ROUTLEDGE ADVANCES IN HEALTH AND SOCIAL POLICY

Alcohol, Power and Public Health

A Comparative Study of Alcohol Policy

Shane Butler,
Karen Elmeland, James Nicholls and
Betsy Thom

ROUTLEDGE

Alcohol, Power and Public Health

In recent years, the reduction of alcohol-related harm has emerged as a major policy issue across Europe. Public health advocates, supported by the World Health Organization, have challenged an approach that targets problem-drinking individuals, calling instead for governments to control consumption across whole populations through a combination of pricing strategies, restrictions on retail availability and marketing regulations.

Alcohol, Power and Public Health explores the emergence of the public health perspective on alcohol policy in Europe, the strategies alcohol control policy advocates have adopted, and the challenges they have faced in the political context of both individual states and the European Union.

The book provides a historical perspective on the development of alcohol policy in Europe using four case studies – Denmark, England, Scotland and Ireland. It explores the relationship between evidence, values and power in a key area of political decision-making and considers what conditions create – or prevent – policy change. The case studies raise questions as to who sets policy agendas, how social problems are framed and defined, and how governments can balance public health promotion against both commercial interests and established cultural practices.

This book will be of interest to academics and researchers in policy studies, public health, social science, and European Union studies.

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This book is dedicated to our colleague and friend Karen Elmeland, 1950–2016.

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1 Introduction

The aim of this book is to compare the extent to which alcohol policy development in four European countries – Denmark, England, Ireland and Scotland – has responded to the emergence of public health perspectives on alcohol control, especially as developed and supported through the World Health Organization (WHO). While it will be described in more detail below, the 'public health' position on alcohol broadly argues that national governments have a duty to tackle alcohol-related harm by introducing regulatory control measures aimed not only at tackling 'problem drinkers' but at reducing consumption across whole populations. In describing the political journey of this principle in recent years, we critically appraise how it has operated in the European context within the constraints of EU 'realpolitik', and in national settings where local cultural, political and economic circumstances create both opportunities for, and barriers to, novel policy development. We also consider how this approach sits within the wider history of alcohol policy advocacy, which stretches back beyond the emergence of the modern public health approach in the late 1960s to the nineteenth-century temperance movements.

Historically speaking, political interest in alcohol waxes and wanes. At times it is an issue of intense political activity, as was the case internationally in the early decades of the twentieth century; at others, it moves down the political agenda. However, even when political interest is intense, alcohol policy tends to display a high degree of equilibrium (Baumgartner et al., 2014). That is to say, established social and political norms, the influence of powerful commercial stakeholders, and an aversion towards risk among policymakers often combine to limit the political viability of radical shifts in either policy framing or legislative action. Novel policy ideas face a range of systemic barriers that put them at a disadvantage compared to the status quo. This book will highlight some of the ways those barriers operate in regard to alcohol.

Policy development is about far more, however, than persuading the right people to follow a given course of action. It is, more fundamentally, about problem definition: in this instance, how alcohol 'problems' are understood by the general public and framed in policy circles (Greenaway, 2011). At the heart of the 'public health perspective' is the argument that alcohol problems exist on a continuum throughout populations rather than as a simple

dichotomy in which 'problem' drinkers, and problem drinking, are clearly distinct from moderate consumption and drinking behaviour. By rejecting the notion that harmful consumption can be uncoupled from moderate drinking behaviours, contemporary alcohol policy advocacy challenges a dichotomous model of harm that was dominant in much of the developed world from the middle of the twentieth century.[1] The translation of this idea into viable political action is a matter of achieving sufficient consensus on how alcohol problems are framed. It is, in that sense, not simply about evidence but about hegemony: about establishing ways of framing alcohol problems such that they become the default understanding among sufficient key groups to make policy change possible (or, indeed, inevitable).

In addition to requiring breaks in established political routines and a shift in the framing and conceptualization of alcohol problems, alcohol policy advocacy presents a direct challenge to the commercial interests of the alcohol industry itself. Because it rejects a dichotomous model of harm, which boxes alcohol problems off from the majority of consumption, and because its goal is a reduction in the basic volume of alcohol sold, the public health frame is opposed forcefully by the bulk of alcohol industry actors. For most producers and retailers, the prospect of state regulation of the supply of alcohol, with the ultimate goal of reducing the scale of the market, is anathema. In a market as diverse and complex as alcohol, there are, for sure, variations, and some ostensibly public health-oriented policies, such as minimum unit pricing, have garnered the support of some industry stakeholders (Nicholls and Greenaway, 2015). Nevertheless, the determined opposition of powerful commercial interests is, undoubtedly, a critical factor in the power dynamics of alcohol policymaking (Babor et al., 1996; Hawkins and Holden, 2012; McCambridge et al., 2013; Gornall, 2014).

Power, of course, is not monolithic but dispersed among an array of actors. Policymakers may be disproportionately swayed by the interests and lobbying muscle of the alcohol industry but they are also responsive to other sources of power. In regard to alcohol policy, the medical establishment is also a key player, especially in health departments. The support of the World Health Organization is not insubstantial in giving weight to the claims of alcohol policy advocates, nor is the formation of advocacy coalitions such as the Alcohol Health Alliance in the UK or the Global Alcohol Policy Alliance internationally (Thom et al., 2016). Furthermore, public opinion – especially as mediated through the mainstream press – retains significant influence in shaping policy. In the 'court of public opinion', alcohol policy is about far more than health: it is about personal freedom, pleasure, leisure, perceptions of tradition, national identity, and so forth. Policymakers, when approaching the subject of alcohol, will be mindful of far more than simply the real or predicted health impacts of a given policy. Where alcohol is concerned, health is only one facet of a complex social and political reality.

While much of this book describes the framing of alcohol debates over time, it is also concerned with understanding the dynamics of how policy

works. In particular, it looks at how policy 'streams' have developed in the alcohol field, and how those streams converge and separate such that, under some circumstances, radical policy shifts become viable (Kingdon, 2011). From this perspective, policy is never simply a case of the best evidence, or even the best arguments, winning out. Indeed, as John Maynard Keynes quipped, 'There is nothing a government hates more than to be well-informed, for it makes the process of arriving at decisions much more complicated and difficult' (cited in Breckon, 2016: 4). Rather, the fixed mindsets and processes that, for most of the time, reinforce policy stability are only likely to be punctured when a number of sociopolitical forces align: when an issue is not only a source of raised public and political concern, but when policy solutions emerge that match both the public framing of a given issue and the ideological values of policymakers themselves. In looking at a number of case studies, this book will focus particularly on these dynamic processes: how, when and why does alcohol rise up the political agenda? How do different constructions of alcohol problems acquire scientific validity and how do they gain political traction? Where do policy solutions come from and how are they advocated for? How does alcohol policy align with ideological principles on both the left and the right, and are there cases where cross-ideological coalitions emerge which drive change in the regulation of alcohol?

The role of 'advocacy coalitions' is crucial in this process (Sabatier, 1988; Sabatier and Jenkins-Smith, 1993; Thom et al., 2016). In the context of ideological, systemic, commercial and political pressures to maintain a liberal frame for alcohol policy, advocates for more stringent alcohol control have needed to form wide-ranging alliances to create political momentum. Examples of alcohol control coalitions can be identified all the way back to campaigns for anti-gin legislation in Georgian England and can be traced – both directly and indirectly – from the Victorian and Edwardian temperance movements through to alcohol policy coalitions today (Harrison, 1971; Shiman, 1988; Greenaway, 2003; Nicholls, 2009; Yeomans, 2015). In all cases, the core principle that government should proactively seek to reduce consumption has drawn together a range of actors to formulate coordinated policy positions and advocacy activities, establish a public profile, maximize credibility, develop persuasive bodies of evidence and – ultimately – gain the ear of influential policymakers. In observing the journey of public health principles, this book will consider how advocacy coalitions have emerged, how they worked both to develop and promote an evidence base that supports more interventionist alcohol policy, and how they have established networks within governmental structures to a greater or lesser degree of success.

Thinking about alcohol policy

At stake in much contemporary debate on this issue is whether policy is 'evidence-based' or not: what the status of evidence on alcohol harms is, how evidence is used and abused, and how evidence-gathering and policy advocacy interact.

There is some value in exploring the degree to which public policy on alcohol *is* evidence-based in different times and places, but (for reasons alluded to above) this is rarely the case in any pure sense of the term. There is also some value in arguing that policy *should be* evidence-based, but doing so needs to avoid the trap of assuming policymakers are ever purely rational, objective actors working beyond the realities of political calculation (Mulgan, 2005; Russell et al., 2008; Hallsworth et al., 2011). In understanding the relationship between evidence and policy, it is most important to remain sensitive to the degree to which social and policy problems, and the multiple evidence bases that address those problems, are socially constructed. That is not to say that problems are illusory nor that evidence is unreliable; rather, it is to say that how social problems are understood, described, analysed and responded to reflects the social contexts in which those processes occur.

By extension, how policy 'problems' are identified, and which policy 'solutions' are adopted or rejected also reflect not merely the validity of the science (or, indeed, the opinions of policymakers) but a complex interaction between social conditions, public and political discourse, research activity, market conditions and broader ideological principles. Indeed, the way in which problems are constructed is not only a consequence of complex social processes, but central to the way in which social power operates. As Carol Bacchi puts it, 'We are governed through problematizations rather than through policies. Therefore, we need to direct our attentions away from assumed "problems" and their "solutions" to the shape and character of problematizations' (Bacchi, 2015). This book follows recent work on problem construction and framing in both drug and alcohol policy (e.g. Thom, 1999; Stevens and Ritter, 2013; Nicholls and Greenaway, 2015; Katikireddi et al., 2014; Katikireddi et al., 2015; Bacchi, 2015). It is less concerned with the simple question 'Is alcohol policy evidence-based?' than with understanding the relationship between problem construction, evidence, advocacy and policy in complex social contexts where politics is moulded by relationships of power.

Policy 'success' is partly about sheer political influence: ultimately, money talks and so commercial actors are always at an advantage. However, it is also about effectively framing a problem such that it acquires traction across the policy landscape. One useful approach to placing alcohol policy ideas in context is to imagine them, schematically, as operating across two dimensions: a *diagnostic* dimension (how alcohol 'problems' are defined) and a *political* dimension (the level of state intervention considered legitimate) (Figure 1.1). In alcohol policy debates, the diagnostic dimension can be thought of as running from a 'dichotomous' problem-construction (in which 'problem drinking' is essentially different from 'moderate drinking') to a 'continuous' one (in which harms are disaggregated and spread across populations, albeit with varying degrees of intensity). The political dimension runs from libertarian (supporting maximum individual freedom) to authoritarian (maximum state intervention). The end points on each dimension are theoretical extremes: few people would pursue an exclusively

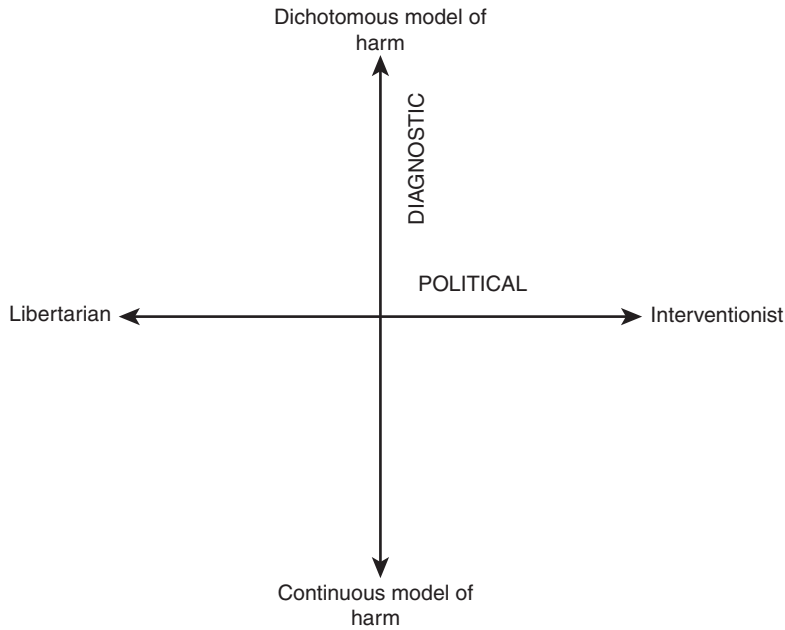

Figure 1.1 Diagnostic and political dimensions of alcohol policy

dichotomous or continuous model of harm, or be entirely libertarian or authoritarian.

National prohibition movements, for instance, were strongly interventionist, but often varied in the degree to which they emphasized continuous over dichotomous harms. Contemporary public health advocacy is strongly committed to a broadly continuous model of harm, but argues for control policies rather than outright bans. Publicly, the alcohol industry tends to promote a dichotomous model aligned to a light-touch interventionism – though through their allied think tanks and lobby groups, they tend to shift much more forcefully towards libertarianism, albeit rarely calling for complete deregulation.

Within such a schema lies an array of complex and important distinctions. However, thinking about these dimensions can provide a useful heuristic for positioning moments in problem construction as well, importantly, as considering where particular problem frames have aligned with wider social and ideological contexts over time. Perhaps most importantly, however, is that it can serve as a reminder that the political and the diagnostic are always in relation to one another where alcohol policy is concerned. The issue is the nature of that interaction, not whether it is there at all.

This book, therefore, rejects naïve 'rational-linear' models of policymaking, which assume policymakers either do, or should, base their decisions primarily on the recommendations of value-free scientific researchers – were 'value-free

scientific research' ever to exist (Russell et al., 2008; Cairney, 2012). Policy is, of course, frequently influenced or informed by empirical research findings but the process is *political*. Policymakers invariably balance research evidence with party politics, departmental interests, ministerial priorities, perceived public opinion, economic interests, and so on (Marmot, 2004; Stevens, 2011; MacGregor, 2013). In this context, public health evidence is one element in a complex struggle for policy influence (Smith, 2012). The 'problem' from this perspective, then, is not the lack of evidence-based alcohol policy, nor the amount of alcohol-related harm in a given society, but understanding how competing bodies of evidence, reflecting competing political, economic and sociological perspectives, achieve power in complex and dynamic political environments.

The commonly used analytical framework of 'multiple streams' policy analysis is helpful in making sense of this (Kingdon, 2011; see Katikireddi et al., 2015 and Nicholls and Greenaway, 2015 for prior applications to alcohol policy). Multiple streams analysis (MSA) is concerned with understanding the combined social, political and economic processes that both cause policy ideas or 'solutions' to form and to become politically viable. Like many other contemporary policy models, MSA asserts that policy change is dependent on the unpredictable confluence of social and political factors at any given time. Describing this process, Kingdon uses the image of 'policy streams' as part of his wider explanation of those moments, referred to as 'policy windows', when opportunities for policy change briefly, and temporarily, arise.

According to this framework, 'policy windows' can open when three 'streams' converge:

1 *The problems stream*: the process by which an issue emerges as an object of political concern. This can be a consequence of objective social change (e.g. a rise in alcohol-related mortality), but is more often shaped by a wide array of activities in which interest groups, journalists, public bodies, and so on compete to both frame a given issue and bring it to the attention of policymakers. Most potential policy 'problems' do not make it onto the political agenda, so this is an intensely competitive process involving advocacy, news agenda-setting, coalition-building and other processes far beyond the gathering and communication of research evidence.
2 *The policy stream*: the developments of policy 'solutions' to a given problem. Again, this is competitive and contingent upon both action and circumstance. Key to the process are so-called 'policy entrepreneurs': individuals or organizations who take the lead in presenting policy solutions and linking them, in both public and political discourse, to a given issue.
3 *The political stream*: the political climate in which the competitive, agenda-setting process operates. Policymakers are receptive to particular policy solutions only when they tally with the ideological and practical realities of the political context. As will be discussed later, for example, the 'solution' of minimum unit pricing to tackle harmful consumption fared

much better in Scotland than England partly because it was amenable to dominant political narratives around national renewal that were critically important to the Scottish government of the time.

Without establishing a powerful 'problems' stream, there is little likelihood of a policy position acquiring political momentum. Since the 1970s, enormous efforts have been made by public health policy advocates to establish their broadly continuous diagnosis of the alcohol 'problem', and their political argument that the state has both the capacity and moral duty to intervene in this issue, as compelling in policy circles. On the other side, the alcohol industry has strived to either push alcohol down the policy agenda, to defend a dichotomous framing of alcohol harms, or to emphasize the libertarian politics of both personal and market freedom.

Our analyses focus on how, over recent decades, recommendations for alcohol control strategies have been made in the countries being studied, either by individual 'policy entrepreneurs' or by more institutionalized 'policy communities', all determined to persuade governments to see alcohol issues from their perspective. Advocacy of this kind is about both science *and* politics. Furthermore, the politics operates at more than one level: what has traction at, for instance, the European Commission may be of little use or relevance at the level of civic authorities; what matters to ministers of state will differ from what concerns local government officials; and policy streams can flow from the top, but also from the bottom – so community engagement may be as strategically important as meetings with senior civil servants (Lorenc et al., 2014; Toner et al., 2014; Nicholls, 2015; Phillips and Green, 2015).

Of course, even in the age of social media, conventional news outlets retain an enormous level of policy power – whether evidence-based or not. The cultivation of effective relationships with journalists, and the framing of research in ways that make it 'newsworthy' have become key to alcohol advocacy in recent years (Nicholls, 2012; Patterson et al., 2014; Katikireddi and Hilton, 2015; Thom et al., 2016). Over the years, public health advocates have developed knowledge of the policy process and lobbying skills that would not routinely be expected of 'pure' scientists, and advocacy coalitions have emerged which often place researchers, campaigners, activists, journalists and medical practitioners in the same space. In alcohol policy, as in many other policy areas, 'evidence' – construed as the conclusions of objective scientific analysis (and often dismissed as not meeting these standards by opponents) – is only one element in the political process.

Understanding the specific role of research evidence in the policy process is less a matter of establishing how evidence-based a given policy arena is than of considering the uses that evidence serves in different settings and the relationship between research evidence and other policy drivers across time. Almost forty years ago, Carol Weiss identified a range of different 'uses' of research evidence that still resonate in the contemporary era of 'evidence-based policymaking'. She proposed that a 'knowledge-driven model' of evidence use,

in which policy is assumed to simply follow the best evidence, was naïve. In reality, evidence is sometimes called on to 'solve' an identified policy problem, applied as one source of knowledge in a messy and often chaotic policy process, or – more cynically – used selectively as ammunition to support a predetermined policy position (Weiss, 1979). Throughout this book, these many different uses of evidence will be apparent: not only in terms of how evidence is utilized by policymakers, but how bodies of evidence are conceptualized and depicted by their proponents.

Kingdon (2011) argues that, to a significant degree, the political stream functions by judging policy recommendations in light of what he refers to as the 'national mood' – a concept broadly equivalent to public opinion, political climate or social movements. Ministers get a feel for this through a combination of constituency or grassroots contacts, public opinion polling and their reading of media coverage. Therefore, ministerial support for alcohol control strategies is unlikely so long as they judge them – however instrumentally effective they promise to be – not to be consonant with the national mood. Research, in and of itself, will do little to impact on this aspect of policymaking; however, where evidence is deployed effectively in the process of problem construction and solution development, and where it is able to prick the interest of journalists, it plays an essential role.

As Kingdon sees it, a policy window opens under the following circumstances:

> The separate streams come together at critical times. A problem is recognized, a solution is developed and available in the policy community, a political change makes it the right time for policy change, and potential constraints are not severe.
>
> (ibid.: 165)

The four case studies presented in this book will focus on processes by which alcohol has, in different periods of time, been framed as a policy problem, on the kinds of solutions that have been developed, on the actors involved in framing alcohol issues and advocating for policy action, and on the wider sociocultural, political and economic conditions that have shaped the direction in which these streams have flowed. As Cairney and Studlar (2014) correctly observe, measuring policy influence involves a range of factors: how control over policy issues moves between government departments; developments at transnational level; changes in problem framing; the level of government attention; how power shifts between stakeholders, and so on. In some cases, a convergence of factors has led to radical policy change; in others, attempts to influence decision-makers have foundered on the rocks of political circumstance, popular opinion, or overwhelming opposition from industry actors. In all cases, however, we see comparable processes at work: the steady development of policy consensus among researchers, medical bodies and alcohol policy campaigners leading to the formation of advocacy coalitions; the clash of medical authority against commercial power; policy windows blown open and

shut by forces only sometimes directly connected to alcohol; and the constant churn of media and political action in which proponents of public health perspectives seek to establish a secure foothold.

The remainder of this chapter discusses the main models that have underpinned alcohol policy in recent decades – the 'public health' model and the 'disease' model. It gives a brief overview of the development of these frames for an understanding of alcohol problems, and describes how the adoption of the public health model by the World Health Organization (WHO) marked an important shift in the pressures acting on policymakers across Europe.

The emergence of the WHO policy ideal

The World Health Organization policy ideal is both complex, in regard to the evidence on which it rests, and relatively simple in regard to the essential policy principles. The key WHO policy areas are set out in the 2010 *Global Strategy to Reduce the Harmful Use of Alcohol* (WHO, 2010):

1 Leadership, awareness and commitment
2 Health services' response
3 Community action
4 Drink-driving policies and countermeasures
5 Availability of alcohol
6 Marketing of alcoholic beverages
7 Pricing policies
8 Reducing the negative consequences of drinking and alcohol intoxication
9 Reducing the public health impact of illicit alcohol and informally produced alcohol
10 Monitoring and surveillance

While WHO action is directed towards all ten areas, three key policy approaches have been identified as the most cost-effective 'best buys' for reducing harm in the general population: (1) reducing the *availability* of alcohol through tighter restrictions on retail licensing; (2) regulating the *price* of alcohol through the use of either general taxation or, more recently, fixed price ceilings per unit of alcohol; and (3) controlling alcohol *marketing*, with a particular focus on preventing exposure to alcohol marketing among young people (WHO, 2014a: 18, 28; 2014b: 19–20). The WHO also calls for strict controls on drink driving (through the enforcement of low or zero blood alcohol levels for drivers) and the promotion of screening, early interventions and brief advice in primary care in order to identify drinkers at risk of developing alcohol-related problems (WHO, 2014b: 19–20).

These policy recommendations have evolved gradually since the mid-1970s, and are closely aligned to the public health perspective described above (Bruun et al., 1975; Edwards et al., 1994; Babor et al., 2010). This is associated with, though not identical to, so-called 'total consumption', 'whole-population'

or 'single distribution' theories, which assert that reducing aggregate levels of consumption in a whole population is essential to achieving reductions in consumption (and, therefore, harms) among those drinking at the highest levels (Skog, 1985). Working from the principle that harms are graduated and continuous rather than dichotomous, it argues that a primary role of the state is to use its powers to reduce those harms by intervening in market supply through controls on price, availability and marketing. This policy approach implies a model of social influence and a set of political values. In recent publications, the WHO has been explicit about this: as Dr Nata Menabde, then Deputy Regional Director for WHO Europe, put it in 2009:

> [A]lcohol policy should reflect the concept of stewardship, the liberal state's commitment to look after the basic needs of its people, individually and collectively. The state that is guided by the ideal of stewardship recognizes that the health of the people is one of its primary assets, and that better health is associated with greater well-being and productivity.
>
> (Anderson, 2009: Foreword)

In this respect, the position of the WHO on alcohol policy aligns with the concept of 'stewardship' and public health as advocated by the Nuffield Council on Bioethics (2007). This concept of stewardship, in which 'the state has a responsibility to provide the conditions under which people can lead healthy lives if they wish' is not value-neutral. It rests on a version of what the philosopher Isaiah Berlin has described as a 'positive' conception of liberty (Berlin, 1969); that is, the belief that the state has both the right and duty to identify external or environmental threats on behalf of its citizens and to impose restrictions which, while ostensibly placing limits on personal freedom, in reality facilitate the greater exercise of freedom. This is in distinction to the 'negative' conception of liberty, which argues that personal autonomy should be protected except where there is a clear and direct threat of harm – as most famously articulated through the philosopher John Stuart Mill's 'harm principle'.

Looked at from this perspective, in the case of alcohol the fundamental question is not: what do we know about the consequences of given policy interventions? Rather, the questions are: at what level of harm is intervention justified? How is harm to self and others defined and quantified? How are the rights to pleasure and personal autonomy to be balanced against a putative responsibility to avoid health risk or social costs? This is not a new debate, and indeed John Stuart Mill himself engaged in a number of public arguments with temperance activists over precisely these questions in the late nineteenth century (Nicholson, 1985; Nicholls, 2009). It is also not a debate purely about evidence: evidence may demonstrate a given relationship between particular policy interventions and harm outcomes, but the question of how competing freedoms (or conceptions of freedom) are balanced in deciding whether to implement those policies is one of ethics and politics. The 'public health

perspective' on alcohol policy therefore represents both a diagnostic model of alcohol harm and a model of citizenship in which the duty of the state to reduce health harms, increase productivity and promote well-being trumps the rights of the individual to make choices that may create social costs or have detrimental consequences for their own health.

On the other hand, neither is the landscape in which alcohol research and policy advocacy take place neutral. The backdrop to the emergence of a research and advocacy nexus around alcohol control policies is both the developing hegemony of free market economics and the sociopolitical backlash to temperance – and the systems of light-touch alcohol control that this engendered in many societies following the collapse of international prohibition in the 1930s. As Room (1999: 15) has put it:

> Alcohol researchers, the residual legatees of the great conflicts over alcohol in these societies, have had the role of pronouncing the eulogy on these systems as they slowly disintegrated. [They] have been able to show the effectiveness of many aspects of these systems only because [they] could study what happened when they were weakened or ended.

In other words, in as much as it can be argued that public health alcohol policy reflects 'an underlying assumption that lives lived in accord with prevailing social standards and attitudes are both desirable and required' (Bacchi, 2015), it can be countered that the alcohol industry has put enormous effort into shaping prevailing attitudes in such a way as to embed drinking in an ever broader array of social practices. Many in the alcohol research field see their role as to counterbalance this, and that 'if researchers do not take this role, the field remains completely open to the producers' (Christie, 1976, cited in Room, 1999: 16).

The public health perspective developed by alcohol researchers in the early 1970s represented a fundamental challenge to dichotomous models of alcohol harms that informed earlier WHO positions on alcohol. Chief among these earlier conceptualizations of alcohol-related problems is what is commonly referred to as the 'disease concept' of alcoholism, which had its recent origins in the 1930s and 1940s in post-Prohibition USA. There is a long history of medical thinking on addiction, with problematic, habitual alcohol use being described as a form of disease as far back as the eighteenth century (Levine, 1978; Porter, 1985; Warner, 1994; Ferentzy, 2001; Nicholls, 2008). However, the version developed in the early twentieth century was self-consciously modern, medically-oriented and conceptually distinct from what had come to be seen in many quarters as the outmoded views of those temperance campaigners who argued for population-wide interventions (such as prohibition) from conspicuously moralistic first principles (Room, 1978; 1984,; Beauchamp, 1980; Booth Page, 1988; Roizen, 1991).

At the heart of the disease concept was the proposition that in any given society the total population of drinkers could validly be divided into two

subpopulations: a majority (perhaps as high as 90 per cent) of 'social drinkers' who drank pleasurably and in a way that was essentially non-problematic; and a minority who drank in a way that was uncontrolled or compulsive and that was invariably linked to a range of health and social problems. This minority group was thought to consist of drinkers suffering from a distinct, and predisposing, disease of alcoholism – a disease that existed as a kind of 'Platonic entity' rather than being in any way socially constructed (Room, 1983: 49). The disease of alcoholism was assumed to be causally attributable to vulnerabilities or predispositions of a biological or psychological nature rather than to any negative properties inherent in alcohol *per se*. Proponents of the disease concept were mainly concerned with the creation of humane, effective and non-moralistic alcoholism treatment systems; but, since they did not see alcohol as playing a primary role in the causation of alcoholism, they neither called for nor supported broader public policy initiatives aimed at prohibiting alcohol or imposing any significant controls on its manufacture, sale and consumption. Within this disease framework it was assumed, more or less axiomatically, that no causal relationship existed between the incidence and prevalence of alcoholism and the overall level of alcohol consumption in any given society. In other words, it was believed that increases in *per capita* consumption would not lead to an increased incidence of alcoholism, just as decreases in consumption would not lead to a decrease in the incidence of this disease.

One of the dominant figures in the mid-twentieth century alcoholism movement was the American alcohol specialist, E.M. Jellinek, who at the end of his career published an influential book, *The Disease Concept of Alcoholism* (Jellinek, 1960), summarizing his views on this topic. Some of Jellinek's introductory comments for this text give a clear indication of the extent to which the disease concept was rooted in and reflective of American preoccupations with drinking problems:

> Around 1940 the phrase 'new approach to alcoholism' was coined, and since then this phrase has been heard again and again, every time that the Yale Center of Alcohol Studies, the National Council on Alcoholism, Alcoholics Anonymous, or individual students make an utterance to the effect that 'alcoholism is a disease'.
>
> (ibid.: 1)

In 1950, soon after the establishment of the WHO, Jellinek was appointed to a position as consultant on alcoholism within the WHO's mental health division, a position he retained at the WHO's Geneva headquarters until 1955 (Booth Page, 1997). His work in Geneva was largely taken up with the drafting of agreed definitions of alcoholism and alcoholics, the identification of chronological 'phases of alcohol addiction', and the development of a statistical formula that, it was claimed, could be used to estimate the number of alcoholics in a given population. While his role at the WHO provided Jellinek

with a platform for the international dissemination of what were essentially American perspectives on drinking problems, it also exposed him to a variety of competing social, cultural and economic perspectives on this topic. Perhaps even more significantly, Jellinek came under the influence of core WHO philosophies, reflecting a conviction that public health authorities should not simply deliver curative services for existing morbidity, but that they had a right and duty to work at disease prevention. This preventive philosophy, which some thirty years later would be transmuted into the even more ambitious project known as 'health promotion' (WHO, 1984), was radically at odds with the view implicit in the disease concept that health policy and practice should solely consist of identifying and treating alcoholism.

Room (1984) has looked in detail at the evolution of Jellinek's ideas during his WHO years, and, drawing on both published and unpublished material, has argued convincingly that by the end of his time in Geneva Jellinek had shifted significantly away from his original espousal of the disease concept. Specifically, Jellinek no longer believed that it was scientifically valid or pragmatically useful to subdivide total populations of drinkers into two simple categories – alcoholics and social drinkers; instead, he now concluded that alcohol contributed to an array of problems, not of all which could validly be considered to be diseases, and of which addiction or dependence was just one element. He had also changed his mind about the aetiology of alcohol-related problems, seeing alcohol (and not just individual vulnerabilities of some drinkers) as playing a key causal role; and, on this basis, arguing that – however politically contentious or displeasing to commercial interests it might be – a scientific, public health approach could legitimately explore problem prevention by means of alcohol control strategies.

While Jellinek had by the mid-1950s personally moved away from the narrow orthodoxy of alcoholism as disease, the WHO displayed little institutional enthusiasm for his change of heart. It did not encourage him to pursue or publicize his new ideas, so that to the outside world Jellinek continued to be associated with the mantra that 'alcoholism is a disease'. In Room's words: 'Jellinek's departure marked the end of sustained programme interest in the alcohol area at the Geneva headquarters of WHO for about 15 years' (Room, 1984: 87): a period when it appeared as though the primary concern of WHO in relation to alcohol was that alcoholism should be seen as a disease and that alcoholics should be treated in a non-moralistic way by health service providers.

The emergence of the public health approach

During this fifteen-year period (from 1955 until about 1970) of limited WHO action in relation to alcohol, the disease concept continued to be treated with deference on the international stage, most notably in English-speaking countries.

It would be wrong, however, to assume that all developed countries subscribed uncritically to what was still being promoted as the new scientific approach to drinking problems that had been 'discovered' in the USA. Commenting on the situation that prevailed in the early 1960s, the British psychiatrist and addictions researcher, Griffith Edwards wrote that:

> Although some European countries (particularly France and the Nordic countries) stood out against the Anglo-Saxon consensus, Jellinek's ideas were read everywhere with respect. The disease concept was the working assumption of science and medicine, the credo of Alcoholics Anonymous, the slogan of the American NCA, the message of every public lecturer and all the media.
>
> (Edwards, 2000: 98)

The promotion of the disease concept within the USA contributed to an expansion of research opportunities and research funding for American social scientists, most of whom – at least in the short term – conducted and published their research in a way that avoided a fundamental challenge to the main tenets of this approach (Roman, 1991). As time went on, however, social scientists, both in the USA and elsewhere, became explicitly critical of this model, tending to view it as a social construct rather than a scientific discovery. As early as 1962, the sociologist, Jack Seeley had commented with considerable prescience on what he saw as the difficulties that might arise through the confounding of policy advocacy with scientific discovery:

> As far as public communication is concerned, however, I think the bare statement that 'alcoholism is a disease' is most misleading, since (a) it links up with a much-too-narrow concept of disease in the public mind, and (b) it conceals what is essential – that is, that a step in public policy is being *recommended*, not a scientific discovery announced. It would seem to me infinitely preferable to say, 'It is best to look on alcoholism as a disease because …' and to enumerate the reasons. This would both take the public into our confidence (and hence really educate) and permit withdrawal of the recommendation if it seemed wiser at a later date. The latter ought to be much easier and more comprehensible than a first announcement of a seeming scientific fact and its later contradiction with no new evidence.
>
> (Seeley, 1962: 583)

From the early 1960s onwards, social scientists at the Social Research Group (later renamed the Alcohol Research Group) based within the School of Public Health at the University of California, Berkeley, were prominent in the development of a research agenda which was increasingly critical of the disease model (Levine, 1992), while similar research was being carried on outside of the USA – particularly in Canada and the Nordic countries.

At the end of this decade, a strongly argued paper by Nils Christie and Kettil Bruun (respectively a Norwegian and a Finn) asked why such a framework had been allowed to dominate the research agenda in the first instance:

> Why did we get into this conceptual mess, why does it persist, how could we work towards its elimination, and what, eventually, would be the consequences if we managed to do so, if we were able to invent words that give clearly and precisely the same message to all the parties concerned?
>
> (Christie and Bruun, 1969: 65)

Christie and Bruun answered these questions by arguing that the conceptual framework of alcoholism as disease had been developed and promoted, not despite but *because* of its vagueness; and that such vagueness (which they characterized as consisting of 'big fat words') served a latent political function in defusing the fundamental ethical and political positions that had motivated the temperance movements of the nineteenth and early twentieth centuries. As will be described in more detail later in this book, temperance – especially in its political and prohibitionist forms – was rooted in the principle that alcohol posed a risk across society: that anyone could fall victim to its habit-forming properties, and that unregulated availability exposed everyone to danger, whether as a drinker or as someone who would be harmed by the behaviour of a habitual drunkard. In the USA, the implementation of national Prohibition between 1920 and 1933 represented the high-water mark of political temperance, and the emerging hegemony of the disease concept in the 1940s needs to be understood in relation to the social and ideological function it served following Repeal (Herd, 1992). As Bruun and colleagues saw it, the primary function of the 'alcoholism is a disease' idea was to create a conceptual fudge which created the impression science had now rendered the fundamental temperance position redundant; there was no longer a necessity for divisive moral or political debate between 'wets' and 'drys', because it had now been scientifically established that alcoholism was a disease. If that were true, then not only did it mean that, for the vast bulk of its consumers, alcohol was a harmless substance but also that alcohol harm was an issue for specialist healthcare treatment, not political action.

Christie and Bruun considered the scientific credentials of the disease model to be more or less non-existent, and indeed once it came under attack, it was remarkable how little scholarly effort was put into defending it. Although they clearly understood the 'many functions of fat words, particularly their use as grease in the social machinery' (Christie and Bruun, 1969: 72), they ultimately believed that it was better for society to engage openly and honestly with the clashing value systems and interest group tensions which they saw as an inevitable part of public policymaking in relation to alcohol. Not surprisingly therefore, Nordic researchers were to the fore from the late 1960s in developing a model that represented an antithesis to the disease concept.

The main features of the developing public health model were:

1 It shifted the focus away from alcoholism and back to alcohol, highlighting its risks at both an individual and societal level.
2 It 'disaggregated' the alcohol problems field by addressing a wide array of health, criminal justice and psychosocial concerns rather than concentrating on the putative, unitary disease of alcoholism.
3 It was less concerned with individual clinical issues than with population-level behaviours and problems.
4 It prioritized problem prevention or health promotion as opposed to treatment and rehabilitation.
5 It presented itself as evidence-based, arguing that its policy recommendations were clearly grounded in empirical research data rather than arising from an *a priori* ideological position.
6 It favoured the use of supply-side alcohol control strategies, particularly targeting price and availability, over more liberal strategies involving educational and public awareness campaigns aimed at promoting 'responsible drinking'.

This model was developed throughout the 1970s, with much of the initiative coming from Nordic researchers, researchers at the Addiction Research Foundation in Toronto, and some dissident American-based researchers. Those committed to developing this alternative to the disease concept drew heavily on the statistical work of the French demographer, Sully Ledermann (1956), whose empirical work had challenged the notion of two sub-populations of drinkers. An early collaboration between the Finnish Foundation for Alcohol Studies, the Addiction Research Foundation and the European Regional Office of the WHO led to the publication of *Alcohol Control Policies in Public Health Perspective* (Bruun et al., 1975), which was to be the first of a series of international collaborative studies of this type – all aimed at drawing out the public policy implications of a broad range of research on alcohol consumption and its related problems. The conclusion of this 1975 report, sometimes referred to as 'the purple book', was that:

> Changes in overall consumption of alcoholic beverages have a bearing on the health of the people in any society. Alcohol control measures can be used to limit consumption: thus, control of alcohol availability becomes a public health issue.
>
> (ibid.: 90)

The 'purple book' led to further collaborative research, most notably the International Study of Alcohol Control Experiences (ISACE), in which researchers in seven jurisdictions – the USA, Finland, Ireland, the Netherlands, Canada, Poland and Switzerland – carried out comparative analyses of alcohol control systems, changing levels of consumption and related problems in the decades

following the Second World War (Mäkelä et al., 1981; Single et al., 1981). It was not until five years later, however, that the WHO itself published a report on *Problems Related to Alcohol Consumption* (WHO, 1980), a report which Robin Room, in a commentary speculatively entitled 'A Farewell to Alcoholism?', considered to mark 'the passage from one era to another in thought about alcohol issues' (Room, 1981: 115).

From this time onwards, the WHO, and in particular its European Regional Office, have consistently promoted the new public health perspective, and a number of key texts have summarized the research evidence for this approach (e.g. Edwards et al., 1994; Babor et al., 2003; Anderson and Baumberg, 2006). The public health approach does not entirely rule out the use of liberal, demand-side strategies, such as educational campaigns aimed at the promotion of 'sensible drinking' among the general public or more specifically-targeted school-based alcohol programmes. Neither does it discount the value of treatment service provision for identified dependent drinkers, although it tends to emphasize the importance of population-level brief interventions in primary care settings aimed at preventing harm among a wider range of actual, or potential, 'hazardous and harmful' drinkers. It has consistently argued, however, that the most effective preventive policies are those which, on the supply side, use pricing measures to reduce the relative affordability of alcohol while simultaneously restricting its availability at the retail level – all with a view to reducing total societal consumption and, thereby, the prevalence of related problems. Most contentiously, the preventive measures proposed under this new dispensation largely consist of universalist, environmental strategies which operate across whole populations (albeit with variations in the degree of impact within the population), rather than relying solely on strategies which are targeted at sub-groups of drinkers deemed to be particularly at risk or particularly problematic – such as heavy drinkers, binge drinkers, young people, motorists or pregnant women.

It would be misleading, however, to suggest that the 'public health perspective' is either monolithic or immune from external or internal criticisms. For instance, there is extensive debate among alcohol researchers as to the precise relationship between consumption at the population level and the prevalence of very heavy or dependent drinking. A key theoretical justification for the argument that the two are structurally related is the 'collectivity of drinking cultures' model, initially developed by Ole-Jørgen Skog (e.g. Skog, 1985). This describes, and seeks sociologically to explain, the observation that in societies where the average level of consumption is high, so the amount consumed by the heaviest drinkers within that population tends also to be higher than countries with lower average consumption. It suggests that, due to a process of social influence that works across society, lower-drinking norms among the majority of the population pull down the amount that the heaviest drinkers consume in that country. This theory has been one of the most influential conceptual models for whole-population policies: underpinning the argument that if you reduce consumption across a population, you will reduce

harms among heavy drinkers proportionately. However, the theory remains subject to debate, and as one researcher recently noted 'even though the theory has now been around for more than 50 years … there has not been a great deal of empirical testing of the theory' (Rehm, 2014: 1397; see also Gmel and Rehm, 2000; Skog, 2001; Gmel and Rehm, 2003; Skog, 2003; Skog and Rossow, 2006). Although some studies give limited support to the model, evidence from other countries suggests that drinking cultures within populations are both more diverse and more prone to moving independently of each other than Skog's model predicts (Roche, 1997; Hallgren et al., 2012; Livingston and Room, 2014; Nörstrom and Svensson, 2014; Rossow et al., 2014).

In addition to theoretical challenges, the empirical evidence for some key tenets of public health-oriented policy, while in many respects compelling, is not such that the case is entirely closed. Recent pan-European analysis has highlighted the degree to which cultural contexts mediate policy interventions, and to which culture can impact more significantly on consumption than legislation (e.g. Allamani et al., 2014). Recent international evidence points to divergent trends within national drinking cultures, particularly marked declines in youth consumption compared to more static patterns among older drinkers, which are not easily accounted for in crude applications of population models (e.g. De Looze et al., 2015; Pennay et al., 2015). Furthermore, recent declines in overall consumption in countries such as both England and Scotland have occurred at times when restrictions on availability have been eased, and appeared to start prior to economic recession impacting on alcohol affordability (e.g. Beeston et al., 2016). Moreover, the notion of whole population effects rests, to some extent, on a conceptualization of national drinking cultures which sociological research has long challenged (Savic et al., 2016).

As with other areas where public health prevention poses a challenge to commercial interests, debate among researchers is inflected by wider political concerns over the role of 'vested interests' in both policy formation and research development (e.g. Hawkins and Holden, 2012; Liverani et al., 2013; PLoS Medicine Editors, 2011). This has led to calls for the strict policing of alcohol industry research engagement (Stenius and Babor, 2010; Casswell et al., 2013) – though some researchers have warned against a 'McCarthyite' drift towards blacklisting researchers who elect to engage with the alcohol industry (e.g. Davies et al., 2002; Gmel, 2010). Narrowly, this reflects the importance of preventing the kind of commercial corruption that occurred previously in tobacco research. The alcohol industry, through national bodies (such as the Portman Group in the UK) and international organizations (such as the International Alliance for Responsible Drinking, formerly the International Center for Alcohol Policies) has a long history of funding research, much of which rejects continuous models of harm.

In an environment in which the alcohol industry consistently promotes dichotomous-libertarian positions on alcohol it is increasingly held within the public health advocacy community that industry partnerships are 'simply a means

for industry to co-opt public health' (Moodie et al., 2013: 7). This line of argument is certainly bolstered when looking at examples of policy partnerships such as the much-fêted 'Alcohol Responsibility Deal' in England (Holmes et al., 2015; Knai et al., 2015). However, the spectre of commercial corruption also risks fostering a research culture in which challenges to public health orthodoxies are perceived or construed as promoting an 'industry argument' and, therefore, being both scientifically *and* morally dubious (Cope and Allison, 2010; Herrick, 2016). In such circumstances, the policing of commercial influence and the policing of ideas can, potentially, blur. Power, and the relationship between power and ideas, are in this respect important: the alcohol industry has considerable power not only in terms of access to policymakers but in its potential to fund research that promotes its interests. At the same time, significant power is wielded within research communities by senior research staff, journal editorial boards, funding institutions, influential individuals, and so on. Just as these structures of power reinforced the hegemony of the disease model in the mid-twentieth century, so they are significant in sustaining the hegemony of the public health perspective today, which is to say, scientific consensus is always a matter of both objective evidence and structures of power, even if the science is compelling.

Culture, resistance and alcohol policy

Alcohol control policies, in all their guises, imply constraints on personal liberty – if liberty is understood as the right to consume freely within an open market. Social historians have, however, long recognized the need to understand cultural resistance in relation to alcohol control – whether legitimated by explicitly moral arguments or by an appeal to a scientific evidence base. Some of this scholarly work has grown from an original focus (e.g. Gusfield, 1996) on the meaning of alcohol in post-Reformation Europe, where *Carnival* (characterized by drinking, sexual pleasures and general jollity) contrasted with *Lent* (ascetic behaviour characterized by abstinence from alcohol and carnal pleasures). That is to say, where alcohol is framed as illegitimate (for whatever reason), the inherent pleasure of intoxication is abetted by the pleasure – attractive to many – of transgressing the demands of powerful social forces. Drinking, in this respect, becomes not only fun but a form of resistance. The relevance of this to current alcohol policy debates is that alcohol control not only targets the association between alcohol and 'time out' from the churn of mundane responsibility (MacAndrew and Edgerton, 1969), but that alcohol offers specifically transgressive pleasures to many drinkers: and such pleasures are as likely to be *intensified* by injunctions to drink less as to be reduced by them (D'Abbs, 2015; Haydock, 2015). Again, alcohol control is an issue of power: and while the alcohol industry undoubtedly uses its economic and cultural power to exploit the trangressive attraction of alcohol in much of its marketing, resistance to both the explicit deployment of state power (e.g. through licensing controls) or to more subtle forms of 'biopower'

(e.g. through the establishment of safe drinking guidelines or the epidemiology of 'hazardous' drinking) by many drinkers is inevitable.

The complex interplay of power and resistance, and of competing frames for defining alcohol problems, run through the history of modern alcohol cultures. Furthermore, the relationship between these dynamics within a given setting is not related to the scale or prevalence of consumption in any simple way. As Levine (1992) argues, objective conditions are not in themselves sufficient to explain the nature or scale of societal tendencies to define phenomena as social problems or to implement strategies aimed at their elimination. Levine argues that, from a comparative international perspective, those countries that had the most persistently negative views of alcohol and the most restrictive public policies governing its use were not necessarily countries that objectively had the highest prevalence of alcohol-related problems. He used the term *temperance culture* 'to refer to those societies which, in the nineteenth and early twentieth centuries, had large enduring, religious temperance movements' (ibid.: 16), identifying nine such cultures – the English-speaking cultures of the USA, Canada, the UK, Australia, and New Zealand; and the Nordic societies of Finland, Sweden, Norway and Iceland. Levine went on to argue that the main common features of these cultures were: (1) that these were all predominantly Protestant cultures; and (2) that these were cultures in which people drank a substantial portion of their alcohol in the form of distilled liquor or 'spirits'.

On the first of these points, Levine drew on classic sociological theory (particularly Weber and Durkheim) to demonstrate that, in the post-Reformation period, Protestantism came to see alcohol as inimical to its values of individual discipline and self-control. Levine's second point acknowledged that while in Protestant, Northern European countries total alcohol consumption might be lower than that to be found in Catholic, wine-drinking Southern European countries, the tendency to drink spirits – a much more potent form of beverage alcohol – was strongly associated with intoxication and a range of behavioural and social problems (see Room and Mäkelä, 2000, for a discussion of cultural 'typologies' of drinking). Levine's thesis was that despite the modernizing and homogenizing tendencies to be found in Western societies, residual influences of such temperance cultures continue to exist (see also Yeomans, 2015). From this point of view, the place of alcohol on national policy agendas is only partially determined by objective factors, such as the prevalence of problem drinking or harm, since those factors acquire political significance in national contexts shaped by their own distinct histories of drinking, attitudes to alcohol and political culture.

There is a long history of proposing national, or regional, 'typologies' of drinking that distinguish between Catholic or Protestant histories, the prevalence of different beverages, different approaches to intoxication, and so on (see Savic et al., 2016, for a detailed overview). While a useful heuristic in some respects, it is clear that the idea of homogenous national drinking cultures is also a simplification that overlooks important internal dynamics. Within any nation,

drinking cultures will vary according to region, class, gender, ethnicity and subcultural norms. In some respects, the idea of a 'national' drinking culture is an illusion that arises when a conglomeration of drinking practices – some (usually male, public drinking practices) more prominent and visible than others – meets a wider ideational sense of national identity. That is not to suggest that the idea of national drinking cultures is unimportant. As we shall see, ideas about national drinking cultures strongly inflect public and political debates on alcohol – both positively (where drinking is associated with positive national characteristics such as conviviality and bonhomie) and negatively. Indeed, alcohol policy disputes are very often arguments about nationhood and identity carried on under the flag of a debate about drink.

Writers such as Levine (1992) have persuasively argued that the receptivity, or otherwise, of contemporary governments to alcohol control policies is rooted in a confluence of their religious, sociocultural and drinking histories. This book will, to some degree, develop that line of thinking. However, it does so with the caveat that the political history of alcohol control is not a direct consequence of a fixed national alcohol culture, but rather a reflection of how ideas about national drinking cultures have combined with other ideas about the meaning and value of drink within any given society to produce a set of policy problems and responses. Sometimes those policies take 'national' drinking culture as their target (as, for instance, in recent Scottish alcohol policy), while at other times they target groups or behaviours within the population. Furthermore, how alcohol policy advocates negotiate the relationship between 'whole populations' and 'nations' is itself a question that justifies close consideration, especially in the era of globalized trade and culture.

Public health in a global consumer culture

Quite apart from residual social and religious influences, the broadly interventionist politics of public health sit uncomfortably with the economically libertarian drift of national policies in the EU and elsewhere over recent decades. Throughout this book, we will see that alcohol policy is rarely about alcohol *per se*, but about the place of alcohol control in the context of dominant political and economic cultures. Alcohol policy advocacy is, in many cases, most effective when it not only establishes consensus on the diagnostic dimension, but aligns with general consensus on the political plane. Clearly, the emergence of a 'neoliberal' political hegemony since the 1970s has been the primary context in which public health advocacy has operated (and, in many respects, against which it presents a critique).

Neoliberalism is a somewhat contested term, meaning different things to different people. In regard to alcohol policy, however, Haydock (2015: 3–4) has suggested three key characteristics: (1) an 'emphasis on market rationality'; (2) an understanding that, in practice, consumers do not always behave rationally, but are amenable to environmental regulations that can nudge them towards preferred behaviours; and, (3) where that fails, the use of coercive

measures aimed at the individual, rather than the system. Arguably, much of this predates contemporary neoliberalism and runs through the long history of alcohol policy debates itself, suggesting wider problems concerning the role of alcohol regulation in modern, market-oriented society rather than just its more recent manifestations (Nicholls, 2009). In any case, drinking (and the existence of a structured market for alcohol) create a tension – or, indeed, a crisis – between the ideal consumer (from an economic perspective) and the problem drinker (from a social perspective). A heavy drinker can, undoubtedly, be both. Alcohol policy, therefore, amplifies a tension in contemporary governance more broadly between encouraging consumption, controlling 'irrational' behaviours and minimizing supply-side regulations. Alcohol is, in this context, not only 'no ordinary commodity': it is the commodity that highlights most sharply the ambivalent relationship in contemporary culture between governance, consumption and rational choice.

