ALCOHOL POLICY IN HUNGARY

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ABSTRACT

The thesis aims:

- to analyse the extent of alcohol-related problems in Hungary,
- to assess available policy options to reduce the incidence of alcohol-related problems
- to understand Hungarian policy making in the alcohol field
- to prepare recommendations for alcohol policy that are relevant to the Hungarian situation

It consists of eight chapters. Chapters follow the aims by first introducing the target and the place of the study (Chapter 1), second providing evidence about the extent of alcohol related problems in Hungary and in comparison to other countries (Chapter 2), third summarising policy means to influence the incidence of alcohol related problems based on experiences of other countries and locate alcohol policy in the broader policy context (Chapter 3), then presenting the framework and the methods used for the analysis (Chapter 4), analysing the policy environment by looking at the legislative background (Chapter 5), the organisational structure and major alcohol policy movements of the past decades (Chapter 6), characteristics of public policy making in general and public health and alcohol policy making in particular (Chapter 7), and the current situation of alcohol policy through actors - their understanding, interests, influence, relation to each other and to specific alcohol policy instruments - (Chapter 8), finally summarising the findings and preparing feasible policy recommendations for Hungary (Chapter 9).

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GLOSSARY

ÁNTSZ	National Public Health and Medical Officer Service
A&E	Accidents and Emergency
AA	Alcoholics Anonymous
AEÁB	State Committee Against Alcoholism
AEOB	National Committee Against Alcoholism
ATMK	Scientific and Methodological Centre of Alcohology
BAC	blood alcohol concentration
BB	Buda Béla
BeerPr	Beer Producers
CAA	Clubs Against Alcoholism
CEE	Central and Eastern Europe
CsJ	Csehák Judit
CSO	Central Statistical Office
Customs	Customs Office
EA	Health Promotion Fund
EC	European Commission
ECU	European Currency
EU	European Union
ÉT	Interest Reconciliation Council
GP	General Practitioner
HFA	Health for All
hld	hectolitre degree
HUF	Hungarian Forint
ICD	International Classification of Diseases
KISOSZ	National Association of Traders and Caterers
LocGov	Local Governments
MAST	Michigan Alcoholism Screening Test
Media	Media
MHPO	Mental Hygiene Program Office
MoAgr	Ministry of Agriculture
MoFin	Ministry of Finance
MoInd	Ministry of Industry and Commerce
MoTrans	Ministry of Transport
MoW	Ministry of Welfare
MPI	Mental Hygiene Program Office
MSSZ	Association of Hungarian Brewers
MSzSzT	Union & Commodity Council of the Hungarian Alcohol Industry
NCPAcc	National Committee to Prevent Accidents
NEVI	National Institute for Health Promotion
NGOs	Non-Governmental Organisations
NHIF	National Health Insurance Fund
NIA	National Institute of Alcohology
NIHP	National Institute for Health Promotion
NIN&P	National Institute of Neurology and Psychiatry
NIPH&MOS	National Public Health and Medical Officer Service
NIWV	National Institute of Wine Verification
NPHC	National Public Health Committee

OAI	National Institute of Alcohology
ODA	Overseas Development Administration
OENI	National Institute for Health Education
OEP	National Health Insurance Fund
OET	National Committee for Health Promotion
OKI	National Public Health Center
ONB	National Public Health Committee
PCH&SA	Parliamentary Committee of Health and Social Affairs
Police	Police
Retailers	Retailers and caterers
RHF	Risk Handling Fund
SanEpid	Sanitation and Epidemiology
sci/re	Scientists, researchers
Smallh	Smallholders
Soros	Soros Foundation
SPHI	State Public Health Inspectorate
SpiritPr	Spirit Producers
SzBSzT	Association and Commodity Council of Wine Producers
SZEB	Parliamentary Committee for Health and Social Affairs
TÁRKI	Research Institute of Social Sciences
UNICRI-MoE	United Nations International Crime and Justice Research Institute- Ministry of Education
VA	Veér András
VAT	Value Added Tax
WB	World Bank
WHO	World Health Organisation
WinePr	Wine Producers

- *CHAPTER 1* -

INTRODUCTION

The introductory chapter seeks to present the subject - ALCOHOL - and the place - HUNGARY - of the study. It summarises general aspects of alcohol and alcohol related problems. First the role of alcohol consumption in history and culture is presented. Then the route and metabolism of alcohol in the human body is summarised, followed by an epidemiological overview of health and social risks related to alcohol consumption. The location of the study, Hungary, is described briefly in a further section.

1 Alcohol in human culture

Alcohol as a substance and alcohol consumption has long been part of human culture.

Alcohol as a substance in the Ancient times

The use of alcohol appears to have developed spontaneously in many cultures and even those people who have developed in isolation from the rest of humanity until recorded history have used it (Austin 1978). The three exceptions, the inhabitants of the arctic region, Australian aborigines and people of Tierre del Fuego, suggest that alcohol production may be intrinsically linked with the cultivation of crops and vegetables. This is consistent with the observation that beer-making probably started around 4000 BC when Sumerians began to cultivate barley (Keller 1958). Chemists have extracted a residue of a substance identified as wine or beer in 3000 year-old ruins (Forbes 1958).

Drinking and intoxication in the old days

It is not only the substance but also the culture of drinking and getting drunk which has long been part of human life. The Mesopotamian civilisation provided one of the earliest descriptions of intoxication and one of the first hangover cures: "*If a man has taken strong wine, his head is affected and he forgets his words and his speech becomes confused, his mind wanders and his eyes have a set expression, to cure him take liquorice, beans, oleander .... To be compounded with oil and wine before the approach of the Goddess Gula (sunset) and in the morning before sunrise and anyone has kissed him, let him take it, and he will recover*" (Goodwin 1984).

In Egypt a hieroglyph of a female courtier from the 17th Dynasty states: "*Give me eighteen bowls of wine*" ... "*Behold, I love drunkenness*"(Goodwin 1984).

Noah, according to the Old Testament "*drank of the wine, and became drunk, and lay uncovered in his tent..*" (Genesis 9:21). The Book of Proverbs proclaims: "*Give strong drink to him who is to perishing, and wine to those in bitter distress; let them drink and forget their poverty, and remember their misery no more*" (Proverbs 31:6).

Alcohol was also well known to the ancient Greeks (MacKenzie et al. 1996, McKinlay 1948, McKinlay 1949, Seltman 1957). Alexander the Great was famous for his drinking. Plutarch describes a mass orgy in 325 BC involving Alexander and his Macedonian Army.

Early drinking restrictions

Throughout history, many leaders have sought to ameliorate the consequences of excessive drinking. As early as 1700 BC the Code of Hammurabi contained restrictions on the sale of wine and entering and opening of taverns by temple priests (Harper 1904). In ancient Greece Solon and Dragon represented a cautious view towards alcoholic drinks, which was reflected in their legislation (Goodwin 1984). The Constitution of Lucorghos also favoured temperance. In the 1st century AD the Roman Emperor, Domitian ordered destruction of vineyards and prohibited new planting (Leibowitz 1967). Later in the 13th century the great Mongolian military leader, Genghis Khan recommended that his "*Soldiers must not get drunk oftener than once a week*" (Goodwin 1984, Tongue 1978).

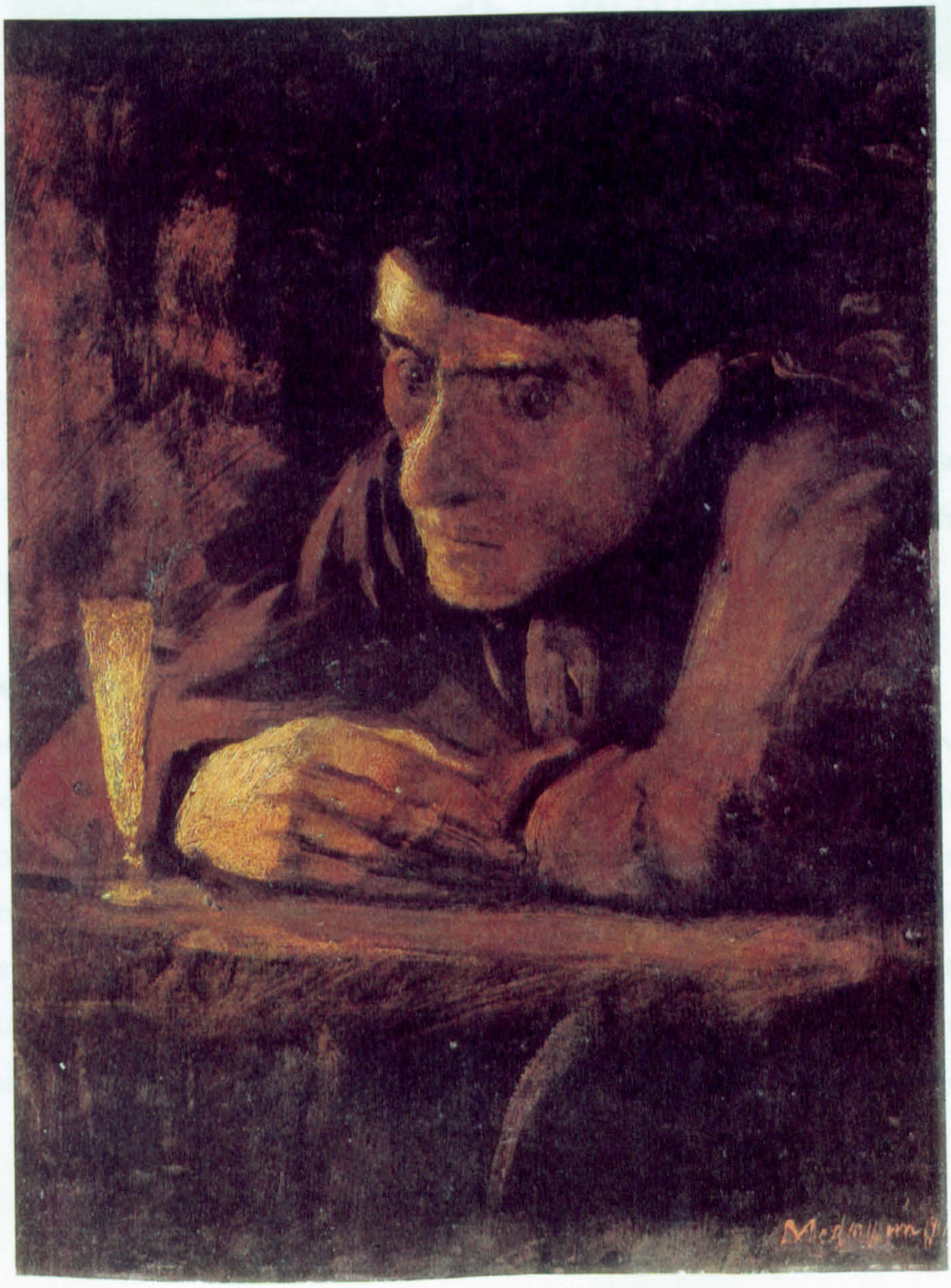
Alcohol and religions

Alcohol and the culture of drinking became part not only of the daily practice of human beings but also of their spiritual and sacred life. In several cultures drinking and wine have their own gods. These include Soma in the Sanskrit in Persia, Ammon in Libya, Osiris in Egypt, Dionyssos in Greece, Bacchus in the Roman Empire (Puruczki 1981). There are however many religious influences on alcohol consumption, most notably the Islamic prohibition in drinking, which contrasts with the role of alcohol in the Judeo-Christian beliefs (Tongue 1978).

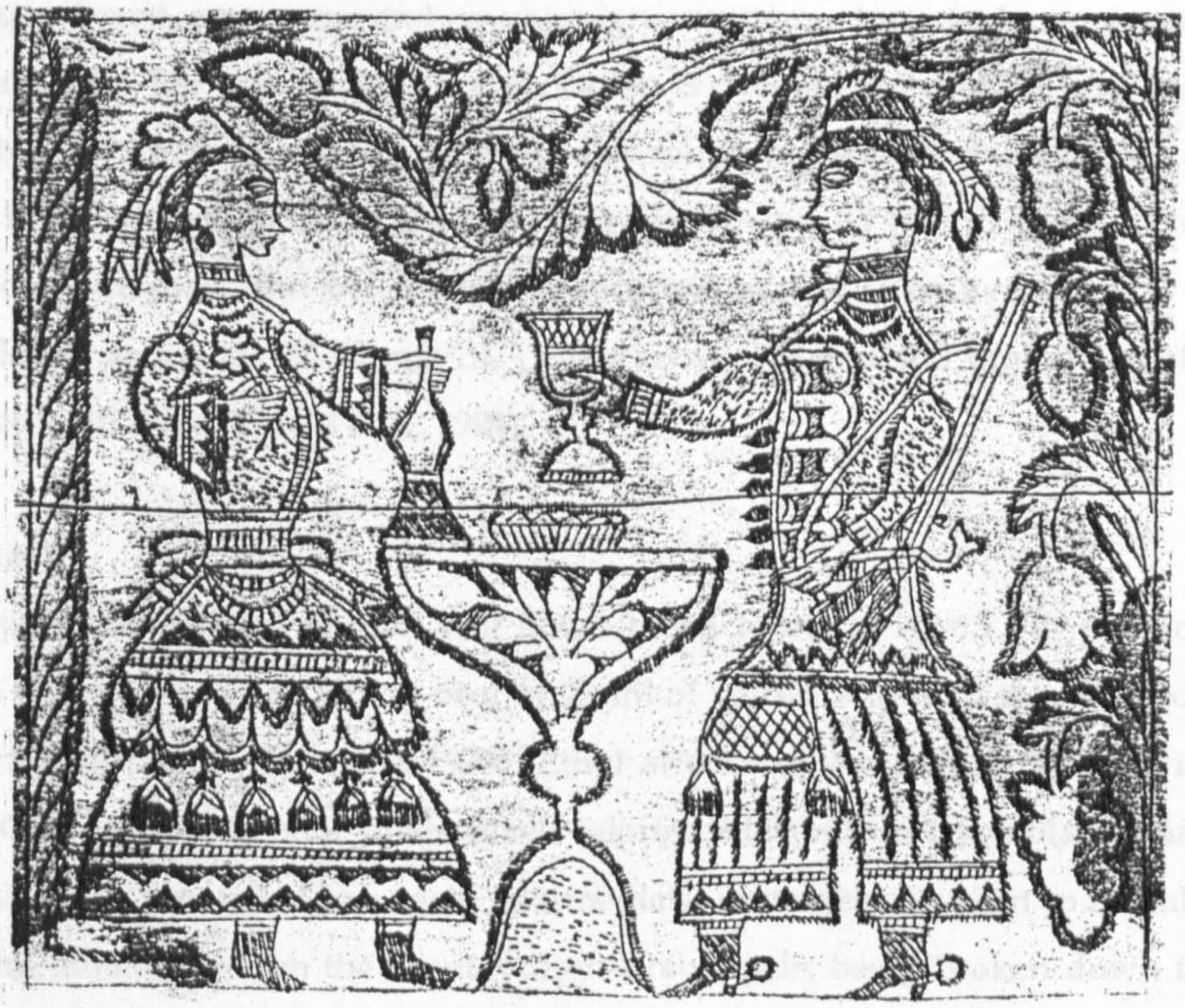
Although alcohol was not totally unknown to Muslims other intoxicants such as hashish were favoured (Goodwin 1984, Puruczki 1981).

In Hungary traditions of alcohol consumption are reflected in relics and art. In the 17th century a notary from Peleske (a small village) sang: "*The doctor treated me with "chinas" of Spain, I did not get better from these powders, but I took the Hungarian cure, the 15-year-old wine of my vineyard, which cured me.*" Frederick the Great during his recovery from a severe disease called the Hungarian wine, Tokaji, the "*balm of health*" (Soós 1995). Drinking has also been a popular theme in poetry, folk and fine art (Picture 1,Picture 2).

Picture 1 - Mednyànszky Làszlò: The Absinthe Drinker (1895-97)



Picture 2 - Highwayman with his sweetheart; on lid of mirror case, second half of the 19th century



2 *Alcohol in the human body*

Alcohol drinking developed in parallel with the history of humanity. It received special attention in culture and religion though because of the impact it has on the human body and mind. The physiology of alcohol is summarised in the following paragraphs.

The effect of alcohol in the human body

Alcoholic beverages are one of the most widespread agents used to relieve stress. They are mixtures of water and ethyl alcohol (Simpson 1979). After drinking, ethyl alcohol is absorbed mainly from the smaller intestine but also from the stomach. Depending on factors such as the amount of fat in the intestinal lumen, the maximum blood alcohol level is reached at around 60-120 minutes after consumption (Goodwin 1984). Once in the bloodstream alcohol has somatic and psychic effects. There is an old saying that alcohol affects a person in four ways.

First, he becomes jocular, then bellicose, then lachrymose, and finally comatose. The effect depends on the dose and can be categorised from medical aspects into three stages based on somatic and psychic signs: excitement, confusion and stupor (Simpson 1979). The level at which intoxication is deemed to occur, in law, varies both between countries and according to the action being undertaken. Typically driving is considered to be impaired at between 50 and 80 mg/dl (5-8‰) blood alcohol concentration, but behavioural, psychomotor and cognitive changes are seen at levels as low as 20-30 mg/dl. Levels above 300 and 400 mg/dl are often associated with death (Fauci et al. 1994).

Metabolism

Typically, metabolism of alcohol will lower blood levels by 12-15 mg per hour, which is the equivalent of 300 ml beer or 23 ml of spirits, although this is affected by nutritional factors (Simpson 1979). Ethyl alcohol as a carbohydrate provides energy. One gram of alcohol yields seven calories. Metabolism takes place mainly in the liver, first converted to a toxic intermediate, acetaldehyde, then to harmless acetic acid, finally through the Szentgyörgyi-Krebs cycle, being broken down into carbon dioxide and water. The main rate limiting steps are two enzymes, alcohol dehydrogenase (mainly in the liver) and aldehyde dehydrogenase (throughout the body). A small amount of ethanol - around 10% - is metabolised in microcosms of the cellular smooth endoplasmic reticulum (Fauci et al. 1994).

3 Production of alcoholic drinks

Production methods

Alcohol (ethyl alcohol) can be produced essentially in two ways: by fermentation although when its concentration reaches 12-13 per cent it inhibits further production, or by distillation when the concentration can reach nearly 100 percent. The use of distillation appears to have begun in Arabia about 800 AD.

The alcohol content of most distilled beverages is expressed in degrees of proof, which refers to 1 litre 100° v/v alcohol.

Types of alcoholic drinks

Beverages vary in terms of the source of sugar used with national consumption patterns reflecting local agriculture: grapes for wine and brandy, grain and hops for beer, grain for whisky, sugar cane for rum, mainly grain for vodka, fruits for "pálinka" (Hungarian spirit). Most alcoholic drinks also contain congeners, such as amino-acids, minerals, vitamins, methyl alcohol (wood-alcohol) and higher alcohols (fuel oils). They provide some of the taste and smell and the colour (Goodwin 1984). Some of them can contribute to specific health effects (Fauci et al. 1994).

4 Alcohol as a risk factor

The negative consequences of drinking have long been known (see above). It is only in this century, however, that specific risks related to alcohol consumption, both health and social, could not only be recognised but also measured.

4.1 Chronic health-related conditions

Several health-related conditions, both chronic and acute, are associated with alcohol consumption, defined as showing higher rate among those with high alcohol intake. These are reviewed in the following paragraphs.

Liver disease

Studies have shown a significant association between drinking and cirrhosis of the liver (Becker et al. 1997, Boffetta & Garfinkel 1990, Coates et al. 1986, Diehl 1989, Kagan et al. 1981, Kono et al. 1986, Pequignot et al. 1978, Thouez & Ghadirian 1986, Tuyns & Pequignot 1984). Major histopathologic features of alcohol-associated liver injuries include steatosis, steatonecrosis, and cirrhosis (Diehl 1989). The effect of alcohol on the liver can become more severe if it is accompanied by hepatitis B infection and high levels of mean daily fat intake (Chevillotte et al. 1983, Iwamura 1983, Rotily et al. 1990). Research also suggests a dose response relationship between the consumption level and the development of the disease. A case-control study in Toronto shows that, in males, the relative risk for fatty liver

was 1.37 for those consuming 40-59 g absolute alcohol/day compared to males consuming less than 40 g/day, rising to 50 for males consuming 80 or more g/day. In females, risk for fatty liver appeared at lower levels (Coates et al. 1986). Individual risk and population risk is different. Patients who develop chronic alcoholic liver disease are usually only mildly dependent on alcohol, as they are able to sustain a continual consumption of alcohol over many years (Wodak et al. 1983).

Alcohol and cancers

Upper aerodigestive system

Alcohol is causally related to cancers of the upper aerodigestive tract, the oral cavity, pharynx, larynx and oesophagus (Doll et al. 1994, IARC 1988, La Vecchia et al. 1986, Launoy et al. 1997, Rogers & Conner 1986, Thomas 1995, Tuyns 1987). The relationship between smoking and drinking with upper aerodigestive cancer has been confirmed (Kono et al. 1987). Histopathologically the squamous cell carcinomas of the mouth, oral pharynx, larynx, and oesophagus and adenocarcinomas of the oesophagus are increased among those who consume alcohol excessively (Thomas 1995). Smoking combines with alcohol in the case of these cancers with an effect, which is more than additive (Thomas 1995, Tuyns 1987).

Liver cancer

Hepatocellular carcinoma is closely associated with alcohol consumption (Blot 1992, Doll et al. 1994, Farber 1996, Holman et al. 1996, Kono et al. 1986, Kono et al. 1987, La Vecchia et al. 1986, La Vecchia et al. 1988, Nagaratnam et al. 1984, Rogers & Conner 1986, Thomas 1995, Tuyns 1987, Yu et al. 1988).

Colorectal cancer

The association between colorectal cancers and alcohol consumption have not been consistent (Blot 1992, Rogers & Conner 1986, Thomas 1995). Possible association was suggested in the case of rectal cancer and beer drinking (Rogers & Conner 1986, Thomas 1995).

Breast cancer

Cancer of the female breast has a special public health importance as it is common. Numerous studies have shown a significant dose-response relationship between alcohol consumption and breast cancer (Babor et al. 1978, Blot 1992, Freudenheim et al. 1995, Friedenreich et al. 1993, Gapstur et al. 1992, Harvey et al. 1987, Hiatt et al. 1988, Holman et al. 1996, La Vecchia et al. 1985, Le et al. 1984, Longnecker 1994, Longnecker et al. 1995, Rohan & McMichael 1988, Schatzkin et al. 1987, Sneyd et al. 1991, Swanson et al. 1997, Thomas 1995, Willett et al. 1987). Contemporary drinking (that is, average intake during the most recent 5-year period) in an American study was directly associated with higher risk if consumption was of 14 drinks or more per week[1] (Swanson et al. 1997), however a study in New Zealand found that contemporary intake led to increased risk only if it exceeded 14 drinks a day (Sneyd et al. 1991). In Australia this limit was found to be 9.3g alcohol daily (Rohan & McMichael 1988). It appears that recent alcohol consumption is a more important factor to increase risk of developing breast cancer than that in early years of life (Longnecker et al. 1995, Swanson et al. 1997). A meta-analysis of 38 epidemiological studies found strong evidence of a dose-response relationship, but as results varied across studies the causal role of alcohol remains a question (Longnecker 1994). There seems to be a difference between risk of alcohol consumption for pre- or post-menopausal women, however results are contradictory (Friedenreich et al. 1993, Hiatt et al. 1988).

Diseases of the circulatory system

Hypertension and stroke

There is evidence for dose-response relationship between the level of alcohol intake and blood pressure (Babor et al. 1978, Ben-Shlomo et al. 1992, Boffetta & Garfinkel 1990, Gill et al. 1986, Kono et al. 1986, Sleight 1996). There is a significant association between stroke and drinking (Kono et al. 1986). Research findings

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[1] Units/drinks (Anderson et al. 1993): In different countries standard drinks refer to different pure alcohol content. Some publications express findings in units, some others in grams. Counting that 1 ml pure alcohol equals 0.785g, one "drink" refers to 12 grams pure alcohol in the US, 10 grams in Australia and Europe and 21.2 grams in Japan. 1 unit refers to 8-10g pure alcohol in the UK and 10 grams in Australia

suggest that drinking alcohol increases the chance of subarachnoid haemorrhage (haemorrhage stroke) (Ashley et al. 1997, Klatsky et al. 1990, Kono et al. 1986).

Cardiovascular diseases

Risk of major coronary events has a U shaped relationship with increasing alcohol consumption, meaning that moderate amounts of alcohol intake reduces the risk of acute myocardial infarction compared to abstainers (Anderson et al. 1993, Berberian et al. 1994, Doll et al. 1994, Hammar et al. 1997, Hanna et al. 1997, Keil et al. 1997, Klatsky et al. 1990, Kono et al. 1986, McElduff & Dobson 1997, Rossow & Amundsen 1997). Light to moderate drinking has been associated with a 36% reduction in death from ischaemic heart disease in a Chinese study (Yuan et al. 1997). The risk is lowest among men who report one to four drinks (10-40 grams) daily consumption and among women who report one or two drinks daily alcohol intake (McElduff & Dobson 1997). In another study the protective effect started at 0.1-19.9 gm per day alcohol consumption (Keil et al. 1997). For other heart diseases, such as cardiac arrhythmia and alcoholic cardiomyopathy, a dose-response relationship between the level of alcohol intake and the risk of disease was described (Anderson et al. 1993, Kono et al. 1986). A Swedish study of a cohort of alcohol dependent men discharged from a detoxification ward found that coronary death contributed significantly to their excess mortality, particularly in a two year period after their discharge (Denison et al. 1997). A recent review raises the importance of the pattern of drinking when the risk is assessed, particularly the issue of binge drinking (Britton et al. 1998).

All cause mortality

The relationship between alcohol consumption and all cause mortality is J-shaped (Brenner et al. 1997, Camargo et al. 1997, Doll et al. 1994, Duffy 1995, Holman et al. 1996, Keil et al. 1997, Kono et al. 1986, Norrish et al. 1995, Shaper et al. 1988, Sleight 1996, Yuan et al. 1997). The lowest segment of the J shaped curve (where relative risk is less than one) corresponds to about 5-20g of daily alcohol intake and the cross-over (where relative risk equals one) is at about 30-40 g/day (Keil et al. 1997). In China those who consumed 1-14 drinks a week and US physicians consuming 2-6 drinks a week had the biggest reduction in overall mortality (Camargo et al. 1997, Yuan et al. 1997). A recent meta-analysis found that relative

risk of all-cause mortality is lowest in male drinkers who consume 1.0-1.9 standard drinks (10-19 grams) per day (RR=0.84 compared to non-drinkers) and exceeds one by 3.0-3.9 drinks (RR=1.01), while in female drinkers these figures are at 0-0.9 (RR=0.88) and 2.0-2.9 drinks (RR=1.13) respectively (Holman et al. 1996). Although moderate alcohol consumption refers to lower risk in all cause mortality than absenteeism or higher consumption levels, the protective causal effect has not been firmly confirmed yet (Duffy 1995).

4.2 Acute health-related conditions

Accidents and injuries

Alcohol consumption is implicated as one important cause of injuries (Cherpitel 1989, Holubowycz 1995, Martin & Bachman 1997, Peden et al. 1996, Sathiyasekaran 1996, Waller 1976). A study suggests that the association between alcohol consumption and the severity of the injury varies by cause of injury, whether it is a motor vehicle accident, fire or violence-related (Cherpitel 1996). An increased risk of motor vehicle collision, traffic and other accidents can be associated with elevated blood alcohol concentration (BAC) (Borkenstein et al. 1974, Gislason et al. 1997, Hansen et al. 1996, Holder et al. 1997, Lerer & Matzopoulos 1997, Li et al. 1996, Odero et al. 1997, Osterberg 1987, Peek Asa & Kraus 1996, Rossow 1996, Wu et al. 1991). Mortality risk for those convicted of driving while intoxicated is also elevated (Karlsson et al. 1991, Mann et al. 1996, Osterberg 1987). A study in Finland suggests that although there are links between alcohol consumption, drinking habits, drunken driving, and alcohol-related traffic accidents, alcohol is not solely and often not directly a decisive factor (Osterberg 1987). The contribution of alcohol to falls, drowning, burns and fires is high, possibly reaching 40-80% (Hingson & Howland 1993).

Suicide

Alcohol abuse and alcoholism are associated with increased risk of suicide attempts (Rabow & Watts 1983, Roizen 1982, Roizen 1989). For example, in a recent study in Russia suicide mortality rates appeared to be high in republics with high alcohol consumption (Wasserman et al. 1994).

4.3 Harm to the community

Violence and crime

Criminal activity is often preceded by drinking and often suspected to be particularly associated with violent crime (Cherpitel 1997, Holder 1997, Martin & Bachman 1997, Young 1997). There are certain offences where intoxication is the principle component, such as being drunk.

Family problems

Heavy drinking can also place stress on family life (Holder 1997, Young 1997). Spending on alcohol and reduced earning due to the results of drinking alcohol may restrict the family budget, intoxicated behaviour may repel or embarrass family members and the drinking member of the family may fail to adopt expected roles and obligations. Excessive drinking is also commonly linked to child abuse (Frany 1991).

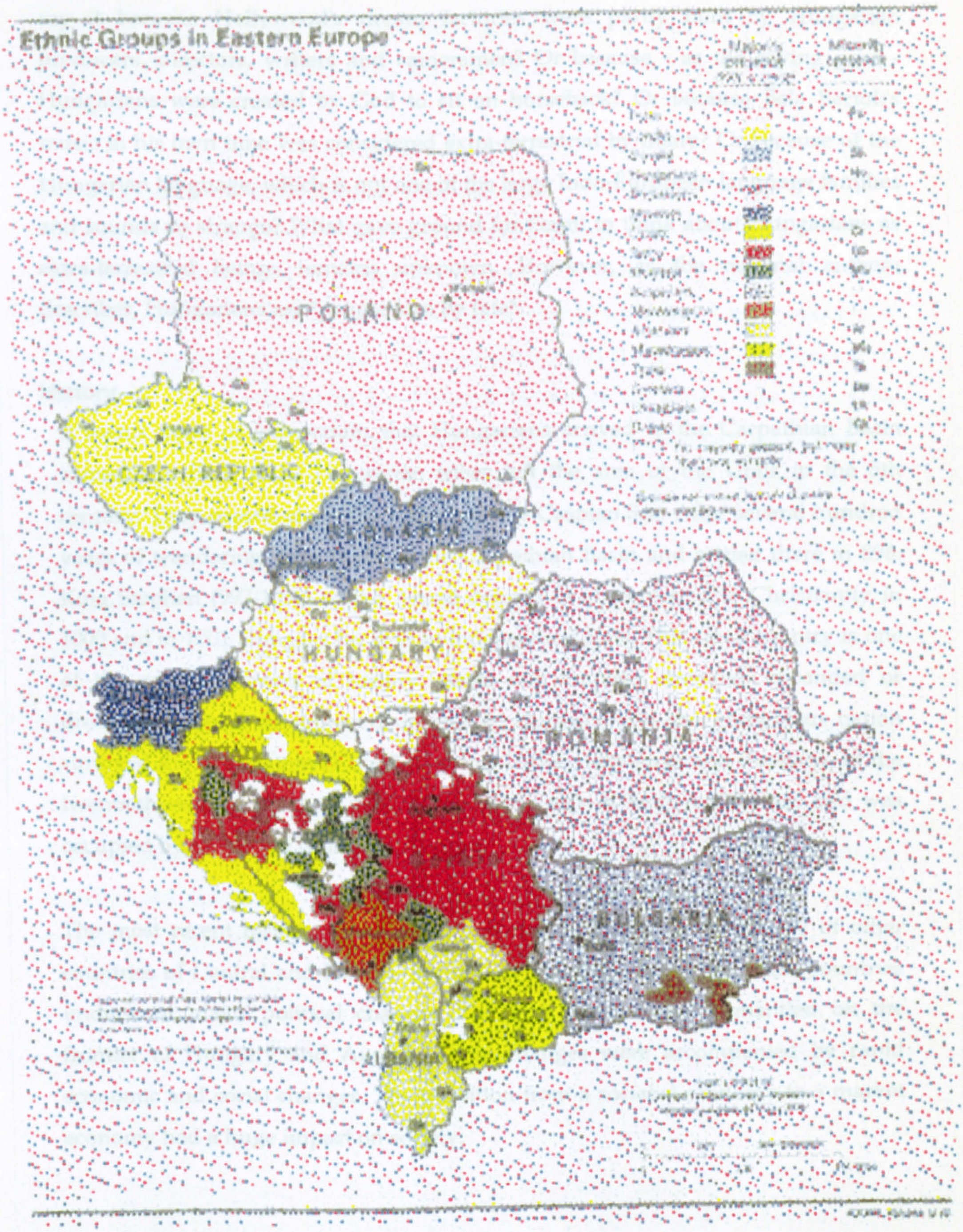
Problems at workplaces

Inappropriate alcohol consumption can cause problems at workplaces for the employer, the drinking employee and his or her colleagues. The employee is harmed by loss of profit and productivity through bad time keeping, sickness absenteeism, loss of efficiency, increased risk of accidents, bad work discipline and petty crime (Ames et al. 1997).

5 Hungary - Place of the study

Having presented the subject of this study, its setting must be described. Hungary is situated in Central Europe, in the Carpathian Basin (Picture 3). Geographically it is strategically located astride main land routes between Western Europe and the Balkan Peninsula and between the Ukraine and the Mediterranean basin. The population is ethnically homogenous, although there are sizeable Hungarian minorities in the neighbouring countries. The biggest minority in Hungary is the Gypsies (4%). The official language of the country is Hungarian. The most widespread religion is Roman Catholic (67.5%), but others are also present (Calvinist 20%, Lutheran 5%, etc.).

Picture 3 - Map of Central and Eastern Europe



Once the Nobel Prize winning Italian physicist, Enrico Fermi, was asked by his disciples in California: "Do extra-terrestrial beings exist?" - "Of course," - Fermi answered - "they are already here among us, they are called Hungarians." Did he say it because Hollywood's dream factories were partly built by Hungarian producers, directors, writers and cameramen? Or because - as the saying goes - Hungarians were created by God to sit on horseback? Or because Bela Bartok's music in his own time was considered extra-terrestrial by many? Or because of the Hungarian language, which is not one of the large Indo-European language families and sounds so strange? What gave ground for Fermi to think about Hungarians as extra-terrestrial beings remains unknown. However, as the national anthem describes, Hungarians are "people torn by fate".

History

It seems more or less certain that Hungarians arrived to the Carpathian Basin somewhere from Asia. Hungarian tribes left the area of the Urals in the 5th century. They passed along the Volga and the Caspian Sea. After several hundred years of wandering, they reached the Carpathian Basin and settled there in 896. King Stephen (997-1038) of the Arpad dynasty was converted to Christianity in 1000 and in 1001 Hungary became an independent state. This small country is one of the great survivors of history: states and empires emerged, expanded or disintegrated and disappeared around it. Hungary and the Hungarian nation survived the devastation of the Tatars and Turks, Habsburgs and Russians. In the twentieth century it found itself in the losing side of both world wars and was occupied by the Soviet Union for 40 years.

The most recent history of the country is closely linked to the history of other countries of Central and Eastern Europe. At the end of the 1980s these countries underwent major political changes. The iron curtain was dismantled on the frontier of Hungary and Austria. These changes were accompanied by rapid economic and social changes. The transition from a socialist economy to a market economy had a huge impact on society.

Population

The population of the country is 10 million. The age profile is: 0-14 years - 18% , 15-64 years - 68%, 65 years and over - 14%, which is very similar to the surrounding countries. The population growth rate is -0.68% as in 1996. Life expectancy at birth is 69.02 years (for men 64.23 years, women 74.04 years; 1996 estimate) (CIA 1997).

Constitutional and administrative arrangements

Hungary is a parliamentary democracy, with a president as head of state and an unicameral parliament, the National Assembly (Szabo 1995). The executive is composed of the Prime Minister as head of the government whose election is based on the recommendation of the president, and the cabinet, the Council of Ministers. All are elected by the National Assembly for a four-year term. The legislature is unicameral, the National Assembly. The judicial branch is formed by the Constitutional Court and the Supreme Court. Judges are elected by the National Assembly.

Hungary has 20 administrative areas. There are 19 counties and the capital, which is regarded a separate entity as one fifth of the Hungarian population lives there.

This chapter introduced the subject and the place of the study. In the following two chapters background information for and justification of alcohol policy analysis in Hungary is presented. The extent of alcohol related problems in Hungary, and elements of alcohol policy that might decrease the incidence of alcohol related problems are discussed, and alcohol policy is put into a broader policy context providing the framework for the analysis.

- *CHAPTER 2* -

ALCOHOL RELATED PROBLEMS IN HUNGARY

This chapter aims to highlight the need for a detailed analysis of alcohol policy by presenting the extent of alcohol related problems in Hungary.

The first part of the chapter summarises how alcohol terminology relating to alcohol is used and interpreted in Hungarian literature to help the reader understand the different concepts used in the literature review. The second part briefly summarises the contribution that alcohol makes to particular diseases. The third part reviews current knowledge about the extent of alcohol related problems of the past fifteen years in Hungary.

1 The Hungarian terminology

The use of terminology related to alcohol in Hungarian literature, such as "addictology", "alcoholism", "alcohol addicts", "alcohol dependence" and "alcoholics", varies from study to study. Alcoholics and alcoholism are commonly used phrases, without being precisely defined. In the following paragraphs, examples of their use in the literature are presented. Verbatim translations are used to highlight the difficulties of interpreting these concepts in a rigorous way.

The first study which discussed the possible contribution of alcoholism to premature mortality, published in 1980, defined "alcoholism" according to categories of alcohol dependence (303) and alcohol abuse (305) of the 9th revision of the International Classification of Diseases (ICD-9) (Simek 1980). During the 1980s "excessive drinking" and "alcoholism" were used interchangeably (AEÁB 1984). The fight against "alcoholism" in this period was directed towards "alcoholics", which - on the basis of what was written - referred to excessive drinkers, alcohol abusers and alcohol addicts (Kovács 1984). In this period "alcohological hospital units" were organised throughout the country with the task of providing detoxification for "alcohol patients" and out-patient care for "alcohol addicts" (Szikszay 1984).

A sociological overview from the middle of the 1980s introduced the concept of alcoholism as developed by Jellinek (Andorka 1985). Jellinek had a disease oriented approach which emphasised the loss of control by alcoholics. It could happen either

because alcoholics consumed alcohol every day and they were unable to stop drinking, or because once they started drinking they could not stop until they got drunk. The reason for the loss of control was the dependence which developed with excessive alcohol consumption (Jellinek 1960). This approach has been commonly used in other studies since then.

In the 1980s the deviant behaviour theory developed by Merton and Durkheim was a popular and commonly used explanation for the increasing problem of alcoholism (Andorka 1985, Andorka 1988).

Terminology used in the 1980s continued into the 1990s. A study of the organisation of the "work of alcohology" used "work on alcohol issue" and "work of alcohology" interchangeably. This paper suggested that "alcohology" dealt with people who drank excessively and therefore were at risk of developing physical and social consequences of drinking (Hajnal 1990). Another study from this period differentiated "alcohol abuse" and "alcohol disease" (Holzberger 1990). "Alcohol disease" was defined as a type of alcohol abuse, when one, after starting drinking, could not stop until getting drunk. "Alcohol abusers" were those who drank excessively, had somatic symptoms, positive laboratory tests and often amnesia for their drinking period. Thus, it was proposed that alcohol disease should be treated separately from alcohol dependence. "Alcohol dependence" was defined as when one could not give up drinking despite being aware of its physical, psychological and social consequences, and being surrounded by intolerant attitudes to drinking. In the presence of dependence, abrupt abstention lead to withdrawal symptoms. A further type of alcoholism, "secondary symptomatic alcoholism" or "problem drinking" was also defined separately.

A methodological letter targeting general practitioners in 1990 also defines alcohol related concepts (OKOI & OAI 1990). "Alcohology" - in this summary - is described as an interdisciplinary science and practice which deals with the harmful effects of alcohol production and trade, prevention, treatment and rehabilitation of patients. This document differentiates between alcoholism as a social phenomenon, alcoholism as a national disease and alcoholism as a disease of the individual.

Without discussing all approaches in the literature, the diversity of interpretation of these concepts emphasises the importance of using terms which are common, well-defined and widely accepted. Throughout this thesis words used are direct translations of the Hungarian as they have been used by Hungarian authors.

The diversity of alcohol terminology is not a unique phenomenon of Hungary. The concept of alcoholism, alcohol addiction and dependence has changed in the rest of the world.

The changing concept of alcoholism in Europe

The concept of alcoholism has undergone major changes throughout Europe during the past hundred years.

In 1849, Magnus Huss, a Swedish doctor introduced the term "chronic alcoholism" (Kunda 1994). Later, Bonhoefer and Korsakow both contributed considerably to the changing clinical understanding of alcoholism, the latter defining occasional, habitual and dipsomaniac drinking. Through the work of Jellinek, published in 1960, the disease concept of alcoholism spread throughout the world in the following decades (Holzberger 1990). He differentiated five types of alcoholics: (a) one who does not lose control and does not have dependence syndrome; (b) one who has somatic complications; (c) one whose alcohol tolerance has already increased, has somatic dependence and often looses control; (d) one who cannot abstain at all; (e) one who is dipsomaniac (Jellinek 1960, Kelemen 1990).

Following the work of Jellinek, Skog and Tabakoff both differentiated two types of alcoholics. Hazardous drinkers belonged to the first category. Their drinking was often a reaction to problematic situations, however they were able to adapt to social norms of drinking. In the second category excessive drinking was independent of the individual's environment. People falling into this category could not adapt to the norms of society. They often had personality problems (Buda 1987/88, Holzberger 1990).

In the 1990s the word "alcoholism" is still widely used by clinicians and the public, although it has no precise scientific meaning (Edwards & al 1994). Alcohol

dependence and alcohol abuse were separated as diagnostic categories in the 9th revision of the International Classification of Diseases (WHO 1978). It defined alcohol dependence syndrome (303) *"as a state, psychic and usually also physical, resulting from taking alcohol, characterised by behavioural and other responses, that always include a compulsion to take alcohol on a continuous or periodic basis in order to experience its physical effects and sometimes to avoid the discomfort of its absence. Tolerance may or may not be present."* This category included acute drunkenness, dipsomania and chronic alcoholism. Non-dependent alcohol abuse (305.0) included *"cases, where a person for whom no other diagnosis is possible, has come under medical care because of the maladaptive effect of a drug on which he is not dependent and he has taken on his own initiative to the detriment of his health or social functioning."* The 10th revision of ICD continues to separate the two classifications.

Since the end of 1970s the WHO has been recommending "alcohol related problems" to be applied to the spectrum of disorders related to alcohol. Alcohol-related problems according to the European Alcohol Action Plan (WHO 1993) involve the following where alcohol is implicated:

- lost productivity, costs to health, social welfare, transportation and criminal justice system,
- ill health, deaths, burdens on health care,
- traffic accidents, domestic, recreational and work accidents, and
- many public order problems including crime, homicide and violence.

2 Alcohol attributability in different disease groups

To discuss and interpret the extent of alcohol related problems in Hungary not only the terminology but also the concept of alcohol attributability has to be addressed.

Earlier in this thesis health and social damage related to alcohol consumption were discussed. In this section the extent to which alcohol consumption contributes to these effects is summarised.

The contribution that alcohol makes to certain diseases is considerable. Its estimation is, however, often difficult because of the difficulty of separating the amount attributable to alcohol and that due to other causes.

Some studies have sought to clarify this issue (Australian Gov. 1995, Maynard & Godfrey 1992, US Dep. of Health & Human Services 1990). A summary of these studies is presented in Table 1. Conventionally conditions directly and indirectly related to alcohol consumption are differentiated. This division is also presented in the summary table.

Table 1 - Alcohol-related disease groups

Diseases	ICD-9 code	alcohol attributable fraction		causality assessment	age
		US Dep. Health [1]	other source	Australian Government [2]	(US, 1990)
Main causes of death					
Chronic liver disease and cirrhosis	571	NA	0.66M, 0.66F[4]	NA	NA
Neoplasm	40-239	NA	0.04M, 0.03F[4]	NA	NA
Diseases of the circulatory system		NA		NA	NA
Cardiovascular diseases		NA		NA	NA
Cerebrovascular diseases	430-438	see above			
Respiratory diseases	460-519	NA	0.11M, 0.02F	NA	NA
Diseases of the digestive system	520-570	NA	0.12M, 0.03F	NA	NA
Accidental deaths		NA		NA	NA

NA: non-available

Table 1 - Alcohol-related disease groups (continued)

Diseases	ICD-9 code	alcohol attributable fraction		causality assessment	age
		US Dep. Health [1]	other source	Australian Government [2]	(US, 1990)
Mental disorders					
Alcoholic psychosis	291	1.00		sufficient	15+
Alcohol dependence	303	1.00		sufficient	15+
Alcohol abuse	305.0	1.00		sufficient	15+
Cardiovascular diseases					
Alcoholic cardiomyopathy	425.5	1.00		sufficient	15+
Digestive diseases					
Alcoholic fatty liver	571.0	1.00		sufficient	15+
Acute alcoholic hepatitis	571.1	1.00		sufficient	15+
Alcoholic cirrhosis of the liver	571.2	1.00		sufficient	15+
Alcoholic liver damage unspecified	571.3	1.00		sufficient	15+
Unintentional injuries					
Accidental alcohol poisoning	E860.0	1.00		sufficient	15+
Accidental ethanol poisoning	E860.1	1.00		sufficient	15+
Accidental methanol poisoning	E860.2	NA		sufficient	NA
Other diseases					
Alcoholic polyneuropathy	425.5	1.00		sufficient	15+
Excessive blood alcohol level	790.3	1.00		NA	NA
Cancers					
Oropharyngeal cancer	140-149	0.50	0.45 [3]	sufficient	35+
Cancer of the larynx	161	0.50	0.45 [3]	sufficient	35+
Cancer of the oesophagus	150	0.75	0.22[3]	sufficient	35+
Liver cancer	155	0.15	0.35 [3]	sufficient	35+
Diseases of the circulatory system					
Cerebrovascular diseases (stroke)	430-438	0.07	0.12M, 0.03F [4]	limited/suff.	35+
Essential hypertension	401	0.08		NA	35+
Hypertension	401-405	NA		sufficient	NA
Digestive diseases					
Chronic pancreatitis	577.1	0.60		sufficient	35+
Acute pancreatitis	577.0	0.42		sufficient	35+
Intentional injuries					
Suicide	E950-959	0.28	65% alcohol intox.[6]	sufficient	15+
Homicide	E960-969	0.46		sufficient	15+
Unintentional injuries					
Accidental falls	E880-888	0.35	0.13-0.37 non-fatal falls [5]	sufficient	15+
Accidental fire injuries	E890-899	0.46	0.09-0.86 burn deaths [5]	sufficient	>0
Accidental drowning	E910	0.38	0.21-0.47 [5]	sufficient	>0
Motor vehicle accidents	E810-825	0.42	0.14 road accident [5]	sufficient (E810-19 road inj.)	>0
Occupational and machine injuries	E919, E920	NA	0.25 acc. at work [5]	sufficient	NA

NA: non-available

[1] (US Dep. of Health & Human Services 1990); 2 (Australian Gov. 1995); 3 (Duffy 1992) ;4 (Maynard & Godfrey 1992) ; 5 (Hingson & Howland 1993); 6 (US Dep. of Health & Human Services 1990)

3 HUNGARY - IS ALCOHOL A PROBLEM?

In this section the extent of alcohol related problems in Hungary is summarised. Investigating of the extent of the problems concentrates on two questions:

(1) To what extent is alcohol a problem in Hungary?

(2) Does Hungary differ considerably from other European countries?

There are many possible indicators (direct and indirect) of the pattern of alcohol use and its consequences in a population. These range from measures of consumption, such as sales data and surveys of drinking patterns, through to measures of the social or health consequences of drinking. This discussion focuses on three principal measures: (1) mortality, (2) morbidity and (3) consumption. In addition economical aspects of alcohol and the impact of the transition period are looked at. The discussion seeks to find answers to the following questions:

- Does alcohol appear to be a major public health problem based on mortality data?
- Does alcohol appear to be a major public health problem based on health services` data?
- Does alcohol appear to be a major public health problem based on consumption data?
- Additionally, to what extent might the transition period have added to previous problems?

The review is built upon findings of the Hungarian literature published in the 1980s and 1990s. It is supplemented by relevant statistical data and original research results.

Computerised literature searches supplemented by hand searching were used to identify studies. Keywords of "alcohol", "alcoholism", "Hungary", "epidemiology", "public health", "mortality", "morbidity", "economic" and their combination for the period 1980-1997 were used for Medline and BIDS databases. The Hungarian Index Medicus was also looked at for the same keywords. Additionally key Hungarian journals were hand searched, such as "Népegészségügy", "Végeken", "Alkohológia", "Szenvedély-betegségek" and "Network". Finding the relevant Hungarian literature involved some difficulties such as the lack of a catalogue of the Hungarian scientific

journals, the limited opening hours of small institutional libraries and inadequate photocopying facilities.

Studies found could be grouped according to their main focus:

- alcohol related mortality
- alcohol related morbidity
- consumption levels and patterns
- social aspects of drinking
- behavioural aspects
- economical aspects
- other aspects, not mentioned above.

The literature review faced the additional difficulty that the Hungarian scientific literature about alcohol-related problems is very diverse and most of the studies do not follow rigorous methodological principles. The articles are rarely structured according to the classical pattern of introduction and research hypothesis, materials and methodology, results and discussion. Studies where the materials collected, the mean of analysing data, results and discussion could be determined were incorporated in the discussion and Appendix 1.

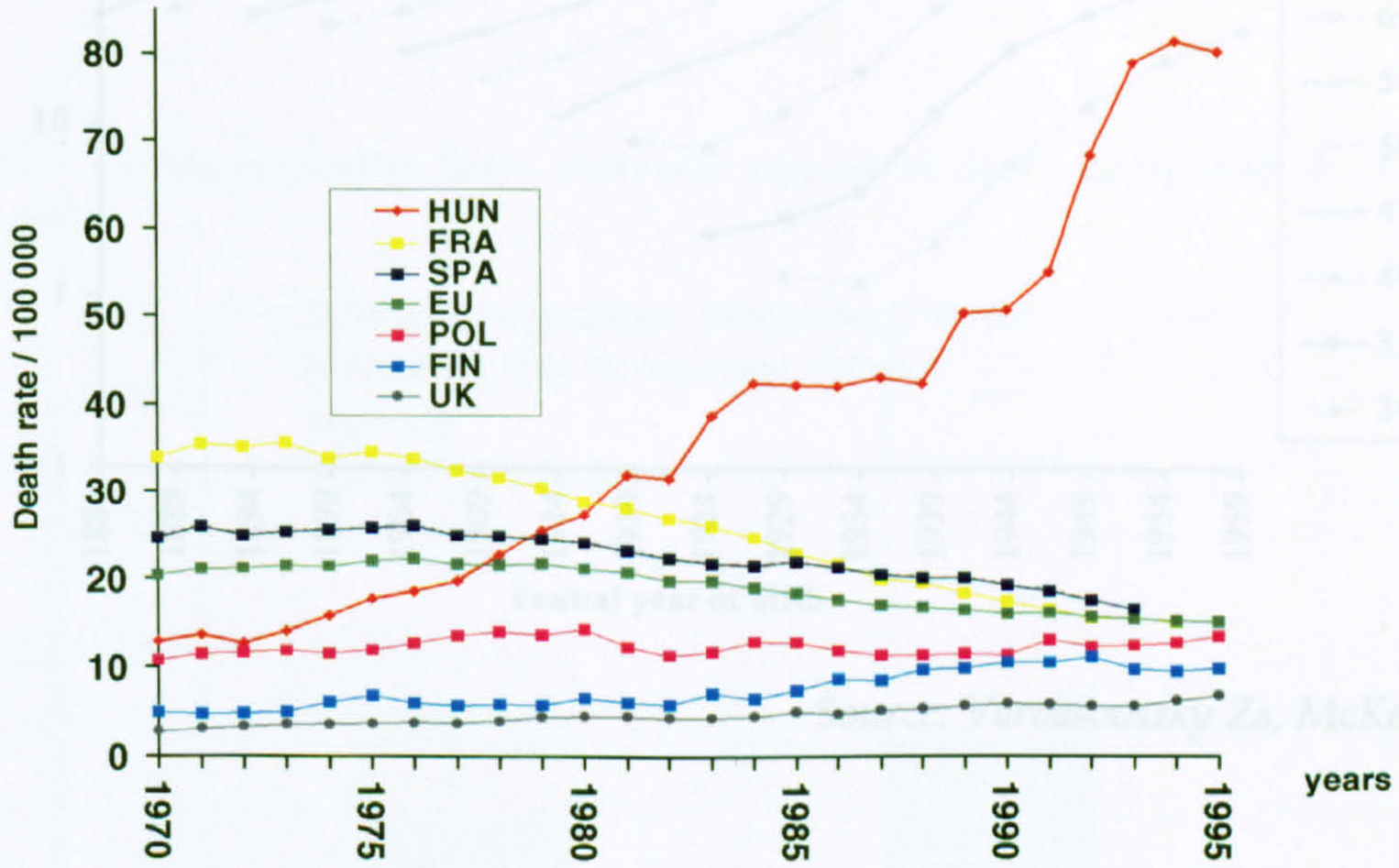
3.1 Alcohol related mortality

Cirrhosis mortality

Mortality from chronic liver disease and cirrhosis mortality is a frequently used indicator to assess alcohol consumption and its consequences at a population level. Recorded deaths from chronic liver disease and cirrhosis show an unprecedented increase in Hungary (Figure 1,Figure 2). This contrasts markedly with the pattern seen in neighbouring countries and in Europe as a whole (Lehto 1993, WHO 1994a).

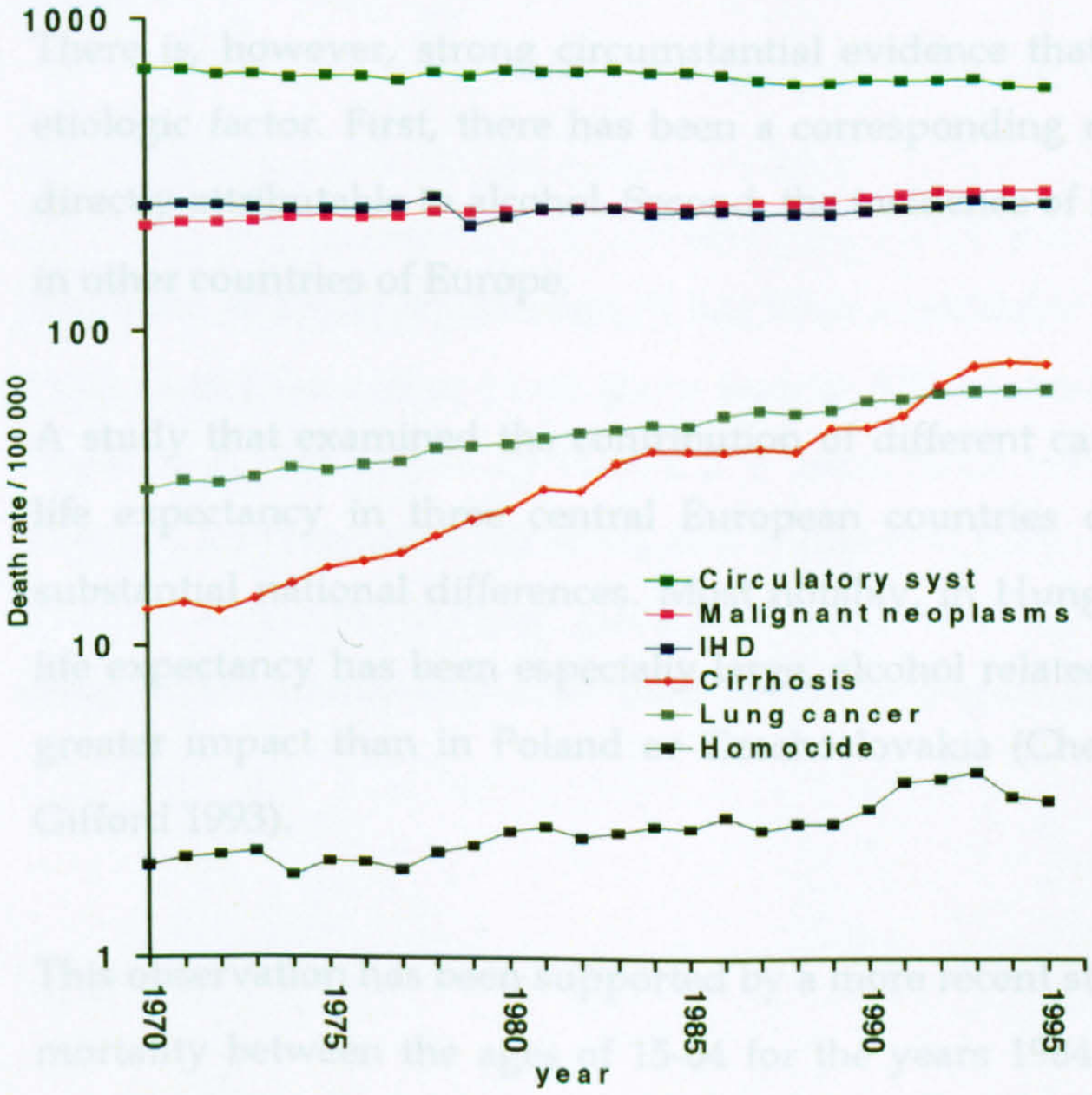
Men are affected more than women (Varvasovszky et al. 1997). The increase has been especially steep among young people, again with the greatest effect among men (Figure 3, see Appendix 2).

Figure 1 - Age standardised death rate of chronic liver disease and cirrhosis (total population, all age-groups; 1970-1995)



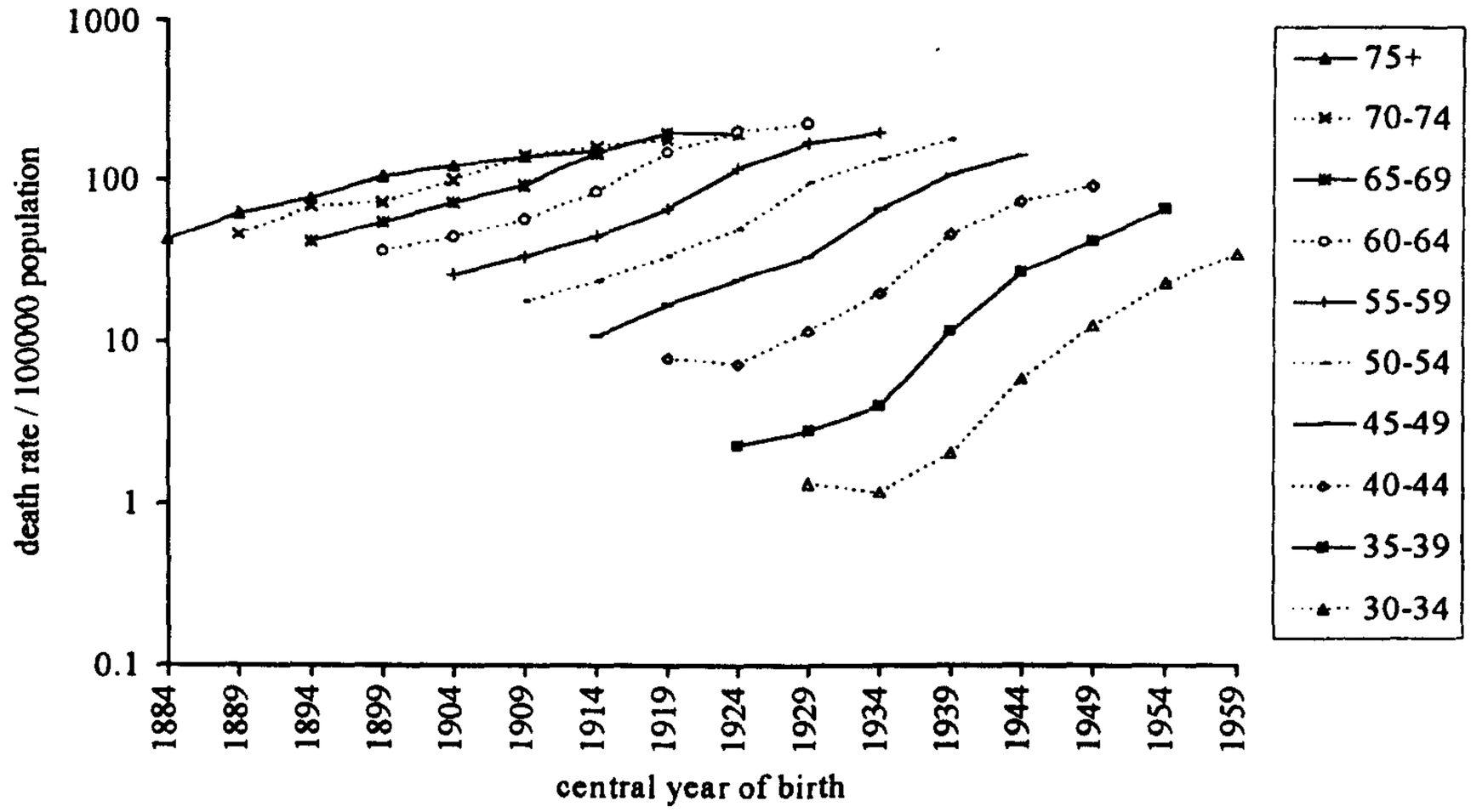
Source: HFA database

Figure 2 - Mortality from selected causes of death in Hungary (1970-1995)



Source: HFA

Figure 3 - Age specific death rate by year of birth: chronic liver disease and cirrhosis, Hungarian men (seven selected periods)



Source: Varvasovszky Zs, McKee M, 1996

Alcoholic liver disease and cirrhosis mortality

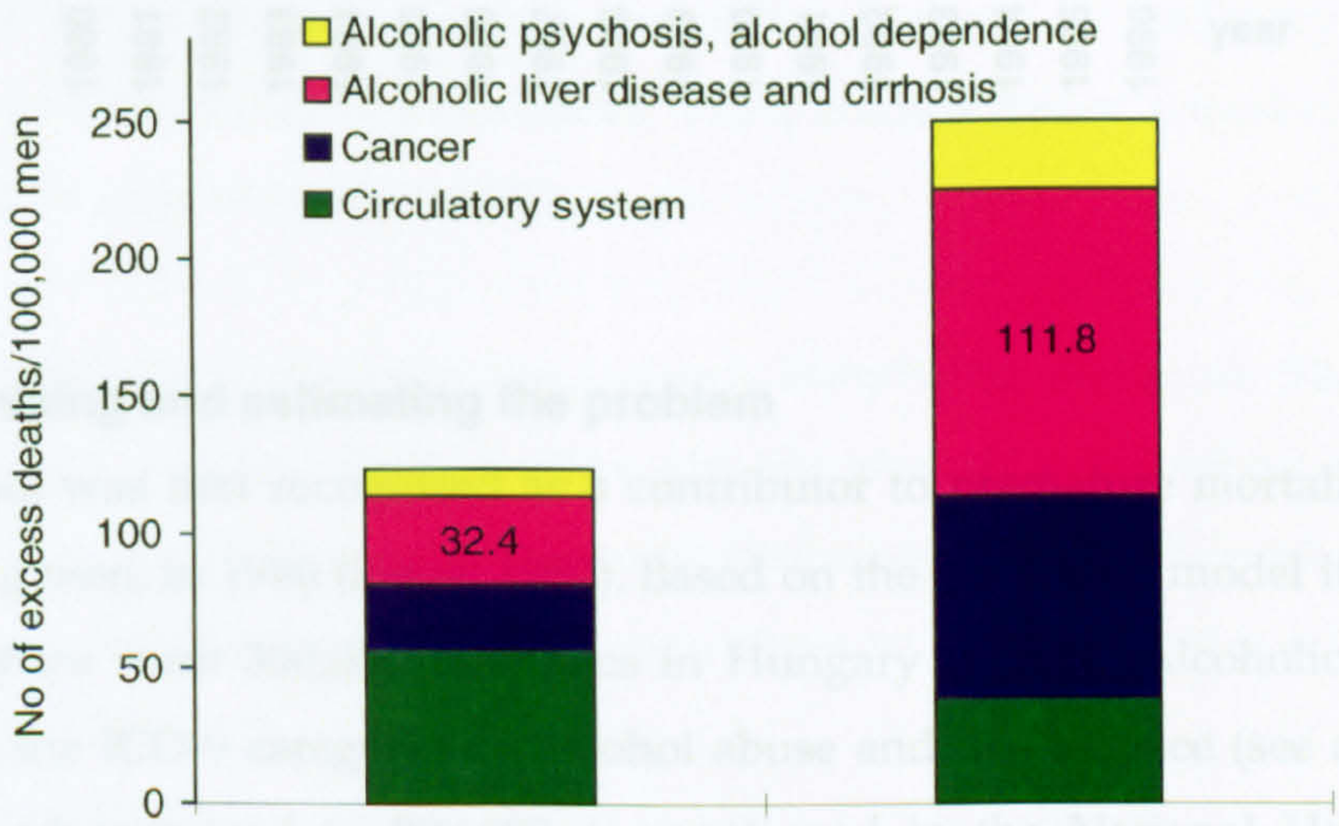
The increase in chronic liver disease and cirrhosis mortality in Hungary could, conceivably, be due either to alcohol consumption or hepatitis B and C infection. There is, however, strong circumstantial evidence that alcohol is the important etiologic factor. First, there has been a corresponding rise in deaths from causes directly attributable to alcohol. Second, the incidence of hepatitis is not worse than in other countries of Europe.

A study that examined the contribution of different causes of death to changing life expectancy in three central European countries during the 1980s showed substantial national differences. Most notably, in Hungary, where the decline in life expectancy has been especially large, alcohol related deaths had a very much greater impact than in Poland or Czechoslovakia (Chenet et al. 1995, Powles & Gifford 1993).

This observation has been supported by a more recent study examining changes in mortality between the ages of 15-64 for the years 1984 and 1994 compared with

1979 (Figure 4) (Hajdu & Boján 1996). This found that 25% of excess male mortality (around 32 deaths/100000 men) in 1984 was due to deaths from alcoholic liver disease and cirrhosis and a further 6 % due to alcoholic psychosis and alcohol dependence (around 8 deaths/100000 men). By the year 1994 it reached 45% and 10 % of the total excess mortality respectively (111.8 and 24.6 excess deaths/100000 men).

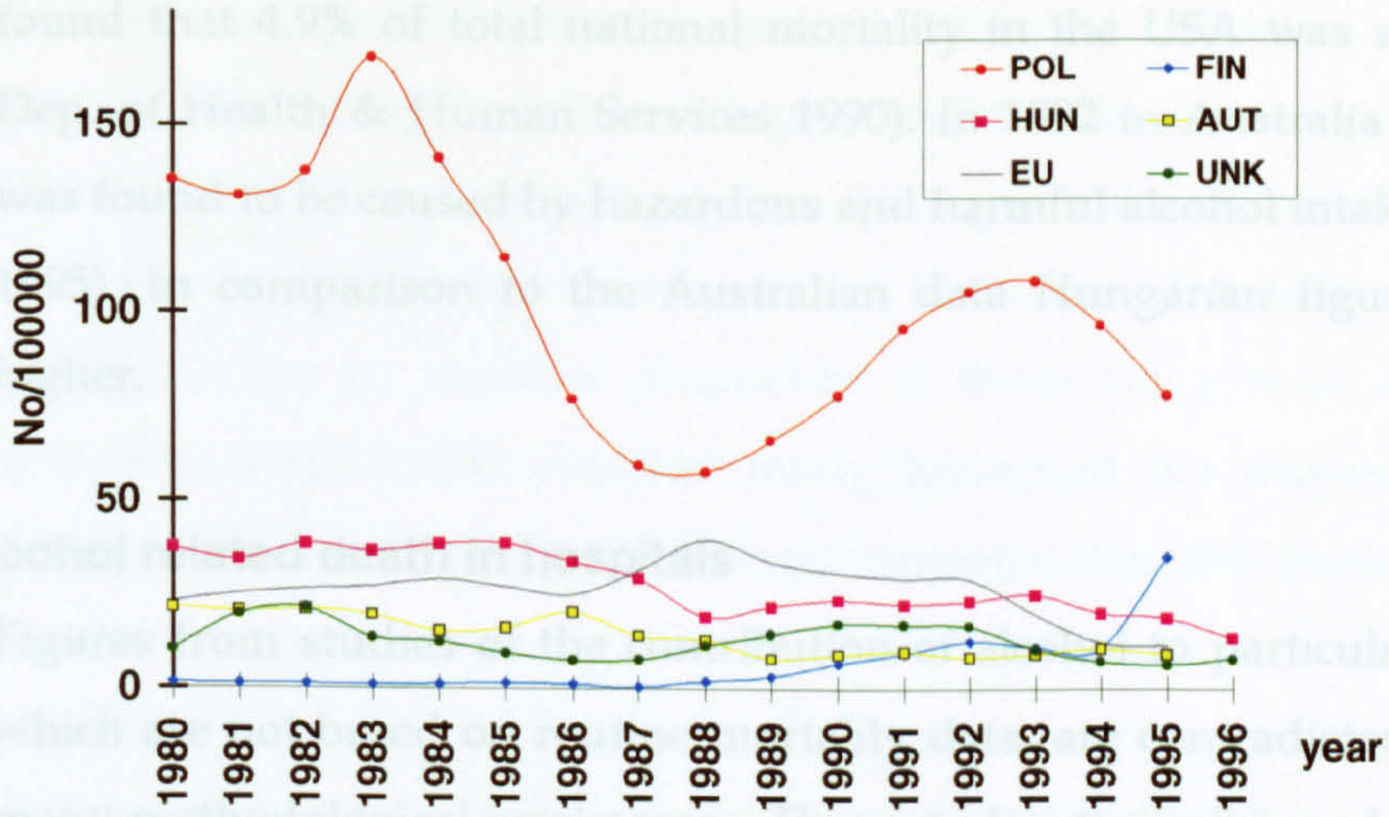
Figure 4 - Excess mortality from different causes of death compared to 1979 (men, age 15-64)



Source: Hajdu P, 1996

As regard to hepatitis infection, it has been a notifiable disease in Hungary since 1950. Data from recent years show that 50-70% of viral hepatitis was caused by Hepatitis A and 10-20% by Hepatitis B virus. Since 1995 blood donors have been screened for Hepatitis C infection and in that year 0.4% of donors were Hepatitis C positive and 0.1% HBSAg positive (Ursicz 1997). Hepatitis incidence figures compare favourably with other parts of Europe (Figure 5).

