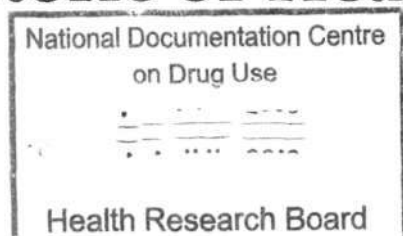


The National Alcohol Policy and the Rhetoric of Health Promotion



by: *Shane Butler*

Introduction

Professional social workers, whatever the agency setting within which they are employed, can expect to come across alcohol-related problems regularly, and so it seems reasonable to expect that they should be equipped with the requisite knowledge and skills to manage these problems, albeit with support and consultancy from specialist addiction services. It is also reasonable to expect, however, that by virtue of their professional education and training, social workers should have an interest in the wider policy aspects of these problems rather than being exclusively concerned with service provision for individual clients. The aim of this article, therefore, is to examine recent alcohol policy developments in Ireland, with a specific **focus** on the *National Alcohol Policy* (1996) which was drafted and published by the Health Promotion Unit (HPU) of the Department of Health.

The fact that this policy originated within the HPU rather than within that section of the Department of Health which deals with mental health services, clearly signifies a policy intent to move beyond treatment and rehabilitation and, within the broader framework of health promotion, to concentrate on the prevention of problems and the promotion of positive health. The remainder of this article will look in detail at what constitutes a health promotional or public health approach to alcohol consumption and related problems; it will then look at the content of the National Alcohol Policy, assess in a preliminary way the implementation of this policy; and finally look at the policy-making process which offers most promise in this area.

Health Promotion and Alcohol

From the time of its establishment in 1946, the World Health Organisation (WHO) has consistently maintained that health should be conceptualised in broad positive terms rather than merely as the absence of symptoms of illness or infirmity, while also arguing that improvements in the health status of populations are largely attributable to a range of environmental factors - such as housing, sanitation or nutrition - rather than being solely reflective of technical developments in medicine or surgery. From the 1970s onwards, this perspective has been developed in a more detailed and explicit way under the rubric of 'health promotion' (see, for instance, WHO, 1978; 1986), a perspective which incorporates two principal components: an *individualistic* component which refers to the impact of individual behavioural choices or lifestyles on health, and an *environmental* component which emphasises the role of socioeconomic and other contextual factors in determining health status. Health promotionists would generally argue that these two components should be seen as complementary of one another rather than as oppositional elements in health policy,

the aspiration being that environments should be structured so as to facilitate healthy individual lifestyles. From a strategic point of view, it is expected that all sectors of Government should contribute to health promotion by recognising the impact which policy and legislation in their respective spheres can have on health and by seeking to 'health-proof' such policy developments.

In Ireland, health promotion was discussed in an increasingly explicit way at a policy level throughout the 1980s (Department of Health, 1986 ; Health Education Bureau , 1987), culminating in the establishment of a formal health promotion structure in 1988 (Kelleher, 1992). Subsequent policy documents from the Department of Health - or Health and Children, as it became in 1997 - have continued to reflect this perspective, suggesting that official health policy in Ireland is now significantly influenced by this concept (Department of Health, 1994; Department of Health, 1995; Department of Health and Children, 2000).

Perhaps the simplest way to introduce the application of health promotion concepts to alcohol consumption and related problems, for those unfamiliar with this topic, is by way of its comparison with its polar opposite, the traditional and relatively familiar 'disease concept of alcoholism'. The main tenets of the disease concept may be summarised as follows:

- alcohol for the majority of its consumers is a relatively harmless drug, and problem drinkers in the main are those who have a genetic or some other psychobiological predisposition to alcohol-related problems;
- the principal problem resulting from alcohol consumption is alcoholism, a discrete disease which affects only a minority of consumers who are unfortunate enough to be predisposed in this way;
- the incidence and prevalence of alcoholism is unrelated to consumption levels and patterns within society , and there is no necessity or justification for the state to attempt to control societal consumption of alcohol;
- the main responsibility of government is - through its health sector - to provide treatment facilities for alcoholics.

It later became clear to social scientists and policy analysts (Room, 1978; Beauchamp, 1980) that this disease concept had its origins in the social and political circumstances of post-Prohibition America, rather than being the product of value-free scientific research but, as originally developed and promoted from the 1930s onwards, it tended to be described as a scientific advance which took the policy debate about alcohol outside the realm of moralism. Ironically, in view of its general espousal of health promotion, the WHO was an enthusiastic

supporter of the disease concept from the early 1950s to the early 1970s, and in 1966 when this perspective was most fully endorsed by Irish health policy makers it was noted by way of introduction that: 'Alcoholism is a disease and is regarded by the World Health Organisation as a major health problem' (*Report of the Commission of Inquiry on Mental Illness*, 1966, p. 77).