In many ways, contemporary 'neoliberal' tensions around alcohol are remarkably consistent with earlier 'classical' liberal problems. While the mechanisms through which power operates may have changed (especially in regard to the political role of health promotion), many policy questions come back to two familiar points. First, to what extent should individuals be free to define what is good for themselves, and to what extent should the state (or scientific experts) make, and act upon, that judgement (Room, 2011; Duffy and Snowdon, 2014; Snowdon, 2015)? Second, to what extent should mechanisms of social control fall on the individual drinker, and to what extent should they fall on the system that supplies the product (Room, 2012)?

In addressing this, contemporary commentators, both implicitly and explicitly, continue to draw heavily on the liberal framing of rights set out in John Stuart Mill's classic text *On Liberty,* originally published in 1859 (e.g. O'Neill, 2011; Saunders, 2016). Mill, himself a vehement opponent of alcohol prohibition, argued that the state should only impose restrictions on individual freedom where the exercise of that freedom either harmed others, or placed constraints on their freedom to act (Mill, 1985 [1859]). This famous 'harm principle' is what is at stake in much of the discourse on alcohol. The question is not so much the principle itself, which is in many respects simply a riposte to totalitarianism. It is, rather, in how 'harm' and 'freedom' are defined, and where one identifies harm to others as starting. The cliché that 'the right to swing my fist ends where the other man's nose begins' is of little use when the consequences of a behaviour are, unlike a simple punch, complex, diffuse and multi-layered. In alcohol policy, then, the argument is often about defining precisely the 'negative externalities' that can arise from drinking. These, of course, can include everything from interpersonal violence to unemployment and neglect – and few of these outcomes affect the drinker alone.

Because harm is not limited to the drinker, it is amenable to public policy even while adhering to the harm principle. The point that alcohol implied harm to others as well as the self was absolutely fundamental to Victorian temperance discourse, and was the point on which temperance activists challenged Mill

directly (Nicholls, 2009). Recent alcohol research and policy advocacy have also developed a close focus on harm to others (e.g. Laslett et al., 2010; Casswell et al., 2011; Hope, 2014; Bhattacharya, 2016). Whatever the position taken on the legitimacy of interventionist alcohol control, it is never a simple issue of private liberty versus state regulation; rather it is about weighing up the balance between the rights of individuals to make choices (including about their own health) and the extent to which preventing some of the demonstrable harms to others that can arise from alcohol consumption justifies infringements on that prior freedom.

However, freedom itself is a complicated issue where alcohol is concerned. Again, Mill himself was repeatedly challenged by temperance activists on the point that 'freedom', and the assumption of rationality that underpinned it, were not obvious either when the subject in question was intoxicated or in any way dependent on alcohol. Both intoxication and dependency raise profound questions about agency and autonomy that cannot be simply brushed aside: how 'rational' are you when drunk, and how 'free' is a dependent drinker? More recently, developments in behavioural economics have cast further doubt on simple assumptions in liberal ideas of autonomy by suggesting – in contradiction of Mill's position – that increased individual autonomy does not inevitably lead to better choices but, because of the cognitive biases to which we are all subject, can equally lead to bad choices (Conly, 2012; Kahneman, 2012). The argument that freedom and rational choice are by no means bound together underpins much of the work of behavioural economists, and informs the essentially paternalistic concept of 'nudging' (Thaler and Sunstein, 2008; Sunstein, 2014). Behavioural economics has now emerged as a distinct strand in alcohol research (e.g. Pechey et al., 2014; Brown et al., 2015; Pechey et al., 2015).

It is also important to note that, while alcohol policy debates may be structured around disputes over the role of the state in constraining individual choice, the question of social control is more complex. The 'neoliberal' framing of alcohol policy does not imply a free-for-all; rather it implies that the work of social control be individualized and internalized. Drinkers are expected both to enjoy the reduced inhibitions alcohol consumption brings (and this is, at bottom, the message of most alcohol marketing) *and* exercise inhibitory control over that effect so as to avoid anti-social intoxication or becoming problem drinkers. The industry, in this framing, is not directly responsible for reducing harm by restricting supply but rather for using its influence to encourage individuals to 'drink responsibly'. In many respects, the public health critique of this – like that of its temperance forebears – is that such a transfer of responsibility is both unethical and ineffective, especially when the phrase 'drink responsibly' becomes a prominent, but 'strategically ambiguous', element of the alcohol marketing landscape (Smith et al., 2006).

While neoliberalism provides an important ideological context for debates on alcohol policy, it also has concrete implications in regard to market systems. In particular, the establishment of transnational trade agreements reduces the

scope for national regulation of commodity markets but also places constraints on the degree to which health promotion or crime reduction can be pursued when it has impacts on the function of free markets. As will be discussed later in this book, the legal challenge to minimum unit pricing in Scotland ultimately hinged on the extent to which national governments were able, within the constraints of EU law, to impose regulations that risked distorting the natural establishment of prices through open competition. Similarly, the power to use taxation to 'nudge' consumption (through, for example, incentivizing lower alcohol products via tax benefits) is heavily constrained by the fact that alcohol tax structures are set at EU, not member state, level.

It has been argued that constraints on the regulation of commodity markets imposed by transnational trade agreements are all the more pronounced when it comes to alcohol – given the core view within alcohol control movements that alcohol is 'no ordinary commodity'.

> In these international trade agreements and economic treaties, alcoholic beverages are almost always treated like ordinary consumer goods. Even when an alcoholic beverage (e.g. wine) is treated as a special commodity, this is usually because this type of beverage falls within the category of subsidized agricultural products, not because it is considered harmful to public health.
>
> (Babor et al., 2010: 100)

However, Anderson (2009: 13) has noted that international trade agreements tend to support national sovereignty in regard to health policy, with the WTO being 'highly deferential to health policies, at least compared to other safeguards'. The tension between the pursuit of health-oriented alcohol policies and the constraints imposed by international trade law have led many public health advocates to call for a UN framework convention on alcohol, based on the existing Framework Convention on Tobacco Control, or a similar international code (e.g. Casswell and Thamarangsi, 2009; Baumberg, 2010; Taylor and Dhillon, 2012).

While high-level policy debates have been increasingly characterized by a polarization between 'public health' and 'industry' positions, it is important to recognize that neither side is as monolithic as may first appear (Holden et al., 2012). The alcohol industry is highly diversified and far more complex than, for example, the tobacco industry. In the EU region, at least, there is not the tobacco equivalent of the local pub, the local brewer or the complex social and cultural rituals of shared consumption associated with alcohol. Nevertheless, conglomeration and the collective defence of commercial interests have, for centuries, been an important feature of alcohol industry actions – from the emergence of large brewers in the late eighteenth century to the development of international trade bodies today. Indeed, globalization has shaped the alcohol industry as much as any other in recent years. While small, regional and independent production is still widespread (and, indeed,

expanding with the development of the 'craft beer' movement), large-scale alcohol manufacturing is characterized by the absorption of small and medium-sized businesses into global conglomerates, such that in many respects the 'global alcohol market is now dominated by a handful of large corporations' (Babor et al., 2010: 75).

With conglomeration has come the development of well-coordinated transnational lobbying through trade organizations such as Spirits Europe and The Brewers of Europe as well as the lobbying (and corporate social responsibility activities) of trade giants such as Diageo and SABMiller. There is, undoubtedly, a research element within this strategy. The International Alliance for Responsible Drinking (originally known as the International Center for Alcohol Policies) has long sought to establish the alcohol industry as funder of scientific research and a responsible partner in the promotion of public health. Additionally, social responsibility activities serve – in the view of many critics – a strategic function in reinforcing a dichotomous model of harm while presenting the industry as a responsible partner in tackling those marginal harms (Grant and O'Connor, 2005; McCambridge et al., 2014). More radically, corporate social responsibility is widely viewed within public health advocacy as an 'industry vehicle to subvert evidence-based public health policy' through both the promotion of what public health advocates deem to be ineffective policies (based largely on education), and voluntary partnerships that effectively cede control for harm reduction from the state to the producers of alcohol itself (McCambridge et al., 2014: 524; see also Anderson, 2004; Babor, 2006; Ulstein, 2006; Hadfield and Measham, 2015). The fact that much industry action in this arena is geared towards preventing restrictive legislation has reinforced the view within much of the public health community that *all* industry initiatives and partnerships are to be viewed with profound suspicion.

Here, again, alcohol policy advocacy emerges not only as a movement for the reduction of alcohol harms, but also as a critique of fundamental aspects of neoliberal culture. The idea that commercial interests, especially when the commodity is unhealthy or dependence-forming, should play any role in research or policy developments is fundamentally opposed within alcohol policy advocacy, and public health advocacy more broadly. The idea that the state should 'steer, not row' when it comes to regulation and the provision of services (Osborne and Gaebler, 2000) invites the kind of partnership approach that defined, for instance, New Labour's 'Third Way' public policy in England (Baggott, 2010). Where commercial interests are identified as essentially inconsistent with the public good, such an approach can be seen as merely a fig leaf for the stripping away of proper state controls (Room, 2004).

Health promotion, joined-up government and the public health perspective on alcohol

Quite apart from the cultural and socioeconomic obstacles already discussed, other public sector management obstacles to the implementation of alcohol

control strategies are in play. References to 'government' or the 'state' convey an impression of a unified institutional system, working towards a common purpose and based upon political or ideological consensus. The reality, however, is that modern governmental systems are largely based upon a sectoral division of labour within which there is considerable potential for conflicts of interest between different government departments. So, while the health sector, and to some extent the criminal justice sector, might welcome the implementation of stronger alcohol control policies, other sectors of government – most obviously those concerned with revenue, trade and employment – may not. Alcohol policy is fundamentally cross-sectoral and interdepartmental, and has historically been characterized by a 'silo' approach within departments, rather than collaborative action (Room, 1999; Baggott, 2010; Greenaway, 2011; Nicholls and Greenaway, 2015).

In recognition of this likelihood of conflicting sectoral interests within governments, in the 1980s the WHO started to promote the idea of national alcohol policies or integrated governmental policies: unified and coordinated policies, agreed and implemented by all sectors of government albeit with primacy being afforded to the public health interest (Moser, 1991; 1992). As one contemporary commentary noted, the call for the development of national alcohol policies reflected the fact that, within the WHO at the time, given 'the apparent ineffectiveness of other methods to prevent [alcohol-related] problems, control over per capita consumption has been accorded priority status' (Casswell, 1985: 357). This was also in line with the WHO's broader espousal of the health promotion concept during this period: a concept which reiterated the desirability of supporting healthier lifestyle choices through the creation of supportive environments. From a health promotion perspective, a health sector response to alcohol-related problems primarily consisting of expanded treatment and rehabilitation services made little sense in a population for which alcohol was becoming cheaper and more readily accessible at the retail level and in which levels of consumption were steadily increasing.

Of course, lack of interdepartmental coherence is not confined to the health arena. Rather, it is recognized as an issue across the general field of public sector management internationally, most explicitly in recent times as part of the wider development of what is referred to as New Public Management (NPM). The NPM movement (Hood, 1991; Christensen and Laegreid, 2011), a loosely defined and loosely structured set of changes within public sector management systems, is often thought to have had its ideological roots in the reforms introduced in the 1980s by Margaret Thatcher in the UK and Ronald Reagan in the USA. However, NPM ideas and practices were adopted globally by governments of all ideological hues, and in the UK Tony Blair's New Labour government was as enthusiastic for such reforms as the Tory government which it replaced. NPM may be seen as an attempt to correct what were seen as the faults of traditional public sector management, tackling bureaucratic policy and service delivery systems that were inflexible, slow and generally

inefficient. Ideologically, it was assumed that private sector business models could be used to transform public sector management.

As part of its general drive for greater effectiveness and efficiency, NPM focused explicitly on what was referred to as 'cross-cutting management' or, in more populist terms, as 'joined-up government'. Advocates of joined-up government believed that many, if not most, important public policy issues could not be adequately managed as part of the remit of any single sector of government, and that 'horizontal' coordination across sectors was an essential element of good governance (Bogdanor, 2005). It was argued that in the absence of such cross-cutting management, the tradition of 'departmentalism' – whereby each central government department pursued its own interests – would continue, with all of the policy fragmentation and conflict that this entailed. The challenge of achieving effective joined-up government in the arena of alcohol policy has proved especially challenging in all the countries under consideration in this book. As we shall see, the cross-departmentalism of alcohol policy has repeatedly acted as a brake on policy change as influential departments have fought for competing sectoral interests.

The idea of developing national alcohol policies in which other sectors of government subordinate their interests to the health interest may be seen as one example of 'healthy public policy' – one of five actions or tasks identified by the *Ottawa Charter for Health Promotion* (WHO, 1986) as being necessary if health promotion was to move from aspiration to political reality. Sometimes colloquially described as 'health-proofing public policy', healthy public policy calls for governments to explicitly scrutinize all legislative and policy proposals with a view to ensuring that, regardless of their other merits, no initiatives proceed if they are demonstrably harmful to public health. However, the reality of government is that while health departments hold very large budgets, their power in regard to policymaking is limited and fully joined-up government remains elusive, especially where alcohol is concerned. Indeed, one problem for health advocates is how to extend their sphere of influence beyond health departments, where they are more likely to both achieve access and receive a sympathetic hearing, to other departments whose perception of alcohol is liable to be very different.

Overall, then, the issue of developing alcohol policies that align with WHO recommendations, and the public health perspective more broadly, is about far more than pressing government to 'listen to the evidence'. It is also about more than a simple conflict between scientific truth and corrupted vested interests. It is about how evidence is established, how diagnostic paradigms achieve (and sustain) consensus, how research and advocacy interact, how advocacy coalitions emerge, how policy positions align with wider social and political contexts, how power blocs push their interests through complex lobbying activities, and how the mechanics of government facilitate or constrain radical breaks in policy equilibrium. In looking at these processes through the lens of four case studies, this book seeks to put recent alcohol policy developments into a wider perspective and provide an insight into when, how and why different perspectives on alcohol harm translate into concrete policy change.

Note

1 Throughout this book, the term 'alcohol policy advocacy' is used to describe advocacy in support of alcohol control policies that extend across the policy sphere. See Room (1999) for a discussion of these terms.

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2 Alcohol and public health
The EU context

Introduction

The European area both produces and consumes the largest amount of alcohol in the world (WHO, 2014). As a result, the need to strike a balance between protection of economic interests and protection of people's health creates considerable tensions between different policy stakeholders, including the alcohol industry and alcohol control advocates. Alcohol duties are set nationally but are governed by EU tax harmonization directives and trade agreements that set clear parameters within which nation states operate. Article 168 of the Treaty of Lisbon (2009) devolves health policy to member states while a role is retained for the EU in coordinating and complementing national policies that are 'directed towards improving public health, preventing physical and mental illness and diseases and obviating sources of danger to physical and mental health' (European Union, 2001). As this chapter will demonstrate, the dynamic relationship between centralized regulation, devolved powers, national and regional cultures and competing stakeholder interests creates a raft of difficulties in establishing coordinated alcohol policy across the EU.

Consumption and cultural diversity

Table 2.1 shows a considerable range in recorded average annual per capita alcohol consumption across the EU: ranging from 6.1 litres in Italy to 14.97 in Estonia. Denmark, Ireland and the UK report similar levels at 10.11, 11.97 and 10.25 respectively (note that estimated consumption rates are higher when illicit alcohol is included, especially in eastern European countries – see Rehm et al., 2012).

While considerable differences exist between countries (and, indeed, *within* countries), for analytical purposes Shield et al. (2012) distinguish between four regional patterns of use of alcohol within EU:

- *Central Eastern and Eastern Europe* (Bulgaria, Croatia, the Czech Republic, Estonia, Hungary, Latvia, Lithuania, Poland, Romania, Slovakia and

Table 2.1 Average annual per capita alcohol consumption in EU countries for adults 15+ (recorded consumption only), 2011

Country	*Average per capita consumption (litres pure alcohol)*	*Country*	*Average per capita consumption (litres pure alcohol)*
Austria	11.90	Latvia	10.18
Belgium	9.79	Lithuania	12.66
Bulgaria	9.72	Luxembourg	11.39
Cyprus	8.88	Malta	7.76
Czech Republic	12.67	the Netherlands	8.9
Denmark	10.11	Norway	6.4
Estonia	14.97 (2010)	Poland	10.11
Finland	9.81	Portugal	10.3
France	12	Romania	9.1
Germany	11.2	Slovakia	10.66
Greece	7.35	Slovenia	10.32 (2010)
Hungary	11.44	Spain	9.79 (2010)
Iceland	6.32 (2010)	Sweden	7.4
Ireland	11.97	Switzerland	9.92
Italy	6.1	United Kingdom	10.25

Source: WHO Global Health Observatory Data Repository (European Region).

Slovenia): Alcohol consumption in these relatively new member states is broadly higher than the European average, with higher rates of unrecorded consumption and patterns of irregular heavy drinking (Zatoński et al., 2008). Traditionally, spirits have been popular even in beer-drinking countries, such as the Czech Republic and Slovakia and wine-drinking countries, such as Bulgaria, Hungary and Romania (Shield et al., 2012).

- *Central Western and Western Europe* (Austria, Belgium, France, Germany, Ireland, Luxembourg, the Netherlands, Switzerland, the United Kingdom): This region comprises five of the six founding members of the EU (Belgium, France, Germany, Luxembourg, the Netherlands), two countries from the first enlargements (Ireland, the United Kingdom) and Austria, which joined later. Switzerland is not a member of the EU. Outside of France and Switzerland, beer is the most widely consumed alcoholic drink in this region. There is extensive alcohol consumption between meals and a higher prevalence of alcohol-related problems here compared to southern Europe. With the exception of the UK and Ireland, which resemble Nordic countries in this respect, there is a low tolerance of public drunkenness despite high overall levels of consumption.

- *The Nordic countries* (Denmark, Finland, Iceland, Norway, Sweden): Here drinking styles have, historically, been characterized by high levels of spirits consumption – although the recreational use of spirits has a much shorter history than wine-drinking in the Mediterranean region. Traditional consumption patterns involve non-daily drinking, irregular heavy or very heavy drinking, and a tolerance of drunkenness in public (Room, 2010). Today beer and wine are widely consumed alongside spirits, especially in Denmark, which has developed a more central-western and western style of drinking.
- *Southern Europe* (Cyprus, Greece, Italy, Malta, Portugal, Spain): Drinking styles here are broadly dominated by wine and characterized by daily drinking and consumption with meals. Irregular, heavy drinking is less commonplace than in other regions and there is a lower tolerance of public drunkenness. The overall volume of consumption is high compared to other regions, except in Cyprus and Malta, but has declined in recent decades.

Levels of alcohol-related health harms also vary across the EU. As Table 2.2 shows, there are differences between European regions in, for instance, alcohol-related mortality for cancer, liver cirrhosis and injuries.

While geographical units such as these are helpful in making broad observations about trends in consumption and harm across Europe as a whole, they are by no means exhaustive or complete descriptions. Drinking cultures vary both geographically and over time, although the era of the European Union has also been characterized by something of a convergence of drinking styles across member states (Grigg, 1998; Järvinen and Room, 2007). Wine has become more widely consumed in historically beer-drinking regions such as the UK while heavy episodic drinking and tolerance of public drunkenness have increased in countries such as France and Spain. The project of transnational alcohol policy principles is, to an extent, legitimized by this convergence of drinking cultures. At the same time, however, continuing regional differences present one of its greatest challenges.

Table 2.2 Alcohol-attributable standardized mortality rates (per 100,000 people), 2010

Region	*Cancer*	*Liver cirrhosis*	*Injury*
Central Western and Western country group	10.99	11.57	5.53
Central Eastern and Eastern country group	12.13	24.48	21.97
Nordic countries	7.46	8.37	8.02
Southern Europe	8.93	8.17	6.26
EU	10.83	14.63	10.49
EU, Croatia, Norway, Switzerland	10.77	14.43	10.47

Source: WHO (2013), Appendix 2, p. 159.

Comparing alcohol policies by country

Historically, there has been little consistency in the development or implementation of alcohol policy across Europe. One significant legacy of the Victorian temperance movement – which was far more influential in Northern Europe than the Mediterranean – was the establishment of alcohol monopolies in many Nordic states in the early twentieth century. Here, a large proportion of alcohol production and retail came under direct state control: the physical availability of alcohol was restricted and alcohol was taxed more heavily than elsewhere – with, importantly, a proportion of the income being directed to alcohol research (Holder et al., 1998). By contrast, for most of the twentieth century, Mediterranean countries tended to have limited alcohol policy measures and comparatively low levels of taxation.

The expansion of the European Union, and the political convergence of states with highly diverse alcohol policies, have necessitated the development of policy analysis capable of both comparing policies between countries and estimating policy effects in various cultural and economic settings. Recently, a number of comparative scales have been developed that rank alcohol policies in order of strength (usually according more restrictive policy a higher score) in order to map policy against consumption and harm trends (see, e.g. Karlsson and Österberg, 2007; Babor et al., 2010: 243–248; Eisenbach-Stangl, 2011; Giesbrecht et al., 2013; Nelson et al., 2013; Naimi et al., 2014; for a critique). Karlsson et al. (2012) divided the European area into four areas (Nordic, East, West and Southern Europe) and found that Nordic regions had both the most restrictive policies and some of the lowest levels of consumption – suggesting a causal relationship from restrictive policy to reduced consumption. In the same analysis, however, Southern Europe received the lowest policy score, but also had the second lowest level of consumption – highlighting the extent to which consumption trends emerge from an interaction of policy interventions and existing cultural norms.

This interaction has been highlighted in recent cross-European policy analyses. In a study of post-war Italian drinking, Allamani et al. conclude that 'alcohol policies had no role in drinking changes in Italy between 1960 and 1988, while they had a minor role in supporting the on-going decline thereafter' (Allamani et al., 2014: 1660). By contrast, analysis of Russian alcohol policy since 2006 suggests that the introduction of strict controls, including increased licensing costs, tightened controls of production monitoring, a ban on unlicensed retail, and restrictions on the sale of products above 15 per cent ABV contributed to a steep decline in both alcohol poisoning and liver cirrhosis deaths (Levintova, 2007; Pridemore et al., 2014). In Italy, gradual policy changes in the context of a cultural shift towards lower consumption had a limited overall impact, whereas in Russia strong policy in the context of very high consumption had a more marked effect.

Measuring the effect of alcohol policy, therefore, requires consideration of the relationship between policy interventions and local drinking cultures. Not

only do 'unplanned' variables (such as urbanization or changing gender politics) appear to have a higher correlation with changes in consumption patterns than alcohol policy changes (Allamani et al, 2012; Knibbe et al., 2014; Voller et al., 2014), but policy development is itself responsive to – and, in many cases, determined by – local practices and concerns. As Bendtsen et al. argue, 'Alcohol policies might be a response to adult drinking patterns or adult drinking patterns may influence the alcohol control policies' (2014: 1865). Noting that alcohol policies tend to be stricter in cultures traditionally more tolerant of heavy episodic drinking and public drunkenness, and vice versa, Nordlund (2014) proposes two ways of understanding the relationship between national social norms and formal alcohol policies: first, a 'congruence hypothesis' suggests that 'restrictive norms lead to restrictive policy and liberal norms lead to liberal policy', and, second, a 'complementary hypothesis' in which 'the informal rules in some countries are very liberal so that alcohol policy must be restrictive in order to keep the alcohol problems at an acceptable level' (ibid.: 25–26). This dynamic clearly has an impact on alcohol policy at EU level, and underpins – along with the powerful role of the alcohol industries – many of the difficulties that are faced in developing an EU-wide alcohol policy framework.

Although the relationship between policy, consumption and harm is complex, policy nevertheless has a crucial role to play. While 'neither imposed control policies nor changing socioeconomic factors exist in isolation' (Plant et al., 2014: 1586), policy is both the socioeconomic variable over which elected governments have control and the primary framework through which industry activity is regulated. Nevertheless, measuring the specific effects of policy developments, especially in settings as varied as the member states of the European Union, is difficult.

The role of WHO Europe

As discussed throughout this book, the work of the World Health Organization Regional Office, since adopting the public health perspective on alcohol policy, has been critical in changing the terms of the debate on alcohol policy in Europe. At the European level, the WHO has stated its policy position a number of times. In 1993, WHO Europe published a European Alcohol Action Plan calling for targeted national policies aimed at reducing overall consumption in member states. This was followed by the publication of a European Charter on Alcohol 1995, which outlined five ethical goals and ten 'strategies for action', including the development of national targets, restrictions on price and availability and further controls on alcohol marketing (WHO Europe, 1993; 1995). A subsequent update to this charter placed a special focus on the reduction of alcohol consumption among young people (WHO Europe, 2001). The European Action Plan was further updated in 2000 and in 2012, in each case, maintaining calls for national alcohol strategies and the overall goal of reducing consumption across the population through the 'best

buy' policies of increasing price, reducing availability and restricting marketing as well as targeting drink driving and supporting the wider adoption of screening and brief advice in primary care (WHO Europe 2000; 2012).

The activities of the WHO in advocating for public health-oriented approaches have been bolstered by the work of alcohol control advocacy groups, some of whom had their origins in the temperance movement of the late nineteenth and early twentieth centuries. In 1990, an advocacy alliance of nine non-governmental organizations, including the International Organization of Good Templars and the Institute of Alcohol Studies, was formed to promote the WHO alcohol policy model within the European Union. This alliance, which came to be known as Eurocare, was invited as an observer to the first WHO European Alcohol Action Plan Counterparts meeting in 1992, and has worked closely with colleagues in WHO Europe since then. According to a former WHO Regional Director for Europe, NGOs such as Eurocare play 'a particularly important role' in supporting WHO action through 'speak[ing] with passion and insight on the true impact of alcohol on individuals, families and communities [bringing] the commitment of energy to work even in the face of political risks' (cited in Rutherford, 2005). Eurocare now has around 58 member organizations across 25 countries and provides coordination, policy leadership and – critically – a voice in both the WHO and the EU for alcohol control advocacy groups across Europe.

A key success of WHO action has been the development and adoption of national alcohol strategies by a number of countries across the EU. Table 2.3 shows the status of national alcohol strategy development for member states in 2014.

Denmark continues without a national alcohol strategy, whereas Ireland and the UK have gone through several revisions of their national strategies – with separate strategies for the home nations within the UK. The development of national strategies is discussed in more detail in other chapters. As those examples illustrate, the existence of a national alcohol strategy is not, by itself, evidence that the kind of policy principles favoured by alcohol control

Table 2.3 National strategies and national action plans in EU member states, 2014

Adoption	*No.*	*Countries*
National strategy and national action plan	14	Czech Republic; Finland; Greece; Ireland; Latvia; Lithuania; the Netherlands; Poland; Portugal; Romania; Slovenia; Spain; Sweden; UK (separately for England and Wales; Scotland and Northern Ireland).
National strategy alone	7	Belgium; Croatia; Cyprus; France; Germany; Italy; Slovakia
No national strategy or action plan	7	Austria; Bulgaria; Denmark; Estonia; Hungary; Luxembourg; Malta;

Source: WHO (2014).

advocates have been adopted wholesale since they often prioritize partnership approaches, rather than restrictive interventions on price, availability and marketing (Karlsson and Österberg, 2007).

Policy and behaviours across Europe

The regulation of alcohol availability is devolved to member states and there is enormous variation across the EU. Germany, for example, has very limited restrictions on hours of sale, levels of outlet density, and so on – indeed, similar to a number of other EU member states, it only imposes licensing restrictions on the on-sale of alcohol. By contrast, Sweden and Finland operate state monopolies for the off-sale of alcohol while both the UK and Ireland have complex licensing systems that regulate the sale of alcohol in both the on- and the off-trade. There is very little uniformity across EU member states in how availability is regulated or how regulations are enforced.

Recent pan-European analyses have concluded that increases in the availability of alcohol are 'associated with increased consumption, especially at their initial introduction, in those countries that had a tradition of restrictive measures' (Allamani et al., 2014: 1709). International research also suggests increased availability is associated with increased consumption (Babor et al., 2010), while there is 'slight evidence that on average introducing restrictive availability can be associated with decreasing consumption' (Baccini and Carreras, 2014: 1689). Cross-country comparisons highlight the fact that the impact of availability controls on consumption is mediated by existing drinking cultures, the prevalence of different types of outlet and the degree to which policy changes represent a departure from existing practice (Holmes et al., 2014a; Gmel et al., 2015). Therefore, arriving at firm evidence-based conclusions as to which availability measures will work in which contexts and among which populations is a significant challenge that differs both between and within individual countries.

While licensing is fully devolved, alcohol taxation is subject to EU-wide harmonization. Estimates vary considerably as to the precise degree of influence pricing changes have on purchasing patterns – depending, among other things, on types of drink, income, age and level of intoxication (e.g., Gallet, 2007; Wagenaar et al., 2009; Fogarty, 2010; Hunt et al., 2010; Griffith et al., 2013; Holmes et al., 2014b; Amlung et al., 2015; Jiang and Livingston, 2015). However, the weight of evidence shows that alcohol consumers are responsive to price, and that higher prices, when passed on to consumers, result in lower consumption – though, one recent study of historical trends in 12 European countries 'was not able to find any relevance of price impacting on alcoholic beverage consumption' (Allamani et al., 2014: 1707). Because alcohol is taxed at a number of points between production and consumption, governments have enormous potential leverage over the shape and scale of the alcohol market. Nevertheless, alcohol taxation has, historically, rarely been used as a mechanism for shaping consumption trends; rather it has tended to be used to

ensure maximum revenue to the state from the alcohol trade. This has not, however, led to universally high taxation since the level of income generated per unit of alcohol needs to be balanced against the risk that excessive taxation will encourage illicit production or a black market in retail.

Alcohol duties are set at national level but tax boundaries for EU members were harmonized in 1992 under European Council Directive 92/83/EEC, which includes different mechanisms for beer, wine, spirits and cider. Because EU alcohol tax harmonization creates variations within and between alcohol beverage categories, attempts to use alcohol duties as a means of reducing consumption are especially difficult. For example, around half of EU countries do not levy any tax on wine – largely to protect national producers. Furthermore, where member states do tax wine, the banding structure means that taxation cannot vary between wine that is 1.2 per cent and 15 per cent alcohol by volume (ABV), therefore precluding the use of tax incentives to produce lower alcohol products. By contrast, EU beer taxes are set by ABV so can be used to incentivize the production of beer with less alcohol content, especially as beer of less than 2.8 per cent ABV can be removed from tax entirely. Again, beer taxation levels vary enormously within the EU, reflecting local drinking cultures, the power of regional producers and levels of public and political concern around alcohol consumption (Cnossen, 2007; Österberg, 2011).

While member states have freedom to adapt elements of alcohol duty in order to reflect changing economic or social conditions, the underpinning framework is notoriously difficult to revise. This is primarily because changes to the key EU tax directives require unanimous agreement, which, given the scale and diversity of alcohol production and retail across the EU, is extremely hard to achieve. Consequently, a duty framework established in 1993 remains largely unaltered two decades later and is unlikely to be changed substantially in the near future.

As with all alcohol policies, the relationship between price and consumption varies according to social and economic contexts. In some countries, sudden and dramatic reductions in alcohol duties have often been followed by spikes in consumption; for example, when Finland reduced its alcohol excise duty rates by a third in 2004, it saw a subsequent consumption increase of around 10 per cent (Mäkelä and Österberg, 2009). In Mediterranean countries, by contrast, where wine consumption was very high in the early part of the century, urbanization and changing drinking trends have led to reductions in wine drinking (despite increasing affordability) and, in some cases, the substitution of beer for wine, as beer has a lower alcoholic content. In some parts of Europe, spirits consumption has increased considerably when its relative price has fallen. In Scotland, vodka sales are now far higher than 'traditional', and more expensive, whisky (Beeston et al., 2013). In Poland, spirits consumption fell between 1980 and 2000, but began to rise steeply during the 2000s – a shift which has been linked by one analyst to the effects of a 30 per cent cut in duties in imported spirits in 2002 (Zatoński, 2014).

These examples highlight the social, economic and political imperatives that constrain alcohol policy at the national level and the difficulties of

applying evidence derived from international research to specific national settings. They also emphasize the enormity of the task involved in developing strategy and action plans that cross national boundaries and the difficulties faced at supranational level by both WHO Europe and the European Union in their attempts to influence the development and the content of national alcohol policies.

The role of the EU

The precursor to the EU, the European Coal and Steel Community, was established under the 1951 Treaty of Paris. In 1957, the six original member states – Belgium, France, Germany, Italy, Luxembourg and the Netherlands – established the European Economic Community (EEC) and the European Atomic Energy Community through the Treaty of Rome. The Treaty of Rome outlined the rules for the creation of a 'common market', but it was not aimed at integrating or harmonizing other aspects of health or social policy and did not give the emerging EC bureaucracy supranational mandates in these public policy areas. In relation to alcohol policy, Österberg and Karlsson point out:

> When discussing alcohol policy matters in the present EU member states and at the EU level, it is important to bear in mind how the Community has enlarged since 1951. The six founding members of what is now called the EU are mostly countries where beer and wine had been the preferred beverage. These countries were and constantly are important producers of wine and beer. On the other hand, in the 1950s alcohol control measures were not very common in the founding member states of the EC, and even if at least some preventive alcohol measures existed in all these countries, not all of them effectively enforced these measures.
>
> (2002: 22)

Denmark, Ireland and the United Kingdom joined the EC in 1973. All three had comparatively high alcohol excise duties and were important producers with particular interests in beer. Ireland and the United Kingdom also had key interests in the production of distilled spirits, especially whisky. As highlighted previously, Ireland and the United Kingdom also differed from most original member states in that they had a long history of regulating availability through complex licensing systems that regulated both on- and off-sales of alcohol.

Greece joined the EC in 1981 and Portugal and Spain in 1986. These were wine-producing and wine-consuming countries with a history of limited alcohol control measures and relatively low duties. Austria, Finland and Sweden joined the EU in 1995. Finland and Sweden were both traditionally spirits-consuming countries with a long history of alcohol control policy including a comprehensive state monopoly system, restricted physical availability and high excise duties. In 2004, Cyprus, the Czech Republic, Estonia, Hungary,

Latvia, Lithuania, Malta, Poland, Romania, Slovakia and Slovenia joined the EU, in 2007, Bulgaria became a member and, in 2013, Croatia. All these countries except Malta and Cyprus are countries with comparatively high levels of alcohol consumption and a tradition of spirits drinking. They also generally have a higher rate of unrecorded consumption and a pattern of irregular heavy drinking occasions (ibid.). The new member states further amplified the existing diversity of drinking cultures, competing business interests, and conflicting approaches to both the purpose and practicalities of alcohol policy.

Importantly, the primary purpose of the European Economic Community, in its initial conception, was to foster free trade and ensure the free movement of goods across national borders. It was not, in its original conception, there to develop public health policies. In this respect, alcoholic beverages were treated like other commodities: as the subjects of policies designed to promote trade and consumption. Indeed, wine production was subsidized by the EU through its Common Agricultural Policy (ibid.) – a policy which, itself, reflects the centrality of wine manufacture to the French national economy.

The principle of subsidiarity places important constraints on EU policy action, which is only possible in fields where it has competence as defined by a number of Treaties. Under the Treaty establishing the European Union (TEU, article 5/2):

> The Union shall act only within the limits of the competences conferred on it by the Member States in the Treaties to attain the objectives set out therein. Competences not conferred upon the Union in the Treaties remain with the Member States.

Alcohol is mentioned specifically in Article 168(5) of the Treaty of Lisbon (2009), which states that:

> [The European Parliament and the Council] may also adopt incentive measures designed to protect and improve human health and in particular to combat the major cross-border health scourges, measures concerning monitoring, early warning of and combating serious cross-border threats to health, and measures which have as their direct objective the protection of public health regarding tobacco and the abuse of alcohol, excluding any harmonisation of the laws and regulations of the Member States.

Thus the principle of subsidiarity rules out EU action when member states can effectively deal with an issue at national, regional or local level. The Community is justified in exercising its powers when member states are unable to achieve the objectives of a proposed action satisfactorily and added value can be provided if the action is carried out at European level. (European Union, 2015).

EU strategic work on alcohol started later than WHO action (Møller and Anderson 2012). Although the internal market framework has affected

alcohol policy issues throughout the history of the EU, specific action on alcohol as a public health issue did not commence until 2001 when the European Council invited the European Commission (EC) to develop a community strategy to reduce alcohol-related harm (European Council, 2001a). In 2001, there was also a Council recommendation to address drinking by young people, particularly children and adolescents (European Council, 2001b). EU action on alcohol culminated in 2006 with the publication of the EU Strategy to Support Member States in Reducing Alcohol-Related Harm (European Commission, 2006).

The EU Strategy highlighted five priority themes:

- protecting young people, children and the unborn child;
- reducing injuries and death from alcohol-related road accidents;
- preventing alcohol-related harm among adults and reducing the negative impact on the work-place;
- informing, educating and raising awareness about the impact of harmful and hazardous alcohol consumption, and about appropriate consumption patterns;
- developing and maintaining a common evidence base at the EU level.

Based on the rationale that alcohol-related harm is a complex problem requiring a coordinated multi-stakeholder response, the Commission also established a structure and working procedures for the implementation of the strategy and to ensure that different stakeholder groups could meet and agree on action. The structure consisted of four main pillars:

- Strengthened coordination and policy development between member states and the European Union, through the Committee on National Alcohol Policy and Action (CNAPA, set up in 2007). This committee comprised representatives nominated by EU member states, Norway, Switzerland and the WHO.
- Stimulation of concrete stakeholder-driven action on the ground, through the European Alcohol and Health Forum (EAHF, established in 2007). At the start, the EAHF had 50 founding members from various NGOs (consumer, health, youth, medical professions); advertisers, broadcasting, publishing and other media; alcohol producers, wholesalers, retailers, caterers and insurers; and observers from WHO, EU institutions, and other interested parties. Members are encouraged to undertake 'commitments' to put in place activities designed to reduce alcohol-related harms.
- Development of reliable, comparable and regularly updated data on alcohol consumption, drinking patterns and alcohol-related harm, as well as on common indicators and definitions, through the Committee on Data Collection, Indicators and Definitions.
- Mainstreaming the reduction of alcohol-related harm into other Community policies (a 'health in all policies' approach).

In addition, a Science Group was set up within the EAHF (2008) to provide scientific guidance to the Forum's deliberations and to ensure that proposed actions were informed by the best available evidence. Members of the Science Group were selected from applicants to an open call.

The 2006 EU Strategy appeared at a time when support for a public health, whole population, approach to alcohol regulation was increasing, accompanied by the growth of alcohol control advocacy both within member states and at European level. The hope that the EAHF would help to bridge the gaps between stakeholder groups was not, however, realized. Despite a promising start which saw an increase in EAHF members from 50 to 61 at the time of the first evaluation and to 68 by 2012, collaboration across interest sectors never developed and most joint initiatives at EU level were between stakeholders belonging to the same category (Directorate General for Health and Consumers, 2009). Increasing tension between industry-allied stakeholders and public health stakeholders, visible at national and European levels, finally resulted in public health groups leaving the EAHF in protest at the Commission's decision not to renew the Strategy, which had ended in 2012. Among other reasons, it was argued that there was no evidence to show that the Forum had had any impact on public health and, with no new Alcohol Strategy planned, the Forum was meaningless (EAHF, 2015). The withdrawal of the public health groups reflected long-standing dissatisfaction with how the Forum operated and the perceived dominance of industry interests (Eurocare, 2015).

Despite the problems that attended the translation of its principles into policy, an evaluation (Zamparutti et al., 2012) and subsequent reviews (e.g. House of Lords European Union Committee, 2015) attributed considerable gains to the EU Alcohol Strategy. Providing a platform for exchange of knowledge about policy, strengthening the knowledge base, and building consensus among members on policy issues, were considered major achievements in support of member states. Surveys of members of CNAPA, EAHF, and external experts and officials reported that the majority of respondents thought the EU Strategy had contributed to the development of policies, actions and strategies in each of the priority themes (Zamparutti et al., 2012). Given the complexity of the factors influencing national alcohol policy and the concurrent activities of WHO, it is not possible to make conclusive statements about the nature and extent of the influence of the EU Strategy on member state policies. In part, that may depend on the stage of policy development in each country at the time the EU Strategy was issued.

As countries that had national policies before 2006, Ireland, England and Scotland were already some way towards implementing policies in line with EU strategy recommendations – and, indeed, these and other countries with existing policies may have influenced thinking within CNAPA and the EAHF. With respect to 'added value', the final evaluation found that:

> The strategy has provided an EU-wide foundation for action on alcohol-related harm. Without it, a common approach across the EU would not

> have developed and EU work on a common knowledge base would likely have been significantly reduced. National efforts to address cross-policy aspects would have been less strong without an EU-wide exchange of information. Dialogue and cooperation across a broad range of stakeholders at EU level would have been unlikely to take place to a comparable extent in the absence of an EU strategy.
>
> (ibid.: 30–31)

At the time of writing, despite concerted calls from public health bodies across Europe for a revised EU Strategy, it appears to have been ruled out following a speech to the EAHF by the Health and Food Safety Commissioner, Vytenis Andriukaitis in May 2015 (Jacobsen, 2015).

Alcohol policy represents one example of an EU policy issue where there is a likelihood of 'deadlock': that is where the diversity, complexity and fundamental disagreements involved render it virtually impossible for the emergence of consensus or the framing of an unequivocal policy solution acceptable to all stakeholder interests. Héritier (1999) argues that, as a young polity, the EU uses the tactic of 'subterfuge' to work its way around such deadlock. Cisneros Örnberg (2009) has identified a number of specific mechanisms by which this operates:

- *Priority* – treating the issue as an important one which is to be kept on the policy agenda.
- *Anchorage* – getting the major policy actors on board the policy process.
- *Lowest common denominator* – framing the debate in terms that are irrefutable or almost certainly acceptable to all stakeholder interests.
- *'Baby steps'* – explicitly presenting the policy process as incremental, one that will take time if agreement is to be reached in defining problems and identifying solutions (Cisneros Örnberg, 2009).

In terms of the 2006 EU Strategy on Alcohol, it seems that these tactics had a degree of success in establishing initial cross-stakeholder support. However, implementation of the Strategy exposed the gulf between the policy framing goals of the industry and public health. The lowest common denominator proved not to be simply an acknowledgement that alcohol harms exist, and are amenable to interventions, but whether those harms were dichotomous or continuous and whether addressing them meant targeting supply or demand. Ultimately, while the drinks industry was largely satisfied with the process, the public health interest became disillusioned. The 'lowest common denominator', which in this instance consisted of identifying and working on specific problems (e.g. drink driving or youth alcohol consumption) around which there appeared to be consensus, was at odds with the public health argument that it is the supply of alcohol *per se* which is the problem to be addressed. Similarly, the 'baby steps' approach appeared to alcohol control advocates as a familiar ploy by the drinks industry to block or delay progress

in implementing public health policy. When the status quo is to your advantage, merely delaying change is intrinsically valuable. The withdrawal of Eurocare from the ongoing policy process signalled its scepticism that alcohol harm reduction was a priority for EU; and for the EU itself their withdrawal was a failure of 'anchorage' in that one key stakeholder interest was no longer on board.

Conclusion

The countries that currently comprise the EU region are enormously diverse in terms of drinking styles, the role of alcohol in their native economies, and their historical approaches to market regulation. This diversity inevitably constrains efforts to develop shared models for alcohol policy and harm prevention. Furthermore, the complex regulatory structures of the EU create blockages to the smooth adoption of new policies. As is discussed elsewhere, in the case of Scottish legislation on minimum pricing, the legality of the policy hinged on how the European Court of Justice understood the relationship between trade policy (set at EU level) and health policy (devolved to member states). Add to this the power of coordinated industry lobbying at the EU level, and it is perhaps unsurprising that alcohol control advocates have struggled to achieve their policy goals, despite extensive pan-European advocacy coalition-building.

While the four countries that provide the focus for this book have many similarities, the analysis in this book also highlights the many ways in which they differ. Consideration of these differences highlights the difficulties involved in implementing the WHO policy perspective even in countries which appear to have much in common. This, in turn, highlights the challenges in imposing alcohol control policies across the full range of European countries when they are characterized by such diverse alcohol cultures.

This chapter also highlights the constraints on the EU acting as a legal and political vehicle for the implementation of alcohol control policies in all member states. Within the EU there are internal conflicts as to the social and economic value of alcohol (and different alcoholic drinks) as well as how alcohol-related problems should be reduced. With their roots in Nordic alcohol monopolies, adoption of the alcohol control strategies embodied in the WHO charters would mark a step-change in policy in those countries with a different political heritage – and one that is fiercely resisted by an alcohol industry with strong contacts at the heart of the decision-making process. While the 2006 Strategy suggested a degree of collective action was possible, the subsequent conflicts between stakeholders and the decision not to renew the Strategy in 2015 exposed the profound difficulty in shifting the status quo at this level. As with all policy development, inertia – the reinforcement of established practices, networks and principles – is a powerful force. As with all alcohol policy, the demands of control advocates face resistance not only from industry, but from populations for whom the freedom to drink remains valuable and, by extension, the politicians who represent those populations.

As the following chapters will show, the motivating factors in these disputes are profound and complex: not simply a battle between health promotion and commercial interests, but a collection of disputes over culture, history, identity and freedom played out in a political domain where power ebbs and flows between politicians, advocates, media gatekeepers, bureaucrats, lobbyists and a public construed as both an electorate and a body of consumers. Successful policy transformation in such an environment is rare, and never easy to achieve.

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3 Alcohol and alcohol policy in Ireland
Historical background

Introduction

Chapter 1 of this book presented a detailed account of the public health or total consumption model of alcohol issues which has been developed and promoted since the 1970s by international researchers, with the institutional support of the WHO. It also discussed cultural, economic and political obstacles to the implementation of such public health-based alcohol policy, and the folly of assuming that public policymaking in this sphere is an essentially rational or 'evidence-based' process. In order to provide a context for a detailed consideration of how Irish policymakers have responded in recent decades to these WHO policy recommendations (which will be presented in Chapter 4), this chapter will review a range of political events, cultural trends and influential personalities pertaining to Irish alcohol issues over the past two centuries.

Nineteenth-century influences on Irish drinking habits

The Irish have traditionally and stereotypically been regarded as a people who have an excessive attachment to alcohol consumption. Perhaps the oldest and most entertaining reference to this topic concerns Saint Brigid, a female, fifth-century Christian saint whose vision of heaven, apparently, was of a lake of beer on whose shores the heavenly family sat sipping through eternity (e.g. Edwards, 2000: 29). Sociological writing which has explored the sociocultural roots of Irish drinking in recent centuries has, however, been dominated by far less benign images of the 'drunken Irish'. Much of the early sociological work dealt indirectly with this topic, in that it was focused not on drinking by the Irish in Ireland but on the drinking habits of Irish-Americans in the United States of America – and particularly on late-nineteenth- and early-twentieth-century influences thought to have shaped the drinking attitudes and practices of this emigrant group. Generally, it was suggested that the emigrant Irish had brought with them to the United States a uniquely pathological package of personal coping styles and interpersonal relationships which made them especially vulnerable to alcohol problems. Two Irish-American

sociologists, Greeley and McCready, summarized the research literature as follows: 'One comes away from reading the empirical literature convinced that the Irish are guilt-ridden, sexually repressed, superstitious, frustrated, unhappy, maladjusted, and given frequently to alcoholism in the search for emotional release' (1972: 42).

Based on their own empirical data from the National Opinion Research Center, which allowed them to compare the personality profiles of Irish-Americans with those of other ethnic groups in the United States, Greeley and McCready modified certain aspects of this very negative representation of the Irish but, in the main, did not repudiate it. Of course, it cannot be assumed that this characterization of Irish-Americans applies in its totality to the Irish who remained in Ireland or, indeed, that it is of continuing relevance to the changed circumstances of Irish drinking in the early twenty-first century. Nonetheless, it touches on many of the themes which emerge from a study of the main influences on Irish drinking habits from the nineteenth century and which will now be considered here.

The Catholic Church and alcohol in nineteenth-century Ireland

The politics of nineteenth-century Ireland were dominated by the Act of Union of 1800 which dissolved the Irish Parliament and drew Ireland into a United Kingdom of Great Britain and Ireland, ruled from Westminster (MacDonagh, 2003). Opposition to the Union continued to be expressed throughout the century, whether by constitutional politicians who campaigned for its repeal and for the restoration of some form of Home Rule or by armed rebels who staged periodic uprisings. Irish Catholics, who made up the vast majority of the country's population, had benefited in civic and political terms from Catholic Emancipation in 1829, which effectively ended the legal discriminations against them that had been a feature of the eighteenth century. This newfound religious freedom contributed to the gradual emergence of a Catholic middle class; but in an agricultural economy where land ownership remained largely in the hands of Protestant (and often absentee) landlords, it conferred no immediate benefit on the bulk of the population of rural Ireland. Native Irish tenant farmers eked out a subsistence living on their smallholdings, developing an increasing reliance on potato farming: a reliance that was to prove catastrophic when the potato crop succumbed to blight during the 1840s. Efforts by the Westminster government to alleviate the resulting famine were hampered by its failure to realize the scale of the situation and by its general adherence to *laissez-faire* economic philosophy. Lee (2008) has calculated that between 1841 and 1851 1 million people (out of a total population of 8 million) died from hunger or associated diseases and that these deaths, when combined with the subsequent mass emigration, led to a 20 per cent decline in population over this decade.

In the midst of the general gloom of nineteenth-century Ireland, one institution which very obviously thrived was the Roman Catholic Church. This century,

and particularly its second half, was marked by: dramatic increases in numbers of priests, nuns and religious brothers; increased building of churches, monasteries and convents; greater conformity by the laity to requirements for church attendance; and an expansion of the influence of Church authorities in all public spheres – but especially in health and education. Larkin (1972) has argued that this 'devotional revolution' among a people not previously remarkable for religious fervour is chiefly explicable in terms of the way in which Catholicism became a badge of identity for the Irish during this period. At a time of economic failure, when the country had lost its parliament and was rapidly losing its native language, religious identity became a source of stability and certainty. For most of the population, to be Irish was to be Catholic, and to be Catholic was to take seriously the teachings and admonitions of Church authorities. Given the moral authority enjoyed by the Catholic Church, it seems important to assess its attitude towards alcohol consumption at this period.

