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CONNECTS HEALTH, SCIENCE AND SOCIETY

BURDEN OF DISEASE WORKSHOP - BERLIN - 18 SEPTEMBER 2026

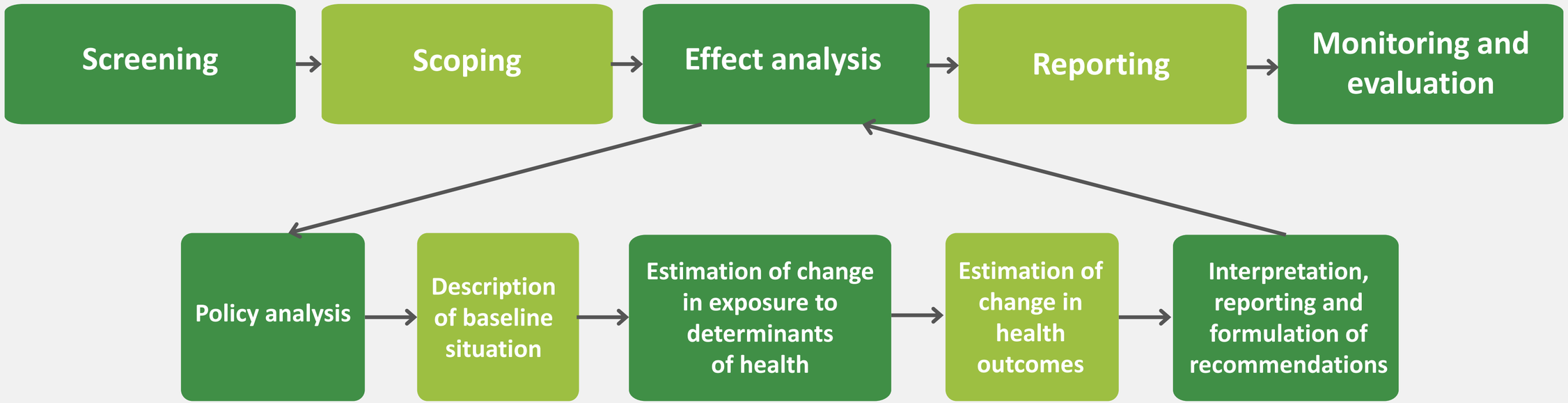
Health Impact Assessment

From burden of disease to policy action – the case to alcohol pricing in Belgium

Sarah Croes – Sciensano, Health Information Service
sarah.croes@sciensano.be

.be

Steps of Health Impact Assessment



Today's focus: not just running these steps, but embedding stakeholders (government, and civil society) at every one of them, from scoping the policy question to monitoring what happens after implementation.

