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Alcohol misuse is the United Kingdom's most insidious social problem. It is the major contemporary public health issue, far overshadowing that of tobacco and dwarfing the problems of illicit drug abuse. Although alcohol is our 'favourite' and most widely used drug, it is also our most damaging one. The range of alcohol-related problems is colossal and multiform, affecting numerous areas of government policy, including health, safety, taxation, law and order, and employment. Between 1950 and 1976 consumption of alcohol in the UK doubled (from 5.2 litres of absolute alcohol per person aged 15 or over to 9.2 .litres), and this was accompanied by an increase in the indices of alcohol-related harm.[1] Alcohol misuse produces 'medical', 'social' and 'economic' costs. According to official statistics in 1985 in England and Wales there were 2,856 recorded deaths from alcohol and a further 4,401 deaths where alcohol was an inferred or mentioned cause.[2] The official mortality statistics, however, mask the true extent of the problem as they exclude deaths in which alcohol was a significant contributory factor, such as deaths caused by drinking and driving and the well-documented high suicide rate among alcoholics.

Unlike cigarette smoking, alcohol misuse contributes more to morbidity than mortality. Alcohol misuse accounted for 15,863 admissions to psychiatric hospitals in England in 1986 [3], and 3,743 in Scotland in 1988.[4] The *First Annual Report* (1987-88) of the Ministerial Group on Alcohol Misuse estimated that alcohol misuse seriously affected the lives and health of 1.5m people in Britain. A Department of Trade and Industry (DTI) report estimated that alcohol consumption was a factor in 43 per cent of deaths from falls and 30 per cent of deaths from fires. Approximately one third of all motor accident victims have a level of alcohol in their blood which exceeds the legal limit. The Royal Life Saving Society has for several years noted, in its annual reports, that alcohol is the most common single factor in deaths by drowning. Of the 127,000 evidential breath, blood or urine tests carried out on drivers in England and

Wales in 1988, 78 per cent (99, 060) were positive.[5] In Scotland, there were 11,353 recorded cases of drunk driving in 1988.[6] Three people will die every day in Britain due to a drinking driver and a further 55 will be injured.[7] In addition, there were 111,517 offences of drunkenness in 1983 in the UK. Although in 1988 offences of drunkenness fell dramatically to 48,643 [8], this decline was due to new police cautioning procedures (under which offenders were arrested, detained in police cells until sober and then cautioned and released rather than prosecuted). Drink is implicated in 30–50 per cent of burglaries, in at least half of all cases of wife battering and in the offences of about 60 per cent of petty recidivists, who contribute so greatly to the overcrowded prison population.[9]

McDonnell and Maynard, in their study of the costs of alcohol misuse, have estimated that the social costs in England and Wales amount to approximately £1,614.5m per year (1983 prices).[10] The vast bulk of these costs (£1,396.18m) are incurred by industry, but the cost to the National Health Service (NHS) is £95.86m while road traffic accidents and criminal activities combined equal £121.42m. The Scottish Council of Alcoholism has suggested that alcohol misuse costs Scottish industry £50–100m per annum (1983 prices). In 1987 the Industrial Society estimated that between 8 and 14 million working days were lost annually because of alcohol misuse. While McDonnell and Maynard point out that such figures are 'extremely crude and conservative', and therefore should be used cautiously:

> Nevertheless, the estimates of total resource cost presented indicate that alcohol related problems are of considerable magnitude and suggest that the consequent costs associated with these problems place a considerable burden on society's scarce resources.[11]

The preceding catalogue gives some indication of the wide implications which alcohol misuse has for an extensive range of government policies. For the most part, however, governments have chosen to ignore the evidence of the medical, social and

economic costs of alcohol misuse and have not responded to the arguments of 'consumption theorists'. The consumption theory is based on the close correlation between the level of alcohol-related harm in a society and the average level of alcohol consumption of the population. It implies that if alcohol misuse is to be reduced then the per capita level of alcohol consumption must decrease.