Figure 5 - Incidence of Hepatitis Infection in European Countries



Source: HFA

Recognising and estimating the problem

Alcohol was first recognised as a contributor to premature mortality, particularly among men, in 1980 (Simek 1980). Based on the Lederman model it was estimated that there were 300,000 alcoholics in Hungary in 1978. Alcoholics were defined using the ICD-9 categories of alcohol abuse and dependence (see above). By 1994 this had increased to 800,000 as mentioned in the National Health Behaviour Survey Report (CSO 1995)

Proportion of deaths attributable to alcohol

On the basis of official mortality statistics, by the middle of the 1970s around 1% of all deaths was due to chronic liver disease and cirrhosis. By the middle of the 1980s this was around 3% and by the middle of the 1990s it was around 6%.

Using the US attributability fractions (see Table 1) the number of alcohol attributable deaths in different years, including not only cirrhosis but other causes, suggest the following figures:

year	alcohol related deaths	all deaths	%
1980	8976	145355	6
1985	11516	147614	7.8
1990	13551	145660	9.3
1995	16513	145431	11.4

The Hungarian figures are higher than the 1987 American ones. In 1987 it was found that 4.9% of total national mortality in the USA was alcohol related (US Dep. of Health & Human Services 1990). In 1992 in Australia 2.9% of all deaths was found to be caused by hazardous and harmful alcohol intake (Australian Gov. 1995). In comparison to the Australian data Hungarian figures are also much higher.

Alcohol related death in hospitals

Figures from studies of the contribution of alcohol to particular causes of death, which are not based on routine mortality data, are contradictory and suffer from many methodological weaknesses. These studies typically used medical records to estimate alcohol attributability.

In a 1984 study from the Semmelweis Hospital in Budapest, 5% of all autopsies were on patients diagnosed as chronic alcoholics according to their medical records (Konyàr et al. 1984). Chronic alcoholism was not defined in this study and there is no information on how representative these autopsies were of all patients dying in hospital.

Between 1983-87, autopsy data were collected on deaths from suicide in a southern county of Hungary. In this group 34% were alcoholics (Jegesy et al. 1995). A history of alcoholism was sought from clinical records. The person was considered alcoholic if the clinical records listed any of the following: "known alcoholic", "participated in rehabilitation" or "alcoholic cirrhosis".

It has to be added that in Hungary the death rate from suicide and self-inflicted injury is high compared to other countries of Europe (HFA database). In 1995 there were 26 deaths per 100,000 habitants, while the European average was around 10. The highest rates, 38 deaths/100,000, were observed in the middle of the 1980s, when the above study took place. The contribution of alcohol consumption to suicidal deaths has been discussed in previous sections.

Alcohol related death in general practices

Studies from general practices provide different estimates of alcohol related mortality from those based on autopsy results of the general population. Between 1987-1990, GPs from five villages from throughout the country estimated that 27% of those who died in their practices were alcoholics (Gulyàs et al. 1992). In a rural family practice an identical proportion of those dying were alcoholics between 1978-1985 (Pèter 1993). Another study looked at the proportion of alcoholics among women in a family practice and estimated it as 25% (Simek 1993).

Summary

In summary chronic liver disease and cirrhosis mortality shows an unprecedented increase in Hungary compared to other European countries. Men, particularly in younger age-groups, are the most affected. Data on directly alcohol related mortality are consistent with the increase in cirrhosis mortality. Using attributability fractions identical to a US study, Hungarian data show a much higher proportion of deaths attributable to alcohol. These proportions are also higher than the 1992 Australian figures.

These observations are not supported by studies based on autopsies and those coming from general practices. Autopsy results in 1984 show lower proportions of deaths attributable to alcohol and general practice estimates from 1987-1990 are higher than the corresponding official mortality figures. These published percentages, however, are from studies with serious methodological problems and thus have to be treated with caution.

3.2 Alcohol related morbidity

The most common aim of studies on alcohol related morbidity is to assess the burden imposed by alcohol related problems on the health care system, with other studies assessing the extent of alcohol related problems in a population.

As it has been described earlier, alcohol contributes to numerous health related conditions. Negative health consequences of alcohol use are of three broad types: the acute consequences of ingesting large doses of alcohol in a short period of time, such

as alcohol-related motor vehicle accidents and alcohol poisoning; chronic disease consequences, such as alcoholic liver disease and alcoholic cardiomyopathy; and the primary chronic disease of alcoholism, or becoming dependent on alcohol (Dufour et al. 1993). Measurement of morbidity, however, is complicated by definition and ascertainment problems.

There is considerable evidence that the health implications of alcohol consumption substantially increase utilisation of health services. Excessive drinkers have double the mortality rate and use health care services at higher rates than those who drink in moderation (Holder & Blose 1986, Klatsky et al. 1981, Reiff et al. 1981, Roghmann et al. 1981). Health care utilisation can be the consequence of the individual's hazardous consumption, but it can also arise from somebody else's drinking, for instance victims of domestic violence and abuse and accidents and injuries caused by drunk people. In addition the families of alcoholics consume more health services than do those of non-alcoholics (Holder 1987).

Burden on inpatient and outpatient care - international experience

Patients with evidence of alcoholism are more likely to be hospitalised (21.5 vs. 16.9%). They are also more likely to die within two years after their hospital discharge than those without alcoholism (Callahan & Tierney 1995). Alcohol abuse is associated with an increased risk of readmission to hospitals for trauma (Rivara et al. 1993).

Hospital inpatients include a larger proportion of alcoholics than that found in the general population (Jarman & Kellett 1979). Between 15% and 30% of patients in short stay general hospitals have alcohol problems, regardless of their diagnosis on admission. Numerous studies have assessed the prevalence of alcoholics in a general hospital setting (Table 2). They show a wide range of prevalence figures depending on the setting and methodology of data collection. In American studies the prevalence of screen-positive alcoholism was 25% in medicine, 30% in psychiatry, 25% in surgery, 19% in neurology and 12.5% in the obstetrics and gynaecology units (Moore et al. 1989, Umbricht-Schneiter et al. 1991). Of course it does not mean that all admissions of alcoholics are related to alcohol. Green estimated that alcohol directly or indirectly contributes to the cause of admission

of 54% of alcoholics and 5.6% of all patients admitted to a general hospital (Green 1965).

Table 2- Alcohol related hospitalisation (partly from Jarman)

Author & year	Hospital ward	Place	No. of subj.	Results
Green (1965)	Medical inpatients	Melbourne (Australia)	841	19% of male 3.7% of female patients were alcoholics
Barccha et al (1968)	Medical inpatients	Washington (USA)	392	27% of male +7% suspected of alcoholism 6% of female +2.5% suspected of alcoholism
Moore (1971)	Medical and surgical inpatients	San Diego (USA)	200	18% of male + 7% suspected of alcoholism 5.5% of female +1.5% suspected of alcoholism
McCusker et (1971)	Medical inpatients	Harlem (USA)	118	69% of male, 34% of female alcoholism
Gomberg (1975)	Medical & surgical inpatients	Veterans Hosp (USA)	172	55% alcoholism (25% currently drinking)
(Jarman & Kellett 1979)	Medical & surgical inpatients; casualty outpatients	London (England)	303	29% of male 8.5% of female patients with alcoholism
(Jariwalla et a 1979)	general medical unit	Manchester (England)	545	43.8% of men, 19.6% of women drink significant amount habitually
(Barrison et al 1982)	all wards (except paediatrics, gerontology.)	London (England)	520	prevalence of abnormal drinking 15.6-20.2%
(Taylor et al. 1986)	acute admissions intensive, medical, surgical, orthopaedic and casualty	London (England)	2598	12% definitely alcohol-related admission
(Umbricht-Schneiter et al 1991)	all medical wards	Maryland (USA)	1964	22.4% overall prevalence of alcohol-abuse
(Mansoor & Edwards 1991	emergency wards	Barbados	203	30% of men and 5% of women prevalence of problem drinking
(Smals et al. 1994)	medicine & surgery	Rotterdam (Netherlands)	1138	7.7% have alcohol problem
(McKnight et al. 1995)	medical unit	Edinburgh (UK)	106	41% men, 24% women alcohol contributed to admission
(Sharkey et al. 1996)	general hospital (A&E, inpatient, outpatient,)	Belfast (N- Ireland)	464	15% outpatients - alcohol misuse 16% inpatients - alcohol misuse 38.5% A&E - alcohol misuse
(Gerke et al. 1997)	city general hospital: medicine & surgery	Lubeck (Germany)	1288	29.3% men, 9.4% women alcohol related disorders
(Andreasson Brandt 1997)	all hosp. admissions 1925 cohort of twins	Sweden	9057	11.3% men, 9.4% women attri-butable to high level alcohol cons.

Alcohol related morbidity in Hungary

In Hungary there are several studies of alcohol-related morbidity in different settings. Most of them report admissions to selected hospital wards` during a defined period of time and some examined the prevalence of alcoholics among patients with different medical conditions. Apart from one study in general practice no other studies used explicit screening methods to assess the extent of alcohol related problems in health care settings. Their results rely on medical records and the methodology used is often unclear.

Alcohol problems in secondary health care - Hungarian experience

General hospital units

In a medical unit in Kaposvàr the percentage of admissions for alcoholic liver disease increased from 0.84% to 9.81% between 1979 to 1995 (Sülle et al. 1989). In another medical unit based on medical records 6,1% of all hospital admissions were "chronic alcoholics" between 1982-84. By 1986 this figure reached 13% (Simonyi 1987/88).

When doctors were asked about their personal experience they produced different figures. At a surgical ward, physicians estimated that 65-70% of men and 10% of women admitted drank regularly (Boros 1989).

The Hungarian figures do not differ considerably from examples from other countries (see Table 2) Alcohol attributability, however, was defined and measured differently in different studies, therefore comparison faces many difficulties.

Injuries

The acute effects of alcohol are often manifest as accidents and injuries. A survey of injured who required medical care at hospitals in the county of Vas between 1988-1989 found that 6.2% were suspected to be drunk at the time of the injury. The influence of alcohol was assessed by the first medical doctor who saw the injured. The assessment was based on the individual assessment of the doctor using a five-grade scale of "not drunk", "mildly drunk", "moderately drunk", "severely drunk", and "impossible to assess". If people presented for medical examination more than 12 hours after the injury "impossible to assess" was coded.

The study showed that injuries of alcoholics were more severe than of non-alcoholics (Kazàr et al. 1993). The major limitation of the study was that the assessment relied on the individual judgement of medical doctors about the level of drunkenness. In another article it was cited that 12.7% of all injured transported by the ambulance service had been reported drunk or had recently consumed alcohol (Novàk 1990). This figure was provided by a manager of the national ambulance service and does not reflect empirical research.

There are similar studies from other countries. In Cape Town, South Africa, among consecutive admissions of injured pedestrians over nine weeks in 1995, it was found that 62% had positive blood alcohol concentration tests (Peden et al. 1996). In Cantabria, in Spain among people with head injuries in the beginning of the 1990s 51% had acute alcohol intoxication (Vazquez Barquero et al. 1992). Considering the different methodologies, populations and types of injuries, comparison with these figures is problematic.

Psychiatric admissions

As expected, directly alcohol related conditions are more prevalent in psychiatric units than at other hospital wards. At a psychiatry unit in the western part of Hungary between 1982 and 1991 the number of alcoholic patients admitted with severe somatic disorders increased. At this unit 17% of the hospital beds were designated for alcohol related problems, accounting for 50% of the patient turnover (Nyuli 1993). At another psychiatry unit in 1991-92, 27% of all admissions were considered to be alcohol related. The number of delirium tremens cases was around 10% of all admissions between 1983-1992 (Környei & Siska 1994). These studies relied on analysing medical records. Findings from a Canadian study show considerably higher rates, although their results are based on the Michigan Alcoholism Screening Test (MAST) and gamma-glutamyl-transferase plasma levels. In Canada 66.2% of men and 40.6% of women were found to be alcoholic (Barral et al. 1992, Dobkin et al. 1991).

Other hospital based studies

There are other hospital based Hungarian studies examining alcohol related hospitalisation. These estimated the frequency of different medical conditions

among alcoholics or the frequency of alcoholics among people with certain medical conditions. The value of these studies is more anecdotal than scientific, as they typically contain a descriptive summary of hospital practices.

A study at the Work Therapy Centre of Pomàz for alcoholic patients analysed social and somatic conditions among 100 alcoholic patients from each of two different wards. The most frequent somatic condition was hepatic encephalopathy affecting 52 and 73% in the two wards (Lakatos et al. 1990). At the National Korànyi Pulmonological and Tuberculosis Institute, in 1988-89, 94% of patients with diabetes mellitus were regular heavy drinkers (Csontos et al. 1990). Between 1982-1989 at a medical unit 57% of patients admitted were alcohol abusers with gastro-enterological diseases (Pàlfi et al. 1992). These studies lacked case definitions of heavy drinkers, alcohol abusers or alcoholics.

A cross-sectional study of 13,772 people in a southern city of Hungary found elevated systolic and diastolic blood pressure for heavy drinkers whose daily alcohol intake was 80g pure alcohol or more among screened people. The prevalence of hypertension was significantly higher among heavy drinkers than among abstainers (Mohàcsi et al. 1996).

Burden in general practice - international experience

Alcoholism puts a burden not only on inpatient and outpatient care, but also on primary care. There are fewer studies which deal with this problem and their results vary. They are summarised in Table 3.

In the chain of health care provision, primary care has considerable potential as a setting in which to detect and intervene with alcohol-related problems. Despite its importance, GPs in most countries rarely identify alcohol related problems in their everyday practice. A study in Australia showed that only 7% of those who were defined as alcoholics based on screening questionnaire results were detected by GPs as having alcohol problems (Rydon et al. 1992).

Table 3 - Alcohol related general practice attendance

Author & year	Short description	Place	No. of subj.	Results
(McMenamin 1997)	screening and clinical detection of alcohol use disorder 339 attendees at age 18-29 in 5 years one practice	New Zealand	339	16% men, 6% women alcohol use disorders
(Rambaldi et al. 1996)	assessment of alcohol use problems by screening questionnaires 123 consecutive attendees one practice	Italy	123	58.4% men, 19.6% women heavy alcohol consumption
(Linden et al. 1996)	national psychiatric disorders study of general practices CIDI-based diagnoses	Germany		6.3% alcohol dependence
(McMenamin 1994)	alcohol use disorders 611 attendees at age 30-69 in three years screening questionnaire one practice	New-Zealand	611	13% men, 2.5% women alcohol use disorder
(Maniam 1994)	62 consecutive attendees one practice assessing drinking volume	Malaysia	562	6% Chinese, 22% Malays drank excessively
(Assanangkornchai 1993)	cross-sectional study of 320 attendees in one practice using two screening questionnaires	Thailand	320	7.5% problem drinkers
(Rydon et al. 1992)	eight practices, 371 patients, alcohol-related problems comparison of screening questionnaires & GPs` judgements	Australia	371	11.4% alcoholics (CAGE) 23.9% alcoholics (SMAST) 7% alcoholics (by practitioners)

Burden in general practice - Hungarian experience

At the beginning of the 1990s in a rural family practice (general practice) in Pilisvörösvár, in a series of 600 people who sought medical care, 10% were alcoholics. 18% of them became disabled before the age of retirement and 80% had at least one other condition which required medical care, the most common being hypertension (39%) diabetes (11%) and chronic bronchitis (11%) (Hidas & Gàbeli 1994) A bigger study involving 15 general practices throughout the country used a screening questionnaire (AUDIT) to assess hazardous and harmful drinking among those seeking primary care. Results from 12 practices found that 31% of men and 8% of women were hazardous or harmful drinkers (using the cut-off score of 10) (Pèter 1995). In this study the means of data collection were not standardised among practices and the response rate showed huge variation

among different practices. For comparison a southern Italian urban general practice, using the MAST questionnaire, found that 32.5% of consecutive attendees had alcohol problems, 45.5% of men and 10.9% of women (Rambaldi et al. 1996).

The comparability of studies between and within countries face similar difficulties to those of inpatient use of care because of the diversity of selection criteria and methods used to collect data.

Summary

Although there have been a considerable number of publications on alcohol and its contribution to diseases in Hungary, the vast majority of studies contain significant weaknesses. Few studies have sought to measure the contribution made by alcohol to the total amount of health care provided. Explicit case definitions are rarely used. Samples are not representative and there is little information about how they might differ from the general population. There is a clear need for research that will address these issues using appropriate methods in Hungary. Comparability of results within and between countries is problematic because of different methodologies.

Because of these problems it is not possible to come to any definite conclusions about the extent of alcohol related problems in health care settings in Hungary and even less so to put it into an international context.

3.3 Alcohol consumption

Alcohol consumption by the population, while not a measure of the extent of alcohol related problems, does provide essential information for developing policies to reduce these problems because of the relationship between the aggregate population risk and different consumption levels.

Population risk and its determinants

It might be expected that the rate of alcohol problems in the population is mainly determined by the number of very heavy drinkers. However, this is not necessarily the case, as the extent of the problem is influenced by the relationship

between consumption and its consequences, how the risk changes between different levels of consumption and alcohol related damage (Edwards & al 1994). This is also described by the prevention paradox (Kreitman 1986). If the risk function was linear for damage related to alcohol intake, an extra drink by any member of the population would contribute equally to the aggregate problem. But, typically, the risk for different types of damage is a non-linear function of intake, where the risk starts to grow faster at higher levels of intake. Therefore the relative contribution of different consumption groups to the population problem is determined by the curvature of the risk function. If the risk function is strongly curved, as with cirrhosis of the liver, different distributions of consumers can be expected to give rise to substantial differences in problems. Consequently the distribution of drinking in the population can have an important bearing on the prevalence of alcohol related problems.

Consumption distribution

For these reasons it is important to ascertain the distribution of consumption levels in the population. Typically the population distribution of consumption is unimodal and skewed with a long upper tail. The skewness of the distribution can be measured by the proportion of the population drinking more than twice the mean. Empirically this proportion is relatively stable across drinking cultures and typically varies between 10-15% (Skog 1985). Thus the upper tail contains a substantial number of drinkers.

Overall consumption and alcohol related damages

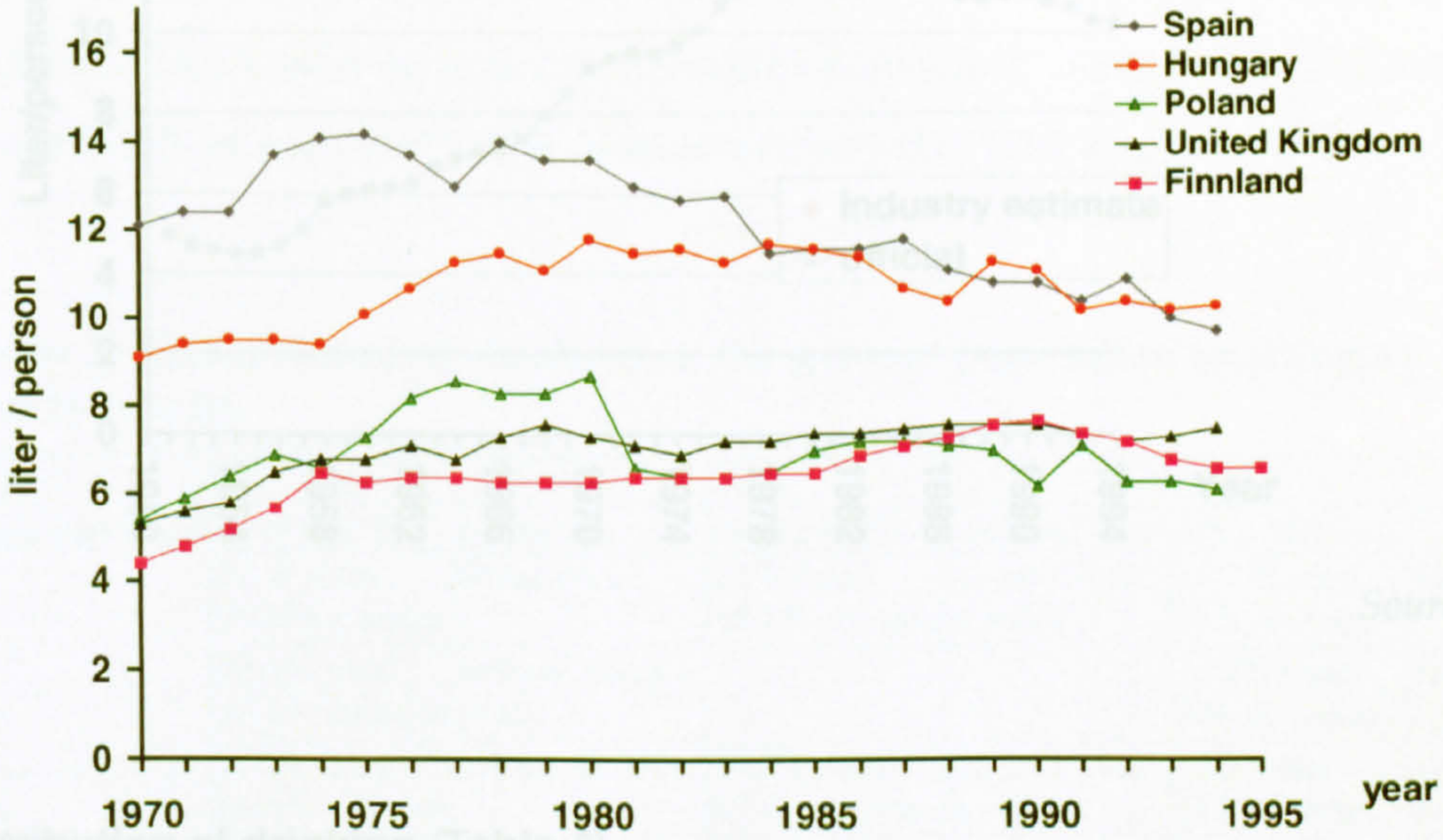
A considerable body of research demonstrated a relationship between the overall level of alcohol consumption in society and diverse types of damages in the population. Thus the evidence supports the notion that aggregate consumption has importance for public health and social policy (Edwards & al 1994).

Alcohol consumption level

At the population level, changes in consumption lead to an immediate response in alcohol-related mortality such as cirrhosis of the liver, despite the long latency at the individual level between heavy drinking and disease onset. This can be explained by the reservoir effect where there is always a number of drinkers who

drink at a level just short of what would lead to death so that a small change could either tip many over the edge or pull them back from it (Edwards & al 1994).

Figure 6 - Annual pure alcohol consumption in different countries of Europe (1970-1995)

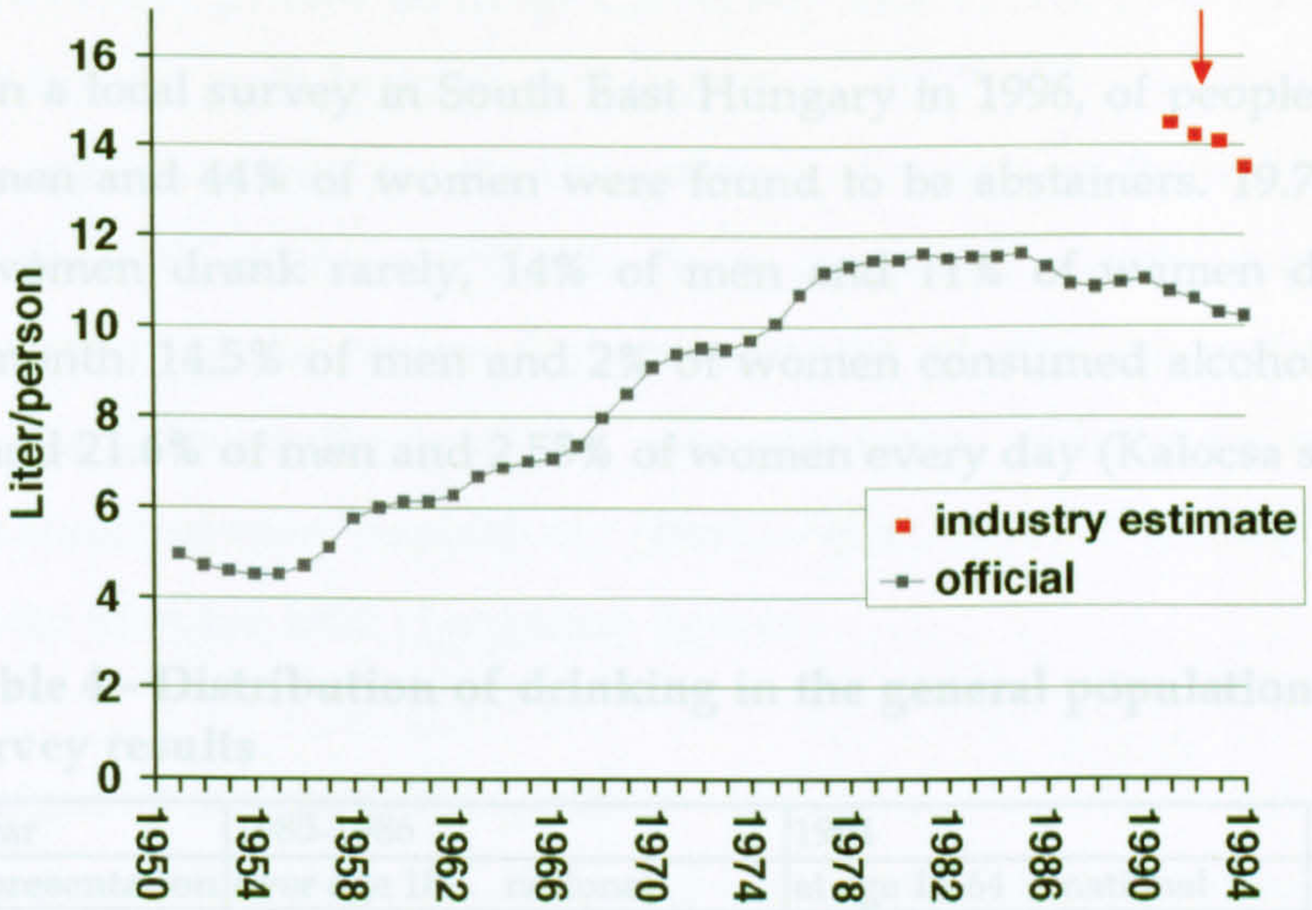


Source: HFA database

Consequently, the observed increase in mortality in Hungary would suggest an increasing trend in pure alcohol consumption, especially since the end of the 1980s. This is not, however, consistent with official consumption data. Annual pure alcohol consumption has been around 11-12 litres per person during the 1980s with a slight decrease at the beginning of the 1990s (Figure 6). It is of course important to note that official consumption is calculated from official sales statistics, thus it does not reflect real consumption in a country with a flourishing illicit and semi-legal alcohol trade.

Alcohol industry representatives estimated that around 30% of spirits consumed in the country and 40% of wine purchased in 4-5 litre cans is from the black market (Béndek 16/10/96, Budai 25/10/96). Their estimates took into account changes in sales volume over time. Using these estimates the annual pure alcohol consumption could be around 14 litres per person (Figure 7).

Figure 7 - Estimated annual pure alcohol consumption in Hungary



Source: CSO

Distribution of drinking (Table 4)

A survey in 1985-1986, which was representative of the population over age 18 found that 6.5% of men and 26.6% of women were abstainers. 33.6% of men and 46.1% of women drank several times a year only. The majority of men, 43.8%, drank once or several times a month while the corresponding figure for women was 28.4%. 10.3% of men and 2.6% of women consumed alcohol several times a week. 5.8% of men and 1.5% of women were daily drinkers (Elekes & Liptay 1987).

A national survey of 6,411 households in 1994, representative of the population at age 15-64, used a different methodology to the previous study to collect information about alcohol consumption. Questions about alcohol consumption were included in a general health behaviour survey. Summary results showed that 22% of men and 47.1% of women never drank alcohol. 34.5% of men and 47 % of women consumed alcohol once or twice a month. 10.6% of men and 1.3% of women drank frequently but not daily. 24.9% of men and 3.2% of women drank every day. The summary report states that about 11.6% of the respondents drank excessively at age 15-64 (CSO 1995). The final report defined excessive drinking as being above 30 ml (24g) absolute daily alcohol intake. It says that among daily

drinkers 81.2% of men and 46.5% of women can be considered alcoholics using this definition (CSO 1996).

In a local survey in South East Hungary in 1996, of people aged 15-64, 18.7 % of men and 44% of women were found to be abstainers. 19.7% of men and 35% of women drank rarely, 14% of men and 11% of women drank once or twice a month. 14.5% of men and 2% of women consumed alcohol several times a week and 21.6% of men and 2.55% of women every day (Kalocsa survey data-set).

Table 4 - Distribution of drinking in the general population in Hungary based on survey results

year	1985-1986		1994		1996	
representation	over age 18	national	at age 15-64	national	aged 15-64	Kalocsa
f	6.5% men 26.6% women	abstainers	22% men 47.1% women	never drank alcohol	18.7 % men 44% women	abstainers
r	33.6% men 46.1% women	several times a year			19.7% men 35% women	rarely
q	16.2% men 14.6% women	once a month	34.5% men 47 % women	once or twice a month	13.9% men 11% women	once or twice a month
u b						
e y	27.6% men 13.8% women	several times a month				
n						
c g			11.7% men 3.7% women	weekends only	11.6% men 5.1% women	weekends only
y e						
n	10.3% men 2.6% women	several times a week	11% men 1.2% women	frequently but not daily	14.5% men 2.1% women	several times a week
d						
e	5.8% men 1.5% women	daily drinkers	22% men 3% women	every day	21.6% men 2.55% women	every day
r						

Comparison of results of these surveys is difficult given the different questions used. In general we can state that the proportion of those who drink every day increased from 1985-86 to the middle of the 1990s. A much greater proportion of men and women, however, considered themselves abstainers, which is difficult to explain.

International comparison

The comparability of these figures with international survey results is difficult as studies done in other countries of Europe focused on daily intake (Harkin et al. 1997). Also when hazardous or harmful drinking is considered, the diversity of expert opinion about eligibility criteria can not be ignored. For comparison in Austria in 1994 16.2% of a survey sample had an average intake of more than 60g

pure alcohol per day. They were considered excessive drinkers (Harkin et al. 1997). The 1994 Hungarian survey report gave a figure of 11.6% of excessive drinkers (CSO 1995). In 1987-88 in the Czech Republic 11% of people interviewed consumed alcohol on a daily basis (Harkin et al. 1997). This is similar to the 1985-1986 Hungarian survey results. Comparison of abstainers from different surveys can be made with more confidence than comparing heavy drinker groups, as the definition of absenteism is more coherent all over the world. In Poland in 1993 11.2% of the adult population were abstainers, with figures of 6.2% and 15.9% for men and women respectively (Harkin et al. 1997). These figures are substantially lower than the 1992 Hungarian figures.

Changes in consumption pattern

Changes in the patterns of alcohol consumption have occurred throughout Europe. In general women drink more than before and drinking alcohol starts at younger ages. The phenomenon of globalisation means that countries adopt foreign drinking patterns. In this process new drinking patterns typically supplement rather than replace the old (Sabroe 1993b).

Figure 8 - Annual wine consumption in Hungary

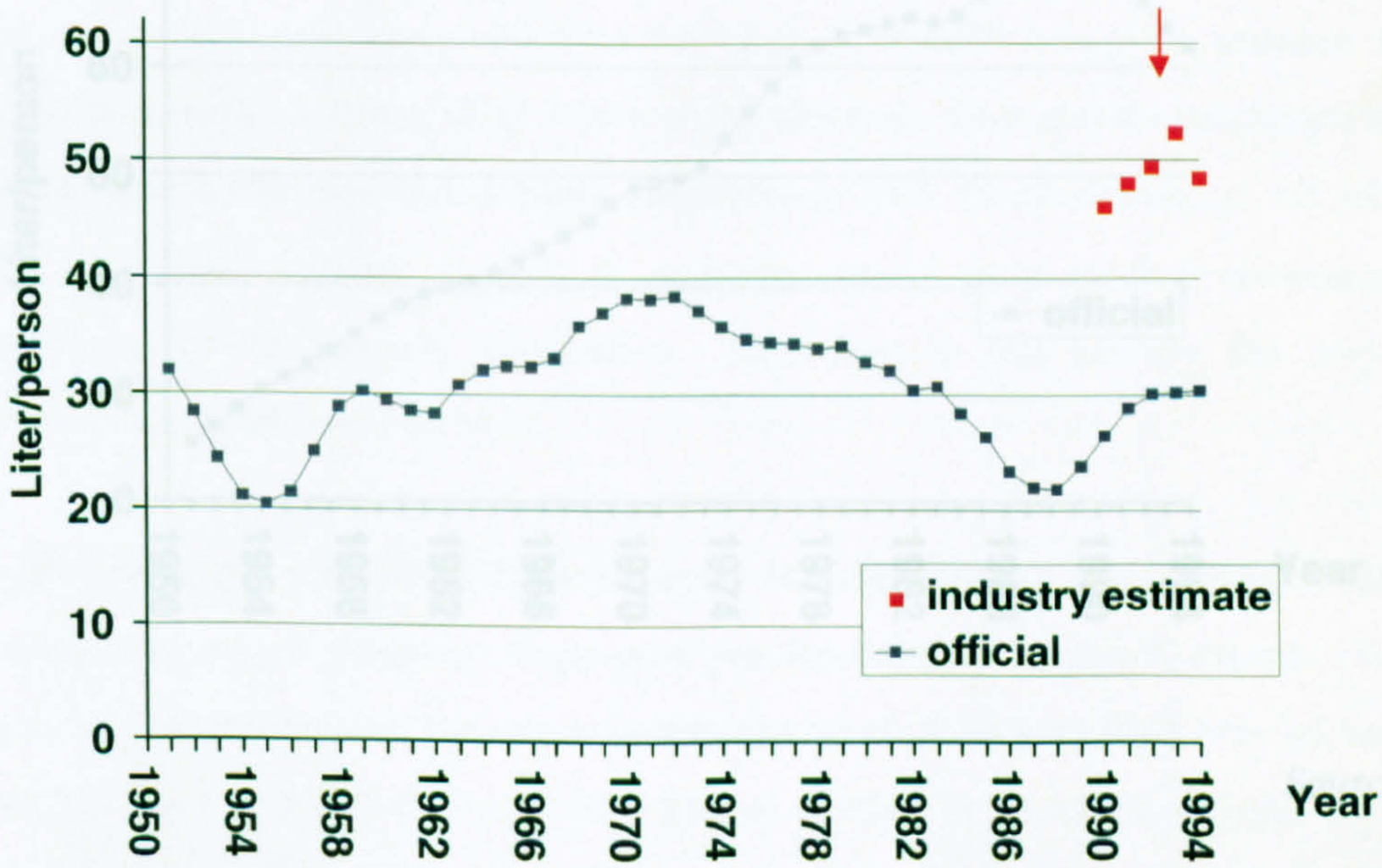


Figure 9 - Annual spirit consumption

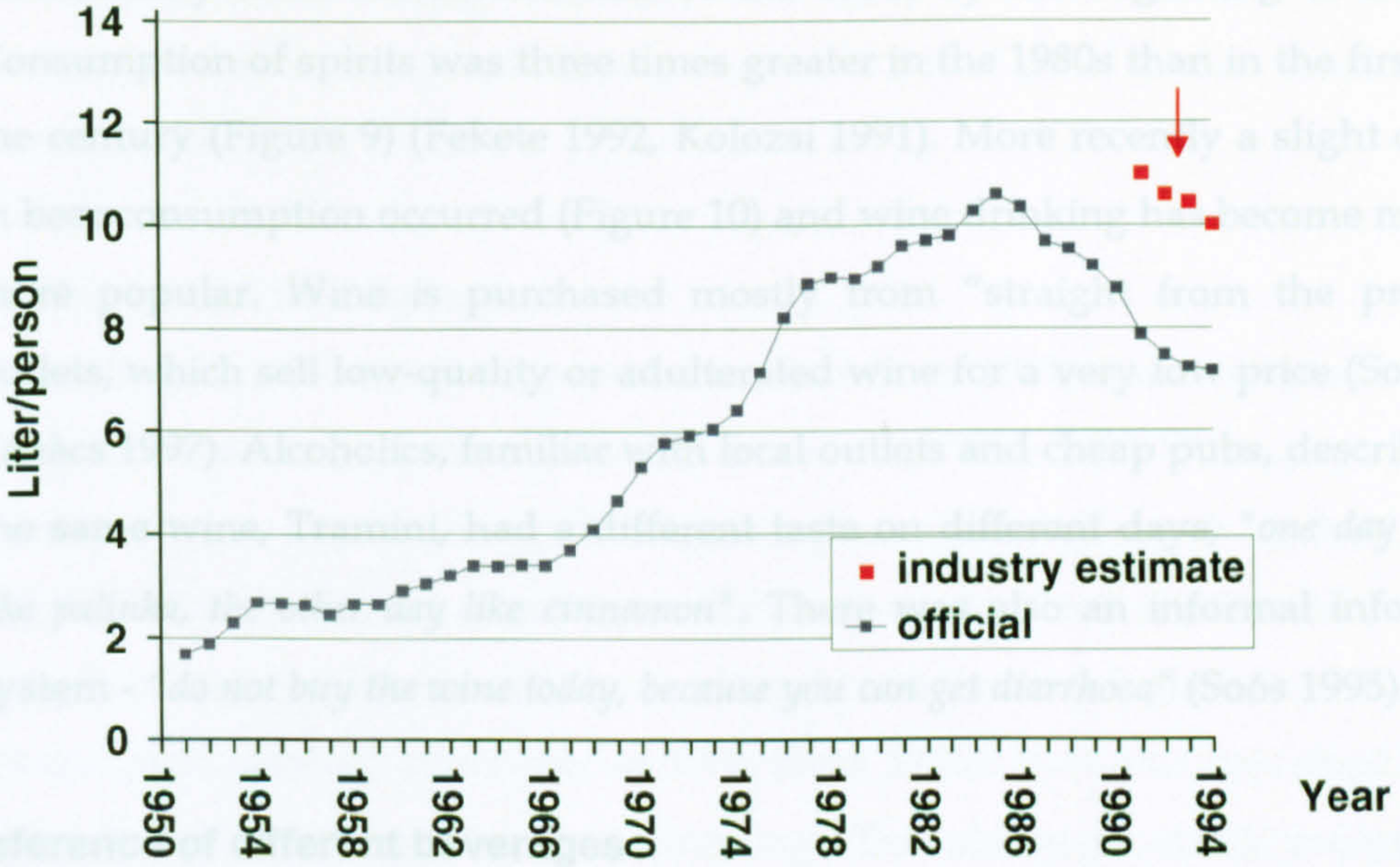
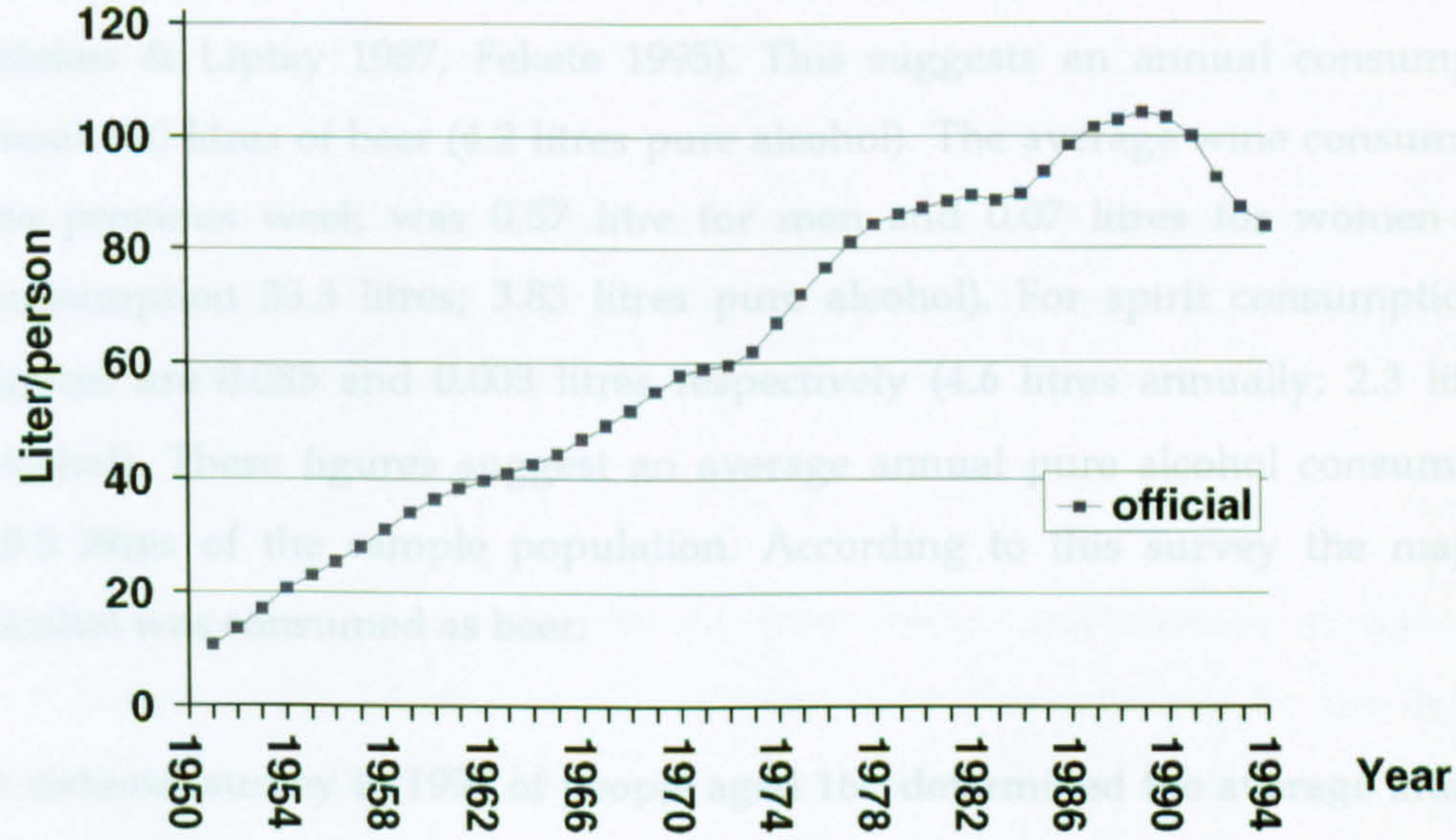


Figure 10 - Annual beer consumption



Source: CSO

In Hungary - a traditionally wine drinking country - wine consumption did not increase significantly from the 1930s (Figure 8). Beer consumption rose considerably from the second half of the 1960s by the beginning of the 1990s. Consumption of spirits was three times greater in the 1980s than in the first half of the century (Figure 9) (Fekete 1992, Kolozsi 1991). More recently a slight decrease in beer consumption occurred (Figure 10) and wine drinking has become more and more popular. Wine is purchased mostly from "straight from the producer" outlets, which sell low-quality or adulterated wine for a very low price (Soós 1995, Tanàcs 1997). Alcoholics, familiar with local outlets and cheap pubs, described that the same wine, Tramini, had a different taste on different days, "*one day it tasted like palinka, the other day like cinnamon*". There was also an informal information system - *"do not buy the wine today, because you can get diarrhoea"* (Soós 1995).

Preference of different beverages

Information about the types of drinks consumed is also available from some of the Hungarian studies.

Based on the 1985-86 survey, the average beer consumption in the previous week was found to be 3.6 bottles (1.8 litres) for men and 0.5 bottle (0.25 litres) for women (Elekes & Liptay 1987, Fekete 1995). This suggests an annual consumption of about 120 litres of beer (4.2 litres pure alcohol). The average wine consumption in the previous week was 0.57 litre for men and 0.07 litres for women (annual consumption 33.3 litres; 3.83 litres pure alcohol). For spirit consumption these figures are 0.085 and 0.003 litres respectively (4.6 litres annually; 2.3 litre pure alcohol). These figures suggest an average annual pure alcohol consumption of 10.3 litres of the sample population. According to this survey the majority of alcohol was consumed as beer.

A national survey in 1995 of people aged 16+ determined the average intake from different types of alcoholic beverages per drinking occasion (Csoboth 1997). For men and women these figures respectively were: 0.82 and 0.45 litre of beer, 0.44 and 0.27 litre of wine, 0.09 and 0.07 litre of spirits. In an average drinking session this is equivalent to 0.03 and 0.016 litres pure alcohol as beer, 0.05 and 0.03 litre as wine and 0.045 and 0.035 as spirits. Thus in an average drinking session, men

consume most alcohol as wine and spirits, while women consume mainly as spirits and wine. This contradicts findings from the 1994 health behaviour survey, which found that among men who were daily drinkers 41.6% of pure alcohol consumed was as beer, and among women 47.3% of pure alcohol consumed was as wine (CSO 1996)

Drinking norms and behaviour

According to a national representative survey in 1985, most people thought it normal to drink one to two beers and one to two "feles" (50-100 ml) spirits a day, which refers to approximately 23-46 grams pure alcohol (Kopp & Strabski). In the 9th district of Budapest, which is one of the most deprived districts of the capital, people considered it normal to have a couple of beers or 1-2 glasses of wine (24-42 grams pure alcohol) every day in 1995 (Soós 1995). It is also described that the community is tolerant towards drinking. The ability to drink excessively is considered a masculine character as it proves courage. Being drunk, however, is not acceptable. Society is not tolerant of the outcome of drinking but tolerant of the process (Simon 1991). At certain situations, drinking is obligatory, such as weddings, name days, birthdays, exams, final exams, discharge from the army and retirement (Kolozsi 1991). The 1995 survey reported that 60% of the people consumed alcohol at public places and 56% at home (Csoboth 1997).

Studies examining consumption and behavioural and social aspects of drinking usually overlap in their foci. Articles describing surveys, according to the age-group studied, are presented by publication year in Appendix 1.

Summary

The rate of increase observed in chronic liver disease and cirrhosis mortality data is not reflected in official alcohol consumption data. The estimates by the industry of the proportion of alcoholic beverages consumed from the black market, however, suggest considerably higher level of annual pure alcohol intake that from official data. There is some evidence that products consumed from the black market are of poor quality.

A substantial change in the pattern of alcohol consumption has happened over the past decades. It affected both the frequency of drinking occasions and the types of beverages consumed. Surveys asking about alcohol consumption found that by the middle of the 1990s the proportion of those drinking on a daily basis increased to 22% among men and 2-3% among women from around 6% among men and 1.5% among women in 1985-86. Wine lost its popularity by the 1980s, but this changed by the 1990s, when beer became relatively less popular. In the population it is a well accepted norm to drink excessive amounts, but people are less tolerant towards consequences of drinking.

Official consumption data are inconsistent with the high level of alcohol related problems in society suggested by mortality data. Official data, however, do not reflect consumption from the black market, the extent of which can be only estimated. Its real extent is unknown. Comparison of available survey results with international figures faces methodological difficulties, thus to make concrete conclusions from these data remains problematic.

3.4 Economic aspects

Alcohol related problems impose costs on society, but estimates of social costs face numerous methodological difficulties. Apart from definitional problems in the alcohol field, there are many physical, mental and social problems that are not related to alcohol dependence and dependence constitutes only a small part of alcohol related problems. Even when it is agreed what to include and not include into the social cost calculus, there is a problem of information availability (McDonnell & Maynard 1985b). There is a further problem in calculating alcohol-related costs that are medical or social, that arises from the gaps in epidemiological knowledge (McDonnell & Maynard 1985b). Causal links have been researched only superficially.

Cost estimates from Hungary

In Hungary, Boòr and Nagy summarised economic aspects of alcohol problems and gave an estimate of cost to society in 1988 (Boòr & Nagy 1990). They found that, in 1988, the estimated cost of damage attributable to alcohol was around 2%

of the gross domestic product. They included into their calculus lost productivity due to sickness absence, treatment, accidents at workplaces and road traffic accidents and criminal activities (imprisonment). This study related to the 1980s and does not reflect the current situation. In 1996 an estimate of the costs of accidents attributable to alcohol consumption from the beginning of the 1990s was published (Hajnal 1996). It estimated that the total cost to society was around 2.8 thousand million HUF, which is 0.05% of the 1995 gross domestic product and 0.08% of total government expenditure in 1995.

Studies from the end of the 1980s and beginning of the 1990s looked at different aspects of social costs. A study between 1989-1990 of 3,000 people obtaining disability benefit from the medical committee found that 22.7% of the cases deemed to be justified had alcohol-related causes (Botos & Kulin 1991). 17.1% of sickness absence in a rural family practice was alcohol related and 10% was a direct consequence of alcohol consumption. The number of days sick for those who became ill because of alcohol consumption was 2.5 times those who had no history of alcohol problems (Pèter et al. 1989).

Summary

Comparison of these data with those from other countries is, again, very difficult because of different types of costs included and methods used. These results are best used to illustrate the extent of the costs related to alcohol within an economy and may thus help to advocate support for alcohol policy in a public health and social policy perspective and to counterbalance speculations about the economic benefits of alcohol (Lehto 1995c).

3.5 The impact of transition

The political and economic transition at the end of the 1980s and beginning of the 1990s also had an impact on alcohol issues.

Changes in availability

Rapid privatisation - a common phenomenon in Central and eastern Europe - first emerged in those sectors of the economy where it was easier to achieve; small

shops, bars and restaurants (WHO 1994a). The number of outlets increased rapidly leading to an explosion in availability of alcohol (Figure 11, Figure 12).

Figure 11 - Change in the number of retail outlets in Hungary

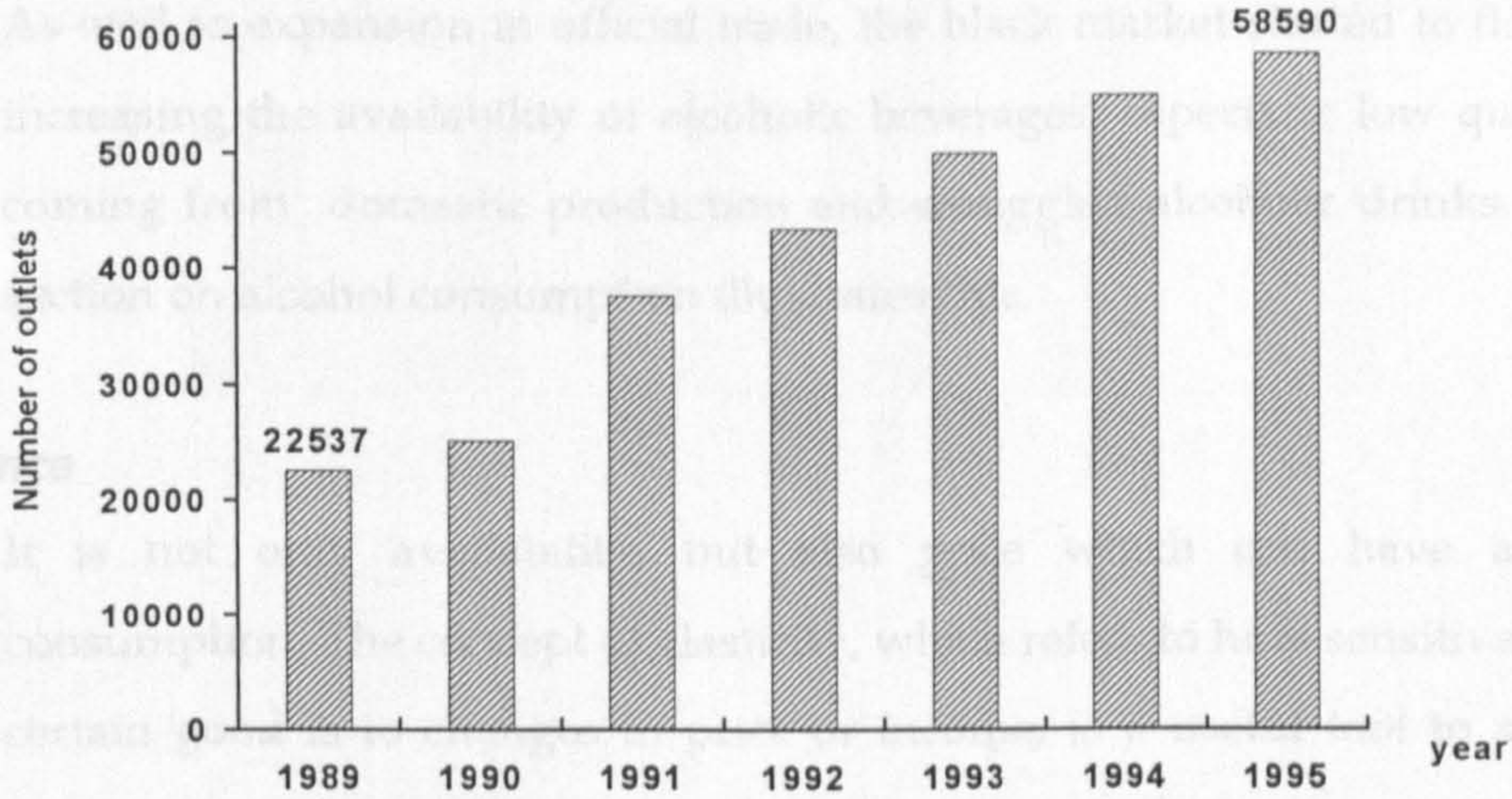
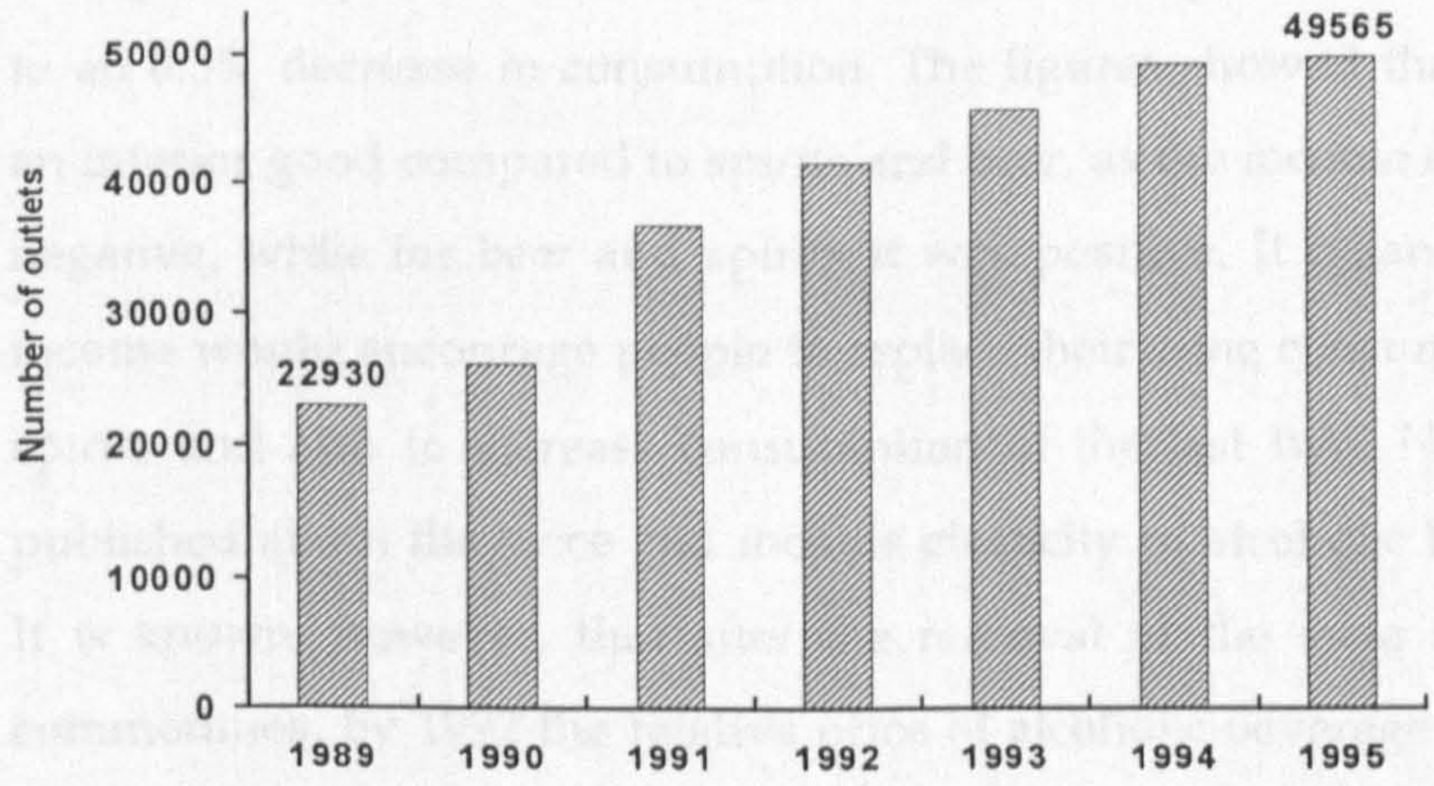


Figure 12 - Change in the number of catering units in Hungary



Source: CSO

Privatisation affect not only retail sales but also led to changes in production, wholesale, imports and exports, the last influenced by the destruction of the

previous common market - the COMECON (Council of Mutual Economic Assistance) - of the Communist Bloc countries. Multinational enterprises saw new market potential in these countries.

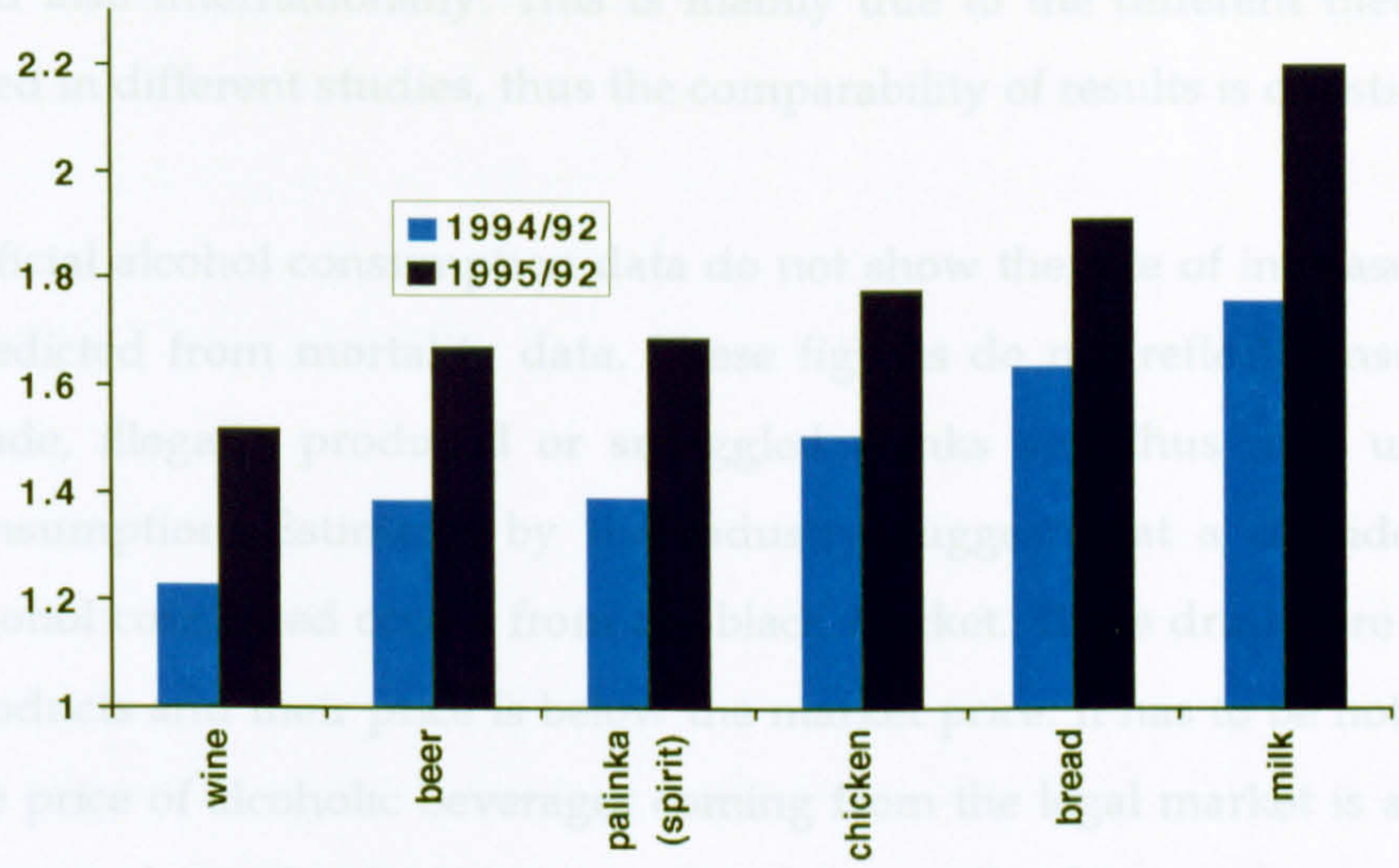
The black market

As well as expansion in official trade, the black market started to flourish, further increasing the availability of alcoholic beverages, especially low quality products coming from domestic production and smuggled alcoholic drinks. The previous section on alcohol consumption illustrates this.

Price

It is not only availability, but also price which can have an impact on consumption. The concept of elasticity, which refers to how sensitive demand for a certain good is to changes in price or income, is a useful tool to assess possible impact of change in price and income on alcohol consumption. The latest calculation of price elasticity of demand for alcoholic beverages was published for the period 1970-1984, when the retail price of alcoholic beverages rose less than the general retail price index. The price and income elasticity for wine was -0.08 and -0.47, for beer -0.77 and +0.58, for spirits -0.83 and +0.35 (Andorka 1986). For example, for spirits it meant that a 10% increase in price would be expected to lead to an 8.3% decrease in consumption. The figures showed that wine behaved like an inferior good compared to spirits and beer, as the income elasticity of wine was negative, while for beer and spirits it was positive. It means that an increase in income would encourage people to replace their wine consumption with beer and spirits and also to increase consumption of the last two. No studies have been published about the price and income elasticity of alcoholic beverages since then. It is known, however, that after the removal of the state subsidies from basic commodities, by 1992 the relative price of alcoholic beverages fell and stayed low compared to other basic items (Figure 13).

Figure 13 - Price index of different commodities in Hungary



Source: CSO

Summary

In summary, the transition period after the major political changes in 1989 brought about considerable changes in the whole economy. In the alcohol field the availability of alcoholic beverages increased considerably. It is also likely that the market share of alcoholic beverages from the black market increased.

3.6 Summary and conclusions

Mortality data suggest that alcohol related mortality is a major contributor to premature deaths in Hungary. The unprecedented rate of increase from chronic liver disease and cirrhosis mortality is not yet fully understood or explained, however, it is unlikely that it can be explained by the increasing prevalence of hepatitis B and C infection, thus alcohol remains the main factor to be considered. Data also suggest that men are more affected than women, particularly at middle ages.

Studies from general practices suggest that the proportion of deaths that are alcohol related is much higher than reflected by official mortality statistics, although these studies have major methodological weaknesses and an autopsy based estimate relying on medical records showed lower rates, which were closer to official figures.

Studies of alcohol related morbidity show a diverse picture both inside the country and also internationally. This is mainly due to the different methods and criteria used in different studies, thus the comparability of results is questionable.

Official alcohol consumption data do not show the rate of increase which would be predicted from mortality data. These figures do not reflect consumption of home made, illegally produced or smuggled drinks and thus may underestimate real consumption. Estimates by the industry suggest that a considerable amount of alcohol consumed comes from the black market. These drinks are often low quality products and their price is below the market price. It has to be noted, however, that the price of alcoholic beverages coming from the legal market is also relatively low compared to other basic commodities. A considerable increase in the availability of alcoholic beverages after the major political changes can also be observed.

The evidence summarised above should be considered more as warning signs about the extent of alcohol-related problems, rather then valid scientific evidence. Their results must be applied carefully and critically. In the past, in the countries of Central and Eastern Europe, including Hungary, there was a lack of sound public-heath oriented research, few epidemiological studies of chronic disease epidemiology, and gaps in methodological knowledge of scientific research. Thus one might not expect systematic research activity according to "western" standards on public health related issues, including alcohol-related problems. The Hungarian scientific literature about alcohol-related problems is very diverse and most of the studies do not follow rigorous methodological steps. The articles are rarely structured according to the classical pattern of introduction and research hypothesis, materials and methodology, results and discussion. Definitions of alcohol-related problems, alcoholism, alcohol addiction, hazardous or harmful level of drinking, quantity and frequency, units used and the exact sources of data are often missing.

This chapter summarised the extent of alcohol related problems in Hungary. The next chapter presents alcohol policy means to address alcohol related problems and alcohol policy is put into the broader policy context.

- *CHAPTER 3* -

ALCOHOL POLICY

In this chapter the definition of alcohol policy and the concept of comprehensive alcohol policy are first introduced. Second, different alcohol policy instruments which have an impact on the incidence of alcohol related problems are discussed. Third, the concept of policy, public policy, public health and health policy are summarised and alcohol policy is put into the context of these policies, providing the framework for further analysis and discussion.

1 Alcohol policy

Alcohol consumption leads to a wide range of different health, social and economic consequences (see Chapter 1). There is significant correlation between per capita consumption of alcohol and various indicators of alcohol related problems, such as alcohol related deaths and hospitalisation, drunkenness and drink-driving convictions, and road traffic accidents (Easton 1965, Ensor & Godfrey 1993, Kendell 1985, Rush et al. 1986, Smart 1987). In the following paragraphs an effort is made to clarify what alcohol policy is.

Different concepts of alcohol policy

Alcohol is widely considered as a public health problem requiring a policy response (Ashley & Rankin 1988, Beauchamp 1990, Edwards 1997, Luby 1969, Marshall 1988, Pratt 1981, Robertson 1990, Room 1984, Safonov 1985, Walsh & Grant 1985, Ziegler 1988). The concept of alcohol policy differs from country to country and authors discussing alcohol policy tackle different areas.

For example, in New Zealand, alcohol policy is associated with strategies on availability, taxation, advertising and education with a focus on adolescents (Laurs 1990). Maynard describes an integrated alcohol policy, which include raising taxes complemented by advertising controls and limits on availability (Maynard et al. 1994). A study of alcohol policies in a workplace in the US focused on alcohol availability and tackling drinking at work (Ames et al. 1992). An analysis of two alcohol control policies compared higher alcohol taxes and health warning labels (Kaskutas 1993). Holder tackles alcohol policy from the personal safety aspect,

such as family harm and disruption, violence, crime and traffic safety. He states that, from this perspective alcohol policy is concerned with the whole population as safety issues extend well beyond the individual drinker (Holder 1997). Another source, focusing on economic aspects of alcohol, defined alcohol policy as an intervention by state authorities in the production, trade and purchase of alcoholic beverages (Lehto 1995b).

The prevailing approach

These different aspect of alcohol policy are reviewed in the book "Alcohol policy and the public good" (Edwards & al 1994). This is based on the experience of different countries and brings together the available international scientific evidence about the use and effectiveness of alcohol policy. According to this review elements of an effective alcohol policy include

- taxation of alcoholic beverages,
- environmental measures, which influence physical access to alcohol,
- drink-driving countermeasures,
- other situationally direct measures (e.g. control of alcohol sales at sport facilities),
- school-based education, public education, warning labels,
- advertising restrictions,
- indicative personal drinking limits as a health education strategy,
- community action programmes, and
- the contribution which treatment can make to public health policies.

These elements contribute to the so called " policy mix" of alcohol policy in which most elements require national or macro level commitment as a prerequisite to operate effectively (see later) (Edwards & al 1994). The expression refers to combining different elements of the policy in an optimal way with the overall aim of reducing the occurrence of alcohol problems in a given cultural setting.