CASE STUDY

BET-ALC: scenarios for affordability

78%
current drinkers

4,000
alcohol-attributable deaths

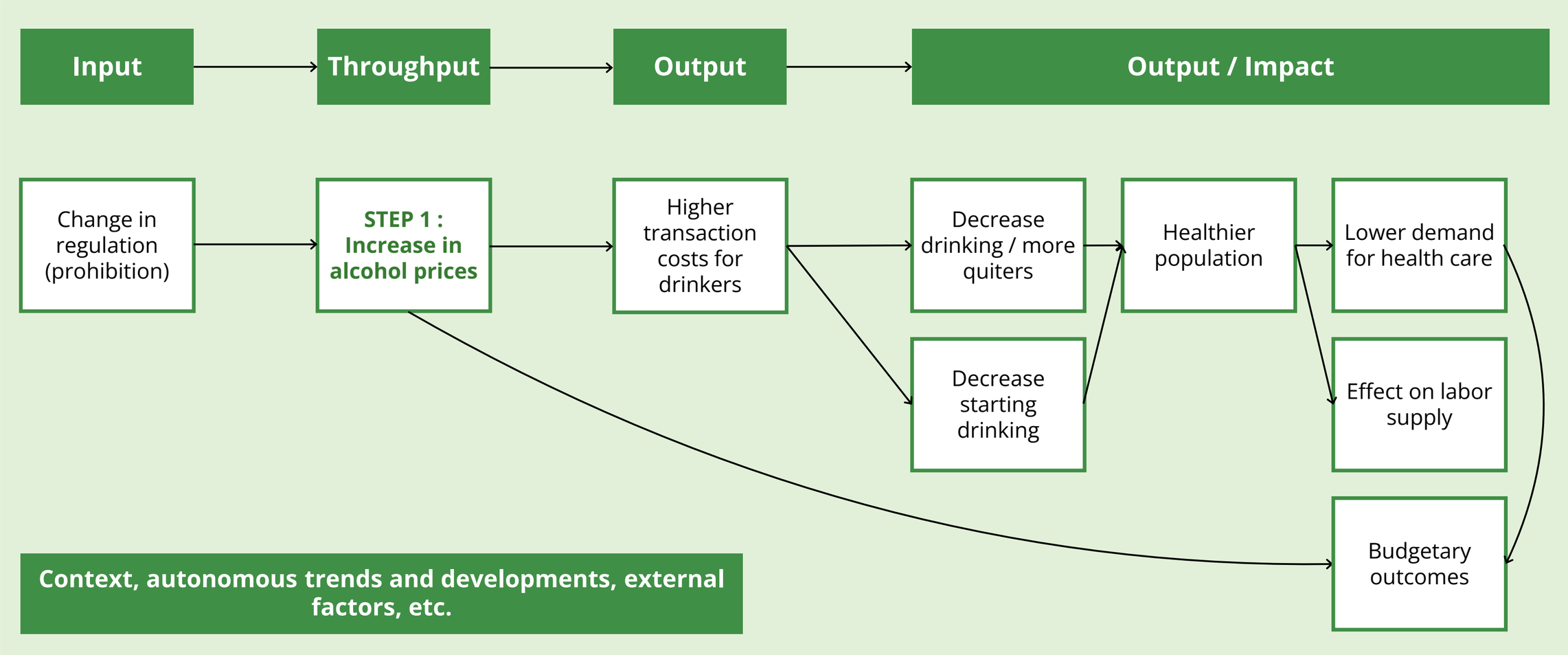
€700M+
in direct medical costs

Policy context: Belgium's Interfederal Strategy on Harmful Alcohol Consumption (2023–2028) sets 75 measures under its 2023–2025 Action Plan, with an evaluation planned for 2026. **Action 68** specifically calls for an assessment of alcohol pricing measures and their potential impact in Belgium.

> ***"Which alcohol pricing policies could have the greatest impact on health in Belgium?"***

CASE STUDY

STEP 1: Policy analysis



Belgian context and policy scenarios

Current policy framework

REGULATIONS IN PLACE

- Legal purchase age 18 (beer/wine: 16)
- Retailer licensing required
- Vending-machine & hospital-shop sales banned
- Night sales at petrol stations restricted

