at work; enhanced conflicts; criminal offences; disturbance of the peace

**SOCIETY**
- poorer population health; reduced work efficiency, resulting in loss of income; treatment-related costs; police involvement; insurance cases

In general, the more people drink, the greater the risk of it affecting themselves, their families and others.
Hazardous alcohol use constitutes drinking alcohol to the extent of possibly causing alcohol-related harm whereas harmful alcohol use is drinking alcohol to the point of actually causing alcohol-related harm.⁶

Alcohol addiction is defined by the presence of at least three of the following phenomena in the preceding year: the ability to tolerate the increasing amounts of alcohol needed to achieve the same effect; physical disorders resulting from alcohol withdrawal [abstinence crisis]; a barely manageable desire for alcohol; problems in managing alcohol use; a continued use of alcohol despite harmful consequences; neglect of other activities due to alcohol use.⁸ ⁹

People consume alcohol in different ways, depending on the beverage and amount involved and how often they drink.¹⁰–¹³ A Slovenian population survey carried out in 2012 among 25–64 year-olds indicated that:

- every tenth resident drank excessively [that is, they exceeded the limit for moderate drinking] and every other resident had engaged in binge drinking at least once in the previous year;
- 28% of men and 16% of women aged 25–34 years had engaged in binge drinking at least once and up to three times per month;
- 20% of the population had not drunk alcohol in the previous year.¹²

Another Slovenian population survey carried out in 2011–2012 indicated that almost half the population aged 25–64 years were hazardous drinkers [drank excessively] and/or had been engaged in binge drinking in the previous year [Fig. 1].¹³

People taking part in surveys usually underreport their alcohol consumption.¹⁴ Thus, the actual number of hazardous drinkers in Slovenia is probably higher than that recorded.
In Slovenia, binge drinking occurs most frequently among the younger population while excessive drinking increases with age (Fig. 2). Fig. 3 illustrates the percentage of the population who engage in binge drinking at least once and up to three times a month.

The percentage of hazardous drinkers is higher for men than women; however, as binge drinking among women aged 25–34 years has increased in recent years (Fig. 4), it can be assumed that this gender difference will decrease in the future.

**Fig. 2.** Binge drinking and excessive drinking, Slovenia, 2001–2012

**Fig. 3.** Percentage of population who binge drink at least 1–3 times per month, 25–34 years, Slovenia, 2001–2011

**Fig. 4.** Increasing trend in binge drinking among women, 25–34 years, Slovenia

Source of Figs. 2, 3 and 4: Izzivi v izboljševanju vedenjskega sloga in zdravja. Desetletje CINDI raziskav v Sloveniji (Challenges in improving behaviour style and health. Ten years of CINDI research in Slovenia).
Every day in Slovenia, two people die for reasons exclusively connected to alcohol. Since 2008, an average of 881 people have died every year in Slovenia as a result of alcohol use, a mortality rate, which is above the European average.\textsuperscript{18–22} Men die more frequently from alcohol-related causes than women, two thirds of them before the age of 65. In addition, an average of 75 people die every year as a result of traffic accidents caused by drunk drivers.\textsuperscript{23} Thus, at least 956 deaths a year are preventable. In 2014 in Slovenia, at least 4368 years of potential life were lost solely as a result of deaths due to harmful use of alcohol (on average 9.8 years per person who died before the age of 65).\textsuperscript{24} Ten people are hospitalized every day due to alcohol-related harm, which adds up to an average of 3876 admissions a year.\textsuperscript{18,25} Although the number of admissions has been decreasing in recent years, the data indicate that the health status of those admitted is poorer than in the past.\textsuperscript{18,26}

Contributing to the numbers of alcohol-related deaths are those caused by various diseases, such as cancer, muscular-skeletal and cardiovascular diseases, and gastrointestinal diseases, for which alcohol is an important risk factor.\textsuperscript{15}

During pregnancy, exposure of the foetus to alcohol can affect its physical and mental development.\textsuperscript{15}

Alcohol-related deaths, injuries and diseases are unnecessary and can be prevented by avoiding hazardous and harmful alcohol use.