The approach reflected in the book by Edwards et al. is in accordance with the WHO recommendations that the overall strategy of alcohol policy must create an environment which helps people to make healthy choices and renders unhealthy choices more difficult or expensive (Harkin et al. 1995).

This broad approach to alcohol policy also means that alcohol policy should not focus only on "alcoholism", the alcohol addict or extreme physical illness, but should take into account the wide range of alcohol-related problems (Harkin et al. 1995). Because most alcohol related problems occur in association with moderate levels of drinking and in a society there is a strong correlation between the average level of alcohol consumption and the number of heavy drinkers, a comprehensive alcohol policy should combine measures to reduce overall levels of alcohol consumption with measures targeted towards heavy and high risk drinking (Anderson et al. 1994). Thus alcohol policy becomes relevant at the population level.

2 *Alcohol policy and its elements*

The following paragraphs discuss the interpretation of alcohol policy used in this study as well as elements of alcohol policy in relation to their effectiveness in controlling alcohol consumption and reducing alcohol related problems.

2.1 Defining alcohol policy

The definition of alcohol policy applied in this study builds upon the prevailing approach promoted by the WHO. It understands alcohol policy in its broad sense: a policy, which aims to reduce the burden of alcohol related problems.

For further discussion of alcohol policy, the concept of a comprehensive alcohol policy is introduced. It refers to a number of policy elements which are considered effective means to decrease overall alcohol consumption and the incidence of alcohol related problems. These elements are summarised in Table 5 and grouped according to their main impact.

The distinction of comprehensive alcohol policy might suggest a higher normative value to this policy compared to other alcohol policies. This assumption, however, is not in accordance with the original aim of this distinction. This terminology is rather

introduced to refer to the prevailing international approach to alcohol policy as compared to approaches of earlier periods.

Elements of a comprehensive alcohol policy (alcohol policy according to the prevailing international approach) operate in combination with each other. Consideration of a comprehensive alcohol policy assumes the presence or at least consideration of all the discussed policy means (Table 5) and how they relate to other public policies (see later). The lack of such a comprehensive policy, however, does not mean the lack of any alcohol policy.

Table 5 - Elements of a comprehensive alcohol policy

Reducing consumption	
♦ Controls on production	state monopoly
♦ Price control	taxation on beverages
	taxation on marketing
♦ Availability	in general
	number and density of outlets
	opening hours
♦ Training of servers	
♦ Minimum drinking age	
♦ Control on advertising	
♦ Mass media campaign	
♦ Primary prevention	information dissemination
	education (creating norms)
Preventing harmful consequences of alcohol	
♦ Primary prevention	information dissemination
	education (creating norms)
♦ Treatment	alcoholism (alcohol abuse and dependence)
	alcohol-related diseases (directly or indirectly)
♦ Control on drink-driving	
♦ Control at workplaces	

2.2 Elements of alcohol policy and their effectiveness

The various elements of a comprehensive alcohol policy are summarised in the following paragraphs. Evidence is provided about the effectiveness of each.

2.2.1 Price control - taxation

Integrated policies to raise taxes in relation to price and income changes have significant impacts on alcohol consumption (Adrian et al. 1996, Bruun et al. 1975, Clement & Selvanathan 1991, Godfrey 1986, Maynard et al. 1994, Ornstein 1980, Partanen 1991). A decrease in price has been shown to be associated with an increase in cirrhosis mortality, the most commonly used indicator for the prevalence of heavy drinking (Caetano 1983, Cook 1981, Cook & Tauchen 1982, Cook 1982). Increasing tax on alcoholic beverages has also been shown to be an effective policy in reducing deaths from alcohol related motor vehicle accidents (Grossman 1989, Saffer & Grossman 1987, Sloan et al. 1994).

Social distribution and penetration

The impact of price changes on the distribution of drinking within society is not homogeneous. A pricing strategy has important equity implications, as there are differences among social classes, age-groups and genders (Molyneux 1993). Indirect taxes, such as those on alcohol, are normally regressive and so impose a proportionately greater burden on the poor. There is, however, some evidence from New Zealand, the UK and the US, that this is less so for alcohol taxes than for other indirect taxes (Ashton et al. 1989, Harris 1984).

There is also evidence that heavy drinkers are more sensitive to price changes than are moderate drinkers (Babor et al. 1978, Coate & Grossman 1988, Grossman et al. 1986, Kendell et al. 1983a, Kendell et al. 1983b, Marmot 1997, Wette et al. 1993).

Elasticity of alcoholic beverages

The relative effectiveness of price policies can be measured as the price and income elasticity of demand for certain kinds of beverages. At the aggregate level it can be seen that there is a close inverse relationship between price relative to disposable income and consumption in volume terms. The policy implication is that price and income have significant effects on the consumption of alcohol (Maynard et al. 1994). One type of drink can also substitute for another (Klingemann 1989). Therefore changes in price of one product have an influence on the consumption of others. This is described as cross-price elasticity. It has usually been found to be modest (Godfrey 1986, Ornstein & Levy 1983, Paciullo 1983, Partanen 1993). In

Sweden in 1992 it was observed that changing taxes on alcohol sold in state stores to a system based on absolute alcohol content led to a shift away from those products that became relatively more expensive (Ponicki et al. 1997).

Table 6 - Price elasticities of beer, wine and spirits (Edwards & al 1994)

Author	Country	Time	Beer	Wine	Distilled spirits
Queck (1988)	Canada	1953-82	-0.28	-0.58	-0.30
Johnson et al (1992)	Canada	1956-83	-0.26 to -0.31 -0.14	-0.70 to -0.88 -1.17	-0.45 to -0.82 NA
Clements & Selvanathan (1987)	USA	1949-82	-0.09	-0.22	-0.10
Selvanathan (1991)	USA	1949-82	-0.11	-0.05	-0.11
Eecen (1985)	Netherlands	1960-83	0.0	-0.5	NA
Labys (1976)/EEC (1972)	Belgium	1954-71	NA	-1.14	NA
Labys (1976)	France	1954-71	NA	-0.06	NA
Labys (1976)	Italy	1954-71	NA	-1.00	NA
Labys (1976)	Portugal	1954-71	NA	-0.68	NA
Labys (1976)	Spain	1954-71	NA	-0.37	NA
Labys (1976)	Germany (Fed.Rep.)	1954-71	NA	-0.38	NA
Wong (1988)	UK	1920-38	-0.25	-0.99	-0.51
Walsh (1982)	UK	1955-75	-0.13	-0.28	-0.47
Clements & Selvanathan (1987)	UK	1955-75	-0.19	-0.23	-0.24
Mc Guiness (1983)	UK	1956-79	-0.30	-0.17	-0.38
Duffy (1983)	UK	1963-78	NA	-1.0	-0.77
Godfrey (1988)	UK	1956-80	NA	-0.76 to -1.14	-0.88 to -0.98
Duffy (1987)	UK	1963-83	-0.29	-0.77	-0.51
Selvanathan (1991)	UK	1955-85	-0.13	-0.40	-0.31
Baker & McKay (1990)	UK	1970-86	-0.88	-1.37	-0.94
Duffy (1991)	UK	1963-83	-0.09	-0.75	-0.86
Salo (1990)	Finland	1969-86	-0.6	-1.3	-1.0
Clements & Selvanathan (1987)	Australia	1956-77	-0.12	-0.34	-0.52
Clements & Johnson (1983)	Australia	1956-77	-0.11	-0.40	-0.53
Selvanathan (1991)	Australia	1956-85	-0.15	-0.60	-0.61
Clements & Selvanathan (1991)	Australia	1956-86	-0.15	-0.32	-0.61
Pearce (1986)	New Zealand	1966-82	-0.15	-0.35	-0.32
Wette, et al (1993)	New Zealand	1983-91	-1.1	-1.1	-0.5
Partanen (1991)	Kenya	1963-85	-0.33 -1.00	NA NA	NA NA

The actual price elasticity differs from country to country and with the type of alcoholic beverage (Table 6) (Edwards & al 1994). Beer consumption was found to be less sensitive to price changes than other beverages. Wine consumption was found to be the least sensitive to price changes in France among all the countries studied, and one study from the USA also reported a very low price elasticity of

wine. Distilled spirit consumption is more sensitive to changes in price than beer. In the UK the elasticities of wine and spirits are considerably higher than that of beer.

Changing price and taxation

Changing price through taxation is one of the most common means of alcohol control policy. It has different forms, such as taxes on purchases of goods (sales tax, VAT) or on company profits. Some authors have suggested taxing companies' promotional expenditure. In most countries marketing costs are counted as production costs. Industry is normally obliged to pay taxes only on that part of the income that exceeds production costs. Thus, by increasing marketing costs an industry can decrease its taxes (Anderson et al. 1994).

Impact on state revenue

The alcohol industry might contribute to central and local government revenues in several ways. It can take the form of excise duties, VAT, corporate tax, income tax and social security contributions or import duties for drinks imported from abroad (Molyneux 1993). A change in the price of alcoholic beverages has an impact on revenue. It has to be noted though, that when the price change is incorporated into the production and distribution costs, state revenue will be proportional to the impact of consumption. Thus, if the price change is due to taxation, in most cases it would raise revenue even when the demand is price elastic and total expenditure on alcohol goes down. Only in situations when the tax rate already is high are added taxes likely to reduce revenue when consumption goes down (Edwards & al 1994). It is also likely that long-term effects of changes in price may be greater than their immediate effects (Ornstein & Levy 1983).

Harmonisation within the EC

The European Community has tried to harmonise alcohol taxation in its member states, but has only succeeded in setting minimum tax rates. The minimum rates from 1 January 1993, are:

- for wine (still and sparkling) ECU 0,
- for beer ECU 0.748 per hectolitre/degree Plato, or ECU 1.87 per hectolitre/degree Plato of alcohol of finished product,

- for intermediate products (beverage with alcohol content under 22% and not belonging to the group of wines or beers) ECU 45 per hectolitre of product,
- for spirits ECU 550 per hectolitre of pure alcohol (Member states which apply a duty not exceeding ECU 1000 per hectolitre of pure alcohol may not reduce their national rate and Member States which apply a duty exceeding ECU 1000 rate per hectolitre of pure alcohol may not reduce their national rate below ECU 1000) (Anderson et al. 1994).

Adverse effects of taxation

Taxation of alcohol might have adverse economic effects. If the price of alcohol features in the general consumer index, to which a wide variety of benefits and wages are often linked, a rise in alcohol prices could exert an inflationary pressure on the national economy. Second, it could lead to growing cross-border trade and resulting loss of government revenue if price differences between neighbouring countries become too great. Third, alcohol taxes are regressive, having greater impact on the poor than the rich, though as noted earlier not all studies have found this (Grant 1982). Fourth, it can encourage black-market activities (Lehto 1995a, Lehto 1995c, Partanen 1993).

These adverse effects on black market activity, such as cross-border smuggling, illegal or semi-legal production and trade, can be particularly important in Central and Eastern Europe. There, partly because of the lack of effective control, during the transition period, illegal and semi-legal market activities increased (WHO 1994a).

In the absence of effective regulation and control there are many related problems (WHO 1994a), such as:

- large scale smuggling and exploitation of loop-holes in legislation relating to trade and import,
- trade in low-quality alcohol, sometimes with dangerous levels of methanol and other impurities, and
- an inability of the authorities to collect taxes and to control the quality of a large proportion of the alcohol consumed.

Summary

In summary, pricing is an effective mean of alcohol control, although taxing may cause some adverse effects. These effects are, in general, not significant, but in the countries of Central and Eastern Europe their impact on black market activities needs special attention because of the lack of legal enforcement.

2.2.2 Availability

There is evidence that a major decrease in the availability of alcoholic beverages results in a decrease of total consumption but especially of alcohol-related problems. This has been shown during strikes of retail workers (Östenberg & Säilä 1991), in war-time (Ledermann 1964) and during anti-alcohol campaigns in the USSR in 1985-87 or in Poland in 1981 (Levin & Levin 1990, Partanen 1993, Wald & Moskalewicz 1984). Among adolescents (age 16-18) in the US, perceived alcohol availability was significantly associated with higher levels of alcohol consumption for males (Jones Webb et al. 1997).

Restrictions in time

In Sweden and Norway an experimental Saturday closing of liquor retail stores resulted in a reduction in alcohol sales and in the number of arrests for drunkenness and domestic disturbances. Total consumption of alcohol, however, remained the same (Nordlund 1985, Olsson & Wikström 1982). A trial of Saturday closing in ten Alko shops in Finland for eight months lead to a small decrease in total alcohol consumption, but, as in the above studies, public drunkenness and alcohol-related violence declined considerably (Edwards & al 1994).

Impact on alcohol-related problems

Hospital admissions

Strikes by retail workers in Finland (1972, 1985) and in Sweden (1963) were associated with a decrease in public drunkenness and the number of hospital admissions due to alcoholism (Östenberg & Säilä 1991).

Accidents and crime

Some studies found that introduction of on-premise (off-licence) sales or an increase in the number of outlets was inversely related to the number of road traffic accidents. A possible explanation provided by the authors was that with the increasing availability the driving distance decreased (Caetano 1983, Colon & Cutter 1983, Smart 1976). Also in the US, in a study of seventy five counties, no significant relationship was found between the number of licensed outlets and motor vehicle fatality rates for men at age 15-24 (Kelleher et al. 1996). When geographical distribution is also taken into consideration studies show different results. In Los Angeles County, in a study of the density of outlets and alcohol related motor vehicle accidents, increased alcohol availability was associated with increased alcohol-related motor vehicle accidents (Scribner et al. 1994). In California a spatial analysis of drinking and driving and alcohol related accidents found that physical availability (number of outlets and minimum drinking age) was unrelated to self-reports of driving after drinking and driving while intoxicated, but it was related to rates of single vehicle night-time accidents (Gruenewald et al. 1996).

The conflicting results of the literature can be reconciled in that, when geographical distribution of outlets are taken into consideration, in most studies an association with the number of motor-vehicle accidents and violence was described. When crude data are analysed the association cannot always be observed.

Cirrhosis of the liver

A number of studies have reported a positive relationship between liver cirrhosis mortality and the number of alcohol outlets (Colon 1981, Donnely 1978, Parker et al. 1978, Rush et al. 1986), though causality could not be proved (McDonald & Whitehead 1983). Using American data, a beverage specific effect of distilled spirits sales on cirrhosis mortality was described (Gruenewald & Ponicki 1995). In Australia, two states with different changes in the number of outlets over time were compared. A higher number of outlets was associated with a significant increase in cirrhosis mortality but also a significant decrease in male driver and motorcyclist mortality (Smith 1989).

Retail monopolies

In a number of countries a licence is required to sell alcohol. The aim of licensing is to ensure that outlets implement regulations on sales, such as age limits, opening hours, days and controls on the quality of on-promise (off-licence) outlets (Anderson et al. 1994). Some American states, Canada and the Nordic countries have state monopolies for retail sales of alcoholic beverages. In America the main aim is to increase state revenue, while in the Nordic countries it seeks to promote public health objectives (SYSTEM BOLAGET). In the USA, Iowa put an end to its spirit retail monopoly in 1987. The privatisation of retail spirit sales led to a 6.1% increase in price, but the purchase of spirits outside the state did not increase, according to self-reported data (Fitzgerald & Mulford 1993). It led, however, to an increase in spirit and a decrease in wine consumption (Holder & Wagenaar 1990). In the Nordic countries state monopolies control also production not only retail.

Since 1997 state monopolies of the Nordic countries have faced challenges in the European Court of Justice to abolish their production and retail monopolies, although they now appear secure (Chenet et al. 1997). Despite that state monopolies in Finland and Sweden have been going through gradual, but considerable restructuring.

Summary

These studies show that restrictions in the availability of alcoholic beverages have an overall beneficial impact on alcohol consumption and alcohol related harm. The impact is altered by the attitude of the population to the policy change. Findings are conflicting concerning the effect of alcohol availability on motor vehicle accidents.

2.2.3 Servers` training and responsibility

Servers` training and responsibility

Servers` training and responsibility, as separate policy instrument, have been proposed by some authors, in particular with regard to decreasing drunk driving and alcohol related accidents and injuries (Farrell 1989, Mosher et al. 1984, Saltz & Stanghetta 1997, Single 1993, Single & Tocher 1992). Compulsory training for all

alcohol servers in Oregon was found to be associated with a lower level of alcohol-related traffic accidents (Holder & Wagenaar 1994). Server training appeared to be more effective if it was linked with training for managers and changes in serving and sales practices (Saltz 1993, Saltz & Stanghetta 1997)

Server liability

Server liability has also been proposed as a preventive policy to encourage safer practices (Holder et al. 1993, Saltz & Stanghetta 1997, Wagenaar & Holder 1991). It is supported by evidence that the frequency of service interventions was influenced by the number of visits and warnings by law enforcement authorities (Edwards & al 1994). Primarily server liability is a reactive approach which, by putting responsibility on the server, warns that serving an intoxicated person may result in a personal loss or injury.

Summary

Server training seems to increase responsible practice. It can be reinforced by introducing a legal liability on servers. The available scientific evidence about the effectiveness of these policy elements suggests a favourable effect on alcohol related harm, but further studies of their effectiveness are needed.

2.2.4 Minimum drinking age

Studies examining the impact of changes in minimum drinking age have been undertaken in the United States, Canada and Australia. In the United States the minimum legal drinking age was reduced from 21 to 18 in 1972. This reduction led to both an increase in alcohol-related accidents among young drivers and an increase in alcohol consumption (Wagenaar 1981, Williams et al. 1983). A similar reduction in Toronto also led to an increase in alcohol-related motor vehicle accidents (Whitehead et al. 1975). Concerns about the effect of youth drinking on road accidents led to the age limit being raised again to 21 in the United States (Wagenaar et al. 1993). The national increase in minimum drinking age was accompanied by lower levels of alcohol use among high school seniors and recent high school graduates. Road traffic accidents among drivers under age 21 fell (O'Malley & Wagenaar 1991). A subsequent telephone survey following the

increased age limit in New York State showed a short term drop in consumption (Williams & Lillis 1988). In Australia the male juvenile crime rate increased after the minimum drinking age was lowered to 18 (Smith & Burvill 1987).

Summary

In summary, increasing the minimum drinking age is associated with favourable changes in alcohol related problems among juveniles

2.2.5 Advertising

The basic aim of advertising is to maintain or increase the demand for alcoholic beverages, so it must be regarded mainly as threat to an alcohol policy which aims to decrease alcohol related problems. Smart concludes that advertising has a weak effect on alcohol consumption (Smart 1988). Mass media campaigns alone have shown little short-term effect in changing behaviour among the majority of the population (Hewitt & Blane 1984, Kohn & Smart 1984, MacKenzie et al. 1996, Moskowitz 1989, Partanen & Montonen 1988). The experimental advertising ban for 14 months in British Columbia or the total ban in Norway and Finland were not associated with clear short-term effects on overall alcohol consumption (Partanen & Montonen 1988, Smart 1988). In Saskatchewan, Canada, lifting a 58 year ban on advertising of alcoholic beverages had no impact on total alcohol sales (Makowsky & Whitehead 1991).

In contrast, Partanen and Montonen concluded that it is equally clear that advertising powerfully shapes and maintains views on the place of alcohol in social life. It depicts drinking as a normal part of life and negative consequences of alcohol use are ignored (Partanen & Montonen 1988).

Advertising expenditure appears to influence demand for beer, wine and spirits, although the elasticity is quite low (0.05) and does not differ between different types of beverages. These values suggest that compulsory reductions in advertising are likely to have only marginal effects on total alcohol consumption (deRyck & Kegels 1993). This view is expounded by the alcohol and advertising industry.

Findings from recent studies which analyse the impact of variations in restrictions on alcohol advertising suggest that advertising may reinforce or weaken overall trends in alcohol consumption (Makowsky & Whitehead 1991). Marketing theory suggests that advertising can only increase consumption in markets that have not reached maturity. In mature markets advertising can only redistribute brand shares (deRyck & Kegels 1993).

The impact of alcohol advertising is more likely to have effects in the long-run, which are difficult to measure, rather than in the short-run, about which more evidence is available. Macro-economic studies in the UK and Australia found a modest relationship between advertising and alcohol sales (Selvanathan 1989, Smith 1990). An international comparison of seventeen OECD countries examined the impact of broadcast advertising between 1970-1983. Countries were grouped into three categories: those with total bans, those with bans on spirits and those without any ban. In the observation period alcohol consumption increased in all countries, but the rate of increase was lowest in countries with total bans. In these countries motor vehicle accidents also decreased the most (Saffer 1991).

A study of advertising in EC countries categorised advertising activities by the place of advertisement: television, radio, cinema, newspaper, magazines, outdoor, sponsorship; and by the type of restriction: banned by law, banned voluntarily, restricted by law, restricted voluntarily, permitted. In most of the EC countries there are bans or restrictions on alcohol advertising. In Luxembourg and Greece in 1992 there were no restrictions on any platforms (Denig 1993). A summary table shows regulations in selected countries of the European Union (Table 7) (Britton & McKee 1998).

The EC has issued a directive on "the co-ordination of television broadcasting activities" setting out criteria for televised broadcasting of alcoholic beverages, such as the need not to create the impression that consumption of alcohol contributes towards social and sexual success, to claim that alcohol has therapeutic qualities, or to emphasise a high alcohol content as being a positive quality of the beverage, etc. (EC 1989, Lehto 1995a). Three Pan-European self-regulatory codes (industry codes) also exist, drawn up by the CBMC (Confèderation des Brasseurs du Marchè

Commun), FIVS (Fèderation International des Vins et Spiritueux) and UEAES (Union Europeane des Alcools, Eux-de-Vie et Spiritueux) (Denig 1993).

Table 7 - Bans, restrictions on advertising in countries of the EU

	Austria	**Denmark**	**Finland**	**France**	**Germany**
Advertising ban	national TV, radio	radio, TV	strong beverages (22% volume)	TV, cinema, restrictions on other media	German Advertising Standards Authority
Voluntary advertising control	voluntary code	voluntary code for media			
	Italy	**Netherlands**	**Spain**	**Sweden**	**UK**
Advertising ban	restrictions on TV by Min. of Communication		TV, radio above 20% vol after 9.30 p.m. other alcohol is allowed	total ban except light beer	
Voluntary advertising control		voluntary for all media	voluntary code for printed media		voluntary code for all types

Summary

Although theory suggests that advertising of alcoholic beverages is likely to affect the level and pattern of alcohol consumption and attitudes to it, the available evidence to support this view is weak. There are several difficulties in measuring the impact of advertising. One is that its effect cannot be separated from other cultural, social and economic factors. Impact assessment is restricted to measurable, direct effects, often only in the short-term. Long-lasting indirect effects of advertising and its impact on consumption in immature markets, however, can not be ignored.

2.2.6 Education

Numerous programmes exist for the primary prevention of alcohol problems. Almost all rely upon educational approaches. These programmes target primarily younger age-groups as patterns of behaviour are established early in life (Shanks 1990), but can be implemented in a variety of settings (Moskowitz 1989).

There are two main types of educational-prevention models. The first is the social influence model, which teaches people specific skills for resisting the social influences promoting alcohol use and conveys knowledge of alcohol related

problems and harm. The second is generic skills training, which provides general individual competence as means of reducing motivation to engage in substance abuse (Botvin et al. 1989).

Educational programmes have been largely ineffective in preventing substance abuse. Whereas many programmes are effective in increasing knowledge, very few influence attitudes and even fewer influence practice (Moskowitz 1989).

Education programmes

Alcohol education may embrace a variety of goals such as promoting abstinence, delaying onset of use, teaching "responsible use" or avoiding negative consequences. There has been little consensus as to which goal is most appropriate (Braucht & Braucht 1984). Education programmes can be divided into two major categories: knowledge-based programmes focusing on facts and skill based or social influence approaches (Anderson 1995). Knowledge based programmes focus on disseminating information about the possible dangers related to substance use. These programmes were found to be effective in increasing knowledge in the short term, but there was no evidence of the effectiveness of these programmes in preventing alcohol use (Bagnall 1990, Goodstadt 1986, Shope et al. 1996). An Italian study found no effect of a school-based alcohol education programme on use and knowledge (Donato et al. 1996). Skill-based, social influence approaches focus on self-understanding and responsible decision making. This type of drug or alcohol education was found to reduce student alcohol use in the short term (Schlegel et al. 1984). A four-country study found that peer-led, school-based alcohol education was effective in reducing alcohol use regardless of the setting (Paciullo 1983, Perry & Grant 1991, Perry et al. 1989). Evidence of the effectiveness of skill-based education programmes is encouraging, but further studies are needed.

There appears to be a consensus that programmes combining a number of different strategies are most promising (Hansen 1992). In South Carolina (US) the combination of an education programme with a media component was found to have more effect on knowledge and attitudes of 10th and 11th grade students in the short term (Collins & Cellucci 1991).

Alcohol education can be delivered not only to young people in schools, but also to adults and in other settings. A prison-based American education programme lead to improvements in alcohol related knowledge and attitudes after release of prisoners (Crundall & Deacon 1997). Another example is an initiative to provide education for low-income pregnant women with computer-based interactive multimedia (Kinzie et al. 1993).

Mass media campaigns

Many mass media campaigns advocate "moderate" alcohol use. They have included: strategies for reducing intake, such as switching to non-alcohol beverages (Barber et al. 1989); portrayal of the negative effects of intoxication or chronic use, such as impaired sexual performance, which was the subject of a French campaign; and portrayal of the positive consequences of moderate use, such as sporting ability or enhanced sexual attractiveness (Wallack 1981). The last showed that awareness of safe drinking levels has been increased but had no demonstrable impact on consumption (Budd et al. 1983, Lefler & Clark 1990). Some campaigns that attempted to prevent alcohol misuse and promote responsible use showed no changes in alcohol-related knowledge or behaviour (Wallack & DC 1982-83). Another common theme has been that of avoiding drinking and driving (Hewitt & Blane 1984). In Canada anti-drink driving campaigns had some knowledge gains and positive changes in self-reported behaviour (Vingilis et al. 1988). In Australia a forceful television advertisement combined with the introduction and enforcement of strict drinking laws and speed limits produced a large reduction in deaths from road traffic accidents (Homel 1988b, Powles & Gifford 1993). Studies concur in findings that most campaigns showed limited effect on the recipient's beliefs and attitudes and little impact on self-reported drinking as a consequence of exposure to these campaigns (Blane & Hewitt 1980, Moskowitz 1989, Wallack 1980). It seems also that anti-drink-driving messages are easier to communicate.

Summary

The effectiveness of education and information dissemination programmes is difficult to assess. There is weak evidence about their effectiveness in influencing

attitudes and consumption. There is more support for their effectiveness in increasing knowledge.

2.2.7 Programmes at workplaces

Alcohol at workplaces leads to several problems, such as lost productivity, increased turn-over rates of employees, absenteeism and accidents. Alcohol policies at workplaces focus on education, problem recognition and treatment (Henderson et al. 1996). A study from the US examined the effect of implementing a workplace alcohol policy and treatment for alcoholism. Following treatment the health care costs of treated alcoholics declined considerably (Holder & Blose 1992). The success of minimal intervention packages, when clients get brief information about the possible dangers related to alcohol consumption and a sensible level of alcohol intake, also proved to be effective. They led to a reduction in alcohol consumption and fewer episodes of heavy drinking (Anderson & Scott 1992, Wagenaar 1981, Wallace et al. 1988). Similar results were shown in the multinational WHO brief-intervention trial (Babor & Grant 1992). The Brief Intervention Package was developed for general practitioners and was tested in a primary health care setting. These programmes cost significantly less than inpatient care.

Few workplace programmes are prevention oriented (Nagaratnam et al. 1984, Nathan 1983, Nathan 1984). Stress management programmes are the most popular programmes in the US and they may be effective in reducing physiological and psychological indicators of stress (McLeroy et al. 1984). Studies of effectiveness of workplace education programmes give varying results (Cyster & McEwen 1987, DeHaes & Schuurman 1975).

Summary

Workplace alcohol policies, particularly treatment focused ones, lead to decreased health care costs and brief intervention programmes lead to reduced alcohol intake. The effectiveness of these programmes is difficult to assess with routine data, as company records may not be the most useful for assessment. Some costs of health promotion in the workplace, for example, can be unrecognised. There are methodological difficulties in assessing long-term effects.

2.2.8 Control on drink-driving

Drink-driving control measures include setting a legal limit of blood alcohol concentration (BAC) for drivers, enforcement of law and punishment. Education and information dissemination has been discussed in previous sections.

Where the legal limit of BAC was increased, reductions in accidents and injuries were observed (Drummond et al. 1987, Hingson et al. 1988, Hingson et al. 1996). The legal level in several countries in the European Union are summarised in Table 8 .

Table 8 - Legal limits of blood alcohol concentration for drivers in countries of the European Union

	Austria	**Denmark**	**Finland**	**France**	**Germany**
Legal BAC limit	50mg%	80mg%	50mg%	80mg%	80mg%
	Italy	**Netherlands**	**Spain**	**Sweden**	**UK**
Legal BAC limit	80mg%	50mg%	80, 50, 30mg%	20 mg%	20mg%

Reviews of law and law enforcement have shown that the certainty of detection is the most effective tool to prevent drink-driving (Homel 1988a, Ross 1982). The positive effect of regular random breath testing was demonstrated in Australia after 1982, when it was included into routine police practice. The number of fatal and alcohol-related accidents decreased (Homel 1988b, Homel 1993). An experimental random breath testing programme in the Netherlands lead to a reduction in the number of drivers who had blood alcohol levels above the legal limit. Reviews of punishments conclude that licence suspension is the most effective tool against drink-driving (Peck et al. 1985, Voas et al. 1997, Waller 1985). This was similarly found in Australia, the United States and the Nordic countries (Homel 1981, Zador et al. 1989). The strategy of the designated driver, which refers to the situation when a group designates a particular member not to drink and drive on an occasion, was criticised because it encourages heavy drinking among other members of the group (DeJong & Wallack 1992).

2.2.9 Summary

There are several policy elements which help to decrease alcohol consumption and the incidence of alcohol related problems. Research suggests that increasing price of alcoholic beverages, controlling physical access, controls on drinking and driving and provision of brief intervention in primary health care settings, are more effective policy means than prevention and management of alcohol problems at workplaces or control of advertising and education programmes.

The policy instruments discussed operate mainly at a macro (national/country) level and few can be implemented locally without high level support (Table 9).

Table 9 - Alcohol policy means and their operation level

Alcohol policy means	Operation level	
	Country/macro	Regional or local/micro
♦ Price control	xxxxx	
♦ Availability	xxxxx	xxx
♦ Training of servers	xxxxx	xxx
♦ Minimum drinking age	xxxxx	x
♦ Control on advertising	xxxxx	
♦ Education, information dissemination	xxx	xxxxx
♦ Mass media campaigns	xxxxx	xx
♦ Control at workplaces	xx	xxxxx
♦ Treatment	xx	xxxxx
♦ Control on drink-driving	xxxxx	x

Most of the policy elements discussed require a legislative framework within which implementation and enforcement can take place (Sabroe 1993a). Thus, a comprehensive alcohol policy has to be embedded in the legislation.

Furthermore, it has to be noted that when alcohol policy is considered the possible impact of different policy actors and the policy context in which it develops and operates can not be ignored. Alcohol policy is directly or indirectly formulated and implemented by policy actors, such as those in the criminal justice system, the alcohol industry, professionals dealing with alcohol related health and social problems, as well as government. It exists in a historical, cultural, social, political

and economical context. These considerations lead to the third section of this chapter in which alcohol policy as a policy is considered and put into a broader policy context. The section aims to draw a frame work, which can be used for the further analysis of alcohol policy in Hungary.

3 *Defining policy, public policy and health policy*

First, the notion of policy as a broad concept is defined, which leads to the concept of public policy. Second, public health policy is placed in the context of other public policies. Third, where health policy fits into this concept and how these different elements relate to each other are discussed. Finally the place of alcohol policy in this framework is addressed.

3.1 Policy

The word "policy" has various interpretations. The Oxford English Dictionary defines it as *"a plan of action, statement of aims and ideals"* (Crowther 1995). Authors dealing with policy issues define policy in various ways, highlighting the complexity of the concept. Some argue that policy is related to a purposive course of action involving a chain of more or less related activities and a series of decisions. This is influenced by personal, group, organisational and other circumstances (Anderson 1975, Harrop 1992, Hogwood & Gunn 1984, Walt 1994). Policy also involves implementation. Sub-processes, sub-decisions feed into policy and the policy process may change over time (Hogwood & Gunn 1984).

Bachrach and Baratz, and Heclo, argue that policy involves inaction as well as action. In their approach, policy behaviour includes involuntary failures to act and deliberate decisions not to act (Bachrach & Baratz 1962, Heclo 1972). Drawing on the work of Heclo, a policy can consist of what is not being done (Heclo 1972).

A modern interpretation is that policy is an attempt to do something about a problem, and as such it is a rational manifestation of judgements. Parsons summarises it thus *"a policy is an attempt to define and structure a rational basis for*

action or inaction. Policy as a term becomes the expression of political rationality. To have a policy is to have rational reasons or arguments which contain both a claim to an understanding of a problem and a solution. It puts forwards what is and what ought to be done. A policy offers a kind of theory upon which a claim for legitimacy is made. In liberal democratic systems political elites have to give rational reasons for what they purpose or what they have done. We expect governments to have "policies" (Parsons 1995).

Drawing on these approaches, in this study, policy is defined the following way :

Policy is a course of action or non-action, decisions or non-decisions which target a problem and a purpose related to the problem. Policy involves - using the stagist approach (Hogwood & Gunn 1984, Parsons 1995) - stages of problem or issue statement, planning, implementation and evaluation, but the lack of the sequential order of these stages does not imply the lack of policy.

3.2 Public policy

Milio describes public policy as being about decisions which shape contemporary environments in communities, workplaces, homes and schools. Public policy sets parameters for the mode and character of, for example, industrial and agricultural production, corporate management and individual behaviour (Milio 1981). She builds a link between health policy and public policies by explaining how different public policies have an impact on health. In her approach, policies in a wide range of spheres, including economics, the environment, energy, farms and food, contribute to public policy, and have some health impact. As public policy is not only an influence on but also an extricable and critical part of the current and future environment, it is a crucial variable affecting the health of the population. In other words, elements of our environment - in their broad sense - have an impact on health. Because public policies are concerned with this environment, they affect the health of the population.

Another approach focuses more on the place and level where public policies are formulated. Hogwood and Gunn, in their attempt to define policy, constantly refer to public policy. They conclude, that for a policy to be regarded as a public policy, it

must, to some degree, have to be generated or at least processed within the framework of governmental procedures and organisations (Hogwood & Gunn 1984). According to Walt, policies, which are developed by governmental bodies and officials, and thus focus on purposive action by or for governments, can be considered public policies. Public policy analysis is concerned with the formal institutions of government, which provide the structure within which the public policy process takes place (Walt 1994).

There are two major elements in these approaches. One is that public policies are policies which, in their own sector, have an impact on all aspects of the environment. By their nature they are macro policies (see later). The other is that public policies have much to do with the leadership of large administrative units (e.g. the European Union, countries, federations), so that their impact can be broad, reaching each individual in the society. Thus, in summary, public policies are made for the public and they are usually in the domain of governments.

3.3 Public health policy

Different public policies are directly or indirectly related to each other and they may overlap in content. As public policies have health impacts (Milio 1981), and because public health deals with processes of mobilising local, national and international resources to ensure the conditions in which people can be healthy (Detels et al. 1997), it is argued that the difference in content between public policies and public health policy is marginal. The difference is rather in its focus.

Elements of public health policies are closely related to other public policies. As such, the task of public health policy is to address public health consequences of different public policies and to ensure an overall coherence around this task and between public policies. When we relate to a specific public health policy, such as sanitation, AIDS, tobacco, or alcohol policy, the task becomes "clearer" and the specific public health policy acquires its content through which it becomes linked to other public policies. For example, the content of alcohol policy refers to all the policy instruments which can have a favourable impact on health and social damages related to alcohol consumption. The mix of different policy instruments,

such as price and availability, requires alcohol policy to be linked to other public policies, such as fiscal and tax policy and market regulation.

Differentiating between health and public health policy

There is no consensus in the literature as to how to differentiate public health policy from health policy. Authors who write about health policy most often are concerned with policies closely related to preventive or curative health care, health and social services (Björkman & Altenstetter 1998, Soliman 1993). Walt, in her analysis of the policy process, uses examples which are mainly related to health care, health and social services (Walt 1994).

Public health policies deal with the health of the public. Their focus often goes beyond a disease, beyond health care. Public health policy is directed at underlying determinants of health which require intersectoral and multidisciplinary action (Huttner 1997). Studies referring to public health policy deal with a wide range of issues, such as lifestyle factors, tobacco, alcohol, drugs or poverty.

Thus the difference between health and public health policy is that, in public health policy, the focus is not mainly or exclusively on the health sector. Therefore a division is proposed that differentiates the two according to policy focus. Public health policy focuses on all sectors which have a health impact. This approach is similar to the public health concept, which defines it as a discipline based around tasks (Lewis 1991). Health policy, however, focuses on the health sector. Thus health policy can be considered being a part of public health policy.

3.4 Summary

The relations of policy, public policy and public health policy are summarised in Figure 14. In terms of their scope, public policies arise in a particular sector and influence the wider environment. They have the potential to reach all members of society. They deal with a public issue, and are formulated at the macro level and thus are the domain of government. It should be noted, however, that the use of the term "sector" suggests a degree of boundary definition which may not be sustained

when we attempt to draw sharp dividing lines, such as between economic, foreign and defence policy. Many public policy sectors, such as economic or agricultural policy, are defined subjectively. It is the individual observer who perceives boundaries. The selection of public policy areas in the figure is arbitrary and follows Milio`s concept. Other policy areas could equally be included. In practice, drawing boundaries between public policy areas reflects administrative considerations, thus in a given administrative context they can be considered generic terms.

Table 10 - Focus, targets and formulation of different types of policy

Type of policy	Policy	Public policy	Public health policy	Health policy
Focus	anything	public issue	health of the public	health of people with certain medical condition(s)
Target population	varies	broad segment of the population (potentially each individual)	broad segment	broad segment, but more people with medical conditions
Formulation	varies	government	government (ministry of health, ministry of public health, other)	government, ministry of health

As Figure 14 and Table 10 show policy, is a broad concept. Policy can be developed for many things, by different agents. Public policies relate to public problems, that involve a broad segment of the population. It has to be added, though, that the private sector has an often considerable impact on the formulation of public policies. Public policies are directly or indirectly related to each other and they often overlap.

Public health policy is a public policy which is concerned with the health of the public. It is closely linked to several public policy areas, such as social and environmental policy, and is also related to other public policies, though the link may be less obvious. Public health policy includes health policy, but it also covers areas other than health care.

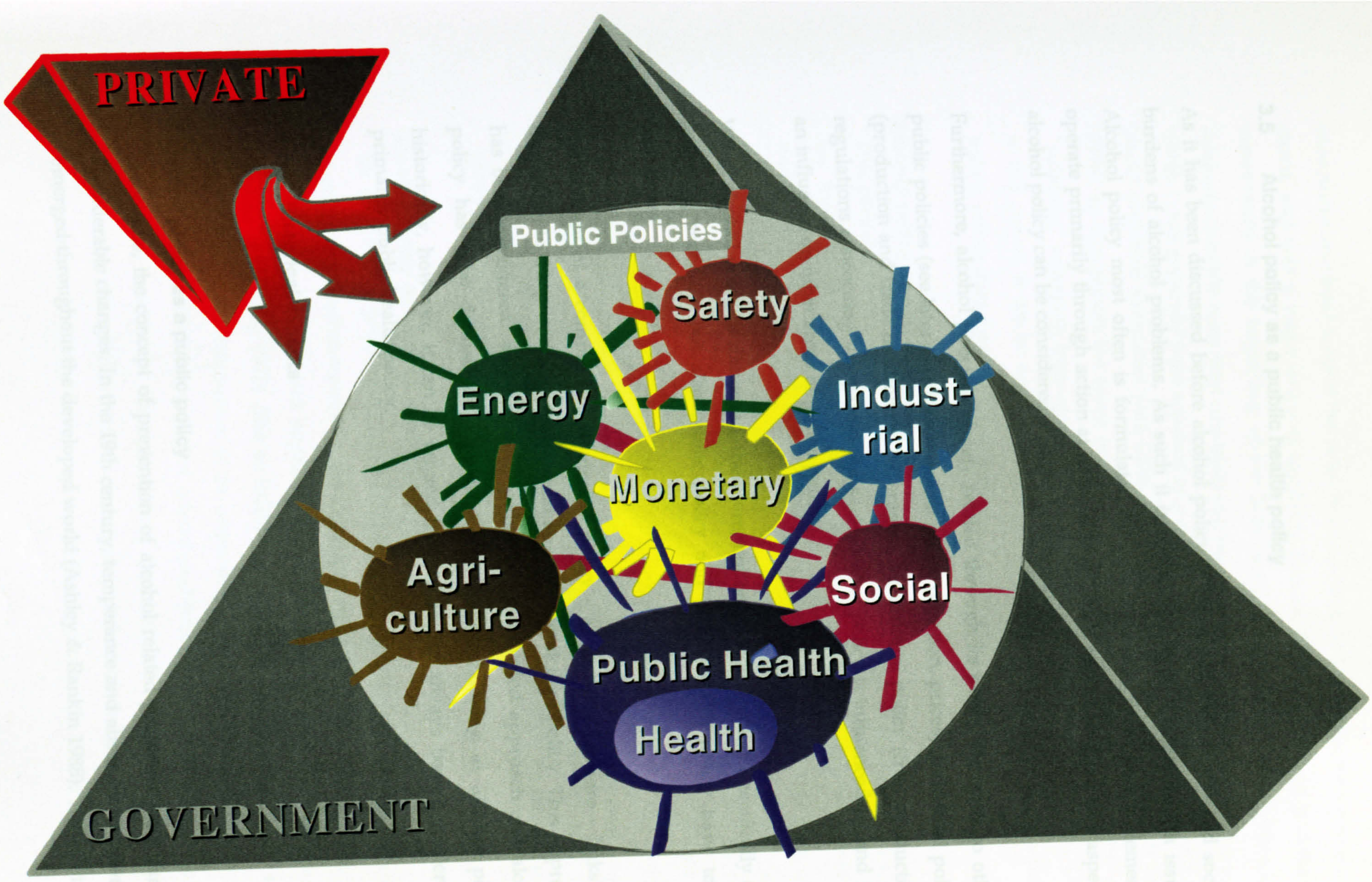


Figure 14 - Public policy, public health and health policy in the policy environment

3.5 Alcohol policy as a public health policy

As it has been discussed before alcohol policy is concerned with health and social burdens of alcohol problems. As such it is considered to be a public health issue. Alcohol policy most often is formulated by government as most policy elements operate primarily through action at national level. With regard to these two aspects alcohol policy can be considered a public health policy.

Furthermore, alcohol policy is closely related through its policy elements to other public policies (see later), such as financial policy (taxation, prices), industrial policy (production and trade of alcoholic beverages), agricultural policy (fruit production, regulations concerning vineyards). As such alcohol policy is influenced by and has an influence on other areas of public policy.

When alcohol policy is discussed, therefore, not only alcohol policy specifically (see following sections), but also public policy and public health policy have to be considered.

The concept of a comprehensive alcohol policy - as discussed before - links the discussion to the prevailing international approach to alcohol policy. This approach has been considered as a primarily public health oriented approach and alcohol policy has been defined as a public health policy. Looking at alcohol policy historically, however, it can be argued that it has not always been considered a primarily public health policy.

3.7 Historical aspects

Alcohol policy as a public policy

Over time, the concept of prevention of alcohol related problems went through considerable changes. In the 19th century, temperance and abstinence movements emerged throughout the developed world (Ashley & Rankin 1988). The abstinence

movement was built around the belief that alcohol was a problem for anyone who drank and was a major cause of suffering (Levine 1978). It fed into prohibition movements in the beginning of the 20th century. One of the most prominent examples was the American constitutional ban on alcohol in the 1920s (Bruun et al. 1975). It has generally been assessed as a failure, but during prohibition health and social problems associated with alcohol use dramatically reduced (Popham et al. 1976). In this period the focus was on a general concern towards the "sin" and "suffering" emerging from alcohol use rather than the health of the public. Thus, in this period, it can be argued that alcohol policy moved towards being a public policy, rather than a public health policy.

Alcohol policy as a health policy

This period was followed by the rise of the disease concept of alcoholism, in which the focus of concern shifted towards those who drank excessively. From the middle of the 20th century until the 1970s the emphasis in many countries of the industrialised world was on education to restrain harmful drinking and on the identification, treatment and rehabilitation of "problem drinkers" (WHO 1976). The disease concept of alcoholism was summarised in the works of Jellinek and some of his followers (Jellinek 1960). This concept encouraged the separation of "normal drinkers" and "alcoholics". The model still has widespread popular acceptance and is the view promoted by the alcohol industry (EUROCARE 1995). The disease oriented, treatment focused concept of alcohol problems moved alcohol policy towards a health policy concept.

Alcohol policy as a public health policy

By the 1970s a growing number of publications emphasised the importance of overall alcohol consumption on the development of alcohol related problems and urged a population based approach (deLint & Schmidt 1968, Ledermann 1964, Makela 1971, Skog 1971). The so called "population consumption model" argues that a change in consumption at the population level leads to changes in outcome measures, in other words alcohol related problems emerge with increasing levels of alcohol intake. At the same time, because differences in the pattern of distribution of alcohol intake between populations with similar levels of consumption is thought to be quite small, an increase in the average level of

alcohol consumption generally leads to an increase in the prevalence of heavy users (Edwards & al 1994, WHO 1976). This approach achieved increasing acceptance over time and was first acknowledged by the WHO in 1976 (WHO 1976). By the beginning of the 1990s it became broadly accepted that the focus of alcohol policy should be on the health, social and economic harm imposed on society by alcohol consumption. Hence, the concept of alcohol policy became linked with public health policy.

3.8 Summary

The nature of policy and public policy has been discussed and it is argued that public health policy is a public policy which is inclusive of health policy. Alcohol policy at present is considered a public health policy. It has been acknowledged, however, that this concept has changed over time. This concept is provided as a framework for further analysis.

The discussion of alcohol related problems in Hungary presented in Chapter 2 and the review of alcohol policy in this chapter leads to the discussion to the next chapter, where the analytical framework for alcohol policy analysis is presented.

- CHAPTER 4 -

ANALYSING ALCOHOL POLICY

THE FRAMEWORK

Previous chapters examined alcohol as a biochemical substance and a risk factor, introduced the wide range of alcohol related problems and summarised the extent of alcohol related problems in Hungary. The means to address these problems were introduced and put into a broader policy context. The development of alcohol policy in the industrialised world was reviewed and the prevailing approach to alcohol policy as a public health policy was presented. Elements of a comprehensive alcohol policy were listed and their effectiveness, based on the scientific evidence, was assessed.

1 "A PRIORI" of the analysis

As we saw above alcohol policy is a broad and complex concept and alcohol related problems are diverse. In the analysis of alcohol policy in Hungary - based on the discussions above - there are several concepts which are considered implicit.

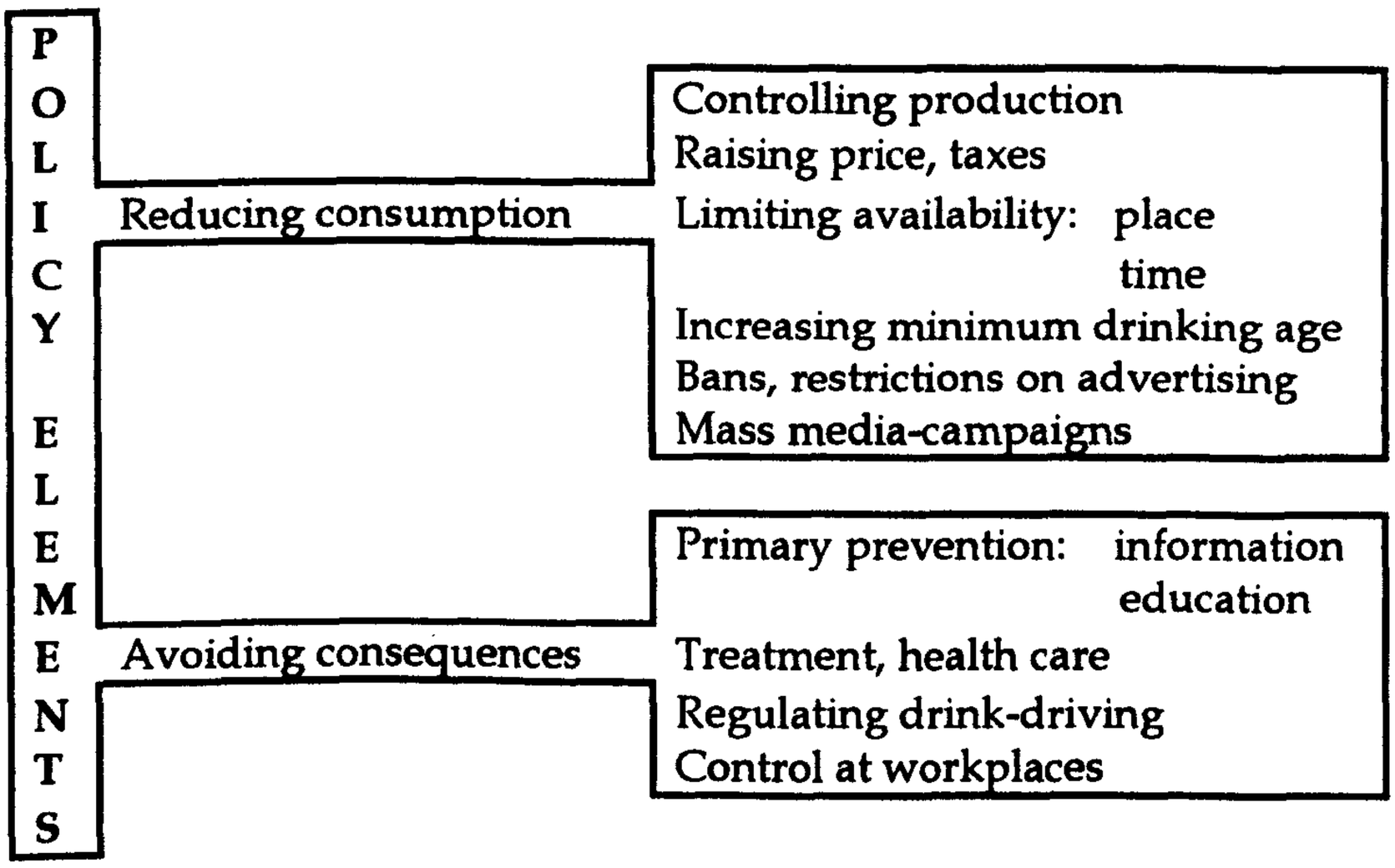
- If measures of outcome of alcohol related problems show an increasing trend an effective alcohol policy can be assumed not to have been implemented.
- There are different alcohol policy elements which can effectively contribute to a decrease in the incidence of alcohol problems.
- These policy elements, as part of the policy mix and in accordance with other public policies, contribute to a comprehensive alcohol policy.
- The aim of a comprehensive alcohol policy is to decrease the incidence of alcohol related problems in society.
- The optimal policy mix can be determined if the scale of alcohol related problems, local conditions and feasibility of different policy means are assessed, together with contextual factors.

2 Rationale

The rationale for this analysis was provided in Chapters 1-3. In summary:

- Alcohol, according to the available evidence, is among the leading threats to the health of the Hungarian population, and is a significantly more important factor than in neighboring countries.
- Alcohol consumption in Hungary has major social and economic consequences.
- There is no evidence that an effective alcohol policy is in place, as outcome measures provide evidence of underlying dysfunction in the policy.
- There are policy means which lead to positive changes in alcohol related problems (Figure 15). In combination they can provide a comprehensive policy.
- Effective alcohol policies have to take into consideration evidence and must be based on careful assessment of the alcohol policy environment.
- Policies must be adapted to the situation in Hungary and should not be imported without adequate understanding of the context within which they develop.

Figure 15 - Elements of a comprehensive alcohol policy



Before formulating policy it is necessary to have a detailed knowledge of the policy environment. This has even more relevance in a country like Hungary, where changes have occurred rapidly. It was, and still is, difficult to follow the newly established political environment. The rapid economic changes and the transition to market economy also contribute to the current situation. Hungary is part of the region of Central and Eastern Europe, which is undergoing a unique transition process and a better understanding of policy making in this region is crucial. Foreign experts, international organisations and donors are also present and have a considerable influence on public health programmes. Analysis of the policy environment will be crucial for the success of new policies and will help at the interface between local and foreign experts. As far as can be ascertained an analysis of alcohol policy has not so far been taken under in any of the Central and Eastern European countries.

In the political sphere in Hungary, alcohol as a problem has become increasingly acknowledged. In the beginning of the 1990s the National Committee to Prevent Accidents was established with the support of the Ministry of Transport, Ministry of Internal Affairs and the Police. It deals with road safety issues, including drink driving measures (OBB 1997b). There is a new World Bank funded project whose development started in the autumn of 1997, with a focus on alcohol and tobacco policy in Hungary. It is supported by the Ministry of Welfare, as are other projects launched under the aegis of the Modernisation of Health Care Project supported from the World Bank loan (NIHP 1998, Republic of Hungary & WB 1993). These suggest that this analysis is relevant and timely and can feed into policy development.

Analysing alcohol policy may help policy formulation in other areas of public health. Understanding the underlying mechanisms of agenda setting, the policy making process, the public health policy environment, and the interests and influence of actors provides useful knowledge, some of which can be generalised and applied in other public health areas as actors often overlap. It raises awareness of the importance of such analysis in other public health areas.

3 The nature and scope of the analysis

3.1 "Of" or "for", "description" or "prescription" ?

Before undertaking policy analysis there are two issues which have to be considered. The first is the nature of the analysis. Ham and Hill talk about analysis of policy and for policy (Ham & Hill 1984). This is the first major question. Some studies are conducted from a rather academic viewpoint, at one remove from the policy making process, others are conducted with the direct intention of producing practical results, that will lead to implementation of change. In this thesis analysing current and previous alcohol policy leads to proposals for the future.

Hogwood and Gunn, writing about policy analysis, differentiate between description - how policies are made - and prescription - how policies should be made (Hogwood & Gunn 1984). Descriptive models address the question of what is there. They try to describe the shape and pattern of the world. Regardless of whether they are based on the rational or the incrementalist model of policy analysis, they describe reality in terms of deviation from perfect rationality. Prescriptive models ask the question of what ought to be there. This approach points towards the possibility of reaching greater rationality. Advocates of rational policy making, such as Simon and Dror, are conceptually linked to the theory of management which presupposes some degree of rationality in the structure of organisations, in which reasoning helps to reach agreed goals (Dror 1967, Simon 1960, Simon 1983). The prescriptive model contrasts with the incremental theory of policy making, associated with Lindblom, according to which rational planning has little role in shaping the policy process (Lindblom 1959, Lindblom 1980). It is instead shaped by incremental adjustments, with the interaction of many influences, by bargaining, negotiating and compromising. This reflects the value placed by most pluralist liberal democracies on consensus seeking.

Assuming that the outcome measures examined earlier can be considered to demonstrate the lack of a comprehensive alcohol policy, trying to analyse a comprehensive policy looses meaning. Analysing successive changes in the legislation, the presence or absence of key elements and the attitude to these elements in the past helps one to understand the policy context. Although this information does not indicate what type of alcohol policy is feasible and whether it can or cannot be adopted in Hungary at the end of the 20th century, knowledge of why previous policies have failed points to what might be feasible. The aim of this analysis is to provide guidelines for public health and, specifically, alcohol policy makers about what should be considered and what difficulties they may face when trying to formulate and implement a comprehensive alcohol policy. In this sense it aims to be the analysis not only *of* but also *for* policy making. By describing the historical context in which alcohol policy has developed, it seeks to offer a prescription for how it can be taken forward. The possibility that a comprehensive alcohol policy does not exist because of inaction is considered in the analysis when feasibility issues are addressed.

3.2 At what level?

The second question is the level of the analysis. Ham and Hilll distinguish three possible levels: micro, middle-range and macro (Ham & Hill 1984). Micro level analysis looks at decision making within a single organisation. Middle-range analysis deals with a set of organisations and their policy formulation, whereas macro level analysis considers political systems, including the role of the state. Walt makes another distinction (Walt 1994). She differentiates macro policies, or high politics issues and micro policies, or low politics issues. The first relates to issues which matter for everyone, which involve long-term objectives of the state and of those in power. The second involves more localised, sectoral issues and interests.

This analysis focuses on alcohol policy at the national level. The study is undertaken at the macro level and it deals with high-level politics. There are three main reasons doing so.

(1) Alcohol related problems are defined at the national level. Although regional variations occur, there are little data on this.

(2) Most elements of a comprehensive alcohol policy cannot be implemented at regional or local level unless empowering steps have first been taken at a national or supra-national level, especially in a highly centralised country such as Hungary.

(3) A national alcohol policy is a basis for regional and local policy making.

4 Main questions

The analysis seeks to answer the following question:

- Which alcohol policy elements exist in Hungary in terms of decreasing the burden of alcohol related problems? How do they operate?
- Who are the actors involved in alcohol policy at the national level? What is their understanding of alcohol policy, and what position do they have in the policy arena?
- What is the broader policy context of alcohol policy in Hungary (major alcohol policy movements of the past, legislative framework, institutional setting and networks)?
- What are the major characteristics of the policy making process which may render successful implementation of a policy in the Hungarian context?
- Which alcohol policy mix can be feasible and effective in Hungary?

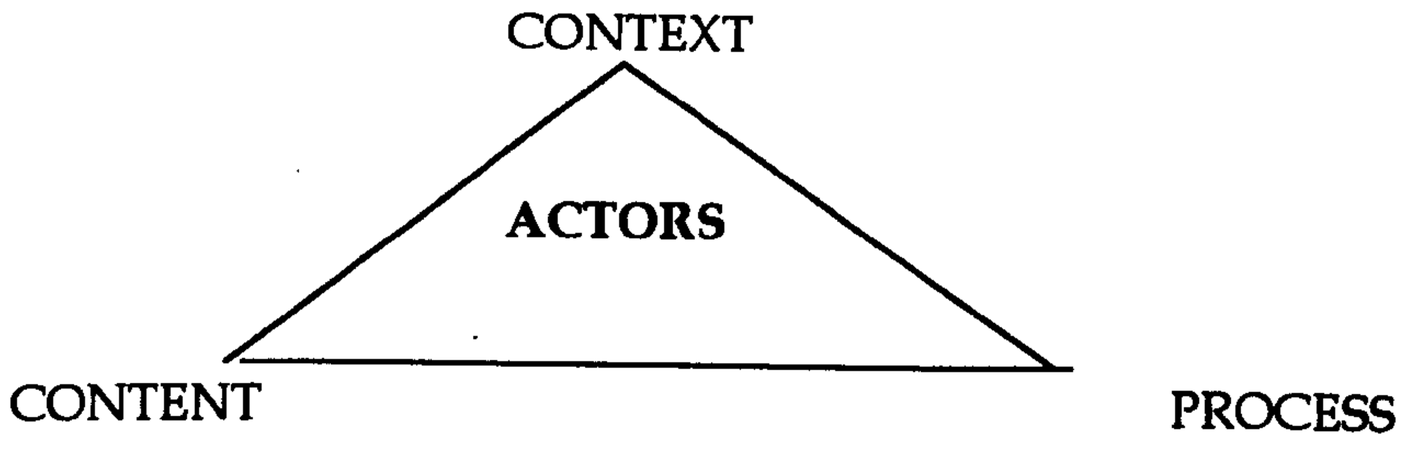
5 Policy analysis framework

To analyse alcohol policy issues in Hungary, the framework by Walt and Gilson was used. Analysis of policy actors followed the approach of political mapping and stakeholder analysis (ODA 1995, Ogden 1996, Reich 1993). The means of data collection were qualitative. Documentary review, semi-structured interviews and participant observation were used.

5.1 The framework

The policy triangle framework sees execution of policy as an integral part of the policy process (Figure 16). In this approach attention is placed equally on the content of the policy, on the context in which policy is introduced, the process by which policy is formulated, implemented and evaluated and the actors who are affected by, and influence policy content, context and process (Walt 1994, Walt & Gilson 1994).

Figure 16 - The policy triangle

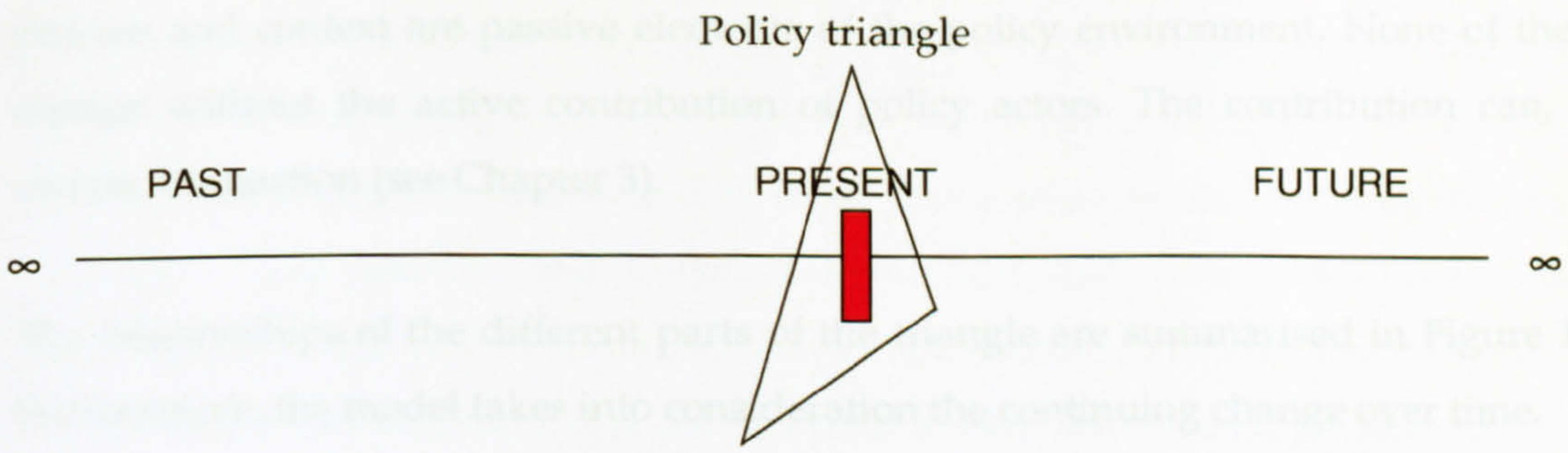


The triangle indicates that these parts of policy are connected. Isolating one from the other is often difficult and misleading. It is a broad framework covering all major aspects of policy. Its use ensures that the major elements of the policy environment are not omitted.

5.2 The third dimension - time

The policy triangle, as a cross-sectional picture, refers to the present. The analysis aims to be not only descriptive but also prescriptive. As such it refers to future, thus it extends the triangle forward in time, which assumes continuity. Historical continuity, however, also implies a link with the past. Time as the third dimension of analysis is represented in Figure 17.

Figure 17 - Third dimension - time



5.3 Four parts of the triangle and alcohol policy

The content of a comprehensive alcohol policy is discussed in Chapter 3, section 2. It examines the scientific evidence about which alcohol policy elements lead to a decrease in the incidence of alcohol related problems, thus providing the basis to determine the content of a comprehensive alcohol policy.

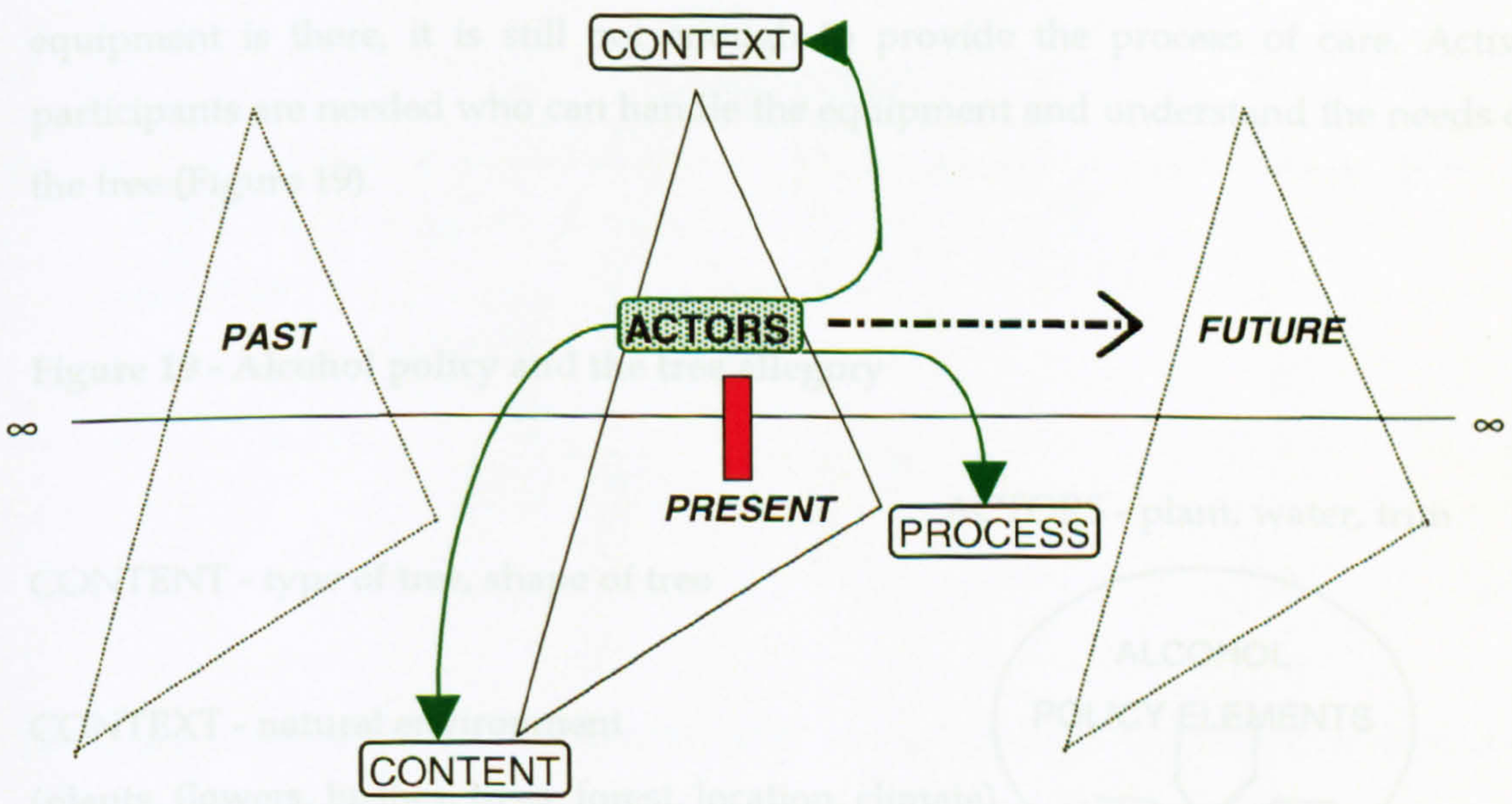
The context of a comprehensive alcohol policy refers to the policy environment in which the policy has to develop. This requires exploration of questions of narrow policy context, such as past and present policy initiatives, institutional, organisational arrangements, legislation and the formal authorisation of a policy. The narrow policy context, however, is part of a broader historical, cultural, social, political, and economic context, which influences it. Some authors see contextual factors as the most important parts of the public policy making process (Rose 1990). Even in a changing political environment, these factors cannot be ignored, as such structures are most often modified by changing political circumstances, rather than swept away.

The process deals with questions about how policy is formulated and implemented. This question can be addressed partly through the examination of the historical context of alcohol policy making and partly by analysing the present situation, from

Actors are in the middle of the triangle. Policy actors are individuals or groups whose interests are affected by the policy. As a result they may participate in the policy process in a direct or indirect way (Walt & Gilson 1994). Unlike the other three components, they constitute the only active part of the triangle. The policy content, process and context are passive elements of the policy environment. None of them change without the active contribution of policy actors. The contribution can, of course, be inaction (see Chapter 3).

The relationships of the different parts of the triangle are summarised in Figure 18. Furthermore, the model takes into consideration the continuing change over time.