CURRENT GAPS

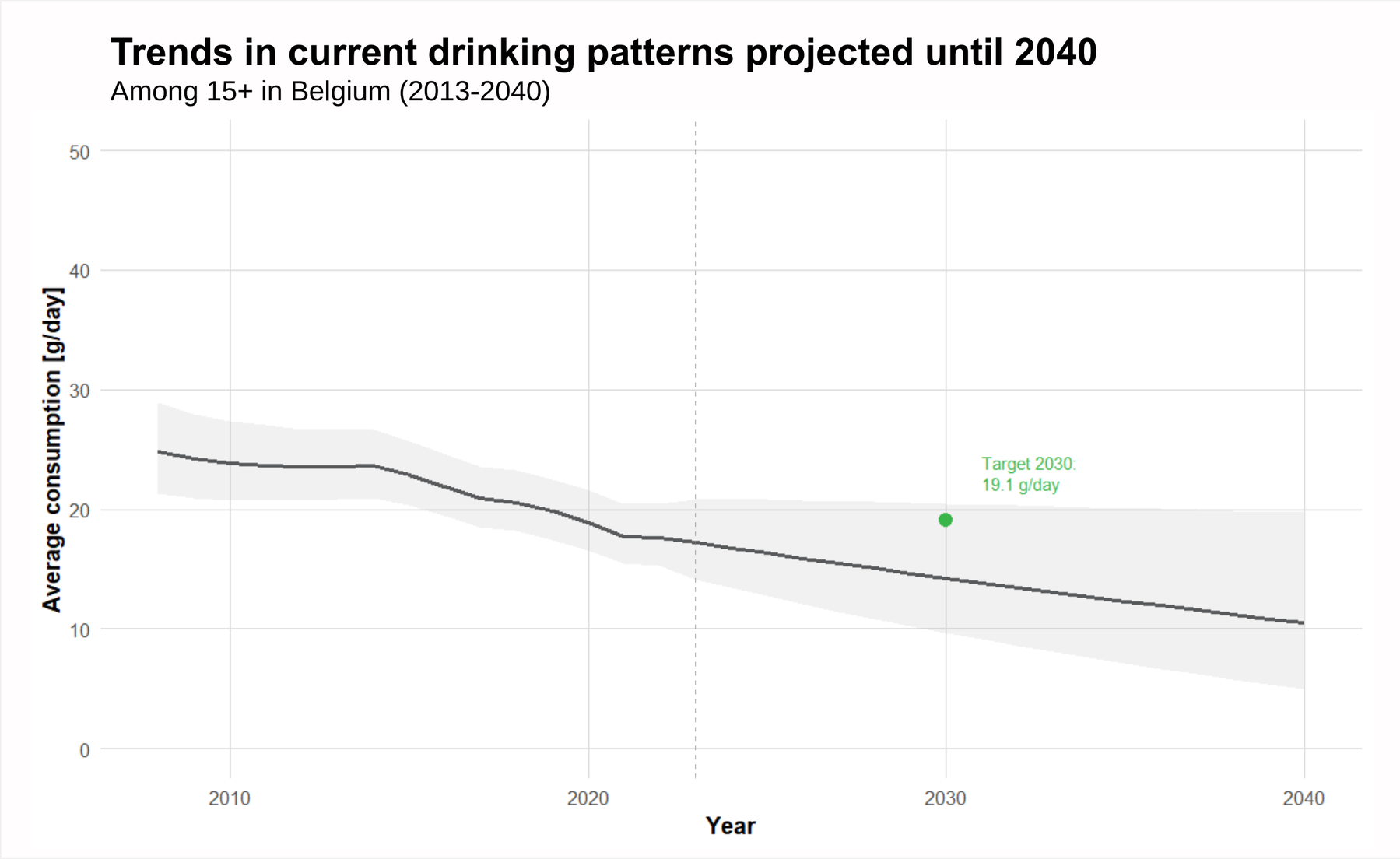
- No national limits on outlet density
- No marketing regulation
- No minimum pricing mechanism
- No excise reform since 2015 / no indexation

Scenario menu ⟶ refined with steering group

- **Minimum Unit Price (MUP)**
  40c / 58c / 75c per unit (± 2% inflation uprating)
- **Ad valorem tax**
  +5% / +10% on retail price
- **Volume-based tax**
  +5% / +10% per 100ml
- **Alcohol-content tax**
  +5% / +10% per 10g ethanol
- **Combined packages**
  MUP + ad valorem / MUP + alcohol tax

CASE STUDY

STEP 2: Definition of baseline situation



CASE STUDY

From price changes to health impact

Price and market share data
Euromonitor

→

Price change per scenario
Taxes and MUP threshold

→

Consumption change (g/day)
Price elasticities (literature, GBD)

→

PIF calculation
BAU vs policy, dose-response function

→

Avoidable burden
Disease burden, (BeBOD, BHIS, WHO)



This pipeline was presented to the steering committee as a ‘draft model’ – the point wasn’t to show results yet, but to jointly identify which data inputs were needed and whare the gaps were.

