OSSERVATORIO PERMANENTE SUI GIOVANI E L'ALCOOL

ITALY AND ALCOHOL: A COUNTRY PROFILE

Allaman Allamani
Simona Anav
Francesco Cipriani
Daniele Rossi
Fabio Voller

CASA EDITRICE LITOS

QUADERNO N. 19

Osservatorio Permanente
sui Giovani e l'Alcool

QUADERNI DELL'OSSERVATORIO
19

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Allaman Allamani
Centro Alcologico dell'Azienda Sanitaria di Firenze

Simona Anav
Osservatorio Permanente sui Giovani e l'Alcool, Roma

Francesco Cipriani
Osservatorio di Epidemiologia, Agenzia Regionale di Sanità, Firenze

Daniele Rossi
Federalimentare

Fabio Voller
Osservatorio di Epidemiologia, Agenzia Regionale di Sanità, Firenze

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Osservatorio Permanente sui Giovani e l'Alcool
Viale di Val Fiorita, 90 - I - 00144 Roma
Tel. +39.06.60 50 77 41 - 06.54 39 32 15 - Fax +39.06.59 12 910
e-mail: osserva.giovani@alcol.net - web: www.alcol.net

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INTRODUCTION

Italy is a country of rich tradition and heritage. A part of this heritage has been the role of alcohol and drinking in the life of its people. Any visitor travelling through Italy can not help but be aware of the many grape vineyards which dot the countryside. Alcohol, especially wine, has been present in Italy from ancient times.

This country profile about Italy is an extremely welcomed and rich source of recent information about this country and its relationship to alcohol and its consumption as noted in the profile, Italy, like most member countries of the European Union has undergone significant cultural and economic changes. With this transformation has come change in the role and use of alcohol, especially wine. One of the changes has been a reduction in the total per capita consumption of absolute alcohol.

Other changes have occurred in the ways in which alcohol is used, and in the increased risk from alcohol impairment on the roadways of Italy. There has also occurred a 50% decline in the amount of land set aside for grape cultivation.

This publication provides a comprehensive summary of key topics including production, total consumption of alcohol, patterns of consumption, alcohol-related mortality, alcohol-related policies and norms, economic aspects of alcohol as well as discussions on taxes and licensing for alcohol distribution outlets. It concludes with discussions of patterns and opportunities for prevention of alcohol-involved harm and the treatment of alcohol-dependent persons.

The authors of this profile have assembled a valuable collection. It is organized in a way so as to take the reader through a complete journey in the Italian alcohol-related history, economics, drinking, and policies. It is also an excellent reference source. Organized in concise chapters, the reader can pick and choose those sections most relevant to his/her individual interests and needs.

Harold D. Holder, Ph.D.
Prevention Research Center
Pacific Institute for Research and Evaluation
Berkeley, California USA

1. ALCOHOL AND CULTURE: ITALY AND SOUTHERN EUROPE

(Allaman Allamani)

Italy and the southern, or Mediterranean, European countries are societies typically based on time-honoured strong family ties and a rural tradition that only during the last decades underwent a process of change in the context of industrialisation and urbanisation characterising the post-World War II era.

Moreover Italy, France, Portugal, and Spain share a common Latin origin of their languages, and Christian Catholicism as the religion most practiced.

The Mediterranean European countries are wine producers, and for most of them wine production and marketing are important economical issues. Drinking wine is part of daily life, and both values and patterns related to alcoholic beverages are different than in countries where drinking is episodic, as is usual in northern Europe. Also, trends in consumption and alcohol-related mortality, as well as changes in the pattern of drinking show themselves in a way which appears specific to the southern countries and diverse from the northern ones (see Simpura & Karlsson, 2001; Östenberg & Karlsson, 2002) .

Even if such a generalisation is arguable, nevertheless we believe that it has an explanatory power when considering drinking values and patterns, changes in consumption and prevention policies.

1.1. Consumption Patterns and Values Attributed to the Alcohol Beverages

According to a number of studies, the European territory has been divided up into two large European regions. Such a distinction has been blurred by the changes in drinking patterns in the last decades, but it still is in use (Cottino 1991, Room 1992, Heath 1995, Allamani, Voller, et. al. 2000):

(a) the northern "dry" area, – as Sweden, Finland, and Norway where spirits and beer are the leading beverages, consumed on weekends and outside mealtimes;
(b) the southern, or Mediterranean "wet" area, – France Italy, Spain, Portugal, and Greece – where by and large wine is the main beverage, usually drunk at meals.

In the northern countries, alcohol is experienced as a psychotropic substance consumed to perform a number of actions, according to a Bacchic and heroic approach, or for satisfying hedonistic needs. Since it is experienced as elating the self, it has been used as an instrument to overcome stress, or to prove one's manliness. It is felt as a means to perceive "having a lack of control" or transgression. Typically drinking is concentrated on relatively rare occasions with high intake per session (Simpura & Karlsson, 2001).

In the southern countries, wine is drunk for its taste and fragrance, often during daily meals within the family and other social contexts with a relatively regular weekly consumption. It is considered to be a food item. Drinking wine is sociable per se, so that people need not drink because they want to be sociable through the chemical effects of alcohol. Usually drinking does not appeal to the topic of control and does not elicit any image of either achievement or performance. In fact, southern Europeans do not equate alcohol with wine, but rather with spirits, while they may identify beer with soft drinks.

Wine is a product of the vineyard. Vineyards are well visible in the countryside, and sometimes cultivated even within one's garden, and it is perceived as being part of the vegetal realm. Purchasing wine by citizens from a country winery still today recalls the values of nature and creation.

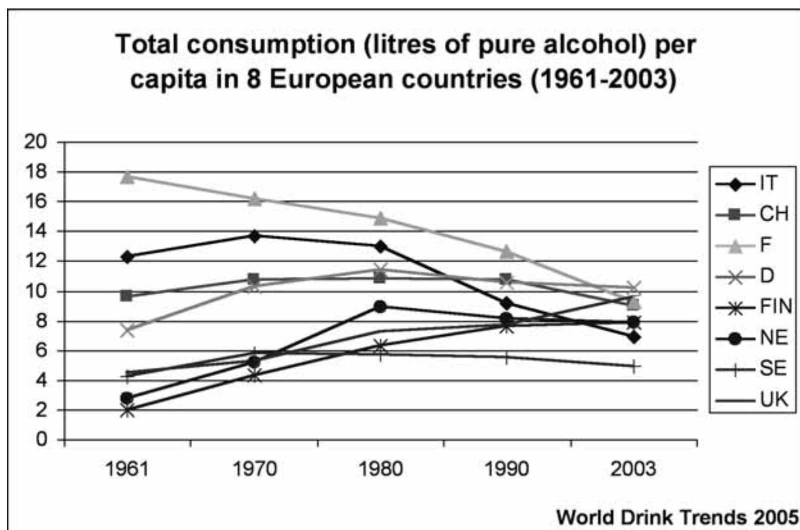
Until recent years, in the Southern rural societies the strong extended families and intense community ties served as a consistent model of a traditional drinking pattern, to be transmitted through generations, and worked as an informal social control process towards excessive drinking. However, since the 1970's the increased urbanisation, industrialisation, migration and tourism have weakened the traditional societal patterns and new attitudes, including new alcohol beverages, have come in from the North.

1.2. Changes in the Amount of Consumption and in Drinking Pattern

Alcohol consumption remarkably declined in the southern European countries, mainly because of a drastic reduction of wine intake - by more than 50% in the period 1970-2005 both in Italy and in France. In the same period beer consumption had increased, but not as much as to balance the decrease in wine, which by and large still stands as the main alcoholic beverage (see Leifman, 2001).

On the other hand, during the same period consumption in the northern countries as well as in central Europe generally increased especially from the 1970s to the early 1990s. On a whole, the dispersion of alcohol consumption in European countries found in the 1960s started to decline in the following decades. By the beginning of this millennium a *convergence* among the amounts of alcohol intake of the European nations was taking shape. Such a trend was quite evident in the case of *wine:* in fact, the wine countries remarkably decreased their consumption, while the other European countries increased their wine intake (Fig. 1.1). However, this does not mean that there are not still large cultural differences among the different countries.

Figure 1.1.



Some kind of convergence of alcohol drinking patterns in the European countries could also be observed during the same period. Especially among youngsters and women, *novel* alcohol beverages had come in at some expenses of the *traditional* ones. As an example, wine has always been a traditional beverage in southern Europe and beer in central Europe, while new beverages were now beer for southern Europeans and wine for the inhabitants of other European states (Hupkens et al., 1993). In southern Europe, the mainly wine-drinking groups seemed to be part of the traditional people, while the more educated and urbanised were part of the groups drinking less wine. The opposite behaviour occurred in northern European countries (Knibbe, Drop & Hupkens, 1996; Allamani, Cipriani & Prina, 2007).

What made such transformation of drinking practices possible? To explain such changes, one should consider different aspects including:

political and marketing factors; evolution of prices of bottles; competition among alcohol and soft drinks, and other food items; growing education and awareness of people about the risk of alcohol abuse; changes in the organisation of workforce; and internationalisation of drinking patterns with the increasing role of youngsters and women in alcohol consumption (Gual & Colom, 1997; Beccaria & Allamani, 2007).

As to *marketing* factors, the wine market may have been weakened by the fact that wine was produced mostly by a large number of small producers, while beer and spirits – and also new alcohol-free or soft drinks entering in the competition – were controlled by a few multi-national companies who were able to effectively advertise and distribute their products across many nations. The advertising companies were well aware of the changing preferences in alcohol beverages of young adults and women, who therefore became special targets (for Italy see Beccaria 1999).

In Italy, the analysis of *households' expenditures* also gave a hint of the changing importance of alcohol in the Italians' way of life. According to the annual General Report on the Economic Situation of the Country, published by the Ministry of Treasure and Budget, (Ministero del Tesoro, del Bilancio e della Programmazione Economica, 2003), the Italian monthly expenditure for foodstuff between 1997 and 2002 increased only by 5.9%, while the major increase came from "non- food" (+9.0%). In the same period, the weight of foodstuff over the overall family expenditure slightly decreased from 19.8% to 19.4%, with differences between geographic areas. The increase regarded mainly bread, cereals, cheese, meat, fish, fruit and vegetables, while oils, fats, sugar and coffee decreased.

Beverages experienced the same growth trend: the average monthly expenditure for beverages of the Italian families reached 43.2 € in 2005 (see ISTAT, I consumi delle famiglie 2005). This growth was mainly due to mineral waters, fruit juices, soft drinks, coffee, tea and cocoa, while alcoholic drinks confirmed their trend of decreasing in real terms.

If we analyse the Italians' food expenditure during the past 27 years, we notice that the percentage weight of alcoholic beverages over food consumption decreased from about 7% in 1975 to about 5% in 1998, to an even lower 4.1% in 2002. In other words, it seems as if consistent sectors of the Italian society may have questioned their wine drinking in the same

way as they have been questioning other components of their diet such as butter or fresh fish.

Just because it is integrated in the Italian eating culture, the demand for wine can become more and more resilient (Allamani, Cottino, Cipriani, et al 1995). By and large, the decrease in alcohol consumption appears to be associated with the increasing family income. This implies that a diversification in consumption, in particular a shift of money towards leisure, self care, transport and communication, and to the general organisation of one's lifestyle and individualistic and healthy trends changed the Italians' habits more towards quality than quantity.

A certain *awareness about the harm* caused by alcohol beverages has grown among southern Europeans, and this was vividly described by mass media. This new phenomenon appears to be due to an informal "healthy lifestyle wave" by which people have become more careful about their own body and mind needs and about their self control (Allamani, Cipriani, Gordon et al, 1995); it seems unreasonable to attribute it to any governmental measures.

Were such changes determined by a general shift in drinking among the whole population, or rather by the fact that just some social groups stopped or decreased their consumption? According to some studies investigating alcohol consumption in Italy, between the 1990s and the 2000s there was a decrease in the relatively smaller proportion of middle-upper class male "heavy drinkers", and an increase in the larger proportion of young, well educated, urban class, "light drinkers". Also there was a rise in the number of female consumers (ISTAT, 2001; Osservatorio di Epidemiologia ARS, 2005;Osservatorio Permanente sui Giovani e l'Alcool, 2006). In other words, during the last years, the overall decrease may also be associated to a decrease in male "heavy drinkers".

Finally the explanation given by Hupkens et al. (1993) is characterised by a *socio-demographic* approach within a European perspective. These authors claimed that the condition of being (a) more educated, (b) younger and (c) female were able to initiate the changes and maintain them. From the Italian viewpoint, we are reminded that the young generations do not seem to consider wine as being a common ingredient of their meals, while their drinking beer is not necessarily linked to the main meals.

1.3. Mortality and Alcohol Related Harm

Traditionally, liver cirrhosis is an indicator of biological damage due to continuously drinking alcohol over a number of years. Its gradient in Europe is North-South. However, by and large, and in keeping with changes in alcohol consumption, the cirrhosis death rate began to decline during the 1980s in the southern countries while it increased in the northern ones, albeit the heigher death rates in the South than in the North (Ramstedt, 1999).

1.4. Prevention and Treatment

Among southern European health professionals, administrators and the general population, some forms of concern about the issue of alcohol-related problems arose only in the late 1970s and in the 1980s.

Some cases of patients affected by alcoholism, and considered as a problem for the community, were hospitalised in mental hospitals. In the late 1960s, Gastroenterology hospital units started to admit people affected by liver cirrhosis and pancreatic diseases related to alcohol.

During the 1960s and 1970s, the U.S. 12-step association Alcoholic Anonymous (A.A.) also had its birth in France, Spain, Italy and Portugal (Alcoholics Anonymous, 2005), spreading slowly, and was followed some years later by AlAnon, the association of Family Members of alcoholics. The non-governmental Clubs of Treated Alcoholics (CAT), an adaptation of AA in the context of socialist Yugoslavia that was born in Zagreb during the 1960s, spread to Italy in the 1980s and subsequently to Spain and to a few other European countries (Patussi, Tumino & Poldrugo, 1996).

Since the 1980s, the World Health Organisation European office, has begun fostering preventative initiatives facing the alcohol-related harm in the Region, including southern European countries. During the period 1984-1992, a collaborative study on community response to alcohol-related problems also involved Spain, Greece and Portugal ("Alcohol and the Community"). During the 1990s, an Early Identification and Brief

Intervention study started involving, among other European countries, Italy, Spain and later on France (WHO Europe collaborative study, Phase IV; Scafato et al., 2006).

According to some information, a few formal measures were adopted to control the intake of alcohol in southern Europe between the 1980s and 1990s (Karlsson & Östenberg, 2001). However, the decline of alcohol consumption in the 1970s –1990s cannot adequately be explained in terms of the impact that the few and late preventive or treatment initiatives - Ministry recommendations on advertising or setting BAC limits when driving - had on the population. It seems more sensible to interpret this change as being part of a more general changing drinking pattern of the southern European populations. Among other factors influencing the drinking pattern, one should consider an increasing concern of the health sector about the harmful effects of drinking alcohol treatment beverages. This concept may also explain the paradox that in Portugal, Catalonia and Italy the number of alcohol treatment services and of self-help groups flourisshed at times when the alcohol consumption level was already declining (Allamani, 2002).

An effective understanding of the declining of alcohol consumption in wine-producing countries during the last 30 years could also be a good guide for new ideas for interventions regarding alcohol-related problems in those European areas where alcohol consumption increased (Simpura, 1998). In fact, recent Italian research identified urbanisation and changes in the family structure on the one hand, and a rise of health awareness on the other, as key factors in the decrease of wine consumption during the period 1970-2005 (Beccaria & Allamani, 2007).

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2. THE COUNTRY
(Fabio Voller – Francesco Cipriani)

According to the 2001 Census, Italy covers an area of 301,336 square kilometres with a population about 57,000,000, of which 27.5 million are men and 29.6 million women (ISTAT, 2001). Compared with the 1991 Census, there was an increase of 0.3%. The country *density* is 189/km2, varying quite a bit from one region to another, ranging from the maximum in Campania, in the South, to the minimum in Val d'Aosta, in the North-West. In 2003, 15.3% of the total population resided in municipalities with more than 250,000 inhabitants, showing a decrease of 5.4% compared to census 1971. The dominant religion in Italy is Roman Catholicism.

After the birth of Italy as a unified country in 1865, Italy faced a num-

ber of problems, such as scant natural resources, little industry or transportation facilities, poverty, a high illiteracy rate, an uneven tax structure, and a high rate of emigration. After World War I, during the Fascist period, Italy became self- sufficient in food through the fertilisation of lands and construction of new motorways and public buildings. The first Penal code (*Codice Rocco)* which among other issues, reversed the previous principle according to which being drunk was considered an extenuating circumstance, was approved in 1931. Thus drunkenness in public was punished and crimes committed by drunken persons were severely punished (Cottino and Morgan, 1985).

After the end of World War II, in 1945 women won the right to vote. In June of 1946, Monarchy was abolished in favour of a Republic. Industrial growth and agricultural reforms were promoted, and economy was remarkably improved. In the 1950s and beginning of the 1960s, Italy grew strongly in a climate of monetary and social stability: this period is remembered as the “Economic Miracle”.

During the fifties, the country changed from being mainly agricultural to being primarily industrial. As to the political arena, Italy joined the North Atlantic Treaty Organisation in 1949 and the European Coal and Steel Community in 1951, and later on in 1958 it was one of the founders of the European Common Market and of the European Community.