Fig. 5. Risk of alcohol-related death in eastern Slovenia as compared to western Slovenia, 2007–2009

The risk of alcohol-related death among the population of eastern Slovenia is 1.7 times higher than that of the population of western Slovenia.

Source: Posledice tveganega in škodljivega uživanja alkohola v Sloveniji (The consequences of hazardous and harmful alcohol consumption in Slovenia).\textsuperscript{14}
A population survey conducted among Slovenian adolescents in 2012 showed that 40% of 15 year-olds had their first alcoholic drink before their 13th birthdays (Figs. 6 and 7). Binge drinking is more frequent among boys but the gender differences have decreased in recent years (Fig. 7). Alcohol has a neurotoxic effect [it is harmful to the central nervous system] at all stages of life. However, researchers have found that developmental changes in the brains of children and adolescents, mainly brain maturation, render them more vulnerable to alcohol-related harm than adults. Alcohol is an addictive drug and the process to addiction can start in childhood or adolescence.

The younger people are when they start drinking alcohol, the higher their risk of developing alcohol problems later in life.\(^\text{27,28}\)

**Fig. 7. Percentage of 15 year-old boys and girls having drunk alcohol at age 13 or younger, Slovenia, 2002–2014**

**Fig. 6. Percentage of 15-year-old adolescents having drunk alcohol at age 13 or younger, Slovenia, 2002–2014**

MOST PEOPLE HAVE THEIR ALCOHOL DEBUT IN ADOLESCENCE

Sources of Figs. 6 and 7: Trendi v pitju alkohola (Trends in alcohol drinking);\(^\text{29}\) Alkohol in slovenski mladostniki v obdobju 2002–2010 (Alcohol and Slovenian adolescents in the period 2002–2010);\(^\text{30}\) Z zdravjem povezana vedenja v šolskem obdobju med mladostniki v Sloveniji. Izsledki mednarodne raziskave HBSC, 2014 (Health-related behaviour of school-aged Slovenian adolescents. Findings of HBSC research, 2014).\(^\text{31}\)
Despite the legal ban on selling or serving alcohol to under-aged adolescents, one third of 15 year-olds has engaged in binge drinking at least twice in their life (Fig. 8). Alcohol seems easily accessible to youth in Slovenia, for example, in their own or friends’ homes, at gas stations or in bars where they have little trouble buying it. When asked why they drank alcohol, they described doing so as a way of fun and relaxation, and the results of its effects as rather positive.

In 2011, more than half of the 15 and 16 year-olds (56%) had experienced being so drunk that they could not walk or talk properly, had vomited or had not been able to remember what happened.

The number of hospitalizations due to acute alcohol intoxication has been increasing among Slovenian adolescents (15–19 years) in recent years; in 2012, as many as 186 were admitted to hospital for this reason (Fig. 9).

Acute alcohol poisoning is also the main reason for administering intoxication treatment to children aged 7–14 years in hospitals.

In 2014, hospitalizations due to acute alcohol poisoning in people under 19 years of age accounted for 5% of all hospitalizations resulting from harmful use of alcohol.
For the period 2011–2014, health costs related to alcohol use in Slovenia were estimated on average at €153 million per year. Adding a rough estimate of costs, for example, of traffic accidents, crime, domestic violence and theft, brings the amount to €234 million (Table 1). On the other hand, annual revenue from excise tax on alcohol and alcoholic beverages in recent years has amounted only to approximately €90 million.

