The Alcohol Health Alliance:

The emergence of an advocacy coalition to stimulate policy change

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Abstract

This paper provides an account of the emergence and early development of the Alcohol Health Alliance (AHA), a coalition of organizations including medical bodies, charities and alcohol health campaigners. Launched in 2007, the AHA aimed to re-frame awareness of alcohol consumption and related harms, to gain greater policy saliency for health compared to criminal justice priorities, and to shift policy towards adopting a population approach as compared to a targeted approach to intervention. The strategies used by the AHA to mobilize support and re-frame understanding of the alcohol problem, were successful in the short term. The alliance benefited from their links with established powerful institutions that helped them secure a strong presence within the policy arena and in the media, not least by forging relationships with political allies. However, in the longer term, it may be difficult to maintain a position of strength and to combat pre-existing entrenched relationships that favour competing alternative perceptions of the alcohol problem and the appropriate policy response.

Keywords: stakeholders, policy advocacy, alcohol, UK

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Introduction

Although there is a growing literature on the role of the alcohol industry as stakeholders in the alcohol policy arena (e.g. McCambridge et al., 2014), there has been little research looking in-depth at the emergence of public health advocacy or of coalition groups to address what is perceived as an imbalance of power between corporate and public interests in this field (Cairney and Donley, 2014). The Alcohol Health Alliance UK (AHA), which was launched in 2007, is a coalition of organizations including medical bodies, charities and alcohol health campaigners. From an initial membership of 24 organizations, the AHA grew to 34 member organizations by October 2013 (when this study was undertaken). Its mission is 'to reduce the damage to health caused by alcohol misuse' by working together to highlight alcohol-related harms, propose evidence based solutions and influence decision makers to take action to address alcohol related harms. The aim of this paper is to present an account, from the perspective of those involved, of the factors that influenced the initiation of the AHA and the strategies employed to recruit and bond a set of diverse stakeholder groups around a common goal. This account reflects the understanding and experience of interviewees and is not concerned with assessing whether or not the AHA was successful in achieving its aims. It tells the tale of the formation and early maintenance of one coalition and presents its view on the evidence for action and on competing interests in the alcohol arena.

Study methods and concepts

As part of a larger European study on stakeholders in the Addiction and Lifestyles in Contemporary Europe Reframing Addictions Project (www.alicerap.eu), taped interviews were conducted in 2014 with nine members of AHA. They comprised one policy-maker, three medical doctors and five non-medical professionals from organisations associated with

AHA; all respondents were part of professional networks other than AHA. The interviews used an open-ended format to allow respondents to present their views and tell the AHA story in their own words. The nine interviews presented a highly consistent account of the main factors prompting the development of a co-ordinated response to the government's approach to alcohol policy and of the initiation and development of AHA membership and working methods.

In addition, a large number of documents produced between 2009 and 2014 and available on the AHA website were viewed. They provided examples of the different types of document produced by the organization, falling largely into four main categories: policy briefings, response documents, press releases/open letters and more conventional reports. The documents were used to gain an overview of the membership, structure and actions of the AHA, to extract information on key areas of interest and to identify some possible interviewees. A selection of 14 documents (4 policy briefings, 5 response documents, 3 press releases/open letters, and 2 reports) across the four categories was examined in more detail, to consider content and presentation of information, authorship, intended target audience, sources and use of evidence and how the AHA was 'positioning' itself with respect to alcohol policy. This was used to inform the development of the interview schedules and as a wider context for understanding the AHA's perspective on alcohol policy and the evidence used to support their arguments. Although the interviews were conducted as open discussions the interview schedules, and later the analysis of data, drew on insights from two theoretical sources, Advocacy Coalition Framework (ACF) and social movement theory.

According to the ACF, the policy process entails competition between coalitions of actors who advocate their beliefs about policy problems and solutions. This competition takes place within policy subsystems composed of actors from a range of different institutions interested in the policy area (Sabatier, 1988). Within the alcohol field, the policy subsystem is itself

divided into a number of inter-related, but distinct, actor networks, many revolving around the government departments which have responsibility for different aspects of alcohol policy. For example, the Home Office is responsible for issues of alcohol-related crime and alcohol licensing; the Department of Health is responsible for alcohol–related health issues; the Treasury has an interest in alcohol taxes. There are, therefore, a number of overlapping subsystems. The ACF suggests that within subsystems there are 'advocacy coalitions', groups of actors who share a set of normative and causal beliefs and who engage in a degree of coordinated activity over time to achieve their policy objectives (Sabatier, 1988; Sabatier and Jenkins-Smith, 1993). These insights are central to an examination of the emergence and early years of the AHA. This paper is concerned with the alcohol health sub-system; it is here that tensions and competition between different 'advocacy coalitions' become most apparent and differences in belief systems are reflected in preferred policy options.

