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What is the problem?: Evidence, politics and alcohol policy in England and Wales, 2010-4

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Abstract

This paper considers alcohol policy development in England and Wales under the Coalition government after 2010. With a particular focus on minimum unit pricing, it examines why policy departures based on supply-side controls drawn from public health models were abandoned in favour of a restoration of policy equilibrium. The paper adopts a historically-informed political science perspective, drawing upon insights from John Kingdon's policy streams approach, with a focus on how the 'alcohol problem' is defined and framed by policy actors. It argues that while the restoration of policy equilibrium was significantly attributable to industry lobbying, also important were the inconsistent framing of policy proposals, lack of departmental synergy, ideological tensions and a lack of coherence in the communication of evidence.

Alcohol policy in England and Wales since 2010: Evidence, policy and politics

In May 2010, the newly formed Conservative and Liberal Democrat coalition government pledged to ban the sale of below-cost alcohol, review alcohol pricing, strengthen licensing legislation, and tackle sales to underage drinkers (HM Government, 2010: 13-14). In March 2012, the Government's Alcohol Strategy replaced the promise of a ban on below-cost sales with a commitment to introduce a minimum price per unit of alcohol: a measure welcomed by the public health community as it appeared to signal a shift in the policy equilibrium (Nicholls, 2012).

Over the following years these policies either failed to be widely implemented or were abandoned. Coalition alcohol policy, therefore, moved from radical supply-side controls to the previous equilibrium of light-touch regulation. Alcohol policy in England and Wales is set by the Government in Westminster, whereas alcohol licensing in Scotland is a devolved power and the Scottish Government have independently pursued the policy of minimum unit pricing. Recent developments in Scottish alcohol policy have been explored elsewhere, as have the tactics used by industry lobbyists against minimum unit pricing at Westminster (Katikireddi et al., 2014 a and b; McCambridge et al., 2014; Holden et al., 2012; Hawkins and Holden, 2012). Taking industry resistance as a given, and focussing specifically on policy at Westminster, this paper will consider what other political factors contributed to prevent fundamental policy change under this administration.

Adopting a historically-informed political science perspective, we argue that the 'problems' alcohol policy addresses are subject to the interaction of complex political forces. Problem-definition plays a key role in determining policy solutions; equally, policy solutions are often made to 'fit' perceptions of what the problem, and policy goal, is. We ask how the framing of Coalition alcohol policies contributed to the development and the demise of policy initiatives and what this tells us about the relationship between 'evidence-based' policy and the pragmatic realities of political decision-making.

Party politics and alcohol policy: a brief historical overview

The three main UK parties have complex historical relationships with alcohol. The Victorian Liberal Party struggled to reconcile its support for local democratic accountability, its valorisation of individual freedom, its defence of free markets, and the New Liberal belief in the role of the state in protecting the individual from moral threats. Historically, Liberals were torn between those who supported deregulation of the alcohol market on free trade principles and those who were attracted to the temperance movement and its vision of social progress through sobriety (Harrison, 1971; Greenaway, 2003; Nicholls, 2009).

The early Labour Party also drew from Victorian temperance (Jones, 1987). Socialist temperance was influential within the early union movement, condemning 'The Trade' as a capitalist interest that exploited workers while

weakening their capacity to organise (see, e.g., Snowden, 1908; Burns, 1914). On the other hand, the Labour Movement also stood for a defence of working class culture, and temperance was often perceived as a thinly-veiled attack on working class lifestyles; moreover, pubs and working men's clubs often provided the infrastructure for local activists. Hence, there was a conflict between socialist critiques of the drinks industry as an arm of organised capital and the defence of pubs in the domain of cultural politics.

The Conservatives became associated with the drinks trade from the 1870s and retained a close ties thereafter. Deregulatory legislation was introduced under successive Conservative administrations beginning with the Licensing Act of 1961. Sunday opening, the removal of the 'afternoon gap', and the de-monopolising 1990 Beer Orders were all introduced under Margaret Thatcher, although this latter caused considerable tensions within the brewing industry (Spicer et al., 2012). The natural fit between Conservative politics and the interests of the drinks industry is, however, complicated by the traditional role of the Tories as the defenders of moral conservatism and the 'party of law and order'. The defence of economic freedom conflicts with the commitment to police moral transgression, especially where a disinhibitory drug such as alcohol is concerned.

Historically, alcohol has proved an awkward problem for parties seeking to arrive at coherent policy positions. This complexity is compounded by the interdepartmental nature of alcohol policy (Baggott, 2012; Cairney and Studlar, 2014). While the role of the Home Office in addressing antisocial behaviour and

the Department of Health in addressing health implications are longstanding, recently the Health Select Committee identified twelve departments with a direct interest in alcohol policy (Health Committee, 2012, 115). Furthermore, relations between these are rarely synergistic (Greenaway, 2011, 416-17.) Not only do departmental perspectives shape ideas about problem definition and policy solutions (Smith, 2012), but the relationship between departments is asymmetrical. Describing efforts to keep MUP on the policy agenda towards the end of the Labour administration, a former Minister for Public Health noted the departmental hierarchies involved:

JN: Is there a hierarchy of departments on this?

Interviewee: Yes.

JN: And is the Treasury the top of the tree?

Interviewee: Absolutely. Well, in this case it would be BIS. Treasury would stand as the next one, but what was the DTI, because obviously there were issues of what would happen to the industry, and they were saying, you know, 'Armageddon', and we were saying 'No, it wouldn't'. But it was up to the DoH to clearly demonstrate that, and the DTI was not about to put lots of resources in to settle it for us.

(Author interview)¹

These conflicting policy outlooks and priorities have consequences not only for the development of policy ideas, but also the framework within which policy is considered.

¹ Author interviews with national policy stakeholders (n=12) were carried out in 2011-12.

Framing the 'Alcohol problem'

Historically, alcohol policy has been framed in radically different ways. In mid-Victorian times there was a division between those seeing alcohol consumption as a moral issue and those couching the debate in terms of individual freedom. By the Edwardian period attention moved to the role of alcohol in the 'Condition of England' question and supposed national degeneration. During World War I, policy was dominated by a concern for national efficiency, followed after 1920 by debates concerning the role of alcohol in leisure activities but also a concern with alcoholism as a 'disease' (Greenaway 2003). After 1945, when Whitehall rather than Westminster had become the chief venue for policy initiatives, the plethora of government departments involved meant that framing became particularly complex and elastic.

The political framing of alcohol is neither stable nor under the control of those driving policy. Politicians are influenced by broader ideological goals, the pursuit of personal ambitions and pressure from outside influences. Thus, in the early 2000s, New Labour originally presented licensing liberalisation as a business deregulation measure. However, this became overlaid with a 'continental drinking culture' frame that was swiftly undermined by a media-driven 'Binge Britain' frame that presented deregulation as a dereliction of duty in the face of increasing youth disorder (Greenaway, 2011; Baggott, 2010; Light, 2005; Nicholls, 2013; Critcher, 2008).

The political failure of New Labour's alcohol policy allowed opposition parties opportunistically to emphasise their own law-and-order credentials. Attacking New Labour liberalisation fitted with a narrative of fixing 'Broken Britain' that formed a key pillar of Conservative election strategy at the time (see, e.g. Grayling, 2009). In framing alcohol as a problem of public disorder, the Conservatives exploited their role as the 'party of law and order', while targeting a policy area that was an Achilles Heel for New Labour (Nicholls, 2012: 258; Critcher, 2008: 166). This reframing of alcohol policy as a law and order issue, rather than an economic development opportunity, was reflected in the decision to move responsibility from the Department of Culture, Media and Sport back to the Home Office. The Coalition also launched a consultation on 'rebalancing' licensing legislation towards greater local accountability (Home Office, 2010): a policy that suited the narrative of 'localism', which had also formed a key plank of the Coalition programme.

Policy frames not only determine policy solutions; they also establish different, often competing, evidence bases: the 'evidence base' for a given policy is not independent of issue problematisation. The evidence base relevant to Treasury officials is not identical to that relevant to officials in the Department of Health. The same is true locally: evidence relevant to a licensing authority concerned with public order will not be identical to that relevant to a local health board concerned with reducing incidences of liver disease (Toner et al., 2014; Martineau et al., 2013; Phillips and Green, in press). Policy frames, then, are not overlaid onto evidence; they are integral to its identification, development and

application, and lack of congruence between frames and evidence can undermine the coherence of policy arguments.

Farnsworth (2007) argues that corporate power in policy arenas is structural: on the one hand excluding ideas from the policy agenda through the threat of disinvestment, but also seeking to theoretically align commercial interests with the 'common interest'. As regards alcohol policy, this latter strategy involves aligning the interests of the industry with those of a notional majority of moderate drinkers. Alcohol policy debates have long been characterised by appeals to wider principles around individual freedom as against the duties of the state to protect its population (Nicholls, 2009). Building on this long history industry advocates seek to make personal freedom for the moderate majority, and the narrow problem of youth disorder, the terrain on which policy debates are fought - a perspective which, as Haydock (2014) argues, dovetails neatly with broader neoliberal conceptions of personal responsibility. By contrast, public health advocacy has sought to shift the ground towards the precautionary responsibility of Government to protect public health across a whole population in which the lines between moderate, hazardous and harmful are not set in stone.

At stake here is not simply the 'evidence base' but a set of political and ethical principles. The international evidence that 'whole population' interventions on availability, price and marketing are effective in reducing consumption and harm is well established with Babor et al.'s influential study *Alcohol: No Ordinary Commodity* providing what one leading health advocate has called the 'Bible' of public health policy evidence (Health Committee, 2012: Ev 2; Babor et al., 2010).

However, the question of whether a Government *ought* to introduce such measures at an unavoidable cost to other liberties is a political question, and not one that can be resolved solely through an appeal to science - especially in a domain as culturally specific as drinking behaviours, where it cannot be assumed intervention effects translate seamlessly across settings.

Targeting price: minimum unit pricing

The genesis of advocacy for minimum unit pricing [MUP] in the UK has been described elsewhere, as have its adoption by the Scottish Government and alcohol industry attempts to derail the policy in both Scotland and England (Nicholls, 2012; Katikireddi et al., 2014a and b; Hilton et al., 2014; Gornall 2014; McCambridge et al., 2013). Put briefly, in 2007 researchers at the University of Sheffield were commissioned by the Department of Health to produce a review of alcohol policy measures. Professor Tim Stockwell, who had played a key role in developing minimum pricing in Canada, acted as an advisor and supported exploration of it as a policy option. The now famous 'Sheffield Model', included MUP in its econometric and epidemiological models of the relationship between price, consumption and harm (Brennan et al., 2008).

Despite the complexity of the Sheffield Model, minimum unit pricing has a natural appeal to common sense: it *seems* obvious that if you make the cheapest alcohol more expensive, then consumption at that end of the market will fall. MUP, therefore, is a both a complex science of econometrics, price elasticity estimates, consumption distributions and harm projections, and an apparent 'no-

brainer' solution to the problem of deep discounting. Consequently, MUP is amenable to operating as a policy heuristic (Cairney 2014b). That is to say, the complicated question 'do you believe the econometric models sufficiently demonstrate MUP will reduce alcohol harms in vulnerable population subgroups?' may be substituted in the minds of policymakers and the public alike for the simpler question 'do you object to very cheap alcohol?' (Kahneman, 2011). The tension between scientific and intuitive approaches to the validity of MUP helps explain tensions in subsequent policy framing.

MUP swiftly caught on as a policy 'idea' (Smith 2012 and 2013). However, to different stakeholders it presented a solution to different problems. Many within public health saw MUP as contributing to the 'prevention paradox' in which small reductions in harms spread across a large population produced a 'maximum public health gain' (Health Committee, 2012: ev10). For others, MUP represented an 'exquisitely targeted' intervention aimed only at heavy drinkers (Sheron et al., 2014), while a third view emphasised that MUP would affect all drinkers to some degree, but disproportionately those drinking at harmful levels, thereby representing a form of what the Marmot Review described as 'proportionate universalism' (2014; Katikireddi, 2014b: 15; Holmes, 2014; Marmot et al., 2010). Although large alcohol producers vociferously opposed the measure, some brewers (such as Molson Coors and Greene King), many pub operators and the consumer group CAMRA, saw MUP as a method for equalising a market distorted by deep supermarket discounting, thereby tackling a long-term decline in pub numbers.

Critically, however, the Home Office construed MUP as tackling the 'scourge of violence caused by binge drinking' (HM Government, 2012: 2). As the Home Office minister Jeremy Browne put it:

It is undoubtedly true to say, regardless of what conclusion one reaches on this issue, that some young people with low disposable incomes drink irresponsibly and are price-sensitive when buying alcohol. They are a particular problem. The question that we need to resolve is whether minimum unit pricing is the best way of tackling that problem. (HC Deb, March 14 2013 c476)

However, this was contrary to conclusions drawn from the Sheffield model which suggested the policy best targeted those consuming large amounts of shop-bought alcohol, typically consumed in the home, not in public where the type of antisocial behaviour identified as a policy concern typically occurs.

In reviewing the Alcohol Strategy, the Health Select Committee drew attention to this contradictory framing. Asked for his views, the Chair of the Alcohol Health Alliance replied 'I do not mind too much how it was framed. What I mind about is how it measures up to what I think it requires in order to reduce our per capita consumption and the concomitant harm' (Health Committee, 2012: ev1).

However, pragmatic social disorder framing weakened the focus on the aspect of the evidence – that MUP would reduce health harms among the heavier drinking subgroups – which was most robust. The Health Committee noted this risk stating that 'the main focus of this strategy is the need to address public order

issues ... but ... the health impact of alcohol is more insidious and pervasive' and called for the Government to 'build its case for a minimum unit price' more effectively (Health Committee, 2012: 3-4). In response, the Department of Health said the crime and disorder focus 'reflect[ed] public concern on these issues' (Department of Health, 2012: 1). However, the need to fit MUP within a familiar (and more populist) frame left the policy exposed to the challenge that it would not achieve what the evidence suggested it should.

While minimum unit pricing divided the alcohol industry, opposition was led by the Wine and Spirits Trade Association who, in addition to the kind of lobbying detailed by McCambridge et al. (2014), launched a high-profile media campaign to "kill" MUP under the banner 'Why Should Responsible Drinkers Pay More' (Quinn, 2013; WSTA, 2013). Seeking to establish commercial interests as the 'common interest', this rejected the claim MUP would reduce crime while emphasising unfairness to moderate drinkers. The success of this campaign is reflected in the terms by which the Government announced it was abandoning the policy in July 2013: that it did not have 'enough concrete evidence that [it] would be effective in reducing harms associated with problem drinking ... without penalising people who drink responsibly'. Those harms were understood to be 'drunken behaviour and alcohol-fuelled disorder' (HC Deb, 17 July 2013 c1113).

Policy streams

The amenability of MUP to an unusual range of stakeholders resonates with John Kingdon's 'policy streams' model of change. Kingdon argues that the policy process is inherently elastic, fluid and shaped by three 'policy streams' that interact in complex and sometimes unpredictable ways: the *problem* stream (an issue becomes seen as a matter of widespread social or media concern, perhaps following media campaigns or some shocking accident); the *policy* stream (a policy solution to the problem is developed and championed within government agencies); and the *politics* stream (the wider political and party conditions, the tenor of public debate and so forth within which policy debates occur) (Kingdon, 1995). When the three streams converge, a 'policy window' opens whereby a particular solution gets onto the agenda. However, as Kingdon puts it, '[O]pen windows are small and scarce. Opportunities may come, but they also pass. Windows do not stay open long' (1995, 204).

The 'problem stream' was partly epidemiological. In the mid-2000s, annual per capital alcohol consumption reached historically high levels, as did alcohol-related hospital admissions, raising the media profile of the issue (Health Committee, 2010a: 14-21; Nicholls, 2012: 259; for examples see e.g. Deacon et al. eds., 2007; Slack 2006). While the night-time economy became the subject of widespread media interest in the mid-2000s (Greenaway, 2011; Critcher, 2008; Nicholls, 2009) a series of 'focussing events' – such as the murder of the parent Gary Newlove outside his home by drunken youths in 2008 – also drew media attention to the impact of cheap alcohol sales in off-licences and supermarkets (Hughes et al., 2008; Newlove, 2008). Giving evidence to a Health Select Committee inquiry into alcohol in 2009, the sociologist Martin Plant described

supermarkets as having 'the morality of a crack dealer' – a comment that was widely reported (Health Committee 2010b: 15; Martin, 2009).

In the policy stream, public health advocacy was critical. Previously, the policy influence of public health alcohol advocates had been constrained by a lack of organisation, despite key individuals playing a role in the policy networks around the Department of Health (Thom, 1999). In 2007, the Alcohol Health Alliance was established as an umbrella organisation calling for government action on price, availability and alcohol marketing, with Professor Sir Ian Gilmore as Chairman. As a number of studies have shown, the amplified 'source credibility' that accrues from medical professionals taking the lead in policy advocacy is significant (Smith, 2012: 64; Jones and McBeth, 2010: 344; Lorenc et al., 2014: 3), and Professor Gilmore's role was critical. As one senior Department of Health civil servant observed, Gilmore's work 'really began to put alcohol onto the agenda ... [he] had an open door because he was the President of a Royal College [but also] because of the profile he was getting' [Author interview].

Over this period support for MUP was expressed by the Home Affairs Select Committee (2008); Health Select Committee (2010a), NICE (2010) and the Chief Medical Officer, Sir Liam Donaldson (2009). The fact that the SNP took the political lead in introducing MUP to Scotland in 2012, also added to pressure on the Westminster Government to act.

Finally in the political stream, the political emphasis placed by the Conservatives on attacking New Labour's alcohol policies meant targeting problem drinking was strategically important. Furthermore, while in opposition the Conservative

Party had moved closer to public health approaches in its health policy (Baggott, 2011: 94). By the late-2000s, no major party was calling for liberalisation of alcohol policies and there was widespread support for action to tackle both the 'scourge of binge drinking' and the demonstrable rise in alcohol mortality and hospital admissions. In that respect, all three 'policy streams' had aligned: however, in England at least, the policy window only remained open for a brief time.

Outcomes

Industry opposition to MUP focused on suggesting that predictive models were not 'evidence' in the conventional sense, and that their findings were 'inconclusive at best' (Health Committee, 2012: ev103; Institute of Alcohol Studies, 2012). They highlighted the weaker evidence for an impact on youth disorder and depicted MUP as unfairly restricting the freedoms of moderate drinkers (McCambridge et al., 2014; Katikireddi et al, 2014b). In submissions to the Health Select Committee the Portman Group stated that policy must 'build on the Responsibility Deal and be evidence-based ... and not penalise the majority drinking responsibly' (Health Committee, 2012: ev103). The Responsibility Deal, a voluntary system of self-regulation established by the Department of Health and the alcohol industry (Department of Health, 2011) had the advantage of presenting a solution that didn't threaten existing policy relationships. As a senior Department of Health civil servant noted:

The voluntary partnership piece is easiest route to go down: it's the route of least resistance. So, the default position will be that the answer is voluntary partnership with industry ... nobody will sack you for going into a voluntary arrangement with the industry. Anything stronger than that is a braver and braver option.

(Author interview)

Hence, 'path dependency' – that is, the tendency for civil servants to rely on well-established relationships when designing policy – adds significant traction to voluntary partnerships over alternatives requiring legislation.

The claim that the econometric models supporting MUP were not reliable evidence spoke to a well-documented tendency for policymakers to approach prospective modelling as 'subordinate' to more familiar types of evidence such as retrospective evaluations (Katikireddi et al., 2014c: 491; Lorenc et al., 2014). While 'real world' evaluations of MUP from Canada boosted the evidence base for MUP, these faced criticism on the grounds that they still applied statistical modelling, and that their validity in a UK setting was limited (Stockwell et al, 2012; Duffy and Snowden, 2012; Zhao et al., 2013). Combined with the fact that path dependency oriented policymakers towards voluntary alternatives, supporters of MUP struggled to counter challenges targeting the methodological validity, and political viability, of the policy.

What are the problems?

Comparing UK tobacco and alcohol policy, Cairney (2014) develops Kingdon's 'streams' model and identifies five factors that can support policy change: shifts in departmental responsibility; changes in policy framing; changes in the balance of power between stakeholders, changes in the socioeconomic context; and lessons from international policy. Many of these factors contributed to the viability of interventionist alcohol policies after 2010 – but what caused the English alcohol policy window to blow shut? Industry lobbying was, of course, a critical factor; however a broader set of categories for clarifying recent 'problems' of alcohol policy can also be proposed:

1 – *Definitional*. Looked at as a solution to specific health concerns, MUP appears strong; but looked at as a solution to youth binge drinking and disorder, it looks less convincing. The difficulty in resolving tensions between framing alcohol as a health and / or public disorder issue has historically dogged effective alcohol policy, with these distinct problematizing frames being more recently associated with an explicit conflict between 'public health' and 'industry' perspectives on alcohol policy. Failure within government to resolve these definitional issues coherently was a significant factor in weakening the political viability of supply-side interventions.

2 – *Ideological*. At the heart of the perennial tensions between alcohol control advocates and their opponents is a question of the role of the state in intervening in markets to protect consumers from the power of commercially-driven industry. These problems, essentially a conflict between what the philosopher Isaiah Berlin described as 'positive' and 'negative' conceptions of freedom in the

domain of public health also have a very long provenance (see, for example, Nicholls 2009: 109-29; Nicholson, 1985), and remain at the heart of contemporary debates on public health – the ‘stewardship’ model of public health developed by the Nuffield Council on Bioethics being one recent example of an attempt to resolve this tension (Nuffield Council on Bioethics, 2007). Furthermore, the Conservative position in this respect is inherently unstable. It has been noted that, ‘it is not unusual for Conservatives to ‘hold both libertarian and paternalist views at the same time, with the outlook depending less on clearly stated principles than on the particular issue or realm of activity that was being addressed’ (Green 2002, cited in Page, 2013: 24). Libertarian criticisms within the Coalition exacerbated significant ideological tensions on this aspect of official policy after 2012 (see, e.g., Conservative Home, 2013).

3 – *Systemic*. The cross-departmental nature of alcohol policy creates systemic tensions which produce incoherent policy development and presentation. Other systemic issues are also important: the impact of civil service ‘churn’ on policy stability, a tendency towards ‘path dependency’ which entrenches the power of established stakeholders, and the institutional tendency within the civil service to maintain established ‘thought styles’ (Hallsworth et al., 2011; Stevens 2011). Importantly, none of these were counterbalanced in England, by any high-profile ministerial advocacy or media support, in contrast to the Scottish situation (Katikireddi et al., 2014a).

4 – *Evidential*. The evidence base for alcohol policy is multifaceted; different bodies of evidence have traction with different policy actors. Furthermore, while

scientific evidence can inform political judgement, personal and political values, as well as pragmatic and electoral considerations, are fundamental elements of the decision-making process (Cairney 2014). The failure of the more radical aspects of Coalition alcohol policy was not simply a refusal to accept research evidence on alcohol harm, but also a reflection of the fact that this body of evidence was not, ultimately, decisive in the wider argument. Additionally, the 'heuristic' adoption of complex policy proposals makes them more easily communicated; however, they may not chime precisely with the original science, exposing inconsistencies that opponents can easily target.

While it is often 'politically important that decisions should be *seen* to be founded in proper, rational processes' (Jenkins, 2007: 27), as many recent commentators have argued, simply insisting that policymakers 'follow the evidence' is naïve in its understanding of the policy process, and unrealistic in terms of understanding how policy should be made (Marmot, 2004; Hallsworth et al. 2011; Cairney, 2014a; Toner et al. 2014; MacGregor: 2013; Stevens, 2011). The 'messiness' of policy doesn't mean 'politicians disregard evidence, nor that they should ... but it also does not mean that ministers will always act exactly as the evidence apparently indicates, nor that they always should. The separation of policy and politics is an unrealistic illusion' (Hallsworth et al., 2011: 84-5).

Conclusion

The Coalition is by no means the first Government to fail in its stated goals of reforming alcohol policy. Throughout history, the role of the alcohol industry

lobbying has been critical. However, developments in alcohol policy have always also reflected the dominant frames for understanding what the 'alcohol problem' is (and been weakened when those frames have been challenged); they have responded to the activities of advocacy coalitions who have fought both for access to policymakers and control of public discourse; they have seen apparently coherent ideas fragment and reshape under the pressures of interdepartmental interests; and they have exposed the difficulty of identifying singular bodies of evidence which operate outside of ethical and political positioning.

The fate of novel alcohol policy solutions is, at the best of times, precarious – especially when restrictions on personal liberty are involved. Research shows that public attitudes to alcohol policy tend to favour non-population interventions and that the 'proportionate universalism' of MUP is not well understood (DeVisser et al., 2014; Pechey et al. 2014; Lonsdale et al. 2012; Moskalewicz et al., 2012). As Katikireddi et al. (2014b: 250) argue, framing alcohol policy 'as a broad, multisectoral health issue that requires a whole-population approach has been crucial to enabling policymakers to seriously consider MUP', and the brief adoption of MUP by the Westminster Government testifies to the success of health advocates in successfully achieving this.

However, history shows that the constraints on alcohol policy are multifaceted, and recent developments bear this out. Challenges to policy equilibrium face barriers that are systemic and ideological, and which speak to the relationships between problem-definition, evidence and political viability. History (and recent Scottish experiences) show that alcohol policy is not intransigent; however, the

combination of factors required to achieve change help explain why, as under the Coalition since 2010, it often appears to be so.

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