If the measure of a good policy is that it attracts widespread agreement, then it is easy to see why the disease concept had a very positive rating. It appeared to have something for everyone: to the general public, it suggested that if one were not alcoholic (and it was commonly, though without any discernible scientific basis, believed that only 10% of drinkers were in this unfortunate category) there was no real necessity to exercise moderation in one's personal consumption; to those who had alcohol problems, it appeared to suggest that they were in no way to be blamed for this 'no-fault illness'; to the drinks industry, it was a tremendous boon in that it located the cause of drinking problems in the predispositions of a minority of consumers rather than in the product itself - 'the problem is in the man, not the bottle', as was sometimes said; to Government, it legitimated the fostering of a strong drinks industry, providing employment in the manufacturing, distribution and retailing sectors, and much-needed revenue for the Exchequer through indirect taxes; and, finally, to those in the 'treatment industry', it provided support for their claims for increased resourcing for this sector.

However, by the early 1970s, policy analysis based upon empirical research was tending to debunk some of the main tenets of the disease concept and to support the emergence of a public health or health promotional perspective. In 1975 an influential international research project, *Alcohol Control Policies in Public Health Perspective* (Bruun et al, 1975) was published under the joint auspices of WHO and the Finnish Foundation for Alcohol Studies; this tradition of public health research into alcohol was continued for the next quarter of a century, resulting *inter alia* in the publication in 1994 of another important study, *Alcohol Policy and the Public Good* (Edwards et al, 1994). In summary, the public health perspective on alcohol consisted of the following propositions:

- alcohol consumption poses risks to all consumers, contributing to a wide range of medical, psychiatric and social problems rather than being implicated in just one unitary disease;
- while some consumers may be at greater risk than others by virtue of their individual predispositions, all consumers face risk which is largely related to their level and pattern of consumption;
- the incidence and prevalence of alcohol-related problems in society is heavily dependent on consumption patterns - when a society starts to drink more alcohol it can expect more alcohol-related problems;
- specialist treatment services for drinking problems have not made major technological advances, and health services should not put all their scarce resources into curative systems at the expense of health promotional developments in this area;
- the health sector on its own cannot realistically be expected to manage alcohol problems; instead, all sectors of Government must collaborate in promoting health in this area of human activity, and public policy on alcohol must be prepared to encompass control and regulation in addition to treatment and education.

Ireland's National Alcohol Policy

The application of health promotional or public health concepts to Irish public policy on alcohol arose in the first instance from the epidemiological work of Dr Dermot Walsh at the Medico-Social Research Board in the late 1970s, but the first comprehensive public presentation of this perspective - again presumably reflecting the work of Dr Walsh - was in *The Psychiatric Services: Planning for the Future* (1984), a mental health policy document which laid down the template for future developments in public mental health services. Chapter 13 of this document dismissed the validity and utility of the disease concept in the most peremptory of fashions, argued that increases in a range of alcohol-related problems were related to increased consumption levels (it was noted that between 1950 and 1984 *per capita* consumption of alcohol had almost doubled in Ireland), and concluded that: 'Because of the involvement of alcohol in many aspects of our society ranging from trade to health, a national alcohol policy can be instigated only by an inter-departmental body, representative of all Government bodies concerned' (*The Psychiatric Services: Planning for the Future*, p. 112).

This health promotional view of alcohol and related problems was presented in a well-reasoned and, to use currently fashionable language, 'evidence-based' way; however, it resulted in no immediate policy action and had it not been for the creation of formal health promotion structures in 1988, perhaps it would never found its way onto the policy agenda. Unlike the disease concept of alcoholism which had wide popular appeal, the health promotional approach to alcohol seemed to have little to endear it to anybody outside of the public health community. From a philosophical point of view, it smacked of old-fashioned paternalism, with the State appearing to be in the position of telling all citizens - and not just young people - how they should conduct themselves with regard to their drinking habits. It had little appeal for those problem drinkers who had become accustomed to thinking of themselves as suffering from a respectable disease, since it blurred the issues here and appeared to suggest that drinking problems were attributable to drinking habits as much as to genetics. Quite obviously, the public health approach was disliked by the drinks industry since it attributed blame to its product and called for tighter control and regulation of this industry. Politicians, if they were to take this new perspective seriously, were expected to give leadership by acting to stabilise, if not actually reduce, consumption levels through: strict enforcement of licensing legislation and drink-driving legislation; fiscal policy aimed at keeping real alcohol prices high; restrictions on alcohol advertising and promotion; and a host of other control measures, none of which seemed likely to be popular with the electorate. And, for senior civil servants, the public health approach to alcohol called for the creation and maintenance of inter-departmental policy networks based upon a public health agenda, a scenario which seemed far removed from the reality of public policy making where each individual sector of Government was accustomed to pursuing its own agenda.