In the decades prior to the famine, Catholic priests and bishops had expressed regular concerns about excessive drinking and related misbehaviour, especially in relation to heavy drinking at wakes, funerals, weddings and local religious festivals (Connolly, 1982). However, by far the biggest and best-known Irish temperance movement of this century was that of Fr. Theobald Mathew (1790–1856), a Roman Catholic priest and member of the Capuchin Order, who started his religiously-based temperance movement in Cork in 1838. This new temperance campaign enjoyed unprecedented popularity and spread over subsequent years to all parts of Ireland, while Fr. Mathew himself developed the reputation of miracle worker among Catholic lay people who turned up in their thousands to take the 'pledge' from the movement's founder (Quinn, 2002; Townend, 2002). For Mathew, the idea of temperance was synonymous with lifelong total abstinence ('teetotalism') from all forms of alcoholic beverage, rather than moderate consumption of alcohol. While historians are agreed on the difficulties involved in calculating precisely how many people took the Fr. Mathew pledge and on the likelihood of exaggeration in relation to these figures, there can be no doubt that this movement was on a vast scale. Claims that perhaps as many as half of the country's adult population had taken the pledge cannot be discounted, and there are also detailed accounts of financial losses suffered by the drinks industry alongside reports of social gains – such as decreases in alcohol-related crimes – attributed to it (e.g. Kerrigan, 1992). Coinciding with this temperance campaign, Ireland's leading politician of this period, Daniel O'Connell – commonly given credit for having secured Catholic Emancipation in 1829 – was running a populist campaign for repeal of the Act of Union. A degree of collaboration developed between the Fr. Mathew temperance movement and O'Connell's Repeal movement, particularly in relation to the holding of 'monster' meetings, and O'Connell aligned himself with Mathew by taking a personal pledge and publicly proclaiming the benefits of abstinence. However, O'Connell had previously been closely associated with the drinks industry and it quickly became apparent that his commitment to the temperance movement was based solely on grounds of political expediency:

> Despite his early endorsement of the physical benefits to be derived from abstinence, he eventually withdrew from his pledge on medical grounds. And in January 1843 he told a meeting called to honour Father Mathew that the temperance movement had passed 'too heavy a censure … on the former condition of the country' by suggesting that the Irish were a 'drunken people'. Using parliamentary figures, O'Connell argued that whiskey consumption was not excessive in Ireland and in fact the Scots drank considerably more. By 1843 O'Connell no longer needed to pander to the views of the teetotalers. He was careful not to criticize Father Mathew personally, but this speech made plain that the support of the drink industry was now more important to him than that of the teetotal crusade. He had captured teetotalism and securely harnessed it to the chariot of Repeal.
>
> (Malcolm, 1986: 130)

Although he lived until 1856 and extended his temperance work to parts of Britain and the United States, Fr. Mathew's Irish campaign lost momentum for the last decade of his life and, like much else in Ireland during the 1840s, was profoundly and negatively influenced by the horrors of the Great Famine. Most historians agree that the Fr. Mathew campaign was based almost entirely on the personal charismatic attributes of a founder who failed to leave behind him organizational structures – at either national or local levels – to continue his work. Whatever the importance of securing the support of politicians such as Daniel O'Connell for his temperance campaign, it was vitally important that Mathew get the backing of his own religious authorities – the bishops and priests of the Catholic Church in Ireland. However, as became apparent towards the end of his life and after his death, Catholic Church leaders were equivocal about the Fr. Mathew campaign. While acknowledging the problems linked to alcohol consumption, many bishops and priests were uncomfortable with the vehemence with which Mathew denounced the evils of drink, since such anti-alcohol sentiment was not a feature of Catholic moral theology or social teaching – and, indeed, since many Catholic priests and bishops were themselves drinkers. Some of his fellow-Catholic clerics were also unhappy with Mathew's willingness to work ecumenically with Protestant clergymen, and some accused him of mercenary motives in the sale of his temperance medals (e.g. Kerrigan, 1992: Chapter 7). What was most telling, however, was that, following his death, no attempt was made by the Catholic authorities to continue his temperance work or give it a secure base within what was now an impressively developed Church bureaucracy.

Over the half-century following his death, many smaller Catholic temperance movements came and went, with none attaining anything like the significance of Fr. Mathew's campaign. It was not until 1898 that an official Catholic Church temperance movement, the Pioneer Total Abstinence Association (PTAA), was established in Dublin (Ferriter, 1999). The approach of the founder of the PTAA, Fr. James Cullen (a member of the Jesuit Order), differed greatly from that of Fr. Mathew. Cullen did not attempt to emulate Mathew's charismatic

style but was instead preoccupied with ensuring that his new temperance movement would have organizational permanence, which, he realized, could only be guaranteed if it had the support of the bishops and was securely locked into official Church structures. While he shared many of his predecessor's views about the evils of drink and the virtues of temperance, Cullen was conscious that public expression of these views could damage his standing with the bishops: 'Only by moderating his essentially hardline teetotal views could Cullen hope to retain the approval of the hierarchy' (Malcolm, 1986: 312–313). Not surprisingly then, the organization founded by Cullen differed radically from the Fr. Mathew campaign, as may be seen from this summary of its key features:

- the PTAA was managed by the Jesuit Order on behalf of the Irish bishops, which meant that it was bureaucratically integrated into official Catholic Church structures and – unlike the Mathew campaign – under the control of the Church hierarchy;
- ideologically, the new movement reflected orthodox Catholic teaching: namely, that alcohol was inherently good, a gift of God albeit one which had negative potentialities when abused by its consumers;
- practising Roman Catholics were under no moral obligation to abstain from alcohol, but those who wished to do so could opt for lifelong abstinence for religious motives;
- the expectation was that religiously-motivated abstinence of this kind would be a minority activity, involving a small group of practising Catholics who would set an example and give a lead (hence the use of the name 'Pioneers') to their co-religionists.

This brief review of the attitude of the Catholic Church towards alcohol in nineteenth-century Ireland fits generally with Levine's (1992) wider analysis of 'temperance cultures'. Despite its prominence and short-term impact, the Fr. Mathew temperance campaign of the 1830s and 1840s was an aberration within a wider ecclesiastical system and a religious culture that was not essentially antipathetic to alcohol. The Catholic Church in Ireland (to which more than 95 per cent of the population outside of the north-eastern corner of this country belonged), while not unaware of the various problems stemming from alcohol, could not be expected to either promote a fundamentalist type of anti-alcohol sentiment among its members or support political measures reflecting such views.

The bachelor drinking group

Before ending this discussion of forces and events that influenced attitudes towards alcohol in nineteenth-century Ireland, some reference must be made to the institution known as the 'bachelor drinking group'. Essentially, this refers to a practice thought to have originated in post-Famine Ireland,

perhaps as late as the 1870s but continuing until about the 1950s, which involved a type of ritualized, heavy drinking by groups of men in rural areas (McNabb, 1964; Inglis, 1998; Stivers, 2000). Sociologists have explained the emergence and function of such male drinking in relation to both the prevailing religious culture and the economic circumstances of the post-Famine decades. For most men living in rural Ireland during this period, marriage was only deemed feasible where the would-be husband had a farm with which he could support a wife and family. Subdivision of family farms, which allowed farmers to pass on land to several sons, could not continue indefinitely and it gradually became the norm that only one son (not necessarily the oldest son) would inherit the family farm. This resulted in a situation where some men routinely postponed marriage until they had inherited the farm, and where many more men had to reconcile themselves to permanent celibacy since they were never going to have farms of their own. These agricultural economic factors coexisted alongside an emphasis on, if not an obsession with, sexual chastity as a major characteristic of the Catholic 'devotional revolution' of this period. Sexual puritanism of this kind was not, of course, unique to Ireland, and it could be argued that similar attitudes were to be found in Victorian England; but it appears that Irish Catholicism, even from the late-eighteenth century, was imbued with extreme views on this topic (Connolly, 1982). And while it would be inaccurate to say that the Catholic Church encouraged celibacy, it is certainly true to say that it insisted on absolute chastity for those who – for whatever reasons – remained unmarried (Kennedy, 1973).

Effectively, this meant that large numbers of men in rural Ireland found themselves in a situation where they could not marry because they were landless and, furthermore, in which – should they opt to remain in their native areas rather than emigrate – they were as single men culturally prohibited from sexual activity. From these circumstances the bachelor drinking group emerged: an institution which excluded women, fostered male bonding, and effectively devalued male–female relationships in general and marriage in particular. For young men in rural areas where bachelor drinking groups existed, admittance to this group was an important rite of passage, and heavy or 'heroic' drinking became a badge of masculinity and of membership of this club; it was also common for married men to return to the bachelor drinking group, a tacit acknowledgement perhaps that marriage was an overrated institution. Stivers (2000) refers to this style of male drinking as 'cultural remission'. While Catholic Church leaders did not explicitly encourage the bachelor drinking group, they generally refrained from attacking it – presumably on the basis that whatever moral evils might stem from such drinking, they were slight compared with the sexual immorality that might occur in its absence.

Irish alcohol issues and events in the twentieth century

If the Act of Union is regarded as the defining moment for nineteenth-century Irish history, then the Anglo-Irish Treaty of 1921 must surely be regarded as

the pivotal event in this country's twentieth-century history: this was the agreement which secured self-government for 26 of the country's 32 counties while the remaining six counties in the north-east remained within the United Kingdom. Following a short but bitter civil war between former allies – some of whom supported the treaty and some of whom were opposed to the partitioning of the country which this entailed – the Irish Free State (which was to leave the Commonwealth and become the Republic of Ireland in 1949) settled into political stability, albeit a political stability which was marked by ongoing economic difficulties (Lee, 1989).

Catholic Church influences on a conservative state

Given the influence wielded by the Catholic Church when Ireland was ruled from Westminster, it was understandable that Northern Unionists and the minority Protestant population in the 26 counties should worry about what might transpire in independent Ireland: the fear being that 'Home Rule' might become 'Rome Rule'. And indeed the history of the new state indicates that, particularly during its first half-century, many aspects of Irish public policy were heavily reflective of the teachings of the Catholic Church. This, as Whyte (1971) has shown, did not necessarily mean that Catholic bishops regularly intervened with government, instructing them how to act in relation to specific policy issues. Direct interventions of this kind were comparatively rare, not because Catholic bishops were respectful of church–state boundaries but because the ethos of the new state was so solidly Catholic that elected political leaders were generally aware of Church teaching and did not need to be instructed on individual policy matters. Politically, economically and socially, the new state evolved along extremely conservative lines, and particularly following the electoral victory of Eamon de Valera in 1932 (who retained prime ministerial office for 16 unbroken years between 1932 and 1948, and served for a further five years in this office between 1951 and 1959) policies of economic self-sufficiency and disengagement from international trade were instituted, largely based on the promotion of native agriculture and industrial protectionism.

The PTAA, the official temperance movement of the Catholic Church in Ireland, flourished during these early decades of self-government. It combined a centralized management system with a network of local branches at parish level throughout the country, and it undoubtedly benefited from the agreement of Church authorities that young people would be encouraged to take a temporary pledge of abstinence at the time of their religious Confirmation. Original expectations that PTAA membership would continue to be low had been confounded, and by the late-1940s it appeared as though the movement had a membership of half a million – at a time when the total population of the Irish Free State/Republic of Ireland was less than 3 million (Ferriter, 1999). However, the association struggled to achieve a balance between its commitment to promoting the personal spiritual aims of its members and its occasional forays into public policy as a lobbyist in relation to licensing legislation.

Furthermore, while the association celebrated the golden jubilee of its founding in 1949 with a triumphalist religious ceremony attended by up to 100,000 Pioneers at Croke Park (Ireland's major sporting stadium), Ferriter's detailed account of this event reveals that the country's bishops continued to be ambivalent on the topic of temperance and less than wholehearted in their support of the Croke Park rally (ibid.: 157–163).

As had been the case in the previous century, Catholic Church leaders appeared throughout the 1930s and 1940s to be much more concerned with sexual impropriety than with the evils of drink. Historians and social scientists have detailed what in retrospect seem like bizarre preoccupations of the Catholic bishops with the evils of immodest dress, dancing, company keeping, jazz music and immoral literature (e.g. Whyte, 1971; Inglis, 1998; Brown, 2004). These preoccupations, when given institutional and public policy status, as they frequently were, contributed to the creation of a highly repressive society and, it seems fair to say, must have contributed to the emergence of the negative characteristics described by Greeley and McCready (1972) as typifying Irish and Irish-American personalities.

In relative terms, neither Church nor civil authorities displayed a comparable level of ongoing concern with alcohol and alcohol policy in the Irish Free State. The only major alcohol policy review during these early decades was that of the Intoxicating Liquor Commission (1925), which had been established by the Minister for Justice to inquire into what appeared to be the unusually large number of licensed premises in this country and to explore the desirability and feasibility of reducing this number. Despite its narrow terms of reference, this commission considered a wide range of alcohol issues and, in addition to publishing its own conclusions and recommendations, published all of the written and oral submissions it had received from a range of stakeholder interests. The general principles underpinning the commission's report reflected the evidence it had heard from Dr. Arthur Shadwell, a British doctor who had studied the effect of alcohol controls implemented in the UK during the First World War. Essentially, the commission accepted that alcohol control policies had a role to play in reducing the prevalence of related problems, but it dismissed as socially unacceptable and politically impracticable some of the more radical control strategies recommended from a variety of temperance organizations – such as those calling for complete Sunday closing of licensed premises or for the reduction by 50 per cent of the total number of licensed premises in the state. The commission believed that the specialist inebriate asylums (which had functioned briefly in the early twentieth century) had been dismal failures and should not be revived, and it also opposed the idea that problem drinkers convicted of criminal offences should be diverted into therapeutic centres rather than prisons.

Modernizing the Irish licensing laws

The licensing legislation regulating opening hours of Irish pubs had been largely inherited from the British and was quite restrictive, particularly in relation to

Sunday opening. On the Sabbath, only pubs in four main urban areas (Dublin, Cork, Limerick and Waterford) were permitted to engage in general trading, and the hours of such trading were greatly restricted. In 1948 and again in 1950, attempts to amend the licensing legislation and permit Sunday trading throughout the country were initiated in parliament by private members' bills – on the basis that many publicans were already being granted special exemptions by local district judges to permit such trading, and that Sunday opening was also permitted by an anachronistic legal provision which allowed publicans to serve *bona fide* travellers. It was argued that the police were now finding it impossible to enforce Sunday closing in rural areas and provincial towns, and that the law should recognize this fact. While the Catholic bishops, as has been made clear, were not as a rule greatly concerned about alcohol policy, the question of preserving the sanctity of the Sabbath was one of particular sensitivity for them; they responded, therefore, to the private members' bills with a degree of ferocity that immediately killed off these legislative initiatives and also made it seem unlikely that similar proposals would find their way onto the public policy agenda for the foreseeable future (Butler, 2002: 29–33).

The first stirrings of economic and social modernization in Ireland are conventionally attributed to the departure of Eamon de Valera from active political life in 1959, when this ageing politician was persuaded by his party colleagues to resign from the office of Taoiseach (prime minister) and hand over the reins of power to Sean Lemass (Girvin and Murphy, 2005). The Lemass years (from 1959 until 1966) saw a reversal of many of the policies most closely associated with his predecessor, specifically those concerned with national, economic self-reliance and isolationism. Under Lemass, the country sought to create an export-oriented industrial base by attracting foreign capital and by broadening its trade links with countries other than the UK – particularly with other European countries. This latter concern led Ireland to begin the process of application for membership of the European Economic Community (usually referred to at this time as the 'Common Market') which eventually came to fruition in 1973. Alongside these economic changes, Ireland in the 1960s witnessed the beginnings of a process of social and cultural change, aided by the establishment of a national television station, access for the first time to relatively cheap holidays 'on the continent', universal free secondary education, university grant schemes, and various other developments which gradually eroded the cultural narrowness and conservatism of previous decades (Brown, 2004). This change process within Irish society was helped by the fact that the Roman Catholic Church itself was also in change mode at this time. The announcement in 1959 by Pope John XXIII that, after centuries of theological and institutional stasis, the Church would hold a General Council to consider how it might renew itself and adapt to the modern world took many people by surprise; and the Second Vatican Council which took place over four sessions between 1962 and 1965, generally reflected an openness to change by Church authorities that could be seen as paralleling the change process under way in Irish society at this time (O'Malley, 2008).

As already described, initial efforts to liberalize Irish licensing legislation in 1948 and 1950 had been quickly snuffed out by the hostility of the Catholic bishops. However, in 1956, due to persistent lobbying by rural publicans and the unwillingness of the then Minister for Justice (a member of the Labour Party) to be dictated to by religious authorities, a Commission of Inquiry into the Laws relating to the Sale and Supply of Intoxicating Liquor was appointed. This commission was chaired by the Master of the High Court and included representatives of all the main stakeholder groups, including the PTAA. The liberal tone of this commission's recommendations and the willingness of government to accept them as a basis for the Intoxicating Liquor Bill, 1959 (ultimately the Intoxicating Liquor Act, 1960) suggest a degree of modernism and a new willingness by the political system to resist Church influence that predated the Lemass era. And, from an alcohol policy perspective, what is especially interesting is how proponents of a more liberalized licensing system drew on the disease concept of alcoholism in defence of policy changes which made alcohol more accessible at the retail level.

In its report of 1957, the commission recommended a general liberalization of pub opening-hours in Ireland, including Sunday opening for the country as a whole. The commission had been persuaded by the police that public drunkenness was not at this time a serious problem for the criminal justice system and that the existing Sunday opening system was virtually unenforceable. It was also the view of the commission that an extension of the hours during which alcohol could be legally purchased was unlikely to have negative social consequences. Although the PTAA representative had not dissented from the commission's report, the Catholic hierarchy objected strongly to it and to the planned legislation, issuing a public statement which argued that: 'Increased facilities for obtaining intoxicating liquor by the extension of the general opening hours will lead to a greater extension of alcoholism …' (Irish Bishops, 1959). A few politicians expressed disbelief at the idea of an episcopal injunction of this kind being simply ignored by legislators, but the overall tone of the parliamentary debate on the Intoxicating Liquor Bill was indicative of a new and more liberal approach to social policy generally and alcohol policy specifically. There appeared to be general agreement that it was time to debunk all remnants of colonial stereotypes of the 'drunken Paddy', that is of the Irish as a drunken and undisciplined people who were incapable of self-government. As one Senator put it:

> This is the sixth decade of the twentieth century and this is a civilized community. We are no better and no worse perhaps than others but certainly we are as well-conducted as any. We are building up a modern progressive democracy. There is no reason why we should fear to get into line with other modern and progressive States which trust their people to be rational in using the liberal facilities they provide for drinking.
>
> (Seanad (Senate) Debates, 1960)

The main burden of defending the new legislation against the bishops' attack fell to the Minister for Justice – who, incidentally, was not the Labour Party minister who had appointed the commission in 1956. While accepting the bishops' right to express their opinion on this draft legislation, the minister quoted official health statistics which indicated that alcoholism ('a disease that requires medical treatment for the rehabilitation of the alcoholic') was of low prevalence in Ireland at this time; and he went on to cite one of the Jellinek-inspired WHO reports in support of the contention that even if easier availability led to increased consumption, no causal connection existed between increased alcohol consumption and the prevalence of the disease of alcoholism (Dáil Debates, 1959). The significance of this legislation was described as follows by the political scientist, John Whyte:

> The Intoxicating Liquor Bill 1959 was a largely uncontroversial measure which caused no great stir when it was passing through the legislature. But in the history of Church-State relations it marks a significant landmark. For it records the only example so far recorded of a recommendation from the hierarchy being simply rejected by an Irish government.
>
> (Whyte, 1971: 30)

What is equally significant, at least in terms of alcohol policy, is that having experienced this unprecedented snub, the bishops, as it were, took their beating; once the legislation was enacted, they did not pursue this issue or, to any notable extent, seek to demonstrate the correctness of their own views or the folly of the state in this matter. Ironically, the bishops' statement quoted above – arguing that increased availability would lead to increased consumption and, in turn, to an increase in prevalence of problems – was almost identical to public health views on alcohol which began to find expression in Ireland twenty years later.

The disease concept of alcoholism in Ireland, 1960–1975

In concluding this historic background to Irish alcohol policy, the most recent period will be presented here as one dominated by the disease concept of alcoholism which, as has just been described, had been invoked by politicians as scientific justification for ignoring the advice of the Catholic bishops at the end of the 1950s. As summarized in Chapter 1, the disease concept viewed alcohol as a relatively harmless drug for the vast majority of its consumers, with responsibility for the *disease of alcoholism* being attributed to the vulnerabilities or predispositions of a small minority of consumers. From a public policy perspective, the disease concept had two main implications: (1) that strategies aimed at controlling alcohol consumption in the general population were unnecessary and unjustified; and (2) that the notion of alcoholism as disease should be promoted through public information and awareness campaigns, while simultaneously alcoholics should be encouraged to seek treatment

and rehabilitation within an expanded and destigmatized alcoholism treatment system.

As exemplified by the previously quoted remarks from the parliamentary debate on the Intoxicating Liquor Bill, there was an emerging consensus that after almost 40 years of self-government – characterized by international isolation and economic and cultural stasis at national level – the time had come for Ireland to embrace modernity. The disease concept of alcoholism sat well with Ireland's new vision of itself. This was a vision that embraced not only economic development, but many aspects of cultural modernization – including new approaches to leisure, social interaction and public morality. As early as 1963, O'Doherty, an Irish psychologist, commented: 'Our society is in a highly mobile phase at present. In fact we are going through a deep and far-reaching cultural revolution' (1963: 130–131).

The idea that the state should take direct action to reduce overall consumption or to restrict access to alcohol was inextricably linked with the temperance movement, which, in its turn, was linked the past. As discussed in Chapter 1, the disease model emerged following the repeal of Prohibition in the USA and was, to no small degree, a reaction to the framing of alcohol associated with a political experiment now widely judged to have been a failure. In being presented as a 'new scientific' approach to understanding alcohol problems, the disease concept appeared to make the previous moral debate on this matter redundant. This new and self-consciously modern understanding of alcohol resonated strongly with a modernizing 'national mood' in Ireland in the 1960s, characterized, among other things, by a reduction in state paternalism and increased individual liberties. It provided reassurance for Irish drinkers that, with some minor exceptions, they could drink with impunity, while simultaneously reassuring legislators that the drift towards reducing control systems and treating alcohol as a normal consumer good was scientifically justified.

Modernizing attitudes to gender also impacted on attitudes to alcohol, contributing to a new cultural acceptance of female drinking. It was during the 1960s that the Irish licensed trade (still containing residual traces of the bachelor drinking group) adapted by creating 'lounge bars' considered suitable for female customers. It was also in this period that drinks manufacturers for the first time marketed products targeted at women drinkers.

The coming of the fellowship of Alcoholics Anonymous (AA) to Ireland in 1946 was of obvious importance in this regard. AA had not previously been introduced into any other European country, and, given its origins in the Protestant evangelical tradition of the USA, there were understandable reasons why early AA members in Ireland were fearful of the wrath of the Catholic bishops. But early AA members negotiated the fellowship's entry to Irish society with relative ease, and by the early-1960s fellowship meetings were widely available across all 32 counties of Ireland (Butler, 2010). In line with its tradition of expressing no opinion on outside issues and avoiding public controversy, the AA in Ireland did not explicitly promote the idea that alcoholism was a disease or lobby for acceptance of this concept at public policy level (Kurtz,

2002); nonetheless, it seems reasonable to assume that the presence of the AA in Irish society contributed incrementally and indirectly to the acceptance of the disease concept as part of the conventional wisdom of the period.

It was not until 1966, however, that the disease concept was unequivocally endorsed by Irish health policymakers, when the *Report of the Commission of Inquiry on Mental Illness* (which made general recommendations for the establishment of community-based mental health services) specifically pronounced that: 'Alcoholism is a disease and is regarded by the World Health Organization as a major health problem' (Report of the Commission of Inquiry on Mental Illness, 1966: 77). The subsequent discussion of alcoholism in this report implicitly reflected the idea that the disease concept was now a scientifically-based and non-contentious development, to which Irish public policy should respond through the creation of dedicated treatment services – particularly in the form of inpatient psychiatric care. Problem drinkers had always been admitted to the country's mental institutions since the creation of these institutions in the nineteenth century, but such admissions had been on sufferance and had not been based on any professional or ideological conviction on the part of Irish psychiatrists that drinking problems were mental disorders; what the 1966 Commission called for was a more welcoming response for such patients from the public mental health system, based on an overt and explicit acceptance of the idea that alcoholism was a disease (Butler, 2014).

The Commission's report also welcomed the establishment that same year of a voluntary body, the *Irish National Council on Alcoholism* (INCA), which had been set up on the initiative of a small group of psychiatrists and which had as its first chairperson the Chief Justice. INCA was modelled on the National Council on Alcoholism in the USA and effectively acted as a lobby group for the disease concept, and in particular for an expanded alcoholism treatment sector. In its legal Articles of Association, it was careful to avoid any suggestion that alcohol played a causal role in alcoholism, and it is also noteworthy that this new body was happy to accept drinks-industry funding (specifically from the Guinness company) to cover its start-up costs (Butler, 2002: 34). The general tenor of the INCA perspective may be discerned from this quote from an article written by its first director and published in *The Pioneer*, the monthly magazine of the PTAA:

> Prevention in its true sense is impossible, as we do not know the cause [of alcoholism]. But *secondary* prevention or the reduction of damage is feasible by education, by information and by understanding. It is possible to produce a climate of opinion in which anyone who has the primary symptoms of alcoholism will feel it is a duty – *not* a disgrace – to do something about it.
>
> (Perceval, 1966: 25)

INCA's perspective on alcohol problems went unchallenged during the first decade of its activities, and from 1973 onwards it received financial support from the Department of Health (Butler, 2002: 34).

Conclusion

In terms of the matrix presented in Chapter 1, the dominant policy view in Ireland during the early-1970s was clearly one that framed alcohol-related problems in dichotomous terms, while simultaneously favouring a libertarian or relatively non-interventionist approach by the state to the overall management of alcohol issues. And, from the perspective of Kingdon's (2011) 'multiple streams analysis', it is equally clear that this policy line – exemplified in the disease concept of alcoholism – was one that was an exceptionally good fit for the 'national mood' of a state that had only recently embraced modernity, had joined the European Economic Community and was gradually loosening its paternalistic grip on citizens' lifestyles.

In concluding this review of the historic background to Irish alcohol policy, it is worth recalling Gusfield's (1963) classic study of religious temperance movements and Prohibition in late-nineteenth- and early-twentieth-century USA, and in particular his basic contention that Prohibition was best understood as a 'symbolic crusade' rather than in terms of its instrumental efficacy. If we apply these ideas to the Irish scene in the 1960s and early-1970s, they suggest that political enthusiasm for the disease concept and all that this implied might also be best explained as symbolic of Irish modernization at this time, rather than as indicative of absolute political conviction concerning the validity of this allegedly 'new scientific approach'. The corollary of this is that it would be naïve to suppose that during subsequent decades (which will be looked at in Chapter 4) the Irish 'political stream' would be quickly convinced by research evidence debunking the disease concept and supporting an alternative public health perspective on alcohol; or that Irish state policy on alcohol would switch decisively to the use of more interventionist tactics reflecting a continuous model of alcohol harms.

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4 Alcohol and public health in Ireland, 1975–2015

Introduction

Following on from the historical and sociological context presented in Chapter 3, this chapter will review Irish alcohol policy developments during the forty-year period between 1975 and 2015. In line with the overall aims of this book, the intention here is to explore these policy developments with a view to discovering:

1 whether or to what effect policy communities emerged in Ireland over this period to champion the WHO's public health approach to alcohol policy;
2 what forces, drinks industry-based or otherwise, challenged WHO recommendations in relation to alcohol;
3 how successive Irish governments actually adjudicated on the conflicting policy perspectives to which they were exposed on this issue.

The forty-year period being presented here is broken down for convenience into three chronological phases:

- *1975–1989*: a phase in which the dominant disease concept of alcoholism first came under threat from the emergent public health approach;
- *1990–1997*: a phase in which expectations that an integrated, national alcohol policy based upon public health principles were raised – but not fulfilled – in the context of the health service's apparent commitment to wider health promotion ideals;
- *1998–2015*: a phase marked by almost constant and contentious policy debate on alcohol issues, open hostilities between public health advocates and the drinks industry, and governmental reluctance to implement the 'dryer' strategies recommended in public health policy documents.

Adult alcohol consumption figures for the period 1975–2014 are presented in Figure 4.1 by way of epidemiological backdrop to the policy events being reviewed in this chapter.

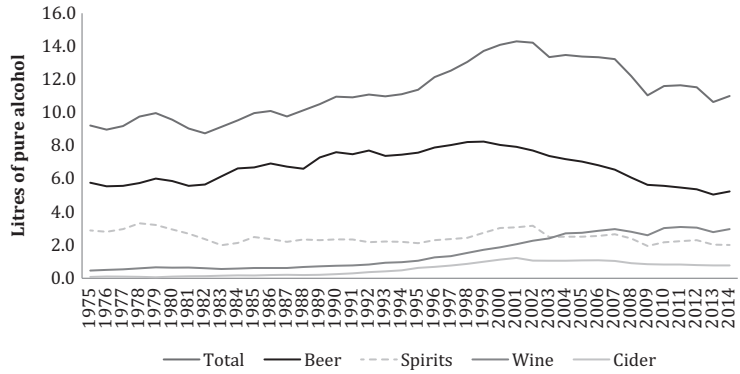

Figure 4.1 Alcohol consumption per capita adult (15+), 1975–2014

Irish alcohol policy, 1975–1989

As discussed in Chapter 3, the disease concept of alcoholism had by the late-1960s achieved consensus status in Irish health policy, apparently viewed by all stakeholder interests as up-to-date, scientific and generally in keeping with Ireland's vision of itself as a modern country on the verge of membership of the then European Economic Community.

In 1973, the *Irish National Council on Alcoholism* (INCA), a voluntary body which promoted the disease concept at a level of publicity and public awareness, while also lobbying for increased alcoholism treatment facilities within the country's mental health services, had its funding from statutory health sources secured through the intervention of a sympathetic Minister for Health. INCA seemed set to play a prominent role in the Irish alcohol policy arena. This, however, did not prove to be the case as it quickly began to experience internal ideological divisions between private-sector psychiatrists who professed continuing loyalty to the disease concept and public-sector psychiatrists who shifted incrementally to a public health approach to alcohol-related issues. As a consequence of this internal dissent, INCA had relatively little impact on the evolving policy process, and by the end of this phase it had been disbanded and the disease concept itself had been – at least in formal policy terms – sidelined as unscientific and unhelpful (Butler, 2002: 50–62).

Table 4.1, which sets out some of the major alcohol policy events during this first phase, starts with a reference to Ireland's participation in the *International Study of Alcohol Control Experiences* (ISACE). This was a collaborative, social history project involving the Finnish Foundation for Alcohol Studies, the Addiction Research Foundation of Ontario, the Social Research Group in Berkeley's School of Public Health and the WHO. ISACE compared alcohol policy developments in five countries (Finland, Ireland, the Netherlands, Poland and Switzerland) and two regional jurisdictions

(California and Ontario) between 1950 and 1975, and its focus – as its name suggests – was on how governmental control, or lack of control, over the manner in which alcohol was manufactured and traded had implications for population drinking habits and alcohol-related problems. The Irish participants on ISACE were Dermot Walsh, a consultant psychiatrist in the public mental health services, who also worked as an epidemiologist at the Medico-Social Research Board, and Brendan Walsh, an economist at the Economic and Social Research Institute, a governmental think-tank.

Although the public health perspective on alcohol was already being disseminated internationally by WHO, it was through ISACE involvement that public health ideas about alcohol policy were first articulated in an Irish context. The Irish participants contributed to the two edited volumes (Mäkelä et al., 1981; Single et al., 1981) produced by ISACE, in one of which they commented critically on 'an increasing tendency, due to the efforts of various bodies such as the Irish National Council on Alcoholism, Alcoholics Anonymous, and the medical profession to regard "alcoholism" as a disease' (Walsh and Walsh, 1981: 120). In this respect, ISACE involvement marked the first occasion on which reputable Irish researchers argued that alcohol, not alcoholism, was the *problem*, and that the appropriate *policy* response involved control strategies rather than treatment or rehabilitation.

While the Medico-Social Research Board annual reports for the years 1977 to 1980 contain brief references to its participation in ISACE, the collaborative project's ideas about alcohol control and public health were not widely disseminated either among the general public or the policy community; not surprisingly, therefore, these ideas had no immediate impact on Irish alcohol policy discussion. In 1984, however, ISACE and the related WHO ideas were explicitly presented in a key mental health policy document, *The Psychiatric Services: Planning for the Future* (1984), which among other things contained a detailed set of recommendations, not just for the management of alcohol problems in the country's mental health services but also for the prevention of such problems. Dermot Walsh was a member of the study group that drafted *Planning for the Future* (the name by which this report was most commonly known) and his epidemiological work underpinned many of the group's recommendations, not least those concerned with alcohol issues. The alcohol chapter in *Planning for the Future* was prefaced by a summary dismissal of the disease concept, followed by an argument for thinking about alcohol-related problems in a 'disaggregated' way:

> Until recently, the generic term 'alcoholism' has been used to refer to a variety of problems resulting from alcohol abuse … The term 'alcohol-related problems', although more cumbersome, is more accurate. This terms acknowledges that alcohol can cause, or at least contribute to, an assortment of social and physical problems …
>
> (ibid.: 104)

Table 4.1 Irish alcohol policy developments 1975–1989

Year	*Event*
1978–1981	Participation by two Irish research institutes (the Medico-Social Research Board and the Economic and Social Research Institute) in the International Study of Alcohol Control Experiences (ISACE)
1981	Establishment of the Drinks Industry Group, an umbrella body representing both producers and retailers and the industry's first formalized lobby group in Ireland
1984	Publication of *The Psychiatric Services: Planning for the Future*, a mental health policy document which dismissed the disease concept of alcoholism and advocated a public health approach to alcohol
1988	Enactment of Intoxicating Liquor Act, 1988, which extended opening hours of pubs while also permitting restaurants to have full liquor licences
1988	Closure of Irish National Council on Alcoholism (INCA)
1988	Establishment of a Health Promotion Unit within the Department of Health
1989	Request by Minister for Health to draft a national alcohol policy along health promotional lines

The chapter then went on to recommend that the practice of routinely admitting problem drinkers for detoxification and extended inpatient rehabilitation should be discontinued and, instead, that the mental health service should manage such patients in community-based services. The most radical content of this chapter, however, was that which challenged the notion that the prevalence of alcohol-related problems was fixed or beyond the reach of public policy. Instead, for the first time in an Irish policy document, it was argued that the prevalence of alcohol-related problems was causally related to population consumption habits, and that the state should use health promotional strategies to control alcohol consumption, thereby reducing related harms. Specifically, *Planning for the Future* recommended that an integrated national alcohol policy should be set in place based upon the use of: (1) taxation measures to ensure that the real price of alcohol remained high; (2) strict enforcement of drink driving and underage drinking legislation; (3) controls on alcohol advertising; and (4) restrictions on the availability of alcohol at the retail level (ibid.: 108).

Although community-based alcohol services were developed within the public mental health services and alcohol-related hospital admissions gradually were reduced (Butler, 2014), the broader public health recommendations on alcohol contained in *Planning for the Future* had no immediate impact. However, it is noteworthy that even before the publication of this mental health policy document, in 1981, the drinks industry in Ireland had established, for the first time, an umbrella body representing both manufacturers and retailers

of alcoholic beverages. This new body, the *Drinks Industry Group of Ireland* (DIGI) operated from the outset as a lobby group for the drinks industry as a whole, commissioning and publishing research which was aimed at demonstrating the importance of the industry to the Irish economy, and lobbying government in relation to alcohol taxes in the run-up to Budgets (www.drinksindustry.ie). The establishment of DIGI is an early indication of awareness by the industry that the consensus on policy issues previously associated with the disease concept was breaking down and a new and – from an industry perspective – less benign approach to the framing of alcohol problems was being proposed. The first and, as the drinks industry saw it, necessary step in staving off this perceived threat was to present its own evidence in support of a dichotomous harm model (even if this was not the previous alcoholic/social drinker dichotomy), while simultaneously emphasizing the importance of the drinks industry to the wider Irish economy.

The mere articulation of a new problem/policy frame is, of course, no guarantee of policy action. The Intoxicating Liquor Act, 1988, and the parliamentary debate surrounding its enactment, suggest the public health philosophy enunciated in *Planning for the Future* had made little or no impact on the political debate at national level. Although this legislation contained measures which were intended to prevent under-age drinking, its main effect was to make alcohol more accessible at the retail level to the drinking public: it made it easier for restaurants to obtain full liquor licences; extended Sunday opening hours and 'drinking-up' periods during the week; and abolished the 'holy hour', the closing period between 2.30p.m. and 3.30p.m. which was mandatory for pubs in Dublin and Cork. Generally, the Intoxicating Liquor Act, 1988, did not in any way reflect the emerging public health view that alcohol was the problem for which the appropriate policy response was increased control or regulation.

Towards the end of this period, however, the public health approach to alcohol was given an indirect fillip as a result of the adoption by the Minister for Health of *health promotion* as a guiding framework for Irish health policy. Health promotion, also commonly referred to as the 'new public health', was a movement which, under the aegis of the WHO and national health authorities, had been evolving since the 1970s and which was intended to correct what was now perceived to be an excessive emphasis on the importance of treatment or curative service provision (e.g. Ashton and Seymour, 1988). It was argued that just as the original, nineteenth-century public health pioneers had increased life expectancy and overall quality of life through the improvement of the physical environment (in relation, for instance, to water supply, sanitation systems, food hygiene and housing standards), health authorities in the late-twentieth century were more likely to promote population health by focusing on the psychosocial and economic environment than by relying exclusively on improved medical and surgical technologies.

The Ottawa Charter (WHO, 1986), one of the most influential health promotion texts from this period, argued that all aspects of public policy had

health implications and that governments should routinely 'health-proof' policy and legislation, regardless of the governmental sector from which it emanated. It was argued, furthermore, that public policy should generally seek to create environments which supported individual and communal healthy lifestyle choices. When such health promotion concepts are applied to alcohol, it is clear that they run entirely counter to the assumption that 'prevention is impossible' – arguing, instead, that prevention of alcohol-related problems is both possible and socially desirable. The divergence between the disease model and the public health frame, in terms of both analysis and policy, is clear. In the first instance, health promotion envisages a relatively modest role for curative services for those already experiencing alcohol-related problems. But, more importantly, it advocates environmental strategies to curtail the presentation of alcohol – through advertising and promotion – as just another consumer item, while simultaneously making alcohol more expensive and less available at the retail level.

The concept of health promotion had been presented in two official discussion documents published by the Irish health authorities (Department of Health, 1986; Health Education Bureau, 1987) before being taken up with particular enthusiasm by Dr Rory O'Hanlon, who served as Minister for Health between 1987 and 1991. As evidence of his commitment to this 'reorientation' of the Irish health services, O'Hanlon created a set of structures which included the following:

- a cabinet sub-committee on health promotion;
- an executive Health Promotion Unit within the Department of Health;
- a National Advisory Council on Health Promotion;
- an academic Department of Health Promotion funded by the Department of Health (O'Hanlon, 1992).

This comprehensive infrastructure suggested that the Minister for Health was seriously committed to the implementation of health promotion in Ireland; and the inclusion of a cabinet sub-committee as part of this infrastructure suggested that by drawing in other cabinet members, he had achieved some degree of political consensus in support of health promotion. Of most relevance to the present study, however, is that during 1989 it was decided by government that Ireland should have a national alcohol policy based on health promotional principles; and it is the formulation of this national alcohol policy which is dealt with in the next section of this chapter.

Irish alcohol policy, 1990–1997

Table 4.2 shows the main events in the period 1990–1997. The governmental decision in 1989 to formulate a national alcohol policy augured well for those supportive of the WHO approach to alcohol policy. The Minister for Health had created an impressive health promotion infrastructure, and it also

appeared as though he had built some degree of political consensus in relation to his plan to use alcohol as a test case of Ireland's new commitment to health promotion. However, as will be detailed below, the drafting and implementation of Ireland's national alcohol policy primarily revealed the gap that existed between the rhetoric of health promotion and the reality of trying to introduce radical policy change into this complex aspect of Irish life. The task of drafting the national alcohol policy became extremely protracted, due both to the underperformance of the structures which were meant to underpin it and to the fact that other sectors of government were unwilling to subordinate their own interests to the health interest.

Invariably, cabinet involvement or non-involvement has a major influence on the outcome of national policy processes, and in 1989, Minister O'Hanlon announced the creation of a cabinet sub-committee on health promotion. In an overview paper on health promotion, Cecily Kelleher (who held the specially-funded Chair of Health Promotion, which was part of the overall health promotion infrastructure) commented that: 'A new cabinet sub-committee for health promotion was formed comprising relevant ministries influencing health status, though in fact this group never met in plenary' (Kelleher, 1997: 37). This may be interpreted as a euphemistic admission that the cabinet sub-committee existed only on paper; certainly there is no indication that such a sub-committee ever considered alcohol policy, or that the various ministers who held the health portfolio between 1989 and 1996 succeeded in persuading other ministers – such as those responsible for finance, revenue, job creation or exports – to prioritize the health interest over their own sectoral interests.

The structure specifically tasked with drafting the national alcohol policy was the National Advisory Council on Health Promotion, but this too failed to perform as expected. Minister O'Hanlon was particularly unfortunate in his attempts to appoint a chairperson to this council: the first two appointees died suddenly, and the third appointee was elected to parliament shortly after accepting this position and, on this basis, could no longer be seen as a politically neutral chair of the Council. It was not until 1991, two years after it was first mooted, that work began on the drafting of the national alcohol policy. It had been accepted at this point that the Advisory Council on Health Promotion might not be best suited to this task, and a new Working Group was formed consisting of members of the Advisory Council and some other members appointed because of their specific interest or expertise in the alcohol field (Butler, 2002). The Working Group, which did not contain any drinks industry representatives, was now chaired by a civil servant, the Principal Officer from the Health Promotion Unit; and from this time on effective responsibility for drafting the national alcohol policy reverted to this section of the Department of Health. In February 1991, the Health Promotion Unit began a formal consultation process by placing notices in the main broadsheet newspapers, inviting interested parties to make submissions:

Table 4.2 Irish alcohol policy developments 1990–1997

Year	*Event*
1990	Creation by the Minister for Health of a comprehensive health promotion infrastructure
1991	Beginning of consultation process on the National Alcohol Policy
1991–1996	Protracted drafting process, culminating in a policy document which reflected public health aspirations but which failed to set in place multi-sectoral ('cross-cutting') implementation structures for a national alcohol policy
1996	Publication and official launch of *National Alcohol Policy – Ireland*, with clear evidence of ministerial ambivalence about the use of alcohol control strategies
1997	The International Centre for Alcohol Policies (ICAP), an industry group, drafts the Dublin Principles – a framework document for collaboration between the industry and public health advocates

> The Government has decided that a National Alcohol Policy should be formulated. In pursuance of that decision, the Minister for Health has requested the Advisory Council on Health Promotion to develop a broadly based policy and to make recommendations to him for presentation to Government.
>
> The Council is examining alcohol, its availability, consumption, use and abuse under broad headings including historical, social, cultural, economic and legal factors, together with such matters as education, advertising, prevention, diagnoses and treatment strategies etc. …
>
> (ibid.: 80)

Between June 1991 and September 1992, the Working Group was actively involved in meeting various stakeholder interests who had already made written submissions; it also considered a commissioned report from the Economic and Social Research Institute, the overall tone of which was antipathetic to the public health perspective on alcohol and broadly similar to the representations made by drinks industry interests. A number of working papers were drafted by Health Promotion Unit staff and circulated to the members of the Working Group; but no subsequent meetings of the Working Group were convened, and effectively it played no role in the policy process from the autumn of 1992 onwards (ibid.).

There then followed a four-year period during which occasional complaints were voiced about the delay in producing the promised national alcohol policy, interspersed with occasional references from official sources to its imminent appearance. In October 1995, for instance, an editorial in the *Irish Medical Times* commented sceptically on a promise from the Department of Health that the national alcohol policy would be published within the next few months, because 'there has already been evidence that the Department is

being particularly slow to meet this issue head on' (Irish Medical Times, 1995). On the other hand, a number of health policy documents which were published in this period – without reference to the complexities involved or the reason why it was taking so long – indicated that progress was being made and that the policy would soon be published. In May 1994, for instance, a general health strategy document, *Shaping a Healthier Future*, referred to 'A national policy on alcohol which will be adopted and launched during the next twelve months' (Department of Health, 1994: 22).

Eventually, in September 1996, seven years after it was first commissioned, the report *National Alcohol Policy – Ireland* was launched by Minister Michael Noonan, the fifth Minister for Health to hold office during this period. Impetus for final publication of this document may have arisen from the fact that Department of Health civil servants who attended WHO's European Conference on Health, Society and Alcohol in December 1995 had endorsed its European Charter on Alcohol, thereby incurring international obligations on this matter. As the report put it: 'The importance of a comprehensive alcohol policy was highlighted when Ireland endorsed the European Charter on Alcohol in December 1995 along with 48 other Member States of the WHO European Region' (National Alcohol Policy – Ireland, 1996: 9).

Department of Health officials were aware that a review of the liquor licensing system was under way at this time through a justice-based parliamentary committee; and, perhaps with a reasonable suspicion that the recommendations of this committee would be more reflective of neoliberal than public health values, had considered it important to have some definitive statement of the public health view of alcohol placed in the public domain. The report of this parliamentary committee (*Report of the Joint Committee on Justice, Equality and Women's Rights on a Review of Liquor Licensing*) (Houses of the Oireachtas, 1998) led ultimately to the enactment of the Intoxicating Liquor Act, 2000, and generally was part of an ongoing liberalization of the drinks trade in the context of Ireland's increasing economic prosperity of this period.

National Alcohol Policy – Ireland was written by Dr Ann Hope, a health promotion specialist who had been employed as a part-time alcohol policy advisor by the Department of Health; it drew heavily on the WHO'S European Charter on Alcohol and, from a research perspective, on *Alcohol Policy and the Public Good* (Edwards et al., 1994) – at this time the most recent international review of the research evidence. The report was presented in three sections: the first summarized alcohol consumption trends and related problems in Ireland, while acknowledging the positive economic role played by the drinks industry; the second discussed the public health perspective on alcohol and reviewed a number of environmental and individual strategies that had potential to enhance public health in relation to alcohol; and the third section presented a 'Plan of Action', which purported to set out in managerial detail how all sectors of government would implement these strategies identified in the Irish context.

From a public health viewpoint, the most important section of the report was its Plan of Action; this, however, proved to be its weakest section since it

was couched in vague, aspirational terms, indicating that the Department of Health and successive Ministers for Health had failed to build the kind of broad political consensus necessary for the successful delivery of a public health-based, national alcohol policy. The introduction to the Plan of Action made it clear that whatever the research evidence might say, the government was not willing to implement alcohol control strategies which lacked popular support: 'High prices and restriction on the availability of alcohol are the most effective measures but cannot be sustained long term without information and advocacy' (National Alcohol Policy – Ireland1996: 59). Political reluctance to impose alcohol controls of a paternalistic or 'nanny state' nature was also evident in the Foreword to the report written by Minister Michael Noonan, which reported that: 'The Government believes that the Irish people are mature, reflective and willing to develop a healthy, long-term moderate approach to alcohol and its part in our culture' (ibid.: 7). This discomfort with anything smacking of paternalism was also made clear in Minister Noonan's response to journalists who, at the launch of the policy document, questioned him about its relative lack of 'teeth':

> The kind of island I would like to see is where we would have what I would describe as sovereign individuals … well educated and mature and that when you give them information which is relevant to their own well-being they will make individual sovereign decisions in their own interest.
> (Irish Times, 1996)

Minister Noonan was not a doctrinaire libertarian who would have been happy to apply these ideas about consumer sovereignty to, for instance, cannabis use in Ireland; it seems safe to conclude, therefore, that what he reflected was a specific political discomfort with the idea of imposing tougher controls on alcohol at this time in the mid-1990s.

From a Kingdon (2011) 'problem stream' perspective, *National Alcohol Policy – Ireland* presented alcohol-related problems in terms of a continuous model of harms: seeing alcohol as fundamentally implicated in a spectrum of difficulties which varied in type and severity. At a *policy stream* level, the report recommended evidence-based policy solutions that focused on pricing, availability and promotion. However, there was to be no policy window for a public health approach to alcohol. At the *political stream* level *National Alcohol Policy – Ireland* must be reckoned an abject failure, reflecting presumably a governmental reluctance to make health criteria the sole or primary factor in decision-making on alcohol policy, combined with the view that Ireland's 'national mood' at this time was not in tune with WHO ideas on this issue. No policy structures were established to implement the new national alcohol policy, either by the government in power in September 1996 or by the government which replaced it in early 1997, and in subsequent years *National Alcohol Policy – Ireland* was rarely cited and exerted no discernible influence on the evolving alcohol policy situation in Ireland. This outcome to

Ireland's first attempt at devising a national alcohol policy based on public health principles must be seen in the context of the broader failure of the health promotional institutions: the cabinet sub-committee never really functioned; the National Advisory Council on Health Promotion functioned intermittently before being disbanded; and the Health Promotion Unit – a traditional civil service unit – was left largely to its own devices in bringing this task to completion, with an acute realization that other departments and governmental agencies were unwilling to 'health-proof' their activities. It should also be noted that frequent changes of minister must have played some role in this matter; the original minister (Minister O'Hanlon) was obviously committed to the public health approach to alcohol policy, but subsequent ministers, some of whom spent short periods in Health, may not have been equally committed to this idea.

Two further explanations are suggested for this failure to deliver on the original scheme of Minister O'Hanlon. The first of these is the absence at this time of a 'policy community' or of 'advocacy coalitions': that is, identifiable groups of specialists who might lobby coherently and consistently for the implementation of a particular policy initiative (Kingdon, 2011: 117–118). The Irish National Council on Alcoholism had ceased to exist in 1987, and between 1989 and 1996 no new, advocacy group had emerged to lobby for the public health viewpoint in relation to alcohol. On the other hand, the drinks industry had many well-organized representative groups that argued against these public health ideas. Second, given that Ireland was not historically a 'dry' culture, open to the idea that alcohol was an inherently problematic substance, the early 1990s was a particularly inauspicious time for a policy initiative which, in a manner not seen in Ireland since the Fr. Mathew temperance crusade of the mid-nineteenth century, set itself in opposition to the drinks industry. This was exacerbated by the fact that, after seventy years of economic under-performance, the Republic of Ireland began to experience unprecedented economic growth in this period. The rise of the so-called 'Celtic Tiger' (Sweeney, 1999) was attributed to many factors, but there was a large measure of agreement among commentators that the 'Social Partnership' – a government-managed process whereby trades unions, employers, farmers, and the social and community sectors drew up three-year agreements on a wide range of social and economic policy issues – was a crucial ingredient in this economic miracle (O'Donnell and Thomas, 2006). Within this consensual atmosphere of Social Partnership, the drinks industry presented itself, and was accepted as, a legitimate and responsible business entity which was entitled to be at the policy table – and any attempt to exclude it from this position would have flown in the face of the Social Partnership ethos.