Table 1. Estimated health and other costs related to alcohol use, Slovenia, 2011–2014

<table>
<thead>
<tr>
<th>DIRECT AND INDIRECT HEALTH COSTS</th>
<th>OTHER RELATED COSTS</th>
</tr>
</thead>
<tbody>
<tr>
<td>First visits to family doctors, visits to specialists, hospital treatments, absenteeism, loss of future earnings, medicaments: €153 million</td>
<td>Alcohol-related traffic accidents, divorces and domestic violence, crime - thefts, vandalism, etc.: €81 million</td>
</tr>
</tbody>
</table>

€234 million

The higher the level of alcohol use in Slovenia, the greater the harm and cost. Prices of alcoholic beverages are strongly connected with alcohol use; according to WHO, in Slovenia these are low, especially for wine [Fig. 10].

Fig. 10. Relationship between level of alcohol use and alcohol-related cost, Slovenia
Alcohol policy deals with the relationship between alcohol use, individual well-being and health, and public welfare, combining national measures aimed at preventing the use of alcohol and reducing alcohol-related harm. Alcohol policy can only be effective if the different stakeholders – policy- and decision-makers (the National Council, the National Assembly, ministries), experts (expert organizations, institutes, expert associations, faculties), civil society (nongovernmental organizations, local communities), and the media – cooperate in creating and implementing it (Fig. 11).

In Europe, the development of alcohol policy started in the 1990s and has been steadily gaining in importance. The turning point was reached at the WHO European Ministerial Conference on Young People and Alcohol (Stockholm, 19–21 February 2001) through the adoption of the Declaration on Young People and Alcohol warning about the international dimension of the problem. This was followed by numerous research studies on the burden of hazardous and harmful alcohol use and analyses of the effectiveness of individual alcohol-policy measures. New findings mobilized experts and civil society working in this field and, consequently, the reaction of international and national policy-makers.

Alcohol policy in Slovenia is funded by the Health Insurance Institute of Slovenia, EU and other European sources, and WHO and bilateral funding.

The milestones in the development of Slovenian and European alcohol policy follow.
7th European Alcohol Policy Conference, Ljubljana, Slovenia, 22–23 November 2016

3rd National Alcohol Policy Conference, Ljubljana, Slovenia, 14–15 January 2015

2nd National Alcohol Policy Conference, Bled, Slovenia, 14 November, and regional conferences 2012

Establishment of an interdisciplinary comprehensive approach for tackling hazardous and harmful alcohol use

Adoption of the Occupational Health and Safety Act, which bans working under the influence of alcohol 2011

1st National Alcohol Policy Conference, Brdo pri Kranju, Slovenia, 2–3 November 2010
Adoption of the Drivers Act introducing health examinations and counselling and rehabilitation programmes for drunk drivers

3rd European alcohol policy conference, Barcelona, Spain, 3–5 April 2008
[organized by Slovenia and Spain]
Emergence of numerous webpages aimed at informing people about the harmful consequences of alcohol use
Establishment of a national alcohol network and development of the MOSA entity

International project for building capacities for the implementation of alcohol policies co-funded by the European Commission 2007
Alcohol Policy Council established at the Ministry of Health of Slovenia

Increase in number of organizations and programmes aimed at prevention of hazardous and harmful alcohol use 2006
Increase in activity of governmental and nongovernmental organizations in defending alcohol policy

Adoption of the Act on Restricting the Use of Alcohol 2003

Adoption of the Act on Regulating the Sanitary Suitability of Foodstuff and Products and Materials coming into Contact with Foodstuff, reallowing alcohol advertising under specific conditions 2002
Inclusion of alcohol-related restrictions in the National Programme for Road Traffic Safety

The Media Act bans alcohol advertising 2001

Excise Duties Act introduces excise duty on alcoholic beverages 1998
2016
- 7th European Alcohol Policy Conference, Ljubljana, Slovenia, 22–23 November
- 3rd European Alcohol Policy Youth Conference, Bled, Slovenia, 12–16 May

2015
- EU Member States called on the European Commission to develop a comprehensive strategy for tackling harmful use of alcohol and alcohol-related harm.