Figure 18 - The active and passive parts of the triangle

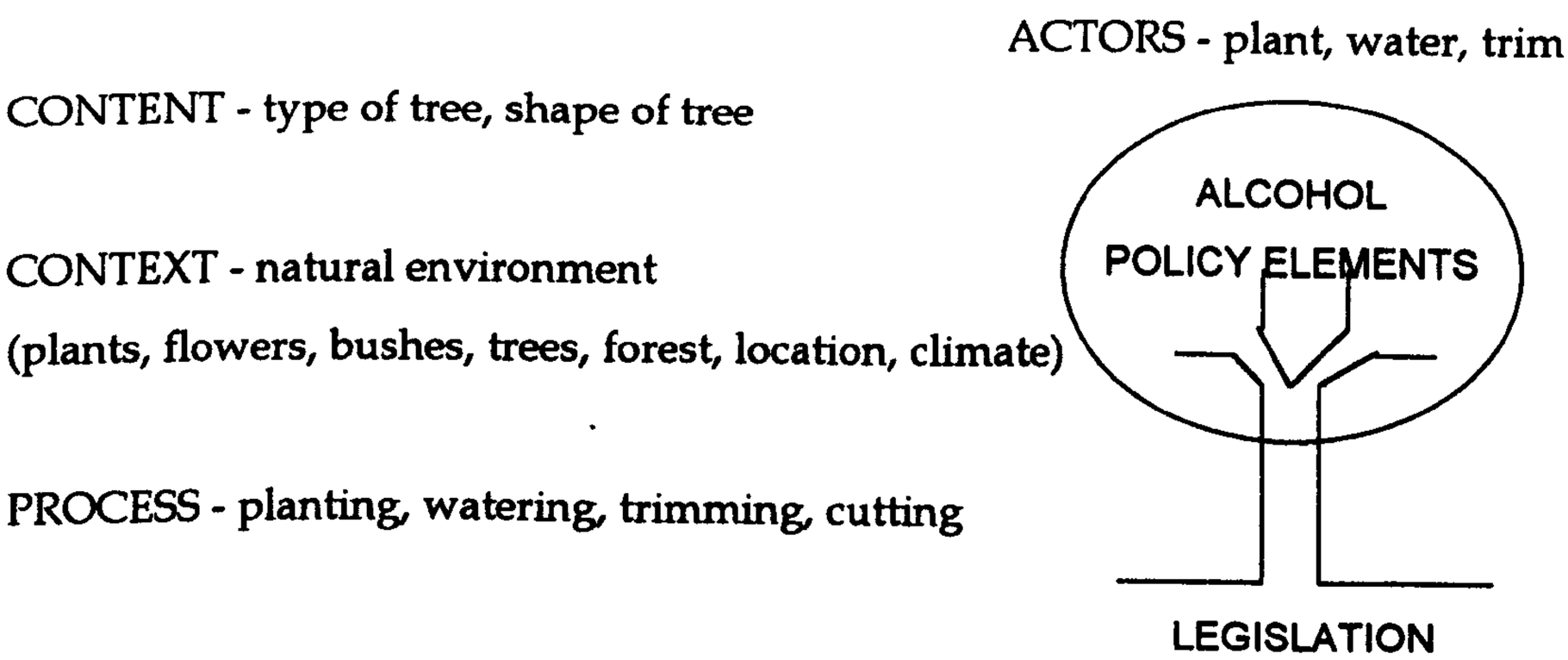


5.4 The policy triangle and alcohol policy reconciled - the "tree" allegory

By the end of the 20th century in the industrialised world alcohol policy was defined as a public health policy (see Chapter 3). Alcohol policy was considered comprehensive if certain elements of the policy are present or considered. It was also argued that the framework of an alcohol policy should be laid down in legislation.

Policy can be considered as a tree. Without legislative roots, the tree of alcohol policy cannot thrive. The type of tree indicates what type of public health policy is being considered. In this case it is alcohol policy. The arrangements of the branches and their unique combination provide the shape of the tree, which reflects the mix of different alcohol policy elements. The tree grows in the context of the natural environment, which is determined by other plants and objects, the location, and the climate. These provide the setting for the tree and also shape the external appearance of the tree. Without the active contribution of actors, however, the tree will not be planted. Even if it is planted from a seed, which is dispersed into the air accidentally by the wind and then into the soil, the tree may die if conditions are not optimal. Even if the tree stays alive and grows, a well-shaped and healthy tree may not emerge except by careful trimming and watering. Even if the technical equipment is there, it is still not enough to provide the process of care. Active participants are needed who can handle the equipment and understand the needs of the tree (Figure 19).

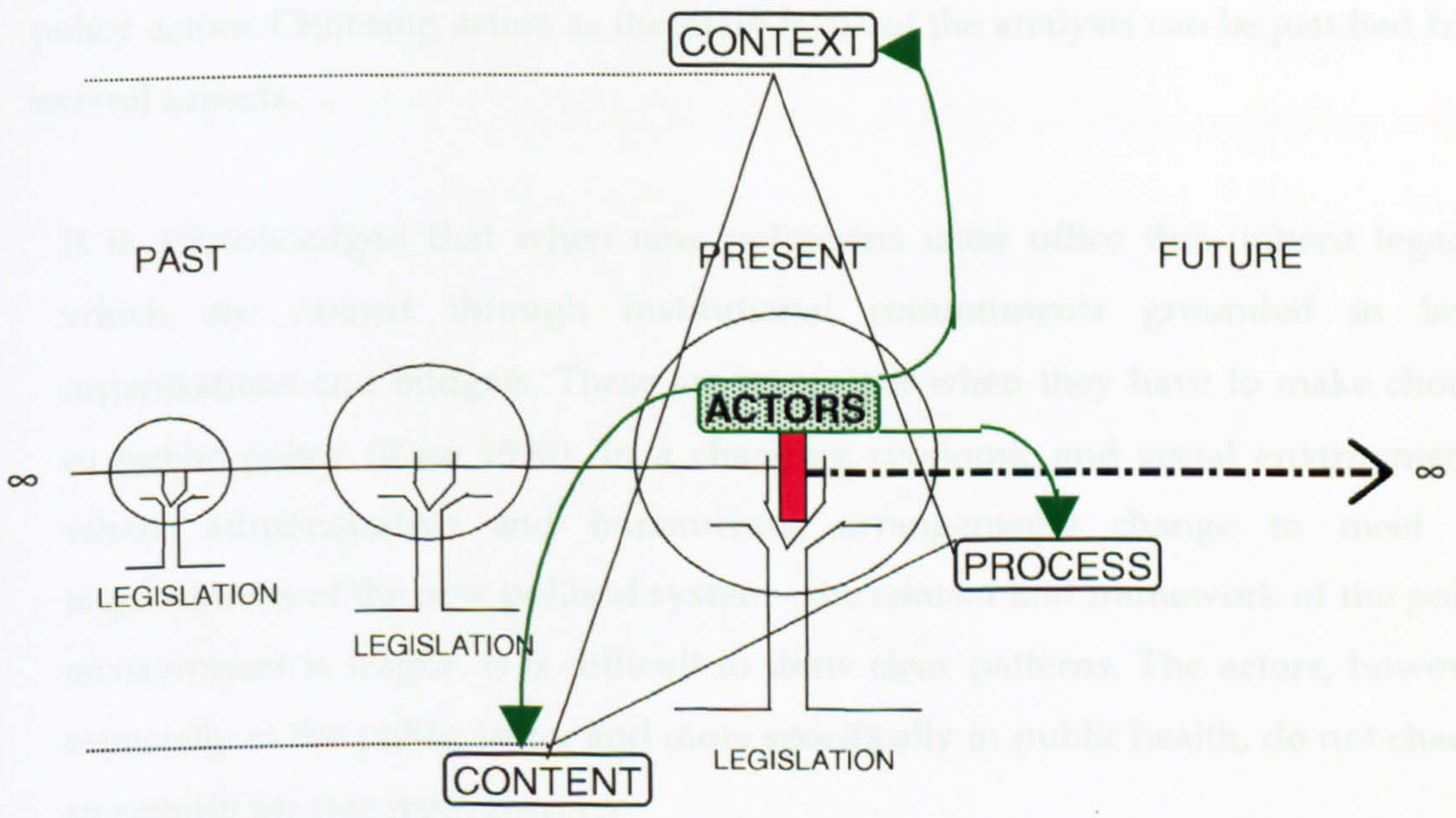
Figure 19 - Alcohol policy and the tree allegory



5.5 The final framework

Analysis of alcohol policy in Hungary includes previous alcohol policies as well as the existing situation, which is the basis for further development (Figure 20).

Figure 20 - The tree of alcohol policy and the policy triangle framework



The analysis first looks at the root of the tree, or the legislative framework as it refers to each of the major policy elements in the past and present (Chapter 5).

Second, the trunk and he branches of the alcohol policy tree are analysed again both in past and present, involving study of alcohol policy documents relating to the development of alcohol policy in the post-war period (Chapter 6). The official organisational structure at the national level and previous institutional changes in the alcohol policy field are discussed (Chapter 6). Finally the broader policy context, characteristics of public policy and the development of public health policy in Hungary are summarised (Chapter 7). These three parts lead from the past to the present, each addressing questions of policy content, context and process together.

Third, analysing the present situation focuses on alcohol policy actors, active contributors to the policy environment (Chapter 8) .

5.6 Focus on actors

The historical analysis build up to the present. The present is a critical point, from where future policy develops. Against a background of continuing change, especially in a country in transition, analysis of current alcohol policy focuses on policy actors. Choosing actors as the main focus of the analysis can be justified from several aspects.

It is acknowledged that when new politicians enter office they inherit legacies which are carried through institutional commitments grounded in laws, organisations and budgets. These are important when they have to make choices in public policy (Rose 1990). In a changing economic and social environment - where administrative and bureaucratic arrangements change to meet the requirements of the new political system - the context and framework of the policy environment is fragile. It is difficult to draw clear patterns. The actors, however, especially in the public sector and more specifically in public health, do not change so rapidly for two main reasons:

- There is a limited number of personnel - especially in public health - who have the necessary skills and experience for certain posts.
- Restructuring of organisations is possible, but resources - especially in an economy in transition - are limited to create something completely new.

One of the major aims of the study is to determine what would be a feasible comprehensive alcohol policy, to help policy makers with the questions of "what?", "why?", "how?", and also "by whom?" Actors are the active contributors to the policy environment. They operate in the policy context and policy formulation happens, to a great extent, through them. They may have the ability to promote or to oppose change.

Actors contribute actively to resource allocation and implementation and so to all stages of the policy making process.

Alcohol policy actors in Hungary overlap with major actors in the public health policy environment. Thus, by analysing alcohol policy with a major focus on the actors, the knowledge generated has the potential to help policy formulation in other areas of public health. Focusing on actors may also identify significant structural barriers to policy development.

Main questions related to actors

As well as the main study questions, the analysis seeks to answer the following questions with regard to alcohol policy actors:

- Who are the main stakeholders in alcohol policy in Hungary? What is their understanding of alcohol policy?
- What are their main activities? What is the relative importance of alcohol in their own agendas?
- What is their position regarding a comprehensive alcohol policy?
- What influence do they have in the policy arena?
- What resource can they contribute to a comprehensive alcohol policy?
- Which other actors are they related to and how?

5.7 Stakeholder analysis

The study of policy actors uses the approaches of political mapping and stakeholder analysis to analyse who are the main policy actors, what are their understanding of alcohol policy, what are their positions, interest and influence (ODA 1995, Ogden 1996, Reich 1993). Stakeholders are those who are involved in and/or affected by the "stake" (the policy).

This approach is relatively new in policy analysis. Its aim is to indicate whose interests should be taken into account and why in decision making. As such it is very much in accordance with the focus of the current analysis.

There are descriptions in the literature how to do a stakeholder analysis, but there is no well-established methodology in practice. Each stakeholder analysis should be in accordance with the aims and the needs of the study, thus providing flexibility.

Despite its flexibility it is also a structured tool, with some common elements. The stakeholders should be located and assessed according to criteria given in the study. A matrix table is a common methodological step. A matrix summary may combine actors concerned with a particular issue, with the resources they can bring (Brinkerhoff 1991), their capacity to mobilise resources (Lindenberg & Crosby 1981), to solve problems (Honald & Cooper 1989), their relative importance, their interests and their objectives (Gamman 1991). As part of the political mapping process, it is a way of thinking about models to analyse the policy environment (Parsons 1995).

Although focused on the actors, it also offers useful means of organising information so as to better understand the context and process.

The literature on stakeholder analysis is for the most part not concerned with national policies. Stakeholder analyses has most often been applied in the preparation of projects. It is well described in guidelines prepared by the British Overseas Development Administration (ODA) (ODA 1995). According to the guidelines, analysis of policy actors - stakeholder analysis - always should be undertaken at the initial stage of any project. Brinkerhoff considers stakeholder analysis as a tool for managing programmes as it helps to identify what is needed from stakeholders for effective implementation (Brinkerhoff 1991). Honald and Cooper are interested in the impact of actors on a series of problems and also their capacity to resolve them (Honald & Cooper 1989). Gamman uses the method to aid strategy design (Gamman 1991). He is interested in actors' relative importance, their conflicting interests and objectives, and who are the group leaders. He encourages examination of unmobilised and/or unrecognised actors, as they might affect policy. Lindenberg and Crosby also try to go beyond the obvious actors. Their approach focuses on the level of resources actors can offer to the project, their capacity to mobilise them and their position on the issue (Lindenberg & Crosby 1981).

The reasons why stakeholder analysis is carried out before project implementation, vary. Crosby summarises them as (Crosby 1992):

"first the analyst needs to identify the client and where he/she sits in the environment and to understand some of the pressure and expectations regarding his/her role. Second the analyst can acquire a broad understanding of the environment and how stekeholders interact with the environment and the organisation in order to play a more effective role with the client. Third, managers can hold strong opinions about stakeholders which conflict with generalised perception in the environment. The external analyst can play a valuable role as an independent auditor of those stakeholders."

The ODA guidelines describe in detail the process of stakeholder analysis and its rationale. Stakeholder analysis involves the identification of a project's key stakeholders (individuals and groups with a special interest/stake in a project and/or its outcomes), an assessment of their interests, and the ways in which these interests affect project risk and viability. It helps those involved to assess the project environment and contributes to project design. It can draw out the interest of stakeholders in relation to the problems, identify conflicts of interests and relations between stakeholders and help to assess the appropriate type of participation by different stakeholders. According to the ODA, stakeholder analysis should be drawn up at the initiation stage and revised periodically. Stakeholder analysis has the advantage of forcing the researcher to be reflexive and reflective (ODA 1995, Ogden 1996).

It must be noted that, in this study, stakeholder analysis is used to examine alcohol policy actors at the national level. The analysis aims to answer questions listed in previous sections. In this context it is not part of the initial stage of a planned project, but it is undertaken in the hope of a "future project", as far as the development of a national alcohol policy can be considered a "project". In this respect the ODA guidelines are useful tools to orientate the analyst, but they have to be applied with caution to the aims of the current analysis.

There are also limitations to this tool. The picture drawn is cross sectional. It may have to be updated if results are not used at once. If used without applying a

broader framework, there is a risk of overemphasising the importance of actors in the policy making process.

5.8 Differences in concepts

The difficulty of reconciling the concepts of public health and alcohol policy between Hungary and other industrialised countries has not been discussed so far.

First, when a comprehensive alcohol policy was discussed in Chapter 3 it was suggested that the concept of a comprehensive alcohol policy refers to the present international approach towards alcohol policy. It was also suggested that comprehensivness, the optimal mix of different alcohol policy elements, offers the best chance of being effective.

Second, alcohol policy has now been defined as a public health policy. It has also been acknowledged that the concept of alcohol policy as a public health policy changed over time, suggesting a continuous process.

It is necessary to consider whether these concepts are relevant in the Hungarian context. The possible difference in concepts has partly been reflected in Chapter 2 where the use of alcohol related terminology in the Hungarian literature was discussed. Interpreting a comprehensive alcohol policy and public health policy in the Hungarian context may be difficult largely because of two factors. First, because of the extent of alcohol related problems in Hungary, the lack of an effective policy can be assumed, which is presumably linked to the lack of a comprehensive alcohol policy. Therefore alcohol policy in its comprehensive form, if not present, cannot be analysed. Only what alcohol policies exist can be examined. Second, the concept of alcohol policy has gone through changes over time throughout the world, which means that policy development is a continuously changing process. So what is the importance of these issues?

First, they provide good starting points for comparison and interpretation of the Hungarian situation. Second, history has its own momentum. This can be seen in the way in which countries of Central and Eastern Europe follow the rest of the

world. Thus continuity can eventually lead to comprehensiveness in alcohol policy, with pursuit of alcohol as a public health problem.

The analysis can provide an additional output, namely how these concepts can be applied and reconciled in the Hungarian context.

6 *Means of data collection - using qualitative data*

Qualitative research methods will be used in the historical analysis of alcohol policy in Hungary and in the stakeholder analysis. They offer means to understand policy development, decision making, distribution of interests and influence of potential actors. In the current study, participant observation, semi-structured interviews and document analysis are the principal instruments. In the following sections the use of these methods in policy analysis and their advantages and disadvantages are discussed.

Systematic and rigorous use of triangulation (Pope & Mays 1995), comprehensive and detailed record keeping and testing of findings ensured internal and external validity.

6.1 Qualitative methods

Qualitative research is open ended and flexible, requires a depth of understanding, penetrates rationalised or superficial responses and provides a rich source of material. Thus qualitative research is best used for problems where the results will increase understanding, clarify the real issues, identify distinct behavioural groups and generate hypotheses. Qualitative research offers the opportunity of identifying potential sources of contextual bias (WHO 1994b). The flexibility of qualitative research allows the researcher to reduce such contextual bias by using interviewing techniques and creating an environment in which respondents feel most comfortable (WHO 1994b). The advantage of observation and interviewing is that they make effective use of the relationships the researcher establishes with informants in the field for eliciting data (Zelditch 1969).

The disadvantages of this type of research are sometimes referred as non-sampling errors, as the samples used are rarely randomly selected. Also, data may not be collected in a standard way. Consequently they may offer limited scope for quantitative analysis and a quantitative relationship often cannot be established (WHO 1994b). Thus the researcher has to depend on a more impressionistic interpretation of the data to produce generalisations. Because of the obvious difficulties of generalising from field notes collected under disparate conditions, observation and interviewing frequently produce masses of undigested data. There is also an issue of misreporting, although this is also a risk of quantitative research. Sometimes respondents may knowingly lie because they fear the negative consequences of a truthful reply. Cultural reinterpretation happens when quotations are not meaningful to respondents in the way intended by the researcher. Contextual bias refers to factors associated with the interview itself (WHO 1994b). Another limitation flows from the researcher's use of the relationships he establishes in the field, introducing potential bias. There is great danger that the research worker will guide the enquiry in accordance with an impression gained from early informants. Some biases are almost certain to be present when the contacts available are limited by the researcher's role and status.

Qualitative methods and policy analysis

There is an extensive literature about how qualitative research findings might be used and incorporated into social policy making (Caplan 1976, Cherns 1972, Coleman 1984, Rist 1981), but little is written about the feasibility of qualitative research methods for policy analysis.

Flynn utilised direct observation, unstructured and semi-structured interviews and document analysis when he studied the planning department of a local authority, which he conceptualised as a study of urban managers (Flynn 1979, Flynn 1983). Kogan and Henkel's study of commissioning research was undertaken at the level of central government (Kogan & Henkel 1983). They attended meetings as observers, had access to committee papers and interviewed members of research units and civil servants. Berridge used interviews to contrast the policy response to AIDS and illicit drugs (Berridge 1992).

Barker sees stakeholder analysis as based mainly on qualitative methods, principally personal interviews (Barker 1996), although other techniques, such as participant observation, documentary analysis, informal panel groups and workshops to explore different options can also be used (Crosby 1992).

The feasibility of applying qualitative methods to policy analysis is justified by the nature of the information needed to complete a stakeholder analysis. Unlike survey methods, qualitative approaches avoid the requirement to have an initial hypothesis to be tested. They offer the possibility to capture the context of policy making and the subjective world of the actors. Qualitative research can also involve sustained contact over a period of time with an organisation and/or a particular actor. Therefore it can incorporate a longitudinal element into the process. Qualitative methods thus have much to offer in the study of policy (Finch 1986).

Although qualitative research offers advantages, there are also practical difficulties in getting access to the closed world of government departments and in conducting interviews with people in elite positions, where the researcher may find it difficult to interact with the interviewee (Edwards 1981, Young & Mills 1980). Conversely, a subject may be willing to be more forthcoming with someone seen as external to the system.

6.2 Specific data collection means

Documentary analysis

Studying documents is considered to be non-reactive. In literate societies, written documents have numerous purposes in a diverse range of settings. Burgess argues that documentary evidence includes not only written but also oral data (Burgess 1991), but this summary focuses on written material.

Documents vary in their style of language and form. Types of documentary source range along a dimension from the "informal" to the "formal" or "official"

(Hammersley & Atkinson 1995). A division of the major types of documents used by Atkinson and adopted by Silverman identifies files, statistical records, public records and images (Silverman 1993). The analytical framework using documents is most developed for ethnographic research, but other frameworks, such as semiotics and content analysis also exist (Silverman 1993). Semiotics focuses on an ad hoc selection of a linguistic unit. Content analysis involves establishing categories and counting the number of instances when those occur. Krippendorf argues, that *"content analysis is a research technique for making replicable and valid inferences from data to their context"*. This context includes the purpose of the document as well as its institutional, social and cultural aspects (Robson 1993).

Documents can be used to cross-check oral accounts or to provide historical context, although ethnographers argue that analysis of documents has to take into consideration the context in which they developed (Atkinson & Coffey 1997). Historical analysis is usually based on a standard range of written documents, but the availability of documents may influence the perspective taken (Burgess 1991).

Participant observation

Participant observation describes the scope of the methodology, rather than being a specific, well defined instrument. It refers to a characteristic blend of methods and techniques employed in studying certain types of subject matter. It involves some genuinely social interaction with the subjects of the study, some direct observation of relevant events, some formal and a great deal of informal interviewing, some systematic counting, some collection of documents and artefacts, and open endedness in the directions which the study takes. Direct observation is necessary in participant observation, but there is a need to supplement it with indirect observation, which can only be obtained from persons who were on the scene in the scientist's absence (McCall & Simmons 1969). Because of the rather heterogeneous quality of this blend it has not lent itself to standardisation. The non-quantitative nature of the results causes difficulties in presenting evidence and in proving propositions. Proponents of participant observation say it is less likely than other methods to be biased, unreliable, or invalid because it provides more internal checks and is more responsive to the data than are the imposed systems of other methods.

Interview

The interview is a kind of conversation with a purpose. According to Cannel and Kahn, as cited by Cohen and Manion, it is one "initiated by the interviewer for the specific purpose of obtaining research-relevant information and focused by him on content specified by research objectives of systematic description, prediction or explanation" (Cohen & Manion 1989). Semi-structured interviews help to fulfil the aims of the stakeholder analysis and contribute to the mapping process. They provide information that helps understanding of key stakeholders once those individuals are identified. Individuals can represent a stakeholder institution or organisation or they may be stakeholders themselves. If individuals with interest and/or influence are involved in policy making it is essential to understand of their motivation, attitude and approach.

There are several advantages and disadvantages to interviewing. It is a flexible and adaptable way of finding things out. Face-to-face interviews offer the possibility of modifying one's line of enquiry, following up interesting responses and investigating underlying motives in a way that postal or other self-administered questionnaires cannot. The lack of standardisation that it implies inevitably raises concerns about reliability. Biases are difficult to rule out. Interviewing is time consuming. In some fields it appears to be increasingly difficult to obtain co-operation from potential interviewees. All interviews require careful preparation, which takes time. Arrangements for visits, necessary permissions, confirmation of arrangements, and rescheduling appointments to cover absence, all take time. Notes need to be written up and tapes, if used, require whole or partial transcription (Robson 1993).

There is a continuum of types of interview based on the degree of structure or formality and the amount of control exercised over the informants (Richardson et al. 1965, Robson 1993).

Unstructured interviews

At one end of this continuum is informal interviewing. *Unstructured* (completely informal) interview, where the interviewer has a general area of interest, let the conversation develop within it (Robson 1993). The goal is understanding rather

than explaining (Barnard 1995, Fontana & Frey 1994, Richardson et al. 1965, Spradley 1979). It is based on a clear plan that is kept constantly in mind but it is also characterised by a minimum of control over the informant's responses (Barnard 1995, Burgess 1982). The in-depth or unstructured interview is a conversation in which the researcher encourages the informant to relate, in their own terms, experiences and attitudes that are relevant to the research problem and the interviewer is not bound by a rigid structure (Barnard 1995, Maier 1994, Robson 1993).

Semi-structured interviews

Semi-structured interviews have many of the same qualities. It has much of the freewheeling quality of unstructured interviewing and requires all the same skills but is based on the use of an interview guide or list to which interviewers want responses (Barnard 1995). It works very well in projects in which one is dealing with people who are accustomed to efficient use of their time. It demonstrates that one is fully of the interview but leaves both the interviewer and interviewee free to follow new leads (Barnard 1995). Semi-structured interviews are quicker to analyse than unstructured ones as the categories are more specified. A strength lies in the comparability of data due to the pre-formulated structure, although the preparation of questions in advance may lead to questions being outside of or irrelevant to the interviewee's reality (Robson 1993).

Structured interviews

Finally there is the *structured interview* in which all informants are asked to respond to as nearly identical set of stimuli as possible (Barnard 1995). A predetermined set of questions is asked, and the responses are recorded on a standardised schedule (Robson 1993).

7 Processing data

After presenting the framework for policy analysis and the use of qualitative data, the process used to analyse data is discussed in the following paragraphs.

7.1 Processing qualitative data for policy analysis

The analysis of data follows the framework recommended by Ritchie and Spencer (Ritchie & Spencer 1994). This framework was developed specifically for the use of qualitative data analysis in applied policy research.

Ritchie and Spencer differentiate five stages in processing qualitative data.

(1) First familiarisation, when the researcher goes through all the collected material and generally becomes familiar with it. He gains an overview that can be used to identify a thematic framework.

(2) Second, identifying a thematic framework, when notes about the range of responses, recurrent themes and issues are taken.

(3) Third, indexing, when the thematic framework is systematically applied and indexing of transcribed texts, documents, field notes is completed.

(4) Fourth, charting, when a picture of the data is built up. In this stage data are lifted from their context and rearranged according to the appropriate thematic reference. Charts can be created in this stage. How the charts are laid out depends on whether the analysis is thematic or by case. Thematic analysis follows each theme across all respondents. By case analysis focuses on each respondents across all themes.

(5) Fifth, mapping and interpretation, when the analyst returns to the objectives of the analysis. This stage includes numerous elements, such as defining concepts, mapping the range and nature of phenomena, creating typologies, finding associations, providing explanations and developing strategies.

7.2 The constant comparative method

This analytical framework is supplemented by the constant comparative method for analysing qualitative data (Glasser & Strauss 1967). This approach has been described by Glasser and Strauss. It comprises four stages of the analysis:

(1) comparing incidents applicable to each category,

(2) integrating categories and their properties,

(3) delimiting the theory, and

(4) writing the theory.

The coding starts with creating as many categories as possible as categories and data emerge. In this process the category coded has to be compared with the previous incident in the same category and different incidents coded in the same category. This constant comparison of incidents starts to generate theoretical properties of categories. The next step involves integrating categories and their properties. This is followed by delimitation, which can occur at two levels. As the theory becomes more solid as the analysis proceeds, major modifications become fewer and fewer. It helps to formulate the theory with a smaller set of high level concepts. Delimitation also affects categories. As the theory becomes clearer, the boundaries are more clearly defined and the number of categories used may decrease. This approach is particularly useful in the stakeholder analysis process, where data are gradually accumulating and new themes and categories occur throughout the process of data collection. This process facilitates development of a complex theory which corresponds closely to the data. It is an inductive approach to theory development.

8 Data collection and analysis in the study

The means of data collection for each of the three parts of the analysis are presented in the following sections.

8.1 The legislative framework

In reviewing the roots of alcohol policy, the legislation was considered against the framework of what could be included in a comprehensive alcohol policy. Legislation was examined in sequence from the beginning of the 1970s. Hungarian legislation is accessible via the COMPLEX data base, which is published on CD-ROM, and covers primary and secondary legislation. The search of this data base was supplemented with a review of original printed material because of the exclusion by the database of law from the period before 1990. Keywords of "alcohol", "alcoholism", "alcoholic beverages", "wine", "beer" and "spirits" were applied. Updating key areas of legislation was undertaken by key informants from a range of sectors. Access to these people was fostered by being based in the Ministry of Welfare.

8.2 Alcohol policy from 1945 to the 1990s

Analysis of the tree of alcohol policy relies on a review of published alcohol policy documents, concepts and strategies. To describe organisational changes in the alcohol field, findings from the literature review on alcohol policy are triangulated with documentary sources concerning existing organisations, interview data and legislation. The broader policy context and the review of public and public health policy in Hungary originates primarily from participant observation. It is supplemented by the review of literature about Hungary.

8.3 Stakeholder analysis

Semi-structured interviews were completed with representatives of national organisations, institutions, and relevant ministries. The interviews were based on topics derived from the project aims. Each interview tried to cover these issues, however minor individual differences occurred as the situation required.

Topics covered were:

- understanding of alcohol policy
- alcohol as a priority, the actor`s position on the alcohol issue
- alcohol policy instruments, which can influence the incidence of alcohol problems (How do actors relate to these policy instruments?)

  price, taxation; availability; minimal drinking age; servers' training; education and mass media campaigns; drink-driving measures; controls at workplaces and treatment.
- relation with other actors
- potential policy input

After identifying five initial interviewees[2] with possible stake in alcohol policy, a snowball technique was used to identify further actors. This led to the identification

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[2] These were: (1) head of a major spirits company, (2) National Union of Retailers & Catering Units, representing production and trade; (3) Secretary of State of the Ministry of Welfare (currently the Minister of Welfare); (4) head of the Parliamentary Committee of Health and Social Affairs; (5) a leading scientist who represents Hungary in international meetings and has been involved in alcohol related issues for decades.

of 49 individuals or representatives of organisations, of which 46 agreed to be interviewed. An introductory letter was faxed to each of the interviewees. The content of the letter was relatively non-specific. It gave only a general introduction and referred to the topic. The time required for the interview was said to be no more than half an hour. Before sending the fax a phone call was made to warn about the fax and to describe its content. These calls were extremely important for two reasons.

- First, in the Hungarian bureaucracy it often happens that a letter or fax goes straight to the filing cabinet without actually being read.
- Second, most of the interviewees had a secretariat (responsible for the filing, and in many cases for arranging the time schedule of the person identified). It was important to make the secretaries understand the content of the fax, to ensure that they forwarded the fax to their chief, and also to convince them to co-operate.

The name of the secretary or the person who answered the phone was taken in each case to emphasise the importance of the fax and indicate that an answer is expected. After sending the fax a few days later the same person was contacted again to fix the time of the interview.

The typical length of the interviews was 45-50 minutes. The interviews were always conducted at one sitting. Note taking was contemporaneous. Immediately after the interview, notes were completed and the context of the interview was written down, including non-verbal actions, ambience and any disturbances.

At the end of each of the interviews the interviewee was asked to name further actors they might have considered important to talk to. As, after interviewing 46 interviewees, no new names were recommended, it suggests that the interviews are representative of the whole of the national policy arena.

The interviews were supplemented with a telephone survey of local government authorities. Two authorities were selected randomly from each of the 19 counties of Hungary and two districts of Budapest, with sampling of rural and urban areas in

each case. It aimed to look at whether local authorities took the initiative to add locally to elements of the national alcohol policy.

The analysis first determines the main focus of policy actors' activity, along with their understanding of alcohol policy. Second their position and influence are described. Third their relationships with other actors are mapped.

The results of the interviews were triangulated with a comprehensive review of the literature on alcohol policy and related issues, and a documentary review of current legislation and policy documents from the organisations included in the study.

A table was drawn up at the beginning of the analysis to structure the information collected (Table 11).

Table 11 - The matrix table used in the study

STAKE-HOLDERS	ACTIVITIES	POSITION	CONNECTION WITH OTHER ACTORS	INFLUENCE	FEASIBILITY OF POLICY ELEMENTS
Who they are?	What they do? How important alcohol is?	How supportive they are towards a comprehensive alcohol policy?	What is their policy network?	How influential they are?	What is their position on different policy elements?

In the following chapters the analysis of alcohol policy in Hungary is presented. It follows the order indicated in the previous sections.

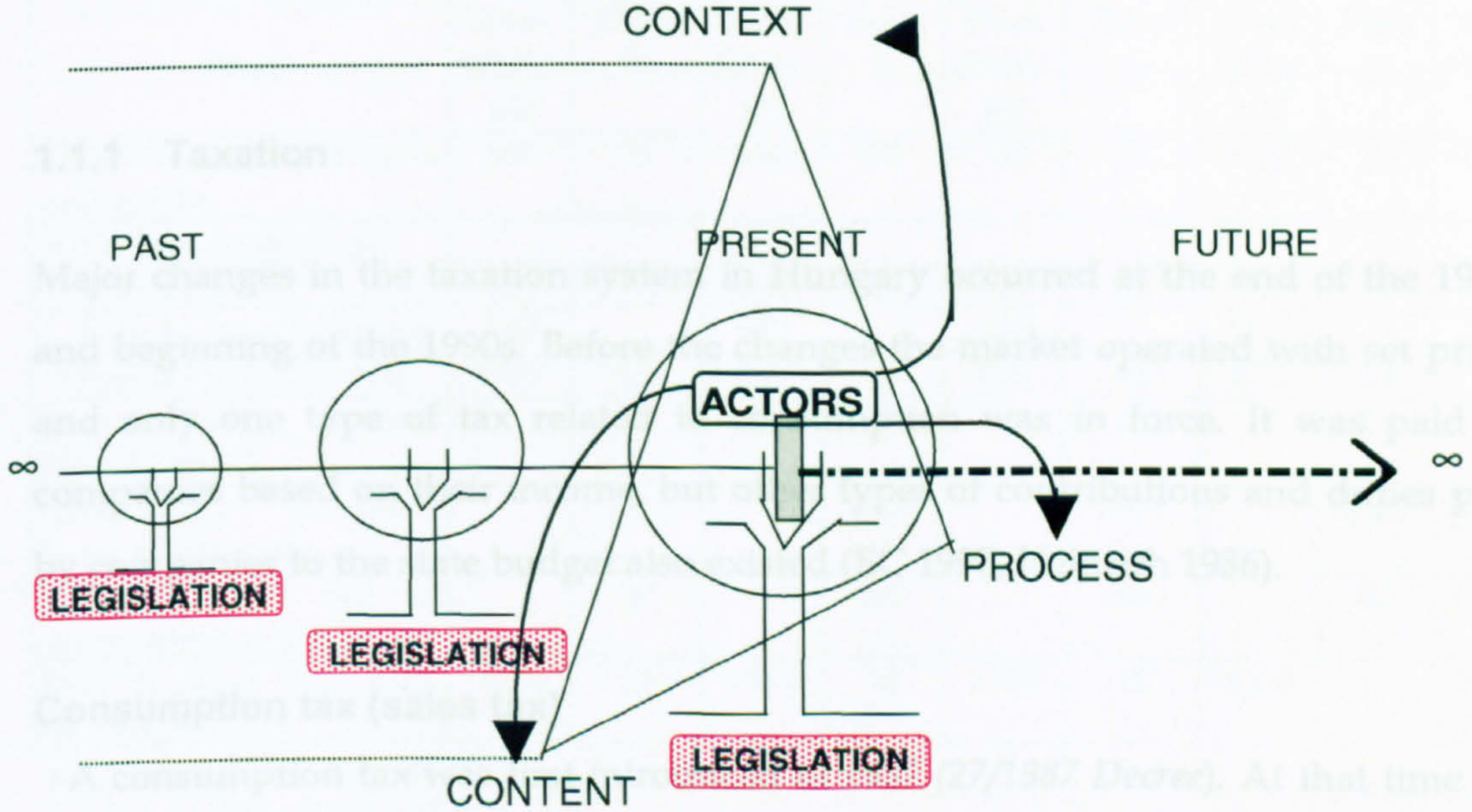
- *CHAPTER 5* -

THE LEGISLATIVE FRAMEWORK

THE ROOT OF THE TREE

This chapter discusses the legislative framework of alcohol policy in Hungary and its change over time. It refers to the root of the tree of alcohol policy (Figure 21).

Figure 21 - The analytical framework



First, regulations specific to the alcohol field are summarised. The review discusses how different elements of alcohol policy are presented in the Hungarian legislation and how these have changed over time. Second the current legislative framework of public health activities is discussed in which alcohol policy could operate as a public health concept. The regulations cited are listed at the end of the chapter (Table 18).

1 *Alcohol related regulations*

In this section regulations on alcohol as a commodity are summarised first. Major types of alcoholic beverages are discussed separately where the legislation differs for wine, beer and spirits. Under this heading legislative considerations relating to taxation, quality, availability and production of alcoholic beverages are discussed together with regulations on servers` training, minimum drinking age and advertising. Second, regulations related to drinking behaviour are discussed,

beginning with basic laws of education, followed by drink driving measures, regulations for workplaces, and finally, legislation related to health, social care and treatment.

1.1 Alcohol as a commodity

1.1.1 Taxation

Major changes in the taxation system in Hungary occurred at the end of the 1980s and beginning of the 1990s. Before the changes the market operated with set prices and only one type of tax related to consumption was in force. It was paid by companies based on their income, but other types of contributions and duties paid by companies to the state budget also existed (EC 1997, Heinrich 1986).

Consumption tax (sales tax)

A consumption tax was first introduced in 1987 *(27/1987 Decree)*. At that time the tax rate on most alcoholic beverages was itemised so that a consumption tax of 310-440 HUF had to be paid per hectolitre degree (hld: 1 litre 100° v/v alcohol) of products based on spirits. On most other alcoholic beverages, with the exception of beer, the tax levied was 1050-1150 HUF/hld. On wine the tax was proportional to the selling price, at 11-40%. It should be noted that at the end of the 1980s, many basic commodities were subsidised, such as milk, butter, bread, etc. This was not the case with alcoholic beverages. Consumption tax had to be paid on products produced inside the country or imported from elsewhere. With regard to imports it has to be mentioned that at the end of the 1980s a differentiation between two import categories existed, depending on whether the product came from the Soviet Bloc or elsewhere *(51/1989 Act)*. With Soviet Bloc countries a Rouble-based settlement took place, whereas with other countries a US dollar based settlement was used.

In 1991 a new act came into practice which is still in force *(78/1991 Act)*. According to this, consumption tax has to be paid on anything on a designated list of

products if they are imported or sold domestically. Depending on the commodity, the consumption tax can be proportional to price, flat-rate or a combination. On alcoholic beverages, both formulae are used depending on the type of drink (Table 12).

Table 12 - Sales tax on different alcoholic beverages since 1991

Item	1991-Jun 1994		July-Oct 1994		Nov 1994-1996		1996		1997	
	Item HUF/ hlf	Prop %	Item HUF/ hlf	Prop %	Item HUF/ hlf	Prop %	Item HUF/ hlf	Prop %	Item HUF/ hlf	Prop %
Ethyl-alcohol products and spirits	580	78	630	78	720	78	820	78	1150	
with the exception of.										
Brandy	400	14	400	14	500	30	620	30	860	
Pálinka (special spirit)	540		580		650		750		860	
Special rum, liqueur	580	43	630	43	720	43	820	43		
Grape-wine (except brandy wine)		11		11		11		11		11
Champagne prepared from grape-wine		15/l		15/l		20/l		20/l	50 /1	
Liqueur made out of grape-wine or fruit-wine		40		40		45		45		45
Beer of more than 1.5% alcohol content	1300	15	1560	15	1760	15	2020	15	2300	15

hld: 1 litre 100° v/v alcohol

HUF: 1USD=200HUF

Applying the annual inflation rate to the flat-rate tax element of different alcoholic beverages, based on the 1994 rates, the expected tax rates by 1997 were calculated. The percentage that the actual tax is of the expected rate is shown in brackets (Table 13).

Table 13 - The expected and the real itemised consumption tax rate on alcoholic beverages

Item	1994	1995		1996		1997	
	Flat-rate HUF/hld	Expec ted	Actual HUF/hld	Expec ted	Actual HUF/hld	Expec ted	Actual HUF/hlf
Brandy	400	513	500 (98)	634	620 (98)	750	860 (115)
Pálinka (special spirit)	580	744	650 (87)	920	750 (82)	1088	860 (79)
Special rum, liqueur	630	808	720 (89)	999	820 (82)	1182	
Beer of more than 1.5% alcohol content	1560	2000	1760 (88)	2472	2020 (81)	2924	2300 (79)

It can be seen that the consumption tax on alcoholic beverages changed over time and, for both on beer and palinka (the most common spirit in Hungary) the flat-rate tax levied in 1997 was around 20% lower in real terms than it was in 1994.

During this period the proportional sales tax component on beer did not change. On palinka and brandy it increased by 16% between 1994 and 1995, but the proportional component was removed completely by 1997.

Major changes in the structure of the sales tax on alcoholic beverages occurred between 1996 and 1997, as tax rates were gradually adjusted to comply with EU directives (Antalffy 07/10/96, Csobánczy 05/11/96). This involves the removal of the proportional tax component from spirits which, taking into consideration the figures presented in Table 13, means that the tax has failed to keep pace with inflation. Furthermore, the Ministry of Finance applies a valorisation policy to the consumption tax on alcoholic beverages at a rate of 14-15%, so that the price increase of alcoholic beverages is around 14-15% lower than would be expected from the inflation rate (Csobánczy 05/11/96).

VAT

Value Added Tax (VAT) has been in force in Hungary since 1988. After four years` experience the relevant legislation was changed in 1992. The new Act takes into consideration European Union directives and the change to a market economy *(74/1992 Act)*. The tax is at 25% and is also applied to alcoholic beverages. There are a few exceptions on which the tax is 12%, such as energy, certain welfare and health care products, post and telecommunication services, etc.

The law makes a further exemption for agricultural products. Taxpayers who are undertaking agricultural activity are not subject to tax on these activities. The taxpayer receiving the product shall pay an additional tax (agio) on these purchases. The rate of the "agio" for products suitable for beverage production is 12% of the purchase price.

Income Tax

Income tax is mentioned for completeness, because, until the very beginning of 1997, there was a loophole in the legislation which had an impact on the wine market. The problem was with income tax levied on income generated as a result of agricultural production. As noted above, taxpayers undertaking this type of activity were exempt from income tax if their income was the result of the sale of

certain products and it did not exceed 1,000,000 HUF in value. Wine and grapes were included in this category *(12/1995 Act)*. This meant that a considerable amount of grapes, wine and wine related products entered the market without any quantity or quality control. This regulation has been modified since then. People undertaking agricultural activity now need to be certified as being primary agricultural producers, otherwise they are not allowed to benefit from certain reductions in income tax *(83/1997 Decree)*. Those who have this certificate are subject to the 17/1997 Act on the Conditions of Tax of Agricultural Producers. According to this act, individuals with the certificate of "primary agricultural producer", who sell grapes to wholesalers, are exempt from income tax if their value does not exceed 250,000 HUF annually (1/4 of previously allowed value). If a certified person produces wine or any other wine products from his own grapes and puts it on the market it can not be sold except to a wholesaler. It is exempt from income tax only if its value does not exceed 400,000 HUF *(17/1997 Act)*.

Control of Excise - regulations on spirits and beer

The Act on the Regulation and Control of Excise and Subcontracted Spirit Distillation Tax was implemented in 1993 *(58/1993 Act)*. The act was created with the aim of regulating and controlling excise levied on distillation of brandy and cognac subcontracted to individuals. The act sought to regulate production, distribution, storage, export, import and retail sales of products subject to excise duties in a standardised way. It also aimed to regulate the rights and obligations of those undertaking such activities. Alcoholic beverages, with the exception of wine, became subject to excise duties as were tobacco, petrol, coffee and paprika.

The act introduced licence to deal in products subject to excise duties. Applications for licences are submitted to the headquarters of the Customs Office or, in case of off-licences, to a notary. The Customs Office keeps records of all such licences. The act had different chapters relating to the conditions for spirit and beer production and retail sales. It also required that bottled spirits and beer can only be sold in Hungary if they have excise seals. The seals are issued by the Customs Office, at a price of 300 HUF/seal for alcoholic beverages.

With regard to the tax on subcontracted spirit distillation and production, the tax base of the activity is the quantity of spirit produced expressed in hectolitre degree (1 litre of spirits of 100 volume percent). The tax is 40% of the VAT levied on palinka (spirits) per hectolitre degree.

This act has recently been replaced by the 103/1997 Act on Excise Duty *(103/1997 Act)*. The new act specifies different products subject to duty than in the previous one. It covers for petrol, spirit products, beer, champagne, intermediate alcohol products (sparkling - between 13 and 22 volume % of alcohol content depending on the production process; non-sparkling - between 1.2 and 22% of pure alcohol content, depending on the production process) and tobacco products. It means that only wine produced by fermentation is exempt from the law (Table 14). The new act determines the excise duty for different alcoholic beverages subject to the law. The tax has to be paid after production or import of the products concerned. The price of a seal increased to 500 HUF and it is still required on bottled alcoholic beverages. The licensing system remained similar to that specified in the previous version of the act.

Table 14 - Excise duty on different products (103/1997 Act)

Product	After 1997 in HUF
Spirit products	1270/hld
Fruit palinka	970/hld
Subcontracted distilled spirit <100 hld/year	390/hld
Subcontracted distilled spirit 100 hld+/year	970/hld
Beer	285/plato/hl
Champagne	60/l
Intermediate alcohol product sparkling	60/l
Intermediate alcohol product non-sparkling	80/l
Seal price	500/piece

Plato (Balling) degree: the dry quantity of beer at 20°C expressed in weight %.

Other taxes

Other elements of the taxation system in Hungary are corporate tax (domestic - 18% of positive tax base (profit), foreign - 3% of positive tax base) and dividend tax (20% on the received dividend), customs duty and income tax *(86/1991 Act; 81/1996 Act; 12/1995 Act; 100/1995 Act; 21/1976 Decree; 101/1995 Act; 45/1996 Decree)*. As they equally affect the production of all products and they have no

specific implications with regard to alcoholic beverages, they are not discussed in detail.

1.1.2 Regulations for grape and wine production

There are a number of special regulations on grape cultivation and wine production which affect the wine market and which need to be addressed.

The production of grapes and wine falls under agricultural regulations. The Regulation of the Agricultural Market *(6/1993 Act)* seeks to establish a regulated agricultural market, consistent with the provisions of the European Union's Common Agricultural Policy. These rules are administered by the Ministry of Agriculture, an Inter-Ministerial Committee and Product Councils[3]. The act defines possible means to influence directly or indirectly the market, such as guaranteed prices, guide prices, self-imposed restrictions on production, quotas, market intervention, permission to export or import, application of export and import levies and subsidies.

Separate regulations apply to the cultivation of grapes, fruit and production of wine. General regulations were laid down in the 36/1970 Decree in Act Force *(36/1970 Decree in Act Force)*. It says that these activities need a licence, whether for cultivation or cessation of cultivation or production. The licence is submitted either to the notary or a judge of the Mountain Community (see later) *(102/1994 Act)*. Since 1997, wine or grapes for wine production can be sold in retail outlets only with the certificate of origin.

The 40/1977 Decree of the Minister of Agriculture and Food Administration defines specific regulations with regard to the cultivation, production of wine and brandy, bottling, marking of bottles and storage *(40/1977 Decree)*. This decree nominates the

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[3] Both the spirit and wine association (discussed before) are product councils. This distinction gets meaning in the agricultural regulation, as associations which are not product councils do not hove the legitimised function to collaborate directly in the agricultural production.

National Institute of Wine Verification and the Commerce Quality Control Institute (KERMI) as executive agencies (see Chapter 6).

This set of regulations was complemented by the Act on Mountain Communities *(102/1994 Act)*. This relates to mountainous areas of Hungary where grapes are traditionally cultivated and wine is produced. These areas differ in type and quality of products. The act was introduced to encourage and maintain high quality wine production and also to regulate the establishment and operation of these "Mountain Communities". The communities are organised on a self-governing basis and have the right to apply their own regulations.

1.1.3 Quality

Some of the regulation related to the production and trade of alcoholic beverages have already been discussed.

The main provisions are, however, in the Act on Food Products, which provides a general framework for the production, quality and conditions of trade in alcoholic beverages, including customer information obligations. The 1/1996 Decree provides detailed regulations for the implementation of this act *(90/1995 Act; 1/1996 Decree)*.

The Hungarian Codex Alimentarius also has specific regulations on alcoholic beverages. The 1-3-1576/89 regulation on alcoholic beverages provides general rules on the definition, description and presentation of drinks *(1-3-1576/89 Rule)*. This is based on the 1576/89 European Council Regulation (EEC). The 2-91 directive gives guidelines on the quality of certain spirit-based drinks *(2-91 Directive)*. The 1-1-87/250 Rule regulates the labelling of alcoholic beverages in accordance with the 87/250/EEC Commission Directive *(1-1-87/250 Rule*). The 1-1-75/106 prescription defines the ranges of nominal quantities and nominal capacities permitted for certain pre-packed foodstuffs (Council Directives No 75/106/EEC and 80/232/EEC) *(1-1-75/106 Rule)*. In this directive the minimum quantity that beer can be sold in is 0.25 litres, for wine it is 0.1 litres and for spirits it is 0.02 litres. Previously according to the 12/1986 Decree of the Minister of Internal Trade, spirits could not be bottled in 0.05 or 0.1 litre volumes *(12/1986 Decree*). This law was surplanted in 1990 by the

6/1990 Decree of the Minister of Commerce *(6/1990 Decree)*. Consequently, the minimum quantity of alcoholic beverages that can be sold in a pre-packed form was reduced.

1.1.4 Availability - Retail sales of alcoholic beverages to the ultimate consumer

Several regulations apply to the conditions of retail sales of alcoholic beverages. This is one of the most complex and frequently changing part of the legislation on alcohol.

Licensing

According to the 19/1977 Decree of the Minister of Internal Trade *(based on the earlier 14/1972 Decree of the Minister of Internal Trade and modified by the 14/1976 Order)*, retail sales of alcoholic beverages required the permission of the authorities *(19/1977 Decree)*. The 1986 version of this decree introduced a further condition, the agreement of the Committee Against Alcoholism (see Chapter 6) *(12/1986 Decree)*. The police also had to be informed. This legislation was in practice until 1997. Since 1994 premises for retail sales and catering should have been reported to the notary *(4/1994 Decree)*. Because it was a supplementary requirement of the law without any serious sanction, it was widely ignored. Since 1997, the notary issues a licence for these promises, so he has an up-to date record of such outlets *(4/1997 Decree)*. The act also regulates other conditions of sale and specifies places where alcoholic beverages can or cannot be sold.

Place

Since 1977, the sale of alcoholic beverages was not allowed at workplaces during working hours, in schools and educational facilities and in slot-machines *(19/1977 Decree)*. In sports facilities and self-catering units only beer could be sold. A later modification in 1986 forbade the sale of any alcoholic beverage at places frequented mainly by youths, at youth clubs, on long-distance bus routes, on public transport facilities (with the exception of catering units at places for public transport and the sale of beer) and at workplaces *(45/1986 Decree)*.

In 1977 the retail sale of alcoholic beverages was allowed only at certain types of premises: general department stores, supermarkets, groceries, confectioneries, shops selling bottled drinks and shops with a mixed profile. Among catering premises, it was allowed at restaurants, pubs, coffee shops, licensed buffets, espressos, patisseries, milk-bars, tea-houses, drink shops, wine catering shops, wine shops of producers, bars, buffets of cinemas and theatres *(19/1977 Decree)*. The 1977 Decree banned wine producers from selling wine without special permission in volumes less than 25 litres. In 1993 the Act on the Control of Excise lists the places where alcoholic beverages can be sold, such as general department stores, supermarkets, groceries, confectioneries, coffee, tea shops, shops selling bottled drinks, catering shops, commercial accommodation and business premises in the area of filling stations *(58/1993 Act)*. At filling stations, only canned or bottles drinks can be sold. This is in accordance with the last version of the act on the operation of premises *(4/1997 Decree)*.

Restrictions on location

The 19/1977 Decree of the Minister of Internal Trade ordered catering units not to sell alcoholic beverages within a distance of 200 meters of workplaces which had more than 100 employees *(19/1977 Decree)*. The 12/1986 Decree extends the regulation to health and education facilities *(12/1986 Decree)*. The 6/1990 Decree of the Minister of Commerce (modified by the 9/1991 and the 4/1994 Decree of the Minister of Trade and Industry and the 4/1997 Decree of the Government) applies the ban only to health, education and children's facilities, excluding from the ban catering units which serve hot meals *(6/1990 Decree; 9/1991 Decree; 4/1994 Decree)*. The 4/1997 Decree of the Government declares that the notary has the authority to licence the sale of alcoholic beverages within this 200 meter distance if it is outside the operational hours of the facilities in question *(4/1997 Decree)*. First the 6/1990 decree, later modified by the 9/1991 and then the 4/1997 decree obliges reporting of retail of alcoholic beverages to the police *(6/1990 Decree; 9/1991 Decree; 4/1997 Decree)*.

The 9/1991 Decree banned the consumption of alcoholic beverages inside premises which sell bottled or canned alcoholic beverages only *(9/1991 Decree)*. The 1997 decree continues this ban.

Availability in time

The 19/1977 Decree banned sales of alcoholic beverages in catering units before 9 a.m. *(19/1977 Decree)*. The 1986 Decree extended the ban. Neither retail nor catering premises were allowed to sell alcoholic beverages before 9 a.m., in case of 24-hour shops between 5 and 9 a.m. *(12/1986 Decree)*. Exception was made for places of importance for international tourism. This regulation was dismantled by the 5/1989 Decree of the Minister of Commerce *(5/1989 Decree)*.

1.1.5 Servers` training

The 5/1990 Decree of the Minister of Trade regulated the activities for which specific training was required. It had legal effect on, for example, hotel staff (in managerial positions), those working in catering establishments and in retail of food-sales *(5/1990 Decree)*. The decree was replaced by a new one in 1997 setting out certain qualifications for some commercial and industrial activities *(5/1997 Decree)*. For example, the retail sale of food products needs a specialised qualification in food and chemical retailing, catering needs a qualification as a waiter , etc.

The National Association of Retailers, under the auspices of the Ministry of Industry and Commerce, organises training courses for retailers from those areas which fall under its competence. The curriculum incorporates training in responsible service (Antalffy 07/10/96, KISOSZ).

The Hungarian legislation, although banning sales to drunk people in catering units (see next section) does not make the server liable for any consequences, for example in the event of an accident or crime.

1.1.6 Minimum drinking age

The 19/1977 Decree forbade the sale of alcoholic beverages by catering units to people under age 18 *(19/1977 Decree)*. Those under 16 could not be present in bars, overnight entertainment facilities, or catering units where alcohol was sold after 10 p.m. Before 10 p.m. they needed permission from their parents. They were allowed

to be present in catering units before 8 p.m. without the permission of parents, but they were not allowed to consume alcohol.

The 6/1990 Decree banned serving alcoholic beverages to drunk people and people under the age of 18 *(6/1990 Decree)*. The 4/1997 Decree of the Government bans service of alcoholic beverages to drunk people and to people under the age of 18 in catering units *(4/1997 Decree)*. It also bans the purchase of alcoholic drinks in retail units and the consumption of alcoholic beverages in catering units for those under the age of 14.

1.1.7 Advertising

Before, 1997 according to Act 1/1978, any advertising was prohibited if it had the aim of increasing sales of the product concerned and of publicising the activity of the company *(1/1978 Act)*. The 19/1977 Decree of the Minister of Internal Trade - as a supplement to the previous law - regulated advertising in retail premises. Advertisements of alcoholic beverages were restricted to between 5 and 10% of the area of the shop-window and the retail area of the premise, depending on the type of premise *(19/1977 Decree)*.

These regulations were dismantled in 1997 by the new act on advertising *(58/1997 Act)*. This is more liberal than the previous regulations. It limits the location and content of the advertisement. Restrictions apply to advertisements targeting young people or places where it is easily visible to them. It bans advertising of alcoholic beverages on toys and their packing, on the front page of any publication and in the theatre or cinema before 8 p.m. Any advertising which targets children and youth, or encourages excessive drinking or tobacco consumption is banned. This act is complemented by an act of 1996 on television and radio broadcasting *(1/1996 Act)*. In principle the content is similar to the advertising act. The advert must not target young people and must not suggest that excessive drinking is positive and abstinence is negative. The advert also must not suggest that consuming low alcoholic beverages may avoid excessive consumption. It must not state that alcohol consumption has any beneficial health effect. Only 15 % of daily broadcasting can be

used for advertising in total. In one hour the time used for advertising can not exceed 12 minutes. Direct advertising can not be more than one hour a day.

In advertising law a tendency towards liberalisation can be observed. EU directives had considerable influence on the new act accepted in 1997.

1.2 Regulations related to drinking behaviour

1.2.1 Drink driving measure

The 1/1975 common Decree of the Minister of Finance and Trade and the Minister of Internal Affairs requires that vehicles can not be driven by anyone who has any alcohol in his body as a result of consumption of alcoholic beverages *(1/1975 Decree)*.

If there is any alcohol in the blood sample, the driver commits either a minor or a criminal offence depending on the blood alcohol level *(1/1968 Act; 4/1978 Criminal Code)*. The National Institute of Forensic Medicine published a "letter of methodology" as a guidance for specialist determination of the influence of alcohol ("alcoholic status" and "alcohol influence") (OIOSzI 1994).

A 1990 Decree on police directives enabled the police to withdraw the driving licence if the driver was proven to have committed the minor offence of drunk driving*(20/1990 Decree)*. This decree was replaced in 1997. The latest version gives the police power to withdraw the driving licence on the spot if the driver is suspected of driving under the influence of alcohol *(48/1997 Decree)*.

Other activities, such as serving under-aged or drunk people with alcoholic drinks, making someone drunk deliberately, breaking rules on road and traffic safety or regulations for workplaces, selling items which are not in accordance with the licensed profile of the premise, are all minor offences *(1/1968 Act)*. Driving with a blood alcohol level (BAL) that exceeds 80mg% is a criminal offence *(4/1978 Criminal Code)*. According to the Criminal Code of 1978, if a person commits a criminal

offence which is related to the alcoholic lifestyle of the offender, he can be sentenced to a period of obligatory treatment. The maximum length of such a treatment cannot exceed six months *(4/1978 Act)*.

1.2.2 Education

Education is regulated by the 79/1993 Act (modified in 1995) on public education *(79/1993 Act)*. This act establishes the framework for a national curriculum. The 130/1995 Decree of the Government describes this curriculum in detail *(130/1995 Decree)*. It sets out different subjects to be taught to different age-groups, as well as general cultural issues which have to be taught. It groups general culture and education requirements according to major areas. One is physical and mental health, in which the responsibility of schools is to prepare children to be able to make healthy choices. Special attention is to be paid to preventing addictions, such as to alcohol, to drugs and to poor nutrition *(130/1995 Decree)*.

1.2.3 Regulations for workplaces

Based on a decree of 1979, workers were obliged to be at work in a condition which is appropriate to perform their work and does not threaten the safety of others *(14/1979 Decree)*. A worker under the influence of alcohol should have been forbidden to work. Special regulations applied to govern the method of checking for the influence of alcohol and the performance of blood alcohol tests *(16/1986 Decree)*.

The 93 Act of 1993 on labour protection and the 5/1993 Decree of the Minister of labour dismantled the previous regulations *(93/1993 Act; 5/1993 Decree)*. The law obliges employers to ensure that workers comply with regulations on health and safety at work. The employer is also obliged to monitor this situation. The law also provides for employers to ban access to alcohol at work. The 25/1996 Decree of the Minister of Welfare regulates general conditions of safe work performance and health requirements of workplaces *(25/1996 Decree)*. Section 88 of the act of 1993, also declares that workers must not be under the influence of alcohol during working hours.

1.2.4 Treatment and care of alcoholics

Legislation on treatment and care of alcoholics has changed frequently. The executive regulation related to the health act in 1972 regulated care and treatment of alcoholics *(15/1972 Decree)*. Alcoholics could be registered for care and treatment as a result of their own decision or based on someone else's initiative. If it was based on an initiative of the relevant health authority the alcoholic was obliged to participate in treatment. Obligatory treatment could be initiated by the partner, relative, any other acquaintance of the alcoholic person or by any state authority, social organisation or co-operative. If the individual did not turn up at the specified treatment centre, he could be taken there by the police. For a period between 1972 and 1978 the Red Cross or the local committee against alcoholism could also make recommendation for obligatory treatment and care (see Chapter 6) *(15/1972 Decree; 3/1978 Decree)*. After 1978 a broader concept of all relevant authorities, social organisations and co-operatives was used *(3/1978 Decree)*.

After 1979 the individual could volunteer for treatment before being required to do so *(3/1978 Decree)*. Treatment could take place at the local care centre for alcoholics[4], in certain hospital wards[5] or at work therapy centres[6] (Buda 1994) The executive decree on voluntary and compulsory treatment was dismantled in 1995 *(7/1995 Decree)*.

With regard to rehabilitation, the 9/1984 Decree of the Minister of Health considers rehabilitation as a part of modern therapy for alcoholics *(9/1984 Decree)*. The law regulates fees and conditions related to these activities.

There is one element of the legislation concerning detoxification (sobering-up) of alcoholics, which is common throughout the former Communist Bloc. From 1972 sobering-up rooms were established*(15/1972 Decree)*, followed by sobering up stations after 1987 *(9/1987 Decree)*. Individuals who were drunk were taken to these

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[4] outpatient type care

[5] specialised in alcohology or addictology

[6] closed hospital type, prison like institutes where patient could not leave the institute during the treatment period; patients participated in work as part of their rehabilitation process

places by the police or the ambulatory service *(2/1979 Decree; 2/1988 Decree)*. The law enabling drunk people to be taken to detoxification centres was still in practice in 1997, with minor modifications.

An interesting element of the legislation was the 1978 directive of the Minister of Health establishing directives for the organisation and operation of clubs against alcohol *(1152/1978 Directive)*. It named the Scientific and Methodological Centre of Alcohology (ATMK) and the National Committee Against Alcoholism (since 1987 the National Committee for Health Promotion) as scientific supervisory bodies of the club movement (see Chapter 6). The directive entitled the organisation responsible for the operation of the club to nominate its leader. The permission of the local council was necessary for the organisation of such a club.

1.3 Summary

In summary it can be concluded that the legislative framework of a comprehensive alcohol policy is in place in Hungary (Table 15). Regulations covering the different alcohol policy elements are embedded in law. While in some cases loopholes in the legislation might exist, efforts can be observed to minimise them.

Hungary is an applicant for European Union membership. Discussion between the Hungarian Government and the EU have already started in 1991 to synchronise legislative and financial background, although official application for membership took place in 1994 (EC 1997). Most recent changes in the legislation take into consideration Directives of the European Union as shown in Table 16.

Table 15 - The elements of a comprehensive alcohol policy as reflected in the Hungarian legislation

Comprehensive alcohol policy elements	Relevant legislation in Hungary
♦ Controls on production	Act on Excise Duty
	Act on the Regulation of the Agricultural market
	Decree on the cultivation of grapes, fruit and production of wine
	Act on Mountain Communities
♦ Quality Control	Codex Alimentarius
♦ Price control	Act on Consumption Tax
	Act on VAT
	Act on Income Tax
	Act on Excise Duty
♦ Availability	Decree of Government on the Operation of Premises & Conditions of Undertaking Domestic Trade Activities
♦ Control on advertising	Act on Advertising
	Act on Television and Radio Broadcasting
♦ Minimum drinking age	Decree of Government on the Operation of Premises & Conditions of Undertaking Domestic Trade Activities
♦ Training of servers	Decree of the Minister of Trade on Necessary Qualifications
♦ Education, information dissemination	Act on Public Education
	Decree of Government on National Curriculum
	Decree of the Minister of Trade on Necessary Qualifications
Preventing harmful consequences of alcohol	
♦ Primary prevention	Act on Public Education
	Decree of Government on National Curriculum
	Decree of the Minister of Trade on Necessary Qualifications
♦ Treatment	Acts and Decrees on Health and Health Care
♦ Control of drink driving	Act on Minor Offences
	Act on Criminal Code
	Decree of the Minister of Internal Affairs on Police Directives
	Decree on Regulations of the Traffic Rules
♦ Control at workplaces	Act and Decree on Labour Protection
	Decree on General Conditions of Safe Work Performance

Table 16 - Regulations in the European Union and in Hungary with the latest year of change in the Hungarian legislation

Measures	EU	Hungary	Year of last change
Drunk driving	20 mg% - UK, Sweden 50 mg% - Au, Fin, Belg, Neth 80 mg% - Germ, Italy, France	0 mg% - minor offence 80 mg% - criminal offence	1968
Taxation	• fixed • proportional • per litre pure alcohol content	11% wine 15% + 2300HUF/l pure alc. beer 860 HUF/l pure alc. spirits	1997
Min age	age limit: 16, 18	buying limit 14 serving limit 18	1994
Availability	limited hours (Denm, Finl, UK) days (Denm, Finl, Swe) type of outlet (UK, Neth)	restrictions on type and location licence needed	1994
Control on production	licence required	licence required excise licence: beer, spirits	1997
Advertising	Bans, restrictions on : TV, Radio, Cinema Strong beverages Voluntary	Restrictions on TV, printed media, cinemas target population and content	1997

A timetable of the evolution of the legislation in the alcohol field is presented in Table 17 at the end of this chapter.

2 Public health in the legislation

As alcohol policy was deemed to be a public health policy in Chapter 3, not only the legislative framework of alcohol policy but also of public health policy has to be understood. The discussion follows in chronological order A more detailed description of institutions referred to can be found in Chapter 6.

2.1 The past decades

The Health Act of 1972 and the 12/1972 Decree of the Council of Ministers has long been the basis of regulation of health, health care and public health until 1998 *(2/1972 Act; 16/1972 Decree)*. The law established essential provisions concerning

health care in the Republic of Hungary and dealt with rights and obligations related to health protection of the population. The structure of the public health element reflected the traditional approach of a division between sanitation and hygiene. The law dealt with health education separately. The section on hygiene included general regulations related to clean water, air and soil, building standards, workplaces and work processes, poisons and radiation, food products and catering units. The section on sanitation covered immunisation, screening, isolation of infected people and surveillance of infectious diseases. This law established the National Public Health and Medical Officer Service (previously State Public Health Inspectorate) as the lead body responsible for sanitation. The section on health education declared the importance of health education and prevention. It required each school, as part of the national education system, to teach lifestyle and health issues. The law also nominated the media as an essential contributor to these actions. This legislation had been the major guidance on public health and remained essentially unchanged for 25 years, until 1997.

In 1987 the 1063/1987 Decree of the Council of Ministers came into force, which established a long term health promotion policy *(1063/1987 Decree)*. This Act was launched short after the inauguration of the new Minister of Health (Dr Judit Csehàk) and made possible certain organisational, institutional changes (see above). This programme was prepared after the 13th Congress of the Hungarian Socialist Worker's Party, in a period when party discipline was loosening considerably, a new generation was entering the Politburo (Political Committee) and changes in the Soviet Union and other communist countries provided a supportive environment (Heinrich 1986).

The decree ordered leaders of the central administration to take the health promotion programme into consideration in all their decisions. It declared that health, as a basic value, had to be considered in all aspects of government activities and in all areas of the economy (e.g. in tax policy, in intersectoral relations, in regulations, etc.). The government also asked for contributions by the media, social and other organisations to the fulfilment of this programme. In the Schedule of the decree the programme was discussed in more detail. It acknowledged the deterioration of health status in Hungary, and warned about the increasing trend of

cigarette consumption and of mortality from chronic liver disease and cirrhosis (500% increase in two decades). It tackled issues such as perinatal mortality, cardiovascular disease, cancer, accidents, suicide, risk factors, inequalities in health, ageing of the population and disability. It considered alcohol in relation to accidents, identifying alcohol as one of the major risk factors for the health of the population. It summarised its aim as being a longer and healthier life for everyone in the country. It also pointed out that to achieve any success everyone had to play a part. Its associated action plan indicated that by the year 1987 a strategy against alcoholism had already been defined. According to this strategy, an important task was to continue health education and information dissemination, particularly to younger age-groups, to enforce non-drinking in workplaces and traffic safety, to impose stricter penalties on those producing spirits illegally, to increase the availability of alcohol-free or low-alcoholic beverages, and through this change the pattern of alcohol consumption. The programme considered itself to be an intersectoral programme. This decree established the creation of the National Committee for Health Promotion (OET) and the Health Promotion Fund (EA).

This programme was quite comprehensive in the sense that it drew conclusions from the analysis of the health status and recognised major health problems. It emphasised intersectoral action and wide-ranging responsibility. It also gave concrete recommendations for action.

2.2 The transition period

The major political changes in 1989-1990 put an end to further development of this programme. The first elected government was preoccupied with restructuring the constitution and creating new laws and regulations. It concentrated on the transition to market economy and public health issues were not among its main priorities (Bartlett 1997, Ilonszki 1992, Vass 1993).