One of the important conclusions of *National Alcohol Policy – Ireland* was that alcohol consumption was income elastic, 'indicating that increasing economic growth in Ireland will lead to a disproportionate increase in alcohol consumption if historic trends and tastes continue to operate' (National Alcohol Policy – Ireland, *1996*: 54), so that very large price increases would

be required to reduce all forms of consumption of alcoholic drink. However, as the Celtic Tiger economy continued to grow, the national mood was in a uniquely celebratory phase, and government displayed no willingness to interfere with market forces or to restrict the newfound capacity of Irish consumers to drink more than they could previously afford. For its part, the drinks industry in Ireland was now working assiduously to present itself to the public and policymakers as a model of corporate social responsibility, and to promote the idea that industry and public health could work in partnership on alcohol problem prevention. Indeed, the phase presented here ended in 1997 with the publication of the *Dublin Principles*, a framework drafted in Dublin by the industry-funded International Center for Alcohol Policies ostensibly to promote partnership between the drinks industry, government and public health interests (Hannum, 2005).

Irish alcohol policy, 1998–2015

The final phase of recent Irish alcohol policy activity to be looked at here, from 1998 until 2015, is one in which alcohol policy was constantly and contentiously on the public policy agenda (Table 4.3). One significant feature of this period was the emergence for the first time of a 'policy community', in the sense of an organized grouping of public health experts and activists, which lobbied consistently for the implementation of its favoured alcohol policies. This development was countered, however, by a streamlining of the drinks industry's lobbying activities; and the period was marked by increasingly adversarial relationships, rather than partnership, between these two blocs. And, as will be seen here, this was a period in which the public health perspective prevailed in relation to a few specific policy initiatives but failed in its broader ambitions for an integrated alcohol policy based upon public health values.

For a variety of reasons, including the reputational damage it had suffered as a result of ongoing revelations about clerical sex abuse, the Catholic Church in Ireland played a less prominent role in social policy issues during the 1990s than had previously been the norm. In 1999, however, in *The Temperate Way,* a leaflet published to mark the centenary of the founding of the Pioneer Total Abstinence Association, Church leaders addressed themselves to the subject of alcohol problems in Ireland; they referred specifically to the World Health Organization's European Charter on Alcohol (1995), describing it as a 'charter that merits careful consideration' and suggesting that 'the State authorities, North and South, set up a task force to study its legal and social implications' (Irish Catholic Bishops' Conference, 1999). What was interesting about this ecclesiastical foray into alcohol politics was not that the bishops were advocating public health strategies but that they appeared to be completely unaware of the existence of *National Alcohol Policy – Ireland* (1996), a document which had done all that they were recommending and which had, in fact, cited and been heavily influenced by the 1995 European Charter. It is not surprising, therefore, that in the debate leading to the

enactment of the Intoxicating Liquor Act, 2000, public health principles did not feature prominently, and that the legislation itself – contrary to the recommendation of *National Alcohol Policy – Ireland* – made alcohol more available to consumers by extending the opening hours of Irish pubs.

In November 2000, following the enactment of the Intoxicating Liquor Act, the Minister for Justice appointed a Commission on Liquor Licensing to conduct an overall review of Ireland's complex liquor licensing system. This commission's primary term of reference was:

> To review the Liquor Licensing system in the light of all relevant factors, including systems for the licensing of alcohol in other countries and to make recommendations for a liquor licensing system geared to meet the needs of consumers, in a competitive market environment, while taking due account of the social, health and economic interests of a modern society.
>
> (Commission on Liquor Licensing, 2001: 20)

The commission was chaired by a lawyer, and its membership was largely made up of representatives of the various commercial groups involved in the retailing of alcohol in Ireland – traditional pubs, off-licences, hotels, night clubs, supermarkets and grocery stores – with representation also from the Competition Authority and the office of the Director of Consumer Affairs. Since the Departments of Health and Education were allocated just one shared membership out of a total of 21 members, it may be readily understood that the public health voice struggled to be heard in an arena dominated by interest group conflict between different arms of the retail trade and ideological debate about the sale of alcohol in an increasingly neoliberal market environment. The commission, which published four reports between May 2001 and April 2003, quickly decided that it could not reconcile what it saw as its main licensing brief with a responsibility for promoting public health and public order, and, on this basis, recommended that a separate committee should be established by government to review alcohol harm prevention measures. It reiterated this viewpoint explicitly in its final report:

> [M]any Government departments have sectoral responsibilities which bring them into contact with the intoxicating liquor code … [D]iverging policy responsibilities inevitably lead to diverging views on the nature of problems … The task of establishing the required balance between these competing objectives lies with the Government.
>
> (ibid.: 3)

The Minister for Health responded immediately to this recommendation and a second committee – the Strategic Task Force on Alcohol – was established in 2001, and charged with responsibility to review changes in Irish alcohol consumption and related harm, and to recommend evidence-based measures to reduce this harm. The Strategic Task Force on Alcohol was chaired by the

Table 4.3 Irish alcohol policy developments, 2000–2015

Year	*Event*
2000	Enactment of Intoxicating Liquor Act 2000, extending opening hours and generally liberalizing the licensing system; also establishment by Minister for Justice of the Commission on Liquor Licensing, which published three reports between 2001 and 2003
2001	Establishment of Alcohol Action Ireland, a voluntary body which lobbied for a public health approach to alcohol
2002	Establishment by Minister for Health and Children of Strategic Task Force on Alcohol, which published two reports – an interim report in 2002 and a second report in 2004
2002	Establishment of MEAS, a drinks industry social aspects group; the December budget introduced a tax increase on spirits which contributed to a decline in spirits the following year
2003	Enactment of Intoxicating Liquor Act 2003, which reverted closing time on Thursday to earlier time, banned 'happy hours' and introduced some further curbs of a public health nature
2005	Following extensive lobbying by the drinks industry and a ministerial change, plans to introduce statutory controls on alcohol advertising and promotion are dropped in favour of continued industry self-regulation
2006	Road Traffic Act 2006 gives Irish police the authority to breathalyze motorists at 'mandatory alcohol checkpoints', roughly equivalent to random breath testing; and abolition of the Groceries Order (an order which for almost 20 years had prevented below-cost selling), thereby permitting below-cost sale of alcohol in supermarkets and convenience stores
2008	Establishment by Minister for Justice of Government Alcohol Advisory Group – which reported within three months with a special focus on alcohol-related public order offences; followed by enactment of Intoxicating Liquor Act 2008, which introduced earlier closing times for off-licences
2009	Announcement by government that alcohol would be included in the workload of the National Drugs Strategy, followed by the appointment of a Steering Group on a National Substance Misuse Strategy, which would make specific recommendations as to how alcohol might be fitted into a policy structure that previously dealt only with illicit drugs
2012	Publication in February of Report of the Steering Group on a National Substance Misuse Strategy
2013	Government announcement in October that, in response to Steering Group recommendations, it would enact a Public Health (Alcohol) Act
2015	Publication in February, of the General Scheme or Heads of the Public Health (Alcohol) Bill 2015

Chief Medical Officer at the Department of Health, publishing an interim report in 2002 and a final report in 2004. Over the course of its deliberations, 28 members served on the Strategic Task Force, most of these members reflecting public health/public order interest; initially one place was allocated to a representative of the Drinks Industry Group of Ireland but later, following the establishment of Mature Enjoyment of Alcohol in Society (MEAS: an industry social aspects organization), an additional drinks industry place was given to its director.

The establishment of the Strategic Task Force on Alcohol by the Minister for Health may be seen as the tacit governmental acceptance of the political difficulties involved in creating a single, integrated alcohol policy animated by public health principles, but effectively it meant that. for approximately 18 months. Ireland had two parallel and conflicting alcohol policy processes in operation. One of these (the Liquor Licensing Committee) was largely concerned with exploring the extent to which the drinks trade could be deregulated, while the other (the Strategic Task Force on Alcohol) explored the extent to which regulatory systems could be used to reduce alcohol consumption and promote public health.

The Strategic Task Force on Alcohol published an interim report in May 2002, in which it provided details of changes in Irish alcohol consumption habits, broadly vindicating the view expressed in *National Alcohol Policy – Ireland* (1996) that Irish alcohol consumption was income-elastic: 'Against the backdrop of the fastest growing economy in Europe, Ireland has had the highest increase in alcohol consumption among EU countries. Between 1989 and 1999, alcohol consumption per capita in Ireland increased by 41% …' (Strategic Task Force on Alcohol, 2002: 5). This interim report also presented data on a range of alcohol-related problems, – including physical and mental health problems, public order offences, drink driving, and disrupted familial and interpersonal relationships – the prevalence of which had generally increased in line with increases in population consumption levels. The Strategic Task Force on Alcohol had consulted with Robin Room, a sociologist and international expert on alcohol policy, who had been involved in developing the public health perspective since its earliest articulations in the 1970s. Room was at this time part of the group compiling a WHO review which would later be published as *Alcohol: No Ordinary Commodity* (Babor et al., 2003); and the interim report was heavily influenced by his public health arguments: namely that the prevalence of alcohol-related problems was best tackled through the implementation of supply-side control measures. The Drinks Industry Group of Ireland representative dissented from the overall thrust of the interim report of the Strategic Task Force on Alcohol, challenging the majority preference for the use of control strategies and arguing for the use of more alcohol education:

> Throughout the discussions leading up to the finalization of the report, the industry has consistently stressed that the contention that a reduction

> in overall consumption of alcohol will lead to a reduction in alcohol related-harm is an incorrect one. Indeed, it has strongly questioned the evidence presented to the Task Force by Professor Robin Room of Stockholm University which gave rise to this contention and which has substantially influenced the nature of the Group's final report.
>
> The industry is concerned that this flawed position has led to certain proposals being adopted which, it strongly believes, will have little or no material effect on the issue under consideration (i.e. a reduction in alcohol-related harm). It does not significantly recognize, for example that the abuse of alcohol rather than its use is the key issue. Thus it will penalize the vast majority of people who consume, enjoy and benefit from the moderate consumption of alcohol …
>
> The Drinks Industry Group welcomes many other actions proposed by the Task Force but is disappointed that greater emphasis has not been placed on substantially increasing educational programmes aimed at securing a better understanding of the proper use of alcohol amongst at risk groups …
>
> (Strategic Task Force on Alcohol, 2002: 23)

The work of the Strategic Task Force on Alcohol did not lead to the creation of an integrated national alcohol policy. However, insofar as it clarified the ideological differences between the public health perspective and neoliberal views on alcohol issues, it provided a stimulus for the establishment of a more organized public health approach to the policy process; and, particularly through the work of Alcohol Action Ireland (a voluntary body established in 2001 to promote the public health perspective on alcohol), to encourage the emergence of advocacy coalitions which lobbied consistently and coherently for the state to base its alcohol policy on the public health 'evidence base'. On the other hand, the drinks industry also stepped up its own lobbying activities from this time onwards, particularly through its establishment in 2002 of MEAS (an acronym for Mature Enjoyment of Alcohol in Society, but also an Irish word for 'respect'), which, like other social aspects organizations, expressed willingness to work in partnership with public health activists in order to promote responsible drinking (Orley and Logan, 2005). However, as previously stated, the relationship between the public health community and the industry in Ireland at this time was usually acrimonious, as exemplified by a presentation given by Dr Joe Barry – a public health doctor and member of the Strategic Task Force on Alcohol – at a MEAS conference on alcohol and ethics; in this presentation, Dr Barry dismissed the idea of partnership as an impossibility, on the grounds of irreconcilable differences between the two groupings, and because, as he saw it, the drinks industry would only implement prevention strategies (such as alcohol education) which had consistently proven unsuccessful (Barry, 2002).

The Commission on Liquor Licensing had recommended that the extended opening hours of Irish pubs on Thursday nights (introduced in the Intoxicating Liquor Act, 2000), which appeared to encourage drinkers to start the

weekend early, should be brought back to those of Monday, Tuesday and Wednesday; and this was done in the Intoxicating Liquor Act, 2003. The broad thrust of the commission's recommendations, however, was at odds with that of the Strategic Task Force, in that the commission focused on problems largely in relation to youth drinking, which it believed could be resolved by more systematic school-based alcohol education. In 2005, following the completion of the work of the Liquor Licensing Commission, the Minister for Justice, Michael McDowell, announced his intention to introduce new comprehensive licensing legislation to codify and replace the complex body of existing licensing legislation, some of which dated back to the early-nineteenth century (Department of Justice, Equality and Law Reform, 2005). Almost immediately, however, controversy arose in relation to one aspect of the planned legislation, the creation of new 'café bar' licences. The proposal to create this new type of drinking venue for Ireland had emanated from the Commission on Liquor Licensing, which had been concerned that existing quantitative restrictions on pub licences had led to the development of 'super pubs', vast drinking emporia in urban areas which appeared by their very size to encourage out-of-control, binge drinking. The new café bars, by comparison, were to be small venues which would serve food and would, it was hoped, generally encourage moderate, 'continental-style' drinking. Interestingly, the café bar proposal was attacked by both sides in the ongoing alcohol policy debate: by the public health policy community on the basis that it would do nothing to alter the super pub phenomenon but would merely enlarge the total number of alcohol retail outlets, and by the existing licence holders who saw it as a threat to their local monopolies. The extent to which licence restrictions serve to benefit established trade interests is rarely commented on, but has long been a key reality of alcohol policy in practice (see, e.g. Nicholls, 2009: 130–149). In the face of such opposition, the Government abandoned its café bar proposal, and plans for a new comprehensive licensing code also failed to come to fruition.

Over the next few years, as indicated in Table 4.3, alcohol policy developments continued, and while these contained some deregulatory measures, they also indicated a shift towards control. The Strategic Task Force on Alcohol (2004) recommended in its second report that there should be statutory regulation of alcohol advertising and promotion, but following a cabinet reshuffle and extensive industry lobbying, the new Minister for Health abandoned draft legislation on this issue and agreed to continued industry self-regulation (Hope, 2006). In 2006, however, a new Road Traffic Act authorized Irish police for the first time to breathalyze motorists at 'mandatory alcohol checkpoints'. By contrast, in the same year, the government abolished the Groceries Order, thereby permitting, for the first time, the below-cost sale of alcohol; the abolition of the Groceries Order encouraged supermarkets and smaller grocery stores to sell below-cost alcohol as a 'loss-leader', a practice that was made even more attractive to Irish retailers by virtue of the fact that they could claim a VAT refund on the difference between the cost price and sale price of beverages sold in this way. In 2008, yet another policy

committee – the Government Alcohol Advisory Group – was appointed with a particular focus on public order offences; this group reported quickly and influenced the Intoxicating Liquor Act of that year, which introduced earlier closing times for off-licences.

Hopes for a fuller political commitment to a public health approach to alcohol policy were again raised in March 2009 when it was announced that the Irish Government had decided to integrate alcohol into its existing National Drugs Strategy, which had previously dealt only with illicit drugs but which was now to be renamed the National Substance Misuse Strategy. The discursive distinction between 'alcohol' and 'drugs', a socially constructed distinction rather than one based upon objective, scientific analysis, had traditionally shielded alcohol from the connotations of substantive risk associated with the word 'drugs'; but this announcement which promised, for public policy purposes, to treat all psychoactive substances in the same way, appeared to mark a significant step away from this old dispensation where alcohol was either seen as not really being a drug or, alternatively, as not being an especially risky drug. This promise to incorporate alcohol into an integrated policy framework also carried with it concrete implications for policy and practice. A parliamentary committee report (Houses of the Oireachtas (Parliament) 2006) had identified the lack of permanent alcohol policy structures as a major barrier to implementation of public health-based alcohol policies and recommended that alcohol be included as part of the remit of the National Drugs Strategy. This recommendation was made on the basis that the National Drugs Strategy had permanent policy structures (including significant 'cross-cutting' features) and an ongoing work programme based on five 'pillars': (1) supply reduction; (2) prevention (education/awareness raising); (3) treatment; (4) rehabilitation; and (5) research; and it was anticipated that managing alcohol policy in this way – particularly through its supply reduction pillar – would go a long way towards the implementation of the WHO's preferred evidence-based strategies for alcohol problem prevention.

In October 2009, the Minister for Health appointed yet another committee – the Steering Group on a National Substance Misuse Strategy – which was charged with responsibility for making detailed recommendations as to how alcohol-related harm might be reduced and how evidence-based alcohol policies might be aligned 'with the existing five pillars of the National Drugs Strategy' (Steering Group Report on a National Substance Misuse Strategy, 2012: 5). This Steering Group, which was asked to report by October 2010, did not in fact do so until February 2012, by which time the National Drugs Strategy had had its cross-cutting capacities significantly reduced, with effective governance for alcohol and illicit drugs now effectively returned to just one single department, the Department of Health. Had there been unambiguous political commitment to a public health approach to alcohol and given the number of previous *ad hoc* committees dealing with this issue, one could argue that the practical arrangements for integrating alcohol into the illicit drugs strategy could have been done in a few months by a small group of civil

servants. But it is clear from its report that the Steering Group, while updating statistical data, essentially replicated the detailed work of previous alcohol committees by arguing strongly that weak state control on the supply of alcohol was the problem, and that restrictions on price, availability and marketing were the policy solution.

The Steering Group was chaired by the Chief Medical Officer at the Department of Health and its membership (43 different people are listed as having been members of the group) included: civil servants from several central government departments; representatives of the healthcare and criminal justice systems; members of the community and voluntary sector; and – in a spirit of social partnership – two representatives of the drinks industry. The Steering Group noted that while Irish alcohol consumption had dropped since the recession (which had begun in 2008), consumption levels remained high in international comparative terms as did the prevalence of related problems. The group linked continuing high consumption at a time of reduced disposable incomes to changes in purchasing and consumption habits, noting that Irish consumers had switched substantially from pub drinking to off-licence purchase for home consumption. This change, it was argued, had been facilitated by an increase in off-licence outlets – 'a 161 per cent increase in the number of off-licenses operating between 1998 and 2010' (ibid.: 7) – as well as by the availability of cheap or discounted alcohol in 'mixed trade' outlets following the abolition of the Groceries Order.

The overall thrust of the Steering Group's recommendations were of a public health nature and were aimed at reducing total societal consumption, the most significant of these being for the introduction of minimum unit pricing. Predictably, the drinks industry representatives on the steering group dissented from the majority recommendations, producing two substantial minority reports (Department of Health, 2011a; 2011b). It is apparent from these minority reports that the relationship between the dominant public health voice and the drinks industry representatives on this Steering Group had been highly acrimonious throughout, and perhaps this acrimony added to the Steering Group's delay in completing its task. As had occurred previously, industry representatives argued strongly against alcohol control measures designed to reduce overall consumption; they also argued that to implement such measures in a time of economic recession would lead to unacceptable job losses. But it should be noted that two central government departments – the Department of Transport, Tourism and Sport; and the Department of Arts, Heritage and the Gaeltacht – had also dissented from the majority recommendation that there should be a statutory ban on drinks industry sponsorship of major sporting events. In other words, dissent within this policy committee was not simply attributable to drinks industry protection of its 'bottom line', but was also reflective of the difficulties associated with achieving policy consensus in an arena where different governmental sectors have different views on alcohol and where the health perspective is not automatically treated with deference (Baggott, 2010; Greenaway, 2011).

Following the publication of this steering group report in February 2012, the policy process continued, albeit at a very slow pace. The public health 'policy community' on alcohol expanded to include a range of existing bodies from the health and social service areas; a new Policy Group on Alcohol was established within the Royal College of Physicians of Ireland and, alongside Alcohol Action Ireland, this new body worked continuously to publicize the WHO's 'evidence-based' approach to alcohol and to lobby for implementation of the Steering Group recommendations. On the industry side, the Drinks Industry Group of Ireland, MEAS, the Alcohol Beverage Federation of Ireland and other groups representing the retail sector lobbied continuously against the total consumption model, while publicly committing themselves to working in partnership with public health interests, particularly in relation to educational and public awareness initiatives.

Government, in this situation, vacillated: apparently being unwilling to legislate in line with Steering Group recommendations, but equally unwilling to say publicly that it was not going to do so. In October 2013, it was announced that, following the Steering Group report, government had approved a number of measures to reduce alcohol-related harm, and that these measures would be incorporated into new legislation, the Public Health (Alcohol) Bill, which would be drafted during 2014 and enacted as quickly as possible. The legislation would introduce statutory regulation of alcohol advertising and promotion, although this would not include a statutory ban on drinks industry sponsorship of major sporting events; but also, and most significantly, the legislation would introduce minimum unit pricing (Department of Health, 2013). These proposals were presented at a press conference attended by the Minister for Health, the Minister for Children and Youth Affairs, and the Minister of State at Health who had responsibility for the National Drugs Strategy; the latter was quoted as saying 'This is a landmark day. It is the first time alcohol misuse has been addressed a public health issue' (ibid., para. 2). However, following this announcement, government did not move swiftly and decisively to enact its promised legislation, and it was not until February 2015 that a new Minister for Health published the General Scheme or 'heads' of the Public Health (Alcohol) Bill 2015. The Minister's press release appeared to indicate frustration with the slow pace of the legislative policy process, an acknowledgement that what was being proposed was a compromise between the two main protagonists and a determination to see this legislation enacted before the government had to call a general election in early-2016:

> These Heads won't satisfy everyone. Industry will complain about the impact on them. Health campaigners will be disappointed that a complete ban on alcohol sponsorship has not been introduced. But I am not prepared to postpone this legislation and continue to have endless discussions and delays.
>
> (Department of Health, 2015)

Despite expressing these sentiments, however, the Minister failed to publish the Public Health (Alcohol) Bill 2015 until the first week of December of 2016, when the government had only weeks to run before calling an election and when it was clear that the legislation would not be enacted during its lifetime. Given the very protracted policy debate which had preceded this, it is difficult to accept that the delay had been caused by unanticipated complexities; and the *Irish Times* commented in an editorial:

> Postponing tricky decisions has been elevated into an art form by this Government … With an uncluttered Dáil [parliamentary] schedule, the legislation could become law by the middle of next year. For that to happen seamlessly, however, the present Government will have to be re-elected and there is no certainty of that happening.
>
> (*Irish Times*, 2015)

That government was not re-elected, however, so it seems unlikely that the Public Health (Alcohol) Bill 2015 will be enacted at any time over the next few years.

Conclusion

While Minister Varadkar may have believed that six years was 'too long' to have spent in discussion of alcohol policy, this chapter indicates that the entire 40-year period reviewed here has been marked by repetitive policy discussion of this kind. The disease concept of alcoholism enjoyed a relatively short shelf-life within Irish health policy, and what had appeared to be a solid consensus about its value and validity broke down quickly in the face of opposition from the WHO's new public health approach to alcohol issues. No comparable consensus emerged, however, in support of actual implementation of this public health approach and no fracturing of the long-standing, alcohol policy equilibrium occurred. Successive governments facilitated debate on this issue and gave nominal support to policy reports recommending the public health perspective; but at no point could it be said that the Irish 'politics stream' fully embraced the WHO line on alcohol policy in the sense of framing alcohol problems in terms of a continuum for which unequivocally tough interventionist strategies were the appropriate policy solution.

The explanations for this unwillingness on the part of the Irish political system to implement the entire range of evidence-based, alcohol strategies called for by public health advocates would appear to be those previously identified. Perhaps the most fundamental of these is that Ireland has never been a 'temperance culture', where a long-standing, religiously-based view that alcohol was inherently evil might provide a basis for state policy of the 'dryer' variety. And, as spelt out in Chapter 3 on the evolving history of alcohol politics in Ireland, the decline of the ideologically moderate Catholic temperance movement (the PTAA) during the 1960s coincided with the rise of

Ireland's first experience of modernity, increased disposable incomes and a view – implicit in the wider disease concept – that alcohol only posed a risk to that minority of consumers with a predisposition to problems.

It was also the case that, as in other jurisdictions, the 'evidence' presented by Irish researchers and public health advocates for tougher alcohol controls has been constantly and vigorously contested by the drinks industry, whose lobbying powers have seemed particularly persuasive to those central government departments concerned with employment, revenue generation, tourism and trade. And while the drinks industry abandoned the disease concept, it continued to lobby for a dichotomous framing of alcohol problems, in which a responsible and overwhelming majority of drinkers was juxtaposed against a tiny minority of alcohol 'misusers'. In line with this framing of alcohol problems, the drinks industry in Ireland has been vehemently opposed to interventionist alcohol strategies which – as the industry sees things – would 'punish' responsible drinkers while simultaneously having no ameliorative effect on alcohol misusers. Although survey research in Ireland reveals reasonably strong support for alcohol control strategies (Hope, 2014), such support as exists outside health circles has never manifested itself in the form of sustained mobilization or grassroots activism; and it seems clear that the Irish political system has not been persuaded that the 'national mood' is well disposed towards tough alcohol control strategies. Finally, as discussed in Chapter 1, the cross-departmental nature of alcohol policy means that in Ireland – as in other countries – decision-making is tied to sectoral interests, and therefore rarely achieves the consensual 'joined-up' or 'cross-cutting' ideal which is required for consistent and coherent policy formation. Critically, in Ireland as elsewhere, health promotion represents just one policy goal in a field of competing values and interests. Health is not automatically given precedence over trade, finance and employment – nor is there any consensus that it should be. The decision as to where health should rank in the scale of political importance is not one of evidence, but one of politics.

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5 Alcohol and alcohol policy in England and Scotland

Historical background

Introduction

The development of alcohol policies in both England and Scotland reflects the complexity of drinking cultures across mainland Britain. Formal licensing legislation in England dates back to 1552, and there have been many periods since in which policy has either sought to reduce consumption or to further liberalize the production and retail of alcohol. Throughout, policy debates have reflected two fundamental tensions. One is between those who see the primary role of the state as being the control of alcohol supply and the reduction of alcohol-related harms, and those who see its role as being to facilitate consumer choice, free markets and business development. A second is between those who see alcohol harms and risks as operating across whole populations and those who view problems as being isolated within specific subgroups. These tensions came to a head with the emergence of the Victorian temperance movement and the arguments worked out in that era left a tangible legacy for alcohol policy in the twentieth century. Many of these problems are now re-emerging as central to contemporary policy debates, albeit framed differently. This chapter provides a broad overview of those developments in the United Kingdom from the formation of licensing until the 1980s.

Early alcohol legislation and the rise of alcohol as a policy concern

Elements of the alcohol market were regulated by state policy throughout the Middle Ages. Statutes existed to prevent the adulteration of imported wine, to manage wine taxation, and to tie the price of beer to the price of other commodities. However, such legislation was primarily concerned with ensuring market equity, preventing fraud and protecting state revenues (Nicholls, 2009). The first national legislation designed to tackle alcohol harms through limiting availability came in the form of a Licensing Act passed in 1552. This Act required anyone intending to open an alehouse to acquire a licence in advance from two local magistrates. The following year, further regulation was introduced to oversee the operation of taverns, which, unlike alehouses, served wine and catered to a more affluent clientele. From the start, however,

the 'harm reduction' elements of early alcohol legislation were underpinned by the desire to achieve wider forms of social control (Clark, 1978; 1983; Wrightson, 1981). The 1552 Licensing Act in particular, was aimed squarely at alehouses – places largely frequented by labourers, farmers and other lower-class drinkers. The legislation sought to prevent, in the words of an Act of 1606, the 'odious and loathsome sin of drunkenness', which the increasingly numerous alehouses were seen as encouraging. However, as much historical research has shown, while the social activity alehouses encouraged were indeed based on heavy drinking, they also provided one of the few spaces in which the poor could socialize (Hailwood, 2015). That this social activity went against elite norms and taboos, and sometimes involved behaviours perceived as politically threatening, was part of the reason it came under such scrutiny (Clark, 1983).

In the early seventeenth century, concerns over the social and political threat posed by alehouses re-emerged, partly as a consequence of the rise of Puritanism. Between 1604 and 1660, a series of new laws was introduced, designed to place more stringent controls on alehouses and reduce incidences of public drunkenness (Nicholls, 2009: 13–16). This legislation invariably identified a similar range of social concerns: idleness among workers, public drunkenness, and the popularity of gaming, and other 'immoral' behaviours among alehouse patrons. Local licensing was the primary mechanism by which such behaviours were policed, allowing for a high degree of flexibility but also creating enormous variations in the implementation of central government directives. In some areas licensing magistrates and local constables placed strict controls on local operators, while in others magistrates were friendly with local brewers or constables who were themselves regular customers in local drinking houses (Hailwood, 2015). This tendency for central legislation to be applied and enforced with considerable regional variation would become characteristic of alcohol policy implementation throughout the UK over the following centuries.

Importantly, alcohol policy at this time was largely unconcerned with the effects of alcohol on health, either generally or individually. The focus of licensing legislation was specifically the maintenance of public order and the promotion of behavioural and moral norms – but with far greater legislative force falling on the poor, despite high levels of consumption being spread across all levels of society (Withington, 2011). Furthermore, national policy was not directed towards consumption in private spaces or other spaces where there was no obvious, or widely perceived, threat to social order. Rather, the majority of legislation was enacted in response to an increase in the number of alehouses operating across the country and the antisocial, or economically unproductive, behaviours with which they were associated.

The rise of spirits drinking and the policy response

The focus and scope of alcohol policy changed dramatically in the eighteenth century following a widespread increase in the consumption of distilled spirits. In the early eighteenth century a combinations of factors, including the

deregulation of distilling trades by King William III in 1690, contributed to a steep rise in the production and consumption of domestically distilled spirits (which were generally referred to as 'gin' despite variations in production methods) in the larger English cities particularly London (Porter, 1985; Dillon, 2003; Warner, 2003). What followed came to be known as the 'Gin Craze': a period from around 1720–1750 in which rising levels of consumption triggered an enormous amount of political action aimed at tackling what one prominent English writer called a 'new kind of drunkenness … which, if not put a stop to, will infallibly destroy a great part of the inferior people' (Fielding, 1988). While accurate figures are very hard to ascertain, it has been estimated that around a pint of gin was being consumed for every man, woman and child in London every week in the early 1720s (Dillon, 2003). Whatever the precise figures, there is no doubt that this period saw a rise in gin consumption among the urban poor; however, it was also an era in which alcohol consumption was high across society (Ludington, 2013). In addition, aggressive economic restrictions imposed on French wine imports encouraged the development of a trade in fortified port wine from the Douro Valley in Portugal. They also encouraged large amounts of smuggled claret drinking in Scotland, where the consumption of French wine remained high after union with England in 1707, partly because large quantities were imported illegally, but also because the continuance of an established market for claret reflected the ongoing cultural affinity between the Scots and the French at the time (ibid.). Georgian Britain, therefore, was a high alcohol-consuming society for a range of social and economic reasons.

Excessive port and wine consumption was occasionally satirized – famously so, in William Hogarth's popular engraving 'A Midnight Modern Conversation' (1732). However, it was concern over gin drinking that led to a raft of legislative action. As with alehouse legislation a century earlier, these interventions were driven both by a demonstrable increase in availability, consumption and harm, especially in London, but also by concern among social elites regarding the effects of drunkenness among the poor. Gin was associated with urban poverty and the perceived immorality of city life – as memorably captured in another famous work by William Hogarth: 'Gin Lane' (1751). Furthermore, gin was often drunk by women, leading many of the campaigners for regulation to see it is a particular threat not only to conventional morality but also to the future economic prosperity of the nation: as one leading advocate wrote

> Distilled spirituous liquors are the greatest enemy to fertility … for this reason, if there were no other, the legislature will think it worth their most serious consideration, how to put a stop to an evil that directly tends to the decreasing as well as the weakening of the breed of the nation.
>
> (Wilson, 1736: 43)

Advocates for restrictive legislation commonly argued that maternal drinking would lead to weak, unproductive offspring: what one contemporary called 'a

fine spindle-shanked generation' of children, unable to fulfil their duties as either labourers or soldiers (Defoe, 1728: 45). Hence, arguments about morality, crime and health were overlaid with an economic concern over the productivity of the labouring poor.

From the 1720s onwards, a series of campaigns was established to call for greater controls on the availability and price of domestically distilled spirits. These campaigns were led by a coalition of clergymen, medical doctors and politicians who argued that the state had a duty to take radical action. One prominent campaigner was the Reverend Thomas Wilson, another was the doctor, Stephen Hales, whose (1734) book *A Friendly Admonition to the Drinkers of Gin, Brandy and Other Distilled Spirituous Liquors* contained analyses of mortality rates as well as vivid descriptions of the effects of spirits consumption on newborn children. The writer Henry Fielding, who also played an important role in the establishment of the first standing police force in Britain, joined a 1751 campaign for new gin legislation, as did the artist William Hogarth, whose engravings 'Gin Lane' and 'Beer Street' were produced as part of a joint campaign for a change in the law.

This broad coalition of anti-gin advocates was effective in changing government policy on alcohol, though the results were very mixed. The anti-gin campaign's most dramatic, and pyrrhic, victory came following an attempt in the 1730s to introduce, in the words of Thomas Wilson, 'a law that shall amount to a prohibition' of distilled spirits (Wilson, 1736: 5). In 1736, a law was passed which imposed such high licence fees on spirits-retailers as to, in effect, make it prohibitively expense to sell distilled spirits at all. However, the overall effect of the 1736 experiment was the development of a widespread black market, general disregard for the law and significant public disorder when illicit spirits-sellers were apprehended (Clark, 1987; Dillon, 2003; Warner, 2003). The law was repealed in 1743. A new campaign in the early 1750s, again led by Thomas Wilson and Stephen Hales among others, was equally successful in that it led to the introduction of a new Gin Act in 1751 that raised the price of a spirits retail licence by a moderate amount, required gin outlets to be of a minimum rateable value, banned the sale of spirits in prisons and prevented brewers or distillers from acting as magistrates where cases involved the sale of spirits.

As Jessica Warner (2003) has shown, spirits consumption began to decline from around 1743. Therefore, while the 1751 Gin Act was widely seen at the time as having finally put an end to the 'Gin Craze', it is more accurate to see it as consolidating a change in behaviours which was already in place: one driven by both economics (especially fluctuating levels of domestic corn production) and by changing social trends. It may well be that the anti-gin campaigns of the time contributed to changing popular attitudes and making new legislation politically palatable: undoubtedly, Hogarth's 'Gin Lane' was very widely printed and commented upon. It is also likely that the provisions of the 1751 act encouraged gin retailers to target more affluent customers. However, these policy interventions worked alongside other social and economic changes,

highlighting the difficulty faced by anyone seeking to separate out the effects of policy from the effects of other social factors.

Partly due to concern over maternal drinking and mortality rates, but also because of developments in medical thinking, the eighteenth century saw the emergence of a medical literature identifying the health impacts of alcohol as a serious cause for concern (Porter, 1985; Warner, 1994; Nicholls, 2008). Many anti-gin campaigners were doctors, and they were explicit in linking excessive consumption to a range of disorders. However, doctors treating affluent patients were also beginning to write extensively about the impact of alcohol on health. One reason for this is that the eighteenth century saw a steep increase in cases of gout among the wealthy, and it had long been understood that alcohol was implicated in the disease. Furthermore, this was an era when famous medical writers such as George Cheyne sold large numbers of books on health promotion and long life – many of which identified excessive alcohol consumption as a source of ill-health (e.g. Cheyne 1733; 1740). Finally, the public concerns over alcohol that ran throughout the eighteenth century also contributed to a new medical interest in what we might now call alcohol dependency. In the UK, a number of medical specialists such as William Cadogan, John Coakley Lettsom and Thomas Trotter began to explore how and why alcohol could lead to habitual drinking, and to propose an array of measures for countering this – ranging from religious piety to aversion therapies such as adding wax to one's wine glasses (Cadogan, 1771; Lettsom, 1798; Trotter, 1988).

By the end of the eighteenth century, then, alcohol was established as a medical issue. Its effects on health had also become key to debates on alcohol policy and the role of the state in regulating the market. Health, however, was not clearly separated from morality. Medical writers, most significantly the Scottish surgeon, Thomas Trotter, were exploring the degree to which alcohol use could be understood in non-judgemental terms (Edwards, 2012). However, perhaps the most famous treatise of the period, written by the American Surgeon-General Benjamin Rush, highlights how closely medical and moral ideas were linked. Influenced by British doctors such as William Cadogan, Rush produced an essay, originally published in 1784, entitled *Inquiry into the Effects of Ardent Spirits on the Human Body and Mind*. Although largely an anti-spirits tract (unlike some of his British contemporaries, Rush did not advocate abstinence from all alcohol), Rush's treatise neatly tied medical advice to a need for spiritual renewal, most notably in the creation of a 'moral thermometer' which, using the visual (and quasi-scientific) trope of a thermometer, mapped patterns of consumption against both health outcomes (such as 'sickness', 'epilepsy', 'madness' and 'death') and moral outcomes including 'idleness', 'obscenity', 'hatred of just government' and 'suicide' (Rush, 1823; see also Lettsom, 1798). Throughout the eighteenth century, then, political, medical and moral concerns over alcohol combined to produce not only a diverse array of writing on alcohol but also a series of organized, politically influential, advocacy campaigns in which the moral authority of

the clergy combined with the medical authority of prominent doctors and the social power of popular communicators to encourage policy shifts.

The Victorian temperance movement in Britain

The anti-gin campaigns in the eighteenth century demonstrated the political power of coordinated, high-level elite advocacy. However, concerns over the effects of alcohol in America led to a different type of social activism: the creation, in the early nineteenth century, of small community groups whose members took it upon themselves to foreswear the use of spirits. The early American temperance movement reflected both the religious culture of the time, but also a 'voluntarist' political culture that emphasized the importance, and power, of grassroots community action in affecting wider social behaviours.

Continuing concerns over spirits drinking – especially following a reduction in spirits duties in 1825 – meant that Britain was fertile ground for the adoption of ideas drawn from the new American temperance movement, whose ideas were brought across the Atlantic in the 1820s (Harrison, 1971). In the late 1820s, a small number of anti-spirits societies were established in the major ports of Ulster and Scotland, and by the following year similar organizations began to spring up across England. Initially, they called only for a reduction in spirits consumption and they were reliant on members (often local clergy and doctors) pledging not to drink spirits themselves. However, following legislation to liberalize alcohol retail in 1830, this nascent temperance movement began to galvanize around the novel idea that all alcohol was socially pernicious. The 1830 'Beer Act' was a free trade measure that allowed beer sellers to retail without a licence, so long as they did not sell wine or spirits. In effect, local licensing controls over the scale of the beer market were removed. The argument for this policy shift was partly that the large brewers, who also owned many of the pubs, had become a monopoly that reduced consumer choice and corrupted the licensing system. There was also pressure from free trade ideologues, who saw the beer market as a clear instance of market failures that occurred when big business dominated both retail landscapes and the regulatory regime. The short-term results of the new legislation were predictable: a sudden explosion in the number of alcohol outlets across the country (an estimated 40,000 unlicensed 'beer shops' opened in the following five years) followed by widespread expressions of concern over increased public drinking and drunkenness (Harrison, 1971; Greenaway, 2003; Jennings, 2007; Nicholls, 2009; Yeomans, 2014).

Within three years of the 'Beer Act', a Parliamentary enquiry was established to consider whether the new legislation had had the desired effect, and, in 1834, a Select Committee on Drunkenness (dubbed by some the 'Drunken Committee') was established to try and identify ways of tackling what seemed to be an upswing in drunkenness across the country. By then, however, a sea change had occurred within the temperance movement, one that would have enormous consequences for alcohol policy debates in both Britain and

abroad. The 1830 Beer Act had drawn attention to the fact that it was not only spirits that could lead to problems of public order, and for some within the temperance movement this posed a fundamental problem: why should the movement only target spirits, when all forms of alcohol could lead to similar consequences? In 1832, members of the Preston Temperance Society took this problem to its logical conclusion by creating a new pledge by which they promised not only to avoid spirits, but all alcoholic drinks. This was the birth of the 'total abstinence' or 'teetotal' temperance movement, which would not only transform British temperance but alcohol policy debates across the world in the following decades.

As teetotalism spread within British temperance, societies in America began to adopt the new pledge – and with this development grew the idea that problems associated with drinking were not confined to particular drinks, drinkers or social groups, but were caused by alcohol itself. This was a deeply significant shift: whereas previously arguments had centred on the relative effects of distilled drinks, or on the problems associated with certain types of outlets, teetotalism turned the spotlight on the substance itself. Although the early teetotal movement had only limited interest in policy, since it was focussed on motivating individual drinkers to reform themselves, it changed the way policy debates developed. Critically, the idea that alcohol was a fundamentally harmful substance, and that society itself could be transformed if alcohol use was reduced, led to the emergence of a campaign for the outright prohibition of alcohol in the 1850s. While voluntary teetotalism was exported from England to America, prohibitionism – the contrary idea that it was the job of the state to make alcohol unavailable – was developed in America and instituted in a number of Eastern states in the early 1850s.

In 1853, a year after the state of Maine introduced the first state-wide prohibition law in America, the first prohibitionist temperance society, the United Kingdom Alliance for the Suppression of the Traffic in all Intoxicating Liquors (often referred to simply as 'The Alliance'), was created in Manchester. The Alliance clearly differentiated itself from conventional teetotalism in that its target was policy, rather than the reformation of individual drinkers. Frederic Lees, one of the leading Alliance activists, made this explicit in writing that 'the Alliance is not a temperance, but a *political* association' (Lees, 1856: 114). Whereas voluntary teetotalism placed its efforts in achieving reform through moral exhortation at the individual level, the Alliance worked to establish a coalition of political actors, local activists, doctors and social commentators to advocate for radical political controls on the supply of alcohol. Their tactics ranged from targeting local politicians during election campaigns, establishing a powerful caucus within the Liberal Party, and regularly presenting prohibitionist legislation to Parliament. Such was the influence of the Alliance on the late Victorian Liberal Party that when it won the 1892 General Election, it introduced a Bill to establish local prohibition within a year. Despite the Alliance spending around £17,000 lobbying for this Bill, it failed to become law – partly because of well-financed trade resistance, but partly because the Liberal Party

remained divided on the subject, and it had only limited popular support (Nicholls, 2009: 136–137).

Although prohibitionism became the politically dominant form of temperance advocacy in the last third of the nineteenth century, the Victorian temperance movement remained complex and diverse. 'Moderationist' temperance campaigners (who were loathed by many prohibitionists) sought stricter licensing control in order to reduce the harms of alcohol, while not banning it outright. Meanwhile, many of the original teetotallers never came to accept the idea that alcohol prohibition was anything more than the transfer of individual moral responsibility to a coercive state. However, while they differed on many aspects of policy, Victorian temperance campaigns shared the fundamental idea that alcohol was, in its essence, a harmful substance – even if, in some respects and instances it could have seemingly beneficial effects. This differed from the alternative view, that alcohol was essentially a beneficial substance – albeit one which could produce an array of harms if misused. Apart from the more radical voluntary teetotallers, most temperance advocates also agreed that the role of the state was primarily to reduce the overall consumption of alcohol through supply-side interventions. Alcohol consumption had to be tackled at a population level because it presented a risk to *all* drinkers, even if only a proportion ended up falling down the slippery slope to outright destitution. In this regard, Victorian temperance displayed many of the characteristics of later social movements: a shared core perspective, but a diversity of opinion on the most effective policy approaches. As with many social movements the differences could be significant, indeed rancorous; however, the shared enemy of temperance – the drinks industry, or simply 'The Trade' as it was known – provided a unified figure against which all sides cohered.

While temperance discourse was grounded in moral arguments over rights, responsibilities and social progress, it was also shaped by developments in medical thinking around alcohol use. The work of eighteenth- and early-nineteenth-century medical writers had helped position alcohol as a substance that could create, in some users, a type of habituation that was both distinctive and amenable to quasi-medical interventions. In 1814, a Scottish naval surgeon called Thomas Trotter produced a book entitled *An Essay Respecting the Effects Medical, Philosophical and Chemical on Drunkenness and its Effects on the Human Body* (Trotter, 1988). Trotter saw habitual drinking as more than mere moral or physical weakness; instead, he analysed it as a type of psychological illness – in his language, a 'disease of the mind' – that required therapeutic interventions which would aid the drinkers in overcoming the anxieties, lack of self-worth, aimlessness or melancholy that were the underlying causes of harmful drinking.

Trotter's work had limited influence at the time, despite containing what a number of recent studies have identified as a prescient and insightful analysis (Porter, 1985; Edwards, 2012). Nevertheless, developments in early addiction science continued through the Victorian era, influenced to some degree by the pioneering work of continental writers such as Magnus Huss and

Jean-Étienne Esquirol, who began to describe habitual drinking as a condition or a pathology that existed independently of the substance of alcohol itself. That is to say, who saw 'alcoholism' or 'dipsomania' as a pre-existing condition that could be triggered by the consumption of alcohol, rather than as simply a description of the patterns of consumption displayed by people whose will power had been attenuated by the amount of alcohol they had consumed. Such perspectives fed into a wider debate regarding the status of habitual drinking, especially whether it was best understood to be a vice (that is, a morally censurable behaviour for which the individual was fully responsible), or a disease (a condition which, to some degree at least, was caused by factors beyond an individual's control). In the UK, such questions led to debates over the proper treatment and prevention of 'habitual drinking'. For many within the temperance movement, alcohol's unique capacity to create dependency was precisely the reason why its availability should be restricted by law: for even if most drinkers would turn out to be moderate, a proportion would not. Restriction by law was, so the temperance argument ran, a small price for those fortunate moderate drinkers to pay to spare the suffering caused by those for whom every drink was a further step on the road to destitution.

Medical models of harmful drinking in this period were not homogenous, and the varying diagnoses produced a diversity of proposals for treatment. For 'moral suasionist' campaigners, the best method for reform was voluntary total abstinence, signified by adherence to a signed 'pledge' and, in many cases, public pronouncements of reform, and reinforced through active engagement with local total abstinence societies. For prohibitionists, the dependence-forming nature of alcohol required it being removed at source through radical state action. Within the medical temperance movement, however, other proposals emerged. In 1858, the Scottish physician Alexander Peddie published proposals for the establishment of 'inebriate asylums', based on the core principle that habitual drinkers were victims of a disease, and so required treatment rather than (as was often the case when their drinking led to criminality) punishment by law (Peddie, 1858). Peddie's idea was taken up in America, where the first inebriate asylum was established in 1864, and such institutions were introduced to the UK following an Act of Parliament in 1879. The 1879 Act allowed for the establishment of voluntary asylums, which proved to be of limited value since they were both costly and required individuals to enter voluntarily. In 1898, state asylums were established that allowed courts to commit convicted criminals who, in the court's view, were also habitual drinkers or who had been convicted of four alcohol-related offences. As subsequent historians have shown, the state asylums in reality were used primarily to commit women accused of prostitution or child neglect; furthermore, their value was never widely accepted and they fell largely into disuse after the First World War (Zedner, 1991; Valverde, 1998).

Temperance was a diverse and varied social movement. It incorporated moral reformers, political activists from both the left and right (there were conservative, progressive and radical wings within the British temperance movement), doctors, social reformers, clergy from all denominations, and many thousands of

ordinary men, women and – especially following the establishment of the Band of Hope in 1847 – children (see Harrison, 1971; Greenaway, 2003; Shiman, 1988; and Nicholls, 2009, for an overview). In all its guises, temperance drove a shift in the way the British government saw its relationship to alcohol and the drinks industry. Temperance activism forced policymakers to ask whether the primary role of policy was merely to ensure the market operated fairly (or, more sceptically, to support powerful industrial interests), or whether it was to proactively seek to reduce alcohol-related harms through supply-side controls. In this respect, the Victorian temperance movement presents clear antecedents to more recent public health advocacy on alcohol policy. For all its diversity, it was Victorian temperance that first established the notion that the state had a responsibility to seek actively to reduce harms, via a reduction in overall consumption, through supply-side controls on alcohol across the board. Furthermore, Victorian temperance first established the argument that the alcohol industry should have no hand in policy development, since its interests were – at the most fundamental level – antithetical to the reduction of alcohol harms.

The decline of temperance and a fall in consumption

Despite the public and political debate that surrounded alcohol in the nineteenth century, the British alcohol industry was largely successful in preventing successive governments from introducing the kind of supply-side restrictions that temperance demanded. An 1871 Bill to introduce limits on outlet density was, for example, fought off by trade interests who successfully depicted the legislation, and the Liberal Party who drafted it, as beholden to a temperance movement that sought to curtail individual freedom (Harrison, 1971; Greenaway, 2003). None of the successive attempts to pass legislation allowing local prohibition were successful, and while a major Royal Commission report in 1899 proposed strengthening the power of local magistrates to reduce outlet density, the eventual legislation passed in 1904 had only a limited effect, not least because it required local magistrates to compensate businesses, using money levied from brewers, when they refused to renew a licence. Indeed, some historians have argued that this measure actually made it more difficult for local magistrates to close down outlets as they could only do so when sufficient funds for compensation were available (Jennings, 2009).

The outbreak of the First World War in 1914, however, created a national crisis that opened a rare window of opportunity for policy innovation. Fears over the efficiency of workers in some of the large munitions factories and shipyards, combined with concerns over drunken troops leaving for action, led to calls for restrictions on access to alcohol from among many prominent industrialists. The addition of a specific industrial concern to the existing moral arguments for temperance-oriented legislation was significant, as was the fact that wartime conditions allowed for legislative actions that would be politically difficult in peacetime (Greenaway, 2003; Duncan, 2014).

Furthermore, the then Chancellor of the Exchequer, David Lloyd George, had long been sympathetic to temperance, representing as he did the wing of Liberal Party thought which saw 'the Trade' as antithetical to social progress. Indeed, in a famous speech in 1915, Lloyd George stated that 'drink is doing us more damage in the war than all the German submarines put together' (Times, 1915). Following the submission of a petition for outright prohibition by shipyard owners, a ban on alcohol sales was seriously considered; however, this was ultimately rejected on the grounds of practicality. Instead, a Central Control Board (CCB) was established and charged with overseeing the liquor trade for the duration of the war.

The CCB was very unusual in that it contained both leading temperance advocates and representatives of major brewers. The crisis of war had brought major industrialists into support for temperance; it had also allowed the Government to blame alcohol for inadequate industrial production in its munitions factories and shipyards (Greenaway, 2003; Duncan, 2014). With the creation of the CCB, moderate brewers fearful of the threat of prohibition joined forces with moderate temperance campaigners eager to seize a unique opportunity. The results were some of the most far-reaching changes to national alcohol policy since the Beer Act. The Central Control Board introduced strict controls on opening hours across the country, banned the buying of rounds and put controls on the sales of spirits. Furthermore, in some areas (including the city of Carlisle), it took control of the entire alcohol trade – from breweries to pubs. As one of the leading temperance members of the CCB later wrote, 'On January 4th 1916 the State, for the first time in modern England, entered business as a retailer of liquor' (Carter, 1919: 174).