2014
- 6th European Alcohol Policy Conference, Brussels, Belgium, 27–28 November
- 2nd European Alcohol Policy Youth Conference, Bursa, Turkey, 10–16 December

2012
- 5th European Alcohol Policy Conference, Stockholm, Sweden, 18–19 October
- 1st European Alcohol Policy Youth Conference, Bled, Slovenia, 8–14 November
- WHO European action plan to reduce the harmful use of alcohol 2012–2020
- Establishment of the European Information System on Alcohol and Health (EISAH)

2010
- 4th European Alcohol Policy Conference, Brussels, Belgium, 21–22 June
- WHO global strategy to reduce the harmful use of alcohol

2008
- 3rd European Alcohol Policy Conference, Barcelona, Spain, 3–5 April

2006
- EU strategy to help EU Member States in their efforts to reduce alcohol-related harm
- 2nd European Alcohol Policy Conference, Helsinki, Finland, 20–22 November

2004
- The European Council invited the European Commission to put forward proposals for a comprehensive community strategy aimed at reducing alcohol-related harm to complement national policies.
- 1st European Alcohol Policy Conference: Bridging the Gap, Warsaw, Poland, 16–19 June

2001
- Declaration on Young People and Alcohol adopted at the 8th WHO European Ministerial Conference on Young People and Alcohol, Stockholm, Sweden, 19–21 February

1995
- European Charter on Alcohol adopted at the European Conference on Health, Society and Alcohol, Paris, France, 12–14 December

1992
- Development of the 1st European Alcohol Action Plan (EAAP)
In recent years, Slovenia has taken some important steps towards effective alcohol policy and introduced several measures to reduce alcohol use. The Media Act of 2001 put a total ban on alcohol advertising and the Act on Restricting the Use of Alcohol adopted by the Government in 2003 contributed greatly to limiting alcohol availability, especially to young people. However, the total ban on alcohol advertising was valid only until 2002, when the Act on Regulating the Sanitary Suitability of Foodstuff, Products and Materials coming into Contact with Foodstuffs came into force, allowing alcohol advertising under certain conditions. The inclusion of health-care measures in road-safety legislation in 2010 resulted in a significant decrease in traffic accidents involving alcohol use. The introduction of outpatient clinics in primary health care increased capacity for the preventive care of hazardous or harmful drinkers. The country’s investment in MOSA and its web portal and regular meetings of experts held at the national and local levels have also contributed to better networking among the key stakeholders.

However, Slovenia has not yet introduced all of the effective alcohol policy measures recommended at the international level and is, therefore, not listed among the most successful European countries (such as, Finland, Norway and Sweden) in this field. According to Mackenbach and Mckee, Slovenia is ranked 16th among 29 European countries with regard to the introduction of effective measures of alcohol policy. The opinion of most key stakeholders in the country is that alcohol policy is being implemented only to a limited extent and that political will to render it effective is not sufficient.

To achieve better results, it is necessary to adopt a comprehensive strategy at the national and local levels, including effective measures to facilitate a better connection among the key stakeholders and ensure the required resources.
Investing in the prevention of hazardous and harmful alcohol use would mean fewer lost years of life and a lesser economic burden on individuals, their families and society, resulting in:

- fewer premature deaths;
- fewer suicides and murders;
- fewer diseases and cases of intoxication;
- fewer traffic and other accidents and, thus, fewer injuries and disabilities;
- greater work efficiency and less absenteeism;
- less violence and mental distress;
- less social exclusion and poverty.\(^5\)

The effect of investing in alcohol policy on the economic burden of alcohol use on society is illustrated in Fig. 12.
The country can choose from among numerous evidence-based measures recommended by WHO for the prevention of hazardous and harmful alcohol use. Effective measures supported by the majority of the Slovenian population are presented in Table 2.