While in 1960 the percentage of employees had been 32.9% in agriculture, 33.3% in industry and 33.8% in the tertiary sector, in 1970 it moved to respectively 17,3%, 34,7% and 35,4%, in 1970 (OECD, 2005). The effects of this growth cycle were socially disruptive: there was a massive migration from the poor South, characterised by its subsistence level agriculture, toward the rich North, which was industrialised and in full economic “expansion”. In a decade’s time, hundreds of thousands of people left agricultural villages, mountain valleys, and small cities and moved into the metropolitan areas.

Between the 1950s and 1970s, Italy passed through a remarkable change: the majority of the population moved away from their traditional rural lifestyle, and the average life expectation became similar to that of developed countries. At the end of the twentieth century, Italy ranked

among the top industrial countries in the world. Especially in the North a diversified industrial base was developed. Italian industries produced textiles, chemicals, motor vehicles, heavy machinery, electrical goods, and foodstuff. However, more than 30 percent of the land area was still devoted to crops, orchards or vineyards, and Italy became one of the leading nations in the production of grapes, wine, and olive oil. Italy attracted a great number of tourists, and the tourist industry brought wealth to the country.

The Italian Parliament consists of a Senate and a Chamber of Deputies elected by popular election for five-year terms of office. The President of the Italian Republic is elected for a seven-year term by a joint session of Parliament augmented by Delegates from each of the 20 Regional Councils, and has the right to dissolve the Senate and Chamber of Deputies at any time except during the last six months of his tenure. The actual running of the government is in the hands of the Prime Minister, who is chosen by the President and must have the confidence of the Parliament and Council of Ministers.

Italy is divided into 20 regions, which are subdivided into 100 provinces. Each region is governed by an Executive responsible to a popularly elected Council. The regional governments have considerable authority.

The *trend of the population distribution by age* during the period 1950- 2004, shows that there was a progressive decline of *people in the younger age group (0-14 years)* - from 26.3% in 1950 to 14.1% in 2004 (-12.2%) (tab. 2.1).

Tab. 2.1. ITALY, Population by Age Group and Gender (%)

Year	0-14			15-34			35-64			65-74			>75		
	M	F	T	M	F	T	M	F	T	M	F	T	M	F	T
1950	27.6	25.1	26.3	31.6	30.9	31.3	33.1	35.1	34.1	5.2	6.0	5.6	2.5	2.9	2.7
1960	25.8	23.7	24.7	31.7	30.1	30.9	34.3	35.6	35.0	5.4	6.9	6.1	2.8	3.7	3.3
1970	25.7	23.4	24.5	29.3	27.7	28.5	35.6	36.3	36.0	6.2	7.7	6.9	3.2	4.9	4.1
1980	23.4	21.1	22.2	30.1	28.1	29.1	35.2	35.7	35.5	7.6	9.2	8.4	3.7	5.9	4.8
1990	17.6	15.8	16.7	32.6	29.9	31.2	37.7	37.4	37.6	7.2	9.0	8.1	4.9	7.9	6.4
1995	15.8	14.1	14.9	32.0	29.2	30.6	38.7	38.0	38.4	9.0	10.9	9.9	4.5	7.8	6.2
2000	15.0	13.5	14.2	29.2	26.5	27.8	40.8	39.6	40.2	9.3	11.0	10,2	5.5	9.3	7,6
2004	14.9	13.3	14.1	26.3	23.9	25.1	42.1	40.6	41.3	9.8	11.0	10.5	6.8	11.1	9.0

United Nation Secretariat 2002; ISTAT 2006

Parallel to the decline in the younger age class was an increase in all the other age classes, and particularly among the *older ones*. The increase of elderly people was definitely greater among women than among the male population, as was the case for all the Europeans countries. The *old age rate,* which indicates the percentage of people over 65 years over the total population, supports the evidence of the noticeable ageing of Italians after the Second World War. During the period 1950-2000 the population over 65 years definitively increased, reaching about 20% of the total population on average. If the old age rate is related to gender, the percentage of the female population over 65 progressively increases during the period 1950-2004 from 8.9% to 22.1% (tab 2.2) while the increase of male population over 65 years on all the male population remained comparatively lower: from 7.7 to 16.6 (United Nation Secretariat, 2002 and ISTAT 2006).

Tab. 2.2. Italy Old Age Rate by Gender
(Old age rate = >65/total pop. x 100)

	1950		**2004**	
	Males	Females	Males	Females
Italy	7.7	8.9	16.6	22.1

United Nation Secretariat 2002 *& ISTAT 2006*

Starting from the 1980s, the main demographic indicators tended to progressively change the traditional image of Italy as a country with high rates of birth and marriage as well as emigration. Since the 1970s, the *average number of children per woman* decreased, being 2.41 in 1961, and 1.29 in 2000 (Istat 2005). As a whole, as to the total *birth rate* – i.e. number of live births/total population - Italy scored among the lowest in Europe. From 1960 to 2004, the total birth rate decreased in Italy from 18.4 to 9.4 (about 50%). Compared with 1980, in 1999 there was a decrease in the birth rate of 36% in the South (from 2.2 to 1.4 children per woman), 22% in the North (from 1.35 to 1.05) and 35% in the Centre (from 1.49 to 1.10) and there was an increase in the average age for the first child which was 28.5 in 1998.

Life expectancy at birth has definitively increased during the past 40 years. Thus, a female born in 2004 may expect to live more than 82 years of age, and a male almost 77 years. In other terms, there was a higher life expectancy among women than among men: on average, the former expected to live 5.9 years longer than the latter (tab.2.3).

Tab. 2.3. Italy. Life Expectancy at Birth by Gender

	1950		**2002**	
	Males	Females	Males	Females
Italy	67.2	72.3	76.9	82.6

ISTAT 2006

Structural economical modifications occurred as to the percentage of *employment* by sector that in 2004 was 4.4% in agriculture, 30.7% in industry and 64.9% in the tertiary sector (tab 2.4).

Tab. 2.4 Italy: Percentage of Employment by Sector.

	1971	1981	1991	2004
Agriculture	20.1	13.3	8.4	4.4
Industry	39.5	37.2	32.0	30.7
Tertiary sector	40.4	49.5	59.6	64.9

ISTAT 2005

The labour force is defined as the percentage of the population potentially wage-earning on the total population. In 1960 Italy had 43.9 of labour force that decreased to 42.2 in 2004, the lowest value in Europe. (ISTAT 2005).

Also the total *unemployment* rate (as percentage of labour force) in Italy was the highest among all the western European countries both in the 1960s (5.5%) and in 2004 (8.1)

As far as *migration* is concerned in the period 1990-2005, there was a wave of *immigration*, mainly from Morocco, Albania, Philippines and Eastern Europe. A recent estimate report confirmed that immigrants reached the amount of at least 1,600,000 people (Caritas, 2004).

The average level of *education* has increased in the last 40 years (see tab 2.7). In 1951, people with a secondary degree were 9.2% of total population, while in 2004 they were 62.9%. However, the percentage of the population with a tertiary level of education was rather low: 1.0% in 1951 and 8.6% in 2004 (ISTAT, 2005). According to the classification of “Key Data on Education in the European Union, 1997”, data related to the different levels of education were aggregated on three levels: (1) basic education, such as Elementary or Primary or Mandatory school; (2) Secondary education; (3) Tertiary education, or University degree.

Tab. 2.5. Level of Education of Italian Population (%) 1951-2004

	Level of education					
	1951	**1961**	**1971**	**1981**	**1991**	**2004**
Primary	89.8	84.8	76.6	61.9	46.9	28.5
Secondary	9.2	13.9	21.6	35.3	49.3	62.9
Tertiary	1.0	1.3	1.8	2.8	3.8	8.6

ISTAT, 2004

As a general *conclusion about the demographics of Italy,* from the aforementioned data it is evident that Italy has become older than ever. This is indeed characteristic of all Western industrialised countries that will certainly become even older in the future. Older people, and particularly older women who outnumber older men, constitute an increasingly important part of the population, and is reinforced by the increasing diminution of births and younger individuals. This demographic phenomenon creates the ground for a special attention to alcohol drinking patterns across the entire life course.

The other striking phenomenon is that women tend to have less children, and at an older age. If we connect this with the fact that somehow women now make up a greater part of the labour force than before, we might infer that a certain decrease in gender difference in alcohol use may be explained by the reduction of family members and their structural changes.

Finally, even if at a lower pace than North European countries, Italy in the last 50 years has increased its level of education.

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3. ALCOHOL PRODUCTION
(Daniele Rossi – Simona Anav)

Alcohol plays an important economic role in Italy. Together with France and Spain, Italy accounts for approximately 50% of world and 84% of European Union wine production (European Commission 2006). In 1995, the global volume of business connected to the production and trade of alcoholic beverages was 1.3% of the gross national product, and 9% of the cultivable land was used for grape-growing. At that time, the national budget, in general, showed a heavy loss, except for tourism, wine exports, and a few other activities (ISTAT, 1996). In the year 2000, the land used for grape growing decreased to 5.4% of the whole "usable agricultural surface". This fall was limited by the increased land dedicated to growing grapes for the production of DOC wines (+17.4% compared to 1990.) During the last decade, land used for growing other kinds of wines and table grapes has decreased by 36%.

The following tables, revised from the publication by "Commissione Mista del Gruppo Epidemiologico della Società Italiana di Alcologia, 1999," show the production of wine, beer and spirits (1985-2003) according to statistics from different international agencies (ISTAT, Italian Ministry of Agriculture, Eurostat, Office International de la Vigne et du Vin, Food and Agriculture Organization, Brewers Association of Canada and World Drink Trends). These numbers show some differences according to the source of data collection indicated in tab 3.1, 3.2 and 3.3. Such dissimilarities are especially remarkable as to spirit production.

Tab. 3.1 Wine Production (‘000hl per year) in Italy (1985-2003)

YEAR	AGENCIES						
	ISTAT (1)	MPA (2)	EUROSTAT (3)	OIV (4)	FAO (5)	BREWERS (6)	PVGD (7)
1985	62,340	61,690	60,760	*	62,340	63,340	83,959 (1980)
1988	61,010	60,360	60,360	*	61,010	61,010	*
1991	59,788	59,328	59,328	59,788	59,790	59,788	59,788
1994	56,717	58,776	58,776	*	59,280	59,277	59,276
1998	54,218	57,112	57,220	*	57,140	57,900	54,188
2003	52,300	56,200	56,115	56,300	48,086	56,800	51,620

* Data not available
(1) Istat 2) Italian Ministry of Agriculture (3) Eurostat
(4) Office International de la Vigne et du Vin (5) Food and Agriculture Organization, 2004 (6) Brewers Association of Canada (7) Produktshap Voor Gestilleerde Dranken

Tab. 3.2 Beer Production (000hl per year) in Italy (1985-2003)

YEAR	AGENCIES				
	ISTAT (1)	ASSOBIRRA (2)	FAO (3)	BREWERS (4)	PVGD (5)
1985	10,381	10,318	10,380	10,316	8,569 (1980)
1988	11,589	11,253	11,590	11,253	*
1991	11,049	11,827	11,050	11,827	10,699
1994	10,258	12,098	10,260	12,098	12,098
1998	11,200	12,193	11,073	12,193	12,193
2003	12,800	13,673	11,800	13,673	13,673

* Data not available
(1) Istat (2) Brewers Association of Italy (3) Food and Agriculture Organization
(4) Brewers Association of Canada (5) Produktshap Voor Gestilleerde Dranken

Tab 3.3 Spirits Production ('000hl per year) in Italy (1985-2003)

	AGENCIES		
YEAR	**ISTAT (1)**	**MF (2)**	**FAO (3)**
1985	2,532	1,076	5,910
1988	1,757	938	7,140
1991	1,322	960	3,020
1994	1,325	933	2,060
2003	1,089	820	1,430

(1) Istat (2) Italian Ministry of Finance (3) Food and Agriculture Organisation

In 1980, wine production was 87 million hectolitres per year. In 1998, it had decreased to 54 million hectolitres, about 65 percent of the 1980 production level. At that time, Italy was the largest wine producer in the world (World Drinks Trends, 1999.) Then, in 1999, France became the first producer in the world (60 mln. hl., Italy 58) and Italy continued being second ranking with 51.6 million hectolitres in 2000 (World Drink Trends, 2004). The increase in beer production went on till the beginning of the last decade, at which time the annual beer production became stable around 12 millions hl.

In 1975, beer production was 6.5 million hl.; in 1985, it was 10.3 million hl. In the period 1990-2000, it increased to between 11 and 12 million hl. per year. In 2003, it grew to 13,673, but decreased in 2004 to 13,170 million hl. In 2005, there were still 7 brewing companies operating 16 breweries in Italy. Of all the beer produced in Italy in 2004, the majority (76.4%) was sold in glass bottles, 14.3% in draught and 9.3% in cans.

In 1975, the amount of imported beer was 0.7 million hectolitres. In 1985, 2.2 million hectolitres were imported, and in 1995 3.0 million hectolitres. This means that in 1995, a fifth of beer consumption in Italy consisted of imported beer. In 1999, Italy imported 3.8 million hectolitres and the increasing trend continued, since the figures for 2003 indicated an importation of 4.7 million hectolitres. Furthermore, a number of foreign beers were produced in Italy under license.

Different sources gave remarkably different figures for spirits production. The figure for 1985 given by the Ministry of Finance, was 1.1 million hectolitres, the one given by Italian National Institute of Statistics 2.5 million hectolitres, and that by Food and Agriculture Organisation (FAO) 5.9 million hectolitres (Commissione mista Società Italiana di Alcologia, 1999). According to all these sources, the production of spirits was lower in the mid-1990s than in the mid-1980s.

From 1985 to 2003, there was a reduction in the land area allocated to grape growing, resulting in a subsequent drop in wine production (see tab. 3.1.) Simultaneously, the production of spirits strongly decreased (see tab. 3.3). On the contrary, during this period, beer production showed a slight increase (see tab. 3.2). This strong decrease in wine production also affected the vineyards, the structures of transformation and those for commercialisation. The reduction in the number of vineyards between 1992 and 2003 was noticeable, almost by 50% (see tab. 3.1.4). Thus, over a period of 20 years, the cultivation of vine was abandoned by half of the farms.

Tab 3.1.4. Number of Vineyards and Hectares of Surface Cultivated (1982-2003)

	1982 *	1990 °	1992 *	1996 °	2003**	Difference 1982\2003
Vineyards	1,617,473	1,188,315	1,098,315	817,802	790,000	- 827,473 (-48,8%)
Surface (hectares)	1,181,942	925,563	861, 400	860,018	820,000	- 361,942 (-69,4%)

*Allamani, et al, 1995

° ISTAT, 1999

** Federalimentare, 2004

The decrease in grape production resulted in a large reduction in the number of working vineyards, especially in small mixed farming businesses and in fringe areas. In these areas, the reduction of vineyards preceded and often determined the definite collapse of the traditional family-run

business which still held out in the 1980s. In many cases, this represented the main cause of environmental impoverishment of hilly areas that could not exploit alternative resources.

This aspect has been overlapped by re-structuring and specialisation, adopted by professional vine-growers who have been more willing to use increasingly competitive and modern techniques. It is also due to this reason that the contraction in wine business has not determined, in general, a technical degradation of production.

During the 1990s, 100,000 positions completely disappeared in the wine industry. Especially in central Italy, the disappearance of many co-operative wine producers contributed to the dispersion of technological skills developed through public funding (Allamani, Cipriani, Cottino, et al 1995).

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4. ALCOHOL CONSUMPTION
(Fabio Voller – Francesco Cipriani)

4.1. Sources

The sources for the analysis of alcohol drinking patterns in Italy are several: (1) Istat (National Institute of Statistics): Food Balance Sheets; (2) Istat: Household Consumption Survey; (3) Istat: National Health and Use of Health Service Surveys; (4) Istat: Multi Purpose Survey on Households: Lifestyle Aspects; (5) INRAN: (National Institute of Nutrition); (6) Permanent Observatory on Youth and Alcohol (Osservatorio Permanente sui Giovani e l'Alcool); (7) "Ad Hoc" Surveys; (8) Studies where Investigations on Alcohol Drinking is a Secondary Aim; (9) Marketing Surveys.

(1) ISTAT (National Institute of Statistics): Food Balance Sheets.

Food balance sheets represent only the average supply available to the population as a whole.

The annual per capita food supply is calculated as:

$$\text{Supply} = \frac{P + (I - E) - OU + (S1 - S2)}{POP}$$

where: P= production, I= imports, E= exports; OU = other uses and wastes, that refers to commodities used for manufacturing for non-food purposes and to wastes occurring at any level between production and household (losses before and during harvest and household wastes are excluded); (S1 – S2) = difference between opening and closing stocks; POP= present population, in which nationals living abroad and tourists are excluded, foreigners living in the country are included.

(2) ISTAT: Household Consumption Survey

ISTAT - Household Consumption Survey, is an annual survey started on a regular basis in 1968 and carried out on an average of 35,000 families, randomly selected from a representative sample of national Municipalities. Families record expenditures for any goods, during selected weeks/years covering seasonal variability, in a self-administered questionnaire. Until 1996, weight of food and beverages, as well as socio-economic information of the head of the family were also indicated. From 1985, a specific diary has been devoted to record self-made and home-made products. Indeed in 1986, ISTAT estimated that 30% of the whole wine consumption by *rural* families was home-made wine; in the urban context, this kind of consumption was supposed to decrease remarkably.

ISTAT publishes only wine per capita consumption according to regions and selected characteristics of the families (number of family members, age and occupation of the head of the family). Beer and spirits intake data are available on specific request from ISTAT, but they are underestimated because consumption outside of the household is not recorded. Moreover, since food consumption is collected at the family group level, no individual data is available.