Two broad schools of thought can be distinguished regarding the appropriate policy response to alcohol–related harm. On the one hand, alcohol–related harm is seen to affect a minority of people who drink in harmful or dependent ways and the appropriate policy option is harm reduction measures targeted at the minority of problem drinkers. This has been the dominant policy approach adopted by the UK government and reflected in alcohol strategies since the first national strategy in 2004 (PMSU, 2004). It is also the approach that is associated with alcohol industry interests despite, in more recent years, less consensus among different sectors of the industry and trade regarding alcohol policy (Katikireddi et al., 2014; House of Lords, 2015). On the other hand, there is the view that problems are linked to the total consumption of alcohol in the population and that measures are needed that target population wide drinking (see: House of Lords, 2015 for witness statements and a discussion of these differing perspectives). This approach has been suggested as an option for well over half a century but has only recently gained a degree of policy attention as public health concerns

have become more central in the alcohol arena and as evidence for a population wide approach has increased (Babor, 2010; Cairney, 2014). It is important, therefore, to examine the belief systems which underpin coalition action and which are part of the 'glue' necessary to build consensus among members – the normative commitments and causal perceptions which serve to unite individuals and organisations and to direct action towards attaining policy goals or policy change (Sobek, 2003).

Stimulating policy change was a main goal of the AHA. Three factors, necessary for the emergence and development of social movements, have been suggested as applicable to advocacy coalitions interested in securing policy change (Kübler, 2001): the political opportunity structure, which sets the context of opportunities and constraints for advocacy action; the mobilizing structure, which consists of informal and formal systems of social organization to facilitate engagement in action and within which belief systems may be seen as a key element in ensuring shared normative commitments and causal beliefs regarding the issue; and framing processes, which take into account the collective processes of interpretation, attribution, and social construction that determine issue definition and perceptions of appropriate policy responses. This paper considers the political/policy context from which the AHA emerged, the strategies adopted to initiate and support the development of an advocacy coalition around alcohol health policy, and the ways in which the AHA attempted to re-frame understanding of alcohol policy and shift national policy towards a population-wide approach.

The political opportunity structure: the alcohol policy context

The political context is an important enabler and constraint on the emergence and evolution of coalitions (Kubler, 1999; Kubler, 2001). It is not possible to understand the emergence of the AHA without considering the backdrop of alcohol policy in the UK, the changes which

have occurred over the past decade and the role of different stakeholder groups in the policy process.

The alcohol policy subsystem is divided into a number of overlapping policy networks formed around ever changing issue specific concerns but afforded some level of constancy through links to major policy domains (such as criminal justice, health, education, leisure/media/sport, work and pensions, the treasury, and so on). The relevance of alcohol to the business of multiple policy domains, and the difficulty of working collaboratively across networks of stakeholders with diverse interests, has been highlighted since seminal studies in the 1980's (Tether and Harrison, 1988). Baggott (2010: 136) argues that alcohol policy has always suffered from 'departmental pluralism' where departments build alliances with interest and cause groups within their field of responsibility; but the adversarial nature of alcohol politics survives within departmental policy communities as well as cutting across departmental boundaries. In particular, the 'alcohol industry' – itself consisting of an increasingly diverse group of stakeholders (Baggott, 2006; House of Lords, 2015) – is pitched against groups concerned about health and social order.

Historians and policy analysts have sketched out shifts in contemporary alcohol policy and have described the factors that have influenced the course of policy development and change (Baggott, 2010; Greenaway, 2011; Nicholls, 2012). There is general agreement that the election of New Labour in 1997 marked a significant change in health and social policy and, with it, alcohol policy. From 1997, there was growing emphasis on the notion of the 'Third Way', which would unite state control and free market activity to solve social problems. A new ideology of collaboration and partnership, including partnership between industry, health and social services was at the forefront of policy, an approach that was continued under the Coalition government from 2010. In the alcohol field, partnership ideology was manifest by the establishment, and launch in 2011, of the controversial Responsibility Deal that was

intended to ensure cooperation between relevant stakeholders, including health and the alcohol industry. To achieve success, this initiative had to address the gulf in normative beliefs among its potential members and provide a professional forum for negotiation acceptable to all parties. As Hellman (2012) argues, the shift towards multi-stakeholder consultation and collaboration is based on a consensus model that requires stakeholders to rise above their differing values and rationalities and commit to overarching, often value-based, aims. However, even where the aim is agreed, conflicting interests are likely to stand in the way of agreement on *how* to achieve the aim. Moreover, inequities in status, power and resources between stakeholders are likely to affect outcomes. In the case of the Responsibility Deal contending policy beliefs proved hard to accommodate; libertarian, market economy and individualistic approaches espoused by some member groups (notably, but not exclusively, industry and alcohol trade groups) came into conflict with more directive, collectivist, population and public health approaches. As one interviewee put it:

> There are a lot of libertarian views out there that don't think that big Government should be getting involved in people's individual behaviours and choices around alcohol, which is all very good and well; but we need to remember that an individual might choose to drink and that's their own decision, but innocent victims don't choose to be run over by a drunk driver or hit in the face with a glass on a Friday night. So we need to remember harm impacts innocent victims as well as the drinker themselves; so I think that the John Mills harm theory does actually play quite well with alcohol (interview #2, July 2013).

As a result, several health stakeholders refused to join the Responsibility Deal on the grounds that it was not in the best interests of public health. According to Nicholl's (2012: 255), throughout their period of office, New Labour 'explicitly rejected both the public health model and its associated policies, adopting instead the "voluntarist" approach favoured by, among others, the alcohol industry'. Nicholl's observation highlights the divide that was to develop increasingly over subsequent years between two major groupings of stakeholders. On

the one hand there were groups who adhered more or less strongly to a public health vision which held the view that the alcohol consumption of the population as a whole must be reduced in order to address alcohol-related harm. They emphasized the need for government intervention to be based on the international evidence which pointed towards the use of taxation, price and availability restrictions to reduce alcohol-related harm (Babor, 2010); voluntarism and partnership with the industry were regarded with suspicion and the involvement of industry in alcohol policy formulation or in the production of evidence was regarded as unacceptable (Nicholls, 2012). By contrast, the policy core beliefs of other groups (including industry) and government – as demonstrated through their policies – emphasized harm reduction, targeted intervention aimed at high risk groups rather than the population as a whole, and partnership with industry (Baggott, 2010).

The adversarial nature of the debates on alcohol policy gained visibility in responses to two major alcohol policies published in quick succession. The 2003 Licensing Act (The Stationery Office, 2003) which relaxed existing licensing regulations at a time when concern about 'binge drinking' was growing, was met with a storm of protest from health campaigners and police alike and raised the profile of alcohol in the media and on policy agendas (Herring et al. 2008; Foster et al, 2009). The 2004 *Alcohol Harm Reduction Strategy for England* (PMSU, 2004) was greeted with equal criticisms. Government policy was challenged as industry led and the industry was accused of misrepresenting the evidence and promoting ineffective interventions. Adding to the complexity was the perceived prominence of a criminal justice led approach to alcohol-related harms – with a focus on the problems associated with binge drinking and the night time economy – which health advocates felt had squeezed out due consideration of the health effects of alcohol on individuals and populations (Room, 2004; McCambridge *et al*, 2013). The debate increased in volume and intensity over subsequent years, adding fuel to the contested vision of a 'broken Britain' (Flint and Powell,

2012). The AHA emerged from within this contested policy space and, following its launch in 2007, was itself engaged in the battle to claim policy attention and raise support for the public health, population approach to alcohol consumption and harm.

The mobilizing structure

Whilst the AHA formally came into existence in November 2007, the idea of building a wider coalition had been the subject of thought and discussion since at least the early 2000s. Interview data indicated that behind the 'visible' groups of stakeholders which became members of AHA, there was an 'invisible' group of stakeholders – policy-makers, activists, health advocates – who initiated the birth of, and acted as midwife to, the new alliance. For one thing, liver doctors entered the alcohol policy arena for the first time. In 2001, a report from the Royal College of Physicians (RCP), '*Alcohol: Can the NHS afford it?*' raised media interest and was a catalyst for action. The British Liver Trust set up a working group on alcoholic liver disease and proposed linking with the British Heart Foundation. They also contacted Ian Gilmore, registrar of the RCP, and invited him on to the working group (correspondence with interviewees).

Other advocacy groups including Action on Smoking (ASH) and the National Heart Foundation (NHF)[1] had demonstrated the potential for collaborative action on public health. ASH, set up by the RCP in 1971 to campaign for tobacco control to reduce the health harms caused by smoking, later became an independent public health charity (ASH website, 2014). The NHF, which was established in 1984 to campaign for policies directed at the prevention of coronary heart disease, was noted as particularly important as it had built up expertise in managing multi-organisation alliances through its work with ASH and this learning was drawn on to initiate and nurture new public health alliances. As with smoking, interviewees argued that the alcohol health lobby was facing a powerful, coordinated industry and a

government that was reluctant to implement public health measures. Several interviewees noted that the learning accrued through the experience of setting up ASH was very important in getting the AHA started, with individuals who had been involved with ASH since its inception providing guidance and support in the early days of the AHA.