### Table 2. Public opinion on introduction of effective alcohol policy measures, Slovenia, 2014

<table>
<thead>
<tr>
<th>EFFECTIVE ALCOHOL POLICY MEASURES</th>
<th>PUBLIC OPINION</th>
</tr>
</thead>
<tbody>
<tr>
<td>Introducing the 0.0 measure for all drivers</td>
<td>77% support the measure</td>
</tr>
<tr>
<td>Imposing an age limit for purchasing alcohol</td>
<td>93% support the introduction of a ban whereby people under 18 years of age may not purchase or drink alcoholic beverages</td>
</tr>
<tr>
<td>Introducing alcohol licensing</td>
<td>79% support the measure</td>
</tr>
<tr>
<td>Raising prices of alcoholic beverages</td>
<td>80% support introducing the requirement that at least half of the non-alcoholic beverages on sale must be the same price as, or cheaper than, alcoholic beverages</td>
</tr>
<tr>
<td>Limiting alcohol advertising</td>
<td>62% support minimum alcohol pricing</td>
</tr>
<tr>
<td></td>
<td>61% support raising the prices of alcohol</td>
</tr>
<tr>
<td></td>
<td>75% support introducing a ban on binge drinking in public areas (parks, lawns)</td>
</tr>
<tr>
<td></td>
<td>57% support the introduction of a total ban on alcohol advertising</td>
</tr>
<tr>
<td></td>
<td>90% support the existing ban on selling and offering alcohol to children and intoxicated persons, and the introduction of a ban on selling and offering alcohol, for example, in schools, during sport events, and at workplaces</td>
</tr>
</tbody>
</table>
It would be prudent for a country to adopt the most cost-effective measures first, especially in times of economic crisis. Table 3 lists the most common of these and describes their cost-effectiveness.