Cross-national studies have shown that those countries with higher per capita alcohol consumption tend to have higher cirrhosis death rates.[12] This point was endorsed by the Central Policy Review Staff (CPRS) which undertook a study of the problem of alcohol abuse in the 1970s. In their Report (which was suppressed by government but was 'leaked' and eventually published in Sweden in 1983) the CPRS observed:

> Experience in a number of countries, and evidence from empidemological surveys, all point to the conclusion that a community with increasing aggregate levels of consumption will tend to support increasing numbers of heavy drinkers, and so of alcohol misuse. We are aware of no reputable evidence from the UK or elsewhere which refutes this general conclusion.[13]

Similarly, the Department of Health and Social Security DHSS declared in 1981 that:

> It is significant, however, that as consumption per head has risen so too have the indicators of harm..... The experience in other countries tends to confirm the link between total consumption and harm. What this implies is that, when total consumption increases, the increase is distributed, to some extent at least, in increased consumption at every level of drinking, with some who had a previously high, but tolerable, level of drinking becoming problem drinkers.[14]

Government appears to accept the consumption theory of alcohol problems, but has chosen to ignore the recommendations of a plethora of reports (including many of its own reports) calling on it to implement alcohol control policies. Control policies have

been advocated by the three medical colleges (Psychiatrists, Physicians and General Practitioners); the British Medical Association; the National Council on Alcoholism; the World Health Organisation; Alcohol Concern; Action on Alcohol Abuse (or Triple A); and three 'official' committees which examined the problem in the late 1970s (the DHSS Advisory Committee on Alcoholism, the House of Commons Expenditure Committee and the CPRS.) In general, these bodies have called on government to halt consumption from rising any further and have advocated four main courses of action to achieve this goal – the explicit use of taxation to increase the price of alcohol in real terms; a moratorium on the extension of licensing hours; extensive health education about alcohol; and stricter advertising controls.

Rather than increasing the real price of alcohol, however, the government has increased excise duty on spirits in only one of the last five budgets (1990), and in the same period has increased the duty on beer and wine by far less than the rate of inflation. Equally, instead of imposing a moratorium on the extension of licensing hours, the government, in August 1988, liberalised the licensing hours in England and Wales, allowing pubs and clubs to serve alcoholic beverages between 11 a.m. and 11 p.m. Monday to Saturday. ***Why have governments followed a policy of liberalisation instead of restraint?***

LICENSING REFORM

The recent liberalisation of licensing hours in England and Wales represents a major policy change for, as recently as 1981, the government declared that it had no plans to amend the licensing laws in England and Wales. There are two main reasons for this policy change. In the first place, in recent years the pressure on government for liberalisation has increased substantially. Among those who have pressed the government on this are many Chief Constables in England and Wales; government

departments (especially the Ministry of Agriculture, Fisheries and Food, Department of Trade and Industry and the Department of Employment); Parliamentary Committees concerned with tourism and employment; Adam Smith Institute; Institute of Economic Affairs; National Union of Licensed Victuallers; the hoteliers and restauranteurs; and the Brewers Society.

Secondly, government has been encouraged by the findings of studies of the effect of changes in the Scottish licensing system.[15] The licensing laws in England and Wales and in Scotland were reviewed by departmental committees in 1972 (Errol) and 1973 (Clayson) respectively.[16] Both departmental committees recommended the liberalisation of licensing laws, arguing that relaxation of the law would lead to a reduction in the pressure to drink, would discourage drink as an end in itself and would encourage more responsible attitudes and behaviour.

While the recommendations of the Erroll Committee were not acted upon, some of the Clayson Committee's recommendations were incorporated into the Licensing (Scotland) Act 1976. This act introduced Sunday opening and allowed greater flexibility in opening hours on weekdays, effectively leading to 11 a.m. to 11 p.m. opening from Monday to Saturday. Studies of the operation of the Act have suggested that it has not had the disasterous consequences that some concerned people anticipated, and that liberalisation has had an almost neutral effect on consumption levels and on the indices of alcohol-related harm. Certainly, the changes were hailed as an overwhelming success by government, the licenced trade and the media. George Younger, when Secretary of State for Scotland, claimed that the changes had "led to more sensible and civilised drinking".[17] His successor as Secretary of State, Malcolm Rifkind, on welcoming the publication of the 1986 Goddard Report on attitudes to drinking in Scotland, said that "the final results of the survey make it clear that the longer hours have led to more civilised drinking habits".[18]

This Scottish 'success' was used to bolster the call for reform in England and Wales. Douglas Hurd, when Home Secretary, stated that:

> After carefully studying all the relevant facts, and in particular the evidence to emerge from the Scottish experience of longer opening hours the government believe that there is a strong case for considering some relaxation of the restrictions of licensing hours in England and Wales. We support the case for reform.[19]

It is extremely difficult, however, to accept such optimistic conclusions about the changes in licensing laws in Scotland. A substantial part of the Goddard Report is essentially an 'opinion poll' of Scottish attitudes (in itself an interesting precedent for a government evaluating the impact of legislation). The survey found that per capita consumption in Scotland had increased by 13 per cent between 1976 and 1984. Alcohol consumption rose very slightly for men (from 14.3 alcohol units per week to 14.5 units), but among women there was a 'statistically significant' increase (from 2.8 units per week in 1976 to 3.8 units in 1984). This 'statistically significant' increase no doubt reflects the changed life-style of women in the last twenty years. It is surprising, however, that such an increase has not been seen as a cause for concern.

Sixty-five per cent of the Goddard sample felt that later evening closing time was 'a good thing', while 55 per cent said that Sunday opening of public houses was 'a good thing'. Overall, 73 per cent of the sample (and 95 per cent of licensees) agreed that the licensing changes were an improvement. Goddard summarised the evidence by stating that:

> On the positive side, people said that drinking had become more leisurely and civilised, on the negative side, that longer hours had encouraged people to drink more..... 71 per cent did feel that people in general were drinking more than they used to.[20]

Unfortunately, the Goddard Report made no comparison with England and Wales, where no change in the law had occurred. Some indices of harm (such as cirrhosis of the liver) are rising at a much faster rate in Scotland than in England and Wales. While official statistics suggest that drunkenness declined at a more rapid rate in Scotland than in England and Wales, this may be due to factors other than the liberalisation of licensing laws – such as the greater impact of the recession, the higher unemployment rate in Scotland than in England, a ban on police overtime in Strathclyde Region during the early 1980s and the impact of the Criminal Justices Act 1980 (which 'decriminalised' drunkenness and thereby produced a dramatic decline in the number of convictions for drunkenness).

Further, discussions about rates of drunkenness have rarely considered the increase in the real price of alcohol through the 1981 budget. As is discussed below, an increase in the real price of alcohol is likely to reduce aggregate consumption and the associated problems. A drop in the overall consumption and problem levels did occur after the 1981 price increases in England and Wales as well as in Scotland. As the real price of alcohol has fallen since 1981, however, aggregate consumption and associated problem levels appear to be on the increase. Even Goddard conceded that the data within the report "[tended] to suggest that there may have been an underlying increase in alcohol consumption among men which has been offset by the effects of the recession".[21] This particular Goddard finding, however, is not quoted by the proponents of liberalisation.

It is inappropriate, therefore, to attribute stable, or reducing, levels of harm solely to the change in the licensing law. It is likely that the legacy of the Clayson Committee will be 'inimical' rather than 'beneficial' [22]. As the CPRS Report argued:

> Longer hours constitute a relaxation of controls on access. If they encourage higher total consumption or harmful habits of drinking they would conflict with the stance we believe government should adopt.

They might moreover be interpreted as suggesting the government believed easier access was desirable.[23]

TAXATION

Household expenditure on alcohol in the UK in 1988 was £18,508m (a figure that is equivalent to half of household expenditure on food!).[24] Over the years alcohol has become cheaper in real terms. The CPRS report noted that between 1964 and 1979 the Retail Prices Index (RPI) increased by 280 per cent, but the cost of whisky increased by just 141 per cent, sherry by 108 per cent and beer by 240 per cent.[25] In 1964 the amount of work required to purchase a typical alcoholic beverage by a male manual worker in the UK was 12.8 minutes for a pint of beer and 6 hours for a bottle of whisky, but in 1984 the figures were just 11.3 minutes and 2.2 hours respectively.[26] This decline in the real price of alcohol, and the concomitant rise in consumption and alcohol-related disabilities, has led some commentators to suggest that taxation policy might be used to control consumption and reduce alcohol-related harm.

The opponents of control policies (including government) have argued, however, that control policies are unfair because they "fall like sober rain from heaven above upon the problem and problem-free drinkers alike."[27] Taxation, they argue, is an overly blunt instrument, reducing the pleasure of the majority for the sake of curtailing the alcohol-related disabilities of a 'tiny' minority. They further claim that little is known about the price-sensitivity of alcoholic beverages, and that it is impossible to predict how consumption will respond to tax increases, or how long any changes will last.