Visible stakeholder activity can be seen from as early as September 2003. Following the publication of the Prime Minister's Strategy Unit's Interim Analytical report (PMSU, 2003) and with the Government's alcohol strategy on the horizon, the Academy of Medical Sciences (AMS) convened a working group, chaired by Professor Sir Michael Marmot (Professor of Epidemiology and Public Health), 'To identify, characterise and document the overall national consumption of alcohol, the evidence that this is a major determinant of harm and the opportunities for effective public health intervention that follow from this' (AMS, 2004a: 45). The working group comprised of academics and clinicians with specific knowledge and interest in alcohol issues. The secretary to the group was Professor Ian Gilmore, who had already been prominent in the debate around the 2003 Licensing Act (The Stationery Office, 2003). The AMS report, *Calling Time*: *The Nation's drinking as major health issue*, was published on March 2004 preceding the Government's *Alcohol Harm Reduction Strategy for England* (PMSU, 2004) by a couple of weeks. The Academy concluded that both consumption and harm had increased significantly and that there was scientific evidence to link *per capita* alcohol consumption with alcohol-related harm in the population (AMS, 2004a). The AMS argued that action to reduce the consumption of alcohol at a population level should be integral to any comprehensive strategy to reduce alcohol related harm and their recommendations included reducing availability, increasing taxation and reducing the drink drive limit (AMS, 2004a). However, the long awaited Alcohol Harm Reduction Strategy (PMSU, 2004) did not propose population level measures, instead it opted for alcohol education, media awareness campaigns and voluntary partnership with industry to

promote sensible drinking. The strategy was met with a barrage of criticism from health professionals and alcohol specialists, particularly in relation to the adequacy of its evidence base, the mechanisms for implementation and the political processes underpinning its development. There was disappointment that the government's own research on effective policies to reduce alcohol related harm seemed to have been dismissed (Room, 2004; IAS, 2004). The strategy appears to have galvanized the alcohol health field. In an interview in 2011, Gilmore stated that, frustrated by the 2004 strategy, health campaigners became 'more strident … and prepared to be more outspoken' (Nicholls, 2012: 259). The Academy was critical of the measures proposed in PMSU's report, arguing that they focused on alcohol abuse and failed to address the overall drinking level of the population (AMS, 2004 b).

Calling Time has been identified by a number of its authors as a turning point (Nicholls, 2012). Similarly, within this study interviewees highlighted its importance in shifting understanding for them as individuals but also for the medical profession more broadly:

> Before then, I saw it very much from a clinician's point of view. But I began to get more involved in the wider policy implications and the way you bring about change through public health and prevention, rather than the sort of things that were more familiar to me, like treating liver disease (interview #1, May 2013).

> So the idea was really that different parts of the medical profession initially saw very different aspects of alcohol related harm. Liver doctors saw a lot of liver disease, maxillofacial surgeons saw the broken jaws and slashed faces and orthopaedic surgeons saw the broken bones, and there was very, very little awareness of alcohol policy and the fact that all of these different manifestations of alcohol related harm actually had a very simple set of evidence based solutions – namely the international evidence base for alcohol policy. I think the real stimulus for that was the Academy of Medical Sciences' report Calling Time (interview #3, August 2013).

Thus, in different ways, policy documents published in quick succession during 2003 and 2004 – the Licensing Act, Calling Time and the Alcohol Harm Reduction Strategy for England – appeared to spur the alcohol health field into looking for ways of exerting pressure

on Government. In addition, there was a concern that policy and media attention was focused on alcohol related crime and disorder and insufficient attention was being paid to health harms, so that action was required to readdress the balance. Although there were a number of existing bodies representing policy positions in relation to alcohol and health, including the RCP, the Institute of Alcohol Studies, the British Liver Trust, Alcohol Concern and the British Medical Association (BMA), there was no forum to bring them together and no mechanism for them to collectively lobby government. Interviewees described the policy environment as 'very noisy', with the various organizations doing slightly separate things. As one interviewee explained:

> So the feeling was, bring them altogether under one roof and create one body that could speak to Government about changes that need to be made on the policy (interview #4, August 2013).