Table 3. Cost-effectiveness of evidence-based alcohol-policy measures

<table>
<thead>
<tr>
<th>GOAL</th>
<th>MEASURE</th>
<th>EFFECTIVENESS OF MEASURE</th>
<th>EXPENSE TO COUNTRY</th>
<th>MEASURE ADOPTED IN SLOVENIA</th>
</tr>
</thead>
</table>
| To prevent driving under the influence of alcohol | Gradual lowering of permitted level of blood alcohol in drivers to 0.2 g/l. | Very effective           | Low                | PARTIALLY The highest permitted blood alcohol level is 0.50 g alcohol per kg blood.
<p>|                                            | Introduction of 0.0 g/l permitted blood alcohol for young drivers, public-transport drivers and drivers of heavy-goods vehicles. | Very effective           | Low                | YES ³                                           |
|                                            | Random testing for breath alcohol content.                               | Very effective           | High               | YES ³   Breath alcohol content in drivers must not exceed 0.24 mg/l. This limit applies only to drivers without signs of behavioural disorders [e.g. impaired speech, balance problems, etc.], which could cause traffic accidents. Professional drivers, driving instructors, new/young drivers and drivers transporting children, among others, are not permitted to have any alcohol in their bodies. ³ |
|                                            | Gradual acquisition of a driving licence.                               | Moderately effective     | Low                | YES ³   Adolescents aged 16–18 years must have an escort when driving. It is obligatory for new/young drivers to participate in extra training at least four months after having received their driving licences. People who lose their driving licences due to drunk driving are required to participate in rehabilitation programmes to regain them. ³ |</p>
<table>
<thead>
<tr>
<th>GOAL</th>
<th>MEASURE</th>
<th>EFFECTIVENESS OF MEASURE</th>
<th>EXPENSE TO COUNTRY</th>
<th>MEASURE ADOPTED IN SLOVENIA</th>
</tr>
</thead>
<tbody>
<tr>
<td>To limit alcohol availability</td>
<td>Lowering the age limit for drinking alcohol.</td>
<td>Very effective</td>
<td>Medium</td>
<td>NO</td>
</tr>
<tr>
<td></td>
<td>Introduction of national-level control of retail sale of alcohol (state monopoly of alcohol sales; introduction of alcohol licensing).</td>
<td>Very effective</td>
<td>Low</td>
<td>NO</td>
</tr>
<tr>
<td></td>
<td>Lowering the age limit of customers to whom alcohol may be sold.</td>
<td>Very effective</td>
<td>No data</td>
<td>YES Selling and offering alcoholic beverages to persons under 18 years of age has been banned.(^c)</td>
</tr>
<tr>
<td></td>
<td>Limitation of selling points.</td>
<td>Moderately effective</td>
<td>Low</td>
<td>NO</td>
</tr>
<tr>
<td></td>
<td>Limitation of sales to certain times [hours/ days].</td>
<td>Moderately effective</td>
<td>Low</td>
<td>YES The sale of alcoholic beverages in stores between 21:00 and 07:00 hours, and of spirits in bars and restaurants between the start of working hours and 10.00 hours, is banned.(^c)</td>
</tr>
<tr>
<td>To increase and regulate prices</td>
<td>Increasing minimum tax rates for all alcoholic beverages in accordance with inflation [rates should be at least proportional to alcohol content]. Introduction of minimum alcohol pricing. Introduction of ban on discounts and promotional prices. Added tax on alcopops.</td>
<td>Very effective</td>
<td>Low</td>
<td>PARTIALLY Excise duties have been imposed on beer, intermediate beverages and ethylene alcohol. Excise duties have not been set, or are equal to €0, for wine and fermented beverages.(^d) Excise duties are not in accordance with inflation.</td>
</tr>
<tr>
<td>To reduce hazardous/harmful drinking</td>
<td>Brief interventions in primary health care for hazardous alcohol users.</td>
<td>Very effective</td>
<td>Medium</td>
<td>PARTIALLY The measure is being implemented in the framework of the Drivers Act(^b) and the National Programme for the Primary Prevention of Cardiovascular Diseases. Not all doctors of general/ family medicine detect hazardous and harmful alcohol use, although clinical guidelines on early detection and brief interventions are available.(^{65–67})</td>
</tr>
<tr>
<td>Goal</td>
<td>Measure</td>
<td>Effectiveness of Measure</td>
<td>Expense to Country</td>
<td>Measure Adopted in Slovenia</td>
</tr>
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</tr>
<tr>
<td></td>
<td>Treatment of mental and behavioural disorders and other diseases related to alcohol use.</td>
<td>Very effective</td>
<td>Medium/high</td>
<td>YES Treatment costs are covered by health insurance.</td>
</tr>
<tr>
<td>Other</td>
<td>Increasing responsibility of staff serving alcoholic beverages.</td>
<td>Moderately effective</td>
<td>Low</td>
<td>NO Serving alcoholic beverages to under-aged people or people showing signs of being drunk is prohibited. The financial fine, however, is imposed only on the person legally responsible (e.g. the bar owner) and not on serving staff.</td>
</tr>
<tr>
<td></td>
<td>Limiting alcohol advertising.</td>
<td>Moderately effective</td>
<td>Low</td>
<td>PARTIALLY Advertising beverages with alcoholic content over 15% vol. has been banned. Advertising beverages with alcohol content below 15% vol. is permitted on radio and television between 21:30 and 07:00 hours only and in cinemas after 22:00 hours. Advertising alcohol on boards or posters or in light boxes within 300 m of schools or kindergartens is banned.</td>
</tr>
</tbody>
</table>

*a Act on Rules in Road Transport; b Drivers Act; c Act on Restricting the Use of Alcohol; d Excise Duties Act; e Act on Regulating the Sanitary Suitability of Foodstuff and Products and Materials coming into Contact with Foodstuff.

Sources: based on the following sources and reproduced with the permission of the authors: Alcohol: no ordinary commodity. Research and Public Policy; Alcohol in Europe; Evidence for the effectiveness and cost-effectiveness of interventions to reduce alcohol-related harm; Handbook for action to reduce alcohol related harm; Reducing drinking and driving in Europe. Report; Reducing drinking and driving in Europe. Recommendations & conclusions; Effectiveness and cost-effectiveness of policies and programmes to reduce the harm caused by alcohol; Alcohol and primary health care: clinical guidelines on identification and brief interventions; Alcohol and primary health care: training programme on identification and brief interventions; O pitju alkohola: priročnik za zdravnikje družinske medicine. 2. dopolnjena izdaja [About alcohol drinking: a manual for family physicians; 2nd revised edition].

