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

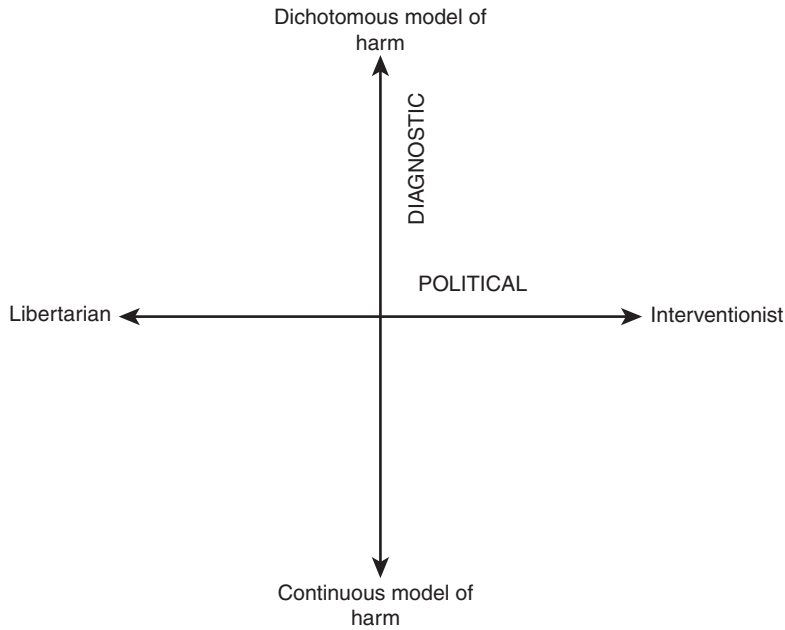

Figure 1.1 Diagnostic and political dimensions of alcohol policy

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