CASE STUDY

STEP 3: Estimation of change in exposure



Alcohol price



Alcohol intake

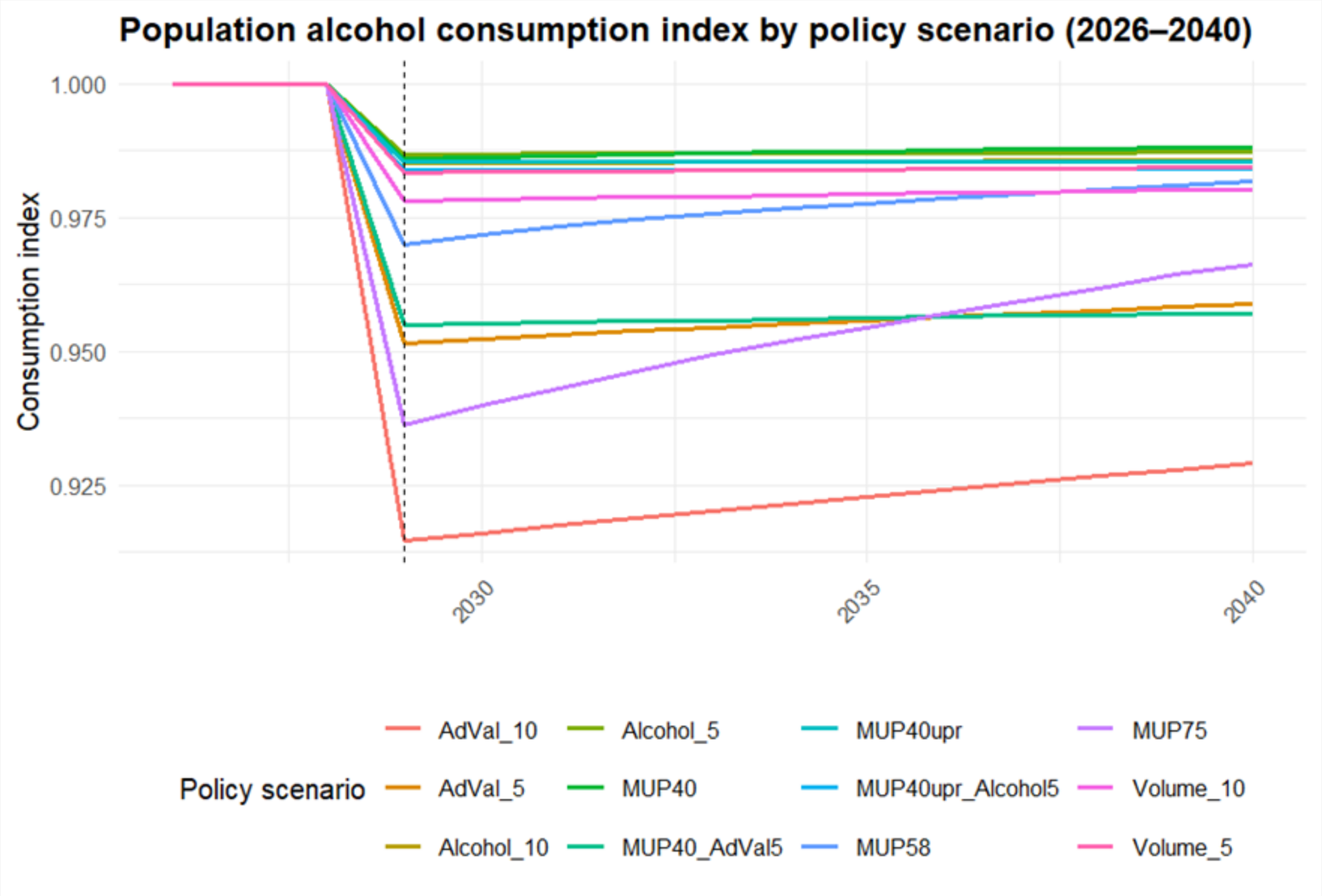
Scenario	Average increase in price	Consumption change
MUP 40c	0.4 % (beer)	1.19 %
MUP 75c	**5.0 % (beer)**	**3.37 %**
Ad valorem of 5 %	**5.0 %**	**4.9 %**
Ad valorem of 10 %	10.0 %	9.8 %