Although there were a number of separate organisations with an alcohol health remit, they were linked informally through their members who often held membership of multiple organisations. Moreover, these connections were strengthened through the formal roles members took on within the organisations; for example, they acted as trustee or as member of an advisory committee, with some individuals holding positions in a number of organisations, either concurrently or sequentially. Interviewees emphasised the value of participation on committees and working groups, not just in terms of the knowledge accrued but also because they 'got to know' like-minded people. What was apparent from the interviews was the crucial role of a few individuals who linked not just organisations but the policy landscape more broadly, with networks that extended far and wide and stretched back in time. In this way, a myriad of interconnections – at a personal and an organisational level – existed informally before the establishment of the AHA and were useful for the emerging alliance.

In 2006 Ian Gilmore became President of the RCP, which provided him with a strong platform to raise awareness of alcohol health harms but also an opportunity to forward the idea that had been formulating for some time of setting up an advocacy coalition for alcohol and basing it at the RCP. The Alcohol Health Alliance, which was launched in November 2007, with Ian Gilmore as Chair, was based on the model of ASH. It brought together independent health organisations with an interest in alcohol and health under the umbrella of the RCP, which provided administrative and policy support. This meant that the AHA could access the RCP's widespread policy networks within the UK Government and beyond into Europe, as well as their extensive media contacts. Interviewees recognised that the RCP and Ian Gilmore gave the AHA a stature and reach that it would not have had if it were led by one of the alcohol charities or by another less well established, less prestigious organisation. Importantly, by creating a collaborative network of existing organisations, rather than a new organisation, the AHA was not a 'competitor'; rather it drew on what organisations were already doing but strengthened it by locating these efforts within an organising framework. Thus while the ASH model influenced the initiation and shape of the AHA, the link with the RCP provided the mechanisms through which it could develop and placed it in better position to 'steer' the debate about the extent and nature of alcohol health harms and the need for policy changes.

> The good thing was that the RCP had great links with Parliament because of their RCP work, so, it (AHA) certainly had much more sway because it was already linked in with various peers and Ministers, and it had much more sway being part of the RCP than it would have done if it was part of [names a prominent advocacy organization] (interview #4).

Policy beliefs

Care was taken from the start that, as far as possible, members would share core policy beliefs. Membership was not open to all – industry and trade, for example, were excluded. Equally, the desire was to have a strong focus on health:

> We have tried to keep a focus on health. So obviously some organizations like Alcohol Concern are not exclusively health; but at the moment, for example, we haven't taken in ACPO (Association of Chief Police Officers) … because their perception is inevitably much more crime and disorder; but that doesn't necessarily mean that we don't speak to them and it doesn't in turn mean that we perhaps might not bring them in. But one of the main reasons for setting up the Alliance was to highlight the health aspects (interview #1).

Medical bodies and charities were approached to become members of the new alliance. At its launch, AHA had 24 member organizations, leading charities including Alcohol Concern and the Institute of Alcohol Studies, English and Scottish Royal Colleges (e.g. Surgeons, Nursing, Psychiatrists), the Medical Council on Alcohol, among others.

The AHA states that its 'mission is to reduce the damage to health caused by alcohol misuse', with member organizations working together to 'highlight the rising levels of alcohol-related health harm, propose evidence-based solutions to reduce this harm and influence decision makers to take positive action to address the damage caused by alcohol misuse' (AHA website, 2014). From the outset the AHA stated that it would campaign for specific policies, including increased taxation on alcohol, restrictions on alcohol advertising and dedicated funds for treatment and prevention. In 2009 the AHA published four concise 'Policy Briefings',[2] each focused on a specific issue – alcohol marketing, minimum pricing for alcohol, treatment services and the mandatory code. They used a 'frequently asked questions' format to set out the evidence of harms and the policy options in a direct and unequivocal manner.

Interviewees shared not only the overarching aim of reducing alcohol health harm but also strong beliefs about the specific policies that needed to be implemented to achieve this aim and the evidence base upon which policies were advocated:

> I think they all (AHA members) share the view that practice should be guided by evidence; so issues like the levers of things – like price and marketing and availability – come up. The inadequacies of treatment services come up – despite good evidence of the efficacy of treatment services. It's a wide range. But there has been virtually no tensions around or any differences in fundamental attitudes to what needs to be done to improve the situation (interview #1).