In the areas where it took control of the trade, the CCB embarked on a unique experiment in 'pub improvement'. In the pubs it now owned, it introduced food sales and table service while placing managers on flat salaries to remove the incentive to sell larger amounts of alcohol to customers. The CCB's pub improvement scheme was itself influenced by an earlier municipalization scheme introduced in Gothenburg, Sweden, in the late nineteenth century (Gutzke, 2006; Duncan, 2014). It is a further illustration of the extent to which alcohol policy innovations and ideas passed between countries as temperance, in its various guises, became an increasingly international movement. To repeat, while there were significant differences between wings of the temperance movement, it was bound together by a core idea about alcohol: that drinking was, essentially, a harmful activity; that any reduction in consumption would represent a net social benefit; and that the state had a responsibility to support such reductions. The CCB was unique in that, in the idea of pub improvement, it found a centre ground on which moderate temperance campaigners could (albeit with some reluctance) stand with the more progressive – or, perhaps, economically astute – elements within the brewing industry. It represented a very different solution to the perceived problem of alcohol consumption: a pragmatic alternative to prohibition, later adopted in America and elsewhere. Rather than pursuing the utopian goal of a society free entirely from alcohol,

it pursued the more limited goal of a society in which the harms associated with alcohol were ameliorated as much as possible through the policy environment which regulated its production and sale.

Prohibitionists such as the United Kingdom Alliance saw the establishment of the CCB as 'at best a palliative – not a cure' (Duncan, 2014: 115). In reality, however, it formed the high-water mark of temperance influence in British alcohol policy. Alcohol consumption fell dramatically over the course of the First World War and, despite recovering somewhat in the early 1920s, remained low for the next 40 years. The actions of the CCB no doubt contributed to this trend, but so too did an array of other socioeconomic factors. Reflecting on declining consumption in 1931, a Royal Commission suggested it was due to more counter-attractions, fewer outlets and restricted opening hours, increases in price and the effects of economic recession, better education, improved housing, and the striking fact that 'drunkenness has gone out of fashion' (House of Commons, 1931a: 9). In 1940, the social researchers Mass Observation noted that young people were more likely to socialize in milk bars and coffee bars than pubs, which were increasingly associated with an older generation (Mass Observation, 1940). In Scotland, local prohibition had been introduced under legislation passed in 1913, though the war delayed its implementation until 1920. However, a Royal Commission on Scottish Licensing in 1931 claimed that local prohibition had 'failed to come up to the expectations formed of it by its sponsors' and should be reformed or abandoned (House of Commons, 1931b: 47).

The decline in consumption in the interwar years points to both the impact of policy on drinking culture and the effect of wider social changes on the alcohol market. Two Royal Commission reports published in 1931 identified the imposition of stricter licensing hours and increased taxation as important influences, but they also recognized that both improved living conditions and the development of alternative forms of leisure were a major factor. In 1940, Mass Observation said little about the policy drivers for changing drinking behaviours, although they did recognize that increased taxation on brewing had led to weaker, lower quality, but more expensive beers – something which made pub-going much less attractive. That culture and policy intersected in this social shift is not surprising: as is demonstrated throughout this book, policy alone rarely leads to radical changes in the way people consume alcohol, nor are the effects of policy interventions entirely predictable. Equally, however, it is impossible to separate culture from policy: a change in the hours at which alcohol is available for purchase is, by definition, a change in the drinking culture. The evidence of the interwar years suggests that both were important in the widespread 'sobering' of British society at the time.

While the Victorian temperance movement continued to decline from the 1920s, it left a durable legacy in the licensing and taxation policies of the time. Although far from the stated goals of the prohibitionist wing of temperance, the restricted opening hours and increased taxation on alcohol that characterized this era were undoubtedly influenced by the activities of the moderate

temperance figures, supported by senior policymakers such as David Lloyd George, on the Central Control Board. While direct comparisons are of limited value, the consequences of Prohibition in America provide a stark contrast to the British experience. Undoubtedly, alcohol consumption fell across America under Prohibition, as did a number of alcohol-related health harms, and it has been argued that National Prohibition did socialize many people to a less alcohol-centric lifestyle, even after Repeal (Blocker, 2006). Nevertheless, the associated problems of black market sales, organized crime, corruption and disregard for the law would become notorious – even if partially misattributed – and would echo the consequences of the 1736 Gin Act in England. In Britain, by contrast, a fall in consumption occurred without any of those externalities through a combination of restrictive policies on availability and price combined with a range of economic and social developments not directly associated with alcohol policy.

The decline of temperance, with its focus on population-wide interventions targeting the supply of alcohol, was accompanied by a rise in individually-oriented conceptualizations of alcohol harms. As we have seen, the Victorian era had witnessed the development of medical models of habitual drinking, some of which (especially the inebriate asylum concept) had policy impact. Following the establishment of the British Society for the Study of Inebriety in 1884, medical models of dependency developed further and moved towards a construction of habitual drinking as a type of disease which shared many traits with addiction to other substances such as opiates (Berridge, 1990). The development of 'disease' models of addiction was one manifestation of a shift towards identifying alcohol harms as being concentrated in particular social groups – especially 'alcoholics' who were increasingly understood to be suffering from a condition that created a predisposition to harmful drinking, which would have manifested itself irrespective of the wider policy environment (Kneale and French, 2008). Nevertheless, throughout the interwar period there was no suggestion that national policy should move away from a focus on reducing overall consumption of alcohol. Indeed, one of the 1931 Royal Commissions, despite having identified a sea change in the consumption and harms associated with drinking, still asserted that 'It is the clear duty of the State to take all reasonable action which will assist to reduce excessive drinking to the lowest dimensions possible' (House of Commons, 1931a: 19).

Despite its lack of clear successes, then, the legacy of the temperance movement played a key role in framing alcohol policy in the first half of the twentieth century. Given the enormous economic and political power of the brewing industry in England particularly, it is perhaps surprising that early twentieth-century alcohol policy was not far more liberal. By the end of the First World War, magistrates were empowered (in theory, at least) to strip individual landlords of their businesses solely on the grounds that their area had too many outlets, hours of sale were restricted to lunchtimes and early evenings, taxation had increased considerably, Scottish citizens were empowered to introduce total prohibition in their localities, and there was a broad

political consensus that the state was directly responsible for reducing alcohol consumption – directly in contradiction to the interests of the alcohol trade. Furthermore, this broad policy approach was sustained despite consumption being depressed for around forty years.

It was not until the 1960s that national policy frames began to move towards a more liberal perspective. A Licensing Act of 1961 marked a key turning point towards a liberal framing of national alcohol policy. It lifted a number of existing restrictions on alcohol sales, especially in the off-trade. Off-licences were allowed to retail continuously, without the mandatory 'afternoon gap' that applied to the on-trade, thereby allowing them to operate in a manner closer to the general grocers than to pubs. Indeed, a departmental committee report published in 1960 had presaged this development, arguing that off-licences 'are all basically shops and … the convenience of the customer requires that they should be treated alike' (Scottish Home Department, 1960: 36). The implication of this was that alcohol itself is not a peculiar, or specifically harmful, commodity; rather that licensing exists to deal with the kind of problems that might occur in and around pubs and clubs specifically. The provisions of the 1961 Act were re-asserted in both a Scottish Licensing Act of 1962 and a 1964 Licensing Act for England and Wales, which also allowed a small increase in permitted hours of trade for pubs. The 1964 Licensing Act would remain the basis of English licensing law for the following forty years, although an Act of 1976 would further liberalize opening hours in Scotland.

From the mid-1960s consumption across Britain began to rise. Whether the new licensing regimes were a cause of this, or simply part of a trend towards more permissive attitudes to alcohol, is impossible to say with certainty. As with the decline in interwar consumption, the reasons for the upturn in the 1960s are numerous. The emergence of a 'baby boomer' generation with high levels of disposable income was undoubtedly a key factor: there were simply more young people with money – and limited personal responsibilities – able to drive the market for alcohol. Furthermore, alcohol producers were engaged in a range of activities designed to expand their sales and, critically, develop consumption among women. Lager, previously a specialist drink produced in very small quantities in Britain, started to be brewed in much higher quantities and began to establish its popularity among a generation of young people for whom more traditional bitter represented the cultural proclivities of their parents and grandparents. Not only that, lager was far more reliable in terms of quality than the cask bitters being produced by more traditional brewers (Cornell, 2003).

At the same time, increased foreign travel – especially to the Mediterranean – not only introduced younger consumers to wine, but helped reinforce a long-standing cultural association between wine and the supposedly more 'sophisticated' drinking culture of continental Europe. Developments in the international wine trade, especially among New World producers, fed into this shift and contributed to perhaps the most significant change in British drinking cultures since the popularization of spirits in the eighteenth century. In 1965,

around 3 litres of wine were consumed annually per person in the UK; forty years later, that figure stood at 22.4 litres: an increase of well over 600 per cent (British Beer and Pub Association, 2012: 27–28). Wine, more than any other drink, drove the long-term rise in alcohol consumption in the UK from the 1960s to the mid-2000s.

While this rise in overall consumption would lead to a renewed emphasis among alcohol control advocates on policies directed at the whole population, treatment continued to focus on individual interventions: initially addressing alcoholism and dependency, but shifting towards a somewhat broader notion of 'problem' drinkers in the 1990s (Thom, 1999). Alcoholism was, in the years following the Second World War, often construed as a disease requiring either in-patient treatment or abstinence-based therapies based on the 12 Steps developed by Alcoholics Anonymous. Underpinning this was a focus on treatment rather than prevention: if harmful use is understood to be confined to isolated groups within the population, then the response will be individually-oriented and predicated on the idea that global prevention approaches will be both disproportionate and of limited use.

The development of public health perspectives in the UK

Public and political concerns over alcohol are always tied into wider social issues. Because of its visibility and ubiquity, alcohol often provides the lens through which other social anxieties are viewed. Eighteenth-century concerns over gin, for instance, were also concerns about urbanization, changing gender relations and new forms of public socialization. The Victorian temperance movement was closely tied to moral anxieties around domestic well-being, as well as a broader critique of unregulated commodity markets. Nevertheless, public concerns about alcohol also respond to trends in consumption. The temperance movement declined after the First World War in part because consumption fell, causing the 'drink question' to slip down the political agenda. The liberalization of alcohol policy from the 1960s reflected, to a degree, a less anxious relationship to drinking across society: from being seen by many as a pernicious source of widespread social disintegration, alcohol was increasingly viewed as a source of positive social pleasure, albeit one that could lead to addiction in a limited number of cases. The rise of the disease model, which postulated alcohol problems as being confined to 'alcoholics' alone, combined with a more relaxed view of the substance itself, made liberalization politically viable.

It so happened that the rise in overall consumption in the UK coincided with the development of the 'public health perspective' on alcohol harms among Scandinavian researchers (described elsewhere in this book). While initially adopted by a relatively small number of alcohol specialists in the early-1970s, public health perspectives began to establish themselves more firmly within key institutions, such as the Royal Colleges of Psychiatrists and Physicians over the following years, as well as gaining traction in high-level policy circles

through the role of influential advocates such as Dr Griffith Edwards (Thom, 1999). In 1979, a report of the Royal College of Psychiatrists, entitled *Alcohol and Alcoholism* set out the key principles of the public health perspective: that alcohol harms existed on a continuum rather than a dichotomy between moderate drinking and the disease of alcoholism, that levels of alcohol harm were directly tied to overall levels of consumption, and that state regulation on the supply side (specifically through targeting taxation and availability) were the key methods for reducing consumption across the population as a whole. By 1981, this perspective had gained sufficient influence in central government for a preliminary report of the Central Policy Review Staff to argue that overall consumption should be addressed and that 'the single most important instrument the Government had for influencing alcohol consumption' was taxation (Kendell, 1987: 1285). However, when the final version of the report, entitled *Drinking Sensibly*, was published, this support for 'whole population' approaches had been expunged – and the preliminary report was only made public after it was leaked by the Finnish alcohol researcher Kettil Bruun some time later (Central Policy Review Staff, 1982). Despite some support for whole-population perspectives within the Department of Health, the approach was strongly opposed at ministerial level and within other departments whose focus was economic development or crime reduction (Thom, 1999: 118–119).

By the 1980s, then, a clear tension had emerged in the alcohol policy landscape of the UK. On the one hand, the political drift towards free-market liberalism meant there was an ideological commitment on the part of the newly-elected Conservative Government, led by Margaret Thatcher, to reducing regulation and encouraging business development in the alcohol market. On the other hand, however, medical professionals were expressing increasingly vocal concerns about the impact of rising alcohol consumption on health across the population. The adoption of public health perspectives by the World Health Organization, and the advocacy of those associated with Kettil Bruun and the 'whole-population' approach began to crystallize opinion among key policy actors. The *Drinking Sensibly* episode not only exposed the extent to which political considerations can contradict health research in the formation of national policy, but also the deep tension between public health perspectives on alcohol and the liberal framing of alcohol policy that held sway in central government. For the former, the primary duty of government in regard to alcohol was to actively reduce harms through interventions in the supply-side; for the latter, the primary role of government was to allow the market to operate with minimal constraints, albeit tackling harmful externalities at the extremes.

Conclusion

The history of the relationship between alcohol policy, culture, consumption and harms in the UK points to a number of different observations. The most significant of these is that changes in consumption and harm are invariably

driven by a combination of economic, social, technological and political factors. How these factors align to trigger, magnify or limit cultural change is unpredictable. However, while policy has rarely, if ever, played the decisive role in major social change regarding drinking, it has, undoubtedly, played a critical role in a number of key instances. Furthermore, this role has often been to amplify trends in increasing consumption through liberalizing the availability of alcohol or facilitating price competition; indeed, it would appear that the major examples of long- and short-term impact have come from liberalizing policies. The deregulation of gin both helped trigger the 'Gin Craze', but also establish spirits consumption as a durable feature of popular drinking culture even once the 'craze' had declined. Licensing liberalization in the mid-twentieth century facilitated (while not being the sole cause for) the explosion in off-sales that helped transform British drinking culture such that wine-drinking in the home became as prevalent as beer drinking in the pub.

Where attempts have been made to reduce consumption through policy interventions, the results have sometimes been counterproductive (for instance, the 1736 Gin Act) or of limited impact (for instance, the 1904 Licensing Act). The Victorian temperance movement failed to achieve most of its policy goals, not least because it moved towards an uncompromising prohibitionism that, while creating much political heat, was undermined by its own inflexibility when it came to the Parliamentary crunch. The Central Control Board stands as an unexpected success, from a control perspective. It adopted elements of the political temperance stance in seeking to effect an overall reduction in consumption; however, it also promoted the 'Gothenburg' principle that there was value in improving the spaces in which drinking occurred in order, paraphrasing Room (1992), to reduce the number of 'problems per pint'. Clearly, the actions of the CCB played only a partial role in the long decline in consumption that followed but they also set a restrictive framework for alcohol policy that lasted for decades, as well as establishing a regime of constrained operating hours that was only finally overhauled in 2003. The example of the Central Control Board demonstrates that, under certain circumstances – and especially moments of crisis – significant shifts in established policy equilibrium can occur and can have demonstrable impact.

The history of alcohol control movements in the UK, dating back to the anti-gin campaigns of the eighteenth century, demonstrate that advocacy for restrictive alcohol policies has often taken the form of coalitions which incorporate moral entrepreneurs, medical specialists, political actors and public communicators. These coalitions can be internally diverse (such as the Victorian temperance movement) but cohere around fundamental, indeed axiomatic, values. These include the classification of alcohol (or, in early iterations, distilled alcohol) as an essentially harmful substance and the belief that reduced overall consumption will produce social benefits. Trade interests also have a long history of multilevel policy influence ranging from local networks of influence linking, for instance, local producers and regulators to high-level Parliamentary lobbying (at Westminster today, for instance, the

All-Party Parliamentary Beer Group remains the biggest single all-party group and it plays a key influencing role). In this often asymmetric contest for power, alcohol control coalitions work to counterbalance the influence of alcohol interests as well as to promote defined policy goals. Therefore, the success of alcohol control advocacy should not simply be measured by demonstrable policy change, but also by the extent to which industry-friendly legislation is restricted or public opinion is shifted in regard to policy interventions.

Policy equilibrium is a long-standing feature of alcohol control in Britain. In other words, established principles (such as licensing by magistrates) and networks of influence tend to become entrenched, militating against policy change. However, there are clear instances where this equilibrium has been punctured. The 1830 Beer Act, for instance, was an explicit attack on the power of property-owning brewers in favour of the new economic concept of free trade. In 1915, the Central Control Board severely curtailed the freedom of brewers and landlords to retail alcohol and, in some areas, introduced the wholesale nationalization of the alcohol industry. Such cases powerfully illustrate the degree to which policy shifts occur when policy 'streams' converge. In 1830, for example, widespread public concern over the adulteration of beer by brewers converged with the development of new economic theories on free trade and the rising power of the Whig Party in Westminster to open a policy window that, for a period, challenged the basic principle of magisterial power in licensing. Similarly, in 1915 the social impact of war with Germany, widespread fear over the under-production of munitions in British factories, and high-level support for temperance within the ruling Liberal Party made the otherwise highly improbable establishment of the CCB politically viable.

As Room et al. (2009) have argued, policy is as likely to follow, or amplify, wider cultural changes in drinking behaviours as it is to initiate such developments. The key questions posed by the historical development of alcohol policy in Britain therefore, are not *if* policy shifts culture but (1) in which instances policy can be seen to initiate, amplify or constrain cultural trends, and whether these effects are long- or short-term; (2) whether impactful policies were restrictive or liberalizing; (3) whether they were aimed at populations or subgroups; (4) under what circumstances breaks in policy equilibrium (whether towards liberalization or control) occur; and (5) whether those breaks in equilibrium prove durable. Those questions remain pertinent today, and remind us that alcohol policy is multidimensional not only in its goals, but in its journey from principles to practice.

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6 Alcohol policy in Scotland, 1990–2014

Introduction

Scotland has a distinctive drinking culture and alcohol policy context. Because consumption data has only recently been gathered separately from the rest of the UK, the historical evidence on overall consumption levels and patterns is limited (though spirits drinking has always been more prevalent); however, it is clear that consumption has been higher than the UK average for the past 20 years, as have levels of alcohol-related health harms. In 2011, 20 per cent more alcohol was sold per adult in Scotland than in England and Wales, and alcohol mortality rates among men were 1.8 times higher in Scotland (Robinson et al., 2011: 4) (Figure 6.1).

Scottish alcohol policy has also often diverged from England (Nicholls, 2012). In 1913, for example, legislation allowing local forms of prohibition was passed and, famously, in 1922 the Scottish Prohibition Party candidate Edwin Scrymgeour unseated the incumbent Winston Churchill in the constituency of Dundee, and held the seat for a further nine years. Scottish licensing has always been regulated under separate Acts of Parliament to the rest of the UK and, while many of the broad trends in licensing practice have matched the rest of Britain, Scottish licensing has often diverged on key points of detail (on pricing, by contrast, the Scottish Government has far less power, with excise duties being set at Westminster). In 1976, for example, new licensing legislation extended opening hours in Scotland while those in the rest of the UK remained subject to restrictions set out in the 1964 Licensing Act. Furthermore, while alcohol policy always touches on wider political principles and ideas of nationhood, this relationship is especially pronounced in Scotland. As the then Deputy Minister for Justice put it in 2000, 'Alcohol – its effects, its control and its production – is a strand that has always run through Scottish reformist politics [and] alcohol is a theme that also runs through Scottish culture' (Scottish Parliament, 2000).

The establishment of the Scottish Parliament in 1998 contributed to a policy context in which alcohol issues were increasingly framed around national concerns and questions regarding 'Scotland's relationship with alcohol'. This

further politicized alcohol policy in novel ways, creating clear differences between not only the Scottish Labour and Conservatives Parties but also, critically, the Scottish National Party. The long association between alcohol policy and reformist Scottish politicians became linked to new debates about Scotland's future as a devolved, and possibly independent, nation. This provided scope for radical thinking on alcohol policy, and a conscious divergence from established political framing, that created opportunities for public health-oriented alcohol policy beyond those available in England.

The establishment of the Scottish Parliament came shortly after the publication of the first European Charter on Alcohol in 1995, which called for the formulation of 'broad-based programmes' to identify and tackle alcohol harms at a national level and to focus on price, availability and marketing (WHO, 1995). The devolved Scottish Government moved faster to apply the principles of the European Charter than the Westminster Government, and it embedded them more firmly in its policymaking – something that would eventually culminate in the adoption of minimum unit pricing (MUP) by the Scottish Government and, perhaps equally significantly, the adoption of 'protecting and improving public health' as a licensing objective under 2005 Licensing (Scotland) Act. Both measures, as well as other restrictions on discounts for bulk purchases and controls on the 'overprovision' of alcohol outlets, faced stiff resistance from sections of the alcohol industry and represented something of a rupture in a previously stable consensus on the broad formation of licensing and alcohol pricing policy. Their adoption was strongly influenced by alcohol control advocates working directly to promote public health policy models, and it is an example of how a combination of external conditions and shifts in the political landscape can create opportunities for significant change in alcohol policy.

Devolution and policy opportunities

Moves towards the development of a national framework on alcohol harm reduction began prior to the introduction of Scottish devolution in 1998. In 1992, a Scottish Home and Health Department Report had identified alcohol as a key health concern and set a 20 per cent reduction in misuse as a national target (Graham et al., 2000: 3). In October 1997, the Scottish Office convened a conference entitled 'Alcohol problems – working together' in Glasgow. Its aim was to 'contribute to the process of the development of a national strategic framework for Scotland' and it led to the formation of a working group to take the framework development forward (Scottish Office, n.d.: 5). The working group recommendations included a review of licensing laws: an idea that was gaining political traction in both Scotland and England at the time; however, its key recommendation was the establishment of an advisory committee to both review evidence on alcohol harms and to establish robust monitoring of the impact of alcohol policies. The Scottish Advisory Committee on Alcohol Misuse (SACAM) was duly established and first met in April 1999. It would

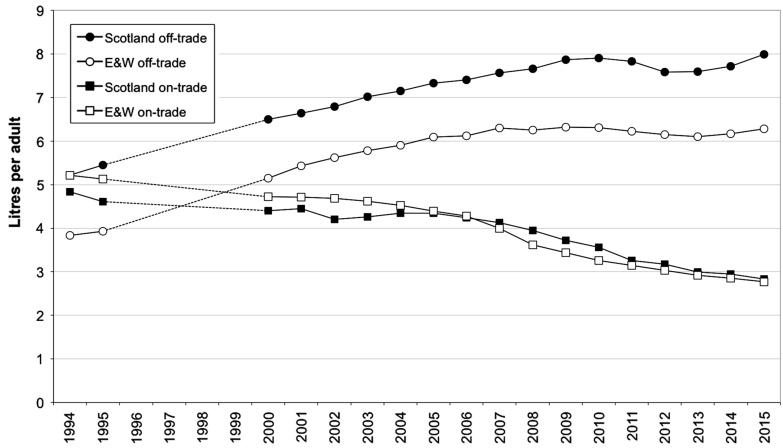

Figure 6.1 Litres of pure alcohol sold per adult in Scotland and England and Wales
Source: Adapted from NHS Scotland (2016).

play a key role in developing new policy frameworks over the following years as well as collating evidence on harm.

While clearly built on a partnership model, SACAM had a strong public health membership and acquired political weight when the then Deputy Minister for Health, Malcolm Chisholm, took up the role of chairman in 2000, a role subsequently taken up by Chisholm's successor as Deputy Health Minister, Mary Mulligan. SACAM's membership included representatives from the Scottish Government and industry bodies, but also a significant number of individuals from primary care, public health and alcohol treatment services. It provided a focal grouping for the development of thinking around national alcohol harms and provided a forum in which proponents of health-oriented approaches to alcohol policy could engage directly with the new Scottish Executive.

The establishment of the Scottish Parliament in 1998 significantly increased the range of powers that were devolved to Scotland, including – critically – responsibility for health policy (though Scotland had had considerable autonomy on health policy prior to formal devolution). The need to establish a devolved public health framework, combined with a longer-term increase in both alcohol consumption and alcohol harms, focused political attention onto the issue of alcohol. In 1998, a White Paper entitled *Towards a Healthier Scotland* identified alcohol misuse as a key area for government action on health and set out targets for a reduction in the number of people exceeding weekly recommended guidelines for alcohol consumption from 33 per cent to 29 per cent of men and from 13 per cent to 11 per cent of women. The commitments set out in *Towards a Healthier Scotland*, alongside the establishment of SACAM following the 1997 conference on alcohol, laid the ground for extensive activity in both research and policy over the following 15 years.

Despite this initial impetus, however, momentum on developing a national plan increased slowly. In December 2000, a short, but long-awaited, debate on national alcohol policy took place in the Scottish Parliament at which Malcolm Chisholm announced that work towards a national Plan of Action would begin immediately. Preparation towards this plan involved extensive reviews of the existing evidence on alcohol policy and harm as well as negotiations with the alcohol industry on harm reduction partnerships. Inevitably, these actions shone a light on fundamental differences between population-oriented alcohol policies favoured by health advocates and the kind of demand-side prevention and education methods broadly favoured by the alcohol industry.

In this early period, differences were already emerging between the leading political parties with regard to how alcohol policy issues should be framed. Most significantly, the Scottish National Party was committed to approaching alcohol policy as an issue of national regeneration and something that could tackle a redeemable flaw in Scottish culture more broadly. In the December 2000 debate, SNP representatives called for action on the 'scourge' of heavy drinking and the need to 'change the culture in Scotland that celebrates and glorifies overindulgence in alcohol'. Furthermore, Scottish National Party Members of the Scottish Parliament (MSPs) had accepted the broad parameters of the public health perspective on alcohol policy: during the December 2000 debate, the Glasgow MSP Kenneth Gibson called for the government to endorse the WHO's 2000 European Action Plan, while Shona Robison MSP described alcohol as 'a major public health issue' for Scotland (Scottish Parliament, 2000). By contrast, Conservative MSPs argued that liberalizing amendments to licensing legislation could encourage cultural change by encouraging a café society, while Labour MSPs argued from the position that most alcohol consumption was moderate, and partnerships with the industry were key to tackling harms at the margin. In the 2000 debate, then, political positions were set out which would remain largely unchanged for a number of years. However, while they differed on fundamental points of principles, the idea that alcohol 'seems to be part of the Scottish psyche' was commonly held.

Developing a national plan for action

Having committed to the development of a national action plan, the Scottish Government commissioned a number of research reviews that considered the international evidence on alcohol harms. The most extensive of these was entitled *Effective and Cost-Effective Measures to Reduce Alcohol Misuse in Scotland*, published first in 2002 with a subsequent updated report in 2004 (Ludbrook et al., 2002; Ludbrook, 2004). Both provided support for a number of key public health principles. The 2002 review made extensive use of *Tackling Alcohol Together*, an edited collection overseen by the Society for the Study of Addiction, which sought to promote international evidence in the context of UK alcohol policy and which identified the WHO *European Charter on*

Alcohol as key to developing 'alcohol policy which boldly acknowledges and balances the conflicting interests for the community' (Raistrick et al., 1999: 19). The 2002 evidence review was, like Raistrick et al., cautious about the claims for interventions on price, availability and marketing on alcohol harms. It recognized that the heaviest drinkers were less price-responsive than more moderate consumers and it cited only 'mixed' evidence that marketing increased either alcohol consumption or associated harms (Ludbrook et al., 2002: 14, 2). Nevertheless, it identified action on price and availability, alongside improved provision of brief advice in primary care, as the most promising policy options for reducing alcohol harms overall.

When it was published in 2002, the Scottish Executive's *Plan for Action on Alcohol Problems* accepted that both alcohol consumption and harms had been rising in Scotland, that action was needed to tackle this, and that 'changing cultures around drinking involves and affects everyone' (Scottish Executive, 2002a: ii). However, while it accepted the principle that alcohol harms existed along a continuum (rather than being isolated among problematic minorities), and while it drew attention to the significant health inequalities associated with alcohol, it asserted that there was no single drinking culture and so interventions should be closely targeted at specific subgroups (ibid.: 2, 8, 13, 15). Consequently, 'tackling binge drinking among 18–35 year olds [was] to be the major focus' of the plan rather than a reduction in consumption at a population level (Scottish Executive, 2002b). In addition, the plan focused on reducing consumption among under-age drinkers. As the consultant psychiatrist, Dr Peter Rice (who would go on to chair Scottish Health Action on Alcohol Problems) noted, this 'narrow focus', when looked at from a public health perspective, represented only 'a small part of a broader picture' (Rice, 2002).

The 2002 *Plan for Action* outlined a range of policy interventions, and – importantly – helped in the development of more systematic data collection on Scottish drinking through the Information Services Division of NHS Scotland. However, its specific commitments were limited to schools education, a media information campaign, the development of a framework for service provision for problem drinkers, and better partnership with the industry. As such, it foreshadowed a similar outcome for the 2004 *Alcohol Harm Reduction Strategy for England*, in which extensive preliminary research identified supply-side controls on price and availability as likely to reduce harm, but the final strategy identified voluntary partnership with the industry as the preferred approach.

Licensing reform

The 2002 *Plan for Action* '[did] not address the role of licensing in drinking culture, and deliberately so' (Mulligan, 2002). Licensing was being radically revised in England and Wales, and the Scottish Government opted for a full, and separate, review of licensing to be launched in 2001 under the Chairmanship of the then Sheriff Principal, Gordon Nicholson. The Nicholson review was

given the remit to consider all aspects of the existing licensing regime and it took advice from representatives of the police, retailers, producers and health bodies.

Broadly speaking, the findings of the Nicholson review mirrored the licensing reforms already being finalized for England and Wales: licensing would be fully managed by local authorities, all vestiges of the principle of 'need' would be removed and instead a presumption to grant all applications would be introduced, with the caveat that objections to licence applications could be lodged in consideration of tightly defined 'licensing objectives'. The licensing objectives, which applications would be expected to uphold, were the same as for England and Wales, but with one critical exception. The Nicholson Committee proposed a fifth licensing objective: 'the promotion of public health' (Nicholson Committee, 2003: 44). This was a major victory for advocates seeking to establish health as a statutory consideration in the licensing process. The idea of a public health consideration for licensing had been mooted in the 1997 conference on alcohol, though it was only mentioned briefly in the subsequent report. However, it was seen by many in the public health community as a critical concession to the principle that licensing was more than an administrative process, but one which should contribute actively and strategically to alcohol harm reduction.

The Nicholson Committee report echoed previous debates in the Scottish Parliament in asserting that many alcohol-related problems were 'deeply engrained in the Scottish psyche', and it argued that 'reform of the law will not of itself bring about changes' (ibid.: 1–2). This framed cultural change (or, at least, changes in negative aspects of drinking culture) as operating largely outside of legislative influence. Furthermore, despite engagement with health both in terms of the committee itself (three of whose 13 members were from health bodies) and through ongoing communication with Alcohol Focus Scotland (formerly the Scottish Council on Alcohol), the broad framing of the final report followed an established perspective which viewed alcohol harms as marginal, even when acute. The first of 'seven guiding principles' set out at the start of the report proposed a politically liberal frame for what followed, resting on a broadly dichotomous analysis of alcohol-related harms. It stated that since 'the majority of people in Scotland drink sensibly and responsibly, the licensing system should be as free from restriction as possible' (ibid.: 3).

The Nicholson recommendations were accepted in full and formed the basis of the 2005 Licensing Act – which was implemented in September 2009. While the broad framing for the role of licensing echoed that enshrined in the 2003 Licensing Act for England and Wales (and which had shaped licensing legislation since the early 1960s), the Scottish Licensing Act came, demonstrably, closer to an accommodation with health perspectives than its English equivalent. In addition to the introduction of a public health licensing objective, the 2005 Act also gave more strength to local authorities in regard to outlet density. Whereas in England there was a non-statutory provision

allowing local authorities to establish 'cumulative impact zones' in limited areas of their jurisdiction, in Scotland every local authority was required to produce a statement on 'overprovision' which would set out whether there were problems of outlet density in their areas and what, if anything, they intended to do to address those problems. Taken together, the public health objective and the requirement for overprovision policies would form the backbone of subsequent efforts by public health advocates to influence alcohol licensing practice such that its primary focus became reducing population-level harms rather than case-by-case regulation and administration.

The Nicholson review also touched on the impact of off-sales on the alcohol market, specifically their capacity to encourage 'uncontrollable drinking in public places' (ibid.: 38). This recognition of the impact of sales in shops and supermarkets, albeit through the lens of a concern over public disorder rather than long-term health, was something conspicuously absent from both the New Labour White Paper, *Time for Reform* (Secretary of State for the Home Department, 2000) and the 2003 Licensing Act in England. Despite a significant (indeed, transformative) rise in the proportion of alcohol being sold for home consumption across the UK, English policymakers paid scant attention to this change. In Scotland, by contrast, the rise of off-sales was subject to serious consideration and had been identified as a 'prime consideration' for licensing by the 1997 working group (Scottish Office, n.d.: 18). In 2003, partly in recognition that the issue had not been sufficiently dealt with in the Nicholson review, the Scottish First Minister, Jack McConnell, announced the formation of a separate working group to look specifically at the impact of increased off-sales in local communities (Daniels, et al., 2004: 1). Although limited in time and resources, this review produced a series of recommendations for how off-sales and home consumption could be addressed through licensing provisions. A further review was carried out in 2007 that identified price as 'a strong force in this market' (Human Factors Analysts, 2007: 5). The 2007 review also provided one of the first discussions of 'front loading' (drinking at home prior to going out to a pub or club) in UK policy literature, and asserted that 'the price difference between on-sales and off-sales is often cited as the reason why young people "front load" before going out at the weekend' (ibid.: 29).

This focus on the shift in consumption from pubs and bars to the home would have a marked impact on Scottish alcohol policy. In particular, the Alcohol Etc. (Scotland) Act of 2010 specifically targeted retail practices in shops and supermarkets: outlawing multibuy promotions (e.g. discounts on cases of wine compared to individual bottle prices), and extending existing bans on discounts and the provision of free alcohol in pubs and clubs to the off-trade. Furthermore, the adoption of minimum unit pricing as a policy by the Scottish National Party was very clearly a response to the social and health impacts of cheap alcohol in shops and supermarkets. The government of England and Wales was much slower, much less dynamic and much less effective in addressing what is, sociologically and

economically, the key development in drinking culture across the UK since the 1970s.

Changing Scotland's relationship with alcohol

It is clear that policy development on alcohol throughout this period was shaped not only by empirical evidence but also by the political framing of alcohol by the major parties in the context of a newly devolved government. The question of culture: how it was defined, how it reflected national aspirations, and how it was shaped by policy decisions, was critical to this process. In 2007, for instance, an update to the 2002 *Plan for Action* was published. This had been largely developed under a Labour and Liberal coalition that had governed Scotland since 2003. This update rejected the idea of wholesale cultural change, and focused instead on an 'innovative partnership with the drinks industry', education, improved server training and improved support for existing drug and alcohol services (Scottish Executive, 2007).

The Scottish Parliament Election of 2007, however, saw significant gains for the Scottish National Party allowing them to form a minority government and take control of health policy. The following year, the SNP-led government published a strategy paper entitled *Changing Scotland's Relationship with Alcohol*, which set out both the key issues and the possible policy responses in a new way. Here, decisive action on alcohol harms was allied explicitly to the 'ambition of a successful and flourishing Scotland' (Scottish Government, 2008: 1). Critically, the conceptual framing of the problem was drawn directly from the public health perspective on alcohol and the approaches supported by the WHO. In her introduction, the Deputy First Minister, and Cabinet Secretary for Health, Nicola Sturgeon, asserted that Scotland 'can no longer view alcohol misuse simply as an individual choice' (ibid.: 1), and the paper went on to outline a new approach based on population models, stating that

> [the] World Health Organization has stated that alcohol interventions targeted at vulnerable populations can prevent alcohol-related harm, but that policies targeted at the population as a whole can have a protective effect on vulnerable populations and reduce the overall level of alcohol problems.
> (ibid.: 13)

The paper accepted public health analyses of the relationship between affordability and consumption and the need to tackle both price and availability in order to reduce harms (ibid.: 10–11). It cited the WHO's view that voluntary agreements and educational interventions are less effective than supply-side interventions (ibid.: 13) and also adopted the language of 'denormalization' which, by that stage, had become commonplace in public health literature, asserting that 'by taking steps to "denormalise" alcohol we can encourage and support people to make more positive choices about alcohol' (ibid.: 11).

Changing Scotland's Relationship with Alcohol represented the substantial acceptance of WHO principles on alcohol policy by the ruling Scottish National Party. Rather than argue from the principle that most consumption is harmless, while accepting problematic drinking needs to be tackled at the margins, *Changing Scotland's Relationship with Alcohol* stated that 'any comprehensive strategy must seek to reduce consumption if we are to be successful in reversing the negative trends in harm' (ibid.: 16). Furthermore, it accepted the WHO policy model on the link between harm, affordability and pricing policies, insisting that 'given the link between consumption and harm and the evidence that affordability is one of the drivers of increased consumption, addressing price is an essential component of any long-term strategic approach to tackling alcohol misuse' (ibid.: 18). In its 2007 General Election manifesto, the SNP had promised to 'do more to address public concerns about licensing laws and the advertising, availability and affordability of alcohol' (Scottish National Party, 2007: 43). *Changing Scotland's Relationship with Alcohol* set out radical plans for achieving this goal, the most controversial of which was minimum unit pricing for alcohol retail.

Minimum unit pricing

The first Ludbrook review in 2002 identified price as a key driver of alcohol consumption, while noting that the heaviest drinkers are the least price-sensitive (Ludbrook et al., 2002: 14). The second review, completed in 2004 – one year after the publication of *Alcohol: No Ordinary Commodity* – argued the case for pricing interventions more strongly again and cited Babor et al. (2003) as providing key 'additional evidence' to make the case (Ludbrook, 2004: 4). A 2006 evidence review of alcohol harms produced by NHS Scotland was more emphatic, stating that

> There is now considerable evidence that a range of fiscal, legislative and other measures are among the most effective in reducing alcohol consumption and alcohol-related crime, violence and disorder. However, the strength of the evidence of the effectiveness of these interventions is not reflected in measures to reducing [*sic*] alcohol-related harm that have been implemented either at a Scottish or a UK level.
>
> (McKenzie and Haw, 2006: 50)

However, since fiscal instruments were not devolved to the Scottish Government, and since taxation on wine was further constrained by European Union directives, there seemed little the Scottish Government could do to directly influence this aspect of the alcohol market. However, an expert group convened in 2007 by the newly established Scottish Health Action on Alcohol Problems dramatically shifted the debate on pricing by proposing a novel approach to the control of cheap alcohol: minimum unit pricing.

Scottish Health Action on Alcohol Problems had been established by the Scottish Intercollegiate Group on Alcohol (SIGA, which had itself been lobbying for health perspectives on alcohol for some time) based within the Scottish Medical Royal Colleges, and Evelyn Gillan – who would go on to become Chief Executive of Alcohol Focus Scotland – was appointed its Director. The Scottish Council on Alcohol had been renamed Alcohol Focus Scotland in 2001. The expert group convened in 2007 included SHAAP, Alcohol Focus Scotland, members of the team involved in the 2002 and 2004 evidence reviews, two representatives of the Institute of Alcohol Studies, the liver specialist Dr Nick Sheron, the social marketing academic Professor Gerard Hastings, representatives from NHS Scotland, as well as an observer from the Scottish Government. While the group included two trade representatives in an open session and received written submissions from trade bodies, it was predominantly made up of individuals whose support for WHO alcohol policy models was a matter of public record.

The report which emerged from this workshop was entitled *Alcohol: Price Policy and Public Health*. In one respect, it was a detailed reiteration of the key principles expressed in *Alcohol: No Ordinary Commodity*: that alcohol harms should be tackled at a population level and that supply-side interventions to make alcohol less affordable were a primary means of achieving this. The authors identified recent Scottish policy as moving towards an alignment with the principles set out in Babor et al. (2003), noting that 'Scotland is already showing leadership in the UK by enshrining a public health principle in the new licensing legislation, acknowledging that alcohol is no ordinary commodity, and outlawing irresponsible drinks promotions in pubs and clubs' (Gillan and McNaughton, 2007: 13). However, the report also recognized that conventional action on price through amendments to taxation was not only politically impractical but also liable to be undermined by the capacity of large retailers to simply absorb tax increases, especially given the importance alcohol sales played in attracting customers to supermarkets. As an alternative, *Alcohol: Price Policy and Public Health* proposed setting a minimum price at which alcoholic drinks could be sold, based on their strength.

Minimum retail pricing was not an entirely new idea. In 1973, the Clayson Committee had suggested that, in the specific case of 'cheaper heavy wines' the government should consider 'the possibility of taxation changes so that the duty on such wines be more closely related to their alcoholic content and the minimum price at which these wine could be sold be significantly increased' (Scottish Home and Health Department, 1973: 9). The Nicholson Review had noted that voluntary local minimum pricing schemes existed among on-trade retailers in 'at least two' licensing board areas in 2003 (Nicholson Committee, 2003: 128) and similar schemes and also been noted in two Scottish Executive reports into off-sales (Daniels et al., 2004: 3; Human Factors Analysts, 2007: 25). The UK Government took advice from the Office of Fair Trading on the legality of local minimum pricing schemes in 2004 (House of Commons, 2004; Bennetts, 2008). However, the idea of minimum pricing as formal

government policy, applicable across the trade in its entirety, was a very different proposition and the SHAAP report contained detailed legal guidance which argued that, since this was a public health measure, it was both an issue for the devolved government and legal under EU trade regulations.

Minimum pricing was an apparently neat solution to a seemingly intractable problem. While it made sense to argue that price was a determinant of consumption, it was well known that supermarkets were more than capable of absorbing limited tax increases and that loss-leading on alcohol by supermarkets was commonplace (Gillan and McNaughton, 2007: 34–5; Bennetts, 2008). Minimum pricing appeared to resolve that problem by setting a floor price below which alcohol could not be sold. At a moment when the sale of cheap alcohol – especially vodka and white cider – was increasingly associated with public disorder, and as alcohol mortality and hospitalization rates were soaring, minimum pricing offered an apparently powerful policy for addressing 'Scotland's alcohol problem'. The Scottish National Party, having now allied itself to the public health perspective on alcohol, having relatively weak political ties to the established alcohol industry, and with the support of prominent ministers such as Nicola Sturgeon and Kenny MacAskill, announced its support for MUP in *Changing Scotland's Relationship with Alcohol* and, following consideration of legislative options, introduced a new Alcohol Bill to the Scottish Parliament in November 2009 which included powers to enforce minimum retail pricing (at a level yet to be decided) under an amendment to the 2005 Licensing Act.

By the time the Alcohol Bill came to be debated in the Scottish Parliament, minimum pricing had already begun to emerge as a policy around which the wider UK health community could coalesce. Research by the University of Sheffield, originally commissioned by the UK Department of Health to explore a range of alcohol policy options, appeared to show that minimum unit pricing would have a dramatic impact on alcohol harms, and especially the kind of long-term population-level health indicators which advocates felt were often missing from both media and political debates more broadly. In Scotland, minimum unit pricing not only addressed specific concerns over cheap alcohol and the rise in off-sales but it provided the Scottish National Party with an opportunity to show innovation, leadership and the capacity to change Scottish culture for the better.

A particular catalyst, acknowledged as such by a number of key players, was the publication in 2006 of an article in *The Lancet* containing a graph comparing trends in liver mortality for Scotland with the rest of Europe (Leon and McCambridge, 2006). The graph quickly became familiar in policy circles, and, according to one civil servant, the curve for Scottish liver mortality rose like 'the north face of the Eiger' while almost all other European countries were showing a decline (Katikireddi et al., 2014: 5). As a striking visual depiction of the Scottish 'alcohol problem', the graph served a powerful symbolic purpose by combining scientific evidence with memorable graphic imagery.

Also important at this juncture was the fact that Scotland had, in 2006, also been the first UK nation to introduce a ban on smoking in public places. The unexpected success of this initially controversial public health measure gave a significant boost to the confidence of alcohol control advocates, among many of whom the principle of 'learning from tobacco' was starting to take hold.

In many respects, minimum unit pricing faced a much more amenable political context in Scotland allowing a 'policy window' to open up more widely than was the case in England and Wales (Katikireddi et al., 2014; Nicholls and Greenaway, 2015). However, the Scottish Labour Party and the Conservatives both resisted the policy. Despite some initial signs of support for MUP, Scottish Labour instead backed stricter control on alcohol containing caffeine (a direct attempt to target the tonic wine Buckfast, which enjoys a particular subcultural popularity in Scotland). As a result, minimum pricing was dropped from the 2010 Alcohol Act – though controls on multibuy discounts remained: another key divergence from policy in England and Wales.

The Scottish National Party, however, remained committed to MUP and it appeared in their 2010 General Election Manifesto – though, notably, it was presented here as an intervention that was 'targeted on the cheap alcohol that fuels so much of the antisocial behaviour and violence on our streets' (Scottish National Party, 2010: 28–29). When the SNP achieved an outright majority in that Election, it cleared the way for them to press ahead with MUP. Opposition from other parties also began to weaken at this time: while the Green Party had always been supportive, the Liberal Democrats switched to supporting MUP in 2011 and, after MUP was announced as UK Government policy in the 2012 Alcohol Strategy, the Scottish Conservatives also fell in behind the policy subject to it being declared legal. The SNP victory also suggested that high profile policies on restricting the alcohol market were not as electorally damaging as was often assumed. A new *Alcohol Minimum Pricing (Scotland) Bill* was introduced in October 2011 and was passed in May 2012 with the support of all parties except Labour, who abstained (Woodhouse and Ward, 2014: 11). The Minimum Pricing Act introduced a minimum unit price for alcohol of 50 pence per unit, making Scotland the first country in the world to introduce MUP in this form.

Predictably, the policy was challenged fiercely by major alcohol producers under the leadership of the politically influential Scotch Whisky Association. Strikingly, however, industry opinion was split on the policy: the Scottish Licensed Trade Association (which represented pubs) came out in support, as did Tennent's – the largest Scottish brewer. As was the case across the UK, opposition within the trade came primarily from those representing pubs and brewers, both of whom had been badly hit by the kind of price discounting that had become commonplace in the off-trade.

The Scotch Whisky Association immediately launched legal proceedings, claiming MUP was not only a breach of European competition law but even the 1707 Act of Union between England and Scotland, which stipulated that there must be a free market across the United Kingdom. The initial

objections were rejected by the Scottish Court of Session in May 2013, but became subject to a protracted legal challenge at the European Court of Justice (ECJ). The Scotch Whisky Association sought to demonstrate that MUP was disproportionate in affecting the whole population, and thus in contravention of European free trade regulations. In response, the Scottish Government argued that the measure was not, in practice, a whole-population intervention but one that – as demonstrated in updated models produced by the Sheffield Alcohol Research Group – targeted heavy drinkers in particular (see e.g. Holmes et al., 2014). Strikingly, the legal challenge highlighted a tension in the framing of MUP in relation to wider public health policy goals. Having been initially understood as a whole-population measure, which helped reduce harms by pulling overall consumption down, it later came to be presented as a targeted measure that had little impact on moderate drinkers (thus moving closer to the kind of dichotomous model of harms challenged by whole-population perspectives).

The question of proportionality would remain at the heart of the deliberations within the European Court of Justice, whose final ruling on the legality of MUP was published in December 2015. The ECJ accepted that, in principle, MUP was not in contravention of European trade law since member states could impose regulations that had the potential to restrict free trade if the goal was the 'protection of human life and health' (ECJ, 2015: para 25). However, such a measure had to be shown to be proportionate, and to be more effective in achieving its public health goals than alternative measures. The question of whether MUP was aimed at reducing consumption across the whole population, or was targeted primarily at harmful drinkers (and, especially, less affluent harmful drinkers) emerged as the key issue. While accepting the legality of MUP in principle, the ECJ – somewhat unexpectedly – took issue with the argument that MUP was specifically justified on the grounds that it was targeted. It suggested that this made the policy *less*, rather than more, proportionate since it potentially ran counter to the stated purpose of the Scottish Government's alcohol strategy, which was to reduce consumption across the population (ibid.: paras 30–50). The ECJ also allowed that an increase in general alcohol taxation was also permissible in pursuit of public health goals. In concluding what was, in the view of many commentators, a convoluted judgement the ECJ ruled that MUP was legal in principle, but that it could only be adopted if it could be shown to be more effective in achieving the goal of protecting public health than general alcohol taxation. Furthermore, it referred the case back to the Scottish courts to make a final decision: thus leaving health advocates in the position of having to further demonstrate that MUP would have general health benefits over and above what was possible through taxation. For their part, industry lawyers were left in the peculiar position of having to argue that taxation was, indeed, an effective way of reducing harms – even as the SWA continued to lobby forcefully for duty cuts to stimulate the alcohol market. Their strategic goal was to prevent MUP at any cost: alcohol taxation is not devolved to the Scottish Government, so winning the argument on

tax, while apparently counter to standard trade claims, would make pricing interventions in Scotland far less likely. Once again, the seeming simplicity of MUP as a policy idea proved deceptive.

Rethinking alcohol licensing

While pricing became the focus for both health advocates and policymakers across the UK from the late 2000s, issues regarding alcohol availability remained high on the political agenda in Scotland. This was, in part, due to the continuing political salience of the public disorder and health harms associated with alcohol in Scotland and the acceptance of the link between availability and harm in *Changing Scotland's Relationship with Alcohol*. It also remained a key focus of health advocates. Although the inclusion of a public health licensing objective had been a victory for supporters of the WHO principles on alcohol policy, practical application of this legislation had proved a challenge. Local licensing boards were not familiar with the application of public health data to their day-to-day decision-making, health teams had very little experience in the pragmatic, case-by-case practices of licensing, and the alcohol industry saw the public health objective as a direct threat to their interests (Nicholls, 2015). As a consequence, there was only limited application of public health considerations by licensing authorities in the years immediately following the introduction of the public health objective (MacGregor et al., 2013: 59; McNaughton and Gillan, 2011: 26; Mahon and Nicholls, 2014).

In 2011, SHAAP and AFS convened an expert group based on similar principles to that which had proposed MUP in 2007. This expert group, however, looked at availability and possible changes to licensing legislation. In particular, it explored ways in which the public interest role of licensing, as enshrined in the requirement for licensing to 'protect and promote public health', could be further embedded in both law and practice. The report arising from this meeting was entitled *Rethinking Alcohol Licensing*, and it sought not only to outline legislative means by which availability could be better tackled by licensing authorities but also to initiate a reconsideration of what the role of licensing should be in regard to wider alcohol harms. Licensing, it argued, should not simply be a matter of administration but of longer-term strategy; it should not simply guarantee the smooth running of a free market but should directly seek to reduce harm through intervening in market processes. It argued that local licensing boards should put a primary focus on the availability of alcohol and the density of outlets in their areas and that strategic licensing policies should form the core of licensing practice and set out specific proposals for achieving this shift (McNaughton and Gillan, 2011: 30–42). A number of these propositions were subsequently included in a public consultation on licensing law reform published by the SNP Government (Scottish Government, 2012).