Among the various health promotion structures set up by the Minister for Health, Dr Rory O'Hanlon, was an Advisory Council on Health Promotion and what was sometimes described as the 'executive' Health Promotion Unit (HPU) in the Department of Health. During 1990, the Minister for Health requested the Advisory Council to draft a national alcohol

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policy, and in early 1991, with the support of the HPU, this task was embarked upon with a public call for submissions from interested parties. The notice which was published in the press at this time announced that:

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 for 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, diagnosis and treatment strategies, etc., and particularly the issues of youth and alcohol, and the role of parents and family

(Health Promotion Unit, February 1991)

Later in the summer of 1991, the Advisory Council on Health Promotion delegated the task of formulating a national alcohol policy to a specific Working Party which consisted of some of its own members and a number of outsiders (including, it must be said, this writer) who were co-opted because of their particular interest in alcohol policy issues. This Working Group met sporadically between the summer of 1991 and the autumn of 1992 but never subsequently, and the drafting of the final policy document was effectively the work of the HPU. Eventually, in September 1996, the Minister for Health, Michael Noonan, launched the completed document, *National Alcohol Policy - Ireland*.

The finished product, which was a model of elegance from the point of view of layout and design, consisted of three main sections: the first section set out the background to the policy by reviewing alcohol consumption and its consequences in Ireland; the second presented the broad rationale for a national policy on alcohol based upon health promotional principles; and the final section was a 'Plan of Action' which dealt with implementation of the policy. From a health promotional perspective, the first two sections were clearly and convincingly presented, drawing heavily upon *Alcohol Policy and the Public Good* (Edwards et al, 1994) and also upon the WHO's *European Charter on Alcohol* (1995). Interestingly, *National Alcohol Policy - Ireland* contained absolutely no reference to 'alcoholism', with this word never appearing in the text of the policy document. As would be expected of a health promotional document, the strategies discussed went far beyond individual interventions - of an educational or therapeutic type - to look at a range of environmental strategies which demanded broad public policy support. The chief environmental issues considered were: access to and availability of alcohol, which could be regulated through the licensing code; the road traffic legislation governing drinking and driving; the advertising and promotion of alcohol; and the taxation and pricing of alcohol.

The third section of the policy, the so-called 'Plan of Action', was however a great disappointment in that it contained no credible, concrete plans for implementing any of the health promotional strategies discussed in the first two sections. A reading of this section would suggest that the HPU had not succeeded in forming collaborative relationships or constructive alliances with other sectors of government, with

the media, with the drinks industry or with community-based groups with a view to delivering on the radical promise of the first two sections. Instead, the proposals for implementation were almost entirely vague and aspirational, referring mainly to 'encouragement' of those outside the health sector to move towards a health promotional stance on alcohol.

In launching the report, the Minister (and it is well to remember that Mr Noonan was the fifth Minister for Health to serve during the time this policy was being formulated) gave further indication that no bold new initiatives were likely to result from this document when he replied to journalists who had asked whether the document could have been tougher. He was reported as saying:

It's very hard to legislate for virtue. It's even difficult enough to legislate for good behaviour. The kind of island I would like to see is where we would have what I would describe as sovereign individuals who are 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*, September 20, 1996).

It goes without saying that if the drug in question had been an illicit drug, such as cannabis or ecstasy, the Minister would have been a good deal less likely to express liberal views of this type about consumer sovereignty. It seems safe to conclude that, whatever the research evidence on the public health value of alcohol control policies, it was the Minister's judgement that the Irish public was not ready for such policies and this undoubtedly is what most if not all Irish politicians would have done in his position.

By Their Fruits.....