The next major legislative document about public health was issued in 1994, towards the end of the period of the first elected government and after restructuring of the National Public Health and Medical Officer Service in 1991-1992 (see above). The 1030/1994 Order of Government set out the principles for the long term health

promotion policy *(1030/1994 Order of Government)*(Government 1994b). This programme, similar to the previous one, identifies major contributors to the deteriorating health status of the population, such as nutrition, smoking, alcohol consumption, environmental pollution, the lack of health and safety measures in newly developing enterprises, problems related to political changes, such as unemployment, increasing poverty and immigration and the lack of capacity of the National Public Health and Medical Officer Service (NPH&MOC) to cope with the increased burden of licensing and control. This document does not use the term "sanitation" and "hygiene", but uses public health instead. Following the Health for All strategy of the WHO, it sets five national aims, 10 national goals and 20 national programmes. One of the goals is to reduce mortality from chronic liver disease and cirrhosis by 10% by the year 2000. The programme related to this goal deals with information programmes and ways of reducing alcohol and drug abuse. The alcohol and drug programme aims to achieve a 10% decrease in the number of accidents associated with alcohol and in the number of deaths from chronic liver disease and cirrhosis mortality. The related action plan identifies the need for elaboration of a minimum health education programme, information dissemination about the harmful effects of alcohol consumption and the expansion of addiction focused health care facilities, the extension of their work to drug addicts and those who are at risk of suicide. The programme sees the NPH&MOS as the major executor of the programme, but it also plans to involve other national agencies with competence in relevant issues. It establishes the National Public Health Committee (ONB). This was one of the last activities of the Minister of Health of the first government (see above) (Kolláth 09/10/96). This programme was prepared and supported mainly by Dr Pàl Kertai, the first Chief Medical Officer after the reorganisation of the service, and has often been called the Kertai Programme. It has been extensively criticised and widely disregarded, although it is still in practice. Among the many reasons for this is that Dr Kertai retired soon after the programme was launched. Another is that there were elections in 1994 and a new Government came to power.

The second government after the major political changes put special emphasis on the importance of public health in its health policy plan for the period 1994-1998 (Government 1994c). It declares that public health has to be considered when legislative changes take place. First it summarises the principles of modern health

promotion. It states that healthy public policies have to give consideration to the health impact of various sector-specific decisions, and should foster the creation of a supportive economic, social, and natural environment, the strengthening and support of local community actions, personal skills to help the choice of healthy lifestyle, the reorientation of health services and the expansion of their mandate to help prevention.

According to the policy document (WHO 1997), the public health programme has to be finalised and a mental hygiene programme was to be developed based on the discussions of the parliament in the Discussion Day on Health in September 1995. The programme states the need for a prevention programme which is based on the pattern of morbidity in the country. It summarises its aims as being to prevent the occurrence of the most prevalent diseases and to decrease premature mortality. Along with the treatment and early diagnosis of diseases, prevention has to be given priority. The national programme of health promotion will be co-ordinated by the National Public Health Committee.

This programme does not have any specific component on alcohol. Unlike the previous Decree this programme is rather a general summary and guideline than a detailed programme or strategy. It does not have any specific aims or targets, does not discuss implementation, and does not include any action plan in the area of health promotion. In its nomenclature it returns to the 1987 decree as it focuses on health promotion, but it also uses the term "public health".

A new Health Act prepared by the second post-transition government was accepted by the Parliament in 1997 and came in force on 1 January, 1998. The new act brought considerable changes in two areas compared to the 1972 act. The rights of patients are discussed in great detail in the first chapter of the act and the whole of the third chapter is devoted to "public health". Public health is defined here as *"an organised activity of the whole nation with the aim to ameliorate the health status of the population, promote health and prevent diseases" (154/1997 Act)*. The chapter about public health is in six sections, namely health development, environmental health, nutrition, radiation, health at workplaces and sanitation. The section on health development covers general guidelines for health prevention and health promotion. It puts

obligations on the education and training system at all levels to teach healthy nutrition, lifestyle, knowledge about mental hygiene, addictions, health care services and ethical issues related to health. Health education issues according to the act, have to be taken into consideration in the programmes of national radio and television. Although the concept of public health is used in the act, the division between different sections resembles the divisions used in the 1972 act. Apart from the section on health development, the public health concept is still poorly reflected.

The act also talks about a National Health Development Programme, which provides the basis for health planning. It shall include a review of the health status of the population, the aims of health development and health promotion, and the strategic plan to meet these aims. This programme according to the act, shall be accompanied by the establishment of the National Health Council which supports health policy formulation. Its members shall come mainly from the health sector. These elements of the act are similar to that in the 1063/1987 Decree of the Council of Ministers which set out the long term health promotion policy and the establishment of the National Committee for Health Promotion (OET, see Chapter 6). There are still many uncertainties related to the future of the Programme and the Committee because of the general elections and subsequent change of government in May 1998.

2.3 Summary

A gradual shift from sanitation and hygiene towards the broader concept of health promotion and public health can be observed over the past decades. The continuity of this shift was slightly interrupted by major political changes. Public health only came on the agenda in any meaningful way five years after the transition started. Major legislative changes are summarised together with changes in the alcohol related legislation in Table 17, at the end of this chapter. The table also includes organisational changes, which are discussed in the next chapter.

Most legislative documents in the field of public health do not refer to alcohol, although it is often mentioned as a problem. The only exception is the 1994 government decree where alcohol is discussed in more detail together with other

major risk factors. Although alcohol is not specifically discussed in most cases the broad concept of mental health seems to have been on the agenda since 1995.

The next chapter focuses on changes in alcohol policy over the past decades. It also summarises constitutional arrangements and organisational arrangements in the alcohol field.

Table 17 - Timetable of legislative and organisational changes

Years

70 71 72 73 74 75 76 77 78 79 80 81 82 83 84 85 86 87 88 89 90 91 92 93 94 95 96 97 98

72 Health act

77 decree on fight against alcoholism

87 long term health promotion policy (alcohol included)

94 principles of long term health promotion policy (alcohol incl)

94-98 health policy of the government

95 Parl.: discussion 97 health act day on health

---

72 voluntary or obligatory treatment

72 sobering-up rooms

78 obligatory can be by anyone's report

79 transport to detox. regulated

78 directive on clubs against alcoholism

87 sobering-up stations

88 transport re-regulated

95 dismantled

---

87 Cons tax

88 VAT

91 Cons Tax

92 VAT

93 Excise & spirit distil. tax

94 Mountain Communities

93 Agricultural Market Regul.

78 Act on Domestic Trade

70 regul on grape, wine production

77 cultivation, production, labelling, bottling, marking, storage of wine and brandy

86 packing and labelling of alcoholic bever.

95-96 EU directives production, packing, labelling, bottling

77 limit on sale of alcoholic beverages; licensing

86 licensing modified (AEAB)

94 Obligatory report to notary

97 licensing of premise by notary

77 alcohol can not be sold at workpl, schools, health facil.

86 ban extended, more detailed

77 200m distance law, from workplaces

86 200m law extended (schools, health care)

97 200m law, exception by notary possible

77 alcohol can be sold only at certain premises

93 Excise, only in certain premises can be sold (similar)

77 alcohol can be sold only after 9 a.m.

86 further restriction (5-9 a.m.)

89 dismantled

77 min. drinking age 18, under 16 strict regul.

97 min. drink. 18, buying 14

78 no advertising

97 liberal advertising act

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68 AEOB

77 OENI

78 ATMK

83 AEAB

87 OET

86 OAI

90 NEVI

95 MHPI

Table 18 -The Hungarian legislation on alcohol

Number and type of regulation	Subject of the regulation
27/1987 Decree of the Council of Ministers	on the Introduction of Consumption Tax
51/1989 Act	on Consumption Tax
78/1991 Act	on Consumption Tax
74/1992 Act	on Value Added Tax
12/1995 Act	on Income Tax
83/1997 (20.05) Decree of the Government	on Conditions of Paying Tax of Agricultural Producers (executive decr. of 17/1997 Act)
17/1997 Act	on Conditions of Paying Tax of Agricultural Producers
58/1993 Act	on Control of Excise and Subcontracted Spirit Distillation Tax
103/1997 Act	on Excise Duty and special regulations of the retail of products subjects to excise duty
86/1991 Act	on Corporate Tax
81/1996 Act	on Corporate tax and Dividend Tax
100/1995 Act	on Custom Law
21/1976 Decree of the Council of Ministers	on Customs Tariffs
101/1995 Act	on Custom Tariffs
45/1996 Decree of Government	on Custom Duty
6/1993 Act	on the Regulation of the Agricultural Market
36/1970 Decree in Act Force	on the Cultivation of Grape and Fruit, and Production of Wine
102/1994 Act	on Mountain Communities
40/1977 (29.11) Decree of the Minister of Agriculture and Food Administration	on the cultivation of fruit and grape, wine production -(executive decree of 36/1970 Decree in Act Force)
90/1995 Act	on Food Products
1/1996 (09.01) Common Decree of Minister of Agriculture, Minister of Welfare & Minister of Trade and Industry	on Food Products (executive decree of 90/1995 Act on Food Products)
	Hungarian Codex Alimentarius
1-3-1576/89	General Rules on the Definition, Description and Presentation of Drinks (1995)
2-91	on Certain Spirituous Drinks (1996)
1-1-87/250	on the Indication of Alcoholic Strength by Volume in the Labelling of Alcoholic Beverages for Sale to the Ultimate Customer (1995)
1-1-75/106	on the Ranges of Nominal Quantities and Nominal Capacities Permitted for Certain Pre-packaged Foodstuffs (1995, modified 1996)
12/1986 Decree of the Minister of Internal Trade	on Packing and Labelling of Alcoholic Beverages
6/1990 (05.04) Decree of the Minister of Commerce	on the Operation of Premises
1/1978 Act	on Internal Trade
19/1977 Decree of the Minister of Internal Trade	on Limitations of Sale of Alcoholic Beverages
14/1972 Decree of the Minister of Internal Trade	on Sale of Alcoholic Beverages

Legislation (continued)

Number and type of regulation	**Subject of the regulation**
14/1976 Order of the Minister of Internal Trade	on Sale of Alcoholic Beverages (modifying the 14/1972 decree)
4/1994 (14.01) Decree of the Minister of Trade and Industry	on the Operation of Premises
4/1997 Decree of the Government	on the Operation of Premises & Conditions of Pursuing Domestic Trade activity
19/1977 (20.12) Decree of the Minister of Internal Trade	on the Limitation on Retail of Alcoholic Beverages
12/1986 (10.12) Decree of the Minister of Internal Trade	on the Limitation on Retail of Alcoholic Beverages
45/1986 (30.10) Decree of the Council of Ministers	on the Limitation on Retail and Consumption of Alcoholic Beverages
9/1991 (26.04) Decree of the Minister of Trade and Industry	on the Operation of Premises
5/1989 (01.04) Decree of the Minister of Commerce	on the Limitations of Sale of Alcoholic Beverages
5/1990 (05.04) Decree of the Minister of Trade	about Specialisation Training & Degree
5/1997 (05.03.) Decree of the Minister of Trade and Industry	about Qualification Needed to Perform Specific Industrial & Commercial Activities
1/1978 Act	on Internal Trade
58/1997 Act	on Commercial Advertising
1/1996 Act	on Television and Radio Broadcasting
1/1975 (05.02) Common Decree of the Minister of Finance and Trade and the Minister of Internal Affairs	on Regulations of the Order of Transport (KRESZ)
1/1968 Act	on Minor Offences
4/1978 Criminal Code	on Criminal Code
20/1990 (06.08) Decree of the Minister of Internal Affairs	on Police Directives
48/1997 (26.08.) Decree of the Minister of Internal Affairs	on Police Directives
79/1993 Act	on Public Education
130/1995 (26.10) Decree of the Government	on National Curriculum
14/1979 (30.11) Decree of the Council of Ministers	on Labour and Work Safety
16/1986 (17.12) Decree of the Minister of Health	On Control of Drunkenness at Workplaces by Testing BAL
93/1993 Act	on Labour Protection
5/1993 (26.12) Decree of the Minister of labour	on Labour Protection (executive decree of 93/1993 act)
25/1996 (28.12) Decree of the Minister of Welfare	on General Conditions of Safe Work Performance and Health Requirements of Workplaces
15/1972 (05.08) Decree of the Minister of Health	on Health Care and Treatment (executive decree of 2/1978 Health Act)
3/1978 (03.06) Decree of the Minister of Health	on the Modification of Health Care and Treatment Executive Decree
7/1995 (10.02) Decree of the Minister of Welfare	on the Modification of the 15/1972 Executive Decree of Minister of Health on Health Care and Treatment
9/1984 (22.08) Decree of the Minister of Health	on the Work Therapy of Patients Treated in Health Care
9/1987 (19.08.) Decree of the Minister of Health	on the Modification of the 15/1972 Executive Decree of Minister of Health on Health Care and Treatment

Legislation (continued)

Number and type of regulation	**Subject of the regulation**
2/1979 (01.08) Common Decree of the Minister of Internal Affairs & the Minister of Health	on the Transport of Drunk People to Detoxification Centres
2/1988 (15.12.) Common Decree of the Minister of Internal Affairs & the Minister of Health and Social Affairs	on Transport of Alcoholic to Detoxification (sobering-up) Stations
1152/1978 Directive of the Minister of Health	on Directives to the Organisation and Operation of Clubs Against Alcohol
2/1972 Act	on Health
16/1972 (29.04) Decree of the Council of Ministers	on the execution of 2/1982 Health Act
1063/1987 (10.12) Decree of the Council of Ministers	on Long Term Programme of Health Promotion
1030/1994 Order of Government	on Principles of long term health promotion policy
154/1997 Act	on Health
20/1949 Act	on the Constitution of the Republic of Hungary
10/1992 Act	on Social and Health Insurance Fund (modifying the 21/1988 Act on Social and Health Insurance Fund)
11/1991 Act	on the National Public Health and Medical Officer Service
1731/1951 Decree of the Council of Ministers	on the State Public Health Service (Inspectorate)
127/1951 Decree of the Minister of Health	on the execution of the 1731/1951 Decree of the Council of Ministers on the State Public Health Service
22/1977 Order of the Minister of Health	on the establishment of the National Institute for Health Education (OENI)
1065/1987 Decree of the Council of Ministers	on the establishment of the National Committee for Health Promotion (OET)
73/1987 Decree of the Council of Ministers	on the establishment of the Health Promotion Fund (EA)
3/1986 Order of the Minister of Health	on the National Institute of Addictology
2024/1977 Order of the Council of Ministers (10.09)	to Increase the Action Against Alcoholism
10/1983 Order of the Minister of Health	on the Scientific and Methodological Centre of Alcohology (ATMK)
1152/1978 Directive of the Minister of Health	on the Scientific and Methodological Centre of Alcohology (ATMK)
1/1988 Act	on Public Safety
2002/1992 Order of the Government	on the execution of 1/1988 Act on Public Safety

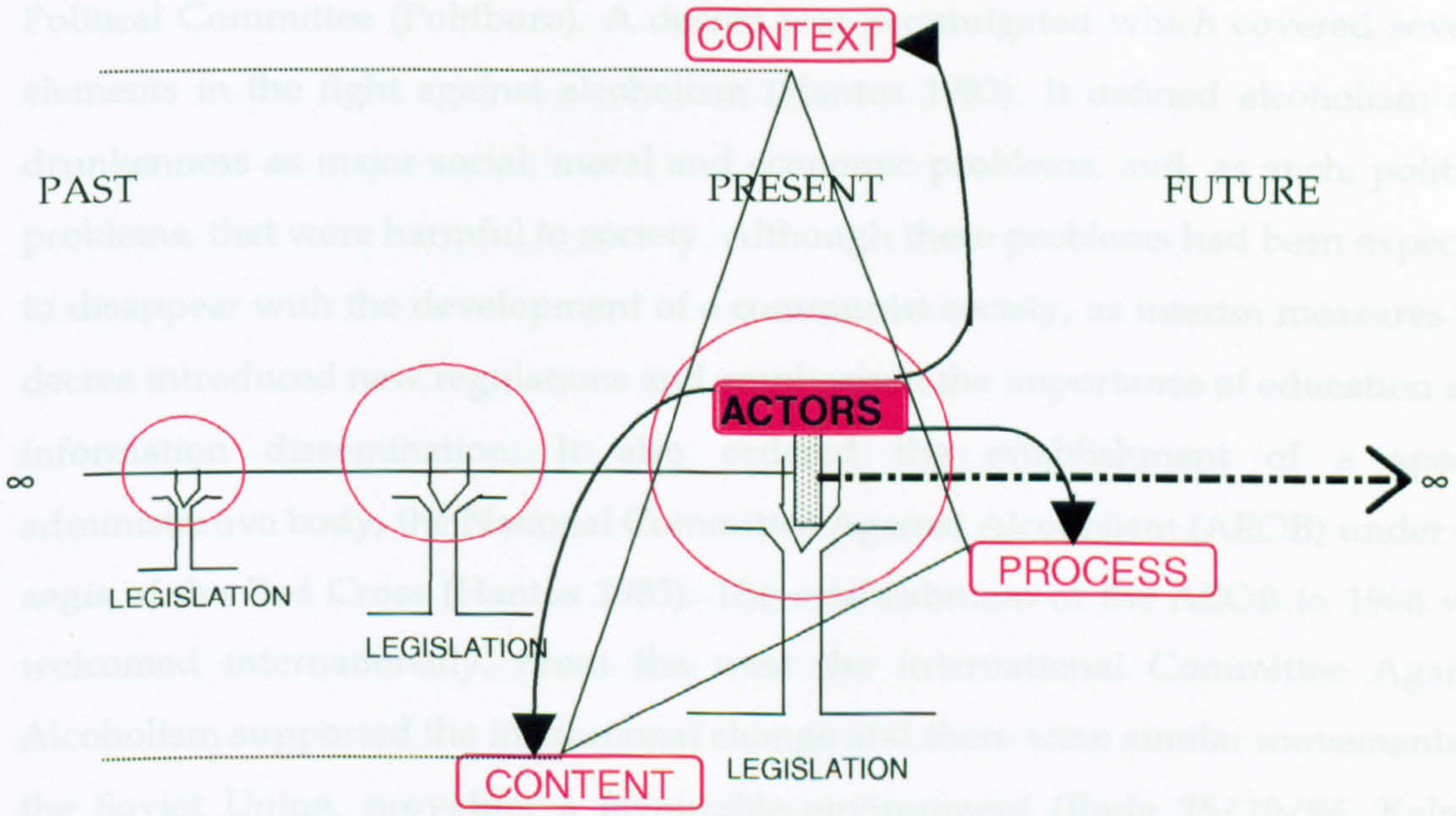
- *CHAPTER 6* -

ALCOHOL POLICY IN HUNGARY & THE ORGANISATIONAL STRUCTURE

THE SHAPE OF THE TREE

This chapter first describes the changing "tree" of alcohol policy over time and second, the constitutional arrangements and the organisational setting in which alcohol policy exists (Figure 22). The discussion addresses policy content, context, process and actors together without making a sharp division, as these elements are closely linked to each other.

Figure 22 - The tree of alcohol policy and the policy triangle framework



1 The changing concept of alcohol policy

The changing concept of alcohol policy is discussed by reviewing published alcohol policy documents. The review covers the post-war period, with a special focus on the period from the 1970s to the 1990s.

Legislative and organisational changes are not discussed here as a detailed description has been given in chapter 5 and this will also be discussed in the second section of this chapter.

1.1 The approach taken by government

Recognition of alcohol-related problems in Hungarian society in the post-war period dates from 1956, when the Minister of Welfare launched a programme enforcing activities concerning alcohol related problems, such as orders for compulsory treatment and special work-therapy institutes (Németh 1991). In the second half of the 1960s alcoholism emerged on the agenda of the Hungarian Workers Party Political Committee (Politburo). A decree was promulgated which covered several elements in the fight against alcoholism (Hantos 1983). It defined alcoholism and drunkenness as major social, moral and economic problems, and, as such, political problems, that were harmful to society. Although these problems had been expected to disappear with the development of a communist society, as interim measures the decree introduced new regulations and emphasised the importance of education and information dissemination. It also ordered the establishment of a special administrative body, the National Committee Against Alcoholism (AEOB) under the aegis of the Red Cross (Hantos 1983). The establishment of the AEOB in 1968 was welcomed internationally. From the west the International Committee Against Alcoholism supported the institutional change and there were similar movements in the Soviet Union, providing a favourable environment (Buda 25/10/96, Kalmàr 1981).

In 1977 the Order of the Council of Ministers summarised "necessary actions to increase the fight against alcoholism" (AEÁB 1984, Council of Ministers 1977, Hantos 1983). This document urged further control on the availability of alcoholic beverages, an increase in the number of hospital beds for patients suffering from alcoholism (addictological beds) and enhancing institutional support. This decree was followed by numerous legislative changes, for example, concerning the availability in place and time of alcoholic beverages (see chapter 5). Following this decree the Scientific Methodological Centre of Alcohology (ATMK) was established (see later) (Simek 1980).

In 1986, changes in the legislation concerning availability of alcoholic beverages occurred. These reflected the Gorbachev campaign taking place in the Soviet Union

that time (see later). However, most of the restrictive measures recommended already existed, so there were no striking changes (see Chapter 5).

In 1987, the government's long term health promotion policy highlighted the increasing death rate from chronic liver disease and cirrhosis. It identified alcohol as a major risk factor for the health of the population (Council of Ministers 1987). In the second half of the 1980s considerable organisational restructuring took place to support a more effective health promotion policy.

After the major political changes, the 1030/1994 Order of Government set out the principles of the government's long term health promotion policy. It is the most recent government policy document which specifically deals with alcohol problems (Government 1994b). Its target for health improvement by the year 2000 includes reduction of deaths from alcohol-related accidents, chronic liver disease and cirrhosis by 10%, and slowing the rate of increase in the number of alcoholics. It urges further legislative changes and a broader scope of alcoholic outpatient care which will also target drug addicts, people at risk of suicide and those with other mental health disorders. Collaboration by a range of agencies is identified as an important prerequisite to achieve the targets. The implementation programme is designated as the responsibility of the National Institute of Alcohology (OAI) and the National Institute for Health Promotion (NEVI). Since this decree, no further government documents have tackled alcohol policy issues. Although alcohol was acknowledged as a problem in the government programme for 1994-1998, it did not include any specific alcohol policy action.

The latest development in the alcohol policy field is a new project for alcohol and tobacco policy development in Hungary. It is a sub-component of the public health component of the Health Services Modernisation and Management Programme supported from the World Bank loan (NIHP 1998).

1.2 Movements outside government

There has been a long tradition of pressure from scientists and physicians in Hungary to respond to the threat posed to health by alcohol.

Problem recognition

Simek, who was active in the alcohol field in the late 1970s and early 1980s urged a long-term alcohol policy which would have included education in "mental hygiene", training, screening and integrated workplace programmes (Simek 1980). Levendel also published influential articles about the extent of alcohol related problems in the same period (Andorka 21/10/96, Buda 25/10/96, Levendel 1990). He noted that by the end of the 1970s the extent of alcohol related problems reached a "critical level", when their existence could no longer be denied by the authorities (Levendel 1990). As a result, the government promulgated its decree setting out the action against alcohol problems in 1977 (see before).

Main research streams

At the same time, the Secretary of the Central Committee of the Communist Party was someone who was interested in social problems, later becoming the director of Research Institute of Social Sciences (TÁRKI) (Andorka 21/10/96, Buda 1994, KEB 1997). Partly because of the general acceptance in government circles of alcoholism as a problem and changes in personnel in the 1980s central resources were allocated to research on deviant behaviour in Hungarian society (Kolozsi 1987/88). This was designated as the "Main Research Stream of Deviant Behaviour in the Society". TÁRKI played a considerable part in it, with links with other leading scientists (Andorka 21/10/96, Buda 25/10/96). The deviant behaviour theory was widely used to explain the increase in alcohol related problems (Andorka 1988, Andorka 1990). Studies arising from this research began to be published by the end of the 1980s. Political changes, however, put an end to the programme and it was not replaced, although smaller programmes related to alcoholism and mental health were funded by the Soros Foundation and, after 1994, by the Risk Handling Fund of the National Health Insurance Fund (OEP 1994, OEP 1995, OEP 1997, Soros Foundation 1995, Soros Foundation 1996).

Institutional changes

During the 1970s and 1980s institutes concerned with alcohol problems were established and reorganised, often several times. These institutional changes were initiated by the country's leadership and implemented at national level through the Ministry of Health (see next section).

The medical approach

The medical approach to alcohol problems was very influential at the end of the 1970s and in the 1980s. It was reflected in numerous documents which urged the expansion of the "alcohological" and "addictological" care (Bànki & Fejèr 1983, Gesztesi 1981, Levendel 1983, Levendel 1990). This approach has persisted through the 1990s. Publications from this period still focus on alcohol dependence and abuse, provision of services and rehabilitation, and the "complex treatment approach of addiction", which means services provided together for any types of addiction (Fekete 1995, Félúton 1994, Holzberger 1990, OAI 1992, OAI 1994, OAI 1995b, OAI 1996, OKOI & OAI 1990).

A move towards a broader concept

Throughout this period, few authors have challenged the prevailing medical approach, although the number of publications which reflect a broader view of alcohol related problems is increasing.

In the 1980s a comprehensive summary of alcohol-related problems was produced by Andorka. Reviewing the costs of a wide range of alcohol related damages he prepared recommendations based on a broad understanding of alcohol related policy, emphasising not only treatment and rehabilitation, but also the importance of controlling availability and price (Andorka 1988).

By the 1990s increasing number of commentators turned to a more comprehensive approach. Pèter, a general practitioner particularly active in the alcohol field, emphasised a multi-disciplinary approach to the "fight against alcoholism". His specific recommendations included printing safe and hazardous limits of alcohol intake in driving licenses and for GPs to screen for alcohol-related problems. This took advantage of the Hungarian requirement for medical examination before issuing a driving license (Péter 1987/88, Péter 1991). He considered government commitment to alcohol policy important.

In 1993 Levendel translated the European Alcohol Action Plan to Hungarian (Levendel 1993b). Based on that he also prepared a Hungarian version (Levendel 1994). It says:

"Central and Eastern European Countries of transition are considered to be in a crisis situation. The different ministries involved in the process of production, distribution and retail sale of alcoholic beverages should work out a common concept and a strategic plan. The existing legislation should be controlled and further regulations might be necessary. The regional community councils must have an important role. The non-governmental organisations need further support and encouragement. With strengthening primary care GPs have a more and more important role in the overall process. This activity should be supported through training and education. The National Institute of Alcohology (OAI) should encourage research. Journals, books are regularly published about alcohol problems and this activity should be carried on. Data management systems need renewing. Workplaces are also important in rehabilitation. As the regulations and responsibilities are divided between different organisations and institutions a strong and effective consensus is needed. The concept of benefits from the avoidable losses should be accepted and incorporated into the financing procedure. The new prevention program must be worked out in detail by the National Health Promotion Council (OET)".

Levendel also prepared a summary of potential responses to alcohol at community level. He highlighted the increasing importance of local communities in actions against alcoholism and the lack of a financial basis for their activities. He continued to emphasise the importance of treatment, rehabilitation and the role of families (Levendel 1991).

At the same time, Hajnal proposed a systems-based approach to combine activities against alcoholism more efficiently. He summarised this approach using the framework recommended by the WHO: health promotion, health maintenance and treatment. His concept was organisationally complex and raised important points for policy formulation, but lacked an evidence base for implementation (Hajnal 1990, Hajnal 1992).

Andorka, in the 1990s, differentiated alcohol policy according to its focus and described three approaches: (1) on treatment and rehabilitation of alcoholics, (2) on regulating availability of alcoholic beverages and (3) on education about its harmful effects. Although he gave a useful summary of alcohol and its effects

based on mortality, consumption and police data, he did not formulate an overall policy concept (Andorka 1994).

In 1995, the National Institute of Alcohology contributed a document on alcohol policy for the mental hygiene programme. This document, apart from emphasising the maintenance and development of addictological care services, also included points about advertising, availability restrictions and price increases (OAI 1995a).

Summary

Alcohol related problems, particularly alcoholism, emerged on the agenda of the government as early as the 1960s. The problem was perceived as limited to alcoholism and a solution was expected as the society changed from capitalism to socialism (see Chapter 7). Alcohol was considered a moral problem linked to capitalism. In this respect the view of alcohol policy as public policy can be observed in Hungary before the 1970s.

By the end of the 1970s the existence of alcohol related problems was increasingly acknowledged and improvement was now expected as a result of increasing the number of "alcohological" beds and limiting availability of alcoholic beverages. Organisations were designated to "handle the problem". Hence, the alcohol problem became medicalised, which moved alcohol towards the concept of being a health problem.

The Gorbachev reforms, in the Soviet Union, in the middle of the 1980s, encouraged some further minor restrictions on availability. The 1980s were also accompanied by institutional restructuring with the aim of handling the alcohol problem better. However, throughout the 1980s, against a backdrop of steady political change, there was growing awareness of a range of other public health problems. The range of activities pursued by the organisations active in the field of public health gradually widened and alcohol became one of many issues (see next section). This tendency was reflected in the government's 1987 health promotion programme, in which a shift towards a broader public health concept became clearer.

Changes in alcohol policy described above were also reflected in the scientific literature. First, in the 1950s and 1960s it was forbidden to write that alcohol was a problem. Subsequently literature concentrated on alcoholism. The medical approach to alcohol related problems prevailed throughout the 1970s and 1980s, although a few scientists showed a broader awareness. By the middle of the 1990s, documents increasingly reflect a broader concept to of alcohol related problems, although they continue to emphasise the importance of treatment and care services.

2 *The organisational structure and constitutional arrangements*

Changes in alcohol policy were accompanied by institutional changes. These are reviewed in the following paragraphs.

This section aims to present

- the formal decision making structures and processes at national level,
- how the different organisations relate to each other in this structure,
- what are their main functions and sources of funding, and
- their specific features that affect policy on alcohol

First the constitutional arrangement and the decision making process in the central administration is presented, followed by a description of specific organisations with roles in relation to alcohol. The discussion follows the classic division of powers in a democratic state: legislative, executive and judicial and the functions fulfilled by different organisations as described in the policy cycle.

2.1 Constitutional arrangements during the communist era

Constitutional arrangements in Hungary, during the communist era, were modelled on the Soviet constitution, as in all countries of the Soviet Bloc (Bihari 1979, Heinrich 1986, Tomaszewski 1989). Hungary adopted a communist constitution in 1949, which it modified several times since then, with a major modifications undertaken in 1972. The constitution designated the people as the supreme authority and the parliament as the highest organ of state power. The National Assembly elected the

Council of Ministers, the Supreme Court Chairman, the Chief Prosecutor and the Constitutional Law Council. The Council of Ministers the Supreme Court and the Chief Prosecutor were guided, controlled and subordinated to the parliament. The parliament had standing committees, where the bulk of the parliamentary work took place.

The parliament only meet 3-4 times a year. In the interim period its function was carried out by the Presidential Council. It operated as a substitute for the parliament and a collective presidency. Although it did not have full legislative functions and could enact only secondary legislation (law-decrees), in practice it adopted the combined roles of a "small parliament and a collective head of state".

At lower levels local administrative power was devoted to elected councils. The system of local government in Hungary was established in 1950. At first, city and district councils handled all local affairs. They were subordinated to county councils, which represented the next step in the hierarchy.

The most important element of government was the Council of Ministers. By law it was subordinated and responsible to the National Assembly, however it had almost complete autonomy and fulfilled the function of the executive. It was established in 1949, although it was only the 1972 reform of the constitution which gave it responsibility to "guide, influence and control the entire constitution of socialism". It consisted of a chairman, five deputy prime ministers, thirteen ministers and the chairman of the National Planning Authority.

Despite the constitutional arrangements in which there was formal division of power with the centre and with local government, centralisation tendencies could be observed in most countries of the Soviet Bloc, especially during the 1950s and 1960s (Tomaszewski 1989). The legislative function of parliaments were reduced, with no real parliamentary discussions taking place and the Presidential Council fulfilling the duties of the parliament. Parliamentary approval of laws became a formality. The increasing centralisation process removed any autonomy from local councils. Major political and economic issues were decided by the party congress and the central committee of the party. Thus, in practice, the dominant position in political

life was assumed by the Communist Party. The basic concept of the system was "democratic centralisation".

The Hungarian Socialist Workers` Party was also centrally organised (Heinrich 1986). At the bottom were the party representative bodies at workplaces. They delegated members to the county level organs which were representated at the Party Congress. Party Congresses took place every five years and were the sounding board for mid-term policies. The party had a Central Committee, which in practice was the parliament of the party, having meetings every three months. The Central Committee was the real locus of power, where all major decisions were made which affected party members and the whole society. It had several departments and a secretariat with eight secretaries each in charge of specific policy areas. The Central Committee formed the Politburo, which functioned as the government of the party. It had thirteen members.

The constitution of 1949 was modified several times before 1989, and apart from the change in 1972 other changes were relatively minor. Although the presence of the communist party became less and less visible by the end of the 1980s, it continued to monitor all political processes and retained ultimate main power.

2.2 Constitutional arrangements after 1989

The major political changes in 1989 were followed by changes in constitutional arrangements. A clearer split of the legislative, executive and judicial functions of the state were introduced. The new Parliament met on 2 May, 1990 for the first time (Ilonszki & Judge 1994).

In this new arrangement a non-executive **President** is the head of the state (Szabo 1995). He represents the Republic of Hungary to foreign visitors. He has certain formal roles and functions, such as the appointment of individuals to certain positions, such as the Prime Minister, the President of the National Bank, the President of the Academy of Sciences and ambassadors. He gives formal assent to legislation enacted by Parliament. Among other roles he decides the date of elections (Parliament 1949).

The legislative function of the administration takes the form of the single chamber National Assembly (Szabo 1995). The **National Assembly (the Parliament)** is the supreme organ of state power and the final setting of decision making. The Parliament opposes or accepts changes to the constitution and law, decides about issues where it has national competence, adopts the programme of the Government and agrees the budget (Parliament 1949).

Members of Parliament are elected for a four-year term, according to a form of proportional representation that combines constituencies and party lists, analogous to that in Germany (Ilonszki & Judge 1994).

The executive function is represented by the **Government**. At the top of the central administrative hierarchy is the government (the cabinet), which includes from the Prime Minister and Ministers (Parliament 1949). Each major public sector has its ministry (department). Currently there are twelve ministries lead by ministers. They can be substituted for by state secretaries. Issues, which by their magnitude and nature, do not require ministerial decisions, are delegated to state institutes with designated competence. These institutes typically are led by state secretaries or deputy state secretaries, and the institutes are subordinated to a minister or the Government. Such an institute is the Central Statistical Office operating under the supervision of the Government (Dudás & Hazafi 1996a).

The system of government is underpinned by a written constitution. It is safeguarded by the Court of Constitution appointed by the National Assembly (Parliament 1949).

The judicial function of the state is headed by the **Supreme Court, the Supreme Procuracy and the Court of Constitution** (Szabo 1995). The president of the supreme court is appointed by Parliament and justices are appointed by the President. Under the supreme organs of the judiciary operates the country-wide court system, with regional and local offices. The judicial system is independent from government (Parliament 1949).

The Office of the President, the Office of the National Assembly and a few other agencies have special status under the constitution. They operate independently from government and the central administration, however they have national public responsibilities. They are known as "quasi organisations of the central administration" (Dudás & Hazafi 1996a).

In addition there are para-state bodies with certain delegated functions. Public bodies, such as the National Pension Fund and the National Health Insurance Fund belong into this group (Dudás & Hazafi 1996a, Hoffer & Bojan 1994, Parliament 1992).

2.3 Decision Making in the Central Administration

With the new constitutional arrangements after the communist regime, a different structure of legislative decision making was established. In the discussion a division is made between primary and secondary legislation. Primary legislation refers to acts, which are the principle means of enacting legislation. Acts cover a wide range of issues necessary for the operation of state, society and economy. These are supplemented by secondary legislation, such as decrees and orders. These usually contain detailed instructions for implementation .

For primary legislation the ultimate decision is made by the Parliament. Secondary legislation is enacted by the cabinet or an individual ministry (sectoral issues).

The decision making process at central level follows procedures laid down in the constitution. The precise procedure depends on the type and nature of the issue, and is determined by the end stage of the decision making process. Without discussing all possible options the most common are presented here.

Proposals are first discussed internally in the relevant ministry. These are circulated to other ministries with an interest in the subject, as well as to expert committees and consultants, if necessary. After considering the results of these consultations, the proposal is discussed at the meeting of State Secretaries. Following this the issue is presented to the cabinet, accompanied by "all necessary information to help decision

making, including its rationale, main objectives, costs, potential societal, economical, internal and external impact" (Dudás & Hazafi 1996a). The cabinet can submit proposals to the Parliament. Each recommendation submitted to the government has to include "all necessary information to help decision making, including its rationale, main objectives, costs, potential impact on society and economy, internally and externally" (Dudás & Hazafi 1996a). The Parliament then enacts the proposal into law, modifies it or rejects it (Parliament 1949). Secondary legislation remains at ministerial or cabinet level.

New proposals can also be submitted to the Parliament by the President, the Constitutional Court, or a parliamentary committee (Parliament 1949).

Expert consultative groups operate at all levels of the decision making process. The Parliament has parliamentary committees, the Government has governmental committees and ministerial commissioners, there are inter-ministerial committees, ministries have cabinets and it is also possible to consult internal or external experts. These advisory bodies can be mandated either to advise or to initiate or scrutinise the legislation. If legislation is initiated by any of these other groups it still has to go through the process described in the previous paragraphs.

3 Organisations with a stake in public health & alcohol policy

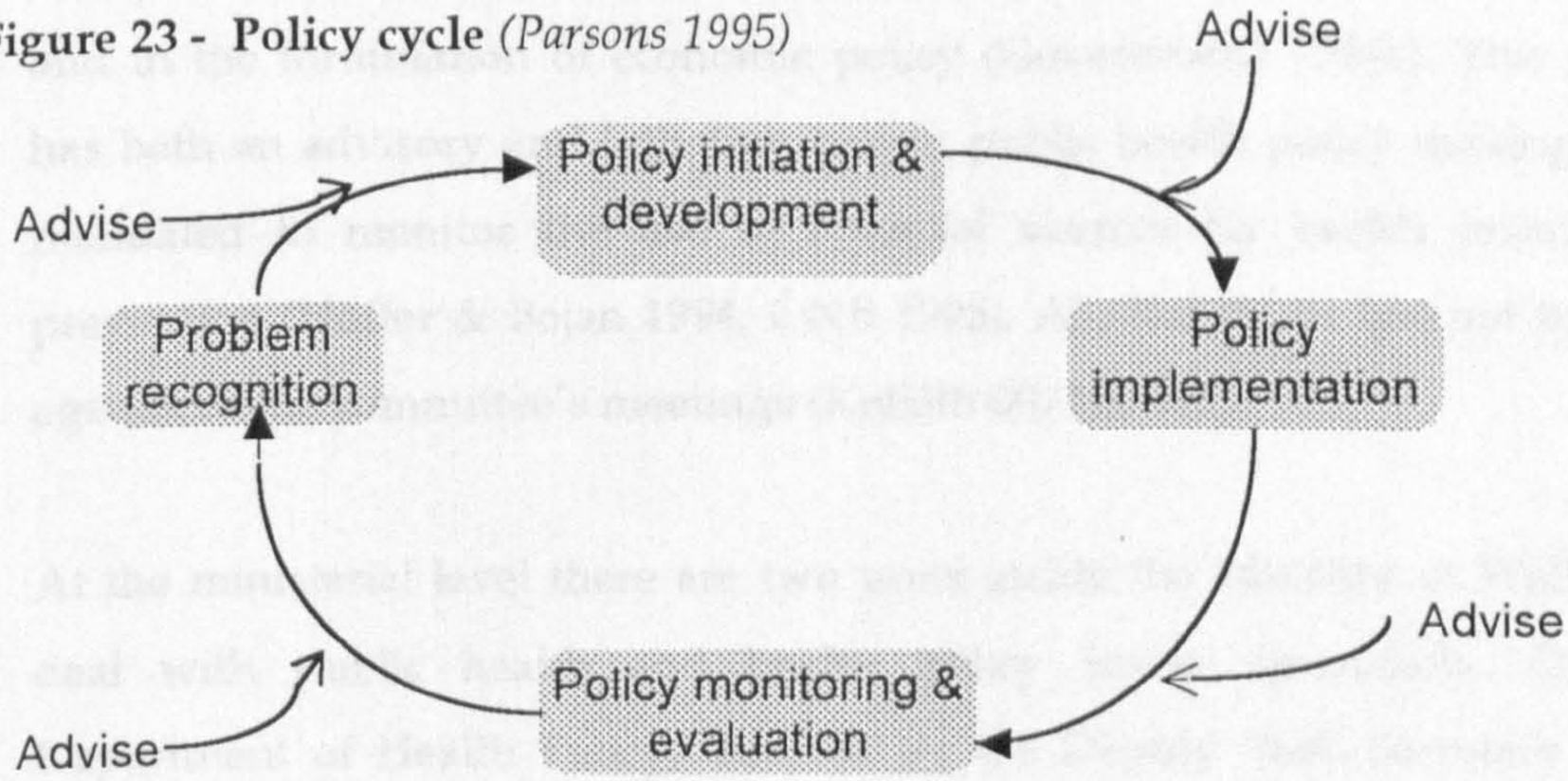
In the forthcoming section the aim is to present major organisations with a stake in public health and alcohol policy and to discuss their official roles. The discussion follows four dimensions:

- formal function,
- major activity focus (whether health, public health, road and public safety, control, production and trade or other),
- place in the policy cycle (Figure 23), and
- significant changes over time.

The policy cycle is used here to help to differentiate between different elements of policy making. It originates from the stageist approach to policy which considers

policy making a sequential order of stages. This approach has often been criticised in that these stages, in reality, are often present together, parallel to each other and a clear separation in a sequential order does not reflect the actual policy making process (Lindblom 1980, Sabatier & Jenkins-Smith 1993). Here this approach is used to guide the discussion, but for this purpose a necessary sequential order of these stages is not implied.

Figure 23 - Policy cycle *(Parsons 1995)*



First, organisations in the health sector are discussed, taking into consideration the medical approach to alcohol problems and the concept of alcohol policy as a health policy. This is followed by a summary of organisations outside the health sector.

3.1 Health sector

Legislative branch

Closely linked to the legislature is the **Parliamentary Committee for Health and Social Affairs (SZEB).** This committee is a standing committee of the National Assembly (SZEB). It focuses on social, health and welfare issues, and as such deals with public health questions. Its major role is to advise the Parliament, but it is also mandated to initiate policy and legislation. It should be noted that the current president of the committee was the minister of health in the second half of the 1980s, before the major political changes, previously also being Deputy Prime

Minister and Chair of the State Committee Against Alcoholism (AEÁB) (Buda 25/10/96, Csehák 08/10/96).

Executive branch

In the executive, the **National Public Health Committee (ONB)** represents the highest forum for public health. This inter-ministerial committee was established in 1994, led by the Minister of Welfare. It is responsible for inter-sectoral co-ordination to ensure that health is considered in sectors outside the health sector and in the formulation of economic policy (Government 1994b). This committee has both an advisory and initiating role in public health policy making. It is also mandated to monitor the use of financial sources for health promotion and prevention (Hoffer & Bojan 1994, ONB 1995). Alcohol so far has not been on the agenda of the committee's meetings (Kolláth 09/10/96).

At the ministerial level there are two units inside the Ministry of Welfare which deal with public health and health policy issues specifically. One is the Department of Health Policy, directed by the Deputy State Secretary of Health Policy, the other is the office of the Commissioner of Health Promotion. The Ministry of Welfare can initiate and develop policy. It supervises funding for public health and health promotion activities. It is also entitled to monitor and evaluate policies. Through the directorship and supervision of national institutes it is indirectly involved in policy implementation (Dudás & Hazafi 1996a, Kereszti 10/09/97, Kricsfalvi 12/05/97, Mogyorós 21/11/96).

Outside the state

At sub-ministerial level, four national organisations could be identified with a stake in the public health and alcohol fields. The first three operate under the broad supervision and the fourth under the direction of the Ministry of Welfare.

The first, the **National Institute for Health Promotion (NIHP or NEVI)** was established in 1990. It is charged with the development of health promotion programmes, planning, evaluation and co-ordination of "healthy public policy" (Hoffer & Bojan 1994, NEVI 1996). It is designated to be a scientific, methodological, training and research centre of the Ministry. As such the

institute's main functions are policy advice, development and implementation. The institute is financed from the central budget through the Ministry of Welfare. Organisationally it is linked to the National Institute of Neurology and Psychiatry, but the precise nature of the link is unclear (Holzberger 16/10/96).

The second organisation under the supervision of the ministry, specifically the Deputy State Secretary of the Health Policy Department, is the **National Institute of Alcohology (OAI)** (National Institute of Addictology until 1992). It was established in 1986 with the aim of providing more effective professional supervision and directorship of specialised alcohological care, and as a scientific and research centre in this field (Kolozsi 1987/88, Levendel 1993a, Minister of Health 1986, OAI 1992). The institute is entitled to initiate, implement, monitor and supervise policy. It can also act as an advisory body.

It has county level representation through "regional chief addictological specialists", thus it contributes to county and local level implementation and evaluation.

The OAI collects information in a standardised form from specialised care units for addicts, such as from addictological care centres (outpatient type care), addictological hospital departments and units. It includes data about their staffing, workload, patient turnover and number of patients registered (OAI 1994, OAI 1995b, OAI 1996)[7] (Table 19).

Table 19 - Addictological Care in Hungary

	No. of Addictological Care Centres	No of registered addicts (end of year)
1991	131	not available
1992	127	not available
1993	124	47398
1994	127	47218
1995	138	50252

[7] Corresponding data from psychiatric outpatient care centers and hospital wards are collected by the National Institute of Neurology and Psychiatry , which are not included in the figures.

Historically the outpatient units were called alcohol units, but in the past few years efforts have been made to reorganise this service. Their range of activity was broadened to include not only alcohol but also drug addicts and those at risk of suicide. The outpatient nature is given greater emphasis and a multi-professional team working has been introduced (Holzberger 1996, Síklaky et al. 1991).

The third organisation under the supervision of the Ministry is the **Mental Hygiene Program Office (MHPO or MPI)**. It was established in 1995. It is responsible for co-ordinating mental health activities through a national network and establishing preventive, health promotion and training programmes. The central office is led by the Ministerial Commissioner of Mental Hygiene nominated by the Minister of Welfare (MPI 1995). The programme office is temporarily working under the framework of the National Institute of Neurology and Psychiatry (NIN&P) (MPI , MPI 1995, MPI 1996). The Programme Office is involved in regional level policy implementation through eight regional offices. It is funded from the central budget through the Ministry of Welfare.

The fourth organisation, the **National Public Health and Medical Officer Service (NIPH&MOS or ÁNTSZ)** operates under the directorship of the Ministry of Welfare. It was established in 1991 (Hoffer & Bojan 1994, Parliament 1991a). This is an organisation in charge of implementation, monitoring and evaluation of public health, sanitation and hygiene. The head of the service is the Chief Medical Officer, nominated by the Minister of Welfare. His work is supported by the **National Public Health Centre (OKI)**. The OKI comprises of the office of the Chief Medical Officer and seven national institutes.

The ÁNTSZ has county and local representation. These organs are subordinated to the OKI hierarchically. They are independent from local governments, although they have to consult them regularly about health and hygiene matters. These units are led by county and municipal chief medical officers. The National Public Health and Medical Officer Service is funded from the central government budget.

Finally the **National Health Insurance Fund (OEP)** should be mentioned. In 1992 this was separated from the National Pension Fund, and it established a Fund for

Risk Handling in 1994. This allocated resources on the basis of competition to organisations with the "aim to assess health risks of the population, to promote healthy lifestyle, education programmes, treatment and rehabilitation of chronically ill" until 1997 (OEP 1994, Parliament 1992). A major component was the lifestyle programme which had two sub-components: one for the prevention and treatment of addiction and the other for alcohology (OAI 1994, OEP 1994, OEP 1995, OEP 1997). In 1994 the first sub-component accounted for 56.6 million HUF (116 awards; £ 175,000) and in 1995 56.6 million HUF (164 awards). The second sub-component accounted for 30 million HUF in 1994 (31 awards, £ 90,000) and in 1995 also 30 million HUF (64 awards). In 1996 the two sub-components were merged into one for "mental hygiene prevention and treatment"[8], allocating 61.2 million HUF to 200 applicants (OEP 1997). Since 1997 the fund has stopped because the National Health Insurance Fund reassessed its policy.

3.1.1 Historical aspects

The role of these various bodies can be better understood by placing them in a historical context. The National Public Health Committee and the Mental Hygiene Programme Office have no predecessors, but all the other organisations mentioned do. A Parliamentary Committee on Health and Social Affairs and a Ministry of Health existed before the 1990 transition (Heinrich 1986). In the alcohol field the two key bodies are the National Institute for Health Promotion and the National Institute of Alcohology.

Policy initiation and implementation

The National Institute for Health Promotion had two predecessors. One of them was the **National Institute for Health Education (OENI)** established in 1977 (Minister of Health 1977). It advised the Ministry of Health on health promotion and prevention. It was financed by the Ministry of Health.

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[8] a new member of the curatorium was the Comissioner of the Minister of Mental Hygiene (head of the Mental Hygiene Programme Office), director of the National Institute of Neurology and Psichiatry, temporary director of the National Institute of Alcohology that time. Since 1998 secretary of the Interministerial Committee Against Drug Use.

Its other predecessor was the **National Committee for Health Promotion (OET)** established in 1987 (Minister of Health 1987). This inter-ministerial committee had members from the health sector, both from government and national institutions, but also from other sectors. The National Committee for Health Promotion was intended with the aim to synchronise sectoral activities in the field of health promotion. It initiated, implemented and monitored policy. A Health Promotion Fund (EA) was also created, to fund implementation. It was funded from a separate part of the budget of the Ministry of Health (Minister of Health 1987). The OET`s establishment followed the long-term health promotion programme launched by the Minister of Health (see above: previously Deputy Prime Minister, and secretary of the State Committee Against Alcoholism, currently the president of the Committee of Health and Social Affairs) (Council of Ministers 1987). The OET was also implemented through county level working groups.

It has to be mentioned that, although the National Public Health Committee was not the successor of this committee and functionally they are different, they are similar in structure.

The OET was not a new organisation but reorganised from a previous inter-ministerial committee, called the **State Committee Against Alcoholism (AEÁB),** established in 1983. The chair of that committee was a deputy prime minister, Judit Csehàk, who urged the reorganisation (AEÁB 1984, Hantos 1983, Buda, 25/10/96 #262). She later became the Minister of Health. The committee was funded from the central budget.

The task of the committee was mainly initiation and implementation of policy specifically in the alcohol field. Over time, however the focus of the committee's activity turned more and more towards general health promotion.

As its members were drawn from relevant ministries and experts of the alcohol field, it provided a good framework for an inter-sectoral approach. Changes in legislation concerning alcohol availability occurred soon after the establishment of the AEÁB (see later). These changes were consistent with the changing context in the Communist Bloc, as illustrated by the anti alcohol movement in Poland (1980-

81) and Gorbachev`s anti-alcohol campaign in Russia (1985-87) (Buda 1994, Lehto 1993, WHO 1994a).

The AEÁB, just like the OET, had county level working groups ensuring county-level implementation and monitoring.

The establishment of the AEÁB was a manifestation of government recognition of the role played by its predecessor, the **National Committee Against Alcoholism (AEOB)**, which was established in 1968 under the aegis of the Red Cross. The head of the committee was the acting minister of health. It had participants from government and professional groups. Its task was to prepare recommendations on issues related to alcoholism and reporting to the chief secretary of the Red Cross (Bànki & Fejèr 1983, Mérô 1980). Financially it was part of the Red Cross. It was the first organisation with a remit for alcohol policy though, as a quasi-governmental organisation it was only indirectly linked to central government. The **Red Cross** was one of the mass organisations in Hungary, which was used to try to engage a wide range of individuals in the fulfilment of national programmes, thus supporting the creation of a communist society (Heinrich 1986).

This committee was active at both national and local level and encouraged the establishment of Social Committees Against Alcoholism at workplaces (Kovács 1984).

Advice

The predecessor of the National Institute of Alcohology was the **Scientific and Methodological Centre of Alcohology (ATMK)**, established in 1978 as a result of a 1977 order by the Council of Ministers on action to counter alcoholism (Council of Ministers 1977, Minister of Health 1978, Minister of Health 1983, Simek 1980). It was established by the Ministry of Welfare, for whom it had an advisory role. Organisationally it was part of the National Institute of Neurology and Psychiatry a link which is maintained, but the precise nature of the link is unclear (Minister of Health 1978).

The establishment of the centre was encouraged by other developments of the policy field. Key scientists published influential articles about alcohol problems in the society (namely Levendel and Simek) at the end of the 1970s (Buda 25/10/96, Fekete 22/07/97). In the same period, as noted earlier, the Secretary of the Central Committee of the Communist Party (Aczel) became interested in social problems, later becoming the director of the Research Institute of Social Sciences (TÁRKI) (Andorka 21/10/96, Buda 1994, KEB 1997). The establishment of the institute was not unique to Hungary. Similar attempts were made in other countries of Central and Eastern Europe at the same time to address alcohol problems (Kalmàr 1981, Lehto 1993, Orlovszki 1981).

Public Health

The National Institute of Public Health and Medical Officer Service, as the major country-wide public health organisation in charge of implementation of health policy also requires attention from historical perspective.

Its Soviet predecessor was the State Public Health Service (Inspectorate) established in 1951 (Council of Ministers 1951b, Minister of Health 1952). Its core was a department of the Ministry of Health, lead by the State Chief Public Health Inspector (Dudás & Hazafi 1996a). The county and municipal centres of the present ÁNTSZ replaced the former county and municipal hygienic-sanitation stations. The old stations were part of the state public health service, owned by local governments which allocated their budget, but in a managerial hierarchy to the centre (Hoffer & Bojan 1994, Parliament 1991a).

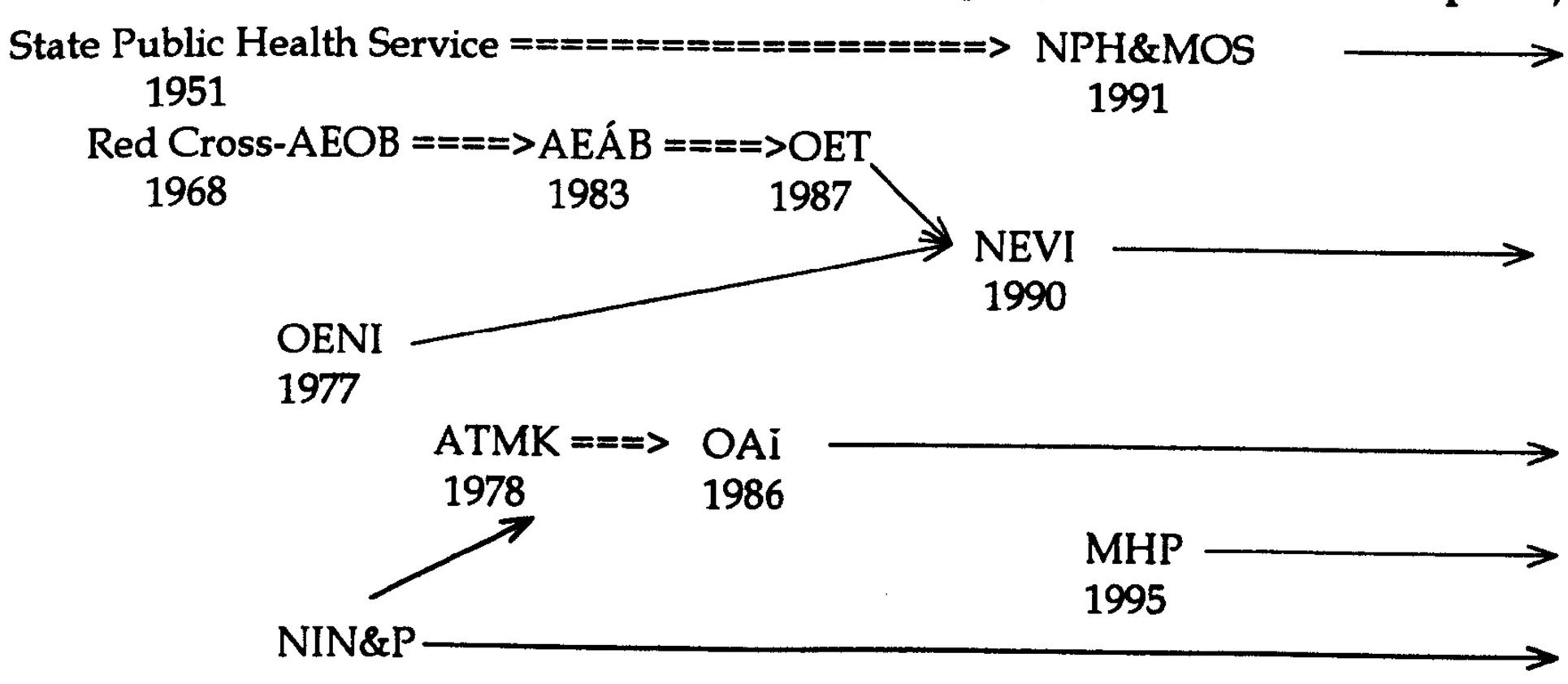
The former stations were responsible for environmental, food and occupational hygiene, health education and communicable disease control, but health education activities were limited. They had a major regulatory and licensing function. The new system inherited the staff and the former functions, but these were supplemented by new tasks. In particular there is a new emphasis in monitoring health of the population, lifestyle factors (smoking, drinking, diet, physical activity, etc.), implementing health promotion programmes and supervising curative services.

Summary

In contemporary Hungary there are many organisations responsible for initiating, developing, implementing, monitoring and evaluating public health and alcohol policy. The functions of different organisations at different levels overlap. From a historical perspective it should be noted that an inter-sectoral approach to alcohol problems was present by the end of the 1970s, persisting through the 1980s, but somewhat diminished by the 1990s. Organisational changes pointed in two directions: a broader public health focus and a narrower "mental-hygiene" approach. Both have less of a specific focus on alcohol. The only institution specifically involved in alcohol is the National Institute of Alcohology, with an unclear position and organisational links. Its activity is very much focused on health services, playing little part in policy initiation and development.

A summary of these organisations discussed and their changes over time is presented in Figure 24.

Figure 24 - Summary of major organisational changes (see also Table in Chapter 5)



3.2 Other sectors

Officially organisations outside the health sector are not mandated to deal with public health issues, other than to contribute to the work of the National Public Health Committee. As such they have a more indirect role in the public health field, and thus in alcohol policy, as long as it is considered a public health policy. On the

other hand they indirectly contribute to alcohol policy just by performing their sector specific roles.

Two major areas are relevant. One is production and trade in alcoholic beverages and the other is road and public safety. In the following paragraphs policy making relevant to alcohol is examined in the same way as was the health sector. It has to be emphasised, however, that policy formulation here is essentially independent of public health considerations.

3.2.1 Production and trade

Executive Branch

Ministries, such as Agriculture, Industry and Commerce and Finance have responsibilities for different aspects of production and trade, initiating and developing policy, and implementing and monitoring it, mainly through national organisations under their directorship and/or supervision.

Such organisations include the Customs Office, which is responsible to the Ministry of Finance, the National Institute of Wine Verification responsible to the Ministry of Agriculture and the Bureau of Consumer Affairs supervised by the Ministry of Industry and Trade. (Dudás & Hazafi 1996a, Government 1991, Government 1994a, Minister of Agriculture 1994). These organisations are in charge of monitoring and implementation. The Customs Office and the Bureau of Consumer Affairs also have regional and county level representation.

The policy making process is influenced by public bodies and interest groups. These include statutory bodies, such as the Hungarian Chamber of Industry and Trade and the Hungarian Chamber of Agriculture. These public bodies operate on a self-governing basis through membership. They are mainly advisory bodies, but have certain mandated functions, such as specialised training and issuing qualifications so they participate in policy implementation (Parliament 1994).

Apart from the chambers, collective organisations exist to represent sectional interests. They play an active role in monitoring and evaluation and they can also promote policy change.

On the production side there are three such influential organisations. The **Union and Commodity Council of the Hungarian Alcohol Industry (MSzSzT)** represents the economic interests of ethyl-alcohol and spirit producers and wholesalers (MSzSzT). Through its membership it represents approximately 100% of ethyl-alcohol and 80% of spirit producers in Hungary. This association has existed for decades (Budai 25/10/96). The **Association of Hungarian Brewers (MSSZ),** established in 1992, is relatively new and comprises the seven biggest Hungarian breweries (Béndek & Várbíró 1995). The Association is a non-profit organisation and its financial management is based on the 16/1989 Decree of the Council of Ministers and on other relevant regulations. The Association works within the National Association of Food Processing Industries (Élelmiszer Feldolgozók Országos Szövetsége) and is a member of the European Brewery Convention. The **Association and Commodity Council of Wine Producers (SzBSzT)** is the interest group for all parties involved in grape and wine production and trade. It has a long tradition (SzBSzT 1994). In accordance with the market co-ordination of agricultural production and the relevant legislation, the association represents the interests of its members under controlled market conditions and promotes possibilities of development (Parliament 1993). The Union of Wine Regions (Borvidéki Egyesületek) as a membership based union provides indirect representation of all its members. The Association represents approximately 60% of grape producers and 90% of wine production and wholesale (as it is more centralised) respectively (Herpay 29/10/96).

From the trade side the **National Association of Traders and Caterers (KISOSZ)** is the most important interest representation body. It represents those middle and small scale private enterprises that are involved in retail and catering (Cox & Vass 1994, KISOSZ , KISOSZ 1996). It monitors changes in the legislation and relevant regulations, initiates policy and represents the interests of retailers and caterers in all relevant forums. The association is in close contact with the Chamber of Industry and Trade by co-ordinating their training programmes. The association is one of the nine members of the **Interest Reconciliation Council (ÉT)**.

The Interest Reconciliation Council, following a major strike shortly after the first election in 1990, became active in interest representation. It became the major forum of the representation of employees` and employers` economic and other interests and a negotiating partner of the government (Cox & Vass 1994). Participation in the reconciliation council is a prestigious role. Its members from the employers side tend to confront the government more than do representatives of employees (Cox & Vass 1994).

3.2.2 Road and public safety

Executive Branch

In the area of road and public safety policy initiation and formulation the major role again is taken by the executive branch of the state, such as relevant ministries including the Ministry of Internal Affairs, the Ministry of Transport and the Ministry of Justice and inter-ministerial committees, such as the National Committee to Prevent Accidents.

The **National Committee to Prevent Accidents (OBB)** was established in November 1992 (Government 1992, OBB 1994a, OBB 1997b, Parliament 1988). The OBB is operating under the directorship of the Police which is subordinated to the Ministry of Internal Affairs. This body fulfils an advisory and policy initiation role. Its presidents are the Deputy Chief Police Officer and the State Secretary of the Ministry of Transport. It has representatives from 20 national agencies, including relevant ministries (significantly, the Ministry of Welfare which is the successor to the Ministry of Health, and the Ministry of Education are not represented) and other national organisations. It has county level organisations and is funded from the central budget.

Concerning implementation, the importance of the police force has to be emphasised.

The judiciary branch of the state, such as the prosecution and court system act in law enforcement in all areas not only road and public safety.

3.3 Summary

In Figure 25 a summary of the institutional structures of the Hungarian state and central administration is presented, which includes all the organisations listed above and indicates their official relations to others. There are five major types of official connections which are indicated separately in this figure

(1) direction, when an agent operates under the direction of another agent (Dudás & Hazafi 1996a) (indicated with a straight line, the arrow shows the direction of the direction ⟶)

(2) supervision, when the agent is supervised by the other agent, but with limited scope for intervention in the arrangements of the supervised agent compared to the direction (Dudás & Hazafi 1996a) (indicated with a dashed line, the arrow shows the direction of the supervision ⋯⋯>)

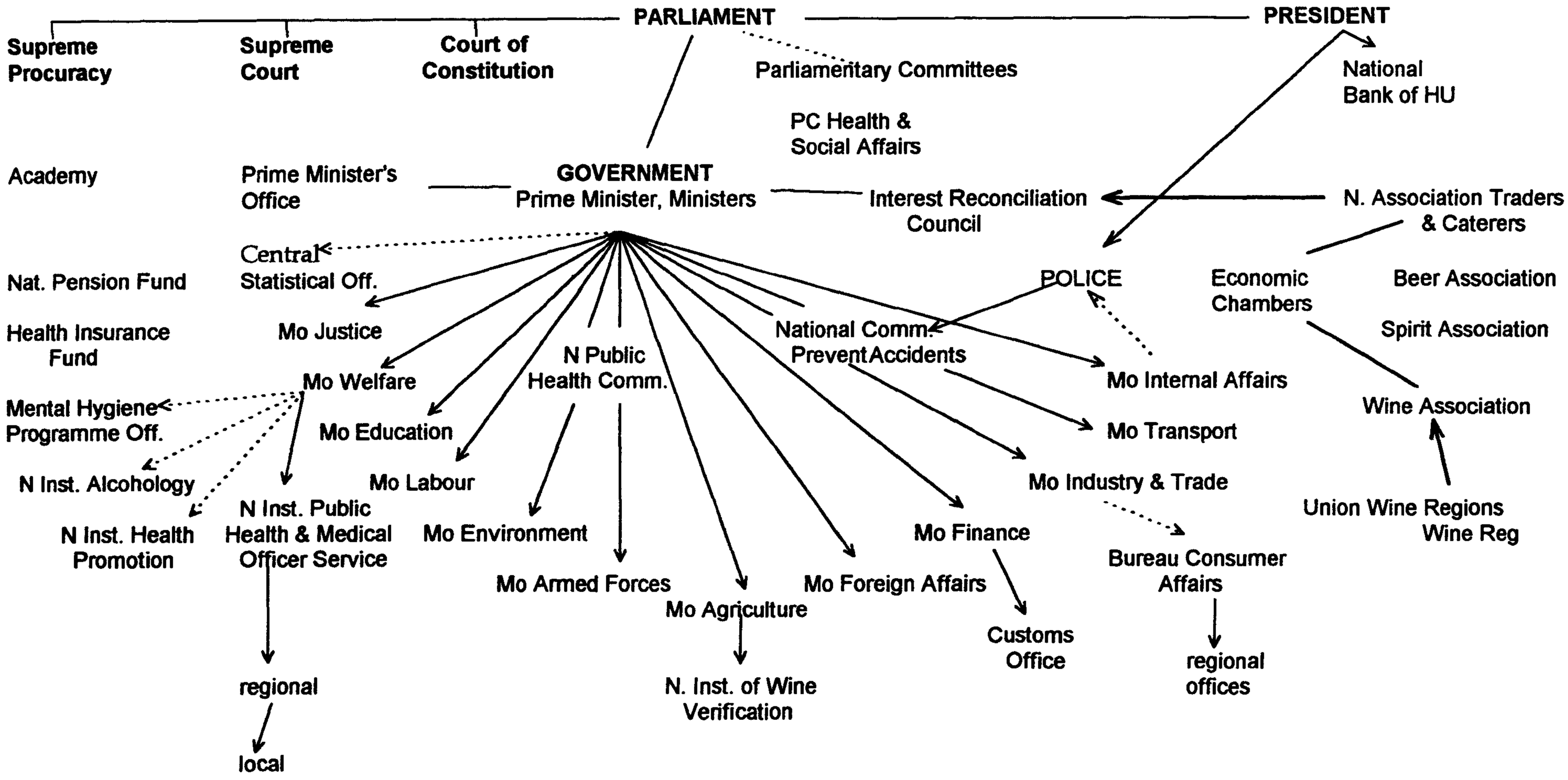
(3) membership and representation, when an agent is a member of the other agent, usually representing its own members` interests (indicated with bold straight line, the arrow shows the direction of the membership ⟶)

(4) official connection with no specific direction or supervisory function (indicated with a straight line, no arrows ———)

(5) consultation, when the agent is an official expert consultative body of another agent. This usually involves mutual communication (it is indicated with a dashed line, no arrows ⋯⋯⋯)

There are organisations presented in Figure 25 which are not discussed above, but are indicated to reflect the structure of the state and the administration, although they do not have specific relevance for alcohol policy, so they are not discussed in detail, such as the Supreme Court, the Supreme Procuracy and the National Bank of Hungary.

Figure 25 - Constitutional Arrangements: the official organisational structure of the central administration



It was shown that the mandate for policy initiation, development, implementation, monitoring and evaluation of public health and alcohol is concentrated in the health sector, and especially in the executive branch of the government. Policy initiation and development at the national level is the task mainly of ministries and inter-ministerial committees, although parliamentary committees, national institutes, interest representation groups also play a role in shaping and advising policy. Implementation takes place both at national and local level through national institutes often with regional, county and local level representation and local governments. A summary of these activities is presented in Table 20.

From the alcohol policy aspect the only specific national forum is the National Institute of Alcohology, although there are other bodies active in public health and mental hygiene which should also cover alcohol issues. Organisations outside the health sector, apart from representation in the National Public Health Committee, do not have tasks in public health policy, thus play rather an indirect role. Deficiencies become more specific when particular issues are discussed. It has to be pointed out for example that in the NPHC the Ministry of Transport and the Police are not represented. In the National Committee to Prevent Accidents, however, the Ministry of Welfare has no representation. These indicate some of the gaps in the official organisational structure.

In general, organisations exist to support public health and alcohol policy. Their contribution largely depends on their sector specific tasks. These tasks and activities, however, are rarely communicated in inter-ministerial forums in a multi-disciplinary way.