By maintaining a focus on availability, and specifically the issues of outlet density and the increasing influence of the off-trade in overall consumption

levels, Alcohol Focus Scotland and SHAAP were able to promote public health policy models at the highest level, at least within the Scottish National Party. The notion of 'rethinking' licensing, such that it is seen as a public interest practice rather than a regulatory and administrative function, has profound implications in regard to how alcohol policy at a local level is conceived. Most significantly, it assumes that the regulation of alcohol availability should proceed, primarily, from the principle that alcohol is a potential source of harm and a non-ordinary commodity and that the role of licensing is to strategically tackle alcohol harms, rather than merely ensure regulatory requirements are adhered to on a case-by-case basis. The adoption of such an approach would challenge over fifty years of policy thinking around licensing and be a significant step towards the mainstreaming of alcohol policies based on the WHO principles.

Scottish exceptionalism

Scottish alcohol policy has always diverged in some respects from England and Wales, but how can the distinctive prioritization of public health concerns since the late 1990s be best understood? There are a number of convergent social, economic and political contexts that can be identified as jointly pushing the new Scottish government towards a closer adoption of WHO policy models. As these overlapped and began to create a more unified pressure, the opportunity arose for political action: a policy window opened and a willing governing party, under the leadership of individuals with a strong personal commitment to the issue, was prepared to challenge industry interests in ways that were hitherto inconceivable (see Katikireddi et al., 2013; Katikireddi et al., 2014).

First, Scottish drinking culture and the harms associated with high consumption reached a point of crisis. The idea of drinking being 'part of the Scottish psyche' is not new; however, not only were the late 1990s a period of very high consumption across the UK, but the collection of separate consumption and harm data for Scotland – partly a result of the establishment of Monitoring and Evaluating Scotland's Alcohol Strategy (MESAS) as a core element of the national Strategy – showed just how far ahead it was of England and Wales on both counts (Robinson et al., 2012). This also had a political dimension: supporting further restrictions on opening hours for off-sales in a 2005 debate on licensing reform, the prominent Labour MSP Wendy Alexander remarked that:

> Keir Hardie stood in North Lanarkshire on a platform that promised three things. He said that we should bring in home rule – we have done that – and proportional representation, which is being brought about. The third part of his platform was temperance and therein lies the issue.
>
> (Scottish Parliament, 2005)

The devolution of powers, including health policy, to Scotland created an opportunity for a reconsideration of where alcohol sat in the national policy framework. Alcohol is, notoriously, a cross-departmental policy issue (Baggott, 2010; Greenaway, 2011) but since health was a key policy area for the new government, it made a health-oriented focus on alcohol attractive to politicians seeking to demonstrate the power and validity of the new government structures. Furthermore, the Scottish National Party not only accepted the evidence linking population consumption to chronic harms but they also selected alcohol as an element of Scottish culture which their nationalist programme should seek to challenge. In this regard, the SNP echoed the work of other nationalist movements throughout history. In the nineteenth century, for instance, many Irish nationalists adopted temperance on the grounds that national renewal required greater sobriety – though, as we see elsewhere in this book, temperance was sometimes adopted as a strategic gesture by Irish politicians rather than an unambiguous commitment to the principles of national sobriety. Nevertheless, the nineteenth-century slogan 'Ireland sober, Ireland free' resonates with the modern Scottish Nationalist emphasis on the need to 'change the drinking culture of Scotland for good' (see Malcolm, 1986).

The work of the WHO European Office also played a key role. The call for national alcohol strategies in the 1993 and 2005 Action Plans created an impetus for alcohol issues to be targeted at a national level (WHO, 1993; 2000). The 1997 conference on alcohol was geared towards the production of the kind of national plan being championed by the WHO at the time, and while the 2002 *Plan for Action* was probably a disappointment to many health advocates, it created a framework within which population measures could be more effectively advocated. The establishment of SHAAP as part of the national plan provided a key platform for health advocates to organize and communicate their messages and the work of Alcohol Focus Scotland was also critical in this regard. Furthermore, the influence of *Alcohol: No Ordinary Commodity* (published jointly by the WHO and the Society for the Study of Addiction) is clear not only in the advocacy work of groups such as SHAAP and AFS but also in the research reviews which informed Scottish government thinking on alcohol. While the Ludbrook et al. review of 2002 absorbed WHO principles through its extensive use of *Tackling Alcohol Together*, the 2004 update made wide use of *Alcohol: No Ordinary Commodity* and it strengthened its position on issues such as a pricing, availability and marketing as a consequence.

The devolution of powers in the context of historically high levels of consumption and harm, alongside consistent and coordinated WHO advocacy through its European Office, provided the opportunity for the Scottish National Party to adopt radical policies on alcohol. Furthermore, as Greer (2008: online) has argued:

> Scotland has long had high status medical leaders closely connected with policy … Electoral battles tend to be about which party better reflects

Scottish distinctiveness and perceived communitarian values; examples of Scottish policies that gained impetus from the chance to lead in the UK include free long-term personal care for elderly people and banning smoking in public places.

The political narrative of national renewal, combined with a personal commitment from key figures within the SNP, a high level of party discipline across ministers responsible for different portfolios, and weak financial and personal ties to the alcohol industry made the adoption of MUP in particular politically possible. It also played a key role in the adoption of a public health licensing objective, the ban on multi-buy alcohol discounts, the reduction of the drink-drive limit in 2014, and the establishment of detailed monitoring systems for evaluating the impact of alcohol policies on health outcomes.

Overall, then, the development of alcohol policy in Scotland since the devolution of powers has provided a powerful example of how policy stasis can be challenged when policy streams converge (Katikireddi et al., 2014). Despite the political and economic power of the Scottish alcohol industry – much, though not all, of which was vehemently opposed to MUP – the Scottish National Party was able to present 'Scotland's drinking culture' as a problem that needed to be resolved. This political framing created the opportunity for alcohol control advocates seeking to promote the WHO ideal to present an alternative conceptualization of alcohol policy as well as a series of novel, and persuasive, policy alternatives. Clearly, the fierce resistance to these developments by the alcohol industry remains a powerful counterbalance; however, the Scottish experience showed, far more clearly than England, that health-oriented alcohol policy could be politically viable in a UK context, albeit under particular conditions.

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7 Alcohol policy in England and Wales, 1990–2014

Introduction

The period under review in this chapter witnessed a number of significant developments in England and Wales. In 1990, alcohol policy was largely framed as an issue of business deregulation, tourism and economic development; by 2014, the health implications of alcohol policy had moved to the forefront of both political and public debates on the issue. In 1989, a Conservative Government oversaw legislation, known as the 'Beer Orders', that was designed to de-monopolize the alcohol retail environment and encourage new operators and producers to develop the alcohol market; in 2012, a Conservative-led Coalition pledged to introduce minimum unit pricing for alcohol as a way of tackling binge drinking associated with the kind of high-turnover, vertical drinking outlets that the Beer Orders had helped establish. Over the same period, public health advocates became more visible in policy debates, drawing attention to the neglect of alcohol-related health problems and arguing for a whole-population approach as a more effective response to reducing harm. Alcohol treatment focus moved from dependency to an expanded target group of 'at risk' drinkers, which was more in tune with public health concerns to change the culture of drinking at the population level.

However, by 2013, MUP had been abandoned and a long-standing policy equilibrium – in which the government pursued a broadly deregulatory programme in partnership with key industry stakeholders – appeared to have been restored. This period, then, saw alcohol established as a pivotal issue in public policy but also illustrated how entrenched processes and frameworks for policy decision-making on alcohol are resistant to external threats. It highlighted the degree to which alcohol was amenable to reframing in policy terms but also the challenges that are faced by those seeking to change alcohol policy in practice.

Developing the alcohol economy

From the eighteenth century, the 'on-sale' of alcohol in Britain was characterized by large property-owning brewers controlling swathes of the market

through a vertically integrated 'tied house' system. The 1830 Beer Act, discussed previously, was introduced largely because the ownership of pubs by brewers reduced consumer choice and led to a monopoly that distorted competition. Brewers were accused of using their connections with local magistrates to stifle competition, of exploiting landlords through controlling the wholesale price of beer, and of ripping off customers by adulterating their products in order to reduce tax margins, safe in the knowledge that the lack of competition meant drinkers would have few alternative sources of beer. By taking independent beer retailers out of the licensing system altogether, the 1830 Beer Act had been designed to break the stranglehold of the big brewers and create a new market in which competition would lead to greater choice and better retail practices (Harrison, 1971; Greenaway, 2003). In reality, it not only led to a huge increase in the number of independent outlets, but it also forced the established brewers to increase the attractiveness of their pubs through developments in design (such as the use of cut glass, ornate woodwork, gaslights and brass fittings) that led to the rise of the so-called 'gin palace' (Jennings, 2007: 80–86). In other words, a measure designed to reduce brewery power had the unintended consequence of creating marketing innovations that not only made alcohol more widely available but also significantly increased the visibility of inducements to drink in towns and cities across the country.

Although not identical, by the end of the 1980s, a similar problem presented itself to the Conservative Government led by Margaret Thatcher. Then, as in the early nineteenth century, waves of consolidation and conglomeration within the brewing industry had created a highly concentrated market in which a small number of brewing companies not only produced the vast majority of beer consumed domestically but also owned the outlets in which it was purchased. In the late 1980s, around three-quarters of all pubs were owned by brewers and brewing itself was consolidated to such an extent that the market was dominated by just six companies, who between them produced three-quarters of all the beer consumed domestically (Monopolies and Mergers Commission, 1989: 2–3). To a political administration ideologically committed to free trade and free enterprise, this presented a market failure that required intervention. In 1989, the Monopolies and Mergers Commission (MMC) launched an investigation into the tied house system, which concluded widespread reform was needed to 'free up the present system to the benefit of greater competition, while maintaining the British public house as it is widely admired' (ibid.: 295).

The MMC report led directly to new legislation, the so-called 'Beer Orders', which imposed a solution that has been called 'by far the biggest shake-up the British brewing industry has ever seen in its history' (Cornell, 2003: 228). Under the Beer Orders, any brewery owning more than 2,000 pubs had to sell half of the surplus number. As a result 11,000 pubs were put onto open sale and the large breweries lost, almost overnight, vast capital assets. The assumption was that the breweries would maintain their production arms while landlords would provide a wider range of beers to their customers, thereby improving choice and encouraging new products to enter the market. The reality,

however, was rather different. Many of the large brewers either sold out to global conglomerates or moved out of brewing and used their remaining capital stock to develop interests in the wider leisure market. In this respect, the Beer Orders contributed to the global conglomeration of UK brewing (in 1995, for instance, Allied Breweries – producers of Tetley – merged with the Danish brewers Carlsberg, while in 2000 Whitbread sold their brewing interests to the Belgian conglomerate Interbrew) and to a short-term reduction in the number of a major UK-based brewers overall (Spicer et al., 2013: 152–164).

A second, unintended, consequence of the Beer Orders was that it amplified an existing trend for retail-oriented business – often based outside the UK – to buy up properties in order to develop chains of themed alcohol outlets. These new pub companies (or 'pubcos' as they would become known) not only continued to employ many landlords on tenant contracts, as was the case under the 'tied house' system, but also established supply contracts with large brewers, all of which, in effect, meant that the choices open to landlords remained hardly less constrained than they had been previously (ibid.: 173–183). A clause in the Beer Orders requiring pubs to offer at least one 'guest beer' did, in principle at least, go some way to encouraging a wider range of choices; however, the reality was far from the idea of free and varied competition envisaged by those who drew up the legislation.

This introduction of new retail chains into the market coincided with a reconfiguration of many town and city centres that followed both years of recession and a trend towards the development of out-of-town retail hubs. By the early 1990s, many urban centres were struggling to maintain an economy based on either shopping or local industry. As premises went out of business, and local authorities faced the prospect of their high streets becoming empty, the opportunity to encourage new investment based on leisure – investment that was strongly led by alcohol outlets – became increasingly attractive (Nicholls, 2009: 224–227). The early 1990s witnessed new thinking in urban planning, partly in response to the economic shock of the 1980s, which emphasized leisure as key to urban regeneration and alcohol-led outlets were seen in many areas as essential to the development of vibrant, urban economies (Lovatt, 1996; Chatterton, 2002; Hobbs et al., 2005; Hadfield, 2006). Although licensed premises were still required to close at 11 p.m. as standard, venues with dance floors were able to apply for 'Special Hours Certificates' allowing them to continue trading until 2 a.m. (Hadfield, 2006: 52). In many town and city centres, late-night destination drinking zones began to emerge, characterized by a high concentration of pubs and bars – often large, themed chain bars – that were open late and that encouraged high-turnover 'vertical' consumption.

As the British economy began to improve in the mid-1990s, so optimism over the potential for alcohol-led night-time economies to drive urban regeneration rose and so the profitability of the outlets began to increase. In a short period, the night-time economies of many urban centres were transformed: having previously been characterized by relatively few pubs, most of which were small 'traditional' venues with seats, tables and little music beyond a jukebox,

they were now locations for numerous large, themed bars offering dance floors, DJs, food, and the kind of interior designs and lighting more often associated with nightclubs. By 2003 – two years *before* the implementation of so-called '24-hour licensing' – 61 per cent of high street bars were already trading beyond 11 p.m. (ibid.: 52).

This transformation of the night-time economy coincided with a number of other key social and economic factors. While the on-trade (pubs, bars and clubs) was becoming in many respects more visible, the off-trade (off-licences, shops and supermarkets) was increasing its market share. Since the 1961 Licensing Act, off-licences in England and Wales had been free to sell alcohol without the compulsory 'afternoon gap' that applied to pubs, and since 1964 – when wine was removed from a system of 'resale price maintenance' that established a fixed retail price for all outlets – they had been able more easily to compete on value. Wine, especially, was increasing in popularity due to global production and marketing trends, an expansion in foreign travel and a rise in its popularity among female drinkers. Furthermore, as discussed in Chapter 5, overall levels of alcohol consumption across the population had been steadily rising since the early 1960s as alcohol became more affordable, more varied, and as earlier taboos on women's drinking began to be lifted as part of wider moves towards greater gender equality (Figures 7.1 and 7.2).

Increasing consumer confidence, raised levels of disposable income, increased gender equality, new trends in retail, and developments in the economic strategies of local authorities all combined to create, in the 1990s, a national 'mood' in which alcohol consumption was increasingly normalized across a range of social activities. In this context, public intoxication became a more familiar sight, especially in the newly 'vibrant' night-time economy.

Creating the 'continental café society' and 'Binge Britain'

The liberal, modernizing drift in alcohol policy reached a peak with the development of the 2003 Licensing Act, which entirely removed the statutory restrictions on opening hours that had been introduced by the Central Control Board in 1915, while also removing the last vestiges of a long-standing power held by licensing authorities to decide on applications with regard to the level of 'need' in their jurisdictions (Light and Heenan, 1999). The 2003 Licensing Act was, initially, regarded as a popular policy that combined cultural modernization with much-needed business deregulation. However, before it was even implemented in 2005, it had become widely identified as an irresponsible and ill-conceived folly that would only exacerbate increasing levels of both public disorder and alcohol-related disease and mortality (Critcher, 2008; Greenaway, 2011; Nicholls, 2012a). The story of how the Act was developed, how it was presented to the public, and how it became embroiled in a storm of protest before even coming into operation provides a further illustration of the degree to which public policy on alcohol in Britain suffers from a lack of

coherence both within government and between government and the wider community.

In 1988, the Conservative administration had removed the requirement for pubs to close in the afternoon, and in 1995 it extended this to allow all-day opening on Sundays. However, calls for further licensing reform continued after New Labour took office in 1997. Initially, these centred not so much on the need for further extensions to opening hours as on the need to simplify licensing law, which had become immensely complex over time and which was felt to be in need of updating, since the last major Licensing Act had been passed in 1964. Business advocates called for less red tape surrounding the licence application process as well as a reduction in the discretionary powers of licensing magistrates (Baggott, 2010; Greenaway, 2011). Local authorities also saw the value in a reduction in the complexity of the existing licensing regime. In 2000, a White Paper entitled *Time for Reform* was published, setting out the government's proposals (Department for Culture, Media and Sport, 2000). These included moving responsibility for licensing away from local magistrates, where it had remained since licensing was first established in 1552, to local authority committees consisting of both officers and elected councillors. Although highly significant, this administrative shift garnered far less public interest than the proposal to remove statutory restrictions on the hours during which alcohol could be sold. In reality, limited restrictions on opening hours had been a feature of licensing legislation for centuries; nevertheless, the universal closing hour of 11 p.m. (and 10 p.m. on Sundays) was the last vestige of the limits on retail hours imposed by the Central Control Board in 1915. It was this that *Time for Reform* proposed to remove on the grounds that it was a restriction on customer choice which was by now anachronistic.

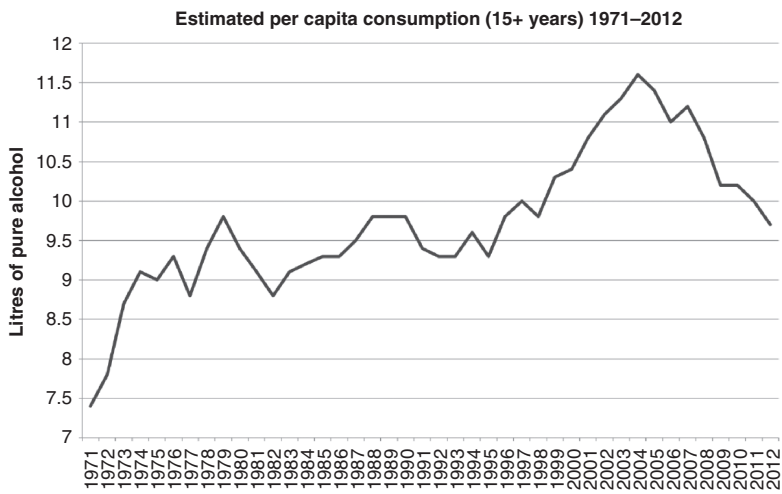

Figure 7.1 Estimated per capita consumption, 1971–2012
Source: British Beer and Pub Association (2013).

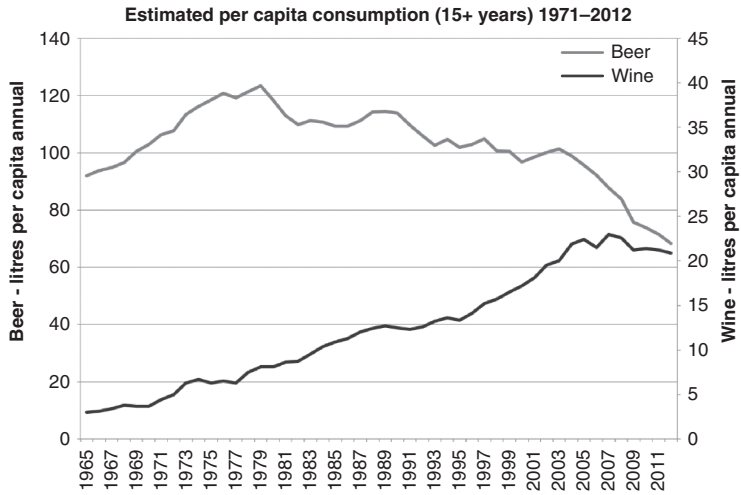

Figure 7.2 Annual UK consumption of beer and wine, 1965–2012
Source: British Beer and Pub Association (2013).

The removal of fixed closing had initially been popular not only with business but also with police who were keenly aware that fixed closing created a problem known as the '11 o'clock swill', in which large volumes of people emptied onto the streets simultaneously creating flashpoints around drinking venues, food outlets and taxi ranks that often led to violence (Tuck, 1989; Marsh and Fox-Kibby, 1992). In a move which many in the governing Labour Party came to regret, the liberalization of opening was presented to the public as encouraging a general change in British drinking cultures: away from a culture of binge drinking, where large amounts were consumed quickly before drinkers were sent back home at 11 p.m., and towards a more sophisticated, 'continental' culture characterized by slower, more leisurely consumption, possibly accompanied by food, with responsible adults free to finish their evenings when they, rather than the state, saw fit (Jowell, 2004).

In one sense, this move fitted with the spirit of the times: the development of a leisure-oriented consumer economy seemed to sit awkwardly with a legislative regime that dictated when drinkers should return to their beds. However, the very rise in alcohol consumption that drove calls for reform also created social and health problems that the proposed reforms appeared to do nothing to tackle. The long rise in overall consumption, which began in the 1960s, reached a peak in 2004; at the same time, the consequences of an alcohol-led night-time economy on social order and urban amenity began to filter into the public consciousness through a series of newspaper reports describing 'the streets of Binge Britain' (Rayner, 2004; Critcher, 2008). Health concerns centred on increasing pressure on hospital Accident and Emergency Departments and the costs to the health service of acute problems associated with the night-time

economy especially at weekends. In addition, advocates for public health perspectives on alcohol policy began to work more effectively to present their message not only to government but also the mass media.

Increasingly public, political and professional concern over the possible consequences of widespread deregulation added to pressure on the UK Government to adopt a more systematic approach to alcohol policy. As is described elsewhere in this book, calls from the World Health Organization for states to adopt national alcohol policies had being growing in influence since the publication of the WHO *Charter on Alcohol* in 1995. After some initial delay, New Labour accepted the need to follow this approach and in 2003 the Prime Minister's Strategy Unit (PMSU) completed an Interim Analytical Report on alcohol's costs to society, which was designed to provide the underpinning of a national alcohol strategy (Prime Minister's Strategy Unit, 2003). The report had been produced in collaboration with a panel of experts that included a number of leading public health specialists working in the alcohol field and it set out in considerable detail the costs of alcohol misuse in terms of health, disorder, workplace productivity and family and social networks – concluding that the annual cost to society of alcohol misuse was around £20 billion. The PMSU report discussed a wide range of possible policy responses, including treatment and brief interventions, education and information, enforcement and community safety, and supply-side controls on price, availability and marketing. While it steered clear of recommending specific policy approaches, the interim report stated that the kind of supply-side measures favoured by public health advocates had 'historically been shown to have an impact, but need to be seen in the context of a complex range of mechanisms' (ibid.: 172). In other words, it had a place in national alcohol policy but should not be seen as having stable transcultural effects, nor as working independently of factors such as social norms, drinking traditions and broader social changes.

Optimism within the public health community was, however, disappointed when the final Alcohol Harm Reduction Strategy for England (AHRSE) was published the following year (PMSU, 2004). While reiterating the social costs set out in the interim report, the AHRSE made no provision for supply-side controls and asserted instead that policy would be built on alcohol education, improved treatment and advice, better coordination among enforcement agencies, and partnership with the alcohol industry to promote responsible drinking (ibid.: 12). Where the interim report had noted that interventions on price and availability did not work in isolation from wider cultural contexts, the AHRSE asserted that while there was 'a clear association between price, availability and consumption … there is less sound evidence for the impact of introducing specific policies in a particular social and political context', therefore 'a more effective measure would be to provide the industry with further opportunities to work in partnership with the Government to reduce alcohol-related harm' (ibid.: 18). Why the argument regarding efficacy and social context only applied to supply-side measures was not made clear, nor

was it explained why the natural alternative was industry partnership. In a scathing review, Robin Room described the AHRSE as providing nothing more than a 'recipe for ineffectiveness' in dealing with alcohol harms by setting out, as core to the national policy, precisely the approaches which were *least* effective according to the World Health Organization (Room, 2004).

The widely held view within public health was that, despite the evidence contained in the interim findings, the government had succumbed to alcohol industry pressure and decided to accept the conventional, dichotomous model of alcohol harms in which the target of interventions should be isolated subgroups of harmful drinkers (in this case, young drinkers and dependent drinkers), while the majority of moderate drinkers should be left as free as possible from state interference (Babor, 2004; Marmot, 2004; Room, 2004; Stockwell, 2004).

In both its licensing reforms and national alcohol strategy, then, New Labour explicitly rejected whole-population, supply-side control policies. It supported instead the principle that moderate drinkers should not be subject to preventive state actions designed to lower their risk of suffering alcohol-related harms. That is to say, it adopted an approach based on maximal individual liberty and *post hoc* treatment over one based on universal prevention and supply-side control.

From treatment to intervention

Although licensing and alcohol taxation have always provided headline policies, this period also saw important developments in approaches to treatment and prevention that also shifted the political frame for addressing alcohol harm. Until the 1970s, concerns over the health aspects of alcohol focussed on 'alcoholics' or dependent drinkers who were provided for largely through hospital inpatient and outpatient psychiatric treatment services and by charitable organizations. But by the late 1970s, a number of changes were beginning to take place in treatment provision. The dominance of psychiatry was challenged by new psychosocial approaches to alcohol-related problems, accompanied by a growth of psychological and community-based services to cater for the 'problem drinker' along with a new group of professionals, largely clinical psychologists and counsellors, entering the treatment field (Heather and Robertson, 1985). The voluntary sector, which had always played a part in responding to dependent drinkers, and which had established community-based alcohol counselling services in the 1960s, began to grow in importance, becoming more coordinated and visible as a major stakeholder under the leadership of Alcohol Concern, an umbrella organization set up by the Department of Health in 1984.

The influx of non-medical professionals, and the possibilities opened up by their perception of the problem, was a key factor in broadening the restricted notion of treatment for dependent drinkers to the idea of intervention for a larger population that was drinking problematically but not necessarily

dependent on alcohol. Parallel trends made it easier to define who these people were. For instance, the expansion of epidemiological health research during this period was reflected in the alcohol field by the initiation of a raft of alcohol consumption surveys, beginning in 1978, and the incorporation of alcohol consumption and harm questions into a range of routine health surveys.

At the same time, key medical bodies led by the Royal College of Psychiatrists, began to develop the concept of quantifying 'safe' limits of alcohol consumption. This was not an entirely novel development: in the late nineteenth century, the British doctor Francis Anstie had proposed safe weekly limits which became established in a range of professions (including actuarial insurance calculations) in Britain and America in the early twentieth century (Kneale and French, 2015). In a 1979 report, *Alcohol and Alcoholism*, the Royal College of Psychiatrists proposed that 'four pints of beer a day, four doubles of spirits, or one standard-sized bottle of wine constitute reasonable guidelines for the upper limit of drinking' (Royal College of Psychiatrists, 1979: 140). The idea of 'sensible drinking' was endorsed by the government in its 1981 report *Drinking Sensibly* (Department of Health and Social Security, 1981), and in 1984 a Health Education Council leaflet entitled 'That's the Limit' proposed safe limits of 18 'standard drinks' for men and 9 for women weekly (House of Commons Science and Technology Committee, 2012: 7). In 1987, the HEC guidelines – now expressed in units – were revised down to 21 units a week for men and 14 for women: guidance that was endorsed in reports published at the same time by the Royal Colleges of Physicians, Psychiatrists and General Practitioners and adopted as formal government advice (Royal College of Psychiatrists, 1986; Royal College of General Practitioners, 1987; Royal College of Physicians, 1987).

The recommended levels adopted by the government were, of course, a compromise between scientific certainty and tractable public health advice. While one of the leading doctors involved came to regret describing the figures as having been 'plucked out of the air' (Smith, 2007), his point was that the limits established at this period were advisory and developed in the knowledge that there is no universal unit-based level that applies equally to all drinkers. Nonetheless, these figures also acquired an epidemiological purpose and were used to categorize groups within the population according to risk based on their reported levels of alcohol consumption. Soon the nomenclature of 'moderate', 'hazardous' and 'harmful' – and, later, 'reduced risk', 'increasing risk and 'high risk' – drinkers became established. While in some national surveys, these categorizations were based on screening tools such as AUDIT (e.g. McManus et al., 2009), most simply reported weekly unit consumption and so estimates regarding proportions of 'hazardous drinkers' in the population were based largely on numbers reporting drinking above advisory levels.

The division of the population into subgroups of drinkers defined by relative levels of risk also provided a more defined population group deemed

suitable for community-based psychosocial interventions. The emphasis, however, was still on the prevention of, and response to, dependent drinking and on chronic, long-term health harm. However, during the 1990s, attention turned to the acute harms associated with binge drinking. A concern that drinkers might be 'saving up' their units for the weekend, combined with new evidence on the relationship between moderate drinking and heart disease, led the government to revise its guidelines in 1995 so that safe drinking levels were given as daily, rather than weekly, amounts of 4 units for men and 3 for women (Department of Health, 1995; House of Commons Science and Technology Committee, 2012: 8).

While sensible drinking guidelines provided one method for ascertaining levels of risk at a population level (by extrapolating from survey data to estimate prevalence across society), they worked in tandem with other tools – especially the AUDIT questionnaire – to support an extended system of screening for alcohol issues in primary care. Screening and brief interventions were a rare example of a policy intervention supported by the WHO (Babor and Higgins-Biddle, 2001) that gained consensus among policymakers and, indeed, the alcohol industry. Early evaluations showed they could be effective, they were relatively affordable to deliver, and (critically) were a population measure that did not imply supply-side constraints on the market. The problem for brief interventions, however, was less support in principle than implementation in practice: the question remained how to deliver this intervention in ways that reached the population at large while ensuring consistent delivery and proper evaluation (e.g. Kaner et al., 2013; McCambridge and Cunningham, 2013) Nevertheless, the widespread adoption of brief interventions as a valid prevention approach marked an important shift in emphasis towards a whole population approach derived from consumption-harm theory, which recognized the importance of the drinking patterns of the population as a whole rather than solely of dependent drinkers.

Towards a shift in perspective

Government support for brief interventions was, however, not the same as government adoption of the public health approach in its totality, and the 2004 AHRSE remained a deep disappointment to many health advocates. In the same year as it was published, and partially in response to the direction in which national policy was moving, the Academy of Medical Sciences, with support from the Society for the Study of Addiction, published *Calling Time: The Nation's Drinking as a Major Health Issue* (Academy of Medical Sciences, 2004). It reasserted the argument that overall per capita consumption remained a 'crucial determinant of harm' and called for price and availability interventions to be used to return levels of drinking back to those of the 1970s (ibid.: 9, 22). The report also called for a reduction in the blood alcohol limit for driving from 80 mg per 100 ml of blood to 50 mg – thereby bringing the UK into line with much of Europe. Finally, the authors asserted the need for

a broad public debate on the relationship between alcohol and health, shifting the focus away from the headline concerns over acute social disorder and onto the chronic personal and social costs of alcohol-related disease.

Publication of the Academy of Medical Sciences report in 2004 allowed the public health community to express in clear terms their contrary view of the purpose and framework for national alcohol policy. At the same time, news media interest in public disorder associated with high-density drinking in urban centres provided an opportunity for alcohol control advocacy to find a wider voice. In a special issue dedicated to opposing the imminent licensing reforms (entitled 'The Great Rebellion'), the populist, right-wing newspaper *The Daily Mail* included among its reports on alcohol-related public disorder an editorial by the then President of the Royal College of Physicians, Professor Ian Gilmore, in which he highlighted the health risks posed by high levels of alcohol consumption (Gilmore, 2004). As a figure representing the medical establishment, Professor Gilmore went on to become a regular public commentator on alcohol policy: a role that he used not only to oppose licensing reform, but to promote the public health perspective on alcohol policy more broadly. In 2007, he helped establish the Alcohol Health Alliance (AHA), an umbrella group that acted to coordinate public health advocacy on alcohol policy building on the experiences of tobacco control advocacy, especially the work of Action on Smoking and Health (ASH) (Thom et al., 2016). As President of a Royal College and head of the AHA, Professor Gilmore was in the unusual position of having access to both key figures in the Department of Health and key journalists (Nicholls, 2012a: 259–230). The establishment of the AHA, in that regard, marked a turning point in public health advocacy: the formation of a wide-ranging coalition united behind a well-defined set of policy positions based on the principles of tobacco control campaigns – something a *BMJ* editorial had called for as far back as 1991 (Dillner, 1991).

2004, then, was a critical year in the development of public and political attitudes to alcohol policy in England and Wales. In the hiatus between the passing of the 2003 Licensing Act and its implementation in 2005, the news media turned on the policy of liberalization such that the impending prospect of '24-hour licensing' was routinely depicted in key newspapers (most particularly, the highly influential *Daily Mail*) as likely to trigger an explosion of disorder and violence in urban centres across the country (Critcher, 2008; Nicholls, 2009: 236). The publication of the AHRSE, designed to affirm the seriousness with which the government took alcohol-related harm, merely served to alienate the public health community and, for many experts in the field, discredit New Labour's entire approach to alcohol. In January 2005, in an effort to reclaim its authority on the issue, the Department for Culture, Media and Sport, the Home Office and the Office of the Deputy Prime Minister published a joint policy paper entitled *Drinking Responsibly*, setting out a range of proposals to tackle alcohol-related crime and disorder (Department for Culture, Media and Sport, 2005). However, despite reasserting the need for retailers to take responsibility on issues of pricing and promotion,

the authors nevertheless made it clear that statutory controls were ruled out and that 'normal price competition in line with competition law should not be put in doubt' (ibid.: 14). Ultimately, the key policy contained in *Drinking Responsibly* – the creation of local 'Alcohol Disorder Zones' – turned out to be an entire failure: not a single one was ever created. Perhaps not unsurprisingly, no local authorities were attracted to having areas within their cities badged with such a stigmatizing title.

In 2007, the AHRSE was updated and more emphasis was placed on local partnerships, on screening for problem drinking below dependent levels, and on the delivery of brief interventions (Department of Health, 2007). The updated Strategy launched a three-year, national 'Alcohol Improvement Programme' (AIP) in an effort to address alcohol-related harm and to refocus the balance of action towards health after decades when alcohol had been viewed through the lens of crime and disorder, when it suffered from a low profile on health service agendas and was subject to relative resource deprivation in comparison with drugs. The AIP saw the establishment of regional alcohol teams charged with coordinating the work of local stakeholders to improve alcohol outcomes (Thom et al., 2013a). Led by a Regional Alcohol Manager, the brief was to focus on primary care, the delivery of IBA (identification and brief advice) and the establishment of alcohol liaison nurses as key 'high impact' interventions (Lloyd et al., 2013). Partnership working, which under New Labour had become an accepted feature of decentralized service provision and the localization of decision-making (Thom et al., 2013b; Hunter and Perkins, 2014), was to be the mechanism for drawing together local professionals and agencies into action networks and raising the profile of alcohol and health issues. Training and information exchange were also seen as essential elements in raising standards of practice and were encouraged through the development of the Alcohol Learning Centre, a web-based facility providing education and training modules as well as opportunities to exchange ideas and examples of 'good practice'. Perhaps unwisely, however, the key indicator of success for the AIP was a reduction in the rate of increase of alcohol-related hospital admissions: a concrete outcome that was difficult to achieve in the short term for what could be described as a series of 'influencing' (rather than implementation) networks, whose primary effects were likely to be long-term developments in practice, attitudes and relationships (Toner et al., 2014).

The updated National Strategy also established a new charity, Drinkaware, which was charged with providing the hub for public information on alcohol harms. However, this new entity was entirely funded by contributions from the alcohol industry and had a remit to focus only on consumer behaviour and demand-side interventions. This posed serious problems for public health advocates: on the one hand, while industry funding ensured that Drinkaware would be well financed, it also meant it was highly unlikely the organization would engage in activities that posed a financial threat to the established trade. Furthermore, its focus on targeting problematic individuals and subgroups ran directly counter to the public health view that interventions should work

across the whole population. It was already well understood that industry-led partnerships for harm prevention implied conflicts of interest that rendered them, at best, of limited value (Baggott, 2006). However, for many within the public health community, Drinkaware was a cynically conceived 'Social Aspects Organization': an entity designed to merely create the appearance of corporate social responsibility, but whose real goal was to deflect government actions away from the kind of supply-side interventions that would genuinely threaten market development (McCambridge et al., 2013).

National alcohol policy under New Labour, then, appeared to run directly counter to the alcohol control policy model. It adopted a dichotomous model of alcohol harms, clearly separating moderate drinkers from distinct sub-groups of binge and dependent drinkers; it rejected the notion that reducing overall levels of consumption would drive reductions in consumption among harmful drinkers; it rejected the principle that the alcohol industry should be excluded from the policymaking process; and it put significant faith in both local and national industry partnerships and in education and social marketing as the most effective levers for harm reduction.

Nevertheless, this was also an era in which alcohol control advocacy gained significant ground. In addition to having some support within the Department of Health, alcohol control advocates gained a media profile, had organized into an increasingly effective coalition, and were establishing their perspective as the standard view of alcohol harm within wider swathes of the medical community. As an advocacy coalition, the AHA incorporated not only the major medical Royal Colleges, but also health charities such as the British Liver Trust and campaign groups such as Alcohol Concern and the Institute of Alcohol Studies. Furthermore, the notion that alcohol policy was, effectively, a battleground between 'industry' and 'public health' perspectives became increasingly accepted within the academic research community, with pressure being applied to prevent researchers from engaging with the alcohol industry (e.g. Stenius and Babor, 2009), increased funding for research aimed at revealing industry lobbying tactics (e.g. Hastings, 2010; Holden et al., 2012), and a developing consensus that the standard public health position was to be accepted as a first principle – with its most recent articulation, Babor et al.'s *Alcohol: No Ordinary Commodity* providing the 'alcohol policy Bible' (Babor et al., 2010 v Health Committee, 2012: Ev. 2).

Punctured equilibrium?: Minimum unit pricing debates in England and Wales

The confluence of ongoing public concern over alcohol disorder, the continuing health impacts of rising consumption that had peaked around 2004, better organized policy advocacy, and increasing calls from the police for the detrimental effects of licensing liberalization to be addressed, meant alcohol was high on the political agenda in the run-up to the 2010 General Election. The Conservative Party attacked New Labour's widely discredited record on

alcohol policy, making pre-election pledges to 'tear up [New Labour's] lax licensing regime' (Grayling, 2009). Following the Election, in May 2010, the newly formed Conservative and Liberal Democrat coalition government swiftly pledged to ban the sale of below-cost alcohol, review alcohol taxation and pricing, strengthen the powers of local licensing authorities, and do more to tackle the sale of alcohol to under-age drinkers (HM Government, 2010: 13–14).

In government, the Coalition moved responsibility for alcohol policy from the Department of Culture, Media and Sport back to the Home Office and launched a consultation on 'rebalancing' licensing legislation towards greater local accountability (Home Office, 2010). At the same time, it introduced plans to strengthen voluntary agreements with the alcohol industry through the Alcohol Responsibility Deal – part of a wider set of commitments by industry to promote responsible practices. Under this agreement, the alcohol industry pledged to 'promote a culture of responsible drinking' through actions such as lowering the strength of some products and tackling irresponsible sales practices (Department of Health, 2011). Coalition policy, therefore, followed a dual (and in some respects, contradictory) track: accepting the argument for stronger state intervention, on the one hand, and reinforcing the role of voluntary industry partnerships, on the other.

The promise of licensing reform was, in many respects, conventional: it framed alcohol problems in terms of public disorder issues that could be targeted through better restriction of on-trade availability. By 2010, however, the issue of alcohol pricing had become unavoidable. Minimum unit pricing had emerged unexpectedly as a policy alternative following a decision in 2007 by the Department of Health to commission a research group based at Sheffield University to undertake a review to 'provide answers to key questions about the relationship between alcohol promotions including pricing, level of consumption, alcohol-related harm and the likely social, health and economic costs and benefits of planned or potential policy interventions' (Booth et al., 2008: 3). While the Sheffield team had established international public health specialists on their advisory board, it was an interdisciplinary team with a strong focus on econometric modelling. The first published review took guidance from Professor Tim Stockwell, who had analysed pricing interventions in a number of Canadian provinces, and looked at not only the impact of changes in general alcohol taxation, but the novel concept of a minimum price per unit of alcohol (Booth et al., 2008; Nicholls and Greenaway, 2015). As discussed elsewhere in this book (Chapter 6), minimum unit pricing had already appeared as a policy idea in the SHAAP report *Alcohol: Price, Policy and Public Health* (SHAAP, 2007); however, the Sheffield Review provided the first rigorous attempt to model how it would work and what its effects might be across the population as a whole.

While MUP appeared to present a relatively simple solution to the complex problem of tax 'pass-through', by which changes to alcohol excise duties could simply be absorbed by retailers, as a novel intervention it lacked a history

of evaluation, testing or review that applied to other policy options. However, because its models were based on detailed reviews of the existing research on alcohol price elasticities (that is, the degree to which purchasing patterns respond to price changes), as well as existing survey data and epidemiological estimates of the relationship between consumption and harm, the Sheffield Review provided the kind of scientific foundations that allowed supporters of MUP to present it as a viable, evidence-based approach. Therefore, it also spoke to the rhetoric of 'evidence-based policy' that had, especially under New Labour, become something of a mantra in political discourse (Solesbury, 2001; Katikireddi and Hilton, 2015).

As Katikireddi et al. (2014a) and others have noted, though, the scientific status of the Sheffield models was always controversial because, as prospective econometric modelling it was open to the claim that it lacked 'real-world' validity. Opponents identified this as a fatal weakness, often suggesting such modelling was not 'evidence' at all. At a central government level, the lack of 'real-world' evaluation also presented a challenge, although during the course of policy debates on MUP, evidence from Canada emerged detailing the impact of similar (though not identical) pricing policies in the provinces of British Columbia and Saskatchewan (Stockwell et al., 2012; Zhao et al., 2013). This evidence lent weight to arguments for MUP, although it was noted by sceptics that the social and cultural environment in Canada was very different to that in the UK.

Once established in principle, MUP quickly became a fluid 'policy idea' (Smith 2012; 2013; Nicholls and Greenaway, 2015). To many alcohol control advocates, it represented an opportunity to reduce overall consumption, thereby, following Skog's theory of collectivity in drinking behaviours, pulling down consumption at the most problematic end of the spectrum (Skog, 1985; Health Committee, 2012: ev10). To others within the health community, it represented a far more targeted approach, impacting only on those drinking at the highest levels – an effect that became more strongly emphasized in later iterations of the Sheffield Model (Holmes et al., 2014; Sheron et al., 2014). Importantly, MUP also benefitted from support within parts of the alcohol industry. Many in the brewing and pub trade saw it as a market equalization measure: reducing the price differential between supermarkets and pubs such that the shift in purchasing away from the on-trade could be stemmed. Other industry actors, however (especially the larger producers and retail chains), vehemently opposed the policy and exploited its roots in whole-population approaches to depict it as an 'unproven … blunt instrument' that unfairly punished the majority of moderate drinkers for the excessive behaviour of a minority (Green, 2012).

To the surprise of many observers, when the Coalition launched a new Alcohol Strategy in March 2012, it included a commitment to introduce MUP (HM Government, 2012). Indeed, it was suggested by some that the surprise announcement partly served to deflect media attention from a Budget the previous week that was being widely decried as an 'omnishambles' (Murphy,

2012). Understandably, the announcement was welcomed enthusiastically within the public health community for whom it signalled a real shift in the policy equilibrium (Nicholls, 2012b). Critically, however, the policy was announced in terms that strongly emphasized law and order, rather than public health. In his Foreword to the Strategy, the Prime Minister David Cameron stated that MUP would tackle the 'scourge of violence caused by binge drinking', while ministers confirmed it targeted ' young people with low disposable incomes [who] drink irresponsibly and are price-sensitive when buying alcohol' (HM Government, 2012: 2; House of Commons, 2013a). The problem was that this largely ran counter to the econometric modelling, which suggested MUP best targeted people who purchased large amounts of alcohol in the off-trade, typically for home consumption.

In some respects, this framing was convenient for alcohol control advocates, despite not aligning fully with the evidence base. Asked for his views on this contradictory framing in a subsequent Health Select Committee hearing, the Chair of the Alcohol Health Alliance replied: 'I do not mind too much how it was framed. What I mind about is how it measures up to what I think it requires in order to reduce our per capita consumption and the concomitant harm' (Health Committee, 2012: ev1). However, this pragmatic approach came with risks. The Health Committee concluded that 'the main focus of this strategy is the need to address public order issues … but … the health impact of alcohol is more insidious and pervasive' and it called for the government to 'build its case for a minimum unit price' more effectively (ibid.: 3–4). The tension between 'selling' MUP as reducing youth disorder and the evidence that it was, instead, a public health intervention made it easier for opponents to accuse the government of introducing a policy that would not work on its own terms.

Although MUP was supported by elements of the alcohol industry, opposition was led by the Wine and Spirits Trade Association who launched a campaign of both 'soft' lobbying as detailed by McCambridge et al. (2014), and high profile public advocacy. Their stated goal was to 'kill' MUP, and the public campaign ran under the politically potent strapline, 'Why should responsible drinkers pay more?'. In addition to its focus on unfairness, this campaign strongly emphasized the lack of research evidence to support the claim that MUP would reduce public disorder (Quinn, 2013; WSTA, 2013). Throughout this period the major alcohol trade bodies – led in this instance by the WSTA and SABMiller, but also via the All-Party Parliamentary Beer group – engaged in extensive public and behind-the-scenes lobbying to resist MUP (Gornall, 2014).

In July 2013, just a year after committing to MUP, the Coalition Government announced it was abandoning the policy. The reasons given for this U-turn reflected the success of the industry lobbying strategy. According to the minister who announced the climb-down in the House of Commons, the government did not have 'enough concrete evidence that [it] would be effective in reducing harms associated with problem drinking … without penalising people who

drink responsibly'. The harms MUP was intended to address were not, in the announcements on its abandonment by the government, chronic health harms but 'drunken behaviour and alcohol-fuelled disorder' (House of Commons, 2013b). The policy had, therefore, been dropped on the grounds of social disorder and unfairness to moderate drinkers: precisely the framing which the industry had been most keen to emphasize but also which, inadvertently, many of the policy's supporters had reinforced when they failed to challenge the presentation of MUP in the 2012 Alcohol Strategy.

Policy streams

In the mid-2000s, annual per capital alcohol consumption reached historically high levels, as did alcohol-related hospital admissions (Deacon et al., 2007; Health Committee, 2010a: 14–21). Together, these were probably necessary to raise the media and political profile of alcohol-related harm, but they were not sufficient by themselves to motivate policy change. Increasing consumption, and associated health harm, meant alcohol became a 'problem' for epidemiological reasons, but this ran alongside the consequences of policy developments that intensified the scale and visibility of disorder in the night-time economy. Furthermore, while public disorder became the subject of widespread media interest in the mid-2000s, increased attention was also drawn to the impact of cheap alcohol sales in off-licences and supermarkets – itself a consequence of shifts in the retail sector, partly in response to social trends leading to an increase in home entertainment and socialization (Hughes et al., 2008). The burgeoning power of the off-trade, and in particular the role of large supermarket chains in driving down prices, put this market sector firmly on the political radar. Indeed, in its 2010 report on alcohol, the Health Select Committee prefaced its chapter on supermarket sales with a quote from oral evidence presented by the sociologist Martin Plant in which he described supermarkets as exhibiting 'the morality of a crack dealer' (Health Committee, 2010a: 93).

However, there is no necessary reason why these developments alone should have led to a reframing of alcohol policy debates along public health lines. For that to occur, coordinated and sustained public health advocacy was critical. Previously, the policy influence of alcohol control advocates had been constrained by a lack of organization, despite key individuals playing a role in the policy networks around the Department of Health (Thom, 1999). The establishment of the Alcohol Health Alliance significantly increased not only the coherence of the advocacy message but also amplified the 'source credibility' that accrues from medical professionals taking the lead in lobbying (Jones and McBeth, 2010: 344; Smith, 2012: 64; Lorenc et al., 2014: 3; Thom et al., 2016). The adoption of minimum unit pricing as a flagship policy provided a political solution that appeared radical, viable and evidence-based, and so was attractive to a wide range of policy actors – and for a wide range of reasons. The speed with which the idea gained traction in key policy circles

is striking. Over this period, support for MUP was expressed by the Home Affairs Select Committee (2008); the Health Select Committee (2010a), NICE (2010) and the Chief Medical Officer, Sir Liam Donaldson (2009).

Finally, in the political stream, attacking New Labour's alcohol policies was strategically important for the Conservative Party in the run-up to the 2010 General Election. Following years of media focus on 'Binge Britain', by 2010, there was widespread support for action to tackle both the 'scourge of binge drinking' and the demonstrable rise in alcohol mortality and hospital admissions. In that respect, all three 'policy streams' aligned. There was widespread public and political concern over the short- and long-term social effects of alcohol consumption; public health advocacy was increasingly coordinated and effective; and a flagship policy idea (MUP) had emerged which appeared to present solutions to an array of the problems identified. However, as Kingdon argues, policy windows do not remain open permanently and opportunities to shift policy in radical directions can be fleeting. In contrast to Scotland, pushback to MUP and other restrictive policy approaches in England was both swift and, at the highest political levels, very effective.

Industry opposition to MUP took a number of forms. In addition to the WSTA's 'Why should responsible drinkers pay more?' public campaign, influential anti-MUP trade figures (such as the Chairman of the Wetherspoons pub chain, Tim Martin) publicly chided those within the industry who supported the policy on the grounds that it was the thin end of a 'neo-prohibitionist' wedge, thereby enforcing discipline within the trade (Perrett, 2012). In public dealings with policymakers, trade opposition focused on suggesting that predictive models were not 'evidence' in the conventional sense, and that the findings of the Sheffield reviews were 'inconclusive at best' (Health Committee, 2012: ev103; Institute of Alcohol Studies, 2012). They highlighted the weaker evidence for an impact on youth disorder and depicted MUP as unfairly restricting the freedoms of moderate drinkers (McCambridge et al., 2014; Katikireddi et al, 2014a). Finally, they leveraged the existing voluntary corporate responsibility schemes as a counterbalance to price controls, arguing that those schemes were working and needed time to develop. In submissions to the Health Select Committee, the Portman Group stated that policy must 'build on the Responsibility Deal and be evidence-based … and not penalise the majority drinking responsibly' (Health Committee, 2012: ev103). The Responsibility Deal was the status quo and, as a policy fully aligned with the existing equilibrium, it had a key advantage over MUP. It posed no threat to existing policy relationships, networks and pathways and, perhaps most importantly, required little direct action on the part of ministers to sustain.

The claim that the econometric models supporting MUP were not reliable evidence spoke to a well-documented tendency for policymakers to approach prospective modelling as 'subordinate' to more familiar types of evidence such as retrospective evaluations (Katikireddi et al., 2014b: 491; Lorenc et al., 2014). While 'real-world' evaluations of MUP from Canada boosted the evidence base for MUP, these faced criticism on the grounds that they still

applied statistical modelling, and that their validity in a UK setting was limited (Duffy and Snowdon, 2012). Combined with the fact that conventional policymaking practice oriented policymakers towards voluntary alternatives, supporters of MUP struggled to counter challenges targeting the scientific validity, and political viability, of the policy. The momentum driving the established political stream was strong, and whereas in Scotland a wide range of contributory factors linked to devolution combined to alter the set course of policymaking processes, in England the status quo was more fixed and, therefore, far harder to shift.

Conclusion

Alcohol policy in England over this period followed an arc which incorporated the consolidation of a long-term liberalizing trend (the 2003 Licensing Act and the 2004 Alcohol Strategy), followed by a brief convergence of policy 'streams' that appeared to facilitate a break in the policy equilibrium (the 2012 Alcohol Strategy) and a return to the liberal policy practice following – but not only as a consequence of – intense industry lobbying. That equilibrium was rooted not only in an ideologically-driven belief in light-touch regulation but also the acceptance of a dichotomous model of alcohol harms and the rejection of the principle of universal prevention that was at the heart of the public health policy model. The pre-2010 Election pledge to roll back liberalizing elements of the 2003 Licensing Act and, more particularly, the adoption of MUP as government policy in 2012, certainly marked points at which public health perspectives on alcohol policy threatened to weaken the principles of business deregulation and industry partnership. However, the policy status quo was re-established by the end of the Conservative and Liberal Democrat Coalition administration. The promised reforms to licensing had been largely ineffectual, not least because of industry attacks on attempts to implement more restrictive policies at local authority level (Nicholls, 2015). Minimum pricing had been abandoned, and the Coalition had reverted to a prior, much-derided, ban on 'below-cost' sales, which was predicted to have an imperceptible impact on alcohol retail (Brennan et al., 2014).

At the same time, however, senior politicians were no longer prepared to appear sanguine about the impacts of alcohol on society and the alcohol control advocacy movement had expanded to incorporate large numbers of public health, clinical, non-governmental and voluntary organizations – all of whom found in minimum pricing a policy banner around which to cohere (even if their interpretations of its effects were varied). While formal, central policy appeared not to shift after all, the wider political context had been transformed: alcohol consumption was now very widely viewed as a political and social 'problem', rather than an opportunity, and it was the public health perspective – now more widely recognized than at any time previously – that appeared to present the viable alternative to business as usual, even if it remained an alternative that government continued to resist. There were

striking successes in indirect policy areas as well. When the Chief Medical Officer announced revised guidelines for low risk drinking in January, 2016, the evidence that risks for some cancers were dose-responsive, and could be identified at very low levels of consumption, were used as the basis for guidance that stated there was 'no safe dose' of alcohol: a position long adopted by health advocates seeking to align the perception of alcohol to that of tobacco. The notion that alcohol was – at any level – not just a risk, but a cancer risk, was now the basis for official government guidance on drinking. Thus, while policy on price, availability and marketing remained in stasis, significant inroads continued to be made by those arguing for the axiomatic principle that alcohol was not simply 'no ordinary commodity' but, in its very essence – and at any levels of consumption – a source of harm.

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8 Alcohol and alcohol policy in Denmark
Historical background

Introduction

Denmark is one of five Nordic countries – Iceland, Norway, Sweden, Finland and Denmark – whose political cultures over the past century have shared many common features, particularly in relation to welfare state developments. However, while Finland, Iceland, Norway and Sweden retained relatively restrictive alcohol policies following their early-twentieth-century experiences with Prohibition, Denmark has always maintained liberal alcohol policies and Danish political culture has never been supportive of 'dry' alcohol control strategies. Concerns about alcohol consumption and related problems have generally not excited public interest in Denmark to the same extent as in the other Nordic countries, and the alcohol question has not featured regularly or prominently on the political agenda. During the comparatively few parliamentary and other political debates which have dealt with this topic, usually it has been argued that Denmark's alcohol policy should continue to be based upon liberal prevention strategies, such as education and awareness-raising, rather than on control strategies. Denmark is also one of the few European countries that still do not have a national alcohol action plan as recommended by WHO. The aim of this present chapter is to review the historic background to Denmark's alcohol policy – tracing the major issues and events over the last few centuries to the early 1990s.

Alcohol consumption and alcohol beverages in Denmark

Historical records suggest that alcohol consumption has always been high in Denmark. The Roman historian Tacitus (56–117 CE) complains of the great lack of moderation displayed by 'these people from the north' who, he suggests, were more easily beaten by wine than by the sword (Mathiesen, 1977). In the middle of the sixteenth century, the royal physician, Cornelius Hamsfort, gave the following description of Danish drinking habits and attitudes towards alcohol: 'In Denmark no man is respected unless he is often drunk [*fordrukken*]. A person who does not like to drink lacks the sense of honor and is a fool for all' (Troels-Lund 1969). It was not until the late nineteenth century,

when religion-based temperance societies were first established, that Danish drinking habits began to be considered a common social problem. However, as will be detailed later, these temperance societies did not enjoy a profound or enduring political influence.

In 1917, during the First World War, the Danish government imposed sharp tax increases on alcoholic beverages; while beer and wine became more expensive at this time, by far the heaviest increase was that levied on distilled spirits. These wartime measures were not primarily intended to improve public health or enhance public order, but were simply aimed at ensuring that, during this emergency period, scarce raw materials would be diverted from alcohol production and secured for food and heating purposes. The effect of the price increases (combined with other social consequences of war) was immediate and significant: annual alcohol consumption decreased from 9.6 litres per person aged 15 years and above in 1916 to 2.2 litres in 1918; and beverage preferences changed completely in character, with the share of spirits dropping from about 70 per cent to about 20 per cent of the total alcohol consumption (Thorsen, 1988; 1990, Karlsson and Österberg, 2002). Reduced consumption was accompanied by reductions in the prevalence of alcohol-related problems both in terms of health, where there were marked decreases in alcohol-related morbidity and mortality, and criminal justice, which experienced similar decreases in arrests for drunkenness and other public order offences (Thorsen, 1990). Levels of consumption in Denmark remained relatively low until the 1960s, when increases in personal disposable income and decreases in the real price of alcohol contributed to a significant increase in annual consumption, peaking in 1983 at 12.8 litres per person aged 15 years and above. Since then consumption has declined, and data for the year 2013 record annual Danish alcohol consumption as 9.4 litres per person aged 15 years and above.

The remainder of this section will offer a detailed breakdown of different types of alcoholic beverages – beers, wines and spirits – and their use and importance in Denmark's drinking history.

Beer consumption in Denmark

From ancient times, fermented beverages – initially mead but more recently beer – have formed part of the traditional diet to be found in Danish households. Until the mid-nineteenth century, the beer consumed in this way consisted of the weak, top-fermented beer or 'ale' that was brewed mainly at home or by small brewers´ guilds. From the mid-nineteenth century, however, following the establishment of the Carlsberg brewery by J.C. Jacobsen, beer production became more industrialized. The new product, a bottom-fermented beer or 'lager' (*bayersk øl*) which had previously been popular in Bavaria, was an immediate success with Danish consumers (Glaman, 1962), quickly replacing the weaker, top-fermented beer as part of the daily life of the Danes – particularly the new urban working classes. In 1879, lager beer even became a part of the

workers' free food in workplace canteens (Yde-Andersen, 1964). Jacobsen was aware of criticism that his new product was a more potent intoxicant than the ale it had largely displaced but he claimed to be unconvinced by such arguments. In 1884, he defended his product in a public lecture given at Videnskabernes Selskab (The Royal Academy of Science), at which he presented what he claimed to be scientific evidence that the intoxicating effect of his beer was minimal and that its consumption could never lead to alcoholism:

> It is a fact that bottom-fermented beer, Bajersk øl, even when it is drunk in excess as in Bavaria, is not intoxicating, for there you never see drunks in the streets and alcoholism is also almost unknown. It seems to be sufficient proof that the often expressed fear that bottom-fermented beer should cause alcoholism is in fact groundless. People seem to forget the medical experience that a beverage is as poison when concentrated, but harmless when it is consumed in diluted form.
>
> (Eriksen, 1993: 11)[1]

It was, however, not until after 1917 – influenced undoubtedly by the sharp increases in government taxes on spirits – that beer became the most popular beverage with Danish drinkers. Before 1917 only about 30 per cent of total alcohol consumption consisted of beer, but by 1918 beer accounted for 83 per cent of all Danish alcohol consumption. Beer continued to be popular and, in 1960, beer consumption still accounted for about 70 per cent of the total consumption. At this time, in the early 1960s, there were about 100 breweries in Denmark and consumer preference was heavily tilted towards the consumption of 'local' beers. By the end of the 1990s, due to commercial mergers, the number of breweries had been reduced to 20 and beer's share of total alcohol consumption had declined to about 50 per cent. From the year 2000 onwards, the structure of the brewing industry went through another change as the 'microbrewery' phenomenon gained popularity and, by 2007, there were again about 100 breweries in Denmark. These microbreweries produce a variety of specialist beers and rely for their commercial success less on allegiance to local producers than on the sophisticated preferences of beer drinkers across the entire market. In its annual report for 2008, the Brewers' Association noted that in 2007 no less than 556 different brands of beers were available to Danish consumers (Bryggeriforeningen, 2008). Nevertheless, beer's share of the market is still declining and in 2013 it accounted only for 37 per cent of total alcohol consumption (Bryggeriforeningen 2014).

Wine consumption in Denmark

Although wine has been consumed in Denmark since the thirteenth century, it was not until the middle of the fifteenth century that imports of wine began to be of any significance. From this time onwards, improved living standards in Denmark and livelier trade relationships with the other Western European

countries contributed to an increase in wine consumption. From the end of the fifteenth century one could find a relatively large selection of French, Spanish and German wines in Copenhagen and the bigger market towns (Elmeland, 1996). However, this form of alcohol consumption was largely the preserve of the upper classes throughout these centuries, and wine was not viewed as an ordinary commodity until the middle of the twentieth century. From the 1950s and 1960s onwards, increases in disposable income and the availability of affordable charter holidays to wine-producing, Southern European countries contributed to the growth of wine consumption by Danes. Red wine became a favourite with Danish consumers, in the beginning primarily among the upper social classes and the growing numbers of female alcohol consumers, but by the mid-1980s wine was established as an everyday commodity in Denmark. In 1960, the share of wine consumption accounted for 11.7 per cent of total consumption. By 1980, this share had increased to 39 per cent and, in 2013, wine was the dominating alcoholic beverage in Danish alcohol consumption with a share of 45 per cent of total consumption.

Distilled spirits in Denmark

The first recorded reference to the consumption of distilled spirits in Denmark would appear to have been in 1507, when accounts from Queen Christina's court list the purchase of brandy for 12 skilling (Troels-Lund, 1969). Initially distilled spirits were imported to Denmark, but soon the Danes learned to distil schnapps from bread grain and, later, potatoes. Alcohol in the form of distilled spirits was originally regarded as a medical product, available to consumers only through pharmacies; but from the middle of the sixteenth century it was seen as a stimulant and intoxicant commonly used by all drinkers. Legal distillation of spirits was a privilege attached to citizenship in the boroughs. At the beginning of the nineteenth century there were about 2500 legal distilleries in Denmark, to which should probably be added a much larger number of illicit home distilleries. In 1843, however, Danish customs authorities offered an amnesty to people willing to surrender their illicit home distillery equipment; many thousands availed themselves of this amnesty, effectively bringing an end to home distillation in Denmark (Mathiesen, 1977). In 1881, the Danish businessman C.F. Tietgen (1829–1901) established De Danske Spritfabrikker A/S (DDSF) (The Danish Distilleries). In 1923, the state granted Danish Distilleries a monopoly on the production and the importation of distilled spirits: the 'price' for this monopoly being state control of prices and terms of trade, thus guaranteeing a satisfactory revenue outcome for the state (Andersen and Weber, 1979). DDSF maintained this advantageous position in the Danish spirits market until 1973 when it lost both its production and import monopoly status.

Following the heavy taxation of distilled spirits in 1917, consumption decreased dramatically and stayed relatively low until the beginning of the 1960s. The reaction of the Danish people to the prohibitive price increases on

spirits introduced in 1917 differed to Sweden and Norway – where both illicit home distillation and smuggling increased substantially in response to similar price increases. The Danish sociologist, Thorkil Thorsen wonders:

> One might ask how it comes about, that smuggling and illegal distillation of spirits did not increase in Denmark in response to the high prices. Perhaps it was because the Danes then, as now, were a happy and well-balanced people who adapt easily to state power.
>
> (1988: 216)

In 1918, distilled spirits accounted for 12 per cent of total alcohol consumption, rising to 19.1 per cent in 1960. In 2000, it had fallen to 11.5 per cent, before rising to 17 per cent in 2013 (Bryggeriforeningen, 2014).

Alcohol consumption and drinking patterns in Denmark

Throughout history, alcohol has played an important role in Danish life, serving variously as a food, medicine and recreational drug for its consumers. Perceptions of how excessive drinking can create problems and how these problems might best be managed have also varied historically.

In the sixteenth and seventeenth centuries, heavy drinking across all social groups in the Nordic countries was so marked that historians later referred to this period as 'The Great Nordic Intoxication' (Troels-Lund, 1969). Throughout this period, Danish monarchs, including King Frederik II (1534–1588) and King Christian IV (1577–1648), gained European reputations for their alcohol consumption (Danstrup and Koch, 1984). An English envoy who visited the Danish Court gives the following description of the king: 'He is mostly drunk, as he was both on Saturday and Sunday and again on Monday. I am told that in this country it is custom to be drunk on three consecutive days' (Troels-Lund, 1969: 234). The royal physician, Cornelius Hamsfort, characterized the Danish nobility as follows: 'Most of the Danish people especially the nobility like to get drunk, and they often spend both days and nights emptying cups. And when a person totally unconscious of drinking is carried away, the rest laugh out loudly' (ibid.: 240).

Whatever attempts were made by the state during this period to regulate the drinks trade were primarily driven by economic concerns – such as controls aimed at restricting imports of German beer – rather than by concerns for public health or public order. But, in an interesting and early example of harm reduction, the superintendent in Sjælland, Peder Palladius (1503–1560), set out to alter popular attitudes towards drunkenness – not by advising people to avoid drunkenness but by suggesting how they behave when drunk:

> When you come together to have a toast with each other, then don't fight and quarrel but instead try to sing some good songs together. And when you later return to your home and wife, then let her also have a good

> night. Do not rebuke her or shout at her when you are drunk. So does no Danish man. If she, maybe, has behaved badly and you want to correct her, then do it in the morning when you are both sober.
>
> (Henningsen and Sørensen, 1982: 83f)

During the eighteenth and nineteenth centuries, many important changes took place in Danish society which, in combination, and in a complex manner, were to influence attitudes towards alcohol consumption. One such change was the introduction of tea and coffee to Denmark at the beginning of the eighteenth century. The fact that it was now possible to have a stimulating drink without getting drunk appeared to make Danes aware, as never before, that drunkenness and sobriety were conscious choices; and this in turn prompted the emergence of moral reflection on alcohol consumption. During the nineteenth century, Denmark also became more open to ideas from other Western European countries, as its trade links with these countries developed. The introduction of the Constitutional Act of the Kingdom of Denmark in 1849 gave Denmark its first democratic constitution, highlighting for the first time both the rights and responsibilities of individual citizens in determining their own fates. Increasing industrialization at this time had profound demographic effects in the form of a mass exodus from the rural areas to the cities – particularly to the capital, Copenhagen. The development of national health and social service systems at this time attested not just to a moral commitment to individual welfare rights but also to the importance of having a stable and healthy workforce (Kolstrup, 2014).

About the middle of the nineteenth century, concerns began to be voiced specifically about the negative impact of excessive alcohol consumption on industrial production and the importance of a sober workforce. The term 'alcoholism' was mentioned for the first time in 1849 when the Swedish physician Magnus Huss used it to describe the effects of a prolonged period of heavy drinking (Huss, 1849). Heavy consumption of alcohol was viewed as an inhibitory factor in relation to individual mobility; and during this historic period citizens' mobility – both the geographical, the social and the mental – was considered an important prerequisite for the socioeconomic development of Denmark (Elmeland, 1996). In the middle of the twentieth century the concept of 'addiction', with its emphasis on loss of control and continued heavy drinking despite clear evidence of serious negative consequences, gained currency in Denmark as elsewhere.

The temperance movement and Danish drinking culture

Numerous attempts to establish religion-based temperance societies in Denmark between 1840 and 1875 failed for lack of popular interest; but from 1879 onwards grassroots support for temperance grew, culminating in the creation of several national temperance associations. The most important of these were: Independent Order of Good Templars (initially founded in America in 1851)

which opened its first Danish lodge in 1880; a Danish branch of the Frelsens Hær (The Salvation Army) was established in 1887; and the Blå Kors (Blue Cross) was established in 1895. The ultimate goal of these temperance movements was to promote total abstinence from alcohol across Denmark, to be achieved by working gradually for:

- dissemination of information on the harmful effects of alcohol;
- motivation of individual citizens to abstain completely;
- legislative and broad public policy support for temperance, including the prohibition of alcohol.

Members of the temperance movements were recruited mainly from the lower classes, and particularly from the poorer, rural areas in the western and northern parts of Jylland. However, the upper and middle classes, and urban populations generally, were not supportive of the temperance movement, generally tending instead to see it as fundamentalist, fanatical and somewhat ridiculous. Although the Danish temperance movement survived into the twentieth century, with a membership of 137,436 in 1905 (Ædrueligh-edskommissionens Betænkning, 1907), it never achieved the political influence which it had sought; and, following increased alcohol taxes in 1917 and the consequent decrease in consumption, popular support for Danish temperance waned significantly.

In trying to explain why temperance ideology in Denmark was never as extreme or as influential as in other Scandinavian countries, two main explanations suggest themselves. The first of these is theological, and relates to subtle differences between various branches of the Lutheran Church. The Danish historian, Sidsel Eriksen, argues that religious temperance in Sweden in the late nineteenth and early twentieth centuries was heavily influenced by Anglo-American revivalist and temperance ideals, which emphasized that people should work constantly to become more virtuous and attain salvation; abstaining from alcohol was one important example of this striving for religious perfection. Danish religious culture, however, was heavily influenced by the nineteenth-century pastor, Nikolai Frederik Severin Grundtvig, a thinker whose views differed radically from those popular in other Scandinavian countries, not least in that he was critical of temperance:

> The Danish Revivalist Movement – especially its liberal Grundtvigian branch – was influenced by German Lutheran tradition. Grundtvig himself was a minister and poet who became a trendsetter in the nineteenth century Danish peasant culture. According to him, an individual could do nothing to achieve salvation, as faith was not a human accomplishment, but something given to the individual. This faith brought such a peaceful state of mind that the individual imperceptibly changed for the better, and this showed itself in daily life. It was only via the internal change that followed renewed faith that the individual could achieve genuine liberation

> from his or her vices. To attempt to better oneself via concrete action showed a lack of faith, and it could easily lead to self-righteousness. Therefore the temperance culture was self-righteousness and unnecessary in a Danish context.
>
> (Eriksen, 1993: 5)[2]

The other explanation commonly put forward for Danish scepticism towards religion-based temperance is simply that temperance ideas were unnecessary, insofar as Danish drinking habits were less extreme and problematic than those prevailing in other Nordic countries; this perspective is reflected, for instance, in the following account of Danish alcohol culture in *The Encyclopaedia of Alcoholism* (1982):

> There is a liberal attitude toward alcohol consumption in Denmark and the country experiences few problems with alcohol abuse. The national drinking pattern is one of frequent but temperate consumption of alcoholic beverages, mostly beer. The majority of the consumption takes place in the home; initial drinking by adolescents is usually done in the presence of adults; and there is little increase in the rhythm of drinking on weekends or holidays. Alcoholic beverages, including distilled spirits are sold in virtually all retail food outlets. There has been little variation in these patterns for years.
>
> (O'Brien and Chafetz, 1982)

Throughout the twentieth century, then, Denmark saw itself as a 'wet' but pleasant and manageable society when it came to alcohol consumption. Danish politicians did not accept the temperance view that alcohol was inherently problematic, that use of alcohol inevitably led to misuse, and that public policy should seek to control and restrict the supply of alcohol. They instead took the position that misuse of alcohol could and should be combated and controlled, without any undue interference with 'normal' alcohol consumption at the individual level. In this respect, alcohol and alcohol misuse were regarded as two different phenomena (Hansen and Andersen, 1985). In a report on alcohol in the Nordic countries, Kettil Bruun drew the conclusion that Denmark handled and viewed the alcohol political question totally differently from the other Nordic countries (Bruun, 1973); and, at a Nordic alcohol meeting on alcohol policy in 1975, the politician E. Jensen stated and defended liberal Danish approaches to alcohol policy:

> Even if it is not explicitly formulated, Danish alcohol policy is based on a completely different point of view than in the other Nordic countries. In Denmark the individual has its full freedom but acts under moral responsibility. And in this responsibility we can trust, as the Danes are enlightened and civilized people. The legislative power then only has one obligation – to see that the needed information is given.
>
> (Jensen, 1978: 26)

At a popular cultural level, differences between Danish and other Nordic perspectives on alcohol policy took stereotypical forms: where other Nordic countries viewed Danish political attitudes toward the alcohol question as ignorant and even stupid, the Danes on their side viewed the other Nordic countries as operating a double standard. On the one hand, Norway, Sweden and Finland had highly restrictive alcohol policies with retail monopolies, heavy taxation and high prices – on the other hand, there was no evidence to suggest that control policies were having any positive impact on consumption habits and related problems in these countries. Outside of Denmark, alcohol consumption was characterized by heavy spirits drinking at weekends, with a high prevalence of behavioural problems invariably linked to this style of consumption. Furthermore, the Danes – especially in Copenhagen and the northern part of Jylland – were regularly confronted by drunken Swedes and Norwegians crossing the borders to Denmark to purchase and drink cheap alcohol.

In 1991, Carlsberg launched a major commercial campaign changing the name of its lager from 'Hof' to 'Carlsberg'. In introducing Danes to the new name, the advertising consistently referred to Carlsberg as 'our beer'. A full-page advertisement in the Danish newspapers consisted of total blackness, other than a caption which read: 'Our humor – our beer'; and another advertisement picturing a gorilla said: 'Our roots – our beer'. One cinema advertisement, which portrayed a Swedish visitor entering a Danish pub and asking for a 'Carlsberg' beer, had the bartender answer: 'Before I can hand "our beer" over to you, you must make three promises: not to sleep in our parks, not to vomit in our streets and, finally, but most important – you have to take the last hydrofoil back to Sweden!' (Elmeland, 1996: 148).

This advertising strategy reflects the extent to which Danes had constructed an image of themselves as a population with a liberal alcohol policy, where the 'freedom to drink', combined with overall information about and education on alcohol, created non-problematic, self-controlled and self-regulating drinking habits. This self-image was quite clearly based on perceived differences between Danish drinking behaviour and the drinking behaviours thought to typify other Nordic peoples. Another example is the description of Danish football fans as 'Roligans'. 'Roligan' is a pun on the English term 'hooligans' (*rolig* means 'quiet' in Danish). The Danish Roligans, in that respect, were the Danish answer to the English football hooligans and were portrayed in the Danish media as friendly, non-violent 'drunken Danes' (Eriksen, 1993).

In 1985, the WHO Regional Office for Europe launched the programme: 'Targets in Support of the European Regional Strategy for Health for All' (WHO, 1985). Target 17 in the program was to reduce alcohol consumption by at least 25 per cent by the turn of the century. All the Nordic countries were officially affiliated with the program. Evaluating the effectiveness of the alcohol target in Nordic countries, the Finnish alcohol researchers Kerstin Stenius and Esa Österberg stated: 'With the exception of Denmark, alcohol is seen as a serious problem for the whole population, and it is held that one of

the most important ways of combating alcohol problems is to reduce the total consumption of alcohol' (1988: 229). They also observed that in Denmark no measures were taken at the governmental level. In a speech at a meeting of the Danish Alkohol-og Narkotikarådet (Alcohol and Drug Council) in 1988, the Danish Minister of Health, Agnete Laustsen, made the following comment on Target 17 in the WHO programme: 'In my opinion the amount of total alcohol consumption is of no interest if we do not see any problems linked to it' (ibid.: 222).

So in the latter half of the twentieth century levels of alcohol consumption in Denmark were regarded as high but relatively unproblematic. This point of view changed significantly around the millennium – how, why and in which directions will be described in Chapter 9.

The Sobriety Commission, 1903

In 1881, the Statistical Bureau reported that the average annual consumption of distilled spirits was about 60 litres per *adult man* and the consumption of beer was increasing (Mathiesen, 1977), and the politicians were aware of the obvious destructive influence of the increasing consumption on the workforce. In 1903, the Danish government established what was known as the Sobriety Commission and asked it to make recommendations as to how consumption might be reduced. In its report, (Ædruelighedskommissionens Betænkning, 1907), the Commission differentiated between strategies which have a direct impact on individual citizens, and indirect or environmentally-focused strategies. This kind of differentiation, which mirrors present-day WHO thinking on alcohol problem prevention, was described as follows: 'There are two pathways to achieving a decrease in alcohol consumption: actions which aim at direct influence on the individual citizen and more indirect actions which aim at regulating the external conditions' (ibid.: 14). Strategies aimed at influencing individuals recommended by the Commission included various types of education or awareness-raising on the subject of alcohol's harmful effects, as well as the creation of 'rescue homes' or treatment centres for drinkers ('drunkards') who had already developed problems. Examples of indirect or environmentally focused actions identified by the Commission included the improvement of public leisure activities, such as sport facilities, libraries, museums, and concert halls. The Sobriety Commission acknowledged that higher taxes and overall increases in the retail price of alcohol could constitute an environmental strategy, but it expressed ideological reservations about their use: 'Is this a legitimate objective for the state? Is it not an unwarranted interference in the freedom of the individual and our freedom to choose the stimulants we prefer?' (ibid.: 28). The commission also discussed the possibility of restricting availability of alcohol at the retail level as an environmental strategy, but concluded that it would be very difficult to take effective legislative action in this regard: 'In our modern times, where we have both the telephone and the railways – you can at any time easily order and get the alcohol you

want – also in an illegal way' (ibid.: 32). However, the commission also strongly recommended that the numbers of pubs and bars should be reduced – a conclusion that mirrored the report of the Royal Commission on Licensing in England four years earlier. So in the conclusion of the report, the need for specifically three areas of future intervention was highlighted: (1) education about alcohol; (2) people drinking in the streets; and (3) treatment for abuse of alcohol.

In the Primary Education Act of 1937, education focusing on alcohol and its adverse health effects was made obligatory in Danish public schools. In the following a description of the development of the other two recommended intervention areas will be given.

Licensing policies

Following the enactment of the Freedom of Trade Act, 1857, which allowed all citizens to start businesses, the second half of the nineteenth century witnessed a major increase in the number of pubs and bars in Denmark. However, a Licensing Act of 1912 obliged owners of public houses to have both a business licence and a publican's licence. The granting of publicans' licences was based on a number of considerations, including the applicants' personal records and histories. In cities, publicans' licences were initially issued by a licensing board, in rural municipalities, by the county council – on the recommendation of the city council.

The law has been revised on several occasions including in 1924 (Roelsen and Skat-Rørdam, 1937), where it was enacted that licences from now on could not be granted on a 'life-time' basis but only for a maximum period of eight years. And according to elections regarding licences in the rural municipalities rules were set up. In rural municipalities in cases where 35 per cent of the municipal electorate was in favour, licences could be revoked. These kinds of elections had been carried out in practice since 1907 without statutory authority – but it was not until 1924 that this practice was put into statutory form (Thorsen, 1993: 77). In the year 1925, there were 43 decisions regarding granting licences based on municipal elections, in the years 1942 and 1943 the numbers of these kinds of decisions had decreased to 19 and 15 cases (ibid.: 78). In 1970, the statutory provision regarding elections in the rural municipalities ceased to exist. The justification for this decision was rather pragmatic – that the municipal reform (1970), which reduced the numbers of municipalities in Denmark from 1098 to 277, made it impossible to differentiate between city and rural municipalities.

In the revised Licensing Act of 1939, the legal age limit for serving alcohol beverage was set at 18 years in § 33, section 2 (ibid.: 84). In 1970, jurisdiction over the administrative revocation of licences was given to the National Licensing Board. In 1978, the law was again revised, among other things to facilitate the revoking of licences. However, the only authority with powers to revoke a licence remained the National Licensing Board. Furthermore, the

1978 amendment imposed comprehensive responsibilities on licensees (prohibiting them, for instance, from serving alcohol to under-age customers or to customers ordered by the courts to undergo treatment for alcohol-related problems, and obliging them to ensure that intoxicated customers were escorted safely home); failure to comply with these detailed responsibilities in relation to supervision of their premises constituted criminal negligence. These provisions regarding mandatory supervision by the licensee were repealed in 1993, as they proved impossible to enforce in practice. A legislative amendment in 1986 transferred the authority to revoke licences from the National Licensing Board to the local level, that is, to the city council or the local licensing board. A provision was also added that licences should be revoked in repeated cases of serving minors or intoxicated customers (Thorsen, 1993). The 1993 Licensing Act is the main legislative instrument in Denmark today, although it has been revised several times since.

The question of opening hours has been a disputed aspect of the licensing system in Denmark throughout the twentieth century. In 1993, the city councils/licensing boards gained the right to exempt licences from normal closing times, which until then had been 12:00 p.m., and allow premises to stay open until 2:00 a.m. Authorization from the police was still required to stay open until 5:00 a.m. The arguments for this change were that customers´ habits had changed so they now arrived at the pubs and bars later than had previously been the case. Furthermore, it was argued that if the opening hours differed too much, it would cause problems with traffic and public order as the guests moved from one bar to another with longer opening hours (Thorsen, 1993). The number of pubs and bars with night licences increased steadily from the 1960s to the 1990s, then it stagnated but remained at a relatively high level (Elmeland et al., 2008).

Views on alcohol abusers and treatment

As previously mentioned, the predominant view – shared by politicians and the Danish public at the beginning of the twentieth century – was that alcohol consumption and alcohol abuse were two categorically different phenomena; the minority of the population which appeared to be incapable of controlling its consumption was regarded as suffering from a kind of 'character weakness'. In this context, the Sobriety Commission of 1903 believed that the goal of the treatment offered to abusers should be: 'To strengthen their body, to educate them to an industrious life and give them moral strength to resist future temptations' (Ædruelighedskommissonens Betænkning 1907). Therefore, during the first half of the twentieth century the prevention of alcohol problems was seen primarily in terms of imposing disciplinary measures on heavy drinkers in order to keep them away from the bottle; such drinkers were sent to labour camps for up to two years, and those considered to be addicted to alcohol were subject to various restrictions of their civil rights – including the right to vote (Thorsen, 1993). However, as in other countries, the outcomes of forced treatment in labour camps and other forms of residential rehabilitation were

poor; and this treatment policy of physically isolating 'the man from the bottle' did not seem very successful (Stürup, 1959).

But by the middle of the century the 'disease concept of alcoholism' had begun to make an impact on Danish policy and legislation. The publication in 1958 of Report No. 208 – a health policy document on the topic of 'care for alcohol sufferings' – provided the impetus for change in the attitude of the health system towards a group of service users previously described as 'drunkards'. As discussed elsewhere in this book, during the mid-twentieth century 'alcoholism' was increasingly regarded as a disease rooted in the individual drinker, and unrelated to issues of supply. After 1960, the care of alcohol-dependent patients was governed by the Hospital Act rather than the Act on Public Care. This led to the establishment of a number of out-patient alcoholism services within the wider healthcare system (Smidth-Fibiger, 1991). Even prior to the formal acceptance at policy level of the disease concept, however, some medical developments in Denmark had already occurred which challenged the idea that problem drinkers were weak-willed 'drunkards'. In particular, the discovery by Erik Jacobsen, a physician, and Jens Hald, a pharmacist, of the potential clinical value of the drug disulfiram contributed to an openness to medical treatment of alcoholism by Danish healthcare providers. Disulfiram (marketed subsequently as Antabuse) alters the way in which the human liver breaks down alcohol, and causes drinkers to experience immediate and unpleasant symptoms – marked by palpitations, shortness of breath and nausea. The way Antabuse was introduced and sold as a medication was markedly different from present practice, where new substances are put through year-long clinical trials and processes of approval. In 1945, following the discovery of disulfiram by Jacobsen and Hald as a possible medication for the treatment of alcoholism, in 1947–1948, clinical trials were carried out by psychiatrist Oluf Martensen-Larsen, where he used disulfiram as a part of the treatment plans. Martensen-Larsen published his results in 1948 in an article on the topic in *The Lancet* (Martensen-Larsen, 1948). As early as December 1948 Antabuse was largely ready for use in the treatment of alcoholism in Denmark (Thiesen, 2007: 123).

Clinicians used this drug with the consent of patients, as a 'chemical extension of willpower' (Jensen, 1981) and generally its use provided an alternative to the view that the only prospect for success in treating alcoholics lay in physically 'isolating the man from the bottle' – now it was also possible to chemically 'isolate the man from the bottle'. The use of Antabuse attained a strong and long-lasting position in Danish treatment of alcoholism. In 1988, an evaluation of the Danish out-patient treatment system was carried out and here it was stated that, in 97 per cent of all the cases investigated, Antabuse medication was part of the treatment (Skinhøj et al., 1988).

In 1975, responsibility for the provision of treatment services for problem drinkers was transferred from the Ministry of the Interior to the county authorities. Administratively, these treatment systems were based within the health sector but tended to be delivered through a combined health and social service arrangement (Karlsson and Österberg, 2002). Throughout the 1970s and

1980s, however, no single model of alcoholism treatment enjoyed undisputed dominance in Denmark. From the early 1970s, challenges to the disease concept emerged both in the form of suggestions that alcohol problems were merely symptomatic of underlying socioeconomic difficulties, and in the form of psychoanalytically inspired models which suggested problem drinkers were best helped by analytically-focused therapies which explored their psychological difficulties (Nielsen, 1992). In 1985, the so-called 'Minnesota Model', which had its origins in the Twelve-Step program of Alcoholics Anonymous, was introduced to Denmark as a private treatment option. The Minnesota Model epitomized the American disease concept: alcoholism was a disease in its own right, for which total abstinence was the only valid outcome of treatment, and treatment primarily consisted of 'working' AA's programme of recovery.

By the end of the 1980s, alcohol treatment was being delivered through three types of institutions:

- publicly established and publicly financed institutions, including outpatient and inpatient clinics – including care in specialized hospital units;
- private institutions, mainly run by temperance movements, on the basis of contracts with county authorities;
- completely private clinics.

There was also some care for problem drinkers provided by general medical practitioners.

The alcohol issue: political actors and organizations

After the Sobriety Commission published their report in 1907, a number of other sobriety and alcohol commission reports regarding the alcohol issue were submitted (in 1918, 1927, 1938 and 1960). The reports all ended up with recommending further public education on, and information about, alcohol. These recommendations might indicate a belief that information and education had proved valuable and therefore 'more of the same' was wanted; by contrast, they may indicate that, throughout this period, little or no attention had been paid to education about alcohol. The 1960 Alcohol Commission report suggests this was the case, stating that: 'It does not seem as though the primary and lower secondary schools fully understand the importance of teaching the pupils about alcohol and its adverse health effects' (Thorsen, 1993).

In 1933, a position was established as a 'Sobriety Consultant' (Ædrueligh-edskonsulent) for the parliament and ministries. The consultant`s role was to follow international alcohol-related work and research, recommend alcohol-related teaching material to the public schools, function as information agency and provide an advisory function to the public in regard to alcohol related-questions. The consultant – Jens Rosenkjær (with an MA degree, a chemistry teacher) – was, however, only given a small fee and no economic resources to cover the costs related to the different tasks. By 1948, this position was unpaid entirely and had fallen into abeyance.

In 1963, the position was re-established now as an alcohol consultant for the Ministry of the Interior. From the start of the 1960s, there was a steady increase in overall consumption of alcohol and the consultant, Svend Skyum-Nielsen (a professor, a social psychology academic) on several occasions pointed to this increase as a phenomenon, suggesting it would create future problems. In his business report of 1963–1965, the consultant recommended a number of concrete measures (Skyum-Nielsen, 1966):

- to strengthen education and information about alcohol;
- to give a higher priority to alcohol research;
- to create a commission on alcohol and traffic;
- to establish more knowledge about alcohol statistics and alcohol-related harms data;
- to provide increased financial support to temperance organizations.

However, none of these recommendations were complied with by the ministry or by the parliament, and in 1971 the consultant resigned.

At that time there was no pressing public or political concern about alcohol consumption. Instead, the growing use of narcotic drugs and marihuana, especially among Danish youth, were the focus of media and political attention. In 1969, an advisory consultant, Peter Schiøler (with an MA degree, a psychology lecturer) was appointed in the Ministry of Education with special regard to narcotic drugs, and a further eight local drug consultants were appointed the same year – each covering different geographical areas. In the same year Kontaktudvalget vedrørende ungdomsnarkomanien (The Consultative Committee concerning Youth Narcomania) was established as an inter-ministerial and multidisciplinary advisory committee. The eight local drug consultancies were abolished in 1976, after the Ministry of Finance refused to prolong their period of employment. The advisory consultant and the advisory committee continued their work, but both now had to take alcohol into account, not only with regard to Danish youth but to the whole population. At the same time the committee was renamed 'The Alcohol and Drug Council'. The argument for this restructuring was, that 'we suspect the amount of alcohol consumed among Danish youth is increasing, and we recognize that prevention of alcohol problems and drug problems are difficult to separate' (Kontaktudvalget vedrørende alkohol- og narkotikaspørgsmål,, 1978: 15). The Alcohol and Drug Council was placed under the Ministry of Social Affairs.

In the latter half of the twentieth century the responsibility for securing and offering treatment for alcohol-related problems was placed in the counties[3] while prevention of these problems was considered the task of the 275 municipalities (then in office).

The Danish alcohol researcher, Knud-Erik Sabroe gives the following description of Danish alcohol policy in the latter half of the 1980s:

> In the growing international debate on alcohol policy, Denmark has not taken a prominent position, which has caused critics of the Danish attitude

> to claim that it is a choice of words, when we characterize our alcohol policy as *liberal*. A more accurate description of the policy would be *indifference* with the implicit understanding that we do not face the alcohol-related problems resulting from the high Danish (per capita) consumption. Though such a statement might get support from, for example, our Scandinavian brothers and sisters, it is unlikely that this view would be accepted or be understood in its problem-formulation by Danish politicians or among the common Danes. Danish alcohol policy has for many years been dominated by the assumption 'That … a liberal attitude, relatively free of restrictions will give the best long-term results' (Minister of Social Affairs in the Danish Parliament, March 1984) … The classical threesome: *control, restricted availability* and *price setting*, thus, in Denmark, is only utilized with regard to the last mentioned and some critics – especially from our Scandinavian sister-countries – would say not even in sufficient degree.
>
> (Sabroe, 1992: 3)

Conclusion

As this chapter has shown, Denmark has always adopted a liberal approach towards alcohol consumption and alcohol policy. Danish alcohol policy has differed markedly from other Nordic countries and other countries, where temperance and prohibition approaches gained a firm foothold in the nineteenth century and continued to exert considerable influence on policy into the late twentieth century. In Denmark, the problem has been framed in dichotomous terms, separating out those who 'abuse' alcohol from the majority of the population who consume responsibly. State intervention in Denmark has focused on raising public awareness, providing education and providing treatment for dependent or problem drinkers; control strategies aiming to restrict availability of alcohol have been deemed unnecessary and culturally inappropriate. In Chapter 9, we will see how Denmark has responded post 1990 to the increasing pressure to develop a comprehensive alcohol policy that promotes the WHO 'ideal' and uses control strategies as the primary response to address alcohol-related harms.

Note

1&2 Quotations from: Erickson, S. The making of the Danish liberal drinking style: the construction of a "wet" alcohol discourse in Denmark. Contemporary Drug Problems pp. 1–31. Copyright © 1993 by SAGE Publications, Inc. Reprinted by permission of SAGE Publications, Inc.

3 At that time the administrative organization of public authorities in Denmark was: state, counties, municipalities. The counties were responsible for issues that required special expertise that municipalities usually did not possess, e.g. because the issue or problem was not that common. This means that municipalities were responsible for basic welfare and counties were responsible for specialized welfare.

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9 Alcohol policy in Denmark, 1985–2015

Introduction

This chapter presents developments and actions taken in the alcohol policy field in Denmark over the past three decades. As shown in Chapter 8, the alcohol question was never a big issue on the political agenda or in general public debates. And this still applies today. However, during this period there have been important shifts and initiatives in alcohol policy, which – although not coordinated and although initiated from different political levels and from different organizations – together have contributed to drive Danish alcohol policy in a more restrictive direction.

The first section of the chapter sketches out the policy actors and organizations involved in the field since the late 1980s. It describes how responsibilities for research, prevention and treatment have changed over time as political and administrative structures changed and as some stakeholder groups declined while new, more powerful policy entrepreneurs emerged. The second section documents the role of research in producing the evidence needed to inform policy, the gradual shift towards accepting a total population model – at least at the political level – and the implementation of some more restrictive measures. At the same time the section highlights continuing resistance regarding adoption at national level of the restrictive measures called for by the whole-population model and illustrates the entrenched nature of the liberal approach and the dichotomous model of alcohol-related harm; importantly, it also highlights the impact of fragmented responsibility for different aspects of alcohol. Two main tools in the Danish approach to prevention of alcohol-related problems are then presented: an annual alcohol campaign and local prevention projects at the municipality level. While the first approach has a focus on individual behaviour, the second adopts an environmental approach to change based on a 'systems' model which requires attention to local systems and interactive processes involving a range of stakeholders as well as consumers. The chapter then considers public attitudes towards alcohol consumption as a factor in influencing the direction of alcohol policy and reflects on the continuing reluctance to support restrictive measures to reduce consumption despite a growing belief that consumption is too high. In conclusion, some of

the possible factors that have influenced Danish alcohol policy over time are discussed and, in particular, the importance of public attitudes and opinion is noted. Danish politicians have claimed public attitudes as one of the most important alcohol policy tools with regard to reducing the harms related to alcohol consumption. The picture which emerges is one of continuing belief in a liberal policy approach which responsibilizes the consumer despite a shift, over the past two decades, to more restrictive policy measures more in line with the WHO 'ideal'.

Policy actors, organizations and research

Sales of alcohol peaked in the mid-1980s with consumption reaching 12.8 litres per annum for people aged 15 or over in 1983 (WHO, 2014). Responsibilities for alcohol policy were divided. The responsibility for monitoring, coordinating and conducting relevant research in the alcohol field was placed with the Alcohol and Drug Council under the Ministry of Social Affairs. The economic responsibility for the treatment of alcohol problems was placed in the counties while the responsibility for the prevention of alcohol- and drug-related harms was placed in the municipalities.[1]

In 1985, the Alcohol and Drug Council took the initiative to establish other research environments. As preparation for this restructuring, a report on Danish Alcohol research 1980–1985 was published (Nielsen and Lund, 1986). The report showed that the alcohol and drug research carried out in Denmark was sparse and most of it was within the medical field with a focus on alcohol abuse. The report furthermore stated that the research carried out was uncoordinated and that there was a serious lack of research environments. In 1988, a five-year research initiative known as the Initiative on Alcohol and Drug Research – RFI (Rusmiddelforskningsinitiativet) was established. This was made possible through the cooperation of the national research councils, the Danish National Institute of Social Research and the Ministry of Social Affairs. The aim of the initiative was to stimulate more alcohol and drug research and to create permanent research environments capable of accumulating knowledge and engaging in more fundamental and international alcohol and drug research (Rusmiddelforskningsinitiativet, 1993). As a result of the RFI's efforts, the Centre for Alcohol and Drug Research was established in 1991 at the Faculty of Social Science, Aarhus University; this was Denmark's first cross-disciplinary alcohol and drug research centre. In connection with the formal establishment of the centre, a new overview of alcohol and drug research in Denmark was prepared (Elmeland, 1993). Following the findings of the overview, it was decided that the centre's research endeavours should cover four main areas: treatment, prevention, consumption and policy, since especially social science research in these areas had hitherto been wanting. From 1991 to 2001, the existence of the centre hinged exclusively on time-limited funds, but in 2001, on the recommendation from the Ministry of Social Affairs, the Danish Budget Bill allocated permanent funding to the

research centre (Pedersen et al., 2010). Today, alcohol research is also carried out at other academic institutions with permanent alcohol research environments (e.g. the National Institute of Public Health, the Danish National Centre for Social Research). These initiatives brought researchers more prominently into the alcohol field as stakeholders, provided a foundation for developing the evidence base for policy and practice, and furthered the participation of Danish researchers in international collaborative networks.

In 2007, extensive reform and modernization of the public sector took place in Denmark. The Structural Reform meant that on 1 January 2007 the counties ceased to exist and instead five regions were formed, and the 271 municipalities were reduced to 98. Substance abuse treatment along with prevention of alcohol- and drug-related harms now came under the authority of the municipalities. This meant that the municipalities could either choose to take over the services from the substance misuse centres of the counties, establish their own centres, or let the regions provide alcohol and drug services. The municipalities chose a range of different models (Bjerge, 2009). Thus, the increased decentralization of responsibility for treatment and prevention from 15 counties to 98 municipalities increased the number of stakeholders at the local level and the diversity of services provided. However, from the mid-1990s, evaluation and research have had a relatively significant influence on the formulation of Danish treatment policy. Changes include: public approval needed for private treatment facilities; all clients enrolled in public as well as in private treatment are registered according to: severity of problems, which services they receive, and the treatment sequence. Following these developments, because of the growing need – and especially political pressure – for 'evidence' in the treatment system, during the 1990s, this field became more professionalized. At the same time, as we will see later, when the municipalities became economically responsible for both prevention and treatment of alcohol and drug problems in 2007, this offered them a new incentive to rethink their local preventive strategies.

A number of other developments were important for the evolution of stakeholder groups and for their centrality to alcohol policy and practice. In 2011, an independent council: 'The Council on Health and Disease Prevention' (Vidensråd for forebyggelse) was established by the Danish Medical Association and the Danish Foundation, TrygFonden.[2] The Council on Health and Disease Prevention consists of 15 members, all experts and researchers with knowledge of different diseases and health risk factors, including alcohol, smoking, mental health, and obesity. The council's main purpose is to gather and disseminate information about health risk factors in everyday life to citizens, politicians, social workers and other relevant professionals. More central to alcohol policy, in 2011, the old temperance societies, which had very few members and no political influence, were closed down and instead the organization 'Alcohol and Society' (Alkohol & Samfund) was established. The organization is independent of political, religious and commercial interests. The society is not abstinence-based as such; rather, it aims to challenge

Danish alcohol culture in order to prevent alcohol problems, and to place the alcohol issue on the political agenda (Alkohol & Samfund, 2013). The activities of the organization include, among other things: building platforms for professionals and organizations that work with prevention, treatment and alcohol policies; citizen-centred prevention and education; and promotion of knowledge and research. On the board of the organization there are researchers, a representative of the former temperance movements and a local politician. In 2011, Alcohol and Society was financed by state funds, but since 2011 the budget has expanded and in 2014, 25 per cent of the expenses were covered by private funding, most of them from the TrygFonden (Alcohol & Samfund, 2015).

In 2012, an alcohol health coalition emerged to push for a more robust alcohol policy. Alcohol and Society, together with 11 of the biggest organizations in Denmark, submitted an alcohol policy appeal to the Health Minister with suggestions for a more comprehensive Danish alcohol policy at both national and local levels. Among the organizations linked with Alcohol and Society were: the Trade Association for Danish Grocers (De Samvirkende Købmænd), the FFF Union Centre (Fagligt Fælles Forbund), the Danish Cancer Society (Kræftens Bekæmpelse), the Council for Traffic Safety (Rådet for Sikker Trafik), the Danish Sports Organization (DGI), and the Danish Medical Association (Lægeforeningen). The policy suggestions included, for instance, a requirement for all municipalities to have a 'night-life-policy', to lower blood alcohol content (BAC) limits in the first years after acquiring a driving licence, a ban on alcohol in marketing to adolescents, and easier entry into the alcohol treatment system for clients. Even though the suggestions in the policy appeal may not seem that ambitious – centred mostly on further information and implementing local alcohol policies, the appeal was a manifestation of a new actor in the alcohol policy field. In contrast to the previous temperance societies, who were considered to be too moralistic in their view on alcohol, these new organizations consist of experts, who claim only to have health interests at heart; and, also in contrast to the temperance societies, they have important economic support. So, for the first time in Danish history, important policy entrepreneurs put the alcohol issue on their agenda.

In the following sections, a chronological description will be given of events and occurrences which have contributed to attempts to activate policy towards a continuous model of harm by shifting perceptions of the alcohol issue from a moral and ideological question regarding the behaviour of heavy drinkers to a common health policy question regarding the lifestyle and health of all Danes.

Alcohol policy: legislation and licensing, 1985–2015

The years between 1986 and 2012 witnessed a steady increase in concern about the effects of alcohol consumption accompanied by the emergence of a strengthened regulatory response to addressing the problems. Concerns were fuelled by growing evidence of alcohol-associated harms, the shift towards a

lifestyle perspective on risk and disease prevention, which included alcohol as one of the risk factors, and the links with international research and policy activities. Major events and legislation are outlined in Box 9.1 and discussed below.

Box 9.1 Major events and legislation, 1986–2012

1986 First analysis of the socioeconomic consequences of alcohol consumption in Denmark.

1988 The counties start the campaign 'Alcohol in the workplace'.

1990 In a report by the Alcohol and Drug Council (A Hundred Years of Alcohol Misuse), a correlation between total alcohol consumption and the proportion of alcohol-related harms in Denmark is demonstrated for the first time.

1990 Low-risk drinking guidelines are introduced in Denmark: 14 standard drinks for women and 21 for men per week. The Danish Health and Medicine Authority's week-long alcohol campaign started in October 1990 and has been repeated every year since, in October.

1995 Denmark signs the WHO European Charter on Alcohol.

1997 The results of the first ESPAD survey are published, showing that Danish youngsters consume more alcohol, are more intoxication-oriented and experience more alcohol-related problems than other European youngsters.

1998 The BAC limit for drink driving is lowered from 0.08 per cent to 0.05 per cent.

1998 An age limit of 15 years for purchasing alcohol is introduced by law.

1999 The first Public Health Programme is launched. The prevention of alcohol-related problems is brought in line with prevention of other lifestyle diseases e.g., from unhealthy diets, lack of exercise and smoking.

2004 The age limit for purchasing alcohol is raised to 16 years.

2005 A supplementary recommendation is added to the drinking guidelines, according to which people should not drink more than 5 standard drinks per session/day.

2007 Structural Reform: the counties cease to exist and five regions are formed. The 271 municipalities are reduced to 98. The responsibility for substance abuse treatment along with prevention of alcohol- and drug-related harms now comes under the authority of the municipalities.

2010 The age limit for purchasing spirits and liqueur (with an alcohol volume of 16.5 per cent or more) is raised to 18 years.

2010 The drinking guidelines are supplemented with very low-risk guidelines: 7 standard drinks for women and 14 for men per week.

2012 Alcohol & Society together with 11 of the biggest organizations in Denmark submit an alcohol policy appeal to the Health Minister.

In 1986, the first analysis of the socioeconomic consequences of alcohol consumption in Denmark was conducted by the Department of the Interior (Indenrigsministeriet, 1986). The analysis showed that the cost of alcohol-related harms in general was a very weighty item in the Danish national budget – and it was not heavy drinkers and treatment that contributed most to the expenses. Costs from lost working-days, visits to the doctor, harms related to intoxication and other difficulties related to 'normal' alcohol consumption, ranked highest. Such economic analyses have been repeated and updated several times since 1986 – with similar results – most recently in 2014 (Kjellberg and Aavang Poulsen, 2014).

In 1988, the counties started a campaign on alcohol in the workplace. Back in the late 1970s, it was estimated that one third of the total consumption of alcohol was consumed in the workplace (Sabroe and Rasmussen, 1995); so in the 1980s there was a stronger focus on the workplace as a 'field of consumption' (Colling, 1989a; 1989b). During the next 5–10 years, alcohol consumption patterns in Danish workplaces totally changed; today alcohol consumption is almost non-existent in workplaces, and there is broad support for a ban on alcohol in the workplace among the Danish population.

In 1990, the Alcohol and Drug Council was closed down and its duties transferred to the Danish Health and Medicine Authority under the Ministry of Health. The last report published by the Alcohol and Drug Council was *Hundrede års alkoholmisbrug* [A hundred years of alcohol misuse] (Thorsen, 1990). In this report a correlation between total alcohol consumption and the proportion of alcohol-related harms in Denmark was proved for the first time. Until this time Danish politicians had refused to accept that the total consumption model was applicable to Denmark. Not only the politicians, but also Danish citizens and people working in the alcohol field refused to take the total consumption model into account – as Denmark was seen as a 'special case' (Thorsen, 1991). When the report was published, almost no political attention was given to the results. The author of the report wrote a commentary where he presented the results and discussed the implications of the findings to rethink Danish alcohol policy; he then sent it to the biggest newspapers in Copenhagen. The newspapers refused to publish the commentary on the grounds that it did not say anything new and certainly nothing of interest to the general public (ibid.). But in 1992, the Danish Minister of Health, in an interview with a Nordic journal, stated that she did not think that in Denmark, there were, any longer, arguments to refute the total consumption model (Thorsen, 1993); and in an article in 1992, two central administrative officials described the total consumption model as the basis for the Danish Health and Medicine Authority´s alcohol campaign (Asbjørn and Iversen, 1992).

Also in 1990 the Danish Health and Medicine Authority introduced low-risk drinking guidelines: 14 standard drinks[3] for women and 21 for men per week. These guidelines have been promoted yearly since 1990 in the annual 'Week 40' campaign that takes place in the autumn. A supplementary recommendation was added to the drinking guidelines in 2005, according to which people

should not drink more than 5 standard drinks per session/day. In 2010, the guidelines were again supplemented with very low-risk guidelines: 7 standard drinks for women and 14 for men per week (Elmeland and Villumsen, 2013).

In 1995, the Danish Government signed the WHO European Charter on Alcohol. No public or political debate took place.

By contrast, in 1997, the results of the first ESPAD survey (the European School Survey Project on Alcohol and Other Drugs) were published (Hibell et al., 1997), showing that alcohol consumption among young Danes was very high, their pattern of drinking was intoxication-oriented and they had very early onset of consumption. Danish youngsters also reported a high frequency of problems caused by their own alcohol use: personal, sexual and delinquency problems as well as problems with relationships generally. As, before 1997, little public or political attention had been paid to drinking habits among Danish adolescents, the results of the survey created headlines as well as a heated debate in all the national media.

In 1998, the BAC limit for drink driving was lowered. Until 1976, there had not been a fixed BAC limit in Denmark, but drivers were punished if they had been drinking so much that they could not drive safely. In 1976, it was decided to prohibit driving with a BAC above 0.08 per cent. In 1998, the BAC limit was lowered to 0.05 per cent (Lov nr. 73 af 04.02.1998).

From 1970 to 1998, no age limit was set on selling alcohol beverages in Danish shops. An age limit of 15 years was set by law for purchasing alcohol in 1998 (Lov nr. 411 af 26.06.1998), raised to 16 years in 2004 (Lov nr. 213 af 31.03.2004), and in 2010 the age limit was pushed up to 18 years to purchase spirits and liqueur (with an alcohol volume of 16.5 per cent or more) (Lov nr. 707 af 25.06.2010). There was a high level of political agreement on the changes – and they also took place almost without any public debate at all.

In 1999, the first Public Health Programme was launched in Denmark by the Ministry of Health (Sundhedsministeriet, 1999) under the Social-Democrat/Social-Liberal Government. The reason for this was a growing concern over the average life span of the Danish population, and the fact that, in a European context, the Danish position was declining heavily. In the Foreword to the programme, it stated: 'Our lifestyle is the cause of this – tobacco, alcohol, accidents, too fatty diet and too little or no activity. All these risk factors can be prevented' (ibid.: 5). In the programme, prevention of alcohol-related problems is mentioned along with prevention of other lifestyle diseases. Goals for initiatives in the alcohol field mentioned, 'The number of heavy users of alcohol has to be reduced significantly. Alcohol consumption among young people should be reduced and alcohol consumption among children and adolescents should be eliminated' (ibid.: 41). The initiatives needed to achieve the goals were:

- All municipalities should have local alcohol policies.
- All workplaces should have an alcohol policy.
- Education of social workers was needed – in early detection of alcohol problems in families.

- National campaigns should inform the public about the drinking guidelines.
- Every educational institution should have an alcohol policy.

In 2002, a new Public Health Programme was launched by the Liberal/Conservative government, with almost the same goals and the same text (Indenrigs- og Sundhedsministeriet, 2002). Consistent with the traditional Danish liberal-political approach to alcohol, the following statement was included: 'It is vital that individual autonomy is respected. The government should not control our lives' (ibid.: 4).

In 2014, the Social-Democrat/Social-Liberal Government launched the latest public health programme, called 'Sundere liv for alle' [Healthier lives for all] (Ministeriet for Sundhed og Forebyggelse, 2014). The programme does not differ much from the previous one. However, two goals for alcohol prevention initiatives are mentioned. First, the proportion of the Danish population drinking more than 14/21 units per week should be reduced by one-third. Second, the proportion of adolescents who have been drunk before they reach the age of 15 should be reduced by one-third. The programme does not give any explanation why the reduction is set at a third.

The different public health programmes stipulate different targets and means – most of them pointing in the direction of solving the problems at local levels. But as there are no financial resources earmarked for the means and measures, the programmes could be viewed more as political statements than activity plans. It is clear that it is up to the different agents in different services and administrations to act as decision-makers and to prioritize and finance public health and the prevention of alcohol-related problems. Thus, local level stakeholders in the municipalities have considerable sway over the priority and financing of initiatives both in competition with other areas of health concern and as regards the kinds of alcohol specific initiatives deemed appropriate and fundable.

Turning to licensing, an Act in 1997 gave the police the right to impose the implementation of specific measures in public houses, for example, video surveillance of people entering the establishments could be required if there was an identified risk of violent behaviour. Public houses with special risks of disorderly and/or violent conduct are seen to be those that typically attract young guests, have many guests at late hours, and have frequent queues. The question of employing doormen or security staff has emerged as an important aspect of the maintenance of public order. According to an amendment to the Licensing Act in 2004, the licensing board may require a company to use trained security staff who have been authorized by the police (Søgaard, 2013; Søgaard et al., forthcoming).

As shown above, Danish alcohol policy is slowly moving in a more restrictive direction. But even though Danish politicians in the 1990s started to adopt the total alcohol consumption model, there still does not seem to be support for more restrictive national alcohol policy measures. In 1997, when the ESPAD-report was published, this – together with the economic analysis

of the costs of general alcohol consumption – in Kingdon's (2011) terms – created a 'problem stream' and opened a policy window. Later on, the lack of political or public debate over legislation on age limits possibly reflected a growing acceptance that some aspects of alcohol consumption were problematic. But the policy window soon closed again, maybe because the forces in the political stream at that time were not strong enough to keep the alcohol issue on the political agenda. Even though alcohol policy, to some extent, has moved in a more restrictive direction, political steps have been taken also in the opposite direction. In 2002, a ban on alcohol commercials on TV was repealed. In 2003, the tax on spirits was lowered by 45 per cent, and a ban on the retail sale of alcohol after 8 p.m. was lifted in 2005.[4]

So there seems to be a serious lack of coordination in the alcohol field in Denmark. This might be due to the fact that the alcohol issue here is not regulated by one particular law but by resolutions in different laws, spread across several ministries, e.g. the Ministry of Taxation, the Ministry of Justice, the Ministry of Health, the Ministry of the Interior, and the Danish Ministry of Education. Fragmentation of responsibility for alcohol may be accompanied by considerable variability between authorities in their views on how alcohol problems are defined (the diagnostic dimension) and on the necessary level of state or authority intervention (the political dimension). Moreover, as implementation of policy is largely devolved to the municipal level, there is considerable variation in prevention and treatment delivery, which is also likely to hinder attempts to gain consensus for, and application of, the recommended WHO 'ideal' policy package.

There have been attempts to promote a more consistent approach to alcohol policy formulation. In 2012, the Danish Health and Medicine Authority published a number of recommendations to the municipalities, e.g. they should develop:

- a local alcohol action plan;
- differentiated treatment options;
- alcohol policy in the workplaces;
- responsible beverage serving;
- alcohol policies in all educational institutions;
- alcohol education in primary and lower secondary schools;
- participation in the national alcohol campaign;
- information about alcohol.

Since the Structural Reform in 2007, when they became economically responsible for the treatment of alcohol problems, many municipalities have had a local alcohol policy. However, they do not have any influence on the price of alcohol or on its availability in general, which are both widely accepted as possibly the most important policy tools in regulating alcohol consumption (Babor and Robaina, 2013) and which lie at the core of the WHO recommendations.

The Danish Health and Medicine Authority, which is responsible for monitoring and coordinating the alcohol field, has chosen primarily to use two tools in the prevention of alcohol-related problems: (1) to run an annual alcohol campaign; and (2) to support local prevention projects at the municipality level in so-called municipality model projects. We will take a closer look here at the development of, and intentions behind, these two preventive strategies throughout the period. Both initiatives illustrate the use of communication and persuasion tactics typically part of stakeholder group strategies within the policy stream, where health advocates vie for public and policy support against commercial and other interests.

The Danish alcohol campaign: an individual behavioural model

The Danish Alcohol Campaign was launched in September 1990 by the Danish Health and Medicine Authority and introduced low-risk drinking-guidelines for the first time in Denmark. The campaign was targeted at the entire Danish population and structured as a central/local campaign, which meant that the overall message and the character of the activities were decided upon at the central level, while the municipalities were responsible for implementation (Jacobsen, 1996). The campaign consists of TV spots, posters, pamphlets and local arrangements and activities.

The drinking guidelines were inspired by the English drinking guidelines (sensible drinking limits), 14/21 units per week. The Danish Health and Medicine Authority at that time was, however, not aware that the English unit has only 8 grams of alcohol in it, while the Danish unit has 12 grams. So the Danish drinking guidelines unintentionally were higher than the English (Tolstrup, 2015). Even though this was recognized a few months after the first campaign in 1990, it was decided not to change the message (ibid.). The overall goal for the campaign was to reduce total consumption. And this was to be achieved through: highlighting the daily consumption of alcohol, putting alcohol on the agenda (political, media, public debate), and by informing the Danish population about the drinking guidelines. In 2010, the drinking guidelines, as mentioned earlier, were supplemented with very low-risk guidelines: 7 units per week for women and 14 for men. At the same time seven different recommendations regarding alcohol consumption were launched by the Danish Health and Medicine Authority (ibid.). These included: do not drink more than 5 units per drinking session/per day; if you are pregnant, avoid alcohol; if you are part of the elderly population, be careful about your consumption of alcohol.

Every year the campaign focuses on a special segment of the population. The very first campaign was targeted especially at the Danish population aged 40 years-old, the age group with the highest alcohol consumption. In 1993, the campaign especially targeted the 18–29-years-old population; in 1995 and 1998, it targeted families with children; in 199,7 relatives of heavy consumers and abusers; and in 2003–2007, teenagers and their parents (Elmeland and

Frank, 2009). From 2008 on, the campaign has focused on the general health-related consequences of alcohol consumption, on Danish adults' responsibility for their own drinking habits, and on their responsibility as role-models for Danish youngsters.

Campaign slogans have varied. The first slogan was, 'Everybody could use an alcohol-free week'. Other slogans have been: 'Drop daily alcohol consumption', 'Less drinking – more living', 'Give him or her a good reason for cutting down on alcohol', 'Less alcohol – more sex'. Similarly, the image of the target group conveyed by the campaign's slogans and messages has differed throughout the years – reflecting wider cultural and social shifts in perceptions of citizens' social roles, rights and responsibilities. In the first years the messages were targeted at the 'consumer'– to cut down on individual consumption. In the late-1990s, there was a shift in focus, whereby the message now was targeted at 'the socially responsible individual', where friends and families of heavy users are encouraged to take an active approach to his or her drinking habits. Later, the focus shifted again to adults with teenage children, where it is now the 'educated individual' who is appealed to. Over recent years, the campaign has focused on the adverse health effects of drinking alcohol and targeted individuals who are concerned about their own health and lives. A common aspect of the campaign messages, however, is that they have focused only on the individual aspects of alcohol consumption – and not on alcohol consumption as an issue at the societal, political or organizational level.

Several evaluations have been carried out to examine how the message of the Danish Health and Medicine Authority alcohol campaign has been received and put into practice by the Danish population. Surveys show that about 70 per cent of men and 50 per cent of women are familiar with the drinking guidelines. There is, however, nothing that indicates a decrease in consumption at the individual level as a direct result of the guidelines (ibid.).

Prevention at the local level: a community, systems-based model

During the 1990s and at the beginning of the twenty-first century, the Danish Health and Medicine Authority launched a couple of 'municipality model projects' with the aim of preventing alcohol-related harm. Although the municipalities were responsible for the prevention of alcohol-related harm, their action in the field was sparse and sporadic. So the projects were meant as an inspiration for the municipalities to develop and implement new preventive strategies and initiatives. (Sundhedsstyrelsen, 2002; 2012). These local projects were indicative of the increasing interest in community action programmes in the international alcohol and drug prevention research field (e.g. Holder, 1998; Holmila, 2000) and the involvement of Danish researchers in this international network. They also reflected the emphasis on a 'systems' approach to understanding alcohol-related harm and developing appropriate solutions (Holder, 1998), an approach which centred on the societal, political and organizational (rather than individual) roots of alcohol-related problems.

The underlying idea of community-based prevention is that communities should define their own problems. As Holmila has pointed out:

> The reasons for problems lie in the community's way of life or its current circumstances, not in the individual characteristics of some of its members. Individuals have their own impact, but curing or removing a problem individual will not result in sustainable reduction in alcohol and drug-related harms if the community dynamics, which caused these problems, are not influenced.
>
> (2000: 103)

Belief in social progress through interaction between all relevant groups of stakeholders – the local public sector and the professionals, on the one hand, and the associations, organizations and groups of citizens, on the other[5] – was an important aspect of the first municipality projects, and both recommendations and warnings followed the evaluations. While the incorporation of wider groups of stakeholders, notably 'citizens', was judged to be a positive move, the fragmentation which might result from increasing decentralization of policy implementation suggested the need for a more centralized, national approach to public sector problem issues, including alcohol. As Prahl (1993: 14) commented:

> The fundamentally greatest significance of the projects in the third wave of decentralization lies within general prevention. The projects indicate that cooperation with citizens, associations and organizations shows potential for cultural and social development. The public sector would not be able to handle this development on its own, mainly because of the lack of resources and the pressure from increasing workloads, but also because it may not be equipped to manage on its own. At the same time warnings emerge that the third wave of decentralization might have negative consequences regarding increased imbalance, reduction of professional competence and negligence of non-resourced groups. These negative consequences all remind us that, in the further development of the Nordic welfare state, progress depends on placing the major responsibility for the public sector within [national] social policy.

Even given this warning, prevention of alcohol-related problems still remained with the municipalities, which means, as discussed earlier, that the interventions carried out differ from one municipality to another.

Public attitudes towards alcohol consumption and policy

As shown, Danish policy measures to address the issue of alcohol consumption have focused rather one-sidedly on regulating demand through influencing Danish attitudes and opinions about the harms that alcohol may cause. Despite this belief in attitudes and opinions as regulating factors on the

individual´s alcohol consumption, very little research has been done to examine whether education and information have had an effect – and if so what kind of effect.

In 2009, a small survey was conducted, investigating the Danes' attitudes towards alcohol policy (Mandagmorgen and Trygfonden, 2009). This found that although the Danes are aware of the drinking guidelines, they do not practise them – as alcohol consumption is primarily seen as a social phenomenon and not as a health issue. So problematic consumption of alcohol is characterized as consumption causing social problems. Furthermore, the Danes divide alcohol consumption into two categories: problematic and non-problematic. Problematic consumption should be treated and the abusers should receive public support and help; non-problematic use is regarded as a private matter. The Danes have a much more dismissive attitude towards regulation in the alcohol field than towards regulation in other health-related areas (such as, smoking, diet, exercise). This might be due to the strong symbolic values connected to drinking alcohol (Järvinen, 2003). Drinking alcohol (moderately) shows that you are enjoying a good life and underlines your sense of community and belief in progress. The ability to distinguish good wine from bad wine, good whisky from bad, etc. is seen as an important part of the individual's cultural capital (Elmeland and Villumsen, 2007).

Some changes in the Danish position with regard to alcohol consumption have, however, taken place since the mid-1980s. The Danes have become more restrictive with regard to some drinking spaces. As mentioned earlier, in the late 1980s, the counties made a great effort to remove alcohol consumption from the workplace, and opinion on alcohol consumption in the work context changed rather quickly (see Table 9.1). Other fields where attitudes towards drinking have changed are drinking and driving in public places, where the Danes have become more restrictive (Mandagmorgen and Trygfonden, 2009).

The relationship between the public view on consumption, on the one hand, and attitudes towards more restrictive alcohol policy measures on the other is not straightforward (see Tables 9.2 and 9.3). According to the surveys, more and more Danes think that the overall level of consumption is too high, but at the same time there is no special support for restrictions that might combat this.

Table 9.1 Proportion of respondents who agreed with the statement on workplace drinking

Statement	*Year*	*(%)*	*CI*	*p value*
It should be prohibited to drink alcohol in workplaces	1989	42.5	(40.2–44.8)	<0.0001
	1994	70.7	(68.3–73.2)	
	2002	73.3	(71.2–75.4)	
	2011	76.2	(74.4–77.9)	

Source: (Elmeland and Villumsen, 2013).
Note: 1989 n = 1891, 1994 n =1374–88, 2002 n =1739–1744 and 2011 n =2225 (unweighted n).

Table 9.2 Proportion of respondents who answered 'too high' to the following questions

Questions	*Year*	*(%)*	*CI*	*p-value*
Do you in general find the Danish youth's alcohol consumption …?	1985	30.0	(27.7–32.3)	<0.0001
	1994	36.8	(34.2–39.3)	
	2011	81.2	(79.6–82.8)	
Do you in general find the adult Danish population's alcohol consumption …?	1985	17.1	(15.2–18.9)	<0.0001
	1994	12.2	(10.4–13.9)	
	2011	60.9	(58.9–62.9)	

Source: (Elmeland and Villumsen, 2013).
Note: 1985 n =1542, 1994 n = 1360–1374 and 2011 n =2225 (unweighted n).

Table 9.3 Proportion of respondents who agreed with the following statements

Statement	*(%)*
Alcohol sales should be limited to special stores that are approved by the state	18.4
It should be prohibited to sell and drink alcohol at all sport events	34.4
The number of public houses, cafés, restaurants and discotheques should be reduced	6.1
The tax on alcohol should be increased	36.3

Source: (Elmeland and Villumsen, 2013).
Note: 2011 n =2225 (unweighted).

One explanation could be that the historical lack of alcohol policy interventions in Denmark has resulted in an understanding of alcohol problems as part of the private rather than the collective sphere. Drinking alcohol is thought to follow social rules, sanctions and implicit norms, not health policy recommendations. Drinking problems are associated with breaking informal social rules – more than exceeding the drinking guidelines. Uncontrolled (excessive) alcohol consumption is stigmatized and self-control and self-discipline are important virtues in the alcohol field as elsewhere. The early policy position, of treating general alcohol consumption and the misuse of alcohol as two quite different phenomena, may be reflected, still, in current Danish alcohol culture. According to the Danes, there appear to be only two types of alcohol consumption: self-controlled 'normal' consumption, which does not require any intervention at all, or uncontrolled (mis)use, which necessitates treatment and other special interventions.

Conclusion

In comparison to Ireland, England and Scotland, Denmark may seem rather special – as the only country that has not published and/or implemented a national alcohol action plan.

We can draw on Kingdon's theory in attempting to explain why there was very little alcohol policy activity in Denmark. For one thing, influential stakeholders or policy entrepreneurs play important roles in persuading key stakeholders to recognize problems and view them in terms of a particular perspective or ideological position. Kingdon argues that policy entrepreneurs have three characteristics: They have an expertise so they can claim to be heard, because of their expertise, they have the ability to speak for others, and they hold a decision-making position within their organizations. Second, they are good at political networking and negotiating. Third, they are persistent (Kingdon, 1995: 180). Until recently, influential policy entrepreneurs as defined by these characteristics were absent in the Danish alcohol policy arena.

The temperance movements in Denmark never attained a position where they could influence dominant views. But the new council, the Council on Health and Disease Prevention, and the new organization, Alcohol and Society seem to have the prerequisites necessary to be such stakeholders, having the power to bring people together, form advocacy coalitions, and reach some sort of consensus or agreement regarding proposals for change. Looking at the members of the boards of the Council on Health and Disease Prevention and the organization Alcohol and Society, it is obvious that it was important to involve leading experts in the alcohol and health fields as well as local political leaders (Alcohol and Society). But it is thought-provoking that the existence of such 'alcohol experts' is a rather new phenomenon in Danish society. As mentioned earlier, until the beginning of the 1990s, research on alcohol and drugs was rather sparse and uncoordinated, and the councils and the consultant positions established by the government had rather short and turbulent lives. The initiation of research in the late 1980s and the establishment of permanent research environments have accumulated knowledge and created 'voices', which today are engaged in both fundamental and international alcohol and drug research, and have the means and the legitimacy to speak. The fact that both the Council on Health and Disease Prevention and Alcohol and Society do not rely only on governmental funding gives them a stable foundation – so they are able to be persistent in their attempts to influence policy. So for the first time in Denmark, we see rather powerful policy entrepreneurs acting in the alcohol policy field.

A criticism of the Kingdon (2011) model has been that it relies too much on change and fluidity, and is unable to explain periods of stability and continuity within a particular policy arena. Given this criticism, a description of the three streams in relation to alcohol policy in Denmark will consider why, for many years, so little public and political attention has been accorded to this policy area.

Considering the problem stream (which issues become recognized and defined as important or significant policy problems), alcohol consumption in Denmark is not regarded as a discrete field for policy intervention. As discussed, for a long time, 'normal' consumption was seen as a quite different phenomenon from the abuse of alcohol, and the political adoption/acceptance of the total consumption model also occurred rather late on (the 1990s). This

kaleidoscopic view of the alcohol field is reflected in the alcohol laws, where these laws are placed in different legal acts, under different ministries. As a result, the alcohol issue is viewed as an issue crossing many policy domains and legislative areas. This was clearly seen, for instance, in 1992 when the tax on beer and wine was lowered. The reduction of prices was announced and put into practice (by the Ministry of Taxation) at the same time as the yearly alcohol campaign was running (by the Ministry of Health). Although some of the media launched a story about this 'funny coincidence', little attention was paid to it. Taxes on alcohol and individual consumption of alcohol were, after all, regarded as two rather different issues.

The policy stream refers to ideas or proposals for change developed by policy actors based on their knowledge and interests in particular issues. As demonstrated in the two Danish chapters, no policy actors have really wanted to stand up for change. The Danish political attitude towards regulation in the alcohol field has, throughout, been linked to the concept of 'the freedom to choose'. This is also reflected in the national health programmes, through repetition of the sentence 'It is vital that individual autonomy is respected. The government should not control our lives.' So, in Denmark, alcohol policy mirrors conflicting legislative and political considerations. Alcohol consumption provides income through taxes and employment but it also causes health and social problems and therefore financial costs. The industry, so far, has not been especially visible in the few Danish alcohol policy debates – but that might not have been necessary as the political focus on public attitudes and opinions so far has not been threatening to the overall interests of the industry.

The political stream relates to the wider political environment, such as public opinion, ministerial changes and lobbying by interest groups. Looking at public opinion on alcohol, in general, it seems that the Danes still view alcohol consumption as an individual matter, which the government should not interfere with. On the other hand it is also seen, that when actions finally are taken (as with alcohol in the workplace) the Danes rather quickly come to terms with them and even support them. In the political stream there are now also important policy entrepreneurs who are working to change public opinion on alcohol.

Kingdon agues that at critical junctures these three streams come together or merge and 'policy windows' open, where shifts and transitions in policy can occur (Kingdon, 1984). This was seen in the mid-1990s when two important factors entered the debate in the alcohol policy field: economic costs and youth. This resulted in legislation on age limits for purchasing alcohol (1998) and a tightening of the laws over subsequent years. But within this 'policy window' only issues of youth and alcohol emerged, and the problem was identified as much as a 'youth problem' and a problem of education of youngsters as a problem linked to national alcohol policy or alcohol consumption levels in the population. As a result, since the beginning of the twenty-first century, national authorities and prevention workers have identified Danish parents as suitable targets for educational intervention as well as empowering parents to function as educators of young people.

So, in conclusion, one of the challenges that Danish alcohol policy faces is that alcohol consumption is not regarded as a discrete issue but is regulated by different laws, with the responsibility for alcohol issues placed in different ministries and spread across national, municipal and local levels. Thus, in the absence of a national comprehensive alcohol policy and without national level intervention, population-level measures as recommended by WHO, such as regulation of price and availability, are not possible.

Notes

1 In 1983, Denmark was divided into 14 counties and 271 municipalities. The counties were responsible for providing a range of specialized welfare services including alcohol and drug treatment and prevention.
2 Trygfonden was established in 2004. It is the majority shareholder in the Danish insurance company TRYG. Trygfonden funds Danish projects and initiatives that aim at securing and developing safety, health and well-being.
3 A standard drink in Denmark has 12 grams of alcohol.
4 Some of these somewhat contradictory policies can be explained by the government being pressured by Danish retail sellers, who, especially in the southern parts of Denmark, are in sharp competition with the alcohol shops in Germany. Due to the higher taxes on alcohol in Denmark compared to Germany, many Danes cross the border to buy alcohol.
5 Also called: 'the third wave of decentralization'.

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10 Conclusion

Alcohol, power and public health

In comparing alcohol policy development in four countries, this book has sought to shed some light on the complex social and political dynamics that shape decision-making. While it is not an exhaustive survey, it points to some consistent themes and challenges especially in regard to the conditions that can facilitate, or constrain, policy turns.

First, it has highlighted the degree to which recent alcohol policy advocacy, working within a public health frame, is the contemporary articulation of a far older dispute over both the nature of alcohol harms and the politics of state action *vis-à-vis* drinking. At stake in all this is the place of alcohol in contemporary society. This question is complex because alcohol is (in the main) commercially produced and distributed; it is intoxicating and potentially habit-forming; but also, for most drinkers, pleasurable and valued. Furthermore, in Europe at least, it is embedded in an enormous range of social and cultural practices. Alcohol *can* be a problem, indeed, it often is a problem, but it is by no means *always* a problem. The essential political question, then, becomes: *what kind of problem is alcohol?*

As this book has shown, the answer to that question is not self-evident. The policy solutions that this book describes all proceed from prior problematizations (see also Bacchi, 2015). In order to focus on the question of policy *change*, this book has, somewhat schematically, proposed that problem-construction be understood as operating along two primary dimensions: the diagnostic and the political. This is not dissimilar to previous formulations, such as the analysis of 'wet' and 'dry' conceptions of alcohol control proposed by Room (1992). Hopefully, however, it helps to sharpen the focus not only on the extent to which science and political value interact in defining alcohol problems but also on which policy movement occurs when problem framing aligns with wider social and political conditions.

It may be suggested that, in focusing on the interplay of evidence, value and cultural politics, this approach overlooks the overwhelming power of the alcohol industry. For centuries, alcohol producers and retailers have used their economic muscle to establish political influence: in this, they are no different to any other commercial sector. That activity takes many forms – from the cultivation of local networks of influence linking operators to regulators, to high-visibility challenges to government policy at national and international

level, as in the case of MUP in Scotland. It involves both hard and soft lobbying: the actions of national and international trade bodies right down to the establishment of personal and individual relationships that exist below any formal radar (Hawkins and Holden, 2014). It involves the use of think tanks to produce ostensibly independent research amenable to industry interests, the funding of research that addresses politically convenient issues, and systematic and coordinated attacks on scientific research that is not conducive to commercial policy goals (McCambridge et al., 2013a; 2013b). It also involves the development of complex corporate social responsibility programmes that pursue the strategic goal of diverting potentially restrictive legislation (Baggott, 2006; McCambridge et al., 2013c).

Much has been written on the subject of industry lobbying, and doubtless more will follow, exposing its depth and complexity (especially, one may assume, in the developing world where the market for alcohol is still being established and where regulatory systems are more vulnerable). In the context of this book, however, industry action is one source of policy pressure among many – often the most significant single influence, but rarely, if ever, the sole determining factor. Its power and purpose are both, in some respects, predictable: in the main, the industry will wield its influence to prevent any threat of increased market regulation. What is perhaps more interesting is when and how the industry strategically shifts position within its broad dichotomous-libertarian framing in order to better adapt and align to prevailing circumstances. It is also important to consider how and when political fractures *within* the alcohol industry affect its actions and influence on policy (Herrick, 2011; Holden et al., 2012). Finally, while it is almost always in the interests of the alcohol industry to adopt a dichotomous-libertarian frame, it does not follow that this frame is, *tout court*, 'the industry argument'. The value of an argument to a vested interest is not, by itself, proof an argument is wrong or that the person holding it is allied to that interest group.

The challenge faced by public health policy advocates, then, is not only to address fierce resistance from powerful commercial actors but also to achieve sufficient consensus among both politicians and the wider public that health protection should be the paramount consideration in regard to alcohol policy. While the primacy of health may appear self-evident to those within the public health professions, it remains contested in the wider community – where pleasure, personal freedom, economic prosperity, and the rituals of drinking all hold significant values of their own.

Looking at the relative impact of alcohol policy advocacy through the lens of 'multiple streams analysis' primarily serves to remind us that policy development is a complex affair involving a host of social, political and economic factors – some structural, others serendipitous. In particular, change to the alcohol policy status quo requires the convergence of various factors:

1 For alcohol harm to emerge as a significant, and visible, social problem. This means not only a raised public and political awareness of alcohol

harms, but a degree of consensus in framing those harms as a particular *type* of problem. This, as we have seen, is often driven by concrete social change – especially increases in the amount of alcohol consumed in a given society. However, it also implies the successful framing of a problem by advocacy coalitions, often relying on the development of a more or less compelling body of scientific evidence, as well as external socio-political factors (such as, for instance, the crisis of the First World War in Europe) that force the political issue and place the public spotlight on alcohol as a social problem in need of tailored political solutions.

2 For proponents of change to convince sufficient relevant stakeholders of the validity of their solutions to the putative problem. These include the scientific community, key policymaking networks, influential sections of the media, and so on. As we have seen, for alcohol policy advocates, this means not only winning the argument that alcohol harms exists on a continuum, but also that the line of justifiable intervention is some distance below that commonly understood as 'dependency' or limited to those who behave badly when drunk.

3 For the proposed policy actions to chime sufficiently with the prevailing political context. That is, for policymakers not only to accept the diagnostic and political arguments but, crucially, to decide that implementation of the proposed solutions is politically viable, realistic, consonant with both the 'national mood' and internal party politics, and – of course – capable of withstanding resistance from opposing interest groups.

Policy ideas also refract as they move across the political field. This is especially the case as concepts enter the arena in which civil servants work to develop policies that are amenable to ministers. Here, not only do certain types of evidence carry additional weight, such as 'the claims of authoritative individuals' (Mabin, 2014: 100), but evidence is selectively marshalled to create 'policy stories' that ministers can readily grasp, and that civil servants can more easily promote (Stevens, 2011; Smith and Joyce, 2012; Stevens, 2013; Smith, 2013). Research evidence is, therefore, necessary, but by no means sufficient, for political decision-making – nor, in the view of many observers, should it be (Mulgan, 2005; Hallsworth et al., 2011; Smith and Joyce, 2012). It can be adduced in support of an argument, but political arguments are, in the end, essentially about values.

Furthermore, evidence is not a unitary entity as far as alcohol policy is concerned: it operates differently at different levels and scales of governance. For instance, recent experience of the use of health evidence in the licensing systems of England and Scotland has shown clearly that the kind of evidence that has primary value in public health research (systematic reviews, randomized trials, and so on) has far less purchase in licensing committees, where local knowledge, professional experience and case studies are far more valuable (Lloyd et al., 2014; Lorenc et al,. 2014; Toner et al., 2014; Nicholls, 2015; Phillips and Green, 2015). In the case of alcohol licensing, the breadth and

diversity of evidence on issues such as outlet density are usually not a strength when applied in the actual conditions of administrative law or local politics (Holmes et al.. 2014; Gmel et al., 2015). In addition, the devolution of governance to, for instance, Scotland and the Danish municipalities, creates spaces for the alcohol policy process to be differently shaped by local actors, and to become more open to 'bottom-up' or grass-roots influence (Katikireddi et al., 2014). Policy windows, therefore, do not emerge simply when 'the evidence' becomes compelling. They emerge when bodies of evidence become linked to policy frames in ways that align with wider political contexts.

Policy is about power. The power to influence and persuade, the power to open political doors, to speak to media gatekeepers, or to shape research agendas is what advocates on all sides seek. As Cairney and Studlar (2014: 320) put it, 'the process of turning evidence into policy is a battle like any other'. Power is, of course, unequally dispersed: throughout the history of alcohol policy the religious and, subsequently, scientific authority of alcohol control movements comes up, time and again, against the economic weight of an alcohol industry that often (though not always) swims with the wider socioeconomic current. Again, however, the course of policy development cannot be reduced entirely to the assumed power of each side – as the eventual failure of the global tobacco industry to defeat tobacco control advocacy demonstrates. It is not simply a question of who has power, but rather of what different forms of power are in operation, how they are deployed, and in what contexts they become politically dominant.

Looking across the four countries in this study, it is clear that while alcohol policy windows have opened on numerous occasions, they only rarely remain open – in the sense of leading to substantial departures in policy direction. Nevertheless, history shows that the framing of alcohol problems can change, and sometimes dramatically. The mid-twentieth-century consensus around a dichotomous model of harm produced both a set of cognate diagnoses and seemingly coherent political solutions. In turn, this had concrete implications for everything from licensing policy (which was widely liberalized on the principle of the rights of both the trade and moderate drinkers) to how treatment was designed, funded and delivered. The subsequent challenge to this framing owes much to its abandonment, and the vigorous promotion of the alternative public health frame, by the WHO. However, in the absence of wider consensus on the continuous model of harm (or, perhaps, the point along that continuity where restrictive state action becomes justified) and in a political culture that continues to prize consumer freedoms, the policy model proposed by alcohol control advocates today faces greater challenges than simply the intransigence of vested interests.

From problems to policies

Ultimately, the political viability of a policy position depends on the extent to which it accords, or is perceived to accord, with public opinion. Alcohol

control advocacy has always struggled to achieve clear, majority public backing in the countries discussed in this book. International research tends to show greater public support for demand-side interventions such as education campaigns than for more restrictive policies (Moskalewicz, et al., 2013; De Visser et al., 2014; Pechey et al., 2014), though recent analysis suggests increased support for restrictive policies in Nordic countries – with the exception, importantly, of Denmark (Karlsson and Rehn-Mendoza, 2013). Historically, despite some high-points – such as Father Matthew's crusade in Ireland, the introduction of local prohibition legislation in Scotland, or the restrictive policies of the Central Control Board – governments in Europe have tended to baulk at strict market control, even during the brief era when prohibition was introduced in America and elsewhere. Undoubtedly, this is partly because of the direct influence of the alcohol industry working at the highest political levels. However, it is also because of the cultural importance of alcohol across these societies, the resonance of alcohol in terms of both individual freedom and social integration, and the sheer fact that most drinkers *enjoy* drinking (even while recognizing the harms of alcohol). The alcohol industry certainly exploits, and seeks to capitalize on, the pleasures of drinking – but that does not mean those pleasures are simply a kind of false consciousness. That they are real, and that they are shared by very large proportions of any European population – including those in a position to make political decisions – form the backdrop to the policy stage.

As argued previously, attitudes to drinking are highly diverse not only across but within nations. The idea of unitary national drinking styles is a heuristic rather than a reality: a handy thumbnail sketch rather than a detailed map of the landscape. Nevertheless, the idea of national drinking styles plays a profound role in the development of national alcohol policies. What policymakers perceive to be the 'national mood' on this issue is partly informed by how they envisage national attitudes to alcohol more broadly. In Denmark, for instance, policy has been shaped by a politically popular assumption that the Danes have a more healthy and tolerant attitude to alcohol than their Nordic neighbours. This Danish exceptionalism motivates a policy frame in which liberalism is taken to be an indicator of a healthy drinking culture: evidence in itself that the Danes do not have an inherently problematic relationship with alcohol. Despite a great deal of activity at the problem and policy streams over the last fifteen years or so, policy in Denmark has not moved towards more stringent control. Instead, the national mood, as read by political leaders, is taken to be one of continuity with the historic tradition, exemplified by Pastor Grundtvig, which regarded temperance as both self-righteous and un-Danish.

By contrast, Scottish exceptionalism tends towards the assumption that the Scots *do* have a problematic relationship with alcohol, so stricter regulation is both a necessary step towards improved health and social outcomes and evidence of a desire for national renewal in the context of greater political independence. In England, despite a deeply held perception that heavy and antisocial

drinking is a long-standing social problem, alcohol policy is always embroiled in notions of individual and market liberties. The 'drink question' in England has always also been an articulation of questions about what freedom means in a liberal state (Nicholls, 2009). In Ireland, alcohol is not only embedded in much social practice but also forms a significant element of external perceptions and constructions of 'Irishness' (something Guinness and other brands have exploited commercially for a very long time). Here, even more so than in Scotland, alcohol control advocacy has tended to be drawn into wider political frames around national renewal and development; however, in practice, policy has tended to remain more conservative.

The notion of community is, then, both powerful and ambivalent in alcohol policy discourse. Ideas of national drinking culture rest on the construction of an imagined community of drinkers whose values and practices transcend geographical and social distance. Whole-population models also, in their own way, construct an imagined community that responds collectively – albeit through complex network effects – to the policy conditions under which it exists. 'Community' is also invoked by all sides to signify organic social entities: whether the idealized community of drinkers at 'the local' pub (itself something of an anachronism in an age dominated by home drinking), or a putative latent source of community mobilization against the actions of the alcohol industry at a local level. As one WHO publication argues, to be effective 'alcohol policy must allow an expression of voice from civil society to counteract the vested trade interests which often dominate political decision-making' (Anderson, 2009: 8). Of course, a given community (at least, in the sense of a population living in a limited geographical area) is never going to be either 'for' or 'against' alcohol; rather, within any physical community there are likely to be individuals who are either more or less attracted to drinking.

Therefore, alcohol policy is characterized by communities of interest (often geographically dispersed) that vary in size, attitude and relative policy influence. To take one example, local licensing in England is now devolved to elected local authorities and yet remains fundamentally permissive in most areas. Why is this, if significant numbers in local communities are indeed concerned about availability? Is it due to a lack of motivated grassroots support for stricter alcohol control? Or is it because the desires of drinkers (who 'vote with their feet', thereby making local outlets economically viable) have a more obvious economic salience than those who would prefer fewer pubs and off-licences in their area? Is it, in other words, about the limited extent to which community groups, when not acting as consumers, are considered as policy actors or stakeholders that warrant policy attention?

In thinking about communities of interest, Ackermann and Eden (2011) propose four categories according to the strength of their policy influence and their degree of interest in a given issue. *Players* are both powerful and have a strong interest in an issue – in the case of alcohol policy, both public health advocacy groups and industry groups would be 'players'. Other stakeholders may be powerful, but have a weak interest in the issue; these are defined as

context setters. Yet other stakeholders may be less powerful, but have a strong interest in the issue; these are defined as *subjects.* Finally, some stakeholders may be less powerful and have a weak interest in the issue; they are defined as *crowd.* While, at national and supranational level, the purpose of advocacy is often to turn *context setters* into *players* on your side, locally the goal is often to both better empower *subjects* (through, for instance, the establishment of local licensing forums) or to persuade the *crowd* of the validity and importance of your position. However, in a culture in which the majority drink (and, as mentioned above, drink for and with pleasure in most cases) persuading the *crowd* to support legislative impositions on alcohol availability and price is a challenge.

However the landscape is parcelled out, what this confirms is that the 'public' in public health advocacy is not a simple concept. In some respects, 'public opinion' represents a challenge, insofar as it has tended overall to oppose greater restrictions on availability and higher alcohol prices – though the dramatic political success of the Scottish National Party while committed to MUP, shows that this is not a fixed state of affairs. In others respects, the public are construed as the subject for policy intervention: a population who, if acted on the collectivity, will benefit from improved health and social outcomes at the level of individuals. From the perspective of community mobilization, 'the public' is viewed as a potential resource for advocacy: an untapped, but latent, voice for change. The question, however, is how to understand the 'latent' voice. If it is the voice of a community that desires change but lacks the means by which to express that desire, then action to empower that community is relatively uncontroversial. If it is the voice of a community that would desire change if it understood the true nature of things (such as how it is manipulated by marketing), then advocacy is, in the Marxist sense, about liberation from false consciousness – which raises the old question of who defines what consciousness is false or otherwise. However, if it is simply the voice of a community that understands, but does not accept, the premise of the public health argument and is, rather, convinced by an alternative view, then a case has to be made for the paternalist adoption of policies that, while ostensibly against the public will, are justified because they are for the public good. Here is where much of the political controversy lies.

The political stream

Alcohol policy does not easily fall into neat ideological frameworks: on the right, deregulatory, free-market instincts vie with moral conservatism and the promotion of law and order; on the left, suspicion of commercial interests vies with the defence of traditional working-class cultures that are often symbolized by the public house (Nicholls and Greenaway, 2015). Undoubtedly, modern alcohol policy advocacy has its roots in a broadly left-wing critique of both industrial power and the individualization of social problems implied in the disease model (Tigerstedt, 1999). Furthermore, in defining commercial

interests (Big Tobacco, Big Alcohol, Big Sugar, and so on) as industrial vectors of non-communicable disease, public health advocacy more broadly rests on the principle that social harms have social, often commercial, causes that the state has a duty to curtail through regulation. Nevertheless, despite this ideological infrastructure, public health advocacy has rarely either slotted neatly into the party politics of the left or been rejected out of hand by parties on the right.

Furthermore, the cross-sectoral nature of alcohol policy means that within government different departments often pursue not just different, but conflicting, policy goals. As discussed in previous chapters: the interests of civil servants and ministers responsible for trade, policing, tourism, health, culture, agriculture, and so on will, in many instances, be directly at odds where alcohol is concerned. Hence the ideological dilemmas faced by ministers are compounded by the sectoral interests represented by their departments. This is the *realpolitik* within the wider policy process: it incorporates the ideological commitments of both party and individual ministers (not to mention their personal hunches on an issue where opinion is deeply informed by personal experience); the sectoral interests represented within departments of state; the real and perceived desires of the public at large; the pressure of an economically powerful drinks industry employing varied and sophisticated lobbying techniques; pressure from health bodies, including the WHO, to move towards stronger control policy; upwards pressure from local authorities whose capacity (or desire) to implement policy itself creates parameters for what is possible in national legislation; and downwards pressure from supranational institutions, such as, in the case of minimum unit pricing, the European Court of Justice. This is the roiling stream in which politicians assess how policy ideas would play out practically, in the context of wider political considerations, value systems, interest group tensions and electoral considerations.

Lessons from the past

As argued previously, the questions raised by any study of alcohol policy are not 'how evidence-based is policy?' but 'under which circumstances do particular bodies of evidence attain political traction?'; not 'can policy change culture?' but 'when and why does policy amplify or constrain cultural trends?'. In other words, how do competing sectoral interests and bodies of evidence intersect with historical conditions and the realities of policymaking 'on the ground' to shape drinking behaviours? What patterns, if any, can we see emerging through time? What lessons, if any, can we draw from those?

At the most obvious level, it is clear that since the industrialization of alcohol production and the establishment of a large retail sector servicing a growing, and increasingly urban, population, the alcohol industry has held significant political power. That power is derived from its importance as a producer and generator of both employment and, critically, tax receipts. It is also derived from the enormous cultural importance of the commodity it

produces: the reality that the might of the alcohol industry is rooted, to a very great extent, in the fact that alcohol plays an important part in the lives of millions of consumers – albeit that consumption is heavily skewed towards those who drink at problematic levels (Meier et al., 2009). Unlike tobacco, production and retail incorporate not only multinational conglomerates but regional and independent brewers, and countless small businesses where – in the case of pubs – retail is inextricably tied to the social ritual and pleasures of consumption. Big Alcohol is powerful, but so too is Small Alcohol – and for reasons of social and cultural value, not just economic weight.

Nevertheless, while the alcohol industry has a long history of fending off legislative threats, it has not always had things its own way. The wave of international prohibition in the 1910s and 1920s is the most stark example, but even in the countries considered here, especially the UK and Ireland, the alcohol industry has been forced to defend its position against waves of pressure from alcohol control movements. Throughout the Victorian era, temperance campaigners were successful in framing alcohol as a population issue demanding supply-side interventions. The establishment of the Central Control Board in the UK in 1915 achieved genuine and sustained ruptures in the political status quo – albeit because compromises were made on both sides. However, the fact that it took an exogenous shock on the scale of the First World War to break the policy equilibrium in this case speaks volumes about the power of the interests involved in maintaining a broadly liberal status quo.

More recently, the adoption by the Scottish Government of a national alcohol policy explicitly rooted in the public health perspective represents another significant moment of change. Analysis of the drivers of this shift point to an array of developments in the problem, policy and politics streams: the creation of the Scottish Parliament; the rise of the Scottish National Party and a narrative of national renewal; the personal commitment of key ministers; the focused and sustained advocacy of regional health groups; the opportunities afforded by a smaller civil service; research evidence showing dramatic levels of harm in the Scottish population; a spike in media interest in alcohol coinciding with a peak in national consumption and reform to licensing legislation; the effective development over many years of a coherent policy programme and a compelling evidence-base by public health advocates (Katikireddi et al., 2014). All contributed to open a policy window at an historically opportune moment.

And yet, this was not the end of the story. On the ground in Scotland, the creation of a public health objective for licensing proved a challenge to implement: resistance from an industry with close connections to local regulators combined with a lack of clear fit between public health knowledge and licensing practice to weaken the impact of this policy innovation (Mahon and Nicholls, 2014; Alcohol Focus Scotland, 2015; Beeston et al., 2016). Nationally, the flagship policy of minimum unit pricing exposed both the degree to which national governments are both constrained in their actions by EU trade law and the capacity of the alcohol industry to pursue a challenge to the

decision of an elected government. In returning the issue to the national courts, but bounded by caveats and inconclusive guidance, the European Court of Justice demonstrated just how muddy and complex the lines of authority really are when probed to this degree.

Undoubtedly, public health advocacy has increased both awareness and adoption of population-based approaches across Europe (and, indeed, much of the developed world). How significant this success is perceived to be depends, to a large extent, on what outcomes are intended. If the goal is to achieve transnational policy consensus on legislation to restrict availability, increase price and reduce marketing, then success has been modest. The Scottish Government is unusual in framing its whole policy approach in this way. However, decades of evidence development and advocacy action have led to the adoption of this perspective among a swathe of powerful social actors: medical Royal Colleges, influential public health bodies, the editorial boards of major medical journals, much of the charitable and voluntary sector working on alcohol issues, large national and pan-European advocacy networks, as well as an increasing number of policymakers. The adoption, albeit briefly, of minimum unit pricing for alcohol as official government policy by a Conservative Prime Minister in the UK would have been politically inconceivable only a few years previously, for instance. That it happened at all suggests a shift, however subtle, in the tectonic plates.

The increasing visibility and influence of alcohol policy advocacy are, then, a reflection of the extent to which, over recent decades, advocates have developed their capacity to work effectively both as individual policy entrepreneurs and through advocacy coalitions. In achieving this, they have demonstrated considerable political sophistication and vastly improved public relations skills. This suggests a considerable move away from an era when alcohol policy and public health advocates could be described as politically naïve actors, who assume that policy formulation is a rational affair and are then baffled and frustrated by the reluctance of policymakers to act upon scientific evidence (e.g. Secker, 1993).

As this book has demonstrated, the relationship between evidence, politics and policy is messy and complicated. However, to recognize that fact is not to say that the process is entirely chaotic or irrational. Policy streams do develop and are shaped not only by the contingencies of circumstance but also by developments in research, the action of lobby groups and advocacy coalitions and, of course, a shifting cultural background that is itself shaped in part by commercial actions. Similarly, to state that decisions on alcohol policy are about far more than an appeal to evidence – and that evidence development also involves a process of problem construction that is not value-neutral – is not to suggest evidence-based policy is simply a pipe dream. To acknowledge that evidence is political is not to dismiss it as unscientific but to recognize that the questions researchers ask, the problems they define as pressing, and the assumptions they arrive at regarding the applications of their findings do not proceed inexorably from pure inquiry. All science is

motivated to some degree, and contemporary alcohol research – because of its historical roots in a quasi-political critique of both the disease model and the unfettered power of the alcohol industry in the post-temperance era – is often highly motivated. Research can be both motivated and rigorous.

However, all this is to say that the journey of alcohol policy advocacy is one in which science, politics and power are inseparable. In establishing itself as the counterbalance to the commercial might of the alcohol industry, alcohol policy advocacy, allied to large swathes of the alcohol research community, develops evidence in pursuit of a set of shared values. These values touch not only on the necessity of reducing alcohol harms within society, but on what the 'good society' looks like in regard to alcohol and on the proper balance between personal autonomy, market regulation and state power. These values are contested: obviously so by an alcohol industry defending its commercial interests, but also – and legitimately – both within the research community (albeit to a limited degree) and across society. In presenting the case, and in winning the political argument, achieving sufficient consensus on the underpinning values and ideas is as important, if not more so, than demonstrating the veracity of the evidence. Alcohol policy advocates may not have won that argument thus far – though in Scotland they have achieved signal policy successes; however, they have certainly succeeded in placing it back on the high table of both political and public discourse.

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