Programmes aimed at informing and raising the awareness of the public do not directly influence the reduction of harmful alcohol use. They are, however, an indispensable part of a comprehensive alcohol policy as they facilitate the public’s acceptance of other measures and increase their effect. Treating hazardous and harmful alcohol use and addiction outside the health-care system and providing health care to family members are another two important aspects of alcohol policy; dealing with the consequences of harmful alcohol use is much more expensive than taking measures to prevent them. Prevention and promotion programmes in the field of healthy lifestyle also play an important role in harm prevention.
One of the nine voluntary goals of the WHO Global Action Plan for the Prevention and Control of Noncommunicable Diseases 2013–2020 is to reduce the harmful use of alcohol by at least 10%. The Slovene experts recognize the following ten target areas as central to the development of a comprehensive alcohol policy with the key goal of protecting the population from alcohol-related harm:

1. leadership, awareness-raising and commitment to action;
2. hazardous and harmful alcohol use in the health-care sector;
3. local community and workplace;
4. drunk driving;
5. alcohol-pricing measures;
6. alcohol availability;
7. alcohol advertising;
8. informal production and illicit alcohol sales;
9. alcohol use and intoxication;
10. monitoring and control.

Combining all ten target areas within a comprehensive alcohol policy would strengthen the country most effectively. Measures proposed within each target area are listed below.
1. LEADERSHIP, AWARENESS-RAISING AND COMMITMENT TO ACTION

- Adopt an evidence-based strategy and action plan to encourage cooperation between national experts and civil society, which will provide an infrastructure and financial resources, as well as a means of management and control.

- Establish an intersectoral coordination body to develop alcohol policy.

- Ensure support of the adoption and implementation of alcohol policy and raise public awareness of the risks of hazardous and harmful alcohol use to the health and welfare of the population and of the benefits of effective action to reduce these risks.

- Raise awareness among alcohol-policy stakeholders of evidence-based measures of implementing alcohol policy.

- Monitor public support of the individual measures.

2. HAZARDOUS AND HARMFUL USE OF ALCOHOL IN THE HEALTH-CARE SECTOR

- Establish a comprehensive system for the early detection of hazardous and harmful use of alcohol and alcohol addiction, involving the health services, the social security services, employment organizations and educational institutions.

- Establish comprehensive and long-term aid programmes for people addicted to alcohol and their families. These programmes should also be available to specific population groups (for example, older or younger age groups);

- Establish a system of detecting and monitoring hazardous and harmful alcohol use among pregnant women and women of child-bearing age.

- Upgrade existing programmes for dealing with the hazardous and harmful use of alcohol with projects aimed at reducing inequalities in specific population groups (children, adolescents, women, older people, ethnic groups).

- Introduce positive incentives for providers, users and employers so that they will sooner and more often opt to deploy, integrate, or – in the case of employers – promote health-care treatment.

- Include health-care profiles other than family doctors in the implementation of short interventions to achieve a higher level of accessibility.
3. LOCAL COMMUNITY AND WORKPLACE

- Provide an overview of all programmes, projects and activities implemented in the local community, educational institutions and workplaces.
- Develop national guidelines for and a system of evaluating the above-mentioned programmes, projects and activities.
- Adopt local policy-action plans based on recognized local needs and involve all key stakeholders at the local level in joint efforts.
- Ensure the availability of proper tools and training for the providers of programmes, projects and activities in the educational system and employment organizations at the local level.

4. DRUNK DRIVING

- Ensure the consistent implementation of the National Programme for Road Traffic Safety.\(^6\)
- Conduct extensive information and awareness-raising campaigns to educate the general public, especially young drivers.
- Lower the permitted level of blood-alcohol content in drivers.