(3) ISTAT: National Health and Use of Health Service Surveys

ISTAT - National Health and Use of Health Service Surveys were carried out in 1980, 1983, 1986, 1990-1991, 1994 and in 1999-2000. Unfortunately, individual drinking habits were only considered in 1983, when 31,400 families were sampled and wine habits were assessed according to the pre-coded categories of: “not consumer” (abstainer or ex drinkers not specified), “less than $^1/_2$ of litre per day”, “from $^1/_2$ to less than 1”, “over 1 litre”, “not indicated”. Beer intake was drawn from: “not consumer”, “yes”, “yes – but only in the summer” “not indicated”. Spirits were not recorded.

(4) ISTAT: Multi- Purpose Survey on Households: Lifestyle Aspects

Since 1993, an annual survey has been carried out on a national sample of 20,000 families.

Wine and beer habits were investigated through a self-administrated questionnaire filled-in by a population sample of individuals over 14 years of age, according to six pre-coded categories: (a) “I don’t’ drink”, (b)“only by season”, (c)“more rarely”, (d)“1-2 *glasses* per day (less than 1\2 litres per day)”, (e)“from 1/2 to 1 litre per day”, (f)“over 1 litre”.

Categories for spirits and aperitifs were: (a)“I don’t drink”, (b)“occasionally”, (c)“more rarely”, (d)“1 –2 *glasses* per week”, (e)“1-2 *glasses* per day”, (f)“more than 2 *glasses* per day”.

In 1996, attempts were made to modify this questionnaire by including multiple-choice answers similar to those of the ISTAT - National Health and Use of Health Service 1983 Survey, but the data was never published. Since 1998, the information on the consumption of alcoholic cocktails, bitters and of spirits has been gathered by means of the consumption categories of (a)“none”, (b)“only on special occasions”, (c)“very rarely”, (d)“a few glasses a week”, (e)“1-2 glasses a day”, (f)“more than 2 glasses a day”. Age and regional and socio-demographic variables were considered.

In 2005, the questionnaire was modified for wine and beer habits including the number of glasses drunk per day. Only for 2005 was it possible to calculate the amount of teetotallers and the overall amount of grams consumed.

(5) INRAN (National Institute of Nutrition)

In 1980-1984 and 1996, two national nutritional surveys were carried out on a sample of 10,000 Italians from 9 out of 20 Italian regions. Among other dietary variables, wine, beer and spirit intake were collected through the diary method.

(6) Permanent Observatory on Youth and Alcohol

The Osservatorio Permanente sui Giovani e l’Alcool (Permanent Observatory on Youth and Alcohol), established in 1991 is an association

whose activities are driven by a multi-cultural Scientific Laboratory and supported by an Institutional Laboratory which includes representatives of some Ministries (Education, Health, Social Affairs, Industry, Agriculture). Since 1991, it has already carried out 5 national surveys on a sample of about 2000 people over 14 years of age, through professional interviews, regarding lifestyles and patterns of alcohol consumption in Italy. Monographic studies on the behaviour of consumption of young people, women and risky groups were also published (Osservatorio Permanente Giovani e Alcool, 1994-1995, 1997-1998, 2001, 2004, 2006).

(7) "Ad Hoc" Surveys

Several cross-sectional studies of alcohol consumption patterns in local populations have been carried out in the northern, central and southern part of the country. A review of some of these studied was published in 1993 (Cipriani and Innocenti, 1993).

(8) Studies Where Investigations on Alcohol Drinking is a Secondary Aim

Some population-based case-control and cohort studies about diet habits and chronic diseases have collected information on alcohol intake. But, as questionnaires differed according to the different studies, results are not comparable. A review of some of these studies was published by Commissione Mista della Società Italiana di Alcologia, 1999.

(9) Marketing Surveys

Marketing service agencies (Nielsen, Doxa, Demoscopea, Eurisko) are used to monitor the items purchased and the preferences for different commodities – among them alcohol beverages - in significant samples of Italian families.

4.2. Consumption of Alcohol Beverages

The amount of *wine* consumption in Italy had regularly increased throughout the 1950s and 1960s, reaching a peak in 1971, when the amount consumed was estimated to be 112.7 lt./per capita/year. Then a progressive

downward trend started, with a drop to 45.7 litres per capita (1960-2005: -55.1%) Still in the early 2000s, wine accounted for 72% of the overall consumption in terms of grams of pure alcohol intake (table 4.1).

In the same period *beer* consumption, which in 2003 represented 21.5% of the total pure alcohol intake, increased almost five fold (from 6.1 in 1961 to 29. 7 litres per capita in 2005) and *spirits* decreased by 25% (from 1.2 in 1961 to 0.9 in 2005) representing 0.5% of the total pure alcohol intake.

The overall alcohol consumption fell by 40% during the period 1960-2003, from 12.3 in 1961 to 6.9 in 2005, accounting for the highest worldwide drop in alcohol drinking (Productschap voor Gedistilleerde Dranken (2005; Osservatorio Permanente Giovani e Alcool, 2007). This decrease was also evident in other wine-producing countries in Europe.

Tab. 4.1 Italy: Per Capita Consumption (1881 - 2005)

Year	Spirits litres (40% alcohol)	Beer litres * (5% alcohol)	Wine litres (11% alcohol)	Total litres of pure alcohol
1881	1,7	0,8	95,2	**13,3**
1891	1,2	0,6	93,4	**12,8**
1901	1,3	0,8	114,2	**15,5**
1911	0,3	2,1	127,0	**15,4**
1921	0,7	3,6	111,1	**13,8**
1931	0,2	1,1	90,7	**11,8**
1940	0,2	1,4	84,2	**10,3**
1961	1,2	6,1	108,2	**12,3**
1971	1,8	11,0	112,7	**13,6**
1981	1,4	17,9	86,2	**11,8**
1991	1,0	24,9	61,5	**9,0**
1997	1,5	25,4	53,5	**7,8**
1998	1,4	26,9	52,0	**7,7**
1999	1,3	27,1	51,5	**7,6**
2000	1,2	28,1	51,0	**7,7**
2001	1,1	28,9	50,0	**7,4**
2002	0,9	28,2	51,0	**7,4**
2003	0.8	30.1	50.5	**7.4**
2004	0.9	29.6	48.3	**7.2**
2005	0.9	29.7	45.7	**6.9**

Sources:

1881-1941 Cottino & Morgan, 1985

1961-1991 World Drink Trends, 1998

1997-2005 Osservatorio Permanente sui Giovani e l'Alcool, 2007

According to a national survey in 2005, 18.6% (9.3 million) Italians over 14 years of age were teetotallers; 13.0% (6.5 million) were occasional drinkers, and 68.5% (34.5 million) were regular consumers, with males drinking less than 40 grams of pure alcohol per day and females less than 20 grams (Osservatorio Permanente sui Giovani e l'Alcool, 2006; see also Cipriani, Landucci, Voller, 1999.) While the total number of consumers in Italy increased between 1994 and 2005 from 35.2 to 41 million people (Tab. 4.2 and 4.3), the average per capita quantity of alcohol consumed per day decreased (ISTAT, 2004-2005; Osservatorio di Epidemiologia ARS, 2005; Osservatorio Permanente Giovani e Alcool 2006).

Independently from the data source and of the geographic area, *males* consume on the average about three times more alcohol than *females.* However during the last 12 years, women have increased their consumption, especially the occasionally consuming ones. Also the share of abstainers is higher among females.

According to different ISTAT surveys, between 20% and 30% of 15-75 year old Italians are presently *non-drinkers,* while about one half consumes up to 30 grams of alcohol/day , and about 15-20% drink more than 30 grams/day if male and 20 if female, i.e. being 'drinkers at risk'. Heavy drinkers, who consume more than 80 grams/day, make up about 5%. The Osservatorio Permanente sui Giovani e l'Alcool reported that *non drinkers* (last three months) were 15% among men and 30.2% among women in 1997; 11.8 and 26.8% respectively in 2000 and 6.8% and 29.3% in 2005. However among *youngsters,* the gender difference in drinking amount is decreasing (Osservatorio Permanente Giovani e Alcool, 1998, 2000, 2006).

As to *age,* the 2006 national survey carried out by Osservatorio Permanente sui Giovani e l'Alcool showed that the percentages of both regular and occasional consumers were very similar in all the age groups, with a peak between 24 and 34 years of age and a sharp fall after 54 years of age. Compared to the 2000 survey, young consumers between 15 and 24 years showed an increase from 77% to 79%. A sharper increase was reported by the 25-34 year olds (from 80% to 88%) while all the other age groups were steady or slightly increasing (Osservatorio Permanente Giovani e Alcool 2000 and 2006).

According to the same survey, in 2005 20.4% of young Italians aged

between 13 and 24 were non drinkers; in the same age group 21.7% of alcohol consumers (mostly drinking beverages other than wine) "had drunk a bit too much without getting totally drunk" at least once over the preceding three months and 9.5% got drunk. The highest percentage of people who experienced drunkenness at least once in the last three months was found in the 25-34 year olds (13.9%) (Osservatorio Permanente Giovani e Alcool, 2006).

Table 4.2. PROFILE OF THE ITALIAN CONSUMER OF ALCOHOLIC BEVERAGES *in 2000 and in 2005*

2000	
❖ **Italian population over 14**	**49,400,000 (100%)**
❖ **Abstainers**	**9.800.000 (19.6%)**
❖ **Consumers of alcoholic beverages** of which:	**39.600.000 (80.4%)**
❖ ***Regular (at least 1 glass in the last week)***	***32.200.000 (65.4%)***
❖ ***Occasional (at least 1 glass in the last 3 months)***	***7.400.000 (15.0%)***
Alcoholics	**316,000 (0.8% out of the consumers)**
Estimates of Osservatorio from at least 3 positive answers on CAGE psychiatric test	
(Source: Osservatorio, 2000)	
2005	
❖ **Italian population over 14**	**50,476,025 (100%)**
❖ **Abstainers**	**9,300,000 (18.6%)**
❖ **Consumers of alcoholic beverages** of which:	**41,138,000 (81.5%)**
❖ ***Regular (at least 1 glass in the last week)***	***3,.576,000 (68.5%)***
❖ ***Occasional (at least 1 glass in the last 3 months)***	***6,562,000 (13.0%)***
❖ **Alcoholics**	***781,600 (1.9% out of the consumers***)
Estimates of Osservatorio from at least 3 positive answers on CAGE psychiatric test	
(Source: Osservatorio, 2006)	

A *regional* variability of alcohol drinking has always been evident in Italy, with a decreasing North-South geographical decreasing trend. For example, dividing the country in the 4 main macro-regions in the 1996 ISTAT family survey, central regions scored highest (21 grams/per capita/per day), followed by north-western (19 grams), north-eastern (17 grams) and southern regions (15 grams) respectively. According to ISTAT (household surveys), in the period 1981-1996 wine consumption decreased by 45% in North-east, 41% in North-West, 34% in central Italy and 38% in southern Italy. In the same areas in 1991, the wine intake represented respectively 84%, 81%, 86% and 76% of the overall pure alcohol consumption (Beer: 5%, 7%, 4%, 9%; Liquors: 11%, 12%, 10%, 15%).

According to the 2005 national survey of the Osservatorio Permanente sui Giovani e l'Alcool (Osservatorio Permanente Giovani e Alcool, 2006) geographic differences, once much more marked than today, are still present (Tabs. 4.3, 4.4, 4.5). Alcohol consumers in North West and North East (82%) as well as in the Centre (81%) were slightly more than in the South (78%) which has always been a more "temperate" area. North East had the highest percentage of regular drinkers (72%), more than Central and Southern areas (64%) and also than North West (69%), but also the lowest presence of occasional consumers (9%), while occasional consumption seemed to be more widespread in the Centre (18%) followed by South (14%) and North West (13%). North East showed a noticeable increase of regular consumers (+2.6 in 5 years) but also a decrease of the occasional consumers (from 11.5% in 2000 to 9% in 2005). Central Italy was the only area where occasional consumers increased (from 17% to 18% in 5 years), compared to a slight increase in the number of regular consumers (from 63.2% to 64%).

Tab. 4.3 – Alcohol Consumers in Italy, 2005. Breakdown by Beverage and Geographic Area (last 3 months before the interview)

	North West	North East	Centre	South and Islands
Non consumers	18%	19%	18%	22%
Consumers	82%	81%	82%	78%
Beer	58.5%	57.8%	48.2%	55.3%
Wine	71.5%	73.8%	69.3%	61.7%
Aperitifs/Digestives	36.4%	33.5%	29.3%	32.6%
Spirits	25.3%	28.6%	29.2%	24.7%

Osservatorio Permanente Giovani e Alcool, 2006

Tab. 4.4. – Alcohol Consumers in Italy, 2005. Breakdown by Frequency of Consumption and Geographic Area - (last 3 months before the interview)

	North West	North East	Centre	South and Islands
Non consumers	18%	19%	18%	22%
Occasional Consumers	13%	9%	18%	14%
Regular consumers	69%	72%	64%	64%

Osservatorio Permanente Giovani e Alcool 2006

4.2.5. Alcohol Consumers in Italy, 2005. Differences in Frequency of Alcohol Consumption 2000-2005. *Breakdown by Geographic Area*

	Regular Consumers	Occasional Consumers	Total Consumers
North West	+2.5	-2.0	+0.5
North East	+2.6	-2.5	+0.1
Centre	+0.8	+1.0	+1.8
South and Islands	+0.5	-1.7	-1.2

Osservatorio Permanente Giovani e Alcool 2006

4.3. Prevalence of Alcohol Dependency

No survey is available to provide an estimate of the number of alcoholics; according to a commonplace estimate - they are about 1-3% of the adult population. In the national surveys carried out by the Osservatorio, the psychiatric test CAGE was administrated to the interviewees. It enabled the detection of individuals potentially at risk of alcohol addiction or alcohol-related problems. The results of the 2005 survey revealed that, compared to the 2000 edition, the number of people who gave 3 or more positive answers to the four questions of the CAGE test increased from 0.8% to 1.9% out of all the consumers. Such an increase followed a period of continuous decline and could partly be due to a different attitude of the respondents towards the alcohol related issues about which people nowadays are more willing to speak. In any case, the reverse trend should be analysed carefully especially with regards to the 45-54 years olds, who showed the highest value (3.6%), while the age group 25-34 seemed to be the most sober (0.3%). (Osservatorio Permanente Giovani e Alcool, 2000, 2006). Differences between the genders were strong: on a total percentage of 1.9% men represented 3.1%, while women accounted only for 0.6%. Southern and Insular areas showed the highest percentage of people who gave 3 or more positive answers (3.2%), followed by North West (1.4%), Centre (1.2% but only for 3 positive answers) and North East (1.1%).

Another evaluation done by the Osservatorio su Fumo, Alcol e Droga of the Istituto Superiore di Sanità (Scafato, 2005) in the ISTAT national survey conducted in 2000, consistently estimated that the number of alcoholics were 1 million, approximately 2% of general population.

According to a study on 4 samples of adults in four different Italian macro-regions, about 10% said that they knew somebody with alcohol problems and 5% said that a member of their family had alcohol problems (Beccaria & Allamani, 2007).

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5. DRINKING PATTERNS
(Allaman Allamani)

In Italy, *wine* has been always a large part of the total alcohol intake. In 1965, it was 85% of the total amount of alcohol which is drunk, while in the 2000s, it has still equalled more than 70% (see Chapter IV). It is considered as being an ingredient of the diet and is commonly drunk everyday.

Drinking wine daily *at home*, *at the table during meals with the family* is a deep-rooted "wet" Mediterranean pattern. Wine is also often drunk at friends' homes and in restaurants, trattorias and pizzerias. According to a few national surveys, wine was drunk during meals at home by 89.1% of interviewees in 1994, 83.5% in 2000 and 84.6% in 2005; at restaurants and pizzerias by 19.6% in 1994, 24.4% in 2000 and 39.6% in 2005 (Osservatorio Permanente Giovani e Alcool, 1998, 2000, 2006).

The reduction in the overall wine consumption during the last 30 years has been partly compensated for by an increase of more expensive high-quality wines, and to a minor extent by sparkling wines, often drunk on special *occasions* (meeting friends, enjoying a special dinner) and even *outside of mealtimes*. In general, there has been a notable decrease in drinking wine at lunchtime. Contemporarily, there has been a clear growth in beer consumption, especially among *young people* and particularly during the 1970s and the 1980s.

Beer in the past was traditionally drunk *at home* or *in bars* and more frequently during the warm season to quench one's thirst. Since the 1970's, its consumption has steadily increased especially among young people. This group drinks it with their peers and family members, at *restaurants* when eating pizzas, as well as with their friends outside of meals. In 2005, beer represented about 21.5% of the total alcohol drunk (see chapter IV).

Spirits (which in 2005 made up 5.2% of the total alcohol intake) are drunk occasionally *at friends' homes* or *in bars* and *pubs,* as well as together with friends *after meals* in upper classes of urban areas. Sweet liquors and digestives are more often drunk by people of the lower classes and by women.

Independently from the data source and geographic area, *males* consume on the average about three times more alcohol than *females*. However, since the number of women who drink alcohol beverages tends to go up, women are partly responsible for the increased number of consumers (see Chapter IV). Compared to the period ranging from the 1960s until the 1980s, in the 2000s, many more women have been drinking alcoholic beverages (ISTAT, 2005), since they take part more and more in social life: they go to the cinema, eat at restaurants, work outside of the home, meet friends, join political or cultural associations. In short, they live more outside of the home and family sphere which gives them more availability to money and occasions for consumption.