Table 20 - Position and function of different organisations in the state and in policy making

	Health							Production and Trade											Road & Public Safety		
Judiciary																					
Legislative	PCH &SA																				
Executive		NPHC																	NCPrev Accid.		
			MoW					MoFin		MAgr		MoInd& Trade								MoInt MoJust MoTransp	
				NIHP	NIA	MHPO	NHIF RHF		Custom		NIVW		Bureau Consum Affairs								Police
														Econ Chamb	Spirit Ass	Beer Ass	Wine Ass	Ass. Traders &Cater			
Initiation	x	x	x	(x)	(x)			x		x		x		(x)	(x)	(x)	(x)	(x)	x	x	
Development		x	x	x				x		x		x		(x)	(x)	(x)	(x)	(x)	x	x	
Implementation			(x)	x	x	x	X	(x)	x	(x)	x	(x)	x	x	x	x	x	x	(x)	(x)	x
Monitoring			x		x	(x)	X	x	x	x	x	x	x	x				(x)		x	x
Evaluation			(x)					(x)		(x)		(x)								(x)	
Advise	x	x		x	x									x	x	x	x	x	x		

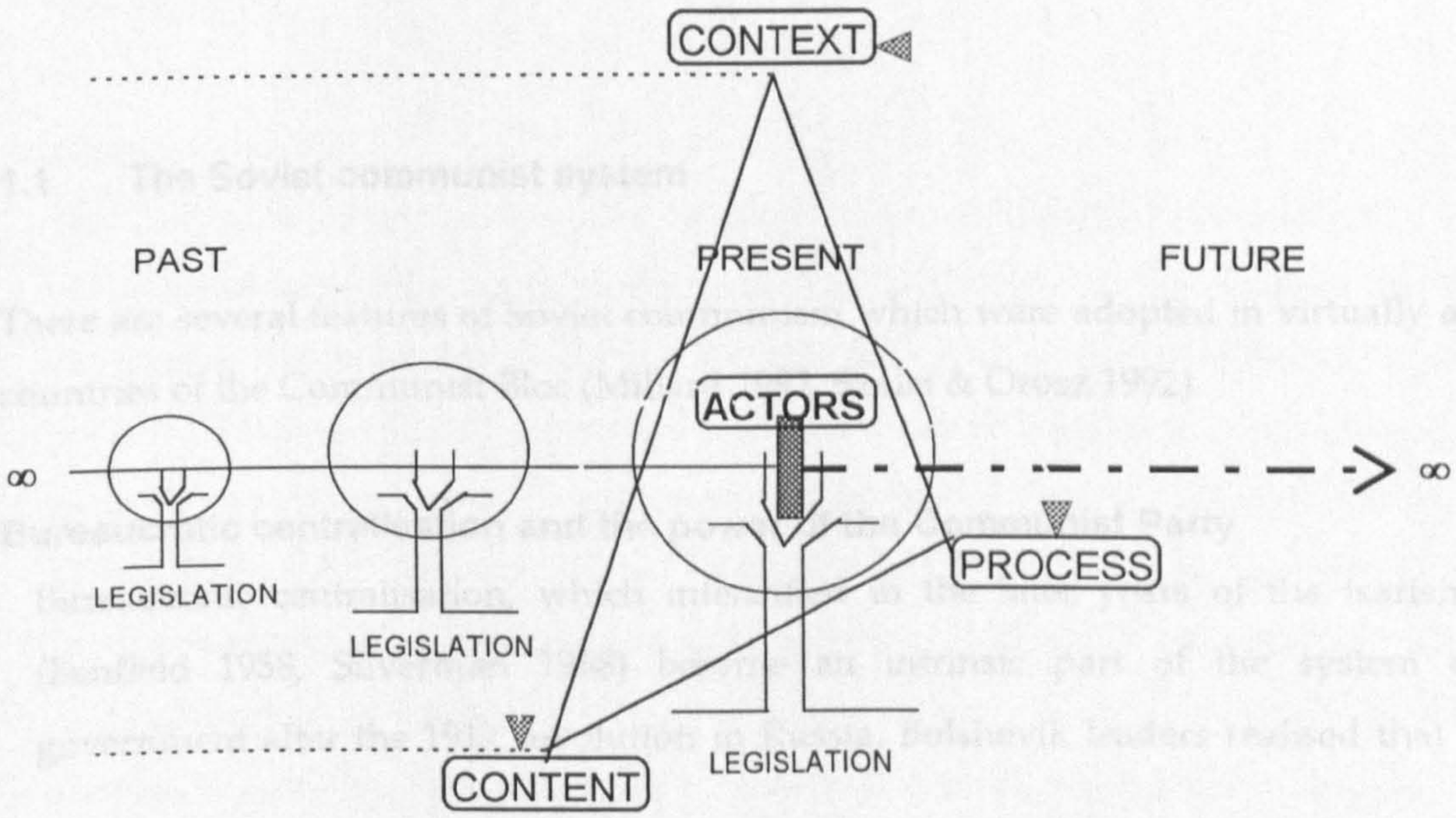
- *CHAPTER 7* -

PUBLIC POLICY AND PUBLIC HEALTH POLICY

THE ENVIRONMENT

Previous chapters showed how the approach to conceptualisation of alcohol policy in the policy environment has been changing over time both in Hungary and the rest of the industrialised world. As it has been argued in Chapter 3, alcohol policy, according to the contemporary international approach is an element of public health policy and as such of public policy. This chapter seeks to summarise some major characteristics of public policy making, which have relevance to the formulation of any public policy. Then the changing concept of public health in Hungary is presented, with a focus on its implications for development of alcohol policy within a public health framework. These refer to the environment of the alcohol policy "tree", the policy environment and its major characteristics (Figure 26).

Figure 26 - The environment of the tree



1 Characteristics of public policy making process in Hungary

When characteristics of public policy making are considered, which involve norms, behaviour of policy makers, and inherited and imprinted mechanisms of the policy making process, one cannot avoid discussing past events. It will be argued that there are characteristics of public policy making which are inherited from the communist-socialist period and there are new characteristics which arose from the

major political changes of the late 1980s and early 1990s. It will be shown how personal connections, institutions, organisations, their function and structural arrangement, traditions and norms of central administration[9] and bureaucracy[10], the influence of international forces and the economic environment have an important impact on public policy making in Hungary.

The discussion is divided into four parts. In the first part constitutional, economic and social features of the Soviet socialist-communist period are discussed. These features are seen in all countries of the Communist Bloc. In the second part, major changes under the framework of communism specific to Hungary are examined. In the third part, public and social policy making under the communist regime are discussed. In the fourth part, public policy making in the transition period, following the major political changes of 1989/90, is analysed.

1.1 The Soviet communist system

There are several features of Soviet communism which were adopted in virtually all countries of the Communist Bloc (Millard 1992, Szalai & Orosz 1992).

Bureaucratic centralisation and the power of the Communist Party

Bureaucratic centralisation, which intensified in the later years of the tsarism, (Benfield 1958, Silverman 1968) became an intrinsic part of the system of government after the 1917 revolution in Russia. Bolshevik leaders realised that if

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[9] administration: The use of the term administration has been traditionally associated with public sector organisations, and management with private sector organisations. Administration, however, is interpreted as a part of the management process. It is concerned with the design and implementation of systems and procedures to help to meet objectives.

[10] bureaucracy: This is a form of organisation which manages a large number of people in a hierarchical structure in order to perform large-scale tasks. Its characteristics - as first described by Max Weber are detailed job specifications, system of supervision and subordination, unity of command, extensive use of written documents, training in job requirements and skills, application of consistent and complete rules and assign of work and hire of personnel based on competence and experience. It has to be noted that bureaucracies can develop other features, such as inefficiency and officiousness, especially if authority is highly centralised. Bureaucracies operate best with processes involving routine tasks that can be well specified in writing and do not change quickly.

they wanted to keep control of the country, a strong administrative structure was essential which at each level was subordinated to the government in Moscow (Mendras 1997). This system was imposed by the Soviet Union became widespread in the countries of the Central-Eastern European Region after World War II. The influence of the Communist Party in the countries of the Soviet Bloc became pervasive and policy making became the sole province of the party (Sabbat 1997). A strong hierarchical command system was imposed in which the Party was the ultimate ruler. It led to strong centralised co-ordination through the bureaucratic system (Arato 1991, Deacon 1992, Fehér & Arató 1989, Szalai & Orosz 1992, Vitànyi 1997). In the vertical structure, control was exerted by a multilevel hierarchy. In the Soviet regime there was a one party-state and workplace paternalism (Deacon 1992). Administrative coercion and legal sanctions compelled individuals and organisations to accept orders and prohibitions from above (Kornai 1991).

Institutionalisation

The vertical relationship was long lasting and institutionalised (Kornai 1991). An example of institutionalisation and the use of command mechanism in the Hungarian public health field was the establishment of the State Public Health Service (SPHS) in 1951. It was separate from the health services and was created to meet the perceived public health needs of the population (Council of Ministers 1951a, Council of Ministers 1951b, Hoffer & Bojan 1994, Preker & Feachem 1995). Its directorate was a department of the Ministry of Welfare. A hierarchical system of County and Municipal Hygienic-Sanitary Stations was set up. These were subordinate to both the Soviet style county and local governments, and to the headquarters of the SPHS.

A similar approach is illustrated by the 1987 health promotion policy (Council of Ministers 1987, Csehák 08/10/96). The policy initiative came from the Minister of Welfare supported by the country`s leadership. It was considered important to enshrine policy in legislation. The policy document saw the execution of the health promotion policy through the establishment of an appropriate institutional network.

Following the legislative order, national and county level institutes were organised or reorganised to fulfil the aims of the program and a directive obliged decision makers to take into consideration health impacts of any decisions made. It was a centrally planned and administered programme.

A further example from the alcohol field comes from the 1970s. In 1977 a decree was issued concerning activities of the fight against alcoholism (Council of Ministers 1977). The decree saw the solution of the problem in the creation of a scientific centre and in the strengthening and expansion of the network of committees against alcoholism (see before) (Andorka 21/10/96, Buda 25/10/96). Following the decree, committees against alcoholism were organised extensively in workplaces all over the country (AEÁB 1984, Bànki & Fejèr 1983, Kovács 1984, Mérô 1980).

Social organisations

During the communist regime social institutions were regarded as "transmission belts" for the exercise of central power. In the first decade there was neither any legal right nor mechanism to articulate the needs and views of the public or to lobby from below (Deacon 1992). By the 1960s and 1970s institutions were cautiously encouraged to fulfil some functions of interest mediation (Anonymous 1988, Kornai 1991). At the same time it also became clear that the central power through the institutional network could not reach some segments of society, thus a number of social organisations were established or re-established. In Hungary these organisations included the Red Cross, the Patriotic People's Front, trade unions, etc. (Heinrich 1986). They tried to ensure the involvement of a wide range of the public to fulfil the aims of national programmes (Heinrich 1986). Their purpose was to tap resources, mobilise support, organise contributions and monitor social processes. These social organisations existed with the agreement and under the supervision of the communist party.

An example of how these social organisations operated was that the small number of "small-trade licence" (private enterprise) holders in the 1960s and 1970s automatically became members of the National Association of Artisans or its sister organisation, the National Association of Small Traders in Hungary. These social

bodies were part of the state bureaucracy and were charged with supervising the "self employed" (Anonymous 1988). The leaders of both organisations were carefully selected by the top party leadership and they were members of the nomenklatura[11] (Róna-Tas 1997). It was not surprising that the first official organisation to tackle alcoholism was created under the aegis of the Red Cross, an organisation under government control, which had access to the general public (Kovács 1984, Mérô 1980).

State ownership and central planning

In the early days of communism, under the principles of Soviet socialism, private ownership was abolished, industrial production and land were nationalised and there was a switch to central planning, based on five-year plans (Róna-Tas 1997). The highly hierarchical and bureaucratic structure and the command system fitted well with the centrally planned economy (Millard 1992). The state owned sector was a strictly bureaucratic command economy with control executed by disciplined bureaucracy (Kornai 1991).

Both in the administrative system and the economic sphere there was a bureaucratic monopoly of power (Brown & Rusinova 1997). For example, in this structure the creation of a state-owned firm was the result of a lengthy bureaucratic process. The appointment of top managers remained the most important linkage throughout the communist period, in Hungary until 1985. Leading executives of firms were appointed by the superior political authority. A successful "manager" was promoted either by moving upwards in the firm or by transfer to another firm or a state agency. One`s career depended to a large extent on the patronage of the top bureaucracy, as well as on party membership and on individual networks inside the party (Hankiss 1990, Kornai 1991, Révész 1997). The root of party friendship was most often in personal interests and/or gratitude. Similar incentives operating inside community networks have been described in the concept of amoral familism in Central Italy, but related to family connections (Benfield 1958, Silverman 1968).

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11 *Nomenklatura:* the list of nationally important positions. In Hungary it was introduced in 1950. These positions of national significance came under the supervision of the central committee, or even higher units such as the secretariat or the Politburo.

The centrally planned economy created shortages, as the "perfect" central planning failed to respond to public needs (Kornai 1980).

Corruption

In a system with the characteristics described above, including excess power of bureaucracy, a strong hierarchy, a command system and shortages, individuals living inside the system required supporters from the upper levels of the hierarchy, or "friends" for survival (see manager selection). It was difficult to make a career without belonging to a network (Brown & Rusinova 1997). The shortage environment generated unmet needs for goods and services, and the absence of private property and businesses, which could have reacted to needs quickly and adequately, created a basis for corruption. As personal enrichment could not take the form of material or money possessions, the impossibility of accumulating personal wealth created a pattern of behaviour based on string-pulling and use of close contacts, adding a further characteristic to the operation of personal networks (Brown & Rusinova 1997, Mendras 1997). In many cases corruption took the form of having access to a service or to goods.

As Brown described in Russia, during the Brezhnev period, organised networks of people developed everywhere (Brown & Rusinova 1997). Corruption was no longer limited to abuse of power on the part of the minor aparatchik[12] or factory foreman. It could be observed in every region at all levels. Leaders participated to some degree in systematic illicit activity at all levels. Corruption became widespread with extensive clientelism and with the development of economic networks (Brown & Rusinova 1997). Corruption and the use of personal networks were prevalent in countries of the Soviet Bloc, though national characteristics shaped its peculiar features.

The Soviet influence

During the socialist-communist period, the influence of the Soviet Union on local decisions in the Soviet Bloc countries could not be ignored (Berend 1990, Kornai

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12 *Aparatchik:* a soviet-communist bureaucrat, civil servant.

1991, Révész 1990). This included public health and alcohol policy. In 1951 the State Public Health System was organised on the Soviet model (Hoffer & Bojan 1994, Weinerman 1969). In the alcohol field, as late as the 1980s, when Gorbachev came to power and implemented an alcohol ban in the Soviet Union, Hungary could not be an exception, and had to act similarly and implement stricter regulation of access to alcoholic beverages. These changes were directed from the top of the administration, but were cosmetic changes and had little impact (Andorka 21/10/96, Buda 25/10/96, Council of Ministers 1986, Fekete 22/07/97, Hajnal 14/10/96, Minister of Internal Trade 1986).

1.2 Divergence of Hungary within the Soviet Bloc

Economic reform

The drawbacks of the centrally planned economy could be sensed in all countries of the Soviet Bloc (Révész 1990). In Hungary, following the revolution of 1956, economic tensions began to emerge (Róna-Tas 1997). It led to the formulation of an economic reform, called "New Economic Mechanism" (NEM), which was then implemented in 1968 (Kornai 1991, Révész 1990, Róna-Tas 1997). The reform was an effort to implement principles of a market economy in the socialist-communist political framework, and to liberalise economic activity in an authoritarian environment (Vitànyi 1997).

The core element of the reform was to cede a large proportion of decision making to enterprise managers, who could decide what to produce and where to buy what they needed (Berend 1990, Révész 1990, Róna-Tas 1997). Old relationships built around the hierarchical centrally organised order, where the communist party dictated the rules, were thus replaced by market-type interactions (Révész 1990). Economically, the reform soon brought results. In the first period of the reform, national income grew by 6-7% compared to the previous growth rate of 4%, and real per capita income grew at a rate of 5-5.6 % (Róna-Tas 1997).

The private sector after the reform

The economic reforms were associated with a new, more relaxed atmosphere (Berend 1990, Róna-Tas 1997). In this context the role of the private sector could be addressed. The part of the private sector that was deemed "socially useful" (that meet society's needs) was promised better access to technical equipment and raw materials, and the possibility of some new type of private partnership was considered (Róna-Tas 1997). The reforms also consolidated the position of agricultural smallholdings. The autonomy of agricultural co-operatives increased. They also started small non-agricultural side businesses to complement their main operation. For example, an agricultural co-operative could set up a small industrial unit to produce components for tractors or prepare bed sheets. Some of these enterprises were run by private entrepreneurs under the legal cover of the co-operative. The typical agreement involved a deal which specified how the entrepreneur and the co-operative were to split the value added by the enterprise. The entrepreneur could also use technical equipment and the space of the co-operative for nominal fee (Berend 1990, Révész 1990, Róna-Tas 1997).

It has to be emphasised that all these changes occurred under the nomenklatura, the political-social-economical framework of central planning, centralised, hierarchical bureaucracy and the ultimate power of the communist party.

Changes in the beginning of the seventies

In the beginning of the seventies the pace of the reform process slowed down, although the NEM was not dismantled (Kornai 1991). Hard-liners in the party started to complain that the private sector fostered economic inequalities and supported emergence of a petite bourgeoisie (Révész 1990, Róna-Tas 1997). The preoccupation with economic self-interest was the main objection to side businesses (Róna-Tas 1997). International movements were also favourable to the hard-liners` viewpoint. In 1971 COMECON (Council for Mutual Economic Assistance) adopted a comprehensive programme which was designed to strengthen the region's self-sufficiency (Révész 1990, Anonym, 1988). It was an attempt to integrate each country's medium-term national macro-economic plans. In 1971 the Hungarian Politburo cracked down on side businesses (Róna-Tas 1997). A strict revision of licences took place. In 1972 the Central Committee

decided to reverse the reforms. Later in the 1970s the previous tendency towards decentralisation was replaced by further concentration of production, which led to a decline in economic growth, a shortage of food and housing, and reduced services, due to a fall in household agricultural production and provision of private services (Róna-Tas 1997).

Deterioration of the private sector

The private sector deteriorated. It was under very strict state control and, until 1982, the award of a licence to a private company was at the complete discretion of local authorities (Róna-Tas 1997). Bureaucrats could deny any permit on the trivial ground of considering it simply "unnecessary" (Róna-Tas 1997). This environment provided ideal circumstances for further growth of corruption. As Della Porta points out, corruption is most in evidence at the public-private interface (Della Porta & Mény 1997), which, in the socialist regime in Hungary, was constantly changing.

Until 1981 the state was eager to exclude any full-time private activity from the socialist sector, the communist party led industrial sphere (Róna-Tas 1997). The tolerated forms of private enterprise had to take place outside the spaces occupied by the public sector and the services and products supplied were to be only for individual private customers. The first constraint was very often violated and "part-timers" often worked on private tasks at their workplaces (Kornai 1992, Róna-Tas 1997). By the end of the 1970s, because of the uncertainties of the political climate, the full-time private sector was small and weak. It was formed from artisans and traders (3.8% of the labour force) (Kornai 1992). The part-time private sector at the same time was large and robust. 28% of the labour force participated in mixed socialist and private sector activities, regularly working in the private sector part time while maintaining a job in a socialist company (Åslund 1985, Berend 1990, Kornai 1992, Social Stratification Survey - 1981 in Róna-Tas 1997). The ideological hostility of the authorities made it prudent not to cut the umbilical cord with state employment. Apart from providing secure state employment, it also provided access to the materials, tools and resources of the socialist company, and also information and clients for private economic pursuits (Róna-Tas 1997).

> Until the beginning of the 1980s the private sector was not very different in Hungary from other countries of Eastern-Europe as all countries faced similar pressures from the inflexibility of large-scale production and each made similar, small, concessions to their private sector sooner or later (Grossman 1977, Róna-Tas 1997, Sampson 1983).

In 1982, Hungary introduced a radical change in the private economy (Róna-Tas 1997). In the 1970s the economy had worsened. The oil crisis, and an increase in prices in the Soviet trading bloc caused the hard currency debt of Hungary to increase fourfold during the decade. Real wages declined, leading to social tension (Berend 1990, Révész 1990).

The changes after 1982

Radical reforms in the socialist sector were politically unfeasible. In these circumstances, by 1981 a new concept of the private sector was developed (Selény 1994). Under the reform package the government authorised new types of private business. The goal was to help blue and white-collar workers in the large state companies to find legal second jobs and thus contribute to the supply of goods and services (Révész 1990). The language used to describe the private sector kept the individual as the focus. The private sector was termed the "second economy" (Kornai 1991).

The change affected commercial farming, industrial activities and services leading to radical change in 1982. The new business partnerships formed the fastest growing segment of the private sector, though brakes were built into the system (Hieronymi 1990, Róna-Tas 1997).

Moving the boundaries

Business partnerships could become independent economic work partnerships if they were operating in production and services. They were, however, excluded from trade. The maximum size was 30 members and anyone who was member of one could not join another. Semi-independent company work partnerships, under the patronage of a parent company, were also possible. In these forms of business the parent firm often provided resources for the private jobs. Between 1983 and

1987 the number of partnerships doubled from about 17,000 to 34,000. The number of people participating in small business enterprises also increased considerably from 180,000 to 400,000 in the same period (Source: Balo-Lipovecz, 1988 in Róna-Tas 1997). As participating full time in the private sector was still very risky most people chose combined forms of employment.

With the private sector no longer rigidly contained, the boundary between private and public became blurred (Róna-Tas 1997). As the process was meant to be consistent with the socialist-communist framework, the nomenklatura were forced to apply the brakes, but tried to encourage the "second economy" at the same time. Bureaucratic and economic co-ordination were thoroughly intertwined in all sectors leading to a schizophrenic set of norms and values (Kornai 1991).

The changing face of corruption

with the development of the "second economy" the former model of corruption with few financial incentives, a focus on better access and personal career progress that was closely related to the party hierarchy and networks changed. The change was influenced by newly emerging, more market oriented interests. Despite the gradual development of the private sector (within boundaries) in the 1980s the public-private division remained unclear as the private sector had to operate within a socialist-communist framework. As a clear distinction could not be made between private and public, different interests, which kept together networks and feed corruption, were mixed. Even though they were often contradictory, they existed beside each other.

Comparison with other Soviet Bloc countries

One might argue that Hungary was not so unique as reforms also took place in other countries of the Soviet Bloc. A similar set of changes to those in Hungary in 1968 and 1982 were introduced in Czechoslovakia in 1967, but the reform process was stopped by the Soviet invasion in 1968 (Bauer 1987). In Poland, the 1982 reform incorporated similar elements to the Czech and Hungarian ones, but widespread shortages in the early 1980s and the temporary retention by the authorities of some forms of centralised resource allocation undermined other changes, as allocation of resources was dependent on the satisfaction of central

plans for outputs (Révész 1990, Stokes 1993). Thus a dual society, with the existence of private entities and the use of market forces within the communist framework lasted longest and was the most developed in Hungary when compared to other countries in the Soviet Bloc.

1.3 The public and social policy, the Soviet influence

If public policy is defined as policy made by government (see chapter 3), all policy under the communist regime was a public policy. Although in public policy areas closely related to the economy central control loosened, the command system was still very much in evidence in the response to social issues Although, as discussed in the preceding paragraphs, much has been written about major features of Soviet communism and its role in the economy, little has been written about other areas of the "communist public sector".

The communist system encompassed all-embracing control of all sectors. The fundamental commitment of the socialist regime was to raise living standards and to provide equal access to social goods and services was (Szalai & Orosz 1992). These were parts of the social-political programme and were to be achieved by centralised state redistribution (Selenyi & Manchin 1987). Each segment of society and the economy, in private and public life, had social considerations as their central focus.

The equity principle was very strong. For example, free and equal access to health care for all citizens was a constitutional right (Anonymous 1988, Brown & Rusinova 1997, Orosz 1996, Preker & Feachem 1995, Szalai & Orosz 1992). There was an established social security safety net (Brown & Rusinova 1997, Szalai & Orosz 1992, Vitànyi 1997) linked to full employment with flat wages (Fehér & Arató 1989).

Social policy in communism

In theory, social policy was the centrepiece of communist government policy, however, in reality it was always subordinated to economic policy (Millard 1992). The ideology of the early days of communism was that social problems would automatically be solved by the liquidation of capitalism. Capitalism was considered the genuine source of social problems (Castle-Kanerova 1992). As time

passed social problems were generated by contradictions intrinsic to central planning and distribution (Millard 1992). By the end of the 1960s and beginning of the 1970s they reached such an extent that "the problem had to be addressed". Consequently social issues became politicised. In fact this had started during the Khrushchev period in the early 1960s (Manning 1992). During the communist regime in the Soviet Bloc, particularly in the 1970s and 1980s the social sector underwent a slow evolution with numerous side-effects (Castle-Kanerova 1992, Manning 1992, Szalai & Orosz 1992).

Economic changes were accompanied by innovations in the social security system. The system became well-developed but an unfavourable side-effect was that it allowed social security benefits to be regarded as an additional source of personal disposable income (Szalai & Orosz 1992). This lead to a considerable increase in the contribution made by in-cash benefits to average disposable income from 11 to 25% (Szalai & Orosz 1992). The shift towards cash benefits left less resources available for public services, such as education, health and transport (Szalai & Orosz 1992). The paradox in the system was that, despite decreasing availability of resources for public investment, the actual institutional infrastructure increased as measured by the number of hospitals or houses (Castle-Kanerova 1992, Kornai 1991, Szalai & Orosz 1992). The Soviet command model emphasised quantity rather than quality so, not surprisingly, it also had a major impact on the social sector (Kornai 1980).

Alcohol as a social problem during the communist regime

Similar changes took place in the attitude to alcohol problems. In the early days, the problem was denied (Levendel 1990). By the end of the 1960s, it could no longer be denied that alcoholism was an increasing social problem, one that did not simply disappear with the elimination of capitalism. The number of alcohol addicts increased and the contribution of alcohol to accidents, crime and problems at workplaces made further denial very difficult. As a first step, the problem was subordinated to a social body, the Red Cross. This arrangement did not seem adequate to solve the problems. By the 1980s alcoholism was acknowledged as a major social problem. The ideological model was based on the philosophy of deviant behaviour. Authors in the late 1970s and the 1980s often used this theory

to explain the increasing number of alcohol addicts (Andorka 1988, Andorka 1994). In the 1980s deviant behaviour was researched intensively from central funding. It meant that the top political leadership acknowledged alcoholism as a social problem. Alcohol became a frequently discussed social problem and research evidence on the growing number of alcoholics in Hungary reached the public agenda. This period was called the "period of overdiscussion" (Levendel 1990). The problem was addressed by institutional development. In the same period the disease oriented aproach of alcohol problems justified the expansion of the specialised care network for alcoholics and national institutions were created to handle the problem (Levendel 1983). Despite expanding services, alcohol related mortality continued to increase.

The dual society

The malfunction or dysfunction of social services became manifest in the 1980s. Thus, while Hungary moved away from the classical shortage economy and basic goods became available, shortages were more severe in services supplied by the state organisations (Kornai 1991). With the changing economic and social environment, by the end of the 1980s a dualised society developed (Deacon 1992). The period of the 1980s, when small private and side businesses were encouraged, was described as a period of dual dependence, referring to the phenomenon that "the system was vertically dependent on the bureaucracy and horizontally on socialist and private suppliers and customers" (Kornai 1991).

The victims of duality were those who were users of existing services, especially those who had less scope to develop personal networks to ensure services. These were closely related to position and power (Brown & Rusinova 1997). Failures of the system were supplemented by frequent administrative interventions by the top leadership, a characteristic of the hierarchical command system (Szalai & Orosz 1992).

1.4 After the major political changes

The end of the 1980s ushered in a period of major political change in all countries of Central and Eastern Europe. The main objectives of the political reforms were to

raise living standards and gain individual freedom (Economist 1997). Each country moved from central planning to a market economy and from totalitarian to democratic systems (Economist 1997, Haggard et al. 1993, Révész 1990, Szalai & Orosz 1992). Liberalisation of trade with mass privatisation and decentralisation took place (Economist 1997). The major political changes focused on restructuring the economy and on constitutional arrangements, thus developing the basis of democratic states. In the transition period, particularly in the first couple of years, the state and the central administration were preoccupied with the overwhelming tasks of the modernisation process (Ilonszki 1992, Vass 1993).

Economical changes

The transition was accompanied by structural adjustment, which happened most rapidly in the financial, goods and services markets and, despite continuing problems, such as a large black market with smuggling and tax avoidance, restructuring led to a clear split between private and public (Economist 1997, Hieronymi 1990). In the economic arena old connections and networks continued to be important, but economic interests soon took priority (Kornai 1991).

International agencies in the transition

International organisations also took part in the process of structural adjustment. A new emphasis on links with the west fitted with the general tendency to get rid of all aspects of the previous regime and of dependence on the Soviet Bloc. It was also a necessity as, in the short term, there was an immediate demand for financial and technical assistance as well as for investment (Manning 1992, Nikolaidis 1993). The IMF signed standby agreements with Poland and Hungary before the political transition in early 1990. As elsewhere it imposed conditionality requiring structural adjustment of the economy. Thus, the first category of IMF loans were for structural adjustment, providing balance of payment support to enable achievement of particular reform objectives, such as privatisation and financial sector development. The second category of loans were designed to restructure businesses (Haggard & Moravcsik 1993). The support for structural adjustment and the conditionality meant that the IMF played a considerable role in the process of transition.

As well as IMF intervention, there were other international agencies which influenced the transition. The EC PHARE programme started to support Hungary and Poland in 1989. The PHARE programme initially focused on immediate needs and not until 1991-92 did it expand to support privatisation and small- and medium-size enterprises (Haggard & Moravcsik 1993, Nikolaidis 1993).

The role of the European Union

In the course of 1990 the general tendency to break with the socialist-communist ties led all post-communist Eastern European governments to announce their desire to join the European Community (EC). Hungary also submitted a formal application to join EFTA. Negotiations with the EC were officially launched in 1990, first by Poland and Hungary and then by Czechoslovakia (Nikolaidis 1993). The negotiating process has continued since then and European Union (EU) laws and policies were taken into consideration in policy formulation and legislation (Ágh 1995, Inotai 1996).

Changes in the public sector

While changes in the economy were rapid, those in the residual public sector were much slower. They also had a different focus. In the first few years after the political changes the state was busy with constitutional and market issues and the public sector was essentially forgotten. The modernisation of the administrative system did not start immediately, taking about 4-5 years before technical and professional innovation started, and even then it was very slow (Ágh 1995).

Individuals in the transition and the public sector

Transition had a major impact on individuals. Under communism, leading officials of the government and the party apparatus, and leaders of state firms and agricultural co-operatives had very close personal ties. Government officials were chosen to be chairmen of co-operatives and vice versa (Révész 1990). In the 1980s, after the long erosion of the power of the political elite, a coalition emerged in the dualised Hungarian environment. This coalition consisted of four social groups: younger members of the Party elite, technocrats in the state bureaucracy, enterprise managers and successful entrepreneurs. These groups were strongly linked through informal ties, and people could easily move from one group to the

other (Hankiss 1990). In the meantime, by the end of the 1980s, the loss of universal state employment and the emergence of a private sector (second economy), which was especially great in Hungary and Poland, gave opportunities for members of the communist elite to participate in legal private enterprises (Róna-Tas 1997). After the major political changes the old elite realised it had an easy opportunity to exit. It could convert its power into advantages in the market economy (Hankiss 1990). This has been offered as an explanation for the peaceful transition in these countries. It has to be added that the escape to the private sector was not open to all of the ruling elite. Many technocrats within the bureaucracy kept their position after the changes (Hankiss 1990). These individuals had worked for decades under the socialist-communist administrative structure. As modernisation took place very slowly, it was not surprising that the norms and practices of the communist administrative system persisted. Cliantelism and hierarchical behaviour still persists in the public sector (Economist 1997, Révész 1990, Róna-Tas 1997).

Example from the alcohol field

The way in which problems are addressed, and the emphasis on institutionalisation, is reflected in the establishment of the Mental Hygiene Programme Office in 1995. Despite limited financial resources, a centrally funded public organisation was created following a decision at the Parliamentary Discussion Day about health in 1995 (Csehák 08/10/96, see chapter 5., Veér 16/10/96). The new office overlaps with other institutions responsible for mental health related problems (e.g. NEVI, OAI, see chapter 6) (Csató 1995, Félúton 1994). The relevant documentation provides no rational justification for the decision.

Networks after the major political changes

After the transition, the importance of individual networks developed in the previous regime could not be abolished and studies show that their importance did not diminish (Brown & Rusinova 1997). As Benfield points out, it is not surprising because networks of individuals tend to persist over time (Benfield 1958). The interesting feature is that those who stayed inside the bureaucracy maintained their networks not only inside the administrative system, but also with the newly "privatised elite" (Hankiss 1990).

Structural adjustment in the public sector

Structural adjustment also had an impact on the public sector. The transition emphasised cut-backs and restructuring. This had two main causes. It was both an economic necessity and a World Bank conditionality to change structurally the large-scale welfare system, to cut back social benefits and to decrease public spending (WB 1995). At the beginning of the transition period it was also felt necessary to break with the former regime.

As a result, in the second stage of the transition period, privatisation was extended to previously state-owned public services, such as telephone and electricity utilities, which lead to a reduction of public expenditure. Restructuring of the welfare system also reached the political agenda. The social insurance scheme which began in 1989 was replaced in law of 1992, that further divided it into a health insurance and a pension fund (Hoffer & Bojan 1994, Orosz 1996, Parliament 1992). Contributions by employers and employees changed, with increase in the employee's contribution. Eligibility for maternal and child benefit became stricter (Szalai & Orosz 1992).

In some areas changes were influenced by foreign aid and/or loans, mainly in the second and third stage of the transition (Haggard & Moravcsik 1993, Sparr 1993). In Hungary both PHARE funds and a proportion of the IMF loan were directed to the public sector with all their conditionalities, such as support for the transport and telecommunication infrastructures, environmental regulations and the welfare system (Haggard & Moravcsik 1993, PHARE 1997).

Areas of less attention

Even where major foreign investments in the public sector and the administrative system were absent, organisational and institutional changes might still have occurred, but there was a lack of real modernisation or restructuring. The political environment, rejecting ties to the Soviet period, often provided the incentive in these cases.

A good example of institutional change but a lack of real modernisation, is the State Sanitation and Hygiene Inspectorate which, in 1991, soon after the political

changes, was reorganised by law and new public health functions were given to the national network of county and municipal offices. It remained, however, a very hierarchical organisation. Introducing the National Public Health and Medical Officer Service essentially meant putting new nameplates on gates (Hoffer & Bojan 1994, Parliament 1991a).

As a result of these influences and due to the need for restructuring and the cut-back in public spending, the public sector received attention, but planning and policy development was less in evidence (Szalai & Orosz 1992). In the public sector, market forces are less visible and their effect is rather indirect. The economic pressures in the public sector are present in the form of a struggle for financial resources, for the maintenance and development of public organisations. The public sector went through less radical and rapid structural changes than the private sector. Consequently norms of public policy making that became imprinted during the socialist communist period could persist after the political changes.

1.5 Summary

In summary the process of public policy making in Hungary has four characteristics (Figure 27).

These characteristics of the public policy making process in Figure 27 are partly inherited from the socialist-communist command system where the party ruled policy making and from the dualisation of society in Hungary parallel to the emergence of a private sector and a market economy under political control. This created an overlap of the private sector and the state owned economical production. Other characteristics developed with the transition through structural adjustment, such as the explicit separation of public and private sectors, and the considerable influence of international organisations through financial aid or loans not only for the private but also for the public sector.

Figure 27 - Characteristics of the public policy making process

1. strongly hierarchical decision making and institutionalisation

2. strong networks of individual

3. economical pressure to survive

4. international influence

2 *The changing concept of public health in Hungary and alcohol on the policy agenda*

As alcohol policy has been defined as a public health policy and, as such, a public policy, in the review of the policy environment the concept of public health has to be addressed as it relates to the Hungarian setting. In previous chapters the changes in the alcohol policy field over the past 40 years have been discussed, but its current place on the policy agenda has not been addressed yet. Some issues in these respects are presented here.

Definition of public health

Public health, according to the Oxford Textbook of Public Health is the process of mobilising local, state, national and international resources to ensure the conditions in which people can be healthy (Detels et al. 1997). Public health focuses on health issues in populations (Maxcy et al. 1992). According to the definition used by the WHO "Health is the state of complete physical, mental, and social well-being and not merely the absence of disease and infirmity" (Terris 1975). The broader one's definition of health the broader is the scope of public health. The Institute of Medicine defined public health as "what we, as a society, do collectively to assure the conditions for people to be healthy" (Institute of Medicine 1988). Public health defined in this manner embraces virtually all aspects of social and economic policies including tax action, social welfare policies, provision of health services, and prevention of war (Rosen 1972).

In the nineteenth and early twentieth centuries the leading health problems included contamination of water supplies, widespread under-nutrition and over crowding which were associated particularly with early industrialisation (Armstrong 1993). These conditions led to a high prevalence of infectious diseases, requiring both social action and scientific knowledge. By the end of the twentieth century another set of health problems, including new infectious diseases and major non-communicable diseases had to be addressed in developed countries, broadening the scope of public health (Detels et al. 1997). The shift from traditional hygiene and sanitation to new public health can be approached from the perspective of both nature and the individual, and how they relate to each other (Armstrong 1993). According to Armstrong "new" public health of the 1970s and 1980s is concerned with the incursion of the activities of individual bodies into nature, compared to previous periods when the incursion of nature into individual bodies was in the focus of public health.

The changing concept of public health in Hungary

In Hungary, after World War II, public health was concerned with the problems of epidemic diseases, unsafe living and working conditions, malnutrition, and lack of public facilities to handle these problems. As a result, an independent and hierarchically structured system addressing environmental sanitation and hygiene

was established. "SanEpid" activities were related to communal sanitation, communicable disease control, maintenance of hygiene in schools and workplaces, health education and provision of public health laboratory service. Activities took place at regional and local level (Weinerman 1969). During the communist period, public health activities were concentrated in the hands of the State Public Health Inspectorate. The institutional framework lacked the flexibility to respond to the emerging concepts of the new public health. Even in 1979, legislation governing local SanEpid stations simply listed their tasks being *"collecting data about population movements* (particularly morbidity and mortality data)"...., *"delivering complex studies locally to explore characteristic of the hygiene and sanitation situation ..."*, etc. (Minister of Health 1979).

By the second half of the 1980s the concept of health promotion was finally introduced and applied as a new concept in 1987, following a decree by the council of ministers about the long term health promotion policy (Council of Ministers 1987). By the beginning of the 1990s, with the change in the State Public Health Service to the National Public Health and Medical Officer Service, new public health tasks were added to the old structures, such as monitoring of non-communicable diseases and of major risk factors, and organising health promotion programmes (Hoffer & Bojan 1994, Parliament 1991a). In 1994 a government order set out the principles of health promotion, in a document where the terminology of public health was used frequently (Government 1994b). The health programme of the government for 1994-98 also cited public health extensively (Government 1994c).

In 1992 a consensus conference was organised to agree on a working definition of public health in Hungary. At this conference seven different words were identified which described particular aspects of public health. The meaning of the words ranged from traditional hygiene to social medicine (McKee & Boján 1996, White et al. 1993). Agreement was reached that *"public health involves multidisciplinary and intersectoral approaches and practice. Its goals are promoting health, preventing disease, and prolonging life of good quality. These are implemented through the organised efforts and efficient use of material and intellectual resources of society and through individual initiatives. Public health relates to the health problems of populations and its practice has a*

scientific basis." Policy makers and academics were open to the "new" public health concept. The new Health Act of 1997 has a separate chapter about public health, which defines it as *"an organised activity of the whole nation with the aim to ameliorate the health status of the population, promote health and prevent diseases"* (154/1997 Act).

Unfortunately, despite the conference and the wording of recent policy documents, people from the Hungarian Public Health Service seem to stick to a model based on hygiene and sanitation (White et al. 1993). Because this organisation is a crucial player, being the biggest institutional network in the public health field, it puts a burden on a widespread conceptual change and makes it difficult to talk about public health with a common understanding.

Alcohol policy during the transition

In the changing public policy environment during the transition, alcohol policy received little attention (Andorka 21/10/96, Buda 25/10/96, Fekete 22/07/97, Hajnal 14/10/96). The all-embracing communist state disappeared, but alcohol problems are still considered to be the task of the state, the Ministry of Welfare or the Mental Hygiene Programme Office to deal with (see chapter 8). At the same time the importance of the industry and those involved in trade is increasing.

At the end of 1997 alcohol finally reached the national agenda within the public health component of the World Bank financed health care modernisation project (NIHP 1998, Republic of Hungary & WB 1993).

The next chapter will discuss the current situation of alcohol policy by looking at the policy actors.

- *CHAPTER 8* -

STAKEHOLDER ANALYSIS OF ALCOHOL POLICY IN HUNGARY

This chapter summarises the findings of the stakeholder analysis of alcohol policy in Hungary at the national level. Its structure follows the matrix developed earlier (Table 21). First, the main actors and their activity focus are described. Second, their position on alcohol policy is assessed. Third, connections between different actors and policy networks are mapped. Fourth, the influence of the various actors is analysed. Finally, findings are used to evaluate the feasibility of elements of a comprehensive alcohol policy. Each part describes the methodology used for the assessment. Stakeholder analysis has not previously been used in a national level public health policy analysis.

Table 21 - Matrix of the analysis

STAKE-HOLDERS	ACTIVITIES	POSITION	INFLUENCE	CONNECTION WITH OTHER ACTORS	FEASIBILITY OF POLICY ELEMENTS
Who they are?	What they do? How important alcohol is?	How supportive they are towards a comprehensive alcohol policy?	How influential they are?	What is their policy network?	What is their position on different policy elements?

1 Who is a policy actor?

Stakeholder analysis focuses on policy actors. Policy actors can be institutions, organisations, individuals or groups. Individuals, organisations, institutions, or smaller units can equally be part of a group. Group members can be tied to each other formally or informally. Groups can be formed around functions, tasks, activities and interests. Stakeholders are those who are involved in and/or affected by the "stake", the policy.

Individual actors

In this study individuals who - using the snowball technique - were identified by numerous interviewees (at least by 5-6) not only as representatives of an organisation, but also as individuals to be approached, were considered significant stakeholders.

There are three individuals identified in the Hungarian alcohol policy field who are considered as separate actors because of their special status in this field. One is the president of the Parliamentary Committee of Health and Social Affairs (CsJ), who was Minister of Health at the end of the 1980s, when many organisational and policy changes took place in the alcohol field (see chapter 6). She is a well respected health expert in government and parliamentary circles. The second is a researcher (BB), previously director of the National Institute for Health Promotion, currently editor of several addiction related journals. He is highly acknowledged in scientific and medical circles in Hungary and internationally. He has striven to disseminate international scientific knowledge on alcohol within Hungary. The third is the Ministerial Commissioner of Mental Hygiene (VA), who is also director of the Mental Hygiene Programme Office, the National Institute of Alcohology and of the National Institute of Neurology and Psychiatry, and is a board member of numerous foundations. He was often referred to as being the head of the "organisation to handle alcoholism" (Czeizel 03/10/96, Lépes 06/11/96). His personal interest and the influence he has by his position in the most directly alcohol-related national health institutions have considerable importance. He is a popular subject of media attention with regard to broader public health issues as well as in alcohol and mental health (Moldova 28/07/97, Nógrádi 07/05/97, Parat Kovács 05/05/97, Sárkány 30/04/97).

Groups

In the study each interviewee represents a single organisation, or a part of it. In the analysis some institutions were "merged" under the category of one actor, as interviewees referred to them as single actors. These are the Ministry of Welfare, the judiciary, scientists and researchers, and the media (National Television, Radio, newspapers). In the case of the Ministry of Welfare, different interviewees were in charge of different units, all considered relevant in the alcohol field. The justice system consists of the Ministry of Justice, the Supreme Procuracy and Supreme Court and the prison service. Researchers, scientists, and experts on addiction make up a heterogeneous group, but they are concentrated around and often linked to the National Institute of Alcohology. Media representatives include the written and the spoken media, all reflecting different angles. After assessing

the interviews in these merged groups findings from individual actors were strikingly similar, emphasising the possibility to treat them as a single actor. A list of actors identified in this study and their abbreviations is given in Table 22.

Table 22 - Alphabetical list of organisations, actors included into the study and their abbreviations

Policy Actor	Abbreviation
Beer Producers	BeerPr
Buda Béla	BB
Csehák Judit	CsJ
Customs Office	Customs
Judiciary	Judic.
Local Governments	LocGov
Media	Media
Mental Hygiene Program Office	MHPO
Ministry of Agriculture	MoAgr
Ministry of Finance	MoFin
Ministry of Industry and Commerce	MoInd
Ministry of Transport	MoTrans
Ministry of Welfare	MoW
National Committee to Prevent Accidents	NCPAcc
National Health Insurance Fund	NHIF
National Institute of Alcohology	NIA
National Institute for Health Promotion	NIHP
National Institute of Public Health & Medical Officer Service	NIPH&MOS
National Institute of Wine Verification	NIWV
National Public Health Committee	NPHC
Non-Governmental Organisations	NGOs
Parliamentary Committee of Health and Social Affairs	PCH&SA
Police	Police
Retailers and caterers	Retailers
Smallholders	Smallh
Scientists, researchers	sci/re
Soros Foundation	Soros
Spirit Producers	SpiritPr
United Nations International Crime and Justice Research Institute- Ministry of Education	UNICRI-MoE
Veér András	VA
Wine Producers	WinePr
World Bank	WB

2 *Alcohol policy actors and their activities*

Alcohol policy actors in this study can be grouped according to two criteria: (1) the organisational structure and place in the administrative system, and (2) the focus of their activities. The first refers to the official organisational structure and links as discussed in chapter 5, while the second points towards alliances independent of official links.

Actors according to their official place

Actors in the field of alcohol policy can be categorised into six groups in terms of organisational structure and their place in the administrative system:

(1) Central government: ministries, governmental organisations and their representatives

(2) Quasi governmental agencies: national institutes, statutory organisations dealing with alcohol-related issues and their representatives

(3) Industry representatives: producers, wholesalers, retailers

(4) Academic community: researchers, scientists, addiction[13] specialists, physicians

(5) Local governments

(6) Others: organisations officially involved in dealing with alcohol-related issues, non-governmental organisations, grant awarding bodies, etc.

It has to be noted that medical, social and economic aspects in this study are all included under alcohol related issues. A caveat is necessary that there is no history of non-governmental organisations of the past forty years as pressure groups in Hungary (Szabo 1995). They do not play an active part in formulating policy or influence public opinion. As the number of non governmental organisations in all sectors has been increasing rapidly, they are often concerned with their financial security above all, thus their credibility in the policy arena and in the public opinion is low. Here they include Clubs Against Alcoholism (CAA), Alcoholics Anonymous (AA) groups, missions of churches dealing with alcoholics.

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13 *addiction specialists*: physicians specialised in patients with addictions; this is usually attained by a further specialist qualification after specialising in psychiatry

Foundations and associations, which work with alcoholics, were also considered. Many of these were "non-official" satellites of the National Institute of Alcohology. Grant awarding bodies refer to the Soros Foundation, World Bank and PHARE. The Soros Foundation until 1997 had a separate budget for grants related to alcohol problems (Buda 25/10/96, Csehák 08/10/96, Soros Foundation 1995, Soros Foundation 1996). The World Bank financed public health programmes first included alcohol into the agenda in 1996 and still have a limited budget for alcohol related problems. Since autumn 1997 a plan for a tobacco and alcohol policy development component have been drafted. There are no specific alcohol related projects financed from PHARE sources.

Actor groups by their activities

The focus of activity of each policy actor is very much related to the profile of their organisation, their individual interest and the position of the actor in the broader policy community. Documents and interview results complemented each other in the assessment.

Four major groups of actors can be identified in terms of their activity (see also chapter 5). A detailed description of each actor is summarised in Table 23.

HEALTH actors - whose activity focuses on treatment, care and rehabilitation of alcoholics, public health and prevention; most often they are operating under or closely linked to the Ministry of Welfare.

SAFETY and CONTROL actors - whose activity focuses on road and public safety and law enforcement.

PRODUCTION and TRADE actors - whose activity is related mainly to production and trade in alcoholic beverages and those who are involved in the economic aspects of alcohol.

OTHER actors - those who do not belong to the other groups.

Table 23 - Main activity of each actor

Actors	Main activities
	Health
Parliamentary Committee of Health & Social Affairs	• public health and prevention is considered important • discuss and revise draft legislation
Ministry of Welfare	• restructure health care system • encourage health promotion, prevention • prioritise public health approach • assure budget for the above mentioned
National Public Health Committee	• public health and prevention is focus • multi-sectoral public health approach *(nothing specific on alcohol)*
National Health Insurance Fund	• encourage preventive strategies *(since 1997 the risk handling fund, which dealt with alcohol projects stopped)*
National Institute of Public Health & Medical Officer Service	• public health and prevention is priority *(no specific alcohol-related programme, accidental activities at local levels)*
National Institute for Health Promotion	• encourage prevention *(no specific alcohol-related programs)*
Mental Hygiene Program Office	• improve mental hygiene • encourage prevention
National Institute of Alcohology	• maintain and expand care and rehabilitation • continue postgraduate specialist training • support research • prepare concepts, provide guidelines
Scientists, researchers	• do research • assure financial support
NGOs, Foundations	• help to solve alcohol-related problems • insure financial base
	Production & Trade
Ministry of Finance	• increase tax revenue • decrease budget deficit
Ministry of Agriculture	• maintain grape crop land • EU harmonisation - protect Hungarian agricultural production • decrease the extent of illegal production
Ministry of Industry and Commerce	• EU harmonisation - synchronise business and market regulations • maintain liberalised market, free market competition
Beer Producers	• increase sales volume • support responsible drinking which may increase beer consumption relative to other main beverage types • decrease tax content of beer
Spirit Producers	• decrease illegal production • maintain sales volume • decrease tax content of spirits
Wine Producers	• decrease illegal production • maintain sales volume • protect quality
Retailers & Caterers	• protect retailers' business interests
Small-holders	• maintain and increase revenue • maintain subsidies & favourable loopholes in the legislation

Actors	Main activities
Safety & Control	
National Committee to Prevent Accidents	• increase road safety • decrease drunk driving
Ministry of Transport	• encourage road and transport safety
Police	• increase road safety • promote crime prevention programmes *(alcohol, drunk driving is built into broader programmes)*
Judiciary	• meet legislative obligations • maintain executive function • assure financing *(alcohol problem is acknowledged, but no specific program)*
Customs	• meet legislative obligation • maintain executive function • control excisable products and activities *(alcohol problem is acknowledged, focus on control of excise)*
National Institute of Wine Verification	• control and assure wine quality
Other	
Grant awarding bodies	• Soros Foundation had special grants for alcohol related problems until 1997, when it stopped • a new World Bank project aims to tackle alcohol and tobacco policy development
Media	• publish interesting, up-to-date stories which attracts the attention of the audience • increase revenue
United Nations International Crime and Justice Research Institute (UNICRI) - Ministry of Education	• increase training capacity among teachers for health prevention, including drugs and alcohol
Local governments	• meet central requirements • increase local revenue *(there are individual differences)*
Consumers	

Health actors

For health actors, health promotion and prevention is an explicit official priority and this includes problems related to alcohol (NEVI 1996, OAI 1992, OAI 1994, OAI 1995b, OAI 1996, ONB 1995, SZEB). Resources committed to alcohol related issues are, however, very limited. Alcohol related activities are most often incorporated into more general programs. The National Institute of Alcohology is the exception (Buda 25/10/96, Fekete 22/07/97, Hajnal 14/10/96, Holzberger 16/10/96, OAI 1992, OAI 1994, OAI 1995b, OAI 1996). It deals with treatment and rehabilitation of alcohol addicts, being the central institution providing specialised care.

Actors of production and trade

Hungarian beer producers are concerned with their decreasing market share and the relatively high taxes on beer products, whereas wine and spirit producers are more worried about black market sales (estimated at around 30-40% of the total market) (Béndek 16/10/96, Budai 25/10/96, Herpay 29/10/96, MSzSzT , SzBSzT 1994). Spirit and wine producers do not place a priority on further increasing their sales volume.

There are actors in this group who are involved in economic aspects of alcoholic beverages other than specifically production and trade. Actors, such as the Ministry of Industry and Commerce and association of retailers are most concerned with market liberalisation for different reasons (Antalffy 07/10/96, KISOSZ , KISOSZ 1996, Nagy 23/07/97). Retailers are concerned with ensuring their interests in the market, a major objective being to keep the market liberal. The Ministry approaches the question from another angle. Market liberalisation is one of the major components of the structural adjustment of the economy and is in accordance with the European Union harmonisation process. The Ministry of Finance emphasises the need for a constant flow of alcohol-related tax revenue to the central budget (Csobánczy 05/11/96). The Ministry of Agriculture and small-holders seek to protect agricultural production. Smallholders are particularly interested in the maintenance of favourable tax and other subsidies (Herpay 29/10/96, Horváth 11/11/96).

Actors of safety and control

Actors from sectors concerned with safety and control, such as the Ministry of Transport, Police, Ministry of Internal Affairs, work closely in the field of road safety with the National Committee to Prevent Accidents (Galambos 28/04/97, Gyurkovics 13/05/96, Kercs 15/05/97, Kiss 15/05/97, OBB 1994a, OBB 1997b). They are concerned with decreasing the number of accidents and the rate of drunk driving.

Some organisations who practice control over quality, production, and trade in alcoholic beverages and public safety, such as the National Customs Office, the National Institute of Wine Verification, Bureau of Consumer Affairs, Police, and

the criminal justice system, function as executive bodies, rather than taking an active part in the policy formulation process.

Other actors

The United Nations International Crime and Justice Research Institute has a programme office, which works under the aegis of the Ministry of Education (Czakó 19/08/97). Their activity focuses on building training capacity of teachers in the primary, secondary, tertiary and post-graduate education system (Bruno 1996).

3 Understanding of alcohol policy

The analysis sought to understand how different actors perceive alcohol policy, which is of extreme importance when the policy is conceptualised. As an introductory part of each interview, the understanding of alcohol policy was discussed[14].

A scoring system was used to analyse understanding by the interviewees. Actors were scored[15] on the following way:

1-Actors who understood alcohol policy in a comprehensive way, in that a number of policy elements, e.g. taxation, price policy, information campaign, availability, etc. (not necessarily including all, but most of them) are parts of a comprehensive alcohol policy (see also chapter 3).

2-Actors who understood alcohol policy as being more than dealing with alcoholics, but referring to only one or two policy elements and not interpreting it in the comprehensive way defined in this study.

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[14] As the word policy does not have a Hungarian equivalent, its translation "alcohol politics" (alkohol politika) as a first choice, supplemented with "alcohol issue" (alkoholügy) or "alcohol question" (alkohol kérdés) were used in the interviews.

[15] A caveat is needed that the number of policy actors identified does not equal the number of interviews delivered, as in some cases more representatives of the same organisation, institution were interviewed, representing different divisions or subgroups. Also, when an individual actor was identified who also represented an actor organisation an effort was made to interview other representatives of the organisation. Numbers used in the discussion refer to interviews.

3-Actors who equated alcohol policy with treatment and care of alcoholic people.

8-Actors who did not understand the concept of alcohol policy at all.

9-Actors with whom the question could not be discussed or their understanding could not be determined.

Results based on this scoring system are summarised in Table 24.

Table 24 - Understanding of alcohol policy by interviewees

Way of understanding:	Compre-hensive	Few policy elements	Only treatment	Does not understand	Not discussed	Total
Number	8	35	3	0	0	46

An important finding to emerge from the interviews was the diversity of the understanding and interpretation of alcohol policy, reflecting the diverse activities of actors. Most interviewees were not aware of the potential complexity of a policy on alcohol and how they might contribute to it. It was often necessary to engage in lengthy preliminary discussions with secretaries to explain why a particular individual was relevant to the study.

Very few actors understood alcohol policy in a broad, comprehensive way. Those interviewees who were broader in their approach came from the industry, research and the media. It is worth mentioning that no actors in the health sector, except for two researchers, interpreted alcohol policy on a comprehensive way. As one health actor stated "alcohol policy is a broad concept, but we deal with addicts. We also organise rehabilitation for them..... " (Salamon 15/10/97).

A sector specific understanding is apparent. The traffic safety division of the police emphasised drunk driving regulations, also mentioning primary prevention, education and availability control (Galambos 28/04/97). The National Health Promotion Institute focused on primary prevention and education, banning advertising and rehabilitation (Czeizel 03/10/96). The customs office concentrated on excise duty (beer, spirits), regulations on availability and law enforcement (Sipos 25/10/96). According to one interviewee "alcohol policy as such does not exist, but control measures do....." (Csehák 08/10/96). Alcohol policy was regarded with some sensitivity and the concept was often obscured. "The alcohol issue is a very

delicate issue. Alcohol problems requires collective responsibility of the society...." (Morava 15/10/96).

Researchers and health professionals neither speak with a single voice nor reflect international developments. Few have challenged the prevailing disease oriented approach. "The alcohol problem is alcoholism ..... it is a disease of denial" (Kovács 07/23/97). Another expert states "alcoholism can not be solved as adequate rehabilitation is limited..." (Holzberger 16/10/96). On the other hand "there is treatment and care for alcoholics, but prevention is missing... " (Buda 25/10/96).

Some interviewees considered alcohol a social problem (8/46) and " (alcohol is)... not an economical problem..." (Csehák 08/10/96), some others perceived it as confined to alcoholics (7/46).

Understanding of alcohol policy as a public health policy was rare. National institutes and ministries outside the health sector have little awareness of the public health relevance of alcohol. Only a few, and mainly health, actors put alcohol policy into a public health context (Buda 25/10/96, Csehák 08/10/96, Kereszti 10/09/97, Kökény 09/10/96).

These interviews indicate that the inter-sectoral nature of a comprehensive modern alcohol policy is not widely understood and existing approaches reflect a sector specific model, which, not only in health, is disease oriented. It is encouraging, however, that few interviewees viewed alcohol policy as exclusively limited to treatment and care of alcoholics.

4 Position

4.1 Analysing position

The position of stakeholders is determined, to a considerable extent, by whether they are willing to accept the importance of a comprehensive policy which takes into consideration the scientific evidence that the incidence of alcohol problems can be influenced by various policy means and thus will support its development. This concept, however, has changed with the progress of the interviews. Because the concept of a comprehensive alcohol policy was not present, as it is reflected in the understanding of alcohol policy by actors, the question was modified after the first series of interviews to assess how supportive the actor is towards policies on alcohol which aim to decrease consumption and the incidence of alcohol related problems.

Results of interviews and statutory documents setting out the official role of the actor, and other relevant documents have been brought together to make the assessment. Based on this information the position of actors with relation to alcohol policy has been categorised into three major groups:

- support
- non-mobilised
- opposition.

Table 25 illustrates the nature and strength of each actor's position. The strength of the position is assessed according to the actor`s policy position and resources committed to alcohol policy. It is assessed on a seven point scale:

- low (1)
- low-medium (2)
- medium-low (3)
- medium (4)
- medium-high (5)
- high-medium (6) and
- high (7).

Assessment of the position and strength of each actor was an interactive process involving three separate evaluations (Glasser & Strauss 1967). The first followed the interview. The second was about 6-8 weeks later after a number of interviews were completed. The third was during the final analysis of data. The first ranking provided the individual assessment of each interviewee, the second and third reassessments complemented the analysis with the possibility of ranking different actors relative to each other. During the assessments, few actors changed category. There was most uncertainty about actors with low level of support and those mobilised to a very small extent. The findings of the final analysis are summarised in Table 25.

4.2 Position of actors

Support

The position of policy actors reveals that the most supportive actors are non-governmental organisations, the National Institute of Alcohology and scientists and researchers. They are the most interested in raising public awareness about alcohol related problems, but they appear to expend considerable energy on ensuring their financial existence rather than on campaigning.

Other health actors are more supportive in theory than in practice. For example, major national institutes, such as the National Institute for Health Promotion and the Medical Officer Service express interest, but display little activity (Czeizel 03/10/96, Morava 15/10/96). Where alcohol is considered it is built into broader programmes, such as school health. They do not consider that they have much responsibility for alcohol policy. They mandate responsibility on the Mental Hygiene Programme Office and the Ministry of Welfare. In practice, however, the Mental Hygiene Programme Office has a similar level of commitment to addressing alcohol as have the two previous national institutes (Gáspár 12/05/97, Veér 16/10/96). As staff members in leading positions stated "it does not have any specific alcohol programme,... we focus the attention on drugs, which is an emerging problem" (Balogh 05/1997, Gáspár 12/05/97).

Actors active outside the health sector, working in the field of road safety or education, are more supportive. They not only express support, but more resources are committed to alcohol related activities than by most health actors (OBB 1994b, OBB 1996, OBB 1997a).

Opposition

There are no prominent actors who oppose strategies to reduce consumption and alcohol related problems, apart from representatives of retailers, owners of catering facilities and small-holders (Antalffy 07/10/96). They express opposition to policy elements targeting reduction in consumption.

Wine and spirit producers, contrary to expectations, do not express clear opposition to a comprehensive alcohol policy targeting consumption. They are supportive of certain elements of alcohol policy, as they are interested in reducing the extent of the black market and illegal industrial activity (Budai 25/10/96, Herpay 29/10/96). Beer producers are more supportive of a comprehensive policy on alcohol, possibly because harmonisation of taxes and other measures might lead to a shift from spirits to beer drinking (Béndek 16/10/96). They are in favour of ways of promoting responsible drinking as long as these do not decrease further their market share or increase taxes imposed on beer. Indeed, they have been active in promoting the idea of a specific policy on responsible drinking[16], which has not been taken up.

Non-mobilised groups

Central administrative organisations, other than those with direct responsibility for health promotion and prevention, such as the Ministry of Finance, Agriculture, Industry and Trade, the judiciary and the customs office, do not appear to have formulated a consistent view on the public health impact of alcohol. Consequently any effect they have is indirect and often incidental.

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16 Policy on responsible drinking: Beer producers initiated a movement in 1996, which aimed to promote responsible drinking patters for the public. They sought the collaboration of wine and spirit producers, which they got in the initial stage. By 1997 because of the lack of collaboration form others outside the beer industry it failed to make further progress. (This movement would have been particularly favourable for the brewing industry, because the market share of beer has been decreasing in the 1990s.)

Table 25 - The nature and strength of positions of key actors on a policy to reduce incidence of alcohol problems in Hungary

Actors	Position	Strength
National Institute of Alcohology	support	medium-high
Scientists, researchers	support	medium-high
BB	support	medium-high
NGOs, Foundations	support	medium-high
National Committee to Prevent Accidents	support	medium
UNICRI - Ministry of Education	support	medium
Parliamentary Committee of Health and Social Affairs	support	medium-low
CsJ	support	medium-low
Ministry of Welfare	support	medium-low
Beer Producers	support	low-medium
Ministry of Agriculture	support	low-medium
Police	support	low
Ministry of Transport	support	low
National Institute of Vine Verification	support	low
Mental Hygiene Programme Office	non-mobilised	low
VA	non-mobilised	low
Wine Producers	non-mobilised	low
Spirit Producers	non-mobilised	low
National Health Insurance Fund	non-mobilised	low
World Bank	non-mobilised	low
National Institute of Public Health & Medical Officer Service	non-mobilised	low
National Institute for Health Promotion	non-mobilised	low
Soros Foundation	non-mobilised	low
National Public Health Committee	non-mobilised	low
Local governments	non-mobilised	low
Custom	non-mobilised	low-medium
Judiciary	non-mobilised	medium-low
Media	non-mobilised	medium-low
Ministry of Industry and Commerce	non-mobilised	medium
Ministry of Finance	non-mobilised	high
Retailers & Caterers	opposition	medium
Small-holders	opposition	medium

Local governments have the possibility to develop locally relevant policies that differ from those at the national level within the limits of existing legislation (Németh 1997 May, Parliament 1991b). They could actively participate in the revision and submission of licenses for premises and catering units and vary the rate of local charges and taxes. However these options are rarely adopted, with only one out of the 38 authorities interviewed having done so. In one district of the capital the local government took the initiative to ban further opening of on-street premises selling alcoholic beverages and to revise the licenses of the existing ones.

5 Who is in charge? - avoiding responsibility

Seeking to identify who is thought to have prime responsibility for alcohol policy was not among the original aims of the study. This theme emerged as the interviews took place, as interviewees tried to deflect responsibility by pointing to others.

The analysis of perceived and delegated responsibility highlights important contradictions. These findings are summarised in Table 26. The table summarises the bodies most commonly identified as having responsibility by each category of actors.

Table 26 - Responsibility for alcohol policy by different categories of actors

Frequency of mandated responsibility	Most frequent	Second most frequent	Third most frequent
Health actors	Mental Hygiene Programme Office	Collective	Ministry of Welfare, professional groups
Production & trade actors	Ministry of Welfare	who deals with addiction	collective
Safety and control actors	collective, national	Ministry of Welfare	
Other actors	Mental Hygiene Programme Office	multiple, sectoral	Ministry of Welfare

Eighteen interviewees named the Ministry of Welfare having the major responsibility for alcohol policy. Thirteen out of them were outside the health sector.

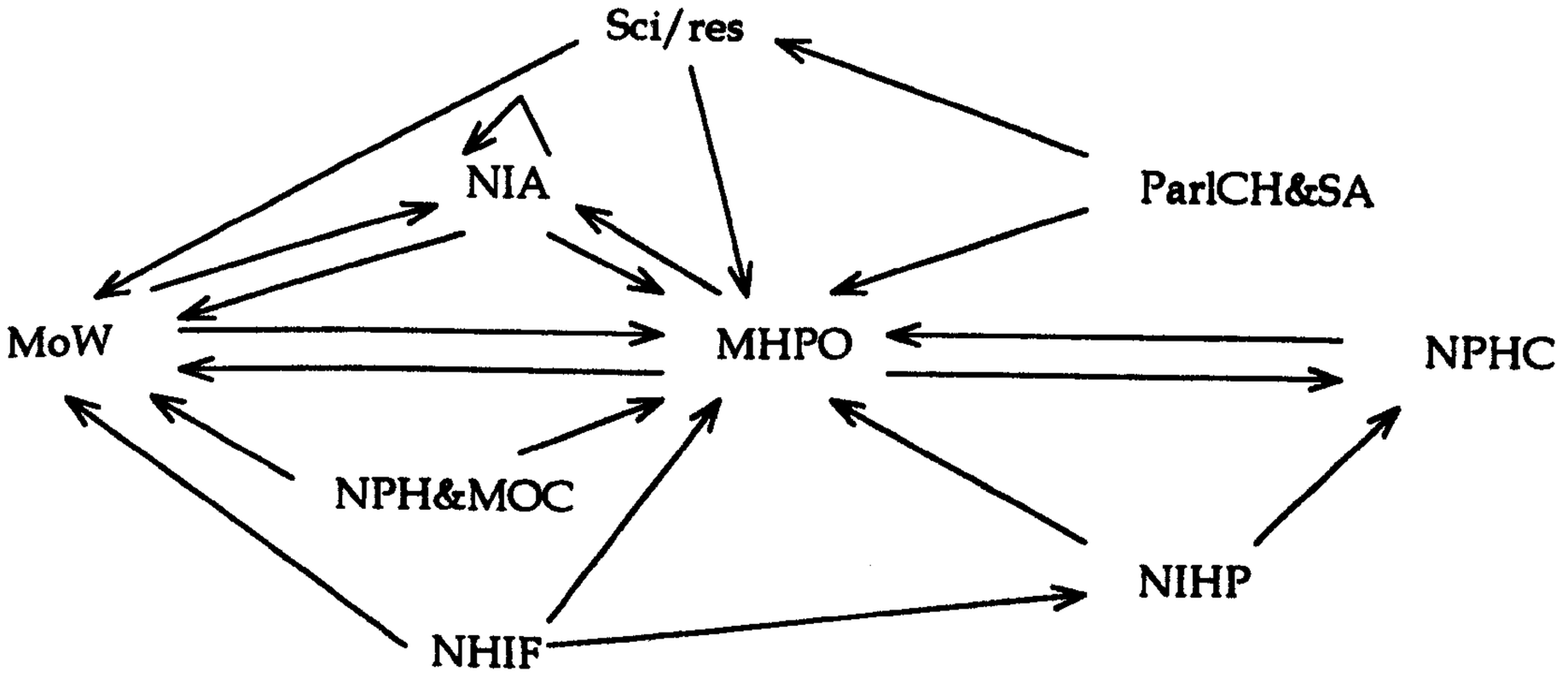
Twenty four of the interviewees said it was a collective responsibility, a problem for everyone.

In practice, responsibilities have a sectoral basis. The Ministry of Transport and the National Committee to Prevent Accidents focus on drunk driving, the UNICRI-Ministry of Education focuses on education and training of teachers and the Ministry of Industry and Commerce focuses on control of availability (Czakó 19/08/97, Gyurkovics 13/05/96, Kercs 15/05/97, Kiss 15/05/97, Nagy 23/07/97). They all realise the need for action in other areas but for that they nominate something termed "collective responsibility" and/or the Ministry of Welfare. Eight interviewees argued that those who deal with addicts should be in charge of the alcohol issue, coming equally from health and other sectors.