It is not possible to attempt a lengthy and detailed evaluation of the national alcohol policy here, but almost five years after its publication it would seem to have made virtually no impact on public consciousness, on policy or on actual drinking habits here in Ireland. It would seem, in fact, that in carrying out his priestly ministerial functions back in September 1996, Mr Noonan was not pouring baptismal waters on the head of a lusty infant, but rather consigning to the grave an unfortunate child, who after a lengthy and difficult gestation had emerged stillborn.

Following its official launch, little or no attempt was made to use the national alcohol policy to inform debate about alcohol and it would seem that many people were unaware of its existence. For instance, in 1999 the Irish Catholic Bishops' Conference published a leaflet entitled *The Temperate Way* to mark the centenary of the founding of the Pioneer Total Abstinence Association. In this leaflet, the bishops note that alcohol problems constitute the major drug problem in this country in terms of negative impact on families and communities, and they go on to say:

Against this background we wish to draw attention to the 1995 Alcohol Charter adopted by the European Region of the World Health Organisation. We strongly recommend that the State authorities, North and South, set up a task force to study its legal and social implications.....

The bishops made no reference to *National Alcohol Policy - Ireland* and it seems reasonable to conclude that they were unaware of it.

From a legislative point of view, the major event since the publication of the policy document was the enactment of the Intoxicating Liquor Act 2000. The main effect of this new legislation, from a health promotional perspective, was a negative one involving extended opening hours for all pubs and off-licences, with later opening hours on Thursdays, Fridays and Saturdays appearing to reinforce existing Irish habits of cramming a lot of serious drinking into the weekend. Undoubtedly, the HPU was consulted and offered its advice on this particular legislation but the national alcohol policy had no apparent effect on the final shape of the new law; public debate during the legislative process never reflected health promotion ideas, but instead was dominated by interest group conflict involving the existing licence holders and their determination to resist any threat to their current monopoly. The inclusion of tougher measures to deal with underage drinking in the new act would of course be welcomed by health promotionists, but would also be seen as missing the point of the national alcohol policy which was intended to be aimed at *all drinkers* and not just at selected groups, such as alcoholics or young people. Indeed, it could be argued that legislation which significantly increases access to alcohol for the adult population while seeking to curb consumption by those below the age of 18 is hypocritical.

And finally, without going into detail, figures issued by the HPU suggest that since the publication of the national alcohol policy *per capita* alcohol consumption have been steadily rising.

What's To Be Done?

While it is reasonable to conclude that health promotional ideas and ideals are stuck firmly at the level of rhetoric in terms of the national alcohol policy, it would seem important to avoid taking up a position of total fatalism or cynicism on this issue. Social workers, like various other human service professionals, are aware on a daily basis of the depredations caused by alcohol consumption, and it would seem excessively defeatist to view our drinking habits as though they were too complex and immutable to be shaped or altered in any definite way by public policy.

Academic literature on policy making as applied to alcohol policy and to a host of other complex areas (Harrison and Tether, 1987; Kickert, Klijn and Koppenjan, 1997) suggests that the most promising models are those which involve *policy networks* which cross different sectors of government and also include all the main stakeholders from non-governmental organisations and interest groups. This unfortunately was not the model adopted by the HPU in its work on the national alcohol policy; indeed it could be said that the HPU did not even succeed in gaining the goodwill or making full use of the Working Party which ostensibly was given the task of drafting this policy. It is also important to note that this idea about policy making through the management of complex networks is not just a figment of the academic imagination but is in fact already central to the changes and reforms in public sector management which have been in train in Ireland since the early 1990s as part of the Strategic Management Initiative (SMI). SMI recognises explicitly that there are many - indeed perhaps most - public policy goals which cannot be efficiently or effectively attained simply through the efforts of *one* governmental department or sector; such policy issues are commonly described in management jargon as 'cross-cutting' issues which demand inter-sectoral or cross-cutting structures for their successful management (Boyle, 1999; Carroll, 1999).

It would be nice to think that the approaching fifth birthday of the national alcohol policy would see an attempt to breathe some life back into its corpse, and by the far the simplest recommendation that suggests itself is that we might apply this network/cross-cutting model of policy making to alcohol, as has already been done with illicit drugs. If we can have a *National Drug Strategy Team*, which is based upon the notion of formalising inter-sectoral policy relationships, why not have a *National Alcohol Strategy Team*?

It would by now seem clear that the HPU as a structure for facilitating real policy initiatives in the alcohol area is unsuccessful, and if no attempt is made to create new structures, it may well be that the fifth birthday of the national alcohol policy will be celebrated only by the drinks industry!

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