Euromonitor →
price and market shares

Literature ⟶
price elasticity

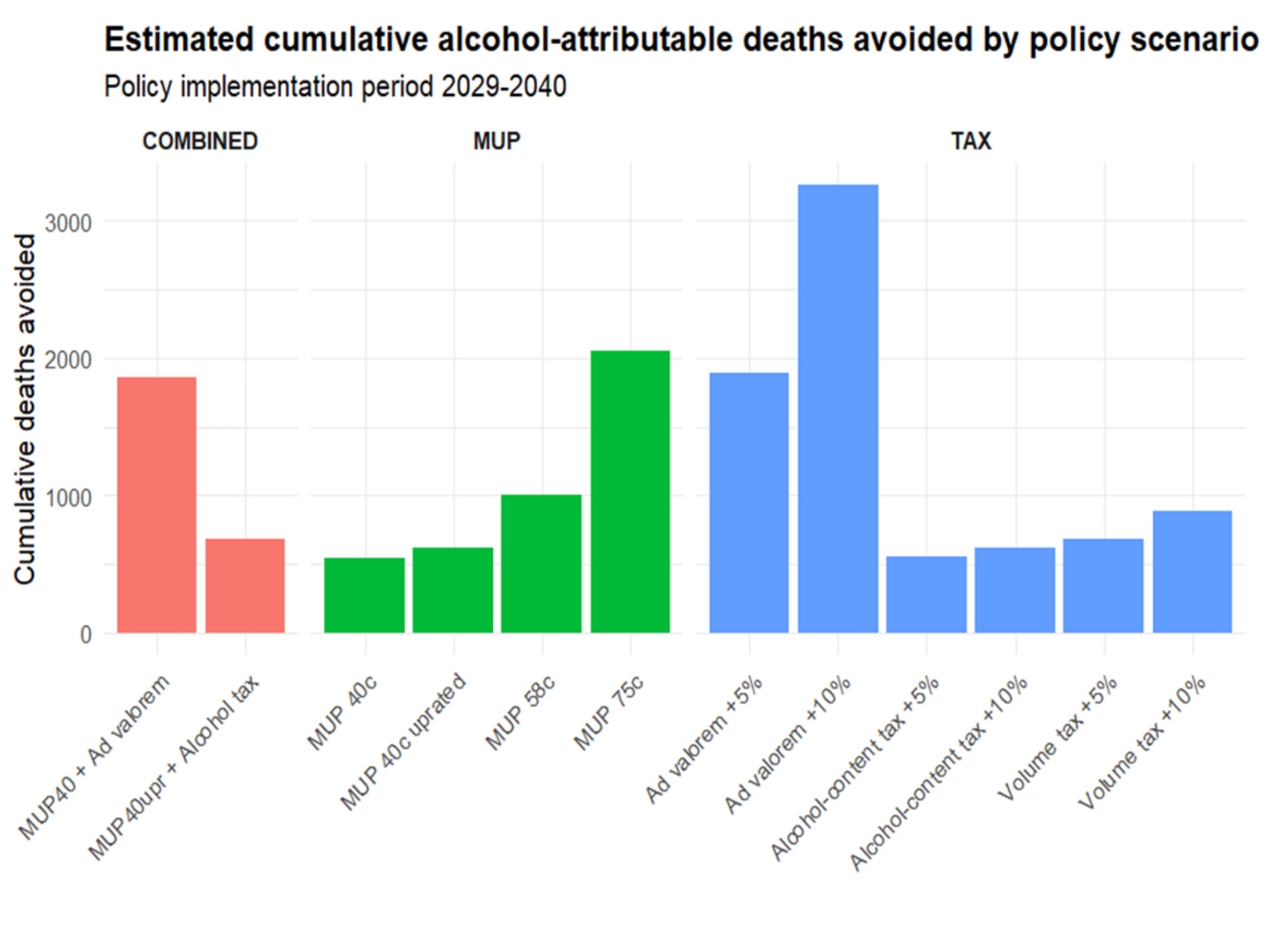
CASE STUDY

STEP 3: Estimation of change in exposure



STEP 4 : ESTIMATION OF CHANGE IN HEALTH OUTCOMES

Stronger pricing policies → larger reduction



Reading results

- All pricing policies reduce alcohol-attributable deaths vs baseline
- MUP shows a **clear gradient**: higher threholds far outperform low ones
- Ad valorem tax has the **largest single-lever effect** - it applies directly to retail price
- Volume- and alcohol-content-based taxes translate in **smaller price rises, hence smaller effects**
- Combined MUP + tax packages perform well by **targeting cheap products AND raising prices broadly**

STEP 4 : ESTIMATION OF CHANGE IN HEALTH OUTCOMES

How complex should the model be?

1

Potential Impact Fraction

Static, one risk factor at a time. Fast and transparent – easy to walk a steering committee through in one meeting

2

System Dynamics

Adds feedbakc loops and timing, can give you more insights into how long impact takes to cause effects.

3

Markov Model

Integrates several risk factors and interventions in one model, so scenarios can be compared, acorss risk factors

The right model depends on the policy questions and on what the stakeholder need to make a decision. A more complex model, asks more data and explanation to stakeholder, but might estimate the reality better.

Turning stakeholder judgment into evidence

SWOT survey

- Online, via Limesurvey → completed by steering group and wider stakeholders

- For each of the 11 scenarios, stakeholders rated **Strengths, Weaknessess, Opportunities and Threaths** – rather than raking option directly

⟶ This reduces strategic / **social-desirability bias** compared with ‘which policy do you prefer’ – surfaces reasoning behind a position.

WHO WE HEARD FROM

- FPS Public Health
- FPS Economy
- FPS Finance
- Academia
- NGOs

What stakeholders told us

Taxation-based approaches

Strengths

- Easier to implement within existing tax structures
- Generates government revenue
- Alcohol-content tax aligns price with health risk

Challenges

- Political resistance & industry lobbying
- May affect all consumers, not just harmful drinking
- Risk of cross-border purchasing

Minimum Unit Pricing (MUP)

Strengths

- Targets cheap, high-strength products
- Better protects vulnerable / high-risk drinkers
- Stronger perceived equity impact

Challenges

- More complex implementation
- No government revenue generated
- Low thresholds may have limited impact

STEP 5: FORMULATION OF RECOMMENDATIONS

Developing a policy roadmap

Combining the modelling results with the SWOT findings → not to pick one 'correct' policy, but to visualise the trade-offs.

Excise duty	**High political feasibility** • Easy to implement • Compatible with existing fiscal structure	**Estimated effectiveness** • High for ad valorem **Perceived equity** • Lower ⟶ seen as a general 'punishment'	*Watch for: cross-border effects & market response*
MUP	**Lower political acceptability** • More complex to implement • No revenue generated	**Estimated effectiveness** • Rises sharply above 58c **Perceived equity** • high ⟶ targets vulnerable populations	*Recommendation: avoid levels below 58 cents + add yearly inflation uprating*

Conclusion

- From scientific exercise to sustainable HIAs
  ⟶ *‘No alcohol tax reform during current goverment’*
- Long term goal: **Menu** with set of health policies
- Organize standing **HIA steering committee**, responsible for:
  - Identifying relevant health policies and calendar for execution
  - Channeling outputs into decision making process
  - Organizing ad hoc policy support
  - Organizing sustainable cooperation

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BET ALC

Sarah Croes Sarah.Croes@sciensano.be

Vanessa Gorasso Vanessa.Gorasso@sciensano.be

Sarah Nayani Sarah.Nayani@sciensano.be

Brecht Devleesschauwer Brecht.Devleesschauwer@sciensano.be

www.sciensano.be