It is important to note that no organisations outside the health sector were held to have ultimate responsibility. When responsibility was attributed to other actors the words "collective"[17] or "national" were used.

Among health actors the picture is further complicated, therefor their opinion about perceived responsibility is showed separately (Figure 28).

Figure 28 - Nominated responsibility among health actors



[17] Collective responsibility: This term was a very commonly used term of the nomenklatura during the communist period.

The Parliamentary Committee for Health and Social Affairs, the Medical Officer Service, the National Institute for Health Promotion, the National Public Health Committee, and some researchers, and media representatives all name the Mental Hygiene Programme Office as the ultimate organisation which should take responsibility for the alcohol issue. "Go to the Mental Hygiene Programme Office, they are in charge...." (Czeizel 03/10/96, Kökény 09/10/96, Morava 15/10/96). "Talk to Veér Andràs, he should know everything you ask....." (Csehák 08/10/96). At the same time, as mentioned before, this office commits limited resources to alcohol and it does not have any specific alcohol strategy or activity (Balogh 05/1997, Gáspár 12/05/97). The National Institute of Alcohology (NIA) developed a strategic plan concerning alcohol and submitted it to the Ministerial Commissioner, but no further action was taken (Holzberger 16/10/96, OAI 1995a). The NIA emphasises the responsibility of the Ministry of Welfare, the Mental Hygiene Programme Office and the Parliament. The Ministry of Welfare representatives delegate the issue to the Mental Hygiene Programme Office.

In summary, everyone views it as someone else's responsibility or as a "collective" issue.

This part of the analysis has relied on interviews, which have the intrinsic problem of social desirability bias. It is realised that respondents, in their answers, may reflect expectations of what would be socially approved or disproved, which is particularly the case when policy makers at the national level are interviewed and asked about responsibilities.

6 *Influence*

To assess the influence of policy actors is a challenging task. As no detailed methodology was available to do so, an approach was developed which fitted with the aims of the study and the data collection methods. After completing the first five interviews, these were considered as an internal pilot to see which factors were taken into consideration by the researcher when the influence of the actor was

assessed. A second researcher helped by asking systematic questions about the variables examined.

When the influence of an actor was first assessed it had to be considered according to whether the interviewee was viewed as an individual actor or was representing an institution or a group.

Regardless of whether the actor was an institution, organisation, a group or an individual, the assessment followed three planes with the main emphasis on the first:

- alcohol policy,
- public health policy, and
- politics.

There were concrete factors which were considered in the assessment. These appeared at three levels.

1. Observer's assessment
   - financial stability *(how secure the financial situation is)*,
   - organisational stability *(how long the institute have been in existence, how secure its position is in the official organisational structure)*,
   - examples of past programmes and initiatives[18] *(how active the institution is/was in the alcohol field, its the ability to implement a plan)*,
   - at what level of central administration is the actor represented or has access to *(networks)*[19],
2. Self-assessment, and
3. Assessment by other actors.

In case of individuals, instead of financial stability, the following factors were explored:

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[18] This has been assessed using the criteria of how much the actor's views are or can be reflected in initiatives for change, in regulations or legislation, and in major national forums.

[19] In Hungary parliamentary lobbying has little role in expressing influence in the policy arena. As one interviewee noted "parliamentary lobbying does not exist in Hungary, it happens through the government instead" (Antalffy).

- personal political stability (leadership continuity in a changing environment),
- level of individual networks in central administration, and
- success of past initiatives in the alcohol (public health or main activity) field.

An interactive process, similar to that used in the position analysis was also used to assess influence.

A difficulty facing the assessment was that extraneous information tended to influence the assessment. Information from media coverage and informal communications were not equally available in respect of all the actors studied. Much of this information emerged from the participant observation of public health policy making when the researcher was based at the Ministry of Welfare World Bank Programme Office.

During data collection it also became clear that some actors had been influential in the past, some actors have an impact now and some actors do not have any influence currently, but have a potential to be influential in the future. Therefore, in the final assessment this division was used. Immediately after the interviews only three categories of influence were used: high, medium, low. Later this was expanded to seven categories, which provided a more subtle division between different actors: high, high-medium, medium-high, medium, medium-low, low-medium and low.

The results are summarised in Table 27. To differentiate those actors whose current and potential influence differs, the following designation has been used. Actors whose potential influence is higher than their current influence are underlined. Where their potential influence is markedly greater (two or more grades) they are also in bold font. Actors whose probable future influence will be less are written in italics. Where this is markedly less (two or more grades) they are also underlined. Past influence is not presented there as it was an issue only in relation to three actors. It is discussed separately.

Current influence

There are three actors whose current influence could not be assessed. The National Public Health Committee has never had any specific alcohol related activity. Several organisations inside the judicial system are passive observers. They perform no alcohol related activity other than enforcing the law. Media representatives interviewed came from a broad spectrum[20]. They were, however, presenting very similar approaches to alcohol policy. The media was considered as a single actor in this study, but their current influence could not be assessed as any coverage of alcohol was largely incidental.

Past influence

Past influence of different actors was considered, but could be assessed only in three cases. The National Institute of Alcohology had had a considerably higher influence in the 1980s than in the 1990s. There were two individuals who died in the early 1990s, who kept alcohol on the agenda (Levendel and Simek) (Andorka 21/10/96, Buda 25/10/96, Csehák 08/10/96, Hajnal 14/10/96, Holzberger 16/10/96, Salamon 15/10/97). They were both professionals dealing with addicts. According to their contemporaries, they were dedicated to this issue. The establishment and development of the National Institute of Alcohology was widely attributed to their efforts. They also played an active role in supporting research in the 1980s (Andorka 21/10/96, Buda 25/10/96, Fekete 22/07/97, Hajnal 14/10/96). Thus, through these two individuals, the influence of the institute had been higher than at present.

The other actor is Judit Csehák, who in the 1980s initiated many changes which had an impact on the alcohol field and at that time was quite influential. Her personal influence on health policy is still high, but, as alcohol receives little attention, her current influence is small, although her potential influence is higher.

One of the other individual actors, Béla Buda, is no longer in a position of leadership, and thus has no institutional backup. Having retired from more and more activities he has less potential influence. However he is still very influential

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[20] *Media:* Representatives interviewed painted a coherent picture on alcohol policy and the media's relation to it, but the study did not aim to map media actors in detail. Because of the diversity of different media channels a further very detailed analysis could help better determine the best means to build alliances.

in the circles of researchers and professionals, and is still well known among the health actors.

Table 27 - Influence of policy actors

Actors	Current influence	Potential influence	Actors
Ministry of Finance	high	high	Ministry of Finance
Media		high	Media
Ministry of Industry and Commerce	high-medium	high-medium	Ministry of Industry and Commerce
Retailers & caterers	medium-high	medium-high	Retailers & caterers
Ministry of Agriculture	medium-high	medium-high	Ministry of Agriculture
Wine Producers	medium	medium-high	Wine Producers
Spirit Producers	medium	medium-high	Spirit Producers
National Comm. to Prevent Accidents	medium	medium	National Comm. to Prevent Accidents
Judiciary		medium	Judiciary
Customs	medium-low	medium	Custom
National Health Insurance Fund	medium-low	medium	**Beer Producers**
Smallholders	medium-low	medium	**VA**
Ministry of Transport	medium-low	medium-low	Ministry of Transport
Beer Producers	low-medium	medium-low	**Mental Hygiene Programme Office**
Police	low-medium	medium-low	Police
CsJ	low-medium	medium-low	CsJ
Parl. Comm. of Health & Social Affairs	low-medium	medium-low	Parl. Comm of Health & Social Affairs
Soros	low-medium	low-medium	*Smallholders*
National Inst. of Vine Verification	low-medium	low-medium	National Inst. of Vine Verification
BB	low-medium	low-medium	Ministry of Welfare
VA	low	low-medium	World Bank
Mental Hygiene Programme Office	low	low-medium	Local governments
Ministry of Welfare	low	low	***National Health Insurance Fund***
World Bank	low	low	*Soros*
Local governments	low	low	*BB*
National Institute of Public Health and Medical Officer Service	low	low	National Institute of Public Health and Medical Officer Service
National Institute for Health Promotion	low	low	National Institute for Health Promotion
UNICRI- Ministry of Education	low	low	UNICRI- Ministry of Education
National Institute of Alcohology	low	low	National Institute of Alcohology
Non-Governmental Organisations	low	low	Non-Governmental Organisations
Scientists, researchers	low	low	Scientists, researchers
National Public Health Committee		low	National Public Health Committee
Consumers	?	?	Consumers

Considerable differences in current and potential influence

Actors whose current and potential influence differs considerably are discussed in the following paragraphs.

Beer producers currently have less influence than wine and spirit producers. Following privatisation, the brewing industry was taken over by multinational companies (Béndek 16/10/96, Béndek & Várbíró 1995, MSzSzT). The newly emerging privatised industry does not have good contacts in government and parliamentary circles, however, with time its influence is likely to strengthen.

The Mental Hygiene Programme Office could be influential if it decided to address the alcohol issue. Its potential role in alcohol policy is accepted widely, including by those outside the health sector. Consequently it seems to be the natural institutional base for alcohol policy. The situation is similar with András Veér, who is the head of the Mental Hygiene Programme Office (MHPO) among others. His institutional support is extensive and he is well known in media circles (Moldova 28/07/97, Nógrádi 07/05/97, Parat Kovács 05/05/97, Sárkány 30/04/97). Thus his potential personal influence is even higher than that of the MHPO.

The National Health Insurance Fund and the Soros Foundation, by withdrawing funding from the alcohol field, have become potentially less influential. The National Health Insurance Fund was especially important as its financial resources allocated to alcohol issues were bigger than those of the Soros Foundation, and it provided opportunities to support a wide range of initiatives throughout the country (Haggard et al. 1993, OEP 1994, OEP 1995, OEP 1997, Soros Foundation 1995, Soros Foundation 1996)

Other interesting results

The Ministry of Finance has the greatest opportunity to promote policy changes. Its initiatives do not, however, take into consideration their public health impact. Those actors involved in the marketing of alcoholic beverages have more influence in the policy arena than do health actors, who are supposed to be in charge. They

have an even greater potential influence if they decide to become more actively involved when their market share is threatened (Béndek 16/10/96, Budai 25/10/96, Herpay 29/10/96, Horváth 11/11/96, Nagy 23/07/97).

The National Committee to Prevent Accidents, an actor in the control and safety category, also has higher influence than those in the health sector. Its influence is reinforced by the support of the police, the Ministry of Transport and the Ministry of Internal Affairs.

7 *Relations*

In the influence map relations are designated by lines (Figure 31). The thicker the line, the stronger the connection is. The ranking is based on whether different actors had accidental links, continuous information exchange links or had common activities. Health institutions are more or less in contact with each other, though this relationship can be relatively weak. They have hardly any contact with those actors involved in other areas, such as alcohol marketing, law enforcement, industry and finance. An alliance of actors involved in road safety, such as the Ministry of Transport, Police, Ministry of Internal Affairs and the National Committee to Prevent Accidents can be identified. Organisations in the education sector have limited contact with health and safety actors. Market interests dominate the alliance of retailers, small-holders, financial and commercial bodies. The vertical nature of relationships mostly follows formal structures (Dudás & Hazafi 1996b), though its strength is influenced by personal factors. Horizontally, even common interest might not be enough to lead to coherent co-operation so personal factors have great importance.

Figure 29 & Figure 30 summarise the position and current and potential policy influence of alcohol policy actors. Applying a matrix table to present alcohol policy actors` positions and influence shows that no actors could be identified who have both a high level of interest in more policy on alcohol and sufficient influence to develop and implement it.

8 Feasibility of policy elements

In each interview the attitude to the various elements that constitute a comprehensive alcohol policy was discussed. In case of those interviewees whose understanding of a comprehensive alcohol policy was limited or absent, elements of a comprehensive alcohol policy were listed by the interviewer and discussed with those interviewees whose understanding of alcohol policy was fairly comprehensive. Presenting the list was not necessary. These people were simply asked how feasible they considered different alcohol policy instuments.

Table 28 - Feasibility of alcohol policy elements

Position / Policy elements	Supports in favour of	Opposes	Does not want to formulate opinion	Was not referred to	Total
Control production	0	4	3	39	46
Raise price, tax	16	14	5	11	46
Limit availability	21	13	5	7	46
Increase minimum drinking age	1	13	3	29	46
Ban advertising	19	9	3	15	46
Mass media campaign	16	2	2	26	46
Primary prevention	40	0	0	6	46
Treatment and care	25	1	0	20	46
Drunk driving regulations	12	1	1	32	46
Control at workplaces	1	0	1	44	46

A striking result is that most interviewees (40) are very much in favour of primary prevention and education, regardless which sector they come from. The importance of treatment and care (25), limiting availability (21) and an advertising ban (19) are also recognised. A caveat is necessary in that, in the 1996-97 session, a new advertising act was ratified by parliament, which might have biased the interview results in that the issue was raised spontaneously more often than would have happened otherwise (Parliament 1997).

Primary prevention

Primary prevention was not referred to at all by wine and spirit producers, the customs office, the National Institute of Vine Verification and some media representatives.

Treatment and care

Treatment is emphasised mainly by health actors, the media and the judiciary. It links to the perception of alcohol policy being mainly concerned with addiction and alcoholics.

Availability control

Limiting availability is supported mainly by actors in the control, safety and health categories. They also mention the possible difficulties of urging further restrictions because of the European Union harmonisation process and the strength of market interests. Actors involved in production, trade and economic aspects of alcohol oppose this approach (Antalffy 07/10/96, Béndek 16/10/96, Budai 25/10/96, Herpay 29/10/96, Nagy 23/07/97).

Price control

Price control measures elicit a mixed response. Those opposed argue that a further increase in taxes would lead to an increase in the black market. Health actors are split on this issue. There is consistent opposition from producers, traders and the Ministry of Finance.

Advertising control

An advertising ban is supported mainly by health actors. They felt let down when the parliament accepted a liberal advertising act (see Chapter 5).

Minimum drinking age

Increasing the minimum drinking age is opposed by the industry (Béndek & Várbíró 1995, Budai 25/10/96, Herpay 29/10/96)), and some other interviewees did not see it as a tool that could be enforced in Hungary (Andorka 21/10/96, Béndek & Várbíró 1995, Budai 25/10/96, Fekete 22/07/97, Gyurkovics 13/05/96, Kereszti 10/09/97, Kricsfalvi 12/05/97).

Drunk driving control

Control measures directed at drunk driving are emphasised nearly exclusively by safety and control actors.

Control on production and at workplaces

Interviewees did not discuss the possibility of controlling production and no interviewee referred to workplaces as a possible setting for action.

Law enforcement & combating the black market

There is one element of alcohol policy, which emerged from the interviews, but is not normally addressed separately in the literature. Ten interviewees considered law enforcement an important element of alcohol policy. Actors who emphasised its importance were not only in the field of control and safety, which would be expected, but also representatives of other categories, such as health, the Ministry of Finance, the Ministry of Industry and Trade and the National Institute of Wine Verification. Twenty-eight people argued that combating the black market was extremely important. On this issue health, production and trade, safety and control and other actors take similar position.

It has to be added that concern about the process of European Legislative Harmonisation was raised by many interviewees. Their comments suggested a passive acceptance. "There is nó point in talking about it as the EU directives determine what we can do anyway " (Nagy 23/07/97).

9 Summary and conclusions

In Hungary, the main focus of activity among actors in the alcohol policy arena is very much related to their official status in the system, with those who do not have an explicit responsibility for a particular aspect of policy tending to be unaware of the public health consequences of their actions.

Understanding of alcohol policy is far from comprehensive. Most actors focus on their area of activity forgetting about other elements. The comprehensive, inter-

sectoral nature of a modern alcohol policy is poorly understood and existing policies are based on a disease oriented model. There is a lack of explicit and coherent goals and a vision shared by all actors is missing. Key actors do not seem to be aware of what they could do as a result of their position.

Responsibility in the alcohol field is sectoral. There is a contradiction between named and actual responsibilities. Actors outside the health sector consider that the Ministry of Welfare should be in charge of alcohol policy or refer to "collective" responsibility. Health actors tend to refer to the Mental Hygiene Programme Office as the organisation with complete responsibility and adequate financial resources to address alcohol related problems. Its activities, though, are focusing on drug related issues and it does not have any specific alcohol programme.

The results of this study, summarised in Figure 29 & Figure 30, suggest that those actors with high and medium level of support and interest in a comprehensive alcohol policy, which could decrease the incidence of alcohol problems, have little influence. Those with influence in the alcohol policy arena have not mobilised themselves. No actors could be identified with strong support, high influence and a major interest in more policy on alcohol. Considerable opposition can be expected from those working in retail and catering facilities and from small-holders.

The network of actors show a sectoral fragmentation (Figure 31). Health, economic and safety functions are very much split among different sectors and there is no overlap of these functions. Actors coming from different areas have little or no communication with each other. Exchange of information between different sectors is accidental. There is a failure to develop strategic alliances.

Figure 29 - Current influence and position of alcohol policy actors in Hungary

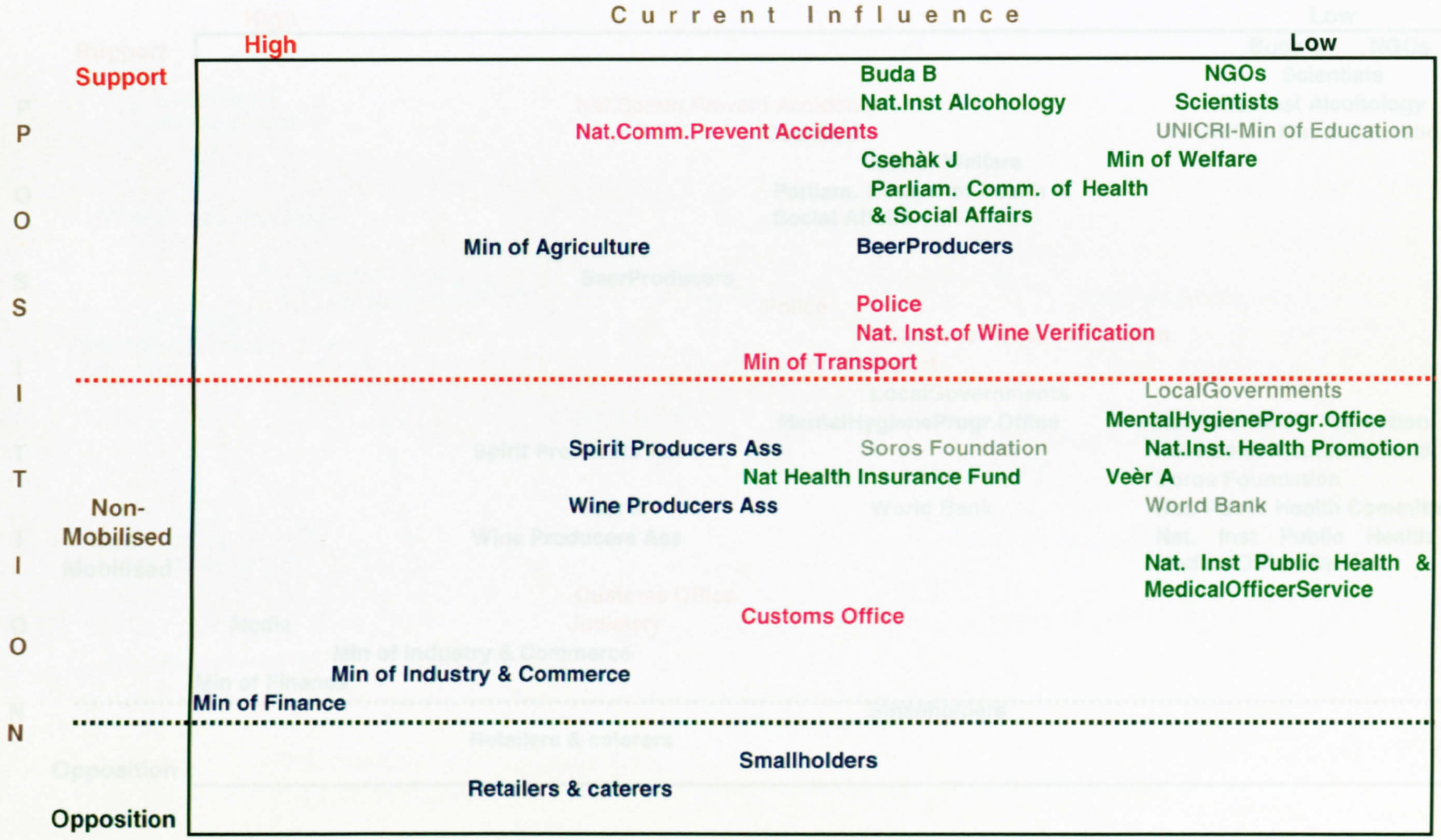
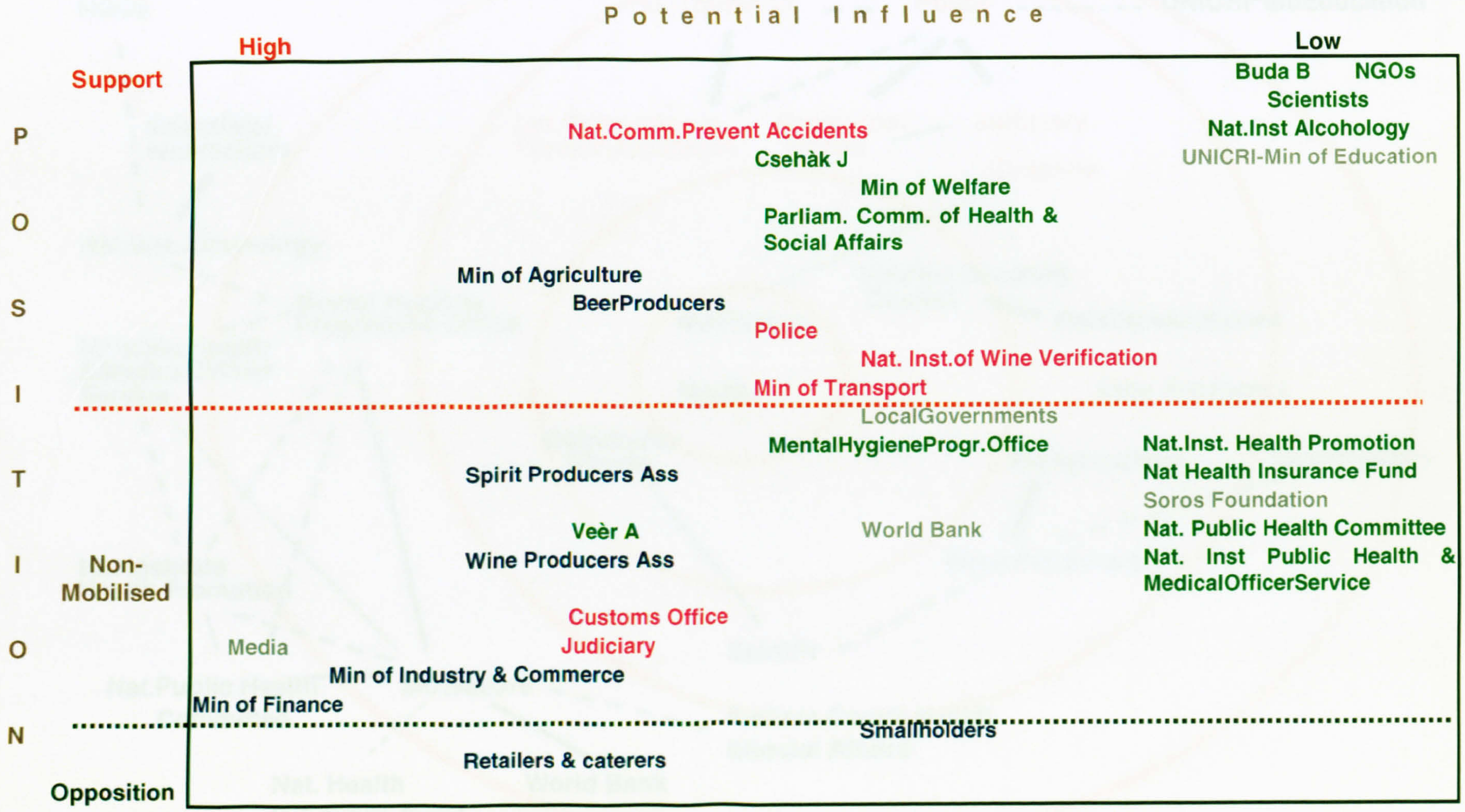


Figure 30 - Potential influence and position of alcohol policy actors in Hungary



INFLUENCE & LINKS

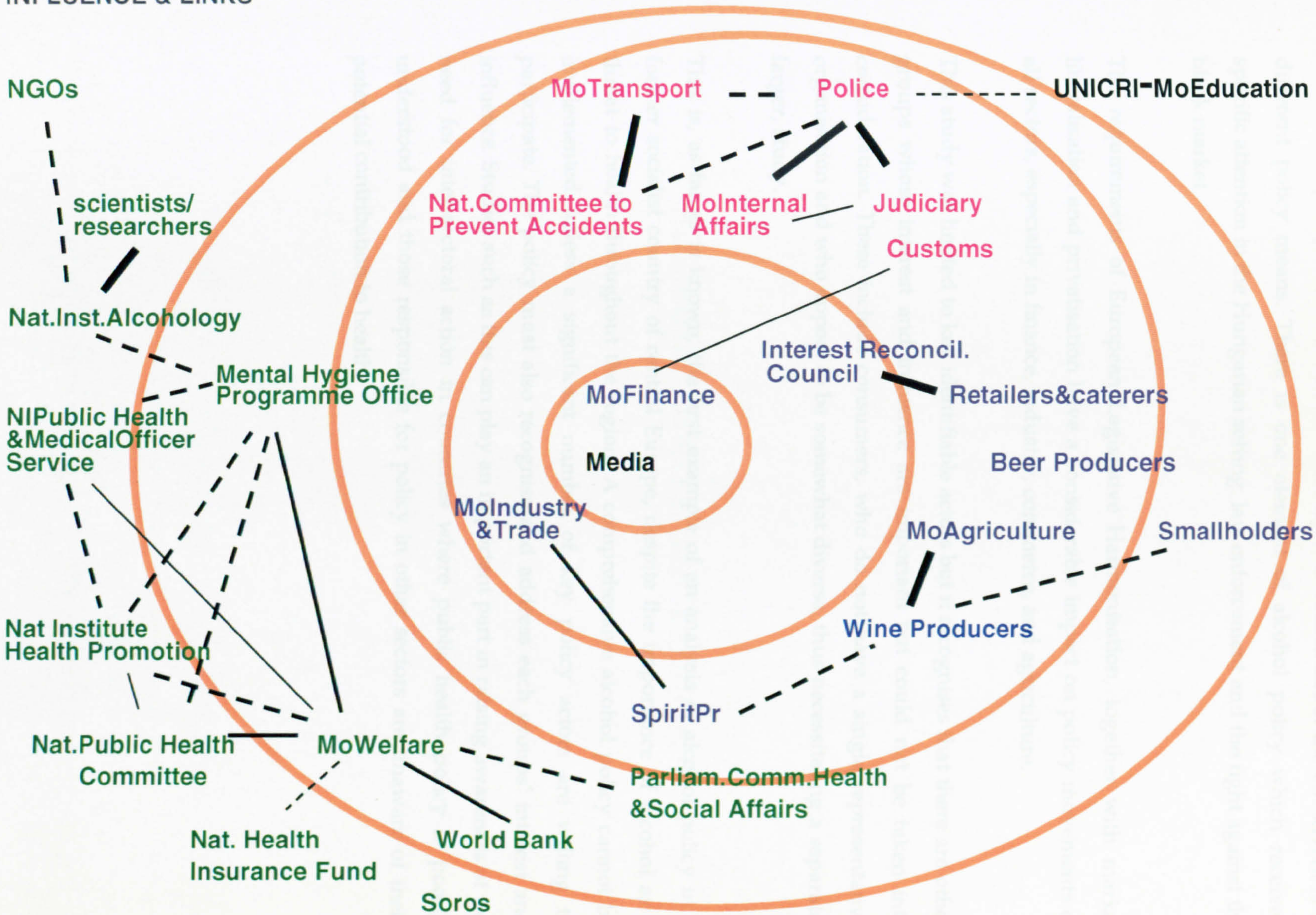


Figure 31 - Influence and links of alcohol policy actors

Most actors consider education and information dissemination the most important and feasible policy element, which is contrary to evidence about the effectiveness of different policy means. There is one element of alcohol policy which received specific attention in the Hungarian setting: law enforcement and the fight against the black market.

The requirements of European Legislative Harmonisation, together with market liberalisation and privatisation have a considerable impact on policy movements of all sectors, especially in finance, industry, commerce, and agriculture.

This study was limited to key identifiable actors but it recognises that there are other groups whose interest and influence are important but could not be taken into consideration. These include consumers, who do not have a single representative organisation and who appear to be somewhat diverse, thus necessitating a separate, larger, study.

This is, as far as is known, the first example of an analysis of alcohol policy in a former socialist country of central Europe, despite the importance of alcohol as a threat to health throughout the region. A comprehensive alcohol policy cannot be implemented unless a significant number of key policy actors are willing to participate. The policy must also recognise and address each groups' interest and influence. Studies such as this can play an important part in raising awareness of the need for inter-sectoral action in countries where public health policy is poorly understood and those responsible for policy in other sectors are unaware of their potential contribution to health.

- CHAPTER 9 -

SUMMARY AND CONCLUSIONS

By summarising major findings of the analysis of alcohol policy in Hungary aims to answer questions about future development, such as "what", "how" and "by whom". It seeks to determine which policy mix is feasible in the Hungarian context.

First the concept of alcohol policy as a public health policy is discussed. A comparison is made between the rest of the industrialised world and Hungary. Second, the tree of alcohol policy is discussed. This leads to the third part of the discussion providing recommendations for future alcohol policy development. Finally gaps in current knowledge and research initiatives for the future are presented.

1 Is alcohol policy a public health policy?

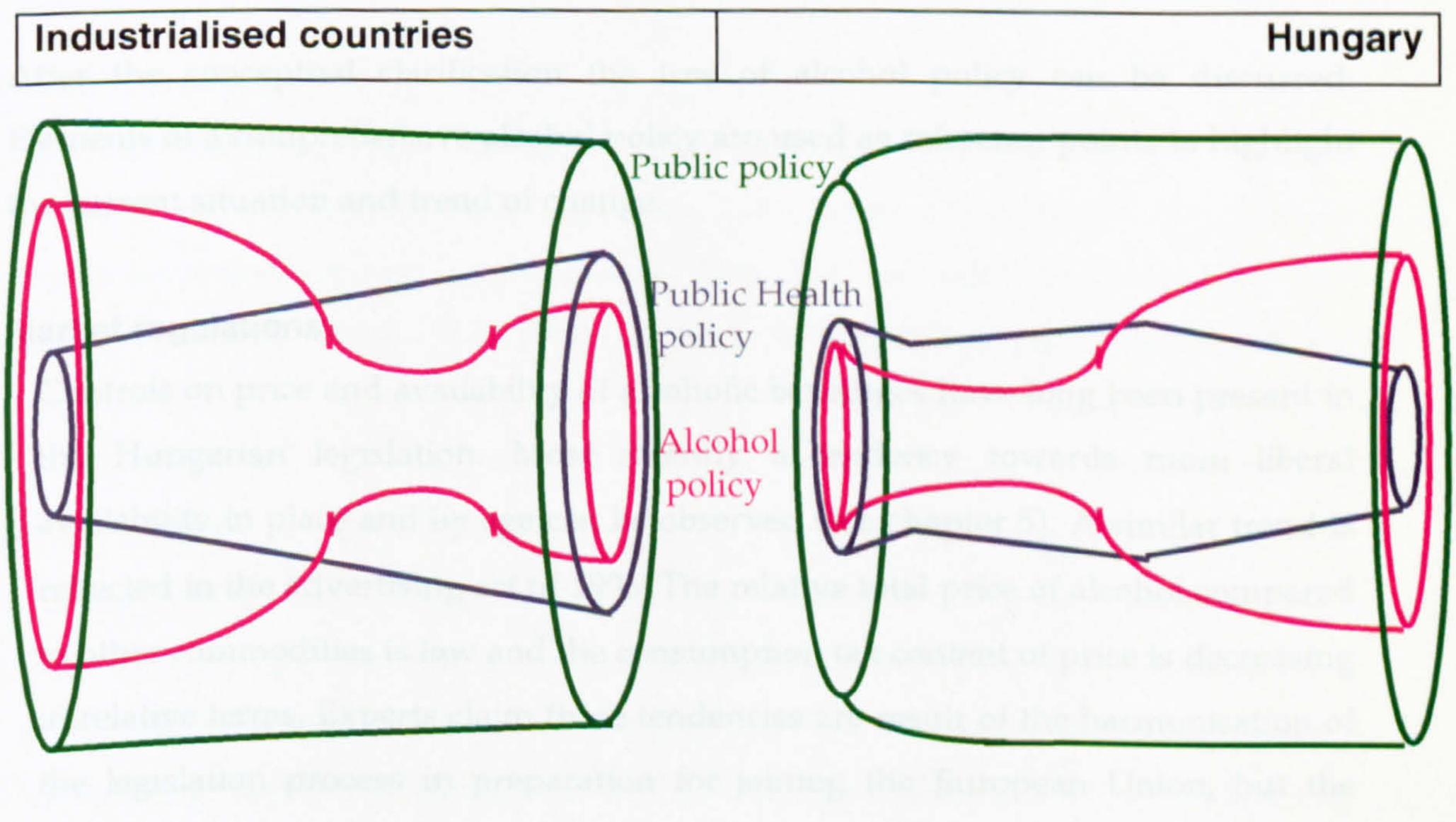
It was shown in Chapter 3 that alcohol policy has not always been interpreted as a public health policy in the developed world. The concept of alcohol policy moved from being a public policy in the first half of the 20th century towards being a health policy in the 1960s and 1970s, focusing on alcohol addiction and abuse as a disease. It became a public health concept by the 1980s, as the policy focus moved towards decreasing the incidence of not only alcohol abuse and dependence, but also other alcohol related problems. Parallel to the changes in the concept of alcohol policy the concept of public health policy also changed. Its scope grew from the control of infectious diseases and traditional hygiene towards the control of chronic non-infectious diseases and other health and health care related issues. The scope of public policies under government control during the second half of the century has been decreasing, especially since the 1970s. These tendencies are represented in Figure 32.

In contrast, in Hungary, in accordance with the principles of the communist state, the diminishing sphere of public policies under government control can be observed only since the 1980s, with a radical decrease in the public sector after 1989. Public health policy in the second half of the 20th century showed progress in the control of infectious diseases and hygiene but failed to take into consideration newly emerging problems of chronic, non-infectious diseases. The disciplines required to address

these challenges could not develop. Thus a relative decrease in the scope of public health policy can be observed over the second half of the 20th century until the end of the 1980s. The slow change in the concept of public health since the end of the 1980s was presented in Chapter 5 and 6 (Figure 32). Alcohol policy could be identified as a public policy concept until the end of the 1960s, when the disease concept of alcohol problems became the prevailing focus of alcohol policy. This concept has not yet changed to any significant extent, although there are signs of more comprehensive approaches, which take into consideration the broad impact of alcohol misuse.

Changes in concepts described above did not happen simultaneously in Hungary and the industrialised world, which leads to discrepancy between concepts.

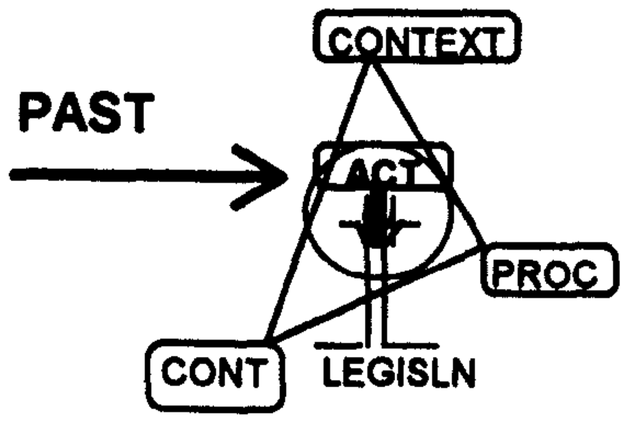
Figure 32 - The changing dimension of public policy, public health policy and alcohol policy in the developed world and in Hungary



Thus a considerable, although tangential, finding of this analysis is that concepts used in policy analysis in the west may apply differently to countries from other parts of the world. Hence, a straightforward translation of notions can be dangerous and misleading for the analyst.

In this study, this difficulty has been overcome by using western concepts, such as alcohol policy being a public health policy, and the concept of comprehensive alcohol policy, as reference points for comparison. These concepts also indicate the possible future direction of change, as developments in countries of Central and Eastern Europe follow the rest of the world.

2 *Alcohol policy in Hungary - summary*



After the conceptual clarification the tree of alcohol policy can be discussed. Elements of a comprehensive alcohol policy are used as reference points to highlight the current situation and trend of change.

Market regulations

Controls on price and availability of alcoholic beverages have long been present in the Hungarian legislation. Most recently a tendency towards more liberal availability in place and by age can be observed (see chapter 5). A similar trend is reflected in the advertising act of 1996. The relative total price of alcohol compared to other commodities is low and the consumption tax content of price is decreasing in relative terms. Experts claim these tendencies are result of the harmonisation of the legislation process in preparation for joining the European Union, but the pressure from private businesses cannot be ignored.

Parallel to the liberalisation of the market, which is a coherent part of the structural adjustment from a centrally planned to a market economy, efforts to create a more transparent licensing system and a more secure revenue flow can be observed.

This is emphasised by the excise law to control production and trade of alcoholic beverages apart from wine. It establishes a new licensing system where licenses are submitted by the notary and the customs office. The inclusion of the local authority into this process provides the possibility of more local control and the incorporation of other than strictly financial considerations, although that does not mean that such considerations will be taken into account. In the case of wine, stricter legal requirements for producers and the establishment of self-governing bodies of wine producers seek to ensure quality products.

Although the move towards a more liberal and transparent production and trade in alcoholic beverages is clearly reflected in legislative changes, enforcement provokes opposition. In the meantime, producer and trader groups, particularly those involved in the production and trade of products involved in the black market or of low quality fight to maintain loopholes in the legislation. They use the argument that the taxation system for small holders, traders and caterers is too complex and taxes are high.

Servers` training

The legal framework for training servers has changed little over the past decades, although the sudden and rapid increase in the number of outlets after 1989 should have increased training requirements. This has not been recognised by the responsible authorities. This might indicate a lack of qualified staff in many premises.

Drunk driving

Unlike market regulations, drink driving measures seem to resist the EU harmonisation process. The zero acceptable blood alcohol level for drivers and the possibility, as a result of the legal change in 1997, to withdraw the driving licence on spot if the driver can be suspected of driving under the influence of alcohol, are very strict regulations in comparison to other European countries. This might reflect a coherent policy among actors involved in road safety. There is agreement about the need to maintain these strict regulations and further restrictions are planned.

Education

The legislative framework for primary prevention is partly included in regulations on education and public health. The National Curriculum of 1995 provides legislative framework for primary prevention activities, especially education and information dissemination throughout primary and secondary schools. Its implementation relies on individual schools. This legislation is a genuinely new element compared to previous decades. Outside the education system the 1030/1994 order of government about principles of long term health promotion policy and the Health Act of 1997 (also the previous one of 1972) provide a legislative basis for primary prevention activities. National institutes and the medical officer service are involved primarily in implementation. Non-governmental organisations complement their actions. Their presence, however, is largely by chance. Thus in both the education and the health sector the legislative basis for education exists. Initiatives for action are reflected in the UNICRI-Ministry of Education training programme for teachers from the education sector, and the mental hygiene programme and healthy schools programme from the health sector. There is an additional programme implemented by the police, the DADA (Drug, Alcohol, Danger, Alert) programme. Collaboration between these programmes is poor.

Treatment and care

The legal framework of treatment and care for alcohol addicts and abusers has been changing. The compulsory element of treatment has been removed, although detoxification centres continue to operate. The specialised treatment and care network is struggling for survival. It tries to change the profile of services towards a more comprehensive care for all types of addicts. The care network is embedded into the general health care service system and is supervised by the National Institute of Alcohology, to which all specialised units and clinics are obliged to report data.

In primary health care settings the brief intervention package for people at risk of hazardous or harmful drinking has not yet been widely introduced, although this package has been developed internationally, specifically for primary care settings

and has proven to be an effective tool. The legislative basis for treatment and care service provision are laid down in the health act.

Beside the health care system, non-governmental organisations participate in the rehabilitation of alcohol addicts. Their presence is not evenly distributed throughout the country and relies highly on individual initiatives. Organisations linked to churches are particularly active. As the number of non-governmental organisations has been increasing rapidly, available financial resources have to be split between an increasing number of organisations. This could threaten their existence.

Workplaces

With the abolition of large socialist firms and the inflow of multinational companies, workplace prevention programmes get little emphasis. In current practice regulations of individual companies are applied, although the act on labour declares that workers should not be under the influence of alcohol during working hours.

The structure of the "tree", actors and the policy environment

For all these policy elements a sector specific vision applies. The lack of collaboration between different sectors has been pointed out in the stakeholder analysis, when informal links between different actors were assessed. Otherwise, collaboration inside each sector also leaves much to be desired, with the relative exception of road safety. Not only collaboration, but also clear boundaries of responsibilities are missing and activities overlap. Policy evaluation is almost absent.

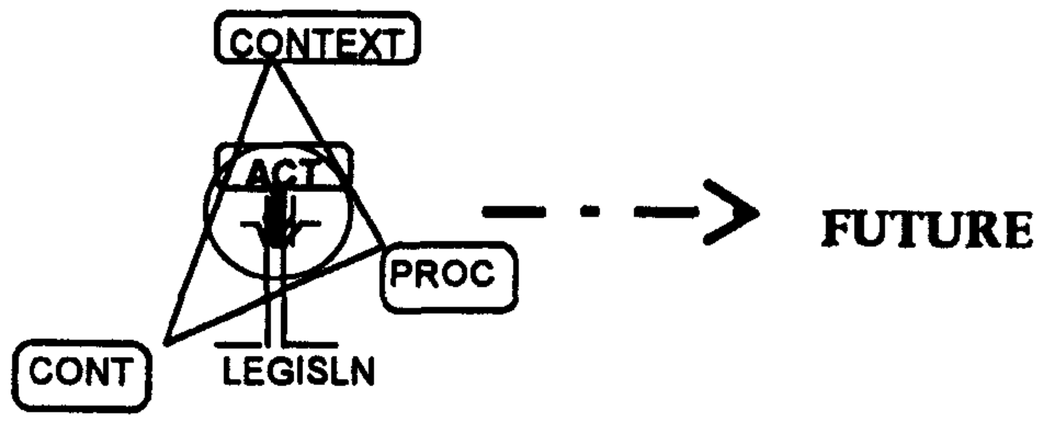
With regard to characteristics of the policy environment, the clear split between private and public spheres has not abolished the importance of individual networks which has developed over decades. It is reflected in the interest representation of wine and spirit producers, for both of which personal connections to government were emphasised by the interviewees. Beer producers, however, because of the complete privatisation of the brewing industry and the considerable role played by multinational companies, lack well developed

personal contacts in public administration. It must be noted that it is beer which is taxed the most relative to its alcohol content compared to other alcoholic beverages. On the other hand, exactly because of the multinational ownership, contacts with international interest representation organisations are much better developed than in the case of the other two beverage types.

In the public sphere the hierarchical organisational structure and decision making persists despite the political changes in 1989. It has been reflected in the theme of responsibility which emerged from the interviews. Interviewees found it necessary to express who should be responsible and why they are or they are not. This characteristic is accompanied by the struggle of individual organisations to survive due to cut-backs in the public sector. In the survival process, international funding sources play a considerable role, and at the same time they shape policy. The whole of the policy making process is subordinated to the process of harmonisation with the European Union.

The stakeholder analysis highlighted that despite the presence of several policy instruments to influence alcohol related problems the majority of actors do not consider alcohol policy in a comprehensive way. No actor could be identified with considerable influence in the policy arena who is interested in developing policy on alcohol. An interesting mixture of health, road safety, quality control, education, agriculture and beer production actors are the most supportive towards more policy, while clear opposition can be expected only from retailers, caterers and smallholders. When the influence of policy actors is considered, the most striking finding is that hardly any health actors have considerable influence in the policy arena. Market actors are the most influential apart from beer producers. This is particularly important as responsibility in alcohol resides in the health sector. The parliamentary committee is the most influential among health actors and there is more potential influence to the Ministry of Welfare and the Mental Hygiene Programme Office.

3 Recommendations



Discussion of recommendations for policy makers follows the opposite direction from that used so far in the analysis. It starts with actors, the active contributors to policy. Then, in the specific policy context, the future content of the policy is addressed. With regard to the process strategic questions and options are presented and evaluated. Thus, beginning with the environment, the possible shape of the tree, the options for content and structure are drafted, which point towards changes in the roots of the policy, the legislation.

In the discussion major strategic points are summarised in one sentence in italics at the beginning of each section. Recommendations try to answer the following questions:

What are the main strategic questions?

What can be done?

What shall be done and how?

What that is likely to achieve?

Which are the likely supportive and opposing alliance groups?

What time is likely to be needed for its achievement?

3.1 Actors and the organisational structure - who should shape the tree and how?

- *A nominated body with authority and a budget should be in charge of alcohol policy with a mandate of inter-sectoral activities and advocacy role.*

Strategic questions

Is there a need for a single organisation in charge of alcohol policy or not? If yes, shall it be a sector specific or an inter-sectoral agent? Shall it be a separate organisation or part of a larger one? Shall it be governmental, quasi-governmental or independent? Shall alcohol policy functions, such as policy formulation, implementation, monitoring and evaluation be separated or not?

From the stakeholder analysis it became clear that in the Hungarian context an issue reaches the agenda if an organisation is mandated to take responsibility for it. This finding suggests that if alcohol policy is expected to be addressed on a comprehensive way such an organisation is needed.

Inter-sectoral organisations in Hungary most often take the form of a parliamentary, governmental or inter-ministerial committee in national level policy making. Inter-ministerial or governmental committees are unlikely to be able to take up strategic planning, policy development, monitoring and evaluation, because of their operational constraints. Their members are officials in high positions with little spare capacity. There is a threat of insufficient and discontinuous expert support. Also committees tend to meet too rarely to maintain flexible. All options concerning the official status of the institute have advantages and disadvantages. If it is a governmental body it has the advantage of strong governmental support, but is less likely to survive if the government changes. It may also gain less public support, compared to one with more independence. In contrast, being an independent body might bring inadequate high level commitment and financial support. If it is an independent body it can be linked to an academic environment.

Because of the characteristics of the public policy making culture, such as strong hierarchy, extreme importance of personal networks and lack of experience in evaluation, the separation of implementation and evaluation can be recommended.

There are several necessary requirements for such an organisation to be able to fulfil its role as the key alcohol policy maker in charge of policy formulation, lobbying, monitoring and evaluation. It must have adequate authority to be able to represent the issue at the national level, thus macro level commitment to the issue is a prerequisite. The other necessary element is adequate and continuous funding to perform its tasks, for which appropriate technical and personnel capacity is needed.

What shall be done? & What can be achieved?

As public health policies tend to operate on a longer time-scale than one or two parliamentary sessions, in an ideal world the best combination would be a quasi-governmental institute, which has strong governmental support but also has some independence. Taking into consideration the limited budgetary resources, a single public health institute with several departments and small multidisciplinary teams allocated to each is desirable. The size of the organisation should be sufficient to be able easily to manage rapidly emerging needs and provide quick responses, thus an over-specified core staff would be inappropriate. Activities should be subcontracted to consultancy companies or academic institutions. This institute could be the leading organisation for strategic public health policy planning and all legislation with a potential public health impact should be submitted to parliament only after expert opinion by the institute. Such an institute could ensure that strategic planning, policy monitoring and evaluation do not become confused with implementation, which could continue primarily the medical officer service. This should not preclude collaboration in policy formulation. The institute's budget could be a separate element of the central budget or top-sliced from each ministry's budget, the second option emphasising inter-sectoral commitment.

How can it be done? and Where support or opposition is likely to come from?

Looking at the currently existing organisations which operate at the national level the only committee which approximates to these criteria is the National Committee

to Prevent Accidents. It has a secure financial flow and is formally an inter-ministerial committee, which works in close collaboration with organisations of road and public safety. Potentially it can undertake the task of strategic development of alcohol policy and is an inter-ministerial committee, although it has no link to key sectors, such as education and health.

The strongly sector specific operation of the central administration is reflected in the committee's operation. It also lacks personnel specialised in areas other than road safety. Its structure is highly hierarchical and most employees belong to the police force. Its task already covers the whole area of road safety and its available resources are just about adequate for it to operate. Broadening its tasks to include other aspects of alcohol policy might create two difficulties. First, because of the predominant sector specific thinking, the police and the ministry of internal affairs are not very likely to take up a public health issue. Second, according to most policy actors, the health and welfare sector should take the lead responsibility for public health issues. Therefore the committee would get little support from health and education actors, who would see it as a challenge to their prestige. Major support could be expected from road safety and control actors and other are likely to have little concern about this arrangement.

Another option is to identify a responsible organisation inside the health sector.

Limitations of inter-ministerial or governmental committees, such as the National Public Health Committee, have already been mentioned. These organisations can, however, be useful for lobbying purposes, similar to Parliamentary Committees. Their commitment can emphasise the importance of alcohol policy.

By virtue of its legal position the National Institute for Health Promotion has the potential to meet the "ideal" criteria with a few legal changes. In reality, its existing personnel lacks specialised knowledge in public health, technical equipment is unevenly distributed and badly managed, financial resources are insecure, its performance in public health and health promotion lacks strategic planning and the institution is fragmented, with most activity concentrated around a couple of projects. Its actual managerial structure is unclear.

Another option is to build all public health related activities around the medical officer service. Considering its organisational rigidity and, apart from hygiene and infectious disease control, inadequacy in relation to broader public health functions, there are major doubts about its ability to cope with alcohol policy development. It is also a very sector specific organisation with no experience of inter-sectoral collaboration.

There are other organisations which, according to their formal roles, operate more specifically in the alcohol field. These are the Mental Hygiene Programme Office, a relatively new organisation, and the National Institute of Alcohology, which has a longer history. The idea behind the establishment of the Mental Hygiene Programme Office, namely to put emphasis on general mental health and well-being of the population, can be justified, but the need for a separate organisation is questionable. Its tasks overlap with other organisations, such as the National Institute of Alcohology, the Medical Officer Service, the National Institute for Health Promotion, and other organisations operating in the drug field. Features of its senior management, its location (the NIA and the National Institute of Neurology and Psychiatry are at the same place in connected buildings) and the organisational overlap with a national health care institute and the National Institute of Alcohology, call into question its operation as an independent organisation. It has shown little real interest in alcohol related issues so far.

The National Institute of Alcohology operates specifically in the alcohol field. It has a good overview of specialised treatment and care services and undertakes some scientific work. An outsider might consider it as the ideal centre for alcohol policy, if the concept of an overall public health institute is ignored. Its treatment and care focused vision, lack of authority or funding, poor reputation, uni-disciplinary approach and limited technical resources provide little support for this concept. It also lacks links with bodies outside the health sector.

Any options coming from the health sector are likely to get little support from actors outside the health sector, a neutral position can generally be expected. It would be very difficult for any of the above listed organisations to act inter-spectrally. If the

organisation is linked to the health sector and is a new one, it is likely to face much opposition inside the health sector or, if leaders of currently existing organisations are involved it may gain support but have a limited scope for action because of interdependence. If one of the above listed organisations is selected and is given the authority to monitor and evaluate policy, opposition by other actors is likely to come to the surface.

In summary no currently existing institutions meet fully the criteria for an effective alcohol policy centre. All have some potential to become one, but all need considerable restructuring and development to fulfil this task. In this situation a clear strategic vision at governmental level is needed. This process should not ignore the importance of policy monitoring and evaluation. In all options which build on already existing organisations it must be remembered that long standing arrangements are extremely difficult to change overnight. Change will require a major managerial commitment and will be difficult.

- *Existing functions and activities should be rationalised and responsibilities clarified.*

The need exists not only for a single body to be in charge but also for the rationalisation and clarification of existing responsibilities.

Before doing so, there is one major aspect which has to be considered: to what extent sector specific responsibilities are necessary and desirable and to what extent a move towards inter-sectoral operation is necessary?

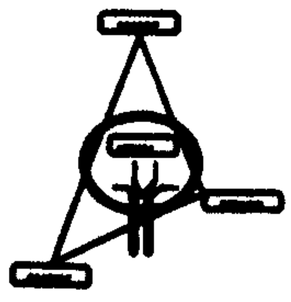
Within each different sector, clarification of responsibilities and minimising overlap of activities is desirable on financial, organisational and accountancy grounds. Unclear divisions and overlaps exist in several areas. Inside the market sector the control of business licensing, production, trade and quality control of alcoholic beverages are the most urgent areas. In the licensing process, the customs office and local authorities are the key bodies, while in product control statutory institutions, such as the customs office, the National Institute of Wine Verification, the Bureau of Consumer Affairs, self-governing organisations in wine production and trade,

commodity councils and interest representing associations have often overlapping roles. In the health sector, public health responsibilities are spread across a number of organisations, each with some activities related to alcohol. Alcohol is specifically under the competency of two national organisations at the same time. In primary prevention, particularly education and information dissemination, the picture is even more complex. The National Institute for Health Promotion, the medical officer service, schools, the police and NGOs operate next to each other under the framework of different programmes. These programmes are often supported by international funding bodies, which all have their own requirements. A major problem of these programmes is their fragmentation and the lack of co-ordination and collaboration.

It also has to be emphasised that the responsibility for policy initiation and development, implementation, monitoring and evaluation within and between organisations is often blurred. In particular, there is a vacuous policy monitoring process and there is lack of evaluation.

All these matters need individual consideration, which requires a clear overall strategy, with specification of the policy content.

3.2 Content of the policy - how the tree should look like?



The following recommendations tackle the feasibility of different elements of the policy content.

Market regulations

- *Prices should be increased through taxation, the law should be enforced, the black market should be reduced. Licensing and control should be made clear and transparent and a central data-set of producers, traders, retailers and licenses should be established.*

Price

Strategic question

Does the price of alcoholic beverages has to be increased in Hungary? If yes, how?

It has been noted earlier that the relative price of alcoholic beverages compared to other commodities is low. One of the arguments for a price valorisation policy is that it helps to secure revenue. Another argument against increasing tax on alcoholic beverages is that it would further encourage black market activities. Third, concerning pricing policy, EU directives have to be taken into consideration.

Economic studies have shown that increased price leads to increased revenue, even when the commodity is price elastic. The only exception to this is when the tax component of price is already very high, which is clearly not the case in Hungary. The problem with the black market is that no data are available about the extent of it. Therefore, estimates of the impact of price changes that take into consideration black market activities becomes extremely difficult.

What has to be done and how? & What can be achieved?

A revision of the current pricing policy is recommended. Increasing price is likely to decrease overall consumption while, at the same time, increase revenue. It has to be supplemented with control of the black market.

Without elasticity estimates and information about the black market the exact impact of price change cannot be estimated. In Hungary the latest price elasticity estimate for alcoholic beverages dates from 1986. Several agencies have produced estimates about the share of illegal products in the market. These estimates, however, are very diverse and often lack empirical support. It has to be noted, however, that estimating the extent of the black market is a very difficult and methodologically complicated exercise, especially when the bulk of this activity is not the result of smuggling.

With regard to EU directives, it has to be noted that these are only minimum guidelines and higher levels of tax are possible. It also has to be considered, though,

that indirect taxes, such as those on alcohol, are normally regressive and so impose a proportionately greater burden on the poor. Some studies, however, have indicated that is less so for alcohol taxes than for other indirect taxes (Ashton et al. 1989, Harris 1984).

To be considered for implementation, the formal proposal for a price increase should come from the Ministry of Finance or the Government. It could be urged by the health sector, using the argument of how much alcohol related problems cost to society. If the price increase is radical it is likely to lack not only public support but raise considerable opposition among producers, particularly from large-scale spirit and quality wine producers, and retailers. Little resistance can be expected, however, from beer producers. Small-scale producers and wholesalers are less likely to oppose increase in price, which would also give a chance to increase the price of semi- and illegal products. Once again, the importance of control has to be emphasised.

Time scale

Price increases are likely to have not only long term, but also short term effects on consumption and thus the incidence of alcohol related problems.

Law enforcement

It has been emphasised that price increase is likely to have a favourable impact on alcohol consumption if it is supplemented by law enforcement. Law enforcement, on the other hand, is a very complex issue and goes beyond alcohol policy considerations. It raises questions about authority and responsibility of different agencies, the legal process and the nature of existing penalties. The overlap of authority and responsibility has already been discussed.

Strategic questions

Is their a need for a division of roles in law enforcement? If yes, shall it be by function or by type of beverage?

Division by function can be into licensing and control. Licensing can focus on cultivation and production of raw materials, beverages, their wholesale and retail.

Control can focus on production of raw materials, beverages, conditions of wholesale and retail trade and operation of premises. Control incorporates quality, hygiene, operational and financial aspects. Division by major types of alcoholic beverages might be for wine, spirits and beer.

Because of the large number of functions, full separation of the organisational structure by functions would lead to a high number of agencies. It has the threat of over-fragmentation and lack of transparency. Complete concentration of licensing and control is technically difficult and could lead to an oversized institution with little flexibility although it would have the advantage of a centralised data collection. A compromise between these two extremes can be a division of licensing and control between the four aspects of quality, hygiene, operation and finance and main beverage brands. A further major division can be applied between the production process and wholesale and retail sales.

What shall be done and how? & What can be achieved?

At present wine and other beverages are dealt with separately in terms of quality control, production, trade and licensing, wine being exempt from excise duty. A separate set of organisations for wine control, apart from sales, has existed in Hungary for decades, some dating from the beginning of the century. These organisations developed parallel to the tradition of quality wine production. Thus the complete restructuring of this division is likely to be difficult.

Considering the nature of wine production, the large number of companies and smallholders involved makes control more difficult than in the case of beer and spirit production and trade, which are more concentrated. In case of wine, the National Institute of Wine Verification (licensing of products and quality control), self-governing bodies, such as Mountain Communities and Union of Wine Regions (licensing of grape production, voluntary code of practices, quality control of products and production), Association and Commodity Council of Wine Producers (interest representation, legal advice, policy initiation, directives for overall production), the Bureau of Consumer Affairs (quality, license, price control and consumer protection), the National Institute for Nutrition (quality control of food products - laboratory services), the Medical Officer Service (hygiene control and

licensing), the Ministry of Agriculture (policy and initiative for regulations), the Office for Control of Taxes and Finance (tax and financial control of all parties), the Customs Office (control of production and trade of wine-type products, other than real wine made out from grapes) and local authorities (licensing, local charges and taxes) are the major agencies involved. This indicates the complexity of the bureaucratic processes. The lack of transparency is accompanied by the lack of facilities for rapid and up-to-date information exchange. It is not surprising that the black market flourished most in the wine sector.

A change involving clearer divisions between different functions is desirable. A possible way is to concentrate all grape production and wine quality control. The first element could be based on the Union of Wine Regions, which should have adequate authority to perform this task. The second could be based on the National Institute of Wine Verification which needs a regional network similar to the division of wine regions and more resources to perform country-wide control. A well established mechanism to involve law enforcement agencies is necessary as this function involves tackling black market activities. This should be either the customs office or the police as a first choice. The customs office is a more straightforward solution because it is already involved in the control of alcohol products. As well as clarification of responsibilities and authorities the establishment of a central and up-to-date database would enormously help information exchange and control. All parties involved in the licensing and control process should have access to it. Its development is costly and requires investment in technology. The investment is, however, likely to be repaid in the long term. This information system can serve not only alcohol control but also other control purposes, but it requires a well-designed, simple method of data collection to keep bureaucracy to a minimum.

Spirit and beer production and trade are slightly less complex. They are considered excise products and their regulation by means of licensing and control has been undergoing clarifications to create more transparency. Key agencies are the customs office and local authorities. Excise control covers the whole of the trade, including import, wholesale and retail. It also covers licensing of premises that sell them. Thus beer and spirit sale falls under more strict control than wine, for which only general regulations for premises apply. Quality control of beer and spirits gets much less

attention than of wine. It relies mainly on the industry. The Bureau of Consumer Affairs and the National Institute of Nutrition participate in quality control. A critical point is the control of small-scale spirit production, where black market activity is present. A tighter law enforcement can have a beneficial impact in this area, too. As with wine, the database described above can facilitate the licensing and control process of beer and spirit products.

With regard to law enforcement, an alliance with quality wine and industrial spirit producers, who also have an interest in the reduction of the black market is worth considering. This activity is essentially in the interest of government as it decreases tax avoidance and may increase revenue. Considerable opposition can be expected from smallholders, small-scale producers, wholesalers, retailers and caterers. Health actors potentially can take a more active part in promoting law enforcement by pointing out negative health effects of low quality products. This can take the form of a mass media campaign or education programmes.

Time scale

In the given arrangement of responsibilities and activities, more effective law enforcement can be reached in the short run through rationalisation and capacity increase, leading to some decrease in black market activity. A more complex reorganisation is likely to be necessary to achieve dramatic decrease in the black market making such activity extremely difficult. This can be achieved only in the long run, as it requires both restructuring and technical development.

Availability control

A further element of control of availability has to be mentioned. In this respect regulations in Hungary are very similar to other European countries. Apart from some geographical constraints, no major controls exist on availability and no changes are being considered at the national level.

Strategic question

Is there a need for more strict availability control? If yes, in what form?

There are some reasons why strict control of availability is not recommended. Historical evidence showed that alcohol bans, despite their beneficial effects, had little public support and encouraged black market activity. Bans are also contrary to the spirit of a market economy and directives of the European Union. Therefore drastic changes in availability are not recommended, but moderate restrictions are, considering their beneficial impact.

What shall be done and how? What can be achieved?

The key factor is that local authorities play a key role in licensing premises. They are in a position to close premises that sell alcohol or deny licenses to new ones. Thus there is scope for some restrictions at this level. Local communities, in theory, could put pressure on local authorities to limit availability. Furthermore, some control of availability can be achieved by modifying local taxes which would benefit local revenue as well as generate price increase.

Despite difficulties of implementing restrictions on availability this policy instrument is supported by safety and control and health actors.

Time scale

Considering the lack of action so far by local authorities, changes in practice are likely to take a long time, particularly if the active support of local authorities is necessary.

Minimum drinking age and server training

As with availability control, no major changes can be expected in the minimum drinking age in the near future. This issue has received little attention in interviews with policy makers. As with control of premises, implementation is secondary to the control of the black market.

Strategic questions

Is there a need to change minimum drinking age or should control only become tighter? Is there a need to change server training? Is there a need to introduce server liability regulations? Should these be done in combination or separate?

Minimum drinking age regulations in Hungary are similar to other European countries. It has been shown that increasing it is unlikely as no actor considers it necessary. A move towards stricter control of minimum drinking age, however, is likely to help law enforcement. This can be more effective if it is accompanied by server training. Evidence from research supports this approach.

What can be done and how?

Realistically, stricter control of minimum drinking age can be tackled only in the long-term, but strategically it cannot be ignored. The control of under-age purchase and consumption could become the major responsibility of the Bureau of Consumer Affairs, which is very much in accordance with its role. If server training remains mainly the task of the Association of Retailers and Caterers, in collaboration with the Ministry of Industry and Commerce, there is the opportunity to promote new norms of service. On the other hand these norms may conflict with the interests of retailers and caterers, which might threaten the interest representation role of the association.

Implementing legal liability of servers is worth considering as a mean of putting pressure on retailers and caterers. This move can gain public support, particularly from people whose relatives or acquaintances have been injured as a result of inappropriate service in a catering unit or from sales to under-aged people in a retail outlet. As this legal change would put extra workload on the police and judiciary, they are not likely to support it strongly. Finding precedents of irresponsible service could be a start.

Time scale

Compliance with regulations on minimum drinking and purchasing age and more responsible service are linked with norms of not only the servers, but also with society. This suggests the need for a long-lasting process and raises the issue of education and information dissemination.

Education and programmes at workplaces

- *Co-ordination and collaboration should be emphasised. Education can become the first example of effective collaboration and programmes can be expanded to workplaces.*

Education

Strategic questions

When education and information dissemination is considered there are two major strategic questions. Should it be a national or a local responsibility? Should it be the task of only and exclusively the education sector or the result of collaboration between different sectors? Also, what should it contain?

Education and information dissemination can take place at national, regional or local level. As the present analysis has focused on national level policy making, the discussion is concentrated at this level, although it must be noted that collaboration in the implementation of policy has the most scope at local level. Education programmes which are skill based were found to be more effective than knowledge based ones.

What shall be done and how?

Given the strongly hierarchical nature of the administration initial action is needed at the national level. The major parties involved are the Ministry of Education, the Ministry of Welfare, the National Institute for Health Promotion, the Medical Officer Service, the Mental Hygiene Programme Office and the Police. National programmes are linked to these organisations, such as the Healthy Schools Programme supported by the World Bank and linked to the NIHP, the UNICRI supported by the United Nations and linked to the Ministry of Education and the DADA programme implemented by the Police. In most of these programmes, several issues, such as drinking, drugs, smoking, mental health and public safety in various combinations are tackled together. The majority involves information

dissemination, the effectiveness of which has not been evaluated so far. There is more evidence about the effectiveness of skill-based education programmes. A move in this direction is desirable.

Interviews with policy makers made it clear that co-ordination and collaboration between these programmes does not exist. An easy way to encourage collaboration for the future would be to organise regular meetings with the aim of improving information exchange and providing the framework for developing collaboration. Other than that, an inventory of education and information dissemination programmes, covering all the sectors involved, would help to keep information on availability up to date. The inventory should contain information about the programme, its aims and a contact person. This could be developed not only for alcohol, but other public health related programmes. As most programmes target youth, the inventory could begin with education programmes for this audience.

Education and information dissemination is a policy instrument supported by most actors, although actors from different sectors target different messages. This general support might suggest that this policy element is perceived as not having much impact on their immediate interests, which is in accordance with the uncertain information about the effectiveness of this policy instrument.

Time scale

Although the effectiveness of education programmes has not been proven and is difficult to measure, any effects are likely to be long-term.

Programmes at workplaces

Education programmes can target not only youth but also workplaces. Apart from the act on labour which bans work under the influence of alcohol, different workplaces have their own practices. With the rapid increase in the number of employers in the 1990s, alcohol policies in workplaces received little attention. In a more settled environment there could be scope to expand education programmes in this direction. This is likely to be long than short term. These programmes are more likely to be effective if the initiative comes from the companies themselves.

Mass media campaigns

- *Carefully designed mass media campaigns, although costly, can usefully contribute to shape norms, behaviour and represent macro level commitment,*

Mass media campaigns, by their nature, involve information dissemination to a wide cross-section of the population.

Strategic questions

Is there a need for mass media campaigns? If yes, what message shall it forward? Where the money shall come from? Shall their organisation be the task of a single agency or of several agencies?

Mass media campaigns have the advantage of reaching wide audiences. They can put an issue on the public agenda, which reflects its importance and commitment to deal with it.

Campaigns about negative consequences of drinking, beneficial effects of moderate use, or promoting to switch to non-alcoholic drinks have not been proven to influence consumption. Programmes communicating drink driving messages have been shown to be more effective.

The high cost of mass media campaigns can not be ignored. For the sake of more effective programme implementation, it could be desirable to concentrate resources in the hand of a single organisation and start with one particular area.

What can be done and how?

If resources are available for mass media campaigns they can be favoured because of their beneficial impact on wide ranges of people. However, because of their high cost, it is recommended that they are undertaken on a highly structured way, most likely concentrating resources in the hand of a single agency. Considering the documented effectiveness of programmes with drink driving messages this can be the first area targeted.

The development of drunk driving programmes together with other road safety issues is the responsibility of the National Committee to Prevent Accidents. The financial resources of the committee are, however, limited. Its public relations strategy emphasise different aspects of road safety each year, which means that drink driving campaigns are not continuously on the agenda. The case for concentrating campaign activities in the hands of this committee can be justified with its considerable experience and expertise in this area. On the other hand, evaluation of their programmes, which could improve effectiveness and measure the impact in the Hungarian setting, is missing.

A considerable proportion of the budget of the Mental Hygiene Programme Office is also allocated for public relations activities in mental health. These are channelled to major newspapers and national television. The Programme Office had no major campaign so far about any alcohol specific message.

In view of the background of the National Committee to Prevent Accidents, resources for mass media campaigns could be concentrated here. It is not likely however, that financial resources from the health sector can be channelled towards road safety because of sector specific budgetary arrangements. and the counter-interest of health actors.

Adequate funding is crucial for success. If promotional expenses of companies, which are considered production costs, and therefore are outside the tax base, could be taxed the money could be channelled towards mass media campaigns.

This change is likely to raise considerable resistance from not only the industry but also from the media if their promotional revenue is threatened.