Neither of these arguments is particularly convincing. In the first place, while control measures affect all consumers, it is also the case that the social costs of excessive drinking fall upon the problem and problem-free drinkers alike. Alcohol misuse causes

harm on the roads, public places and in the home. Again, the impact of alcohol-control measures, such as taxation, is roughly proportionate to the amount of alcohol a person consumes: the 'sober rain' may fall on all drinkers, but it falls with a greater intensity on heavy drinkers than on others.

Further, the impact of price increases upon consumption is predictable. As the CPRS pointed out:

> Alcohol reacts to market forces in the same way as other commodities: when the real price increases total consumption tends to fall and vice-versa.....the general relationship is clear: a major factor in increased total consumption since the war has been the relative cheapening of alcohol.[28]

Certainly, there is considerable evidence that alcohol misuse is directly linked to the real price of drink. In a study in the United States, Cook found that those States that raised their liquor taxes in the period 1960 to 1974 had a greater reduction, or smaller increase, in cirrhosis mortality rate than any other States in the corresponding year.[29] He claimed that his results indicated that taxation was both effective and surprisingly well targeted on heavy drinkers: it was they who paid most of the tax bill and their drinking was quite responsive to tax changes. Cook estimated that a doubling of federal liquor tax would lead to a reduction in the US cirrhosis mortality rate of 20 per cent.

Kendall et al. examined the relationship between the level of excise duty and alcohol consumption.[30] They found that, following the 1981 Budget (when the duty on alcoholic beverages was increased, causing the cost of alcohol to rise faster than other prices for the first time in 30 years), suspected heavy drinkers in the Lothian Region of Scotland reduced their consumption at least as much as light or moderate drinkers. Although unemployment played some part in the reduction in alcohol consumption during this period, Kendall et al. showed that the overwhelming factor behind the

reduction in alcohol consumption was the increase in excise duty, with 80 per cent of the reduction being a direct result of the increase in taxation. They concluded that: "Increasing the excise duty on alcoholic beverages can therefore be an effective public health measure".[31]

The claims of Kendall et al. are substantiated by the official statistics. In the UK as a whole, consumption of beer, wines and spirits fell by about 10 per cent between 1980 and 1982.[32] These figures, together with the findings of the Kendall et al. survey, indicate that an increase in excise duty on alcoholic drinks can be an effective means of reducing the ill-effects of excessive alcohol consumption, *at least in a period when incomes are rising more slowly than the cost of living.*

Government is reluctant to use taxation as an instrument of public health policy, not least because taxation of alcoholic beverages provides an appreciable source of revenue for the government. As the DHSS has stated:

> Although taxation has been used to limit consumption, the primary purpose of duties on alcoholic drinks remains ... to raise revenue.[33]

There is a clear conflict of interest for government between its revenue and public health objectives. Conflict can also be identified between a government's micro and macro economic policy, and between macro economic policy and market pressures. In the 1980s, for example, the problems of the Scotch Whisky industry had an impact on the public health perspective, with governments feeling that they must protect the industry from contraction. In particular, duties on whisky have been held down in most recent budgets to compensate the industry for the abolition of corporation-tax stock relief, which hit them particularly hard in 1984.[34]

Duty changes also affect the RPI. In 1979 the CPRS calculated that if the duty

on a pint of beer was increased by one pence (13 per cent) the RPI would increase by 0.2 points. After the March 1988 budget, Treasury ministers acknowledged that if excise duties on alcohol had been raised in line with inflation, the rate of inflation would have increased by 0.5 per cent. This has considerable consequences for the public health perspective, especially in a period of inflation, as the duty on alcohol is one of the few elements in the RPI which the government can control directly. Membership of the European Community, of course, has an impact on budgetary strategy. In 1984 the government was forced to cut excise duty on wine because of a European Court ruling that wine and beer were 'like products' and should be taxed at a similar rate according to the strength and volume. Thus, even if the British Government was committed to using excise duty as a public health policy instrument, its use could be undermined by membership of the European Community.

THE ALCOHOL LOBBIES

The ability of the alcohol industry to influence government policy is considerable. By any standards the alcohol industry is a huge economic enterprise. In 1986 there were 192,147 licensed premises in the UK [35], the industry contributed £6,320m to the Exchequer in duty and accounted for £1,324m in exports. Brewers annually use some 6,000 tonnes of mostly home-grown hops or hops extracts.[36] The industry is dominated by six large brewing companies, which in 1988 made pre-tax profits of approximately £1.8bn. In 1989 these six brewers accounted for 75 per cent of UK beer production and 74 per cent of brewer-owned retail estate.[37] In the 'league table' of the world's alcoholic beverage firms in 1980, Allied Brewers ranked third, Bass sixth, Whitbread eleventh and Grand Metropolitan twelfth (by beverage sales).[38] The alcohol industry is an expanding force. In 1970 the industry employed some 600,000 (2.7 per cent of all those employed), but by 1980 the number had risen to 750,000 (3.4 per cent of all those employed).[39] In so far as absolute size creates producer groups able to influence government policy in their favour, the leading brewing

companies are amongst the major interest groups in the UK.

A dramatic example of the political power of the brewers was provided in 1989 when they were able to resist government attempts to increase competition within the industry. A 1989 report by the Monopolies and Mergers Commission (MMC) declared that the leading brewers enjoyed 'a complex monopoly' and recommended that, to remedy the situation, no brewing company or group should be allowed to retain more than 2,000 outlets.[40] Initially, Lord Young (Minister for Trade and Industry) indicated that the he was 'minded to implement' the commission's recommendations, but the brewers quickly mobilised within Parliament and mounted an extensive public advertising campaign. In face of this reaction the government was forced to modify its stance and eventually required that the brewers sell-off only half of the outlets they owned above the figure of 2,000. Sir George Young (Junior Health Minister, 1979-81) commented:

> [the episode] did give the impression that the brewing industry had a disproportionate pull on the Conservative Party and I just think it was caving in to some fairly clumsy political pressure by the brewing industry.[41]

The Conservative Party has strong historical links with the licensed trade, and today still receives political contributions from that source. In 1987 the brewers donated £250,000 to Conservative Party funds. In 1984 no fewer than 11 government ministers, prior to taking office, had direct financial links with the drinks trade [42], and dozens of MPs of all parties have a direct or indirect financial interest in the trade, as directors of companies or parliamentary advisors. In addition, the Advertising Industry, with its extensive political links, is heavily dependent upon the drinks trade. In 1985 the Brewers alone spent £179.9m on advertising and marketing (excluding expenditure on salaries).[43]

In some circumstances the alcohol industry can count even on the support of the Labour Movement. If jobs are threatened (particularly in difficult economic times) the alcohol industry draws upon the support of the trade unions. The Labour Party has indicated that in office it would take action on alcohol abuse. In the past, however, Labour administrations have recoiled from implementing control policies, and it is worth noting that it was the Labour Government in 1979 that was first to suppress the findings of the CPRS report.

The alcohol industry has not endeavoured to conceal its anxiety about the growth of alcohol misuse. The industry has provided funds for research into the causes of alcohol misuse and has helped to fund 'Don't drink-and-drive' campaigns. In October 1989 the drinks industry set up a research body - the Portman Group - to recommend practical initiatives aimed at reducing the social and health problems associated with alcohol misuse. Their current campaign is for the adoption of a national voluntary 'proof of age' identity card scheme in an attempt to control under age drinking.

Concern over its public image has encouraged the industry to adopt a 'responsible attitude'. As Baggott highlights, this reflects sound commercial reasoning:

> The industry has become increasingly worried about the marketing implications of the growth in alcohol problems, and in particular the effect on the image of its product. Moreover, there has been a clear recognition that alcohol problems could actually reduce the size of the drinks market in the long-term. In short, the industry has realised that DEAD CUSTOMERS RING NO TILLS.[44]

The drinks industry is fully supportive of the government's approach to the problem of alcohol misuse. Health education programmes aimed at persuading consumers to drink in moderation are unlikely to have a negative impact on the long-term

commercial success of the drinks industry. The industry, however, has strenuously opposed the use of control policies which are likely to affect consumption levels. Their opposition to control policies has been a critical component in the government's rejection of this option. The economic importance of a producer group such as the alcohol industry, ensures that it enjoys privileged access to policy-making arenas and consequently its activities are reflected in the shape of policy agendas and policy outcomes.

The anti-alcohol lobby contrasts starkly with the drinks industry in that it is highly fragmented and extremely feeble. Within it there are significant disagreements about strategy, and persistent inter-agency rivalries hinder campaigning for more 'stringent' government policies. A Department of Health policy document in the early 1980s found that the voluntary bodies in the alcohol health lobby had 'serious deficiencies'. The document recommended that parliamentary campaigning against alcohol misuse should be undertaken by a small and compact organisation which should be modelled on ASH (Action on Smoking and Health), the highly successful anti-smoking organisation, and should receive government funding.

Dr David Player, the then Director-General of the Health Education Council, began the task of helping to set-up Triple A (Action on Alcohol Abuse). Subsequent events have convinced Dr Player, and many others, that the power of the drink trade is one of the major determinents of the shape of alcohol policy in the UK. Dr Player has stated that:

> [since 1981] government has been more than guilty of evading its responsiblities. It has ... ***effectively allowed the alcohol industry to take control of public policy***.(our emphasis)[45]

In a 1986 BBC television programme, 'Brass Tacks', Dr. Player claimed that he had been forbidden by the government to attend meetings of Triple A 'in office time' and

that he must charge rent for any meetings which Triple A might hold in the offices of the Health Education Council. Dr Player also claimed that when he approached the responsible Minister for funds for Triple A he was 'bluntly told' that they were not available and never would be. One interpretation is that Dr Player's very public statements may have inspired the government to abolish the Health Education Council, at what seemed like extremely short notice.

Dr Player maintains that the main reason why the alcohol industry is even more powerful than the tobacco industry in its effect on government decisions is that "....they have more influence and more MPs than the tobacco industry".[46] He also claims that the drinks trade has considerable influence with the DHSS. Some commentators saw the removal of Sir George Young from the Health Ministry in 1981 as an example of this influence at work. It may be noted that his replacement, Mr Geoffrey Finsburg, had previously been a Parliamentary consultant to the National Association of Licensed Victuallers.

DEPARTMENTALISM

Government has an extensive interest in the alcohol industry. It receives substantial tax revenue from the sales of alcohol; it imposes certain restrictions on the availability of alcohol; and it incurs the cost of the consequences of alcohol misuse. There are a great many 'alcohol policies' and the hallmark of the alcohol policy terrain is complexity and diversity. The CPRS report included an annexe listing 16 Government Departments with an interest in some aspect of alcohol policy. Moreover, as Harrison and Tether illustrate in their study of the co-ordination of UK policy on alcohol (and tobacco), there may be a number of separate divisions with responsiblity for some facet of departmental policy. The Home Office has three departments concerned with aspects of alcohol and crime – the Criminal Department, the General Department and the Police

Department. In addition, the Research and Planning Unit regularly undertakes work in this area. The DTI's responsibility for alcohol issues is split between its General Policy, Consumer Affairs and Overseas Trade divisions, so that within just two of the sixteen government departments involved in the alcohol sector there are seven separate entities dealing with alcohol policy.[47]

Clive Ponting argued that:

> Much of the work of Whitehall is institutionalised conflict between the competing interests of different departments. Each department will defend its own position and resist a line that, while it might be beneficial to the government as a whole or in the wider public interest, would work against the interest of the department.[48]

This would appear to be even more true of alcohol than of most policy areas. Several government departments oppose the use of control policies. MAFF is the sponsoring department and as such identifies strongly with the industry and acts as the industry's spokesman within government. The DTI's opposition to control policies emanates from its concern about export performance, tourism and the retail trade. The Department of Employment is anxious about the likely impact on aggregate employment levels.

It is the opposition of the Treasury and the Home Office, however, that is of the greatest significance because these departments have executive responsibility for the control policy instruments. The Treasury rejects an explicit policy on alcohol taxation mainly because of its belief that taxation policy should be based on government's revenue requirements. The Home Office's opposition was reflected in the policy document *Alcohol and Social Policy: Are We On The Right Lines?*. This paper attacked the accepted validity of the consumption theory of alcohol problems – precisely the theory on which the recommendations of the CPRS and the DHSS' Advisory

Committee were based. In effect, there exists 'departmental pluralism' on most alcohol issues, with the Home Office and the Treasury on the one hand, and the DHSS on the other, occupying polar positions. Other government departments fall somewhere in between these two poles depending on the issue. In this situation responsibility and accountability have become very blurred.

The very structure of government militates against the formulation of any coherent national strategy on alcohol consumption and the reduction of alcohol-related harm. What is lacking is a mechanism to ensure that different departments, and divisions within departments, pull in the same direction, and take consistent account of the consequences for alcohol-related harm. The Cabinet fails to function as a coordinating mechanism, with this being even more true for alcohol policy than for many other areas of govenment policy. The Cabinet tends to consider issues which are of 'political' significance rather than 'intrinsic' importance, and, unfortunately for the health lobby, alcohol falls into the latter category.

There appears to be some validity in the claims made by the health lobby and the CPRS that there exist inconsistencies in the way alcohol policies are formulated. In 1985, for example, when government began considering the possibility of relaxing licensing laws in England and Wales, it was simultaneously limiting the sale of alcohol at sporting events (in particular, football matches) due to the apparent link between alcohol misuse and hooliganism. Such inconsistencies were recognised by the CPRS:

> The first problem is essentially one of internal coordination. Although distinct responsibilities do not necessarily prevent coordination we have been struck by the lack of coherence ... Alcohol policies are for the most part conceived of as disparate. Some are recognised as interacting, and are handled accordingly, but others are considered largely in isolation. ***There is no departmental responsibility for alcohol generally.*** (our emphasis)[49]

The CPRS called for the establishment of an 'Advisory Committee on Alcohol Policies' to coordinate government policy. The government rejected this recommendation, arguing that there was no need for a coordinating body in the alcohol policy sector:

> Well established arrangements already exist for all the interested departments to inform each other about matters of mutual concern, to coordinate their advice to Ministers and to implement the government's policies. In each case, the responsibility for the necessary coordination rests firmly on the department with the leading interest in the aspect of policy under consideration. The government agrees coordination of policy on all aspects of alcohol is essential; it believes, however, that this can be more effectively secured throught the well established processes ... than by the creation of a new non-departmental public body.[50]

The reluctance to create an inter-departmental coordinating body may reflect the low priority accorded to alcohol problems and issues compared with those accorded to tobacco or illicit drugs. Harrison and Tether found that the resources allocated to the alcohol area at the DHSS show that it has low priority in government policy. They observed that as governments have only 'limited stocks of commitment', they will only implement contentious policies if some 'ideological', 'electoral' or 'financial' benefit clearly outweighs the cost.[51]

In September 1987 the Home Office announced the establishment of an Inter-Departmental Group (IDG) under the Chairmanship of the then Leader of the House of Commons, John Wakeham (now chaired by Sir Geoffrey Howe). This group is responsible for reviewing and developing the government's strategy for combating alcohol misuse. The IDG's areas of interest include under-age drinking laws, drinking and driving, alcohol advertising codes of practice and encouraging the development of alcohol workplace policies - precisely the type of reforms to which the alcohol industry would have no objections. Consequently, the group has been criticised for not taking comprehensive action to combat alcohol misuse. Given the past record of both Labour

and Conservative governments, however, it is very easy to be cynical about the establishment of such a group. The group may have been established primarily to exhibit government's concern about alcohol misuse, and to remove the issue from the immediate political agenda.

Anthony Downs argues that there is a systematic 'issue-attention cycle' which:

> causes certain individual problems to leap into sudden prominence, remain there for a short time, and then gradually fade from public attention - though still largely unresolved.[52]

Downs maintains that the issue cycle has five definable stages which occur in a predictable sequence: at the 'pre-problem stage', the issue attracts little public attention; at the 'alarmed discovery stage', public awareness is captured; at the 'evaluation stage', the cost of significant progress in solving the problem is realised; at the fourth stage, there is a decline in intensity of public interest; and at the final 'post-problem stage', the issue loses its prominent position at the centre of public attention.

If, as Downs argues, issues do pass through such a five-stage cycle, then by the time that it is evident that the IDG is doing little, the issue may well have passed through the cycle, and will have been 'de-energised'. Such 'placebo policies' are particularly enticing to politicians because they can be extremely effective in managing the political agenda and protecting government from the emergence of 'hostile' or 'threatening' issues.[53] The potentially critical pitfall with placebo policies, however, is that they may be recognised as such, and when this occurs the problem can be soon forced back onto the political agenda. Whether this will happen in the case of alcohol misuse remains to be seen.

CONCLUSIONS

Government has acknowledged the extent and range of alcohol-related problems. It apparently accepts the consumption theory, and the need for a preventative strategy, but rejects using taxation or liquor licensing as control policy instruments to regulate consumption. The perceived revenue and employment effects of utilising such policies is prominent (if not paramount) in government thinking. As Baggott highlights:

> It was not so much that government believed these policy instruments to be ineffective. On the contrary, it appears that the government rejected control policies precisely because of their likely effect on consumption.[54]

The rejection of control policies is also a consequence of the power differential between the pro- and anti-alcohol lobbies. As the British Medical Association expressed it:

> The power, influence, wealth, efficiency and modernity of the drinks trade contrasts greatly with the sad disarray of the anti-alcohol lobby.[55]

The alcohol industry is one of the major producer groups in the UK, and as such enjoys privileged access to policy making arenas. Its significant economic leverage means that, as discussed earlier, it is a potential veto group. This situation contrasts starkly with the weak and highly fragmented anti-alcohol lobby, which does not enjoy the use of such vast resources. Inter-agency rivalries within the health lobby hamper a coordinated plan of action and the lobby's governmental focus has been the Department of Health - not a key arena for control-policy decisions. The weakness of the health lobby has allowed the drinks trade a disproportionate influence within government and created little pressure for the adoption of control policies.

Outwith governmental arenas, the trade has had more success mobilising opinion

in its favour (as was illustrated by the successful campaign against the MMC report). Public opinion data in recent years have generally shown a clear majority against using taxation or licensing laws to regulate consumption. Leedham has compiled data from various opinion polls over several years and has found that the only legal measure which has consistently enjoyed a substantial degree of public support has been stricter drinking and driving laws (in particular, a consistently clear majority has been in favour of the introduction of random breath testing).[56] Public opinion statistics have allowed governments to claim that popular support exists for their policies: in the alcohol policy sector public opinion has played a validating role in the policy process.

The politics of alcohol gives rise to 'chronic departmentalism'. As illustrated by the CPRS and Harrison and Tether, the alcohol policy terrain is complex and very little conscious coordination of policies occurs. In addition to this, the very structure of the policy-making process itself appears to hinder the anti-alcohol lobby. A major characteristic of policy-making in Britain is 'sectorisation', whereby policy is made in artificially created sectors composed of a limited number of groups that are able to consider only a restricted number of policy options.[57] Richardson argues that sectorisation both 'facilitates' and 'restricts' group participation in the policy-making process:

> It facilitates it because sectorisation enables problems to become *manageable*, by artificially breaking linkages between many policy problems. It hinders it because it tends to confine groups to participation in 'their' communities and networks, even though the business of other communities and networks may be very relevant to their interests.[58]

This is clearly so in the case of the alcohol policy sector. The health lobby (in particular the medical profession) has good contacts within the Health Ministry. The instruments of control, however, lie outside that department, and executive decisions

relating to control policies are made in other communities and networks. The health lobby is excluded from these arenas while the drinks trade enjoys access to them. The industry plays an integral part in setting agendas and thus limiting the options for consideration (options which exclude the use of control policy instruments). Taxation on alcohol is determined primarily by the government's revenue-raising needs, not its public health requirements. The health lobby's insistence on the use of control policies makes it, by definition, an 'outsider', as is it attempting to encourage radical policy change within communities which value incremental change.

Can the anti-alcohol lobby increase its chances of success? If a coordinated strategy was formulated, if all the relevant groups pressurised government in the same direction, if wider and effective political contacts were developed - then the lobby might achieve more success than it now enjoys. As it is, however, the anti-alcohol lobby faces major obstacles in that the structure of government, and the structure of the policy-making process, tend to militate against its chances of success. As illustrated above, the process of sectorisation tends to lead ministers to identify with 'their' relevant groups and, in its turn, this identification tends to reinforce sectorisation. In the alcohol policy sector the tide appears to flow against the anti-alcohol lobby. While the drinks trade is extremely influential, it has not had to use the full reserve of its powers to force government in the direction it would like it to travel. Government and the trade appear to share a mutual interest in the continued prosperity of the industry. To adapt a phrase of Griffith Edwards: ***The politics of hedonism currently appears more powerful than the politics of health!***

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