5. ALCOHOL-PRICING MEASURES

- Investigate the possibility of increasing alcohol prices further and distribute information to the public on the importance of such measures.
- Investigate the possibility of introducing taxation on alcoholic beverages that are especially attractive to young people, for example, alcopops.
- Raise excise duties in accordance with inflation.
- Investigate the possibility of minimum pricing.
- Use revenue from excise duties on alcohol and alcoholic beverages for programmes aimed at reducing the hazardous and harmful use of alcohol.
6. ALCOHOL AVAILABILITY

- Improve legislation, especially with regard to facilitating the interpretation of measures aimed at limiting and controlling alcohol availability.
- Investigate the possibility of introducing additional measures to reduce the number of alcohol selling points and shorten their operating hours.
- Investigate the possibility of banning the sale of alcohol at gas stations and roadside lay-bys.
- Encourage local communities with problems of binge drinking among youth to ban binge drinking in public areas not designated to sell alcohol.

7. ALCOHOL ADVERTISING

- Introduce a total ban on alcohol advertising.
- Ban sponsorship and donation activities that promote alcohol and, especially, the sale of alcohol.
- Ensure high-quality systems of monitoring and evaluating the marketing of alcoholic beverages in the media, including the Internet and mobile applications.

8. INFORMAL PRODUCTION AND ILLICIT SALES OF ALCOHOL

- Improve control of the production and sale of alcoholic beverages, for example, by introducing tax labels.
- Establish an effective system of controlling the quality and use of unregistered alcohol.

9. ALCOHOL USE AND INTOXICATION

- Train serving personnel and ensure security in drinking environments.
- Adopt regional and local action plans for the prevention of hazardous and harmful alcohol use, especially among young people, in drinking environments and the local community, and establish local action groups.
- Investigate the possibility of introducing special licences/permits for the sale of alcohol products [alcohol licensing] with the possibility of revoking licences in cases of law infringement.
- Make it mandatory to introduce health messages about the risks of drinking alcohol during pregnancy, and other health-related warnings, on the packaging of alcohol products.
10. **MONITORING AND CONTROL**

- Introduce a comprehensive system of monitoring the consequences of hazardous and harmful alcohol use and the effectiveness of measures taken to prevent it.
- Monitor alcohol availability, both physical and price-related.
- Conduct assessments of the economic burden of alcohol on individuals and society, and establish a system of measuring the effectiveness of alcohol-policy measures in relation to the economy.
- Establish a system of monitoring the consequences of hazardous and harmful alcohol use, as well as addiction to alcohol during pregnancy.
- Collect data on the hazardous and harmful use of alcohol in different population groups (women, young people, older people, ethnic groups, and unemployed people) and recommend solid measures to counter it.
- Ensure the systematic monitoring of prevention/promotion programmes, research carried out, and problems met by stakeholders working in the field of alcohol.
- Establish a system of evaluating prevention/promotion programmes and harm-reduction programmes.
- Ensure comprehensive periodic reporting on alcohol use, drinking patterns, the consequences of hazardous and harmful alcohol use, prevention programmes and the implementation of alcohol-policy measures at the national and regional levels.


22. European Health for All [online database]. Copenhagen: WHO Regional Office for Europe; 2010 [data.euro.who.int/hfadb, accessed 2 May 2016].


64. Raziskava javnega mnenja o podpori ukrepom na področju tobaka in alkohola [Survey of public support on tobacco and alcohol use reduction]. Ljubljana; Ministry of Health of the Republic of Slovenia; 2014.


81% of 15 year-olds have already tried alcoholic beverages.

3876 annual alcohol-related hospitalizations.

10 people are hospitalized every day as a result of alcohol use.

956 deaths due to alcohol per year.

Two out of five adolescents have engaged in binge drinking at least twice in their lives despite the ban on the sale of alcohol to people under 18 years of age.

77% of the public support a blood alcohol concentration limit of 0.0 for all drivers.

Annual estimated health costs related to alcohol use between 2011 and 2014 amounted to €153 million.

153 million annual alcohol-related health costs.