Time scale

The effect of mass media campaigns in the short term, particularly with drink driving messages are likely to have short term effects on incidence of drink-driving and related accidents, especially if they are combined with law enforcement and random breath testing. If resources are available they can be implemented in the short run. They may also have long term effects, but that is difficult to measure.

Advertising

- *Stricter regulations are recommended*

The impact of advertising is difficult to measure. The industry claims that advertising can increase consumption only in immature markets. Once the market reaches maturity it can only influence preferences for different brands.

Strategic questions

Does advertising have to be regulated? If yes, shall it be through national regulations or voluntary codes of practices of the alcohol industry? Shall there be a total ban or shall restrictions be limited to certain areas?

It has been shown that countries with total bans on advertising, have lower rates of increase in alcohol consumption than countries with less strict bans. Regulations in the European Union on the advertising of tobacco products have became stricter, which shows that restrictions can exist and freedom of advertising is not necessary feature of market economies. No studies are available which compared the effect of national and voluntary regulations. Some experts argue, though, that voluntary codes benefit the interests of the industry itself There are examples for both practices in European countries. A total ban is not in practice in any European country.

What can be done and how?

A move towards stricter regulations is recommended. In Hungary, regulations became very liberal after a major legal change in 1997. This applies not only to alcohol but to other commodities, such as tobacco. This is in contrast to trends in the EU. There is no background in Hungary, however, of voluntary codes. The most progress is made by the brewing industry, largely due to its multi-national nature.

Although a move towards stricter regulations theoretically is possible, it is not likely to happen in the near future. The legislative change in 1997 followed a regulation which practically meant total ban of advertising. Despite that, advertising happened and was in the interest of not only the industry but also the media. The change

achieved in 1997 suggests the considerable influence of these parties. Change in the opposite direction could be initiated by health or safety actors, particularly if negative effects of advertising could be documented, but particularly after the events in 1997 health actors became less enthusiastic.

Time scale

A move towards stricter regulations is likely to happen only in the long-run.

Drunk driving

- *Support for road safety measures should be continued, including an increase in random breath testing.*

Drink driving control measures in Hungary are strict in comparison with other European countries. The continuance of these is desirable, particularly as their effectiveness is well documented. Random breath testing accompanied by mass media campaigns are effective tool. The Police and the National Committee to Prevent Accidents are the key players. Monitoring and evaluation is important to demonstrate effectiveness of these programs. This could show that results can be achieved and could encourage action in other areas of alcohol policy.

Treatment and care

- *The treatment and care network would be retained, but rationalised and made more flexible and responsive. Links should be encouraged with NGOs. Brief intervention in general practices should be encouraged and promoted.*

Strategic questions

There are essentially two types of questions which have to be answered: some concerning specialised and some general health care services.

Is there a need for specialised treatment and care for alcoholics? If yes, what form shall it take? How can its performance be improved? Is there a need for more responsive general health care services for alcohol related problems? If yes, what form shall it take?

What shall be done and how? What can be achieved?

A specialised treatment and care network already exists in the country, therefor the need for it is not discussed here. Its effectiveness, however, has not been assessed. Such studies are necessary to gain information about its role and to assist further development. An up-to-date inventory of organisations and NGOs by geographical areas also likely to be useful to those seeking access to services. The National Institute for Health Promotion developed a similar inventory in 1995. It was available as a booklet and was distributed mainly to those working in the alcohol field. Unfortunately it had limited availability and was inaccessible to a broader audience. County level chief addictological doctors contracted by the NIA could play a key role in creating such an inventory. Easy access to it by GPs and social workers could improve the process of referral.

There is little information about the responsiveness of general health care services to alcohol related problems. International studies indicate that the recognition of alcohol problems by physicians is generally lower than is possible using screening methods. Consequently, the introduction of these methods into in-patient, out-patient and primary care settings widely is recommended. This would require a co-ordinated strategy, one element of which would be improved post-graduate training courses where these screening methods are presented to professionals. Not only physicians, but also nurses can be involved. The initiative could come from the organisation in charge of alcohol policy, but for successful implementation the support of the Hungarian Medical Association and the Ministry of Welfare is essential.

Apart from screening tools which help problem recognition, brief intervention for primary prevention in primary health care settings is proven to be effective. Hungary participated in the WHO trial which tested its effectiveness. It could be widely promoted with the involvement of those general practitioners who took part and found it useful. Other general practitioners, who recognise the importance of alcohol problems in their own practices, could also participate in this process. The National Institute of General Practitioners as a leading organisation could play a crucial part to develop the Hungarian version of the brief intervention protocol and produce guidelines for general practitioners. The initiative, however, is unlikely to

come from their side. The promotion of the programme has to be the task of the organisation in charge of alcohol policy. In the current institutional arrangements the NIA could fulfil this role.

Time scale

If there is commitment is there to screening methods and to primary prevention through brief intervention, their implementation can be achieved in the short run and results can be expected both in the short and long term.

Summary

Taking into consideration available scientific evidence about the effectiveness of different alcohol policy instruments, their feasibility in the Hungarian context and policy environment, there are three major areas where change is possible and likely to lead to both short and long term effects.

First, either within a public health framework or independent from it, a single organisation or unit should be in charge of alcohol policy development and monitoring and evaluation of implementation. For its successful operation high level commitment and support is crucial.

Second, an upward correction of the price of alcoholic beverages is likely to have beneficial effects on consumption and government revenue. This must be backed up by effective law enforcement.

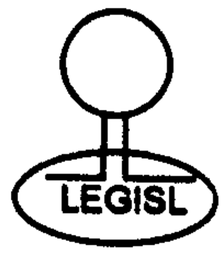
Third, brief intervention packages in general practice could contribute to a reduction in the incidence of alcohol related problems.

There are two areas where continuity is desirable. One is drink driving control, the effectiveness of which has been well documented internationally. The other is education, with a move towards more co-ordination and skill-based programmes. The effectiveness of these programmes has not been proven yet, however, they undoubtedly have importance in shaping norms and behaviour.

Long-lasting changes are only likely if norms related to drinking change. There is a tendency among policy makers to doubt the possibility of change. Examples exist where change could be achieved, such as the anti-tobacco movement.

Data from this study are not sufficient to make estimates of the impact of these recommendations. This was not among the original aims of the study. Future studies in this area, however, can be used to determine precisely the scope of changes in policy.

3.3 What legislative changes are necessary? or how the root must change to support best the nutrition of the tree?



The need for legislative change has to be looked at in the light of an alcohol policy strategy. This section does not aim to discuss very specific legal changes for each possible change in policy. A review of feasible policy elements is presented here rather than dividing them in terms of whether major legislative changes are required or not.

With regard to the three major recommendations, legal change is necessary in three areas. The first is the taxation of beverages. This would involve the modification of an act of parliament. The second is more complex and affects regulations of production and trade, most notably of grape and wine. Most of the necessary changes could be done by secondary legislation. Third, the legal basis of the mandated organisation in charge of alcohol policy has to be established. This again is possible through changes only in the secondary legislation.

4 Need for further research

The review of the Hungarian scientific literature highlighted many gaps in our knowledge. Most importantly, there are gaps in our knowledge of the epidemiology of cirrhosis of the liver, other alcohol related health conditions and risk factors specific for the Hungarian population. For policy makers an estimate of the social cost of alcohol misuse could help to determine the cost to society and could support action. Better information about the extent of the black market is essential to predict the impact of changes in market regulations.

4.1 Epidemiology of chronic liver disease and cirrhosis

The rate of increase in chronic liver disease and cirrhosis is unprecedented in Hungary. No epidemiological study managed so far to understand this phenomenon completely. A small-scale case-control study in Budapest looked at alcohol consumption and hepatitis infection as risk factors. The study, however, faced many methodological problems. A well-planned case control study representative of the Hungarian population is recommended to look at the contribution of some risk factors, such as pattern of drinking, nutritional factors and possibly genetic influences. Relative risk estimates derived from it would contribute to calculation of etiologic fractions for the Hungarian population.

Although cirrhosis mortality is an indicator of alcohol related problems in a population, there are other important conditions, which by volume are also considerable. Case-control studies, therefore, would also be important to estimate the fraction attributable to alcohol for a range of other alcohol related diseases and conditions. Among the most considerable are accidents and injuries. They contribute first to overall alcohol related morbidity and represent the highest costs for health services.

4.2 Social cost estimate of alcohol misuse

According to a WHO recommendation, social costs are best used to illustrate the extent of the costs related to alcohol. Thus it may help to advocate support for alcohol policy in a public health and social policy perspective and to counterbalance speculations about the economic benefits of alcohol (Lehto 1995c).

As mentioned before, relative risk estimates derived from epidemiological studies of alcohol related diseases, such as cirrhosis help to determine etiologic fractions. Where population specific fractions are not available, results of international studies or estimates from pooled mortality and morbidity data can be used although with caution. Furthermore, etiologic fractions associated with low, hazardous and harmful levels of alcohol consumption are also necessary.

There are direct and indirect costs for society associated with alcohol. Direct costs include health care costs, losses associated with the workplace, administrative costs for transfer payments, costs for prevention and research, law enforcement costs and other costs, such as fire damage, motor vehicle property damage and intangible costs of pain and suffering of families and victims. Indirect costs include productivity losses due to morbidity, mortality and crime (Australian Gov. 1995, Coyle et al. 1994, Lehto 1995c, Maynard et al. 1987, Single et al. 1997).

To prepare a comprehensive social cost estimate is a complicated exercise, as attributability fractions are difficult to obtain for each alcohol related condition and for the services used in these conditions. Definitional problems in the alcohol field are enormous. There are many physical, mental and social problems that are not related to alcohol dependence and dependence constitutes only a small part of alcohol related problems. Even when it is agreed what to include and not include into the social cost calculus, there is a lack of information (McDonnell & Maynard 1985b). For instance little is known about the costs imposed on general practice by alcohol misuse. The costs to industry are similarly imperfectly identified particularly in relation to the effects of drinking on the quality rather than the quantity of work. There are gaps in epidemiological knowledge (McDonnell & Maynard 1985b). Causal links have been researched only superficially. There is also a problem of

causation with crimes, too. When social problems are considered it has to be assumed that other factors remain constant or do not affect the prevalence of alcohol-related consequences. In the social costs calculus if unemployment is present, it is an opportunity cost to society only if it is assumed that full employment is a feasible goal. The cost to society in terms of lost output prior to retirement will fluctuate according to the level of unemployment and the training and skills needed to prepare people to fill vacancies.

The contribution of health care costs to the total economic (social) costs of alcohol misuse is relatively large and undoubtedly important from viewpoint of hospital costs in each country. Because the relationship between alcohol consumption and its effect on health of individuals is often difficult to identify, only a small proportion of the total cost can be estimated with any degree of accuracy. Some evidence suggests that even where a causal relationship can be positively identified, medical personal have sometimes not recorded or have not been aware of the contribution that alcohol has made towards the condition of the patient. A greater awareness of the many effects that alcohol can have upon the health of individuals, together with more research into the rate of utilisation of health care facilities by individuals with alcohol-related problems would greatly enhance our knowledge of the resource cost that imposed by alcohol, not only upon the public hospital system, but also upon many other services of both the public and private sector.

All reviewed social cost estimates apply the "top-down" approach to determine total costs for all major variables and alcohol attributability fractions are allocated to each major type of costs (Ashton & Casswell 1984, Australian Gov. 1995, Coyle et al. 1994, Godfrey 1992, Godfrey & Maynard 1995, Lehto 1995c, Maynard et al. 1987, McDonnell & Maynard 1985a, McDonnell & Maynard 1985b, McDonnell & Maynard 1985c, Parker et al. 1987, Rayner & Chetwynd 1987, Single et al. 1997).

4.3 The black market

It has been discussed before that price control is one of the most effective alcohol policy means to change consumption, with an impact on the incidence of alcohol related problems. The effect of price control, however, can be considerably distorted

if there is space for extensive illegal production, trade and smuggling. The contribution of smuggling to the market can be estimated from customs data. Illegal or semi-legal production and trade are more difficult to measure. This can be approached from two directions. Consumers can be asked about the source of alcohol they consume. If it is undertaken as part of a larger survey, the additional cost of the study can be minimal. Another way is to estimate total possible production of the country from available raw materials and compare it with official production. This has the advantage that it relies on routinely collected data. The validity of these data, however, may vary, influencing the accuracy of the estimate.

The review of the Hungarian scientific literature most importantly highlighted considerable deficiencies in methodologies. Therefore, in any research activity, an effort has to be made towards better planning and rigorous implementation.

Personal Reflections

During this research exercise I learned a lot not only about alcohol policy, but also about politics and the whole operation of the administrative system. This, I believe, is a well transferable knowledge in any public health area and crucial for success.

It took three years to prepare this thesis, which three years were useful, interesting and challenging. I am glad I did not know how difficult it was going to be at the beginning of the PhD, otherwise I might not have started it!

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- *APPENDIX 1* -

ALCOHOL RELATED PROBLEMS IN HUNGARY

SURVEY RESULTS

Author	Subject	Method	Results
		Adolescents	
(Ràcz & Hoyer 1995a, Ràcz & Hoyer 1995b, Ràcz & Hoyer 1995c) Sept 1993-March 1994 Budapest Jerevàn living estate	children at age 14-20 playground group at the Jerevàn living estate (area with tall blocks of flats)	participant observation 122 days - note taking 23 semistructured interview ethnographic study about: drug and alcohol use its role in personal connections activities and their impact on drug, alcohol use reactions of social environment	• 75 days (61%) of observation pupils consumed alcohol (related to whether they had money for it or not) • 39 days (32%) were drunk • alcohol consumption is part of everyday life, considered normal, encourage sexual contact, present at violent events • group activities: get drunk; violence against other groups, subgroups of the society, usually located outside their area, impaired with dringink; making business - grey activity (illegal trade of gooods purchased in different ways (taken from home, robbery),item sometimes put into trade after repair; • 40 days (33%) drug use
(Bàcskai & Gerevich 1994) (1994) 1994? Szolnok	primary school (5-8 grade) and secondary school (9-12 grade) out of 10 schools 12 classes each 604 students 42% men, 58% women	self-completed questionnaire about: smoking, drinking, drug use family patterns relation to school, to parents	• already drank alcohol: 63% pr.sch., 88% sec.sch. (77% together) • has been drunk already: 12% prim. sch., 37% sec.sch. • pr. sch. drinking several times a week beer: 7%, wine: 4%, spirit 3% sec. sch. drinking several times a week beer: 10%, wine: 10%, spirit: 5% • pr. sch. 16%, sec.sch. 20% feels lonely regularly • relation to parents: the better the less substance use (very good connection: 34% drinks (18% smokes as well), bad connection: 52% drinks (24% smokes as well)) • relation to school: likes school 27% drinks (14% smokes as well); hates school 47% (23% smokes as well) • drug use: 1-2%)
(Németh et al. 1994) 1991-1992 Gyôr	primary & secondary schoolchildren 120 8th grade 114 11th grade	self-completed questionnaire about: adopted American Drug & Alcohol Survey lifetime prevalence use last year, use last month	• girls consider alcohol more harmful than boys do • girls are as likely to experiment with alcohol as boys, but less likely to consume it excessively • girls drink more often at home with parents` knowledge than boys • 8th grade boys: 20%, girls 6% has been drunk already • 11th grade boys: 44%, girls: 51% has been drunk already

Author	Subject	Method	Results
		Adolescents	
(Fekete 1992) 1988-1989 ?	1456 pupils primary (231) and secondary school (1225)	questionnaire about: health behaviour (had questions about alcohol cons.)	• last week alcohol consumption at least once 5% at primary school 7-8 grade 31% at specialised secondary school 38% at secondary school 43% at politechnique • pupils previous week drinking according to their father`s education level were similar (fathers with a university degree (22.3%), politechnique (29.6%) of all those drinking the previous week) • Place of first alcohol consumption: home (56.7%), with friends (19.75), as a guest (14.4%) • Motivation of first drink: self-decided (40.4%), parents (23.1%), friends (20.6%)
(Mándoki 1991) 1990 ?	7676 schoolchildren age 11-18 school types: primary: 6th, 8th grade secondary: 10th, 12th grade specialised sec.: 10th, 12th grade politechnique: 10th grade	self-completed questionnaire about health status of pupils including questions about alcohol: frequency, rural or urban, type of school, gender, being drunk, self-assessment of health status, alcohol consumption and smoking	• 77% already tried alcohol • 5.7% drink alcohol regularly (once or more times a week): 11.4% of men and 2.1% of women • 30.6% abstainers (both genders) • 63.6% drinks occasionally (monthly or less frequent) • higher grade less abstainers (52% 6th, 33% 8th, 19-21% 10th, 13-14% 12th grade), less abstainers in politechnique 12th grade • No of regular drinkers increases with grades (2-2.5% primary school, 5-6% secondary school 12th grade, except politechnique 13%; 9-14% last year of secondary school) men 10.3%, women 1.2% drinks regularly • 48% of men and 35% of women have been drunk already at least once (higher than in a previous study in 1986: men 19%, women 9%) , the difference between genders is small (smaller than in 1986) • those who drink more consider their health status worse • those who drink regularly smoke more than others

Author	Subject	Method	Results
		Adolescents	
(Csòka 1990) ? ?	children at age 14-18 Budapest? 212 from a children`s home 42 same primary school with children from children`s home 673 normal family background	attitude survey about attitudes towards alcohol and smoking	• 38.7% of all children had some negative attitude towards drinking. • 65% thinks that alcohol consumption is normal • among children`s home people 52% of men, 39% of women have already been drunk, 11% has never drunk before • they predict that some of them will be alcoholic, but in a lower extent than it is thought about them by the other group • this prediction of the normal family group for children who grow up in children`s home is 71%
		University / Politechnique students	
(Pajor 1987/88) 1985-1986 Szombathely	Berzsenyi D. Tanàrkèpzô (Teachers` Training School) first (361) and 2nd, 3rd & 4th year students (296)	self-completed questionnaire about: drinking experience knowledge behaviour	1st year: • most students had their first drink on class excursions • 80.4% has heard about the harmful effects of alcohol in the secondary school • favourite drinks: beer 2nd-4th: • favourite drink: spirits • drink mostly at restaurants or home • knowledge limited about harm
(Paláti & Tanyàs 1991) 1990 Dec. Budapest	Univ. Med. School Univ. Faculty of Law Univ. of Economics 208 students (4% of all students)	self-completed questionnaire about: social, family background income, religion quantity, quality consumed place of consumption knowledge of price, alcohol content of drinks	• medical students new the best alcohol content (slight difference between the universities in results) • correct price of beer: 63%, wine: 53% right alcohol content: palinka(spirit)-74% liqueur-57% beer-36%, wine-32% • place of cons.: 1. parties (home) 2. pubs (sörözô) • 81% drinks alcoholic drinks • 84% does not reject drunk people & 76% tolerable • 41% feel sorry for alcohol addicted people

Author	Subject	Method	Results
		University / Politechnique students	
(Varga & Buris 1994) 1992-1993 Debrecen	Univ.Med.School 5th-year medical students (250)	self-completed questionnaire about: experienced alcohol problems (AUDIT+SMAST)	mean AUDIT score: 8.2 33% screened positive (cut-off score 11) 19% screened positive (cut-off score 13) 4% "harmful drinking" (cut-off score >19) SMAST: 8.8% regarded themselves abnormal drinkers 12% were thought to be abnormal drinker by their friends
(Pèter 1995b) 1994 Dec. Szeged	Univ.Med.School general med. & pharmacy students (165)	self-completed questionnaire about: drinking habits, problems, opinions, adopted SAQ (Student Alcohol Questionnaire) & Alc.AttitQues.	• favourite drinks: 1.beer 2.spirits 3.wine • <7% abstained • 59% has had hangover already • alcohol is not a drug: 51% med.sts, 68% pharm. sts • 93% drink alcohol more than once a year
		Youth	
(Lampek & Csanaki 1986) 1984-85 Baranya county	worker class (1259) age 18-33: industrial manual workers (689) agricultural manual workers (220) administrative staff in the industry (200) miners (150)	interview about: consumption social level healthy consumption limits preferences to different types	• 52% drinks occasionally • **23% abstained** • daily regular cons.most likely among agricultural workers; and men **quantity** consumed: men: <20g/day 40%; >70g/day 6,4% women: < 3g/day 41%; >70g/day 5,6% • **average consumption**: 30g/day men (2 bottle beer, 3dl wine or 1 dl spirit); 10g/day women (those who drink every day: men 54 g/day; women 47g/day) • consumed average: 24g/day • **norms of healthy daily limits**: beer-42g; wine-68g; spirits 42g(white-collar workers specified lower limits)

Author	Subject	Method	Results
		Youth	
(Horvàth 1996) ? ?	Medical University (Budapest?) third-year medical students (age 20-21) 50 representatives of 254 third year medical students	self-completed questionnaire about: alcohol consumption (Q, F, type, place, time, occasion)	• consumption is related to social get togethers • 10% (only men) consume alcohol alone, women don`t • 70% drinks for the company`s sake, 34% for feeling more relaxed • most frequent drinks: women - wine, spirit or mixed, beer and Champaign men - wine and beer, spirit and mixed men and women do not differ considerably in spirit consumed • 40% drinks regularly (?) (once or more a week)
		Adults with or without deviant behaviour	
(Cserne & Elekes 1986a, Cserne & Elekes 1986b) 1983 Dolina & Budapest	240 patients: 80 from sobering up stations 80 under compulsory treatment 80 voluntary treatment	in-depth interview and questionnaire about social aspects: childhood, parents, youth, education, workplace, leisure activity, family, children, marriages, housing, income, friends, health conditions, deviant behaviour in the family, place of drinking, age of first and regular consumption	compared to the Hungarian average: • parents low education level, more inact. mother, worse housing • higher rate of lonely people • equal education level of patients comparison between the 3 groups: • voluntary groups in better social conditions, 33% suicide attempts (the highest, mainly among women) • detoxicated people are the most deprived general: • poor leisure activities • 36% of men, 28% of women have already been punished by criminal justice system • age at first drinks: 14-18 years • women drink mostly at home • short after getting their salary they do not have any money left
(Veres & Sàhò 1986) 1984 Somogy county	517 elderly people age 55-94 daily care centre for elderly - 33% social homecare for elderly - 32% special 24hour centres for elderly people - 35%	interviewed questionnaire about: drinking patterns previous professions reason for drinking knowledge personal opinion about health status	• 54% drink alcoholic beverages • **14% regular drinkers** • most of regular drinkers worked in the **agriculture** • the most popular drink is **wine** • the reason for drinking: healthy (women), habit(men) • during driving, childhood and pregnancy most would prohibit alcohol consumption, they would not forbid it for elderly people • their knowledge about the harmful effects of alcohol comes form radio and television programs

Author	Subject	Method	Results
		Adults with or without deviant behaviour	
(Szoboljeva 1987/88) 1985 Budapest	blue-collar workers from the industry (188): - healthy - treated at alcohological ward in hospital	self-completed questionnaire about satisfaction: work, family, leisure activities, achievements in life	• returned U shaped satisfaction function from abstains to heavy drinkers • people under rehabilitation the satisfaction is considerably lower • women are more satisfied than men motivation of drinking differs between groups: consumer: euphoric effect rehabilitated: maintain somatic & psychotic functions categories are specified: abstained or rarely consumer; consumer; frequent consumer; rehabilitated patients
(Veèr 1989) Csengersima	Village of Csengersima (North-East of Hungary) Population in 1984: 857 "Sociopsychiatric research"	conversations, interview of relatives, questionnaire (not specified any further) about : neurosis prevalence in 1961, 71, 81 at age 16+ annual alcohol consumption expenditure (total and relative to wages) on alcoholic beverages between 1961-84 No of chronic alcoholics (by age, sex, education level)	• round 25% of population had neurosis based on three years data • based on official sell statistics (1961, 64, 68, 75, 84) between 1961 and 1975 annual wine consumption increased from 13 to 21 litres, and decreased to 4.3 l by 1984 • beer consumption increased from 17.2 in 1961 to 130.4 in 1975, and decreased to 74.0 litres by 1984 • spirit (pàlinka) consumption increased from 3.7 in 61 to 10.7 in 75 and decreased to 8.6 litres by 1984 • in 1961 4.2% in 1984 3.4% of population was chronic alcoholic • 90% of chronic alcoholics had no higher education than primary school • in 1961 12%, in 1984 8.6% of personal income was spent on alcoholic beverages
(Kolozsi 1990) 1985-86 Hungary	570 alcoholic patients others with deviant behaviour general population	interview, questionnaire about: education somatic disorders marital status profession affairs with jurisdiction regional differences suicide attempts	compared to the general population: • lower education level in alcoholics • men 5 times, women 4 times more often divorced • lower housing facility level for alcoholics • more suicide attempts 16% of alcoholics has already had suicide attempts among alcoholics: • among skilled manual workers more alcoholics, than among white-collar workers more alcoholic patients in the North than in the South

Author	Subject	Method	Results
		Adults with or without deviant behaviour	
Lakner G, et al (1990) ? ?	338 people (adult) coming from: people at new living estate (98) people at old living estate (109) workers of a textile factory (131)	questionnaire about: health status and risk factors	• alcohol consumption (317): 59% occasionally, 19% regularly • men drink more regularly than women, women rather drink on occasions
(Andorka 1990) 1980-census 1982 -society report 1986-survey		comparing consumption calculated from official statistics (mortality data, annual consumption) and self-reported data about: social status, regional differences suicide attempts	mortality data and self reported data suggest the same effects: • lower education level, lower social class is a risk for higher alcohol consumption levels • women: alcohol consumption shows U shape association with education level • men: higher cons. level in Budapest, lower cons. level other cities and rural areas equally • among women at Bp is the most frequent alcoholism • there are differences in families about the critical level • the rural consumption is mainly from self production, price changes have no effect • suicide attempts are more frequent in lower social classes Regional differences in suicide attempts which differ by the data source Conclusion: 2 types of alcoholism: 1 - based on traditional patterns: rural, urban areas 2 - anomie type alcoholism: Budapest
(Elekes 1991) 1989 Budapest, Tököl	drug users (120): 30-inmates in a prison for juveniles 30-special educational institute 30-problem youth from Pentecostal Community 30-youth selected from the community by snowball techn.	in-depth interview and questionnaire about: demographic char, social background, childhood, social contacts, used types of drugs, other deviant behaviours, religion, leisure activity, housing, education	• mean age 12 years • first time they became drunk: 13-15 years old • 46% had at least one suicide attempt • >75% has already had affair with the police • first alcohol consumption mostly at home • spirits are drunk at home • the most frequent drink on the last occasion: wine

Author	Subject	Method	Results
		Adults with or without deviant behaviour	
(Kàrolyi & Balàzsy 1991) 1986, 1991 Hajdùszoboszlò	people at age 82+ (82-94) No: 128 (1986); 88wom., 40men No: 61 (1990) sample selected from those who were still alive from a sample of 1412 people in 1964-66 who were born before 1904	longitudinal follow-up study data collection method: ? about: alcohol consumption smoking No of diagnosis in 1964/66 -1986 No of death between 1986-1990	• between 1986-90 78% of smokers and 49% of non-smokers died • in 1986 114 non-smokers and 14 smokers alive (most of the smokers died by 1986, but mort. rate was still higher at this age) • among the three drinking categories (never, occasional, regular drinkers) similar (50-54%) rate of people died by 1990 • among people alive in 1986 49% did not drink at all, 15% drank occasionally, 36% regularly • average daily alcohol intake: men 19.3g, wom 17.9g pure alcohol • alcohol consumption is not related to the mortality of elderly people (authors` conclusion)
(Szèll 1991) 1990 Oct.- 1991 Feb. Pesthidegkùt	35 men, 28 women patients with alcohol problems at the psychiatric ward	"sociological survey" ? assumingly from medical records	• 41% had divorce in the past • 21% had penalty from the criminal justice system • 76% started to drink regularly >age 25 • 60% drink daily • 71% childhood in cities • equal distribution in the sample by profession
(CSO 1996) 1992 Hungary	stratified random sample (6411) age: 15-64 resp. rate: 85%	interview about health behaviour: smoking, drinking, diet, lifestyle drug intake, health service utilisation	• 24% abstainer (men 11%, women 36%) • 11,6% drink excessively (800000 habitants) • favourite drinks: men - beer; women - wine • drinking patterns: men are social drinkers, majority of women drink in company too • knowledge: men non-abstainers 12%, women non-abstainers 2% told drinking would be harmful to their health

Author	Subject	Method	Results
		Adults with or without deviant behaviour	
(Csoboth 1997, Kopp et al. 1997) 1994-1995 Hungary	representative sample for Hungary: appr. 13,000 age: 16+ resp. rate: ?	interview (1-2 hours), structured questionnaire about psychological , sociological , health, risk factors and health care utilisation characteristics major theme: depressive symptomatology	• overall morbidity rate closely connected to depressive symptomatology • depressive symptomatology is more frequent among people with low education, at age 50+, among unemployed and in the Eastern - Northern counties of Hungary • most important psychological background factors of depressive symptomatology are hostility attitude, increased achievement motivation and low social support • with regard to alcohol consumption • 60% of people consumed alcohol at public places and 56% at home the average intake from different types of alcoholic beverages per drinking occasion: men 0.82 and women 0.45 litre of beer men 0.44 and women 0.27 litre of wine men 0.09 and women 0.07 litre of spirits • in an average drinking session, men consume most alcohol as wine and spirits, women as spirits and wine
(Pèter 1995a) 1995	Patients at 15 voluntary GP practices all over the country No at age 18+: 9868 answers Population at age 18+: 30649 Time: 15 Febr-30 Apr 1995 Place: GP practices, patient visits in 2 of 15 practices response rate unknown out of 13 practices response rate 97% out of 3 practices (where no of patient was also recorded not only number of patient visits), 59 % of patients who turned up at GP practice were asked and out of them 95 % answered the questionnaire (resp rate)	AUDIT questionnaire (screening) most often provided by nurse in the waiting room self-completed presented to GP at visit (some differences occurred between practices, e.g. at one practice patients were visited at their homes, at another people turning up for health examination for work) GPs were very individualistic, no preliminary discussion or meeting took place before administering the questionnaires	15 GP practices provide service for 30649 people at age 18+ Sex was specified only in 12, age-distribution only in 11 practices. based on 12 practices • 31% of men and 8% of women scored >10 (hazardous or harmful drinking), • 19% of men and 13% of women scored 8-10 (drink on the sensible limit - not examined by the author) • 50% of men and 78% of women scored <8 (abstainers, or occasional drinkers - as author present "sober lifestyle") based on all 15 practices (male+female) • 19.5% score >10; 20.6% score 8-10; 59.6% scored <8 based on 12 practices harmful drinking • men: 19-34 18% ; 35-59 16% ; 60+ 41% of men in that agegroup • women: 19-34 4%; 35-59 10.2%; 60+ 15% of women in that agegroup

Author	Subject	Method	Results
(Tùry et al. 1997) Debrecen, Varbò 1995	adult population, age 15+ four countries involved: Hungary, Austria, Check Republic, Poland sample selection: Kish walking method Debrecen: 554 (out of 750, 73.8% response rate) Varbò: 143 (out of 167, 85.6% response rate)	CAGE using cut-off 1 and 2 to assess • hazardous drinking • alcoholism Alcoholism: if score is 4 (max) Hazardous: above the cut-off score By age, gender, marital status Effect of using diff. cut-off scores	HUNGARY - 657 answers (261 men, 390 women) • 27.3% hazardous (43.3% men, 16.9% women) - 12.9a; 23.4m,5.9w • 4.9% alcoholics (9.2% men, 2.1% women) among people at age 30-44 and 45-59 are the most hazardous (28% and 30%) and alcoholics (7 and 7.4%) [at cut-off 2 it is highest among people at age 30-44 (18%), while at age 45-59 smaller (13%) • estimated No of alcoholics in Hungary 285000 minimum based on patient visit numbers to psychiatry or alcohol care centres (532 cases/100000 habitants getting care for alcohol related problems) • estimate at age 18+ of alcoholics 3.4-6.8% GENERAL - all countries • significant gender difference in all countries • age differences are significant in Hungary and Austria • Austria age 60+ most hazardous drinkers, under that age similar proportions each agegroup, at age 45-59 most alcoholics at cut-off 1 at cut-off 2 most hazardous at age 15-29 (30%) • in Checkia and Hungary significant differences according to marital status: Hungary significantly higher average score at cut-off 2 for widowed, divorced, separated, lowest average score for single. Check Republic: higher average score for single people, and lower for widowed or divorced
		Ethnic minorities	
(Bères & al 1993) 1991 Egyhàzaskozàr	245 csàngò interviewed 87 laboratory tests for liver functions etc. controls: 80 healthy people from Budapest age: >20	interview interview with family members/GP medical records laboratory tests about: quantity and quality consumed demographic questions number of children acute reactions for alcohol liver functions	• low number of people with higher education level • pregnancy at early age (15-19) consumption men: drink everything, 20% >90ml pure alc./day women: mainly wine, 2.4% >90ml pure alc./day laboratory tests: GGT, GOT, GPT(normal range), CHE(normal range) significantly elevated compared to healthy population • high alcohol tolerance • no particular liver problems • leading cause of death: **liver cancer**

Author	Subject	Method	Results
		Ethnic minorities	
(Bères & al 1994) 1992 Màtraderecske	615 palòc interviewed 74 (random) medical examination and laboratory tests for liver functions etc. controls: 80 healthy people from Budapest age: >20	interview with family members/GP medical records laboratory tests about: quantity and quality consumed demographic questions number of children acute reactions for alcohol liver functions	• low number of people with higher education level • pregnancy at early age (15-19) consumption men: 90% drink alcohol, they drink everything, 25% >90ml pure alc./day women: 70% drink alcohol, mainly liqueur, 1% >90ml pure alc./day laboratory tests: GGT significantly elevated compared to healthy population • morbidity and mortality patterns do not differ considerably from the general population

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- APPENDIX 2 -

DEATHS FROM CIRRHOSIS IN POLAND AND HUNGARY:

THE IMPACT OF DIFFERENT ALCOHOL POLICIES DURING THE 1980S

Deaths from cirrhosis in Poland and Hungary: the impact of different alcohol policies during the 1980s

Zsuzsa Varvasovsky, Chris Bain, Martin McKee

Abstract

Objective **– To compare patterns of deaths from cirrhosis in Poland and Hungary in the context of differing alcohol policies in the 1980s.**

Design **– Cohort analysis of deaths from chronic liver disease and cirrhosis between 1959 and 1992 using mortality data from the World Health Organization database.**

Results **– The pattern of alcohol related mortality in these countries is quite different. In both countries, death rates increased in the 1960s and 1970s. In Poland, this increase was arrested in 1980 and death rates have levelled out, with the exception of those in young females. In Hungary, rates have continued to climb, although the rate of increase decreased in the 1980s. This change coincides with the introduction of a policy, following the introduction of martial law, to reduce alcohol consumption.**

Conclusions **– The countries of central and eastern Europe display many similarities in both political history and measures of health such as overall life expectancy. When examined more closely, substantial differences emerge. Policy makers must be cautious about adopting global solutions to health challenges that fail to take into account national variations.**

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It is now apparent that levels of health in the former socialist countries of central and eastern Europe are substantially worse than those in the west.[1] Despite rapid improvements in mortality in the period immediately after the second world war, by the mid 1960s the health of their populations began to stagnate. The subsequent steady improvement in the west has left them further and further behind so that now their life expectancy at birth is typically five to six years less than in the west. This phenomenon has stimulated a growing body of research, summarised recently by Bobak and Marmot.[2] In brief, the groups most affected in these countries are men, especially those in early middle age and who are unmarried,[3] and the greatest increases among causes of death are those from chronic diseases and, especially, ischaemic heart disease and cancer. As adult health has deteriorated, infant mortality has improved, so that global measures such as life expectancy at birth conceal a rather complex pattern.

Most authors, in seeking to explain this phenomenon, have directed their attention to the substantial differences between the two parts of Europe and have paid rather less attention to the existence of heterogeneity within central and eastern Europe. This seems rather surprising as, in western Europe, it is widely recognised that there are very large variations in death rates from, for example, ischaemic heart disease and many forms of cancer.[4] One study that examined the contribution of different causes of death to changing life expectancy in three central European countries during the 1980s showed substantial national differences. Most notably, in Hungary, where the decline in life expectancy has been especially large, alcohol related deaths had a very much greater impact than in Poland or Czechoslovakia.[5] This study seeks to develop this observation further. It examines the apparent difference in alcohol related mortality between Hungary and Poland, two countries with, superficially, broadly similar experiences in the post war era. It employs cohort analysis to ask whether this apparent difference is real, whether there are any factors that could account for it, and whether any period, age, or cohort effect could be observed.

Methods

Data from the World Health Organization mortality tapes from 1959 to the present were analysed. These contain data in five year age bands (one year for the under 5s) broken down in relation to sex and cause of death using the abbreviated mortality codes. Over this period four different editions of the *International Classification of Diseases* (ICD) were used. Deaths categorised as cirrhosis of the liver or chronic liver disease and cirrhosis were studied as the categories within the abbreviated codes most closely linked to alcohol consumption. The codes used in each edition of the ICD are shown in table 1.

As these data span three editions of the ICD it is important to consider whether this could have any effect on the trends observed. There was no consistent discontinuity in death rates coinciding with changes in ICD editions, al-

Table 1 International Classification of Diseases (ICD) codes used in the analysis

ICD edition	*Label*	*Code*
7th	Cirrhosis of the liver	A105
8th	Cirrhosis of liver	A102
9th	Chronic liver disease and cirrhosis	B347

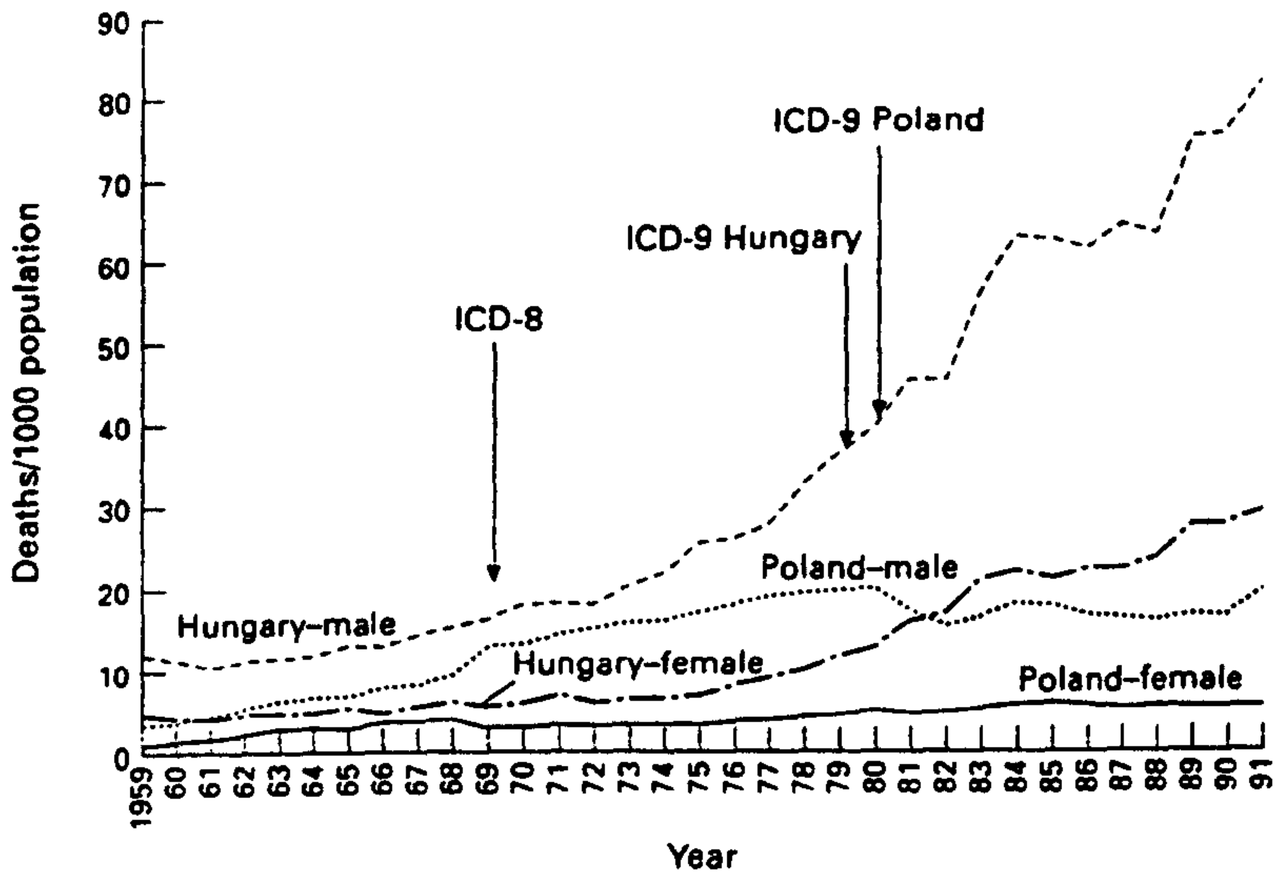

Figure 1 Crude death rates from chronic liver disease and cirrhosis – effect of a change in the edition of the International Classification of Diseases.

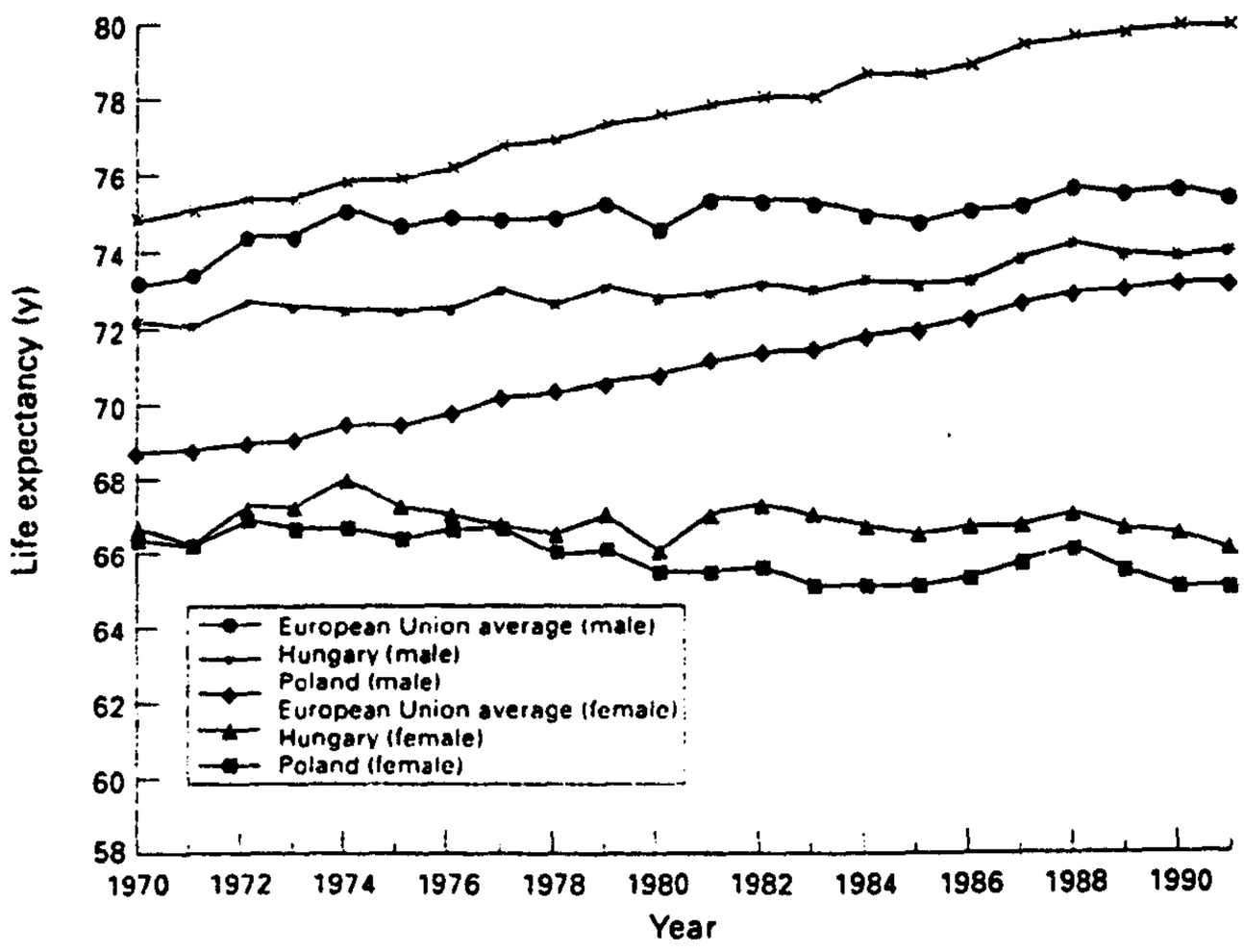

Figure 2 Life expectancy at birth in the European Union, Hungary and Poland between 1970 and 1991.

though the death rate among Polish males did increase when ICD-8 was introduced and fell when ICD-9 was introduced (fig 1). This effect was not seen for female deaths in Poland or for either male or female deaths in Hungary. As will be seen later, there are other factors in Poland that could explain the change seen in 1980 and the absence of an observed effect in either Polish women or Hungarians suggests that this is unlikely to be an effect of coding differences. This is supported by the finding in the bridging study undertaken by the United Kingdom Office of Population Censuses and Surveys that found that over 97% of cases coded A102 in ICD-8 were coded as B347 in ICD-9 and vice versa.[6]

Results

Although published data are only available in the *United Nations Demographic Yearbook* for selected years until 1970, life expectancy at birth was similar in Poland and Hungary during the 1960s. In the early 1970s the two countries began to diverge but, from the mid 1970s, the trends remained parallel and relatively constant until the present, with the figures for Poland typically being about 1.5 years longer than in Hungary. In contrast, life expectancy in western countries has steadily increased over this period, leaving Poland and Hungary increasingly far behind (fig 2).

While the trends in life expectancy suggest that the health situations in Poland and Hungary have been broadly similar since the 1970s, this view is dispelled by a more detailed examination by cause of death. In the case of chronic liver disease and cirrhosis, the topic of this paper, there has been a dramatic increase in deaths in Hungary since the early 1970s but little change in Poland over this period.

Two sets of graphs have been drawn to illustrate changes over time. In the first, deaths have been aggregated into ten year age bands and, indexing the rate in the first period (1959–63) as 100, show the change relative to the initial period in each subsequent five year period (figs 3 and 4). In the second set of graphs, age and sex specific death rates, in five year bands, were plotted by the central year of birth for those dying in each five year period from 1959–91 (except that the last period spans only three years from 1989 to 1991 because of non-availability of data). A semilogarithmic scale has been used, as is conventional in cohort analyses, to show the rate of change (figs 5 and 6). In both cases, because of the small numbers involved and to enhance clarity of the figures, data for those dying under 30 are not shown. To place the changes in context, figures for annual alcohol consumption between 1970–91, as reported in the World Health Organization's Health For All database are also presented (fig 7).

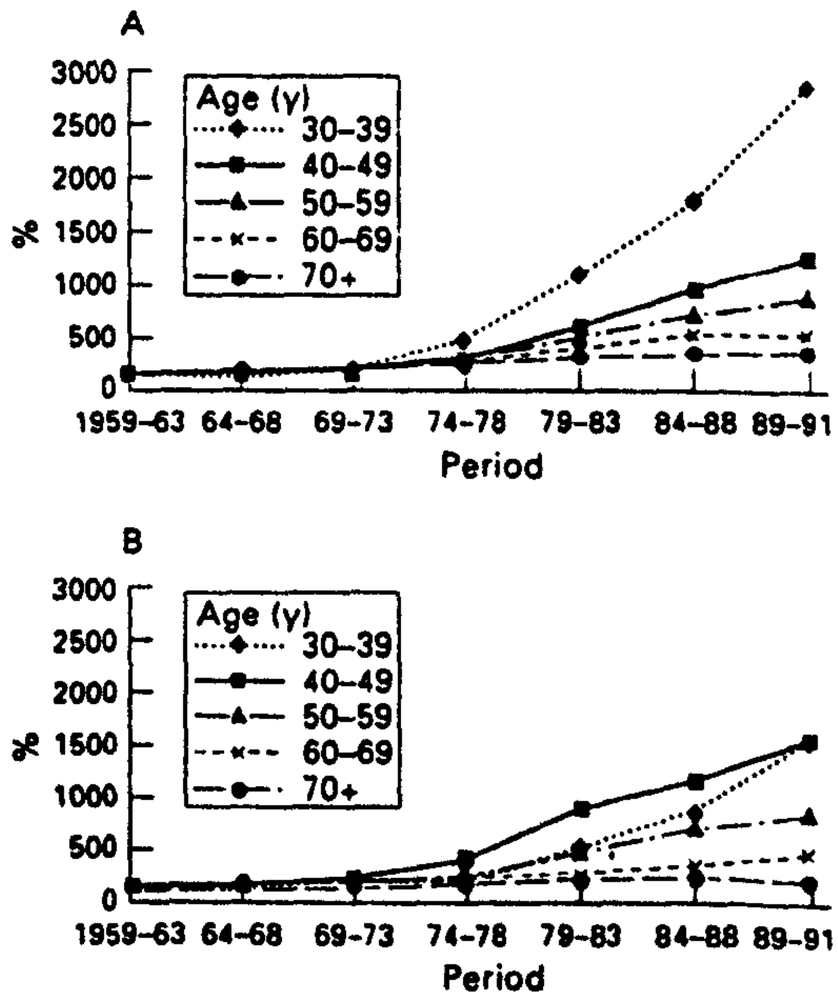

Figure 3 Changes in age specific death rates from chronic liver disease and cirrhosis among Hungarian men (A) and women (B) (1959–63 = 100).

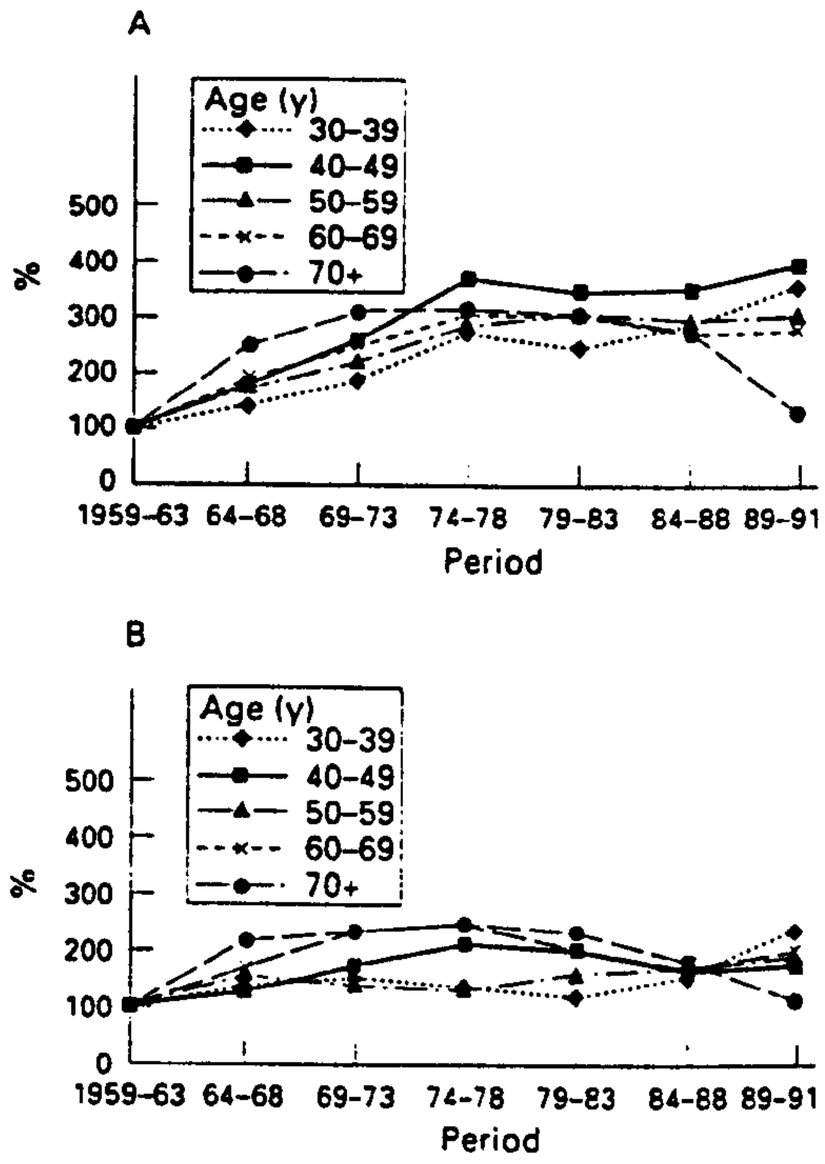

Figure 4 Changes in age specific death rates from chronic liver disease and cirrhosis among Polish men (A) and women (B) (1959–63 = 100).

Inspection of age specific death rates in each period of death reveals strikingly different patterns in the two countries. In both countries, and in all age groups, there have been increases in mortality but the magnitude of change is very much higher in Hungary, with an almost 3000% increase among men aged 30 to 34. This increase is progressively less among older age groups but, even for those aged 60–64 the increase has been over 500% (fig 3A). The increases have been somewhat less among Hungarian females but, even here, in the youngest age group it has been over 1500% (fig 3B). In contrast, among Poles, while death rates increased in the early part of the period under study, there has been little further increase since the early 1980s (fig 4).

The second set of graphs show differences in the rate of change over time in relation to year of birth. The extreme left hand point in each series represents deaths occurring in 1959–63 and the extreme right hand point represents deaths in 1989 to 1993. In Poland, male death rates increased for all age groups until about 1981 and subsequently levelled out, except for small increases among the young in the late 1980s (fig 5). The curves are almost parallel until the age group 55–59. Above this age, while the transition from an underlying upward trend still occurs around 1981, there is also an earlier slowing of the rate of increase. The lower numbers of female deaths introduces a greater element of instability but there is still a general upward trend in the earlier years of the study period, although an abrupt change around 1981 is less apparent (fig 5). The pattern in Hungary is markedly different. For both sexes, the rate of increase during the 1960s (the left side of each data series) was similar to that seen in Poland. Thereafter, instead of levelling out as in Poland, the rate accelerated upwards (fig 6). The rate of increase has, however, slowed during the 1980s. As suggested earlier, the rates of increase have been greatest among the younger age groups.

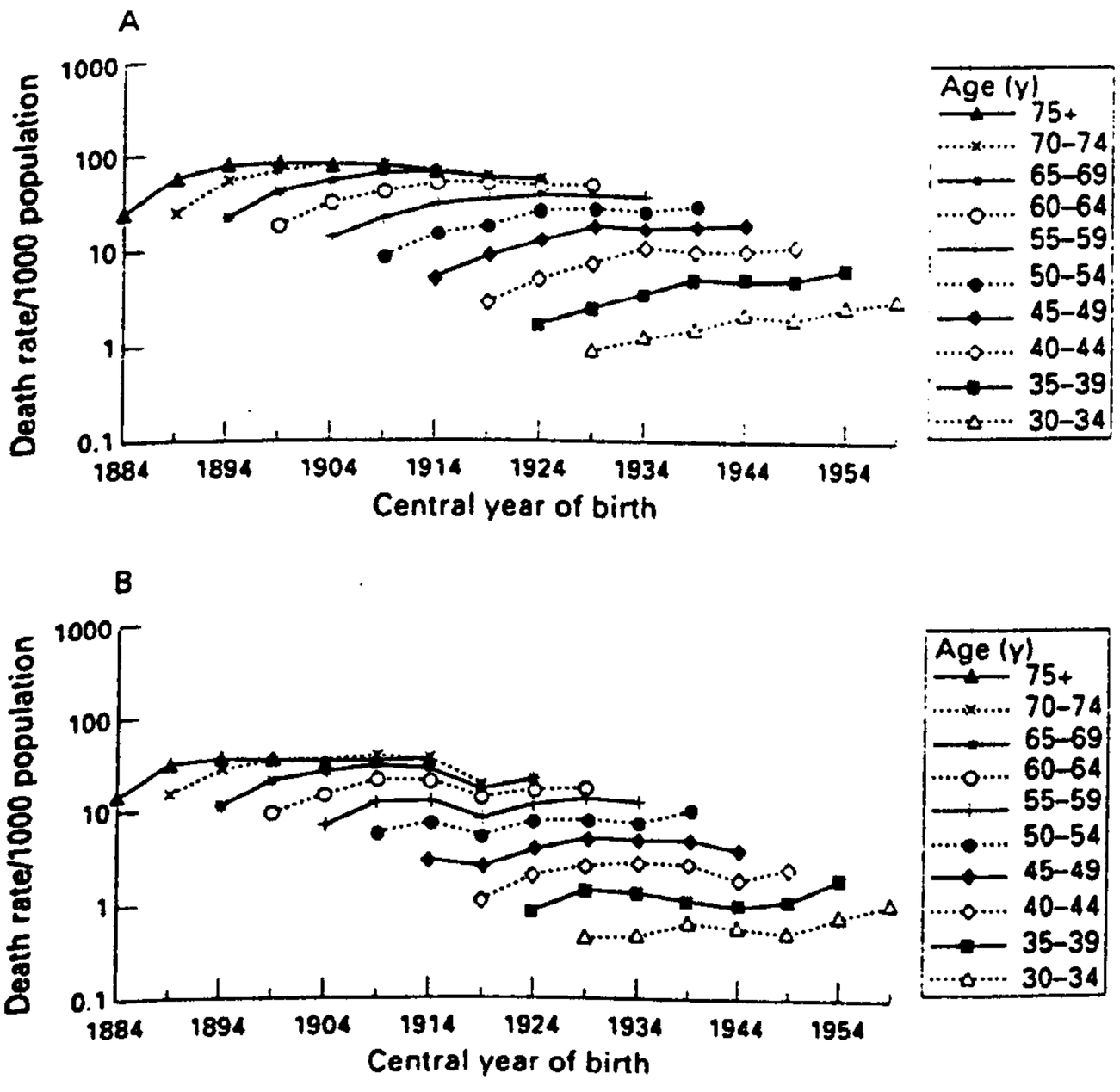

Figure 5 Age specific death rate from chronic liver disease and cirrhosis in relation to year of birth in Polish men (A) and women (B) for seven selected periods.

Discussion

For diseases with a distribution heavily influenced by age, simple analysis of trends in mortality, even when age standardised, may be misleading. Age period cohort analysis can add substantially to understanding of underlying trends.[7] In particular, it can help to differentiate cohort effects, in which changes in frequency of disease across the age groups of successive cohorts reflect the unique exposures of those cohorts; period effects, in which a common experience causes changes occurring across all age groups alive at a particular time; and age effects, in which changes in frequencies are related only to changes in age and not to either period or generation. For example, this approach was used by Susser in 1961 to challenge the then current view that the incidence of peptic ulcer was rising.[8] The analyses contained in this paper similarly challenge widely held views about the pattern of alcohol related mortality in Poland and Hungary.

A few caveats are necessary. This study is limited both in terms of types of deaths studied and in the analysis undertaken. There are many other diseases that are linked aetiologically to alcohol. Although the category "chronic liver disease and cirrhosis" will include a spectrum of non-alcohol related diseases, these constitute only a small proportion of these deaths. According to some sources the percentage of

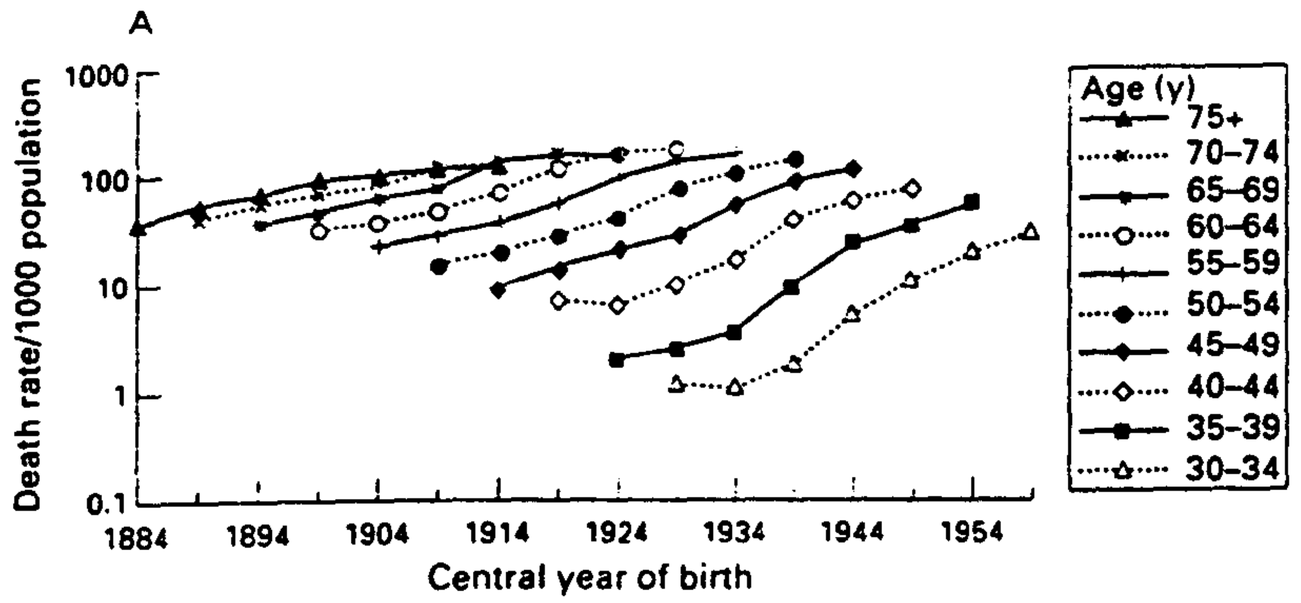

Figure 6 Age specific death rate from chronic liver disease and cirrhosis in relation to year of birth in Hungarian men (A) and women (B) for seven selected periods between.

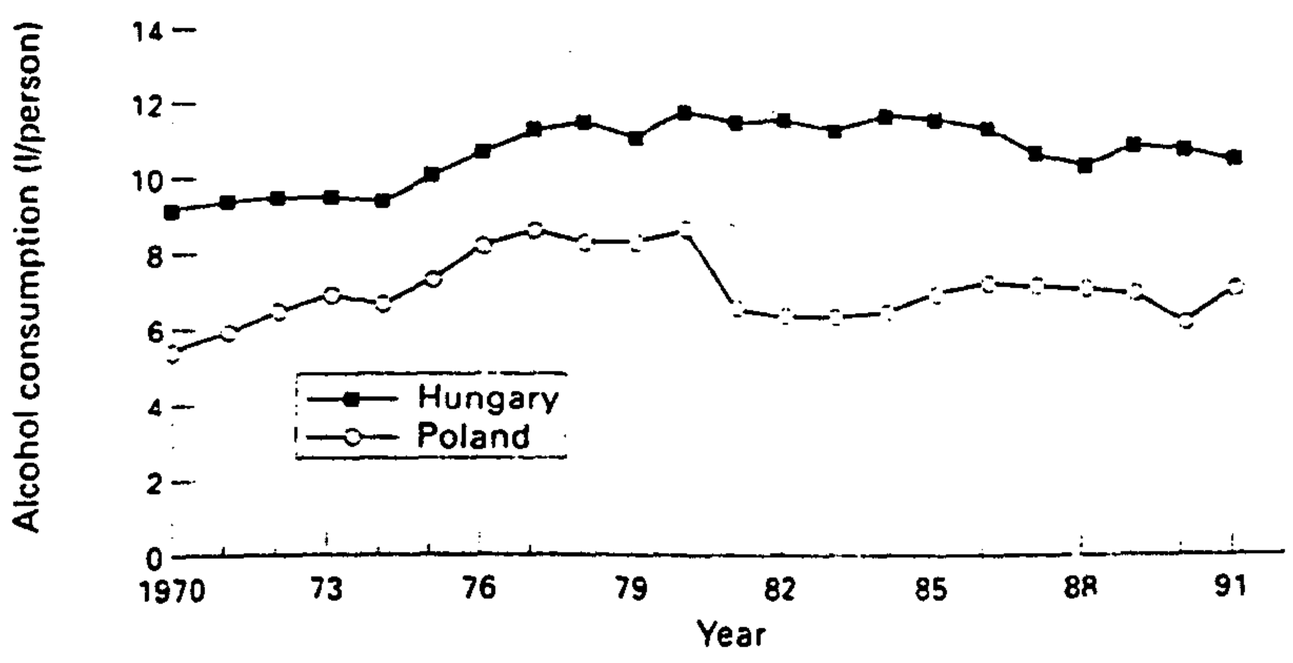

Figure 7 Consumption of pure alcohol in Hungary and Poland, 1970–91.

deaths attributable to alcohol in chronic liver disease and cirrhosis ranks from 66 to 100% making it possible to consider this cause of death as a relatively good marker of alcohol problems within a community.[9] Furthermore, unlike the situation with alcohol where there is strong independent evidence of changes in exposure, we know of no similar evidence that would suggest that the other causes of liver disease have changed significantly. A pragmatic consideration was that data are only easily available throughout the study period in the form of the abbreviated mortality classification.

The analysis has been limited to visual examination of the various curves generated. It is recognised that some authors, when undertaking cohort analysis, have supplemented visual inspection with statistical modelling in an attempt to separate age and period effects. A more detailed critique of modelling is set out in a paper by Kupper who concludes that "such regression methods cannot be said to provide important interpretational advantages over graphical approaches".[10]

Despite many superficial similarities between these two countries, the patterns of deaths from chronic liver disease are quite different. This is an important cause of death, accounting for a reduction of over half a year in life expectancy at birth among Hungarian males between 1979 and 1990.[5]

Cohort analysis helps to demonstrate who is dying from this disease and how this has changed over time. In Hungary, alcohol continues to pose a substantial and increasing threat to health. Although the rate of increase in death rates has slowed, the trend is still upwards. All age groups over 30 are affected but the greatest increases have been among the young. In Poland, in contrast, despite a rising death rate before 1980, this has now ceased, except among young women.

The greater importance of alcohol as a risk factor in Hungary than in Poland receives independent support from a report of recent trends in cancer of the oesophagus, for which alcohol is also an important risk factor. The age standardised death rate has increased much more steeply in Hungarian men than in their Polish counterparts and cohort analysis demonstrates a pattern similar to that reported here.[11]

The official statistics on alcohol consumption also support this view. Although such figures are notoriously unreliable because of, for example, illicit production, they can give some idea of trends. They show a steady rise in the volume of pure alcohol sold in both countries from 1970 but, unlike Hungary where it has continued to rise, there was a substantial fall in Poland after 1980 (fig 7).[12] This coincides with the change in the rate of increase of cirrhosis mortality in Poland and can be considered as a period effect. Unfortunately, as these figures are based on aggregate consumption statistics, they give no idea of the pattern of drinking. In neither country are there adequate survey data covering this period.

It may seem surprising that the change in consumption in Poland could cause such as rapid cessation in the increase of deaths from cirrhosis given the long period over which cirrhosis develops. Such an effect has been described in other situations, such as that in Paris in 1942 when alcohol rationing was introduced due to shortages arising from the war. Alcohol consumption was estimated to have fallen by 80% in one year and deaths from cirrhosis fell by 50% in the same period.[13] This has been explained as reflecting the reservoir of people with cirrhosis for whom short term changes in consumption may either hasten or delay death quite considerably.[14]

The circumstances surrounding this decrease have been described by Wald and Moskalewicz.[15] In 1980–81, Solidarity blamed the Polish government for promoting alcohol to hide the deeper problems of society and to obtain more revenue. Faced with this pressure, alcohol policy was tightened. Production decreased, temporary prohibition and rationing

were imposed, and alcohol prices rose substantially. The policy was continued after the imposition of martial law and only slightly liberalised during the mid-1980s.[16] In Hungary, no similar policy initiative was introduced during this period, although the problem was recognised. Several new bodies were established to tackle alcohol related problems and research was initiated but this activity focused on the management of those who already had clinically apparent problems.[17 18] Despite these measures, the availability of alcohol steadily increased[19] during the 1980s and their price lagged behind inflation.[20] It was only at the end of the 1980s, partly in response to the crackdown on alcohol in the Soviet Union, that access to alcohol became more restrictive, with laws limiting the sale of alcoholic beverages before 9 am, bans on the sale of alcohol around schools and health care facilities, and price increases.[21] In practice, these Hungarian initiatives seem to have had little impact on alcohol consumption and consequent mortality.

This study provides further evidence of the complexity of the health challenges facing central and eastern Europe. From a distance, it is clear that the countries in this region have many similarities. In each of them, life expectancy increased in the immediate post war period but subsequently has either stagnated or, for men, fallen. This has been due to an increase in chronic diseases affecting, especially, those in early middle age and has been offset to some extent by improvements in infant mortality. As one looks closer, however, the differences emerge. Some, such as the high level of HIV/AIDS and maternal mortality in Romania have received considerable attention. Others, such as the consequences of alcohol, are less well known.

The countries of central and eastern Europe may look similar from a distance but differences emerge on closer inspection. Much that has been written on this topic has focused on the gap between east and west. As the cases of death vary, so too should the policy responses.

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