In explaining what the central policy aims of the AHA were, interviewees referred to the 'top ten' recommendations made in *Health First: An evidence-based alcohol strategy for the UK* (University of Stirling, 2013). *Health First*, (also known as the 'Stirling Report') which the authors refer to as an 'independent strategy' (independent from government and industry) was produced by a group of experts (academics, clinicians, advocates) under the auspices of the AHA. The strategy group was chaired by Ian Gilmore and took two years (2011-2013) to produce. The group reviewed the evidence on alcohol-related harm in the UK, considered what could be done to tackle alcohol-related harm and set out a framework for action in both the immediate and longer term. The aim, according to one interviewee, was to produce a seminal report akin to *Smoking and Health*, published in 1962 by the RCP and subsequently updated in 1971 at the time of the launch of ASH. *Smoking and Health* set out the evidence about smoking related harm in an unequivocal manner, made clear recommendations, with priority given to population-wide measures and called on the government to take action. This report caused a 'seismic shift in attitudes to smoking and to the role of government in the public health aspect of smoking' (Arnott, 2012: 4). Similarly, *Health First* focused on population level measures to reduce alcohol-related harms, arguing that 'significant reductions in harm will only be achieved by changing the price of alcohol, the range of

products available, the promotion of alcohol and the availability of alcohol through all places of sale' (p.36), and this is reflected in the thirty recommendations made in the strategy.

Interviewees thought that the development of *Health First* had been a very useful process as it enabled existing consensus to be formalized, established a framework for action and highlighted the 'top ten' recommendations (notably including minimum unit pricing of at least 50p) which encapsulated the core policy aims. *Health First* was regarded as a valuable resource for AHA members to draw on in discussions with policy-makers at local and national level and, possibly, was an aide to ensuring a high degree of consistency of messages delivered by the different member organizations.

Thus the core policy beliefs and the key elements of the principles for action were stipulated clearly from the start and their strength and consistency protected by the structural location of the alliance within the RCP and the selective nature of the membership. However, there was evidence of differences in beliefs about policy options and also that (in some cases) these differences appear to have been accommodated. For example, *Health First* (University of Stirling, 2013) calls for a total ban on alcohol advertising, and whilst all members would acknowledge the part played by advertising, as one respondent explained:

> I would say that members of the Alliance are a little divided on that, not split, because I think everybody was comfortable with putting it in with a caveat, but it was a long term ambition ... So I think other organizations, and I would say ourselves included, are probably more comfortable with the concept of arguing for a step by step approach (interview #2).

In other areas, the differences seemed more difficult to reconcile and were seen to create tensions. Whilst members of the AHA shared the belief that it is the role of Government to formulate alcohol policy and not that of the alcohol industry, when it comes to contact and relationships with industry a range of strongly held beliefs emerged; as one respondent noted:

> There's a perennial discussion in any group of people involved in alcohol regarding links with the drinks industry, from a spectrum of those who will take funding from industry to those that won't go in the same room if anyone from the industry has been there in the last five years (interview #1).

There were AHA members who regarded it as problematic for the AHA to include organizations and individuals that communicate with, or take funding from, the alcohol industry. Those interviewees argued that there should be no associations and that such links act to legitimize industry's role as a contributor to public health:

> You've got some people on this group who are funded by Diageo and that's a very good advocate for Diageo being an important contributor to public health. That's problematic (interview #5, August 2013)

Despite these belief differences, it was recognized that being a member of the AHA conferred benefits on individual organizations, particularly the smaller, less powerful ones, as it allowed their voice to be heard alongside others and provided strength in numbers. Interviewees recognized the power of having a unified voice that could act separately and collectively to maximize impact:

> It makes sense given that we are so small to be part of a larger grouping and more powerful one because that's clearly going to have more impact. I suppose that's the sort of rationale which makes sense of why it's good for us to be able to input through the AHA rather than relying on our own individual efforts (interview #6, August 2013).

> I think that because we've got such big and important players in the field signed up, when everybody gets together and speaks with one voice, it actually does make quite an impact, which is brilliant. But it also means that strategically, because we are made up of 32 member organizations, if we can all collectively agree on a set of principles, each member organization can go away and speak on their own, from the same hymn sheet. So having a coordinated unified voice is really helpful, both acting separately and collectively together (interview #1).

Access to those in policy-making positions was also facilitated by joint action and through the connections of powerful member organizations. One interviewee suggested that the ability of the AHA to engage with key stakeholders was crucial:

> The beauty of it is that one organization can speak for the many and they can engage; and there's something very powerful about that, rather than a disparate group all talking to the same people. So the Liver Trust coming forward doing this and Alcohol Concern, all trying to meet the Minister, you can get one hit here and you can say something on behalf of the many (interview #7, August 2013).

In this way duplication was avoided – which was viewed as attractive to policy-makers, in particular to senior ones (e.g. Ministers) who were spared a series of similar meetings. It was also attractive to members who could access policy-makers more efficiently. With a strong structural base from which to organize support and action, with a clearly defined set of core policy beliefs to bind members together, and with powerful member organizations to legitimize the arguments and provide access to policy-makers, the AHA emerged as a potentially powerful contender in the alcohol stakeholder field. It aimed to reframe understanding of alcohol issues and shift policy towards adopting a firmer public health approach.