To sum up an evolutionary country pattern profile, while Italians frequently taste wine in their childhood during some celebration or meal (Allamani, Basetti Sani,Voller et al, 2003), they begin drinking at *a young age (10-14 years of age),* often consuming small amounts of wine during meals at home. During the *adolescence period (14-19 years of age*) beer intake increases, and wine intake decreases, presumably as a reactive behaviour to family rules. However, getting a job, marrying and having a baby are again associated with preferences for the traditional wine drinking pattern, while alcohol consumption peaks in the second part of life (Osservatorio di Epidemiologia ARS, 2005, p 32-33). In the 18-20 year old age group, drinking increases regularly with age for men, while a little bit later for women; drinkers drink more, and more teetotallers become drinkers.

According to some studies in the year 2000, 41% of Italian 15-19 old year students were *drunk* during the last 12 months at least once, and 5.9% 10 or more times (ESPAD 2004). Other research documented that in 2005, 9.5% of young Italian alcohol consumers (mostly drinking beverages other than wine) aged between 13 and 24 had got drunk at least once over the preceding three months (Osservatorio Permanente Giovani e Alcool, 2006). Such figures were, in any case, quite lower than in other European countries like England, Denmark and Greenland (HBSC 2004). However they revealed that new drinking behaviors, such as *binge drinking,* "imported" from northern Europe gained a certain success among

Italian young people: 10.4% of the young drinkers between 13 and 24 years of age reported binge drinking at least once in 3 months, while 2.8% reported doing so more than twice. The highest percentage of binge drinkers was in the 16-19 age group (4.3% more than twice in three months) and among men (4.9% more than twice, 9.7% at least once or twice). as reported by the Osservatorio Permanente Giovani e Alcool in 2006.

As to *regional differences,* it is more common to drink spirits and to drink outside of meals in Italy's northern regions, whose economy is based on industry, rather than in the southern regions, where drinking wine at meals is more diffused and where a rural economy is still present.

Socio-economic conditions, largely related to family transmission of cultural values, influence people's alcohol consumption habits. Those from the lower social classes tend to drink cheaper and low-quality wine often bought wholesale or sometimes at country wineries, while upper class consumers drink less but a higher quality wine. Liquors (Whisky, Cognac, Brandy, Gin, and Rum) are more common among the upper classes in urban areas, while spirits distilled from grapes, lemons or tangerines (often home-made) are drunk by the middle and low classes, especially in the North-East and North-West regions. Sweet liquors and digestives ("Amari") are drunk particularly among lower social classes and among women who are more inclined than men to make singular alcoholic choices(see Allamani Bloomfield et al, 2000).

Bars and cafés, often opened until late at night, usually allowing the sales of alcoholic beverages, have undergone some changes since the 1980s, providing a context in which a mixed clientele can socialise, while sitting and talking at a table. The types of drinks sold have ranged from mineral water to coffee, ice- cream based, soft and long drinks, spirits, wines and beer. A cake or other light food can also be consumed. The number of places selling alcoholic beverages on premises in Italy amounted to 251, 452 in 2004. This number included Restaurants, Pizzerias, Bars and Coffee Houses, Pubs, Discotheques and others (see Chapter VII).

While according to old rural tradition, *offering* wine to any male visitor was mandatory, in modern times, hospitality has consisted in offering

guests other alcohol beverages as well – e.g. beer, whisky, aperitifs, - or non-alcohol drinks. A freedom of choice has evolved. In connection with nearly all family and social rituals, such as weddings, birthdays, work celebrations, Christmas holidays and special family meetings, wine has been the main beverage drunk, but also champagne and sparkling wines have been consumed (Allamani, Voller et al., 2000).

Drinking alcohol on the *work site* was not infrequent in Italy, at least for men. Some ad hoc studies carried out in central Italy during the 1980s documented that no relationship existed between jobs within a given work site and alcohol consumption. The culture of drinking was more rooted in the country and particularly among agricultural workers and residents of rural areas; here wine was considered as being a drink endowed with positive qualities. Within the industrial sector, the amount of alcoholic beverages drunk among blue collar workers was greater than that among white collar ones Allamani, Cipriani, Innocenti et al., 1988).

Teachers (mainly women) on an average drank less than any other professional. This may have reflected a post-industrial lifestyle attitude towards avoiding potentially unhealthy behaviours, such as drinking alcohol. Craftsmen were more ambivalent: while conforming to a traditional male model of drinking large quantities of alcohol, they also perceived that they had to control or even abstain from alcoholic beverages (Allamani, Cipriani, Gordon et al., 1995).

A drinking pattern is built up on local traditions transmitted during the centuries through generations. A drinking pattern constitutes an informal control of drinking behaviour that may be as or even stronger than formal laws that restrict time and places allowed for drinking (see Chapter I). An *informal control* indicator is the commonplace belief that drinking alcoholic beverages between the main meals, or in the morning, instead of drinking them at mealtimes or in the evening, is a socially deviant behaviour.

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6. ALCOHOL RELATED MORTALITY
(Fabio Voller – Francesco Cipriani)

While Italy still has always been ranked among the top countries for wine production, consequences regarding health and their related social costs have only recently been considered. In particular, the paucity of hospitalisation statistics on alcohol-related diagnoses makes it especially difficult to estimate the morbidity ratio (i.e. patient days due to alcohol related diagnosis/total patient/days) and related direct costs.

In the 1990s a few studies tried to estimate the alcohol-related mortality (ARM) through national mortality statistics. A set of diagnoses causally related to alcohol use and abuse were preliminarily reviewed according to the ICD-9-CM classification system (see table 6.1) (Cipriani et al, 1998).

Alcohol-attributable fractions (AAFs) were estimated for each diagnosis in order to define the proportion of deaths due to alcohol consumption. For each diagnosis, alcohol-related mortality (ARM) is to be calculated by summing up causes of death both directly and indirectly attributable to alcohol. According to this study, overall alcohol-related deaths were 18,003 (males: 12,937; females: 5,096), accounting for 3.3% of all deaths in Italy (males: 4.6%; females: 1.9%). During the 1980-1990 period, ARM decreased by 17% in both sexes (from 51.3 X 100.000 to 42.2 in males; from 18.1 to 15.2 in females). The analysis of liver cirrhosis mortality rates by geographic area indicated that the most relevant etiologic factors were alcohol (mainly among males in Northern Italy) and hepatitis viruses (mainly among females in Southern Italy).

A preliminary study estimating the Italian ARM rates taking into account a broad list of death causes during 1983 –1993 showed that in that period, Italy had experienced a decrease in male ARM (from 78.3 in 1983 to 61.3 in 1993), while the female ARM remained stable (from 318.3 in 1983 to 25.7 in 1993 (Cipriani & Landucci, 1999).

Table 6.1 Alcohol-Related Causes of Death ***classified into causes directly attributable to alcohol (DAA) or indirectly attributable to alcohol (IAA), acute (A) or chronic (C) causes of death, and their own alcohol-attributable fractions (AAFs) expressed as percentages of deaths due to alcohol.***

ICD-IX CODE	DISEASE	AAF	A=Acute C=Chronic	**DAA**
291	Alcoholic psychosis	100	**A**	CAUSES OF DEATH DIRECTLY ATTRIBUTABLE TO ALCOHOL
303	Alcoholic dependence syndrome	100	**A**	
305.0	Nondependent abuse of alcohol	100	**A**	
357.5	Alcoholic polyneuropathy	100	**A**	
425.5	Alcoholic cardiomyopathy	100	**A**	
535.3	Alcoholic gastritis	100	**A**	
571.0	Alcoholic fatty liver	100	**C**	
571.1	Acute alcoholic hepatitis	100	**A**	
571.2	Alcoholic cirrhosis of liver	100	**C**	
571.3	Unspecified alcoholic liver damage	100	**C**	
790.3	Excessive blood level of alcohol	100	**A**	
E860.0,E860.1	Accidental poisoning by ethyl alcohol, not elsewhere specified	100	**A**	
ICD-IX CODE	DISEASE	AAF	A=Acute C=Chronic	**IAA**
140-149	Malignant neoplasm of lip, oral cavity and pharynx	50	**C**	INDIRECTLY ATTRIBUTABLE TO ALCOHOL
150	Malignant neoplasm of oesophagus	75	**C**	
155	Malignant neoplasm of liver and intrahepatic bile ducts	15	**C**	
161	Malignant neoplasm of larynx	50	**C**	
401	Essential hypertension	8	**C**	
430-438	Cerebrovascular diseases	7	**C**	
571.4-571.9	Other non-alcoholic cirrhosis	50	**C**	
780-799	Not clearly defined causes of death	10	**C**	
E800-E999 (*)	Deaths due to injury or poisoning	33	**A**	

Age group: > 35 yr.; E800-E999: all ages
(*) excluding E860.0-.1
(Cipriani & Landucci,1999)

An extensive study accomplished by the Epidemiological Group of the Italian Society of Alcohology collected a wealth of data from national and international sources about alcohol-attributable deaths, as well as of

alcohol preventable deaths (Commissione Mista del Gruppo Epidemiologico della Società Italiana di Alcologia, 1999). As to mortality figures, the same study conservatively estimated that in 1994 deaths attributable to alcohol amounted to about 36,000 persons per year, that is 6.6% of total deaths, while the avoidable deaths amounted to about 7,000, that is 1.3%.of total deaths. Thus the difference may be calculated as 29.000 persons per year, that is 5.3% out of the total deaths.

In 1996, a study was published indicating that alcohol-related mortality in Italy fluctuated between 12,042 (conservative hypothesis) and 15,108 ("middle" hypothesis) deaths (Osservatorio Permanente Giovani e Alcool, 1996). In 2000 the Osservatorio Permanente updated its figures to 11,386 (conservative hypothesis) and 14,352 (middle hypothesis).

According to Scafato, in 2002, deaths attributable to alcohol were between 30,000 and 40,000 per year. In the same year, 6% of all deaths of people under 65 years of age were a crude estimate of mortality attributable to alcohol: 10 % of all cancers, 10 % of all ordinary hospital admissions and 20 % of all hospital emergency admissions were attributed to alcohol (Scafato, 2005).

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7. ALCOHOL ECONOMY AND DISECONOMY
(Daniele Rossi)

7.1. Alcohol Economy

Economic wealth coming from alcohol production and distribution is remarkable (see tab 7.1.1). When the Italian national budget faced a heavy crisis in the '80s, wine export was one of the few active items. Wine production has been decreasing in Italy at least from the late 1970s (Hurst et al., 1997).

Tab 7.1.1. Wealth Deriving from Alcohol Production and Consumption (billion €)

	WINE	SPIRITS	BEER	TOTAL
Intermediate costs	**5.80**	**1.14**	**1.05**	**7.99**
Value added at factors cost ?	1.80	0.74	0.70	3.24
of which:				
Salaries and wages	0.42	0.15	0.24	0.81
Social contributions	0.05	0.06	0.10	0.21
Other revenues and amortizations	1.33	0.53	0.36	2.22
Production at factors cost	**7.60**	**1.88**	**1.75**	**11.23**
Net tax on production (VAT excluded)	-1.13	-0.04	0.50	-0.67
of which:				
Production tax (VAT excluded)	0,01	0,30	0.50	0.81
Contributions to production	1.14	0,34	0.003	1.48
Real production	**6.47**	**1.84**	**2.25**	**10.56**
Import	0.30	0.37	0.50	1.17
of which:				
Import (CIF)	0.27	0.31	0.42	1.00
Import tax (VAT excluded)	0.03	0.06	0.08	0.17
VAT burden on resources	**0.23**	**0.07**	**0.07**	**0.37**
Value of additional services	**2.32**	**0.69**	**0.67**	**3.68**
of which:				
Transport	0.27	0.15	0.15	0.57
Distribution/Retail	2.05	0.54	0.52	3.11
Available resources (at market prices)	**9.32**	**2.97**	**3.49**	**15.78**
Total duties (contributions excluded)	0.23	0,28	0.56	1.07
GDP at market prices	9.09	2.69	2.93	14.71
Value added	8.91	2.40	2.71	**14.02**
Some typical relations				
a) Intermediate costs/production at f.c. of the sector (technical coefficients)	0.85	0.78	0.65	0.80
b) Import coefficients (Import/GDP)	0.03	0.12	0.17	0.07
c) Direct impact on production (I-b)	0.97	0.88	0.83	0.93
d) Total impact (Leontieff coefficients)	4.95	3.24	3.87	**4.33**

(ISTAT 2005, Federalimentare 2006, Input Output 2005)

Wine *production* still represents at factors cost 8 billion Euro, compared to 1.9 of spirits and 1.8 of beer on a total production of alcoholic beverages of 11.2 billion Euro (2005). The whole sector accounts for 15.8 billion Euro at market prices, of which more than one half is due to wine (9.3 billions Euro).

The import/export ratio changes according to the different beverages. Thus wine is the alcoholic beverage that is mainly exported, while spirits and beer import significant and increasing quantities. In 2005, the Italian import in value was 1.2 billion Euro. This amount was due to wine for 0.3, to spirits for 0.4 and to beer for 0.5.

The commercial balance between import and export sees wine in active, while beer and spirits are imported more than exported. In 2005, the balance for beer was –354 billion Euro (it was -321 in 2004) showing an increasing import (412.4 million Euro) and a slight decrease in export (58.5 million. Euro.) Export of wine and special wines reached 3,162 billion Euro in 2005, with an increase of 3.6% compared to 2004, and an active balance of 2,887.8 billion Euro.

In 2005, both import and export of distilled beverages decreased. Import reached 317 million Euro with a decrease of about 2% compared to 2004, while export was 442.8 million Euro with a decrease of almost 6% in one year. Notwithstanding a decreasing trend compared to 2004 (-8.8%,) the balance was still active with 125.8 million Euro.

Distribution and *retailing* of alcoholic beverages, had different values for wine on the one hand and for spirits and beer on the other. Wine distribution reached 2.05 billion Euro (2005 purchasing power) that, if added to 0.27 billion Euro of transport, gets to the total amount of 2.32 billion Euro of additional services. Spirits and beer were at lower levels: the total value of additional services for beer was 0.69, of which 0.15 for transport and 0.54 for distribution. As for spirits, they summed up to 0.52 for distribution and 0.15 for transport for a total value of added services of 0.67 billion Euro.

The coefficients of activation (Leontieff) of the total production of the economic system by the alcohol sector in Italy are very high: 4.95 for wine, 3.24 for spirits and 3.87 for beer. These values indicate the increase in national wealth corresponding to one added unit of demand towards the

three branches of the alcohol sector.

Regarding the number of places in which alcoholic beverages are sold on premises, Italy has shown an unsteady trend. There were 258,000 on premise establishments in 1992, and every year a further reduction was experienced, falling to 210,000 in 1999. Then, after an increase to 228,500 in 2001 and further to 233,500 in 2002, in 2003, a new slight decrease fixed the total at 230,000 on premise establishments. This number included restaurants, pizzerias, "trattorias", restaurants in tourist resorts, hotels or pensions, "fast food" establishments, bars and coffee houses, pubs and discotheques (FIPE Italian Federation of Public Premises, Nielsen, Italian Ministry of Industry, Italian Brewers' Association, 2004).

7.2. Alcohol "Diseconomy"

Alcoholic beverage drinking may induce problems that have not only a social cost, but an economic one as well. The Permanent Observatory on Youth and Alcohol, in collaboration with CENSIS, carried out an analysis of the economic cost which comes from alcohol abuse or alcoholism (see tab. 7.2.1). The analysis took into account the costs of the treatment itself, costs due to sickness or mortality, those due to accidents provoked by the abusers, and the loss of production due to morbidity or mortality of the alcoholics. One of the most interesting results was that the entire alcohol system in Italy produces and consumes wealth by less than 2% of the GNP, thus reinforcing the impression of an overestimation of both alcohol-related economies and diseconomies, respectively estimated as 1.3% and 0.6% of the GNP.

Tab 7.2.1. Estimation of the direct or indirect economic costs due to alcohol abuse
Billions euro on base and mean hypothesis

TYPOLOGIES	HYPOTHESIS	
	BASE	*MEAN*
Direct core costs	**1.34**	**1,49**
Costs referring to alcoholics treatment	**1.34**	1,49
of which: hospitalizations	1,00	1,15
of which: rehabilitation/reinstatement	0,18	0,18
of which: other health services	0,12	0,12
of which: continuous services to handicapped	0,03	0,03
Indirect core costs	**2,88**	**3,20**
Alcoholics morbidity	1,97	2,07
of which: absence from work due to accidents or illness	1,46	1,51
of which: loss of job for chronic infirmity	0,47	0,52
of which: family nursing	0,04	0,05
Alcoholics mortality	0,91	1,13
of which: production loss (employed)	0,91	1,13
Direct related costs	**1,91**	**2,29**
Costs linked to accidents provoked by alcoholics	1,91	2,29
of which: health treatment expenses	0,08	0,10
of which: administrative expenses	0,67	0,80
of which: costs linked to property damages (public and private)	1,17	1,39
Indirect related costs	0,41	0,49
Morbidity of the victims of accidents provoked by alcoholics	0,12	0,15
of which: production loss (employed)	0,12	0,15
Mortality of the victims of accidents provoked by alcholics	0,28	0,34
of which: production loss (employed)	0,28	0,34
TOTAL	**6,54**	**7,47**

(Osservatorio Permanente Giovani e Alcool, 1997)

In 2005, the overall social cost of alcohol abuse summed up to 6.54 billion Euro in the basic hypothesis and to 7.47 billion Euro 2005 in the average hypothesis. In both hypotheses, the primary costs, i.e. those concerning the alcoholic population, were between 64.5% and 63.0% of the total costs. Therefore, costs related to damages provoked by alcoholics in terms of victims or damaged objects were between 35% and 37% out of the total costs (secondary costs). The direct costs, i.e. added burden on the general public due to alcohol abuse, represented just less than 50% of the total costs. The indirect costs, i.e. loss in production due to the mortality

of the alcoholics or of their victims, as well as their temporary or permanent disability, were a very important item: more than 50% of the total (Osservatorio Permanente, 1996 and 2005).

Other studies considered the annual cost of *all* road accidents, which was estimated up to 34,108 billion Euro in 2001 (Scafato, 2006) - 2.5% out of the total Italian GNP. However, it is difficult to evaluate the cost of *alcohol-related* road accidents: if we considered that Censis estimates were between 3 and 4 billion Euro for 2005, than we could argue that alcohol-related accidents were 10% - 12% of the total annual cost of all the road accidents.

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8. ALCOHOL POLICIES
(Allaman Allamani)

8.1. Alcohol Policies in Europe

Changes in alcohol drinking and European national policies during the last 40 years and more generally in the post-world war II period, have been recently well studied at the multi-national level. (Norström 2002; Room 2002; Karlsson, Mäkelä, Mustonen et al., 2005). These studies have concluded that while the role of prevention policy is to control alcohol consumption, the gold-standard prevention model has been one of relatively high taxes and state monopoly, and traditional consumption in Nordic countries, Britain and Ireland. Apparently, the weakening of this model, as with the lowering of alcohol taxation, due "partly to internal pressures for liberalization, but mostly under pressure from the 'single market' ideology of EU" (Room 2005) has lead to an increase in alcohol consumption - as happened in different ways in Nordic countries during the last decades.

On the other hand, the decrease in alcohol consumption in the Mediterranean Latin countries since the 1960s has appeared to have had multiple causes. Examples of these have been urbanisation, industrialisation inside country migration and changes in the family structure. Few prevention policies have been implemented during this period.

Alcohol policies in Europe marked by different approaches have mainly been experienced in Northern countries. By and large, the Northern countries have always been concerned about the harmful consequences of alcohol beverages; thus explaining the wealth of both restriction and prevention programs implemented there. Typically, control over alcohol could be implemented by the State in order to increase taxes and restrictions of production and trade, the licensing system, physical availability, prices and advertising. Measures of public order and health preventive interventions have supposedly been effective as well. Alcohol restrictions in the field of communication – as in advertising and in sponsorships of public events - or warnings about the dangers of alcohol may have had

an indirect impact on alcohol beverage consumption. A stricter control on driving, such as the lower blood alcohol concentration (BAC) limits, if enforced, have appeared to have had an immediate effect on road accidents. In Southern Europe, on the other hand, there has been a rather loose approach to the issue, with scant preventive actions regarding alcohol policies being enforced.

However, control over physical availability by means of restrictions of licenses or business hours and of minimum legal age for accessibility has generally resulted in being poorly accepted by the public (Karlsson, Mäkelä, Mustonen et al., 2005).

The Directives of the European Union have affected most of all advertising and measures of control over some specific aspects of alcoholic beverage sales. New preventive approaches have been promoted by the World Health Organisation. According to the 1992 WHO European Alcohol Action Plan, the population-based approach was considered to be as important as the high-risk approach toward groups at risk. A sustained action at the *community* level was able to influence the perceptions of possible benefits of reduced levels of drinking and therefore has had long-term cultural consequences within the general population. The community was supposed to be a complex system composed of different sectors (Holder 1988). An integrated preventative approach to the various sectors has made public education messages coherent and mutually reinforcing, and has more easily distributed results generated from one sector to another, or subgroups. Examples of sectors have been the following: (a) health and welfare (b) agriculture and food industry (c) education and schools (d) transport/ police and (e) mass media.

WHO Europe has been able to influence both the health professionals' and the politicians' attention towards the alcohol-related risk of patients and of the population at large. An example of the consequences at the country level of the WHO European Alcohol Action Plan was the chapter on alcohol in the Italian National Health Plan 1998-2000.

The alcohol community action research projects experienced in Malmö, Sweden (Larsson, 1990), and Lahti, Finland (Holmila, 1997) should encourage both policy makers and preventive experts to appreciate

the advantages of a “down-top” approach in front of the “top-down” one (i.e. advertising, excise, licensing, business hours). The former ought to be locally oriented as well as interacting with the subjects involved in the alcohol-related issue through community actions and local campaigns.

8.2. Alcohol Policies in Italy

The question of alcohol in Italy was initially raised by the first temperance organisation, *La società di temperanza,* established in Turin in 1863. The Italian Temperance League was founded in 1892, and was particularly concerned with drinking among the urban proletariat. It explicitly demanded measures of control regarding the availability of alcohol and laws against public displays of drunkenness. Two views advanced by the well-known criminologist Lombroso and his followers won the attention of public opinion. The first one stated that alcohol abuse had organic causes and the other that it was strongly correlated with crime. As a result, the definitions of the “alcohol problems” became issues of drunkenness, law and order, that later on, during the Fascist era, was reflected by the Rocco Penal Code (Cottino and Morgan, 1985).

However, the history of the relationship between alcoholic beverages and Italians after World War II and until the 1980s has always been characterised by a passive attitude by the State towards preventive and control policies regarding alcohol. Nearly no norms or laws were approved until the 1980s, while the existing ones were hardly enforced in the context of the Primary Health settings.

During the 1990s a focus on the relevance of communities to attain successful outcomes from preventive interventions begun to be appreciated, due to The World Health Organisation efforts.

A focus on community and local intervention seems to imply the relevance of drinking patterns, and particularly of the Mediterranean drinking pattern, in the area of prevention (Simpura, 1999). In Italy, at the *community level,* the issue of “responsible drinking” seems appropriate for the country’s cultural values. Health professionals should integrate new scientific information about the risk of eccessive alcohol consumption and the

traditional Mediterranean practice of drinking. Interacting with local people, alcohol experts should take community beliefs about alcohol beverages into consideration. Also, it is more effective to have a positive approach, e.g. mentioning advantages from either restraining or not drinking, focusing on the message that "drinking less and better is better", linking consumption alcohol consumption education with healthy eating education programs. Such an approach implies that the health professionals involved in prevention should develop educational competencies.

Programs which act locally should therefore:

(a) approach the entire local population;
(b) support the existing drinking tradition;
(c) link wine drinking to food;
(d) promote the role model of parents and elderly people as informal controllers of wine drinking patterns;
(e) highlight the possible danger of alcohol when drunk over certain limits or when there is a disease, and find prompt solutions if problems are discovered.

On the other hand, a growing concern is arising among both the general public and professionals regarding young people who, especially in the urban context, tend to drink according to the Northern pattern, i.e. outside of meals, and with the search for the psychotropic effects of beer and spirits. Other *groups at risk* are drivers who drive after having drunk alcoholic beverages. Also groups of immigrants who are not integrated into the Italian approach to alcohol may be at serious risk of alcohol-related harm.

Here, a set of effective policy measures either to decrease or abstain need to involve local administrators and police through, e.g.:

(a) the prohibition of selling alcohol beverages near sporting and music events;
(b) frequent ethylometer checks by policemen alongside roads as deterrents against drunk driving;
(c) compulsory courses of information about alcohol-related risks for those who apply for a driving or a bar/restaurant licence.

8.3. Public Opinion in Italy

In Italy, the issue of the alcohol question has been attributed either to the criminal, medical or sociological competence. For a long time, and until today among the public, the idea of an alcohol beverage – mainly wine - essentially is the appreciation for its positive effects, while the concept of alcoholism implies a personal problem related to one's problematic behaviour. On the contrary, the cases both of illicit drug consumption and cigarette smoking, subjects of nation wide educational campaigns, have long been considered social problems in this country. Smoking advertising was prohibited in 1975, and since January 2005, smoking has been forbidden by law in all public spaces in the country; a control effort which has been surprisingly well-implemented.

Among health professional circles, the meaning of an alcohol beverage has moved from a narrow definition, i.e. "alcoholism," which was morally translated into the concept of vicious behaviour, to a broader term as "little alcoholism" sometimes used in the 1960s and 1970s (Iandolo & Capuano, 1968; Morettini & Allamani,1975), up to the modern idea of "risky" or "hazardous" drinking. Primary Health care, a few general practitioners interviewed in some studies in central and northern Italy reported both low identification of high-risk drinking among their patients (Alberti et al., 1987; Allamani & Centurioni, 2000), and ambivalence when asked whether they wanted to participate in an alcohol intervention training course (Axerio, 1994).

In the 1970s and 1980s, the first Alcoholic Anonymous groups and later on the Clubs for Treating Alcoholics spread throughout Italy. These gave the public an awareness that alcoholism was a more diffused problem than it was commonly thought to be. The recent growing number of alcohol misuser treatment services, have contributed making the diagnosis of alcoholism less stigmatising and more acceptable, even in the case of women. Opinions and feelings of Italians about this subject have differed according to the various regions. Denegation and shame of this diagnosis, for example, seem to be stronger in Tuscany and central Italy, rather than in Veneto and north-eastern Italy.

During the 1980s and 1990s, TV and newspapers started representing dramatic stories of alcohol abuse, especially among youngsters. Cases of road accidents involving young people, or more recently, immigrants from Eastern Europe began being reported in the daily press. In the 1990s, the issues of alcohol and alcohol-related problems began being considered relevant by a few politicians and public administrators.

During the last number of years, articles have appeared in the press about the benefits of alcohol to prevent death from coronary disease.

8.4. Pressure Groups in Prevention

Producers of alcohol beverages and people involved in the agricultural system on the one hand, and public health system authorities as well as some non- governmental organisations on the other, have maintained opposite and conflicting interests. Since the 1970s, Italy's beer and liquor industries have begun investing in newspaper, radio and TV advertising. Ads for wine came about later on, with wine producers taking a position in favour of moderate consumption of better quality wines. All in all, the alcohol beverage industry has tended to support those scientific efforts aiming at demonstrating the healthy effects of moderate alcohol drinking, e.g. on coronary heart disease.

It is common for health professionals to share an attitude in favour of "responsible" drinking. The philosophy of responsible drinking takes into account both the Mediterranean tradition by which wine is drunk daily during meals in a social context like the family, and the recent concept of risky behaviour and hazardous drinking when intake is above 20-40 grams of pure alcohol per day, and when it is drunk outside of meals. However, some groups in the health sector, who are close to the Clubs of Alcoholics in Treatment, seem to be in favour of a sort of light prohibitionism, looking for stricter rules on advertising and sales of alcohol beverages. In such a context, the political parties and the Parliament seem to maintain a middle position between the position of the Ministry of Agriculture and the Lobby of Alcohol Producers on one side, and the Ministry of Health and the Health Professional sector on the other.

8.5. Effectiveness of Alcohol Policies in Italy

We think that it is necessary to implement further studies regarding the factors affecting changes in alcohol drinking, with preventive intervention policies being one of those factors. A possible research model can be the Italian study on the consumption decrease during the years 1970-2000 (Beccaria & Allamani, 2007). This study drew on a time-series analysis of several factors, such as urbanisation, demographics employment, social mobility, health consciousness, and globalisation of lifestyles among population subgroups, and provides sociological and epidemiological evidence that while wine is traditionally integrated with eating habits, it has undergone changes that can be directly related to traditional Italian food items like eggs, bread and sugar, and is inversely related to new types of food such as fish, cheese and meat.

If, as we think, factors affecting changes in alcohol consumption are not well studied, how can we evaluate the real impact of prevention policies regarding such changes? Certainly this is not to say that prevention policies are or were ineffective. Some prevention programs, as well as country-level measures, have shown their effectiveness. Also, community intervention projects or trials, operating in well defined areas, actually documented significant changes in terms of harm indicators and even in community awareness about the risks of alcohol (Holder, 1988; Holmila, 1997).

However, a critical re-formulation of the Northern approach to problematic alcohol consumption prevention in terms of different country cultures seems appropriate, in order for prevention policies to sound convincing both to the general population and policy makers. Unfortunately, it may happen that the indications of WHO and of international bodies are directly incorporated by the country experts as a means to strengthen their preventive work when reporting it to Administrators and Policy Makers. Committments to general ideologies and professional interests may result in rendering preventive programs unsuccessful.

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9. ITALIAN LAWS, ADVERTISING AND DRUNK DRIVING (Simona Anav)

9.1. Laws, Norms and Codes

In 1889, the National Minister of Justice, Zanardelli, who was involved in the temperance movement, had the first penal code resolution passed against public drunkenness, considering it "offensive or dangerous to the public". This law also punished those who caused such a state of intoxication in somebody else (Cottino & Morgan, 1985). Years later, in 1913, restrictions on working class drinking taverns was enforced, with a law limiting the number of establishments to one every 1000 inhabitants. Essentially, a great many of the Italian alcohol control laws date back to the fascist period (Table 3).

Such laws passed during that period, limited the production and distribution of alcoholic beverages, as well as reduced grape production to the advantage of corn production. According to the 1931 Penal Code, known as Code Rocco, still in force, drunkenness in public became punishable and crimes committed by drunken persons became more severely punished than the same crimes committed by sober people (Cottino & Morgan, 1985). The 1931 Penal Code also made 16 years the minimum legal age for of all kinds of alcoholic beverage purchases, both on- and off-premises.

While in 1974 the provision establishing a ratio between the number of alcohol outlets and the population was abolished (Mosher, 1992), it was actually during the 1980's that alcohol began being an issue in the public media and gaining importance in political debate. In 1988, a Ministerial Decree (6/9/88 n. 438) imposed the indication of alcohol content on alcoholic beverage labels. In the same year, another Ministerial decree (10/8/88) established blood alcohol concentration (BAC) of 0.8 grams per litre as the threshold above which driving was not allowed (see also Table 3).

Then, in 1990, the "Iervolino - Vassalli" law n. 162 of 26/6/90 on drug addiction and alcohol dependence was passed. This law promoted a strategy by which drug and alcohol addicts involved in the criminal justice sys-

tem, sentenced to a maximum of four years' imprisonment, were entitled to choose between prison and rehabilitation.

In the 1990-1992 period, six more alcohol-related laws or decrees were passed in the Italian parliament. Three of them were applications of EEC directives on alcohol advertising (Table 9.1.1.). Of the other three, two regulated television advertisements and one updated the norms establishing public premises and prohibiting the sale of beverages with more than 21 degrees of alcohol by volume at public performances, such as concerts and sporting events.

At the beginning of the 1990s, two Regional health authorities - Lombardy and Tuscany – passed Acts on experimental treatment and prevention centres or services for alcohol-related problems. These were generally characterised by both a psycho-social and preventive approach, and by special attention to the community (Bollettino Ufficiale Regione Lombardia, 1990; Bollettino Ufficiale Regione Toscana, 1993). In the following years other regions, starting with Friuli-Venezia Giulia, Veneto and Piedmont, also approved acts about the organisation of their alcohol-related services.

In August 1993, a Ministry of Health decree recommended some guidelines to the Italian Regions for the prevention and treatment of alcohol addiction (Gazzetta Ufficiale della Repubblica Italiana, 1993). It recommended a multi-professional approach on a local level and the increase in the number of hospital beds for alcoholics, thus underlining the medical component in the system. It indicated self-help groups as the rehabilitation side of the treatment.

The 1998-2000 National Health Plan aimed at cutting down the number of risky drinkers (drinking over 40 grams of pure alcohol per day if male, 20 grams if female, or drinking alcohol outside of meals) by 20-30% within the year 2000 (Piano Sanitario Nazionale, 1998-2000). The 2000-2003 National Health Plan confirmed the previous approach by giving the Regions autonomy to implement alternative strategies and programs.

According to Law n. 165 of 1998, which was a slight modification of the previous Iervolino-Vassalli law of 1990, if a crime is committed by a person under the effect of alcohol he (or she) is simply punished accord-

ing to the crime. However, if the person is diagnosed as being an alcoholic and the punishment is not over 3 years, he (or she) can be put on probation with the obligation of entering into an alcohol treatment program.

In March 2001, the Italian Parliament approved a Frame Law concerning alcohol and alcohol- related problems, according to the proposal by the senator Rocco Caccavari. The Frame Law gathered 11 proposals presented to the Parliament in the previous decade by Parliamentary members of different parties (*Legge quadro in materia di alcol e problemi alcol-correlati* (Frame Law Concerning Alcohol and Alcohol-Related Problems), number 125, 30th March 2001).

According to article 2, its main goals were as follows:

- to ensure all the population, particularly children and adolescents, a family, community and working life protected from the consequences of alcoholic beverage abuse;
- to promote access to heavy drinkers and their families to medical treatment and social services;
- to promote information and education among citizens about the negative consequences of alcohol consumption and abuse;
- to foster research and ensure professionals dealing with alcohol - related problems training and education;
- to support those non-governmental and voluntary organisations aiming at preventing or reducing alcohol-related problems.

This law especially focused on the re-organisation of community addiction services and hospital centres specialised in treating alcohol-related problems and stimulating precautionary actions. For example, it established a maximum blood alcohol concentration permitted when driving (BAC) at 0.5 grams per litre; it regulated the advertising of alcohol beverages; it prohibited the drinking of alcoholic beverages or their provision in work environments at risk for people's health and safety.

As to the latter point, according to article 15 of the Alcohol Law, a violation of this was punishable with fines between Euro 500 to Euro 2,500. Workers interested in seeking treatment for their alcohol-related

problems had access to the same health programs and got the same allowances as people addicted to drugs.

In 1998, the Italian highway society prohibited the sale of alcoholic beverages containing more than 21% alcohol in volume from 10 p.m. to 6 a.m. in the area of on-premises built along highways. This prohibition became part of the 2001 Italian Alcohol Law, article 14, with violations punishable with fines between Euro 2,500 and Euro 5,000.

In order to protect young people from the risk linked to alcoholic beverage consumption, the Police Prefect could issue a prohibition of selling beverages with more than 21% alcohol in volume on the occasions of concerts, sporting events or other situations with a massive presence of young people.

Table 9.1. summarizes the Italian laws and decrees on alcohol beverages.

Tab. 9.1. Italian laws concerning alcohol

LAW	CONTENTS
CODE ROCCO (1931) *Minimum legal age and public order*	16 years legal age for purchasing alcohol Repeated abuse punished
Ministerial Decree 10 Aug. 1988 and Law 23 Aug. 1988 n. 400	BAC Limit set at 0.8 g/l
Ministerial Decree 6 Sept. 1988 n. 438 *Enforcement of the Dir. N. 87/250/CEE*	Indication of the alcohol content in the labels of alcoholic beverages
Ministerial Decree 22 May. 1990 n. 196 *Rules for the individuation of tools for the measurement of alcohol in the blood of the drivers through immediate analysis of their breath*	Ethilometers
Law 26 June 1990 n. 162 *Updating, modification and integration of the L. 22 Dec. 1975 n. 685, ruling drugs and psychotropic substances, prevention, treatment and rehabilitation of addictions.*	- Creation of the Central Service for the Addictions (Ministry of Health) - Promotion and coordination at national level of the educational and information activities (Ministry of Education)
Law 6 Aug. 1990, n. 223 *Rules and regulations of the public and private radio and TV systems*	Radio and TV advertising forbidden to those whose main activity is sale or production of spirits >21°.
Ministerial Decree 4 Jul. 1991, n. 439 *Rules on the sponsorship of TV programs*	Radio and TV advertising forbidden to those who got the brands thanks to licenses or agreements (only for spirits >21°).
Law 25 Aug. 1991 n. 287 *Updating the norms on the establishment and activity of public premises*	Prohibition to serve beverages >21° (and sometimes even <21° by the Mayor's temporary order) in any place where young people can be present in mass.
Law 5 Oct. 1991 n. 327: *Ratification and enforcement of the European Convention (Strasbourg, 5 May 1989) on trans-border television*	Advertisement shall not: - be openly addressed to minors - link alcohol consumption with physical performances and driving - suggest that alcohol has therapeutic properties - encourage excessive consumption - take the high content of alcohol as a good quality

LAW	CONTENTS
Ministerial Decree 30 Nov. 1991 n. 425 *Regulations for the enforcement of the articles 13, 15 and 16 of the Council of the European Communities of October 3rd 1989 (89/552/CEE) concerning TV advertising of tobacco and alcoholic beverages as well as minors' defense.*	TV advertising shall not: - be openly addressed to minors - link alcohol consumption with physical performances and driving - give the impression that alcohol consumption makes easier the social or sexual success - suggest that alcohol has therapeutic properties - encourage excessive consumption - present the high content of alcohol as a good quality
Legislative Decree 25 Jan. 1992 n. 74: *Enforcement of the Directive 84/450/CEE on deceptive advertising*	It is considered as deceptive any advertising concerning products that can be dangerous to the health and safety of consumers, without warning them, thus leading to disregard the ordinary rules of safety and control.
Ministerial Decree 3 Aug. 1993 *Guidelines for prevention, care, social recovery and epidemiological survey on alcohol addiction*	- Regions entrusted for health promotion, prevention, care and social recovery of alcohol addicts - Establishment of teams for alcohol addiction at local level
Law Decree 28 Dec. 1998 converted in Law 26 Feb. 1999 n. 39 – *Chapter "The goals of Health" page 17-18*	Enforcement of the National Health Plan 1998-2000: - Decrease by 20% of the mail consumers exceeding 40 grams alcohol/day and of the female consumers exceeding 20 grams alcohol/day - Decrease by 30% of those whom drink alcohol out of the meals - Carry out specific actions of primary prevention and promotion of moderate consumption, by national provisions and regional or local interventions.
Law 30 March 2001 n. 125 *Frame Law on Alcohol and Alcohol Related Problems*	– Prevention, care and social reinstatement of alcohol addicted – Institution of National Council on alcohol and alcohol related problems – Courses of Alcohology in the social, health and psychological university faculties – BAC lowered from 0.8 to 0.5 g./l. – Rules on commercial communication on alcohol and spirits – Working out a self regulation code for State and private owned TV and advertising agencies – Norms on alcohol advertising with attention to minors – Spirits selling on highways banned between 10 p.m. and 6 a.m. – Security on workplaces
Law Decree 15 Jan. 2002 n. 9 Integrative and corrective provisions on the new Road Code according to art. 1 comma 1 Law 22 March 2001 n. 85	Scored driving license – Drunk driving = - 10 points – Refusal to test BAC = - 10 points
Law 1 Aug. 2003 n. 214 (updates Law Decree 30 Apr. 1992, n. 285) Modifications and integrations to the Road Code	- Drunk driving sanctioned with high fares, driving license suspended or withdrawn. In more serious cases up to 1 month imprisonment - Though respecting the driver' s privacy, road police can ascertain their BAC even by mobile devices (ethilometers) - The health structures, when requested by the road police, can ascertain the BAC of those drivers involved in road accidents

December 2002 ***Self Regulation Code on TV and Minors***	In any time band: – Minors should not be shown while drinking alcohol – Alcohol drinking should never be presented as positive – Abstinence from alcohol should never be presented as negative In the protected time band (4 to 7 p.m.) – Advertising of spirits and alcohol banned
Self-regulation Code on Advertising – updated 2001 **Art. 22 – Alcoholic Beverages**	Advertising shall not - Encourage excessive consumption - Show alcohol addiction - Address to minors - Link alcohol and driving - Link alcohol and physical/mental efficiency - Point out alcohol content

Source: Osservatorio Permanente sui Giovani e l'Alcool, 2007

9.2. Advertising

Before 1991, alcohol advertising was not regulated at all. Since 1963, the need for regulating advertising had emerged during the general meeting of advertising agencies. In 1966, some rules were settled and alcohol producers and manufacturers, media agencies, TV and NP networks subscribed to a voluntary *self-regulation code* on media advertising. This code underwent many revisions in a restrictive sense.

In 1996, the alcohol industry also subscribed to a self-regulation code. Advertising was not to encourage excessive consumption; show alcohol addiction; be addressed to minors; link alcohol and driving; link alcohol and mental or physical special performances; or present alcohol content as a good quality of the product. The norms ruling advertising of alcoholic beverages were to adopt measures aiming at preventing advertising from deceiving the consumer, rather than trying to limit consumption.

In 1991, a national law (n. 425), which was an application of an ECC directive (1989\552\ECC) was approved by the Italian Parliament. According to this law TV alcohol spots were not to:

(a) clearly refer to minors or represent them drinking alcoholic beverages;

(b) represent people driving and drinking alcoholic beverages simultaneously;

(c) give the impression that drinking is synonymous with social or sexual success;

(d) lead the belief that alcoholic beverages possess therapeutic qualities or could resolve psychological problems;

(e) encourage the abuse of alcoholic beverages or present in a unfavourable light its abstinence or the state of sobriety;

(f) use the indication of the graduation of alcoholic beverages as a positive quality beverage.

The Legislative Decree 25/1/92 n. 74 enforced the Directive 84/450/ECC on deceptive advertising. Any announcement of products the consumption of which could be harmful without any warning, thus lead-

ing consumer to disregard the ordinary rules of safety and control, was to be considered as being deceptive.

According to article 13 of the 2001 Law on Alcohol, public and private TV networks and advertising agencies, as well as alcohol industries have to adopt a self-regulation code. Alcohol advertising (for alcohol beverages and spirits) was to be considered illegal in programmes for children and adolescents; when children and adolescents were represented consuming alcohol and when drinking an alcohol beverage was shown as a positive attitude. Radio and television advertisement of spirits was forbidden between 4 p.m. and 7 p.m.. Fines were to be imposed from Euro 2,500 to Euro 10,000 and over that, be applied to the alcohol industries, TV networks, magazine and cinema owners.

According to art. 22 of the Self - Regulation Code on Advertising during 2002, and revised in 2003, greater attention was paid to the possible meanings young people can attribute to alcohol. Therefore, a difference in the measures taken according to timeslots in the media was considered.

In any time slot:

- minors should not be shown while drinking alcohol;
- alcohol drinking should never be presented as positive;
- abstinence from alcohol should never be presented as negative.

In the "protected" time slot (4 p.m. to 7 p.m.)

- advertising of spirits and alcohol must be banned.

Advertising was never to:

- encourage excessive consumption;
- show alcohol addiction;
- be addressed to minors;
- link alcohol and driving;
- link alcohol and physical/mental efficiency;
- stress alcohol content.

Nonetheless, it should be observed that some complaints making reference to the aforementioned norms and presented to the Institute for Self regulation in Advertising were often rejected. Further, motivations supporting such complaints, were, at times, not acknowledged as being valid reasons for blocking or sanctioning the spot/advertising.

9.3. Drinking and Driving

According to the Ministerial Decree of August 10, 1988, the blood alcohol concentration (BAC) limit in Italy was to be considered at 0.8 g/l. The usual tool used by the Police to ascertain the BAC level, is the ethilometer. A driver whose BAC was found to be higher than 0.8 g/l, had to pay a fine (ranging between Euro 250 to Euro 1,000), his/her driving license was suspended from 15 days to 3 months, and he/she might have been sent to prison for up to 1 month or longer. An even longer period could have been judged as a prison sentence, according to the harm caused or if the behaviour had been repeated. The 2001 alcohol law lowered the BAC limit from 0.8 to 0.5 grams per litre.

According to the 2001 Alcohol law, article 6, a medical board was established to examine people who manifested symptoms or behaviours attributable to alcohol - related problems, in order for them to get or maintain their driving licence. Also, the Ministry of Transports had to provide driving school teachers with training and education on the negative consequences of drunk driving. Alcohol education programs had to also be included in the programmes for new drivers.

On June 20, 2003, the Law Decree n. 121 on Road Safety established the score driving license. Every license started with 20 points that are then decreased according to the seriousness of the infringement. As far as alcohol was concerned, driving with BAC higher than 0.5 grams/liter was punished with10 points; the same score if a driver refused the BAC test.

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10. TAXES AND LICENSING
(Simona Anav)

10.1. Excise Taxes

Taxation on alcohol is often regarded as a measure which enables the government to limit alcohol consumption. There are major differences among tax systems applied to the various alcoholic beverages.

The excise duties on wine and intermediate products are calculated per hectolitre finished product. For wines at or under 12 percent alcohol by volume, (the traditional Italian drinking beverage,) the excise tax is set at zero, which is different from many other EU countries. Until July 1996, the excise tax on wine containing more than 12 percent alcohol by volume was bound to excise taxes on spirits made from wine or fruit. In 1996, the excise tax for aromatized and fortified wine, as well as for all other intermediate products, was set at 96,000 Lire per hectolitre finished product.

Excise taxes on beer are levied on all beer on the basis of degrees of Plato and hectolitres. Starting from 1/1/2004, the excise duty has been 19.88 Euro per hectolitre, which is more in tune with other EU countries than it used to be.

Excise tax on spirits is levied on the basis of hectolitre pure alcohol in the finished product. Excise taxes are payable when alcoholic beverages are released for consumption at the declarations made by the brewer or distiller. These declarations are controlled by finance officers. Spirits (at 40% alcohol volume) have always paid the highest excise although this sector used to rely upon a good contribution to production that in 1996 was 652.5 billion Lire.

In 1984, the excise taxes for spirits were increased and the categories changed to comply with an EEC ruling. The excise tax for spirits made from molasses was set at 420,000 Lire per hectolitre pure alcohol and for spirits produced from other materials to Lire 340,000 per hectolitre (Horgan & Sparrow & Brazeau, 1986; Sparrow et al., 1989). In May 1991, the excise taxes for spirits were increased by 172 percent as were the excise tax for spirits made from molasses. The latter was increased to Lire 1,146,000 and the excise tax for spirits made from other materials to

928,000 Lire per hectolitre (Sparrow et al., 1989).

Since May 1991, the difference in excise taxes between these two groups has been gradually decreased. At the same time, the excise rates for these two groups of spirits were gradually increased to reach a common rate of Lire 1,249,000 in July 1996 per hectolitre pure alcohol for all spirits. Since January 2004, the excise tax on spirits has increased to Euro 731 /hectolitre/anidre.

On March 14, 2005 the Law Decree n. 35 increased the excise duty on beer, intermediate beverages and spirits. The increase was greater on beer, that passed from 1.59 to 1.97 Euro/hectolitre/degree/plato with an increase of 24% in one year; also the intermediate products passed from 56.15 to 62.33 Euro/hectolitre (+ 11%) and spirits from 730.97 to 765.44 Euro/hectolitre anidre (+ 5%).

Table 10.1.1. Excise Taxes on Alcoholic Beverages in Italy in 2004 and 2005

Alcoholic beverage category	EURO 2004	EURO 2005
Beer: average excise per hectolitre	19.88	24.63
Beer: excise duty per hectolitre/degree plato	1.59	1.97
Wine, and fermented beverages other than wine and beer, per hectolitre of product	0	0
Intermediate products, per hectolitre of product	56.15	62.33
Spirits: average excise per hectolitre (at 40% alcohol/vol)	292.34	306.16
Spirits: excise duty per hectolitre anidre	730.87	765.44

(Italian Ministry of Treasure, 2005).

This increase came one year after the approval of the 2004 Financial Law that had already increased the excise on alcoholic beverages, with the exception of wine. The large increases in spirits excise taxes at the beginning of the 1990s must be seen in connection with the need of bringing up excise rates on spirits, intermediate products and beer in order to match the EU minimum requirements. The current rate on beer is one of the highest in Europe, while intermediate products and spirits are more or less on the average EU value.

During the 1970-2000 period, the value of the Italian currency

decreased because of inflation. The increase in general *price* level in Italy can be described by the consumer price index (CPI). If the period 1980-2004 is taken into account, we can notice an increase of 298.1%. Five years later the increase was 107.1%. Passing to the period 1990-2004, the increase was 57.7%, reaching 12.7% between 1999 and 2004 (data ISTAT 2005.)

After taking into account inflation, it can be concluded that beer excise tax was approximately on the same real level either in 1980 or 1990, but have since then decreased by a quarter. Now the trend is changing due to the new measures. The real value of special taxes on spirits was, in 1990, about one fifth or one fourth of their real value in the beginning of the 1970s. By the year 2000 the real value of special taxes on spirits more than doubled. However, in 2000 the real value of special taxes on spirits was about one half of their real value in the beginning of the 1970s. The increased excise in 2005 does not affect the existent situation very much.

10.2. VAT Taxes

A value-added tax (VAT) of 20 percent is nowadays applied to all alcoholic beverages. As table 10.2.1 shows, uniform value added taxes for all alcoholic beverages is quite new. In the 1970s, VAT was clearly lower both for table wine and beer than for distilled spirits. Furthermore, the VAT tax rate for brandy was lower than, for instance, for whisky and gin. This indicates that setting VAT rates as well as excise taxes rates have been one measure for protecting domestic producers. Making VAT the same for all types of alcohol beverages by the year 2000 meant that VAT rates for beer and wine were increased both in absolute terms as well as in relation to spirits.

Table 10.2.1. Rates of Value Added Tax in Italy (%)

Year	Beer	Spirits		Wine*	
		Brandy	Whisky	Still	Champagne*
1973 January**	6	14	35	6 – 12	30
1981 January***	8	18	35	8 - 15 - 35	35
1982 August	10	20	38	8	38
1984 December	9	18	18	9	30
1987 September	9	18	18	9	19
1988 August	9	19	19	9	19
1990 July	19	19	19	9	19
1993 January	19	19	19	13	19
1995 January	19	19	19	16	19
Starting from 1st January 1999	20	20	20	20	20

* According to Sparrow et al. (1989) the percentage for Champagne in the 1987-1992 period was 38 percent.

** Before 1973 the turnover taxes were 7 percent for beer, 12 percent for distilled spirits and 4 percent for wine

*** 8 percent for bulk wines, 15 percent for bottled wines and 35 percent for quality wines.

(Brown, 1978; Sparrow et al., 1989; Hurst et al., 1997)

In 1980, approximately 14 percent of the price of beer was made up of different taxes; the share for wine was six per cent and fluctuated for spirits from 20 to 40 percent. In the late 1990s, taxes accounted for about a third of the price of beer, some 40 percent of the price of spirits and about 17 percent of the price of wine.

10.3. Licensing Policy

As to *Production,* the Ministry of Finance grants licences, while the Technical Offices of Finance, established at regional and provincial levels, exerts a control over the excise at the firm. The licence is permanent, year-

ly paid and re-confirmed. Its annual cost is about 104 Euro for wine and beer and about 260 Euro for spirits. A special office in each Region grants the quality of the plants. The Province Administration also controls a few aspects of the plant building.

As to *Sales*, Municipalities grant licenses both to importers and to wholesalers. The wholesalers have to enrol to the Chamber of Commerce in each Municipality. After having checked the fiscal deposit and been given an excise code, the Ministry of Finance authorises the license through the Municipality, which costs about 34 Euro per year and has to be renewed periodically.

In 1991, a national law (N. 287) was passed, which divided into three categories all the stores which can apply to the Municipality for a license to sell alcohol beverages:

Type A- Restaurants and foods stores, which can sell foods, any kind of beverages and milk;

Type B – Bars and pubs, which can sell coffee, any kind of beverages, food, ice-cream, sweets and cakes and gastronomy products;

Type C - Entertainment premises, which can sell food and any kind of beverages.

Until 1991 (Law N. 524\1974,) there were two kinds of licenses to sell alcohol beverages: one to sell wine and beer, and another to sell spirits. Since 1991 (Law N° 287,) there has been only one license that allows the selling of all types of alcoholic beverages. The "delivery tax", required to be paid until then by retailers, has since been abolished.

For the "off and on premise" retailers, the Municipality Office for the Public Stores grants the license to sell alcohol beverages to medium size wholesalers and retailers (up to $150m^2$ in cities with less than 10.000 inhabitants; up to $250m^2$ in cities with more than 10.000 inhabitants) as well as to trade centres. The license is permanent as long as the store operates and its cost depends on the Municipality system of taxation. As an example, in a city like Florence in 2002 it was about 35 Euro.

According to an EC directive (552/1989/ECC) as well as an Italian law (Law N. 425/1991,) a temporary license is granted to "on and off

premises” retailers by the Municipality Administration to sell alcohol beverages at public happenings such as rock concerts and sporting events. This kind of license does not allow the sales of beverages containing more than 21° of alcohol.

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11. PREVENTION
(Allaman Allamani)

11.1. Prevention Policy and Programs

There was no public health policy on alcohol in Italy until the end of the 1980s, differently from what was going on in northern Europe (Cottino & Morgan, 1985; Mosher, 1992). All in all, *at the national level,* Italy has been traditionally tepid in starting preventive programs.

By and large, the experiences of Italian prevention programs about the issue of problems related to alcoholic beverages can be divided into 4 areas: (1) school education, (2) drinking and driving, (3) brief intervention as delivered by health professionals to their clients, and (4) community programs. The first three types of programs regard groups or individuals at risk, while the last one focuses on the idea that a community is an interaction among members and that alcohol-related problems are part of these interactions (Holder, 1988).

11.2. Prevention Program Experiences

(1) Preventive Programs Aimed at High Schools

Inereasingly since the 1980s, several alcohol educational programs throughout Italy have been implemented particularly in *high schools*, funded through Public Health Agencies and the Public School System (where there is one teacher who is appointed for planning and carrying out information projects on health education). They started locally, usually with no national or regional planning, and have been hardly evaluated. However many information tools have been produced, such as brochures, stickers, T-shirts, parking discs, video clips, videotapes, booklets and exhibition kits (Orlandini, 1999), CD-ROMs (Beccaria, 1998).

(2) Drinking and Driving Programs

Since the 1990s a few *drinking and driving* projects have been imple-

mented. One example is the project Young People, Alcohol and Driving carried out in 2001, thanks to the collaboration between the German Automobile Club (ADAC), Italian Automobile Club (ACI), Italian Brewers' Association (ASSOBIRRA) and the Italian Federation of Wine Producers (Federvini). The project was funded by the DG Traffic of the EU Commission and the Amsterdam Group. It developed a video clip addressed to young drivers (and played only by young non-professional actors) aiming at informing them about the risks of driving after having drunk or underestimating the effects of alcohol on their capacities.

A project called *Alcohol and Driving* was planned by the local Health Agency in Bergamo in 1994 with the aim of increasing awareness and changing behaviour as to the issue of drinking and driving in different contexts: driving schools, high schools; and among professional drivers and the general population (Noventa, 2004).

Other Health agencies have promoted discotheque *programs* targeted at young people. Typically, a camper fitted out with an ethylometer to measure alcohol levels is parked outside local discotheques, and informative material is distributed to the discotheque clients.

(3) Brief Intervention Programs

People at risk for drinking may be early identified by both general practitioners and PHC professionals, who can deliver a brief educational intervention to help their clients either to cut down or to stop drinking. During the last 15 years interesting literature reporting various experiences in this area has been produced (Babor & Higgins-Biddle, 2001). Some projects targeting at general practitioners recently started in Udine (Friuli Venezia Giulia) and Florence (Tuscany), Italy, as part of an European WHO study involving many countries (see Struzzo, 2005; Scafato et al., 2006). An important part of the project is alcohol training for health professionals.

(4) Programs Carried out at the Community Level

At the *community level* a few projects have been carried out in the last decade.

11.3. The Campaign *"To a friend who drinks too much I would say"*

This project was implemented by the Osservatorio Permanente sui Giovani e l'Alcool (Osservatorio Permanente Giovani e Alcool, 1997) in the Provinces of *Padova, Rimini-Forlì-Cesena and Bari*, respectively in northern, central and southern Italy. Meetings were held with the local authorities, school representatives as well as with "informal operators" (the peer group, DJs, sport trainers, youth group leaders, bar tenders, and any other kind of people who can get in touch with the local youth world), a basic element of the community action. The messages communicated a suggestion of "responsible drinking" and a better knowledge of the risks of "abuse", while a great importance was paid to the language that aimed at being a "youth to youth invitation". A pilot study was carried out in three Italian Provinces, comparing the recalling by three groups of youngsters after each of them had been exposed to the message spread by one of the following: (a) disc-jockeys in discotheques, (b) local and country wide radios and (c) posters with the photo of a young woman saying «the more you drink, the less I like you» displayed along the streets. The groups scored respectively 33%, 35% and 46%, suggesting a greater relevance of the visual tool and of the role of women in the informal control of drinking behaviour. The experience, once tested, was successfully repeated also in the Province of Biella, North Western Italy.

11.4. The Rifredi Community Action Project in Florence

An inter-sector and multi-component prevention project combining the top-down with the bottom-up perspectives, started in 1992 in a 17,000 resident area in Rifredi, a north-west neighbourhood in the city of Florence, and ended in 1998. Eventually the project demonstrated that a preventative community action on the alcohol issue was feasible in Italy (Allamani e Basetti Sani, 2003; Allamani, Basetti Sani, Morettini, 2004).

Its *purpose* was both to promote 'responsible drinking' and to bring about awareness of the risks implied when drinking alcohol, in order to change the Community policy in facing alcohol- related problems. The

goals of the Project were to assure that:

(a) the Community population should be able to perceive the risks related to alcohol intake;

(b) the Primary Health Care professionals should identify alcohol-related problems among their clients, and motivate them towards a behavioural change;

(c) overall alcohol consumption should decrease;

(d) the local community be mobilised.

Four combined components were identified: public information, i.e. promoting healthy lifestyles; community pre-school, elementary and middle school programmes; alcohol training for Primary Health Care professionals; and alcohol training of the volunteers involved in transportation of people traumatised at hospital Emergency Rooms.

This project was able to activate several formal and informal groups in the Community: school teachers, children and parents; GPs and other PHC professionals; some volunteers and local elderly associations; local activists and key persons; the district municipality. During the development of the Project, many events were produced. In 1996, a local municipality committee on healthy lifestyles involving 16 local associations was established in order to implement preventive actions locally. Among other events during that year, 5,500 alcohol carousels (a movable round cardboard which neutrally informs how many grams of alcohol is drunk during a certain period) were distributed in the community. The carousel was understandable, useful, and able to elicit discussions about alcohol-related issues. Also, it was perceived as a neutral health instrument.

Figure 11.1 – Alcohol Carousel

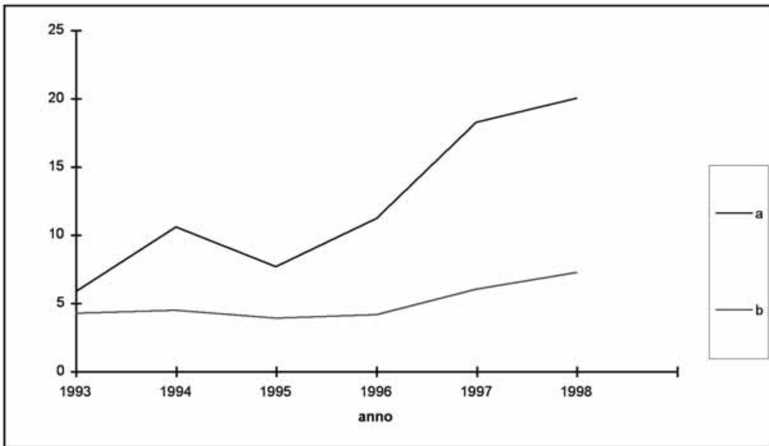
The indicators of the impact of the project on the community, documented a good involvement of the local population in preventive interventions, and a higher awareness of the risks of drinking alcohol compared to before the community action. The perception diffused in 1992, that an "alcohol problem" equals alcoholism for a few individuals, in 1997 shifted to the idea that alcohol consumption may be risky for the community.

During the years when the project was implemented, there was an increase of hospital admissions for alcohol-related problems among the residents in the targeted intervention community, compared with the admissions of residents from the contiguous communities where no preventive intervention had been done. Such an increase was explained

according to the hypothesis that community residents had became more aware of the biological risk of alcohol misuse.

In this case, they would more easily go to the closest hospital for specific diagnosis and treatment, feeling perhaps more open to talk with the hospital staff about their hazardous drinking. As a consequence, the diagnoses of alcohol-related problems would increase as a function of the increased patients' awareness over the years.

Figure 11.2 – The Rifredi Community Project. Alcohol-related diagnoses, Careggi Hospital 1993-1998 regarding residents in (a) Preventive Intervention Territory (17,000 inhabitants) vs. (b) No-Intervention Territory (90,000 residents) (1:10,000)



An epidemiological study which was carried out in the community documented that in the period 1994-2000, males drinking more than 40 grams per day decreased from 15.3% to 13.5% and that moderate consumption increased at the expense of hazardous drinking (Cipriani, Voller et al., 2002). The change could not be easily attributed to the prevention project since such results were paralleled by a similar general change in actual consumption in the country.

11.5. The Community Alcohol Action Project at Scandicci (1999-2004)

In 1998, another inter-sector and multi-component community action alcohol Project was held in Scandicci, a town Southwest of Florence at the edge of the Chianti area, and endorsed by the municipality of Scandicci, the Florence Health Agency, and the greater Florence School System. Three out of 5 districts were chosen by the town council, totalling 21,851 residents (Allamani, Basetti Sani, Voller et al., 2003). At the beginning, a Project Promoting Group, meant to support the project development, was appointed also including 3 Districts, the Municipality of Scandicci itself and the greater Florence School System. Later, a 19-member local prevention co-ordinating committee, in which local initiatives were suggested, discussed and approved, was established and regularly met throughout 4 years. The Project *aim* was to prevent alcohol - related problems in the sectors of health, school and traffic.

In February and March 2000, 154 key persons, representing 33 institutions or groups, were interviewed by means of 19 focus groups and 13 individual interviews, about the effects of alcohol drinking and the related suggestions. The need analysis in the community indicated that residents had a concern about alcohol abuse especially among youngsters, alcohol - related violence within the family, drinking and driving, and problems of public order. The traditional drinking pattern, i.e. assuming wine at mealtime, was felt as somehow changing. The main preventive initiatives implemented were: **(a)** The production of drawings by 320 elementary & middle school pupils, a selection of which were displayed in 2001-3 at a Scandicci Spring exhibition and at the Scandicci October fair. Eventually nine drawings were printed and appeared on buses, at local fairs and in a large supermarket; **(b)** 6,000 Alcohol Carousels were distributed in Spring 2002 in shops, health offices, markets, schools, pharmacies and were greatly appreciated by the public; **(c)** Two alcohol consumption intervention training programs, for GPs and PHC employees were implemented in 2000 and 2002-3 with the aim of identifying risky drinkers and motivating them to change their drinking habits.

The Scandicci Project had a "down top" perspective (Larsson, 1990), even if the town Institutions appeared, on the contrary, to be more

acquainted with a “top down” approach towards their citizens. Also, the context of the co-ordinating committee meetings was somehow more formal than participatory, probably because of the institutional links among the committee members. By and large, the Project partly mobilised the community members: school teachers, parents, pupils and policemen. A couple of district presidents were especially involved. Project process and impact evaluation studies documented firstly that the carousel was visible, interesting and retained by the community members one year after its distribution, while the children drawing prints were visible and retained even some months later. Secondly, both educational tools were effective in mobilizing the local population because they were locally produced, widely distributed and displayed in prominent community locations. Thirdly, a change in community opinion occurred during the course of the project, from a more rigid idea in 2000 that only alcoholism was a problem, towards a more comprehensive understanding of community risk from alcohol consumption in 2003.

Figure 11.3 - Rifredi Community Project A printed poster for a child drawing

On the top of the poster a heading reads “*will you make well-balanced choices for your health?*”, while the bottom message says ”*you don’t age at table, if you eat and drink with moderation*”.

11.6. Messages in Prevention Programs

Advertising a few brands of liquors through posters or journals has been common since the beginning of 1900. Modern advertisement messages about alcohol (spirits and beer, and so far to a quite less extent, wine) began in the 1970s, their content being social success, friendship, and sexual attraction. Advertising companies used images of young women as bait in encouraging men to buy alcohol products: women themselves on TV were addressed as “prey”, i.e. potential consumers of alcohol beverages (Beccaria, 1999).

The health education sector, has used at times, since the 1980’s, “scare” messages based on descriptions of the bad consequences of drinking, especially in schools or on street posters. However, negative messages have been rather ineffective. WHO itself has recently taken the stance that health messages dwelling on the positive benefits of responsible drinking have the greatest impact on the target population (European Alcohol Action Plan, 1992).

Two initiatives showed the effectiveness of positive messages. One example was the alcohol community action carried out by the Osservatorio Permanente sui Giovani e l’Alcool, in which health messages produced by young people, who were the target of the intervention, were conveyed through already existing mass media channels, i.e. radio and posters (Osservatorio Giovani e Alcool, 1997). The language used was that actually spoken by the people to which the intervention was addressed, making use of local dialect and youth slang. The contents of the messages were suggestions to “drink well,” knowing the risks of “abuse” and were diffused by disc-jockeys in discotheques, on local and national radios and posters. The posters’ subjects were selected according to the local social and cultural conditions. One poster has a young woman saying, “The more you drink, the less I like you;” another one features, a group of young people addressing a friend with “Stop it there, numbskull!”.

Figure 11.4.
A PRINTED POSTER TARGETING YOUNGSTERS
The slogan of the campaign is "The more you drink, the less I like you"

Figure 11.5.
A PRINTED POSTER TARGETING YOUNGSTERS
On the top of the poster a heading reads "Stop it there, numbskull!"

Another example was the outdoor display of a few school children's drawings about the consequences of drinking alcohol, created through a teaching/ learning process within a number of Florence local pre-schools, elementary and middle schools both in the Rifredi and Scandicci Community Projects to prevent alcohol-related problems and promote responsible and moderate drinking (Allamani, Forni, Basetti Sani et al., 2000; Allamani, Basetti Sani, Centurioni et al, 2006). The fact that the messages were created by the youngsters of the community made them more acceptable by the local population. The youngsters behaved as if they were their parents' educators.

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12. THE TREATMENT SYSTEM
(Allaman Allamani)

12.1. The Administrative Structure of the National Health System

Major changes have occurred in Italy since 1970, when Regional governments were given a certain amount of autonomy and the basis for the National Health System was created. The 1970 national law number 352 established that the regional administrations be delegated the competency of Health issues, while the National Government retained the competency for enacting laws and approving related specific guidelines. In 1978, the National Health System (Sistema Sanitario Nazionale, SSN) was established, following the philosophy of the British National Health System. In 1994, in keeping with a National Health reform, the Local Health Units were transformed into Local Health Agencies (ASL or Aziende Sanitarie Locali) with budgetary responsibilities.

The administrative structures for treatment and prevention of alcohol-related problems in Italy are part of the SSN Administration. The Ministry of Health, finances regional health-related activities and funds special national health projects. It approves national laws and acts, recommends guidelines to the Regions and promotes the National Health Plan. The Regions' Health Departments (Italian Regions are 20, each with a capital city) take into account the national guidelines, laws and acts, receive Government funding and are responsible for the regional health budget. They delegate Local Health Agencies to carry out the treatment and preventive activities. These Local Health Agencies, which are about 2 or 3 in each of the 101 Italian provinces, receive in turn their funding from their Region and are responsible for the local budget. They support prevention programs through their Health Education Offices. Preventive initiatives can also be taken into account through the Provincial governments or by the Municipalities, as well as by private agencies (e.g. Consumers' association, COOP, the CESAR Foundation of the UNIPOL insurance company).

The SSN offers universal coverage financed by welfare insurance contributions and taxations. In different circumstances, citizens have to

pay a small percentage of the costs that are involved (the so called "health ticket"). Health expenditure is approximately 6% of the gross national product. Both hospitals and primary health care centres are mainly under public ownership and free of charge to the public. Some private agencies support aspects of such programs.

In 1978, the SSN recognised alcoholism as a disorder. In that period, only a few Gastroenterology or Psychiatric Hospital Units offered in-and out- patient clinics for the treatment of alcoholics. In the following two decades out-patient Alcohol Services were created mostly as part of Local Health Agency Drug Units. In addition, some Community Centres were established for the treatment of alcohol related problems, partly supported by the SSN. In 1993 the Italian Government delegated by decree the Regions to provide preventive and treatment programs for alcohol addicts based on a multi-professional approach.

According to the 2001 Frame Law on Alcohol, the treatment of patients with alcohol-related problems and pathologies should be carried out in appropriate hospital units. The Regional governments were entitled to have Hospital and University beds assigned to treat patients affected by acute alcohol intoxication. Brief rehabilitation units, where patients could stay up to 30 days, were to be set up as well (Legge Quadro in Materia di Alcol e di Problemi Alcol-correlati, 2001).

12.2. Development of the Treatment of the Alcohol-related Problems in the Public Health System

At the end of the 1970s, four Local Health Services in Italy independently experimented two different kinds of specific treatment programs for chronic alcoholics. They were three hospital units: the Geriatric Unit in Udine, region of Friuli-Venezia Giulia, in the north-east of the country; and the Gastroenterology Units in Florence and in Arezzo, Tuscany; the out-patient drug-addicts Service of Dolo, in Regione Veneto. In Udine and Arezzo a treatment care program was operating in keeping with the method of Vladimir Hudolin, creator of the Club for Treated Alcoholics, while in Florence and Dolo a choice-oriented multi-modal approach was

provided. Both programs, developed to overcome the ineffectiveness of the traditional medical approaches, aimed at putting together medical, psychological and social practices. The professionals involved had competencies not just in medicine, but in psychiatry and sociology as well (Patussi, Tumino & Poldrugo, 1996).

Since the beginning of the 1990s several experiences of treatment program have evolved in different cities and towns in the country. Administratively, they have been side activities of general medicine or gastroenterology units, of centres for treating drug-addicts and of psychiatric services. According to two Italian Ministry of Health National Health Service censuses, their number was 280 Alcoholic units with 21.500 clients in 1996, and 344 with 33,000 clients in 1999 (Ministero della Sanità, 1999, 2003).

Alcohol treatment programs in Italy were hospital-oriented and community-oriented. The former approach, that is now much less diffused, emphasised the diagnosis as well as the treatment of both acute intoxication and of withdrawal syndrome; also, the hospitalisation gave patients affected with severe alcoholism opportunities to improve their motivation to stop their drinking. More recently a few day-hospital programs and a sort of half-way houses have been planned to support patients with minor medical ailments and with major psychological or social problems.

Out-patient clinics, obviously less expensive than the costly hospital units, apparently targeted to less severe cases. Community programs were based on the principle that alcohol problems should be treated in the context where they are experienced, i.e. the social network of friends and acquaintances. The idea of the primacy of community stemmed from the revolutionary studies and practice of the late psychiatrist Franco Basaglia, and from the blossoming of both Alcoholic Anonymous and the Clubs for Treated Alcoholic (CAT).

In fact, out-patient services were growing to the detriment of in-patient clinics. This may have affected the increase of women in the alcohol treatment. As an example, while in the 1980s the Female/Male ratio was 1:4, in 1995 a study of a limited number of out- and in- patient alcohol services showed that the F/M ratio was 1:1.9 (Allamani, Voller,

Lubicka and Bloomfield, 1999). A recent study in Tuscany, demonstrated that such convergence between females and males was increasing (Osservatorio di Epidemiologia ARS, 2005).

However, more patients with different severity of alcohol problems, affected also by psychological problems, or multiple substance abuse, or even anorexia/bulimia, still applied to Alcohol Services to enter a treatment program. On the other hand, traditional alcoholics with biological disease as liver cirrhosis or polyneuropathy have been less represented in the out-patient alcohol services and enter less frequently the treatment program, while they may be more often hospitalised.

In the future the present economical restrictions might limit the dimensions of public programs, and increase the activity of no- or low cost programs: AA, CAT, half-way houses, Minnesota clinics.

12.3. Non-Governmental Organisations (NGOs)

The main Non-Governmental Organisations involved in the treatment of alcoholics and their families in Italy, are *Alcoholics Anonymous (AA)* and its derivations, i.e. *Al-Anon and AlAteen* (relatives and children of Alcoholics, respectively) as well as the *Clubs for Alcoholics in Treatment (CAT).* In 2000, about 40,000 people, at least 0.07% of the whole Italian population was estimated to be involved in either a 12-step or a Club alcohol treatment program, women probably amounting to half. These associations are capable of co-operating with public health and social services. The presence of both therapeutic systems can also enable professionals and patients to opt for the programme more suitable to patient needs and features. They are an essential resource in the treatment of alcoholics especially in two instances: 1) when medical and psychological treatments turn out to be unable to motivate the client to stop his/her drinking and 2) when after detoxification the alcoholic begins to retain his or her abstinence and forestall relapses.

The co-operation between the Health system on the one hand, and AA or CAT on the other, is one of the most promising examples of modern co-operation between professionals and user associations, wherein the former

are in direct contact with the needs of the citizens at large and the latter are supported in their self-help itinerary by the tools that medical and behavioural sciences can make available.

At the regional level, after the Lombardy 1990 Regional Project (Regione Lombardia, 1990), as well as after the acts approved in the regions of Tuscany and Veneto (Regione Toscana, 1993; Leggi e Orientamenti Regionali, 2004), AA and Al-Anon as well as CAT were formally considered as part of the regional health care network. At the national level the 2001 Alcohol Law indicates the relevance of Self Help Groups in the treatment programs of alcoholics.

12.3.1. *Alcoholics Anonymous and the 12 Step Associations*

The Italian Alcoholics Anonymous was born in Rome in 1972, when an Italian alcoholic joined a local English-speaking group. The foundation of another group in Florence in 1974 was accompanied by the first-ever public conference held on Alcoholics Anonymous in Italy. The AA message then spread first to Milan and later to other towns in northern Italy.

For some years AA groups were scant, attended by few persons. In Italy, where little concern had been given to alcohol problems through the years, AA was opened relatively late and in the beginning was mainly considered as an isolated sectarian movement. Its spirituality, independence and self-orientation kept the biologically-oriented medical profession away from understanding it for many years. Later on, in the second half of the 1980's, AA started expanding. This was paralleled by the growing attention towards alcoholism and its related problems among both professionals and lay people.

Contemporarily a few examples of co-operation between public Institutions for alcohol treatment and AA were built up, where AA members were regularly accepted to testify to their problems and their changes in the presence of alcoholics, in out- or in- patient clinics (Alcoholics Anonymous, 2004).

AA Italy General Service Office reported some 55 groups in 1980. A total of 340 was registered in 1990. By 2005 there were about 500 Italian

groups counting an estimated number of at least 10,000 participants with more than 3,000 being women (F/M ratio about 1:2).

These groups, which number from a few persons up to 30-50, usually meet more than once a week, and are now distributed both in the metropolitan areas and in small towns, and more in the north-west Italy then in the south.

AA states it is an autonomous and self-supporting fellowship of women and men associated with no other political, union, health care, religious or private organisation. As known, its programme is based on 12 Steps, 12 Traditions and 12 Concepts. As in other countries, AA Italy is organised into Areas (normally covering the same territory as an Italian administrative Region), whose Delegates meet at an annual Conference and elect the General Service Trustees, whose office is in Rome. Committees, including Public Information and Relations with Institutions, are active at the regional and national level. An interesting sign of renewal was the 1997 election of the first non-alcoholic Trustee, an established practice in other world countries. The magazine *Insieme* containing meeting information and stories by recovering alcoholics is published every other month. All AA literature, mostly Italian translations of the official English language literature generated in the US, is available at AA national headquarters of 35 via Torrerossa, Rome.

At least three Italian surveys were carried out to describe AA and its participants. A first survey was completed by AA in 1990 and 1992 on 138 AA group members from Florence, Pistoia and Empoli, in Tuscany. Two other national surveys were accomplished by AA General Services in Italy in 1996 on 1813 AA group members, and in 1998 on 3.045 AA members.

As a whole, the results are similar and are summarised as follows (Allamani, 2000):

- the women are half the men. In National Health Services or Hospitals the w/m ratio is quite lower;
- average age is between 40 and 50 years, varying between 17 and 77 years;
- about 70% are either married or living together, while 10% are

either separated or divorced;

- more than 60% possess either an elementary or middle school diploma, and 5% have a University degree;
- people employed make up about 60%.

On a whole, group attendance by females and younger adults has increased over the past few years.

12.3.2. *Other 12 Step Associations*

AA meetings are generally only attended by those who express a desire and want to stop drinking; relatives and friends are not allowed. The AA programme was however the basis for other associations which were created in the US and later spread across the ocean. The fellowships for relatives and friends are: Al-Anon *(Relatives and Friends of Alcoholics)* and Alateen *(Adolescent Children of Alcoholics).* Family groups have their own meetings and rooms independently of AA (Zavan, Brambilla & Cibin 1997).

The first Italian Al-Anon Group was opened in Rome in 1976. The Italian Al-Anon General Services report that nine groups were active in 1979 and 206 in 1989. 341 Al-Anon groups, 35 Alateen and 18 AChoA groups were active in the country in 1997. By the 2000s there were about 415 Al-Anon groups including the Alateen (children of Alcoholics) that are considered as part of Al-Anon (Al-Anon 2004).

Altogether the participants to AA and Al-Anon groups are estimated to be presently about 20,000.

Other 12 step associations involved with other dependencies are developing in Italy: Narcotics Anonymous (NA) (Wells 1992), Overeaters Anonymous (OA), Co-dependence Anonymous, Sex and Love Addicts (SLA), Gamblers Anonymous, Nicotine Anonymous, Debtor Anonymous and A.R.T.S. Anonymous as well as their related family member associations. The organisation of these associations follows the international tradition: General Services, Areas, and Committees as public information,

press, relationship with public institutions. Literature has been possible mainly through the translation of the original official English literature.

12.3.3. *The Clubs for Alcoholics in Treatment (CAT)*

The other major association is the *Italian Clubs for Alcoholics in Treatment (CATs)*, which stems from a multi-family group program born in Croatia during the Sixties (Hudolin, 1991; Patussi et al., 1996) from the ideas and the practice of Vladimir Hudolin, a psychiatrist at the University of Zagreb who was able to communicate the principles of Alcoholics Anonymous in a country with Socialist Marxist values.

In 1979 they were imported into north-eastern Italy through experiences in Trieste and Udine. The first experiences occurred within some hospitals where a few physicians initiated their alcohol treatment programs; later on they spread into the community, especially in the Addiction units already dedicated to the treatment of illegal drug patients, or into therapeutic communities and other public services. Since its start, the system greatly and positively affected the birth of alcohol treatment services and the diffusion of the awareness of the alcohol-related problem in Italy among professionals, and the general public.

This aspect has to be acknowledged more than has been done so far. For many years both professionals and health institutions funded and supported the CAT groups. However, more recently groups have made some efforts to better define their own autonomy in relationship with the public services, with which they tend to co-operate anyway through local meetings and training experiences. Community key people and professional are involved as a means to favour such kind of interactions (Colusso, 2004).

Clubs are groups of up to 10-15 persons, in which the alcoholics and their family members meet once a week for one hour and a half, and are guided by a social or health professional, or by a "recovering alcoholic", or a family member. The Clubs are located in sites such as churches, municipalities, NGO facilities, close to the homes of the alcoholics' families. The group treatment is based on multi-family interactions and its con-

tents are the issues of alcohol-related problems and harm and of social relationship. Acceptance is open to every "alcoholic" person as a peer in the group. Alcoholism is not just a problem of the individual, but of the whole family, and beyond that of the society at large. Usually to support her/his abstinence each person is asked to take a tablet of Disulfiram daily, given from the spouse or a friend and sometimes by people in the Club. Presently this practice has been abandoned by some groups.

A Club is split into two if its participants exceed a certain number. Sometimes a Club accepts a family having an illegal drug use problem or addiction, or people with social or psychiatric ailments. Clubs (Patussi et al., 1996) differ from AA in that meetings are co-ordinated by a qualified leader (or servant) and alcoholics and their relatives or close friends take part in the same meeting together. Nearby clubs are organised into associations (ACAT, or association of CAT); these associations are part of larger associations at the province (APCAT) and regional (ARCAT) levels. The Italian CATs National Office (AICAT) has been in Udine, via Chisimaio n. 40 since 1989. Each level has a president who is periodically elected.

This method quickly found acceptance in many regions in Italy, especially by the second part of the 1980s. In the beginning its most important representative was Renzo Buttolo, the chief of a medical hospital unit in Udine (Colusso, 2004). Clubs are distributed mainly in the North of Italy, but are present all over the country. The death of Vladimir Hudolin in 1996, did not hinder the association's energy. In 2000 there were about 2,600 clubs with about 20,000 alcoholics and family members; women constitute one half of the participants (F/M ratio 1:1).

Alcoholics and their families are referred from hospitals, addiction units, or social services, or from other alcoholic families. Such organisations try to have an impact on society in terms of promoting information and social consensus and support about issues such as treatment for alcoholics and their families, information about the risks of drinking in the work system, or when driving.

Special attention is paid to the training of group leaders or servants who have to qualify after participating in a brief workshop (Salerno, 2004). An on-going educational program is provided for servants.

Alcoholics and their families are encouraged to attend alcohol-related educational programs for families and their community. Local inter-club meetings, and Regional and National conferences are regularly held. CATs may be part of community programs for the prevention of alcohol-related problems.

12.3.4. *Differences between CAT and AA*

CATs differ from AA in that meetings are co-ordinated by a certified leader (or servant), often a health professional or social worker, and alcoholics and their relatives take part in the same meeting together. AA have meetings of only alcoholics (and family or friends have a separate group, Al-Anon) with a coordinator who is a group participant having been sober for some time.

While AA shares the principles of anonymity and autonomy of all AAs in the world, the CAT overtly co-operates with public treatment systems for alcoholics and with the political authorities. AA implies that its members share the same totalizing existential viewpoint, specific for a limited number of people in the community, that is, the alcoholics. The Clubs actively move towards the community as a whole, and try communicating their message of abstinence from the risks associated with an eccessive consumption of alcohol to all the population. AA approaches to alcoholism as a medical, psychological and existential illness; CATs refer to it as a lifestyle. Both associations work towards a common result, i.e. promoting a better awareness of alcohol problems and their treatment among the general public and professionals.

Alcoholics Anonymous remained aloof from health care professionals and institutions and co-operation was quite limited for a long time. However only positive interactions between AA and professionals have occurred since the early 1980s in Milan, Dolo (Veneto), Senigallia (Marche), Florence (Gallimberti et al.,1981; Ricci et al., 1988; Allamani, 2000).

Perhaps, due to an excessively rigid observance of the tradition of anonymity, there was an initial need to grow separately from the health-

care world or the spiritual content of the AA programme so remote from medicine's solid biological approach. It is not surprising that a survey completed in Florence in 1980 revealed that a sizeable number of leading hospital directors did not know of AA's existence seven years after it had started operating in that town (Allamani & Petrikin, 1996). Alcoholism had little room in the interests of physicians and psychiatrists at that time save for treatment of its acute stages and even so to quite a limited extent. The Fellowship started opening up to the outer world during the late 1980s. As a consequence of debate within its groups, more information in the mass media and better knowledge of its spiritual orientation in the Italian culture, it started becoming better known by doctors, politicians and the public at large. Then for example, a treatment centre based on the Minnesota method, was opened in Rome (Fanella et al., 1996).

On the contrary, the beginning of the movement of the Clubs for Alcoholics in Treatment was quickly successful because their approach, initially non-spiritual, was more acceptable to the medical paradigm. In addition, they challenged the young health professionals to participate in the aftercare of potentially severe patients, as alcoholic people may become. For many years the diffusion of the CAT was much wider than AA. CAT mostly contributed to the development of alcohol treatment services and to the increase in the number of professionals culturally and scientifically involved in the arena of alcohol consumption intervention in Italy.

Summarising the main differences between the two types of associations (Pini, 1996):

- AA aims at reconstructing the personality of its members, who adopt AA's spiritual principles which are considered to be essential for an individual's development; CAT approaches the whole family;
- CAT envisages the role of family and society at large in the determination of alcoholism, that have to be faced through social networking; alcoholism is part of a continuum which stems from drinking alcohol, from moderate or social to risky behaviours. AA is concerned with individual problems experienced by alcoholics,

considered as “life or death” issues, the solution of which demands change lasting throughout a person’s whole life;

- CAT indicates that alcohol dependence can be cured after some years; AA implies long and indefinite involvement with the group and upholds that “you cannot be cured of alcoholism”;
- AA considers alcoholism to be a disease, refers to previous World Health Organisation definitions and the current classifications of American Psychiatric Association DSM; CAT views alcoholism as a lifestyle problem, in tune with the recent approach of WHO to hazardous drinking.

12.4. Interaction between NGOs and the Health Care System

It is frequent, according to the local health service programs, that after or parallel to a period of out- or in-patient clinic treatment the patients is referred to AA (and its derivations) or to Clubs for Alcoholics in Treatment (CAT). Family doctors, psychotherapists or social workers may also invite their patients to attend a group, either directly or through a group member such as a patient with whom the professional keeps in touch.

By and large the interaction between Italy’s Health Public Care System and the two NGOs may be described according to three approaches: (a) the Hudolin model, wherein alcoholic patients, after they have been diagnosed and treated, are sent to CAT by professionals; (b) a one-way model when the Public Health Service professionals refer all its clientele to AA; (c) a multimodal model approach, where a Public Health Care service has the choice to refer its patient and his/her family either to AA, or to CAT and sometimes to family therapy and/or other types of psycho-social and medically-oriented treatment. Nowadays the multimodal approach seems to be more diffused, probably due to the larger availability of the two NGOs.

The type of referral is decided upon according to criteria, which are related to the local availability of the two associations, but more often is

linked to the inclination that the health professional has towards the one or the other system.

By and large, a tendency towards extroversion, being at ease in social interactions and having a strong and positive family member or friend, is associated to a better success of CAT. A tendency to be introverted, individualistic, and having a sensitivity to being controlled by the family or the environment are traits that "prognosticate" a better success of AA.

Few studies have been done in Italy evaluating the interaction of self-help groups and the Health Care Service. One published study involved 480 new patients admitted to six Italian alcohol services in 1995, of whom 297 (62%) were also referred to AA. After 12 months, a high percentage (70%) of patients referred to AA remained in touch both with the group and the Health Care Service. Therefore, such a study has documented that entry into a self-help group does not deter people with alcohol-related problems from returning to their general practitioner (Jean, Cibin, Pini et al., 2004).

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Stampa LITOS - Roma
06.5750152 - litos@litos.it