Framing the issues

While policy change may result from large scale political, social and economic changes, the way in which an issue is defined and understood, and the policy salience granted to a particular 'frame' of understanding, is a key factor in securing change (Heclo, 1974; Sabatier, 1988; Rein and Schon, 1991). Heclo (1974) emphasised the importance of interaction between competing political elites within a policy community in developing and using knowledge to gain a dominant position in defining the nature of the problem and the appropriate means of addressing it. Sabatier (1988: 131) argued that it is necessary to include

'actors at various levels of government active in policy formulation and implementation, as well as journalists, researchers, and policy analysts who play important roles in the generation, dissemination, and evaluation of policy ideas'. Policy actors may aggregate into coalitions of organisations which share a set of policy beliefs and adopt a strategy designed to further policy objectives. These processes are relevant to examining attempts to secure policy change in the alcohol field.

Greenaway's (2011) examination of shifting responsibility for alcohol licensing between government departments testifies to the way in which alcohol policy is susceptible to being framed in different ways and in different contexts. Pressure groups, policy networks, officials in Whitehall departments, Parliament and the mass media all have a role to play. Katikireddi et al. (in press) consider the processes by which the minimum unit pricing of alcohol model was able to influence policy thinking; they highlight the central role of rhetoric as a way of presenting the evidence to a range of stakeholders, but point out that its influence needs to be underpinned by credible policy actors and their strategic framing of the issues. Researchers have also examined how the alcohol industry has attempted to influence policy by framing the debate on alcohol pricing and promotions in terms favourable to industry interests (e.g. Hawkins and Holden, 2014; Katikireddi et al., 2014). Drawing on earlier research on framing, Hawkins and Holden (2014: 54) note: 'The specific framing of an issue is of great importance in policy debates as it opens up certain policy responses whilst precluding others. It may create an imperative for political action or act as a buffer against this. Consequently, the competition to define the terms of the debate is a vital component of the policy process'.

The AHA clearly understood the need to frame arguments around alcohol-related health harms in such a way as to convince the public as well as policy-makers that action was needed. In doing so, they engaged in the production and dissemination of evidence through a variety of mechanisms – including the use of their own website, publications in academic

journals, appearances on the media and the presentation of evidence to policy-makers. While this activity was more outwards directed, it also served to affirm the core policy beliefs within the coalition and to provide members with a body of evidence on which there was general consensus.

As noted earlier, the main rationale for setting up the AHA was to focus on alcohol health harms and to put pressure on policy-makers to implement evidenced based interventions. Interviewees felt that setting out the policy priorities was straightforward, arguing that there are only a few interventions with a good evidence base. The message was that alcohol policy should be focused on the four P's of marketing: price, product, place of sale and promotion, as recommended by WHO (2010; 2014) and other sources (Babor 2010; University of Stirling, 2013). For a number of reasons, much of the debate and much advocacy activity centred around the issue of minimum unit pricing.

> The core objective is to reduce alcohol related harm. In terms of how to do that, the evidence shows that changing the price of alcohol is the most effective and the most cost effective. The other things which we know are effective are changing the availability of alcohol, that is something that is slightly more difficult to do ... I can't really see us going back to the 1970's when you couldn't buy alcohol on a Sunday ... Tackling promotion of alcohol is really, really important but particularly important in terms of changing the patterns and behaviour of young people ... So really the AHA has policies on all of those fronts and they are probably best summed up in the report that we published earlier this year ... with the Stirling Group (interview #3).

For interviewees the challenge lay in changing the minds of policy-makers, and so a key role of the AHA was to draw the media and policy-makers' attention to the evidence. Members of the AHA, as individuals and collectively, were engaged in the production of evidence, in the reproduction of evidence in a form which was both persuasive and accessible, and in seeking opportunities to present this evidence to a wide audience. The evidence was produced in a variety of forms including policy briefings, scientific reports which drew together the latest

research evidence on alcohol and health harms, and academic papers in peer-reviewed journals.

Aside from disseminating evidence which, from the AHA perspective, was credible and appropriate, interviewees felt that the AHA had a central role in combating what was often referred to as 'misinformation', emanating from the drinks industry. This was especially pertinent to minimum pricing where there was felt to be a lack of understanding, on the part of both policy makers and the public, around what minimum pricing is:

> There is a huge job to be done to counter the output from the drinks industry and the AHA is very aware of that; it sees that as a key thing, a counterweight to what's coming from the drinks industry, absolutely. So there is this enormous machine that is producing a lot of disinformation and the AHA has an absolutely huge, important role to counter that (interview #6).

> We have faced a very, very well organized campaign of misinformation from the drinks industry ... So the first one, the reasons why they are trying to say, well this is basically the Scotch Whisky Association and Wine and Spirit Trade Association, if you look on their website, the reason they are opposed to minimum pricing is to preserve that export market. Okay, quite how that follows is a little bit of a difficult one to follow, on the basis that they then argue that it won't work (interview #3).

This 'unknowingness', as it was described about what minimum unit pricing (MUP) entails, was thought to create an environment that allowed industry myths to flourish and to gain a popular and political foothold:

> Whether it would decrease alcohol related harm – the evidence is that it absolutely would, but that's been questioned. So there are a number of arguments that have been used, generally not well supported by evidence, but that have a certain sort of political popularity; and my understanding is that with inference of the Cabinet and Conservative party there are a number of people who don't support MUP for those sorts of reasons. They feel it's not effective, or that it penalizes moderate drinkers and as we are in a particularly sensitive time in terms of recession and so on, that people aren't going to tolerate it. So it's seen as an unpopular political move (interview #6).

Conveying the evidence

The framing process employed a number of ways to convey a new awareness of the issues of alcohol – related health harm and to impart the evidence that underpinned the stance taken by the AHA. The value of academic papers published in peer reviewed journals, for generating positive media coverage and questions to policy-makers, was acknowledged in the interviews. For example, a paper published in the *Lancet* (Sheron *et al*, 2011) used official statistics to project alcohol liver death rates on the basis of four policy scenarios and called for the introduction of population level measures to reduce the number of liver deaths. This *Lancet* paper received a great deal of publicity. The findings were reported on the BBC (BBC, 2011) and five national daily newspapers ran articles on it on the same day (Daily Mail, 2011; Daily Mirror, 2011; The Daily Telegraph, 2011, The Guardian, 2011, The Independent 2011). However, the alliance was also pro-active in its use of the media and in seeking opportunities to get the message across.

As mentioned before, being part of the RCP bestowed a number of advantages on the AHA, in terms of credibility, connections to Parliament and a well connected press office with established links with the media. Interviewees felt that over time the AHA had become more adept at organizing and coordinating their actions; one describing it as an 'evolutionary' process, so that their campaigns came to have a real impact. The issue of credibility was recognized as a key factor in gaining public and policy support and part of the strength of the AHA was thought to be rooted in the fact that they were an 'alternative' voice, separate from the Government and industry:

> I think there is a strong view of being an alternative voice to the Government and the alcohol industry; to actually express what we collectively believe and that the AHA is composed of many different groups, not all of whom are primarily medical, but all of whom are separate from the alcohol industry and separate from the Government; and there is a view that we need to express effective policy interventions, policy and other

> interventions actually, as coming from the AHA as opposed to coming from the Government or coming from the alcohol industry (interview #6).

Interviewees spoke about 'changing the background noise', and then keeping the 'background music' going by placing alcohol and health firmly on the news agenda and also through maximizing the opportunities to put the case to MPs and civil servants and to build up these links through the AHA members.

> So people are, MPs are aware that there are these issues, this is the research and that's the evidence and to keep pressing on that message (interview #4).

Thus, securing media coverage and getting people talking about the AHA was central to the re-framing process and was a core part of the strategy:

> We collectively respond to public consultations; we try and develop a media, an advocacy strategy in the sense of if we see important issues where we really want a voice heard, we act collectively and sign, have joint letters sent to the press ... (interview #1).

Ian Gilmore, because of his position at the RCP, was already on journalists' contact lists and was seen as a credible 'messenger', a crucial element for conveying the message successfully to public and professionals alike:

> Ian Gilmore is very highly respected and regarded ... I do actually think that having Ian Gilmore as a figurehead is actually useful because he's a well-known media person and he is very effective when he is on the media (interview #5).

> You've got a strong figurehead who speaks with authority on this subject and is clear about what they want to see, so actually those tick quite a few boxes in getting messages across (interview #7).

Soon, according to interviewees' accounts, the AHA became the 'go to' organization, with Gilmore, in particular, being a regular contributor to news items about alcohol. Nicholls (2011) in a study of UK TV and newspaper reporting on alcohol during 2008-2009 found that, compared to previous studies, public health perspectives played a central role in the framing of alcohol related stories, with long term liver damage dominating this framing process rather than alcohol dependence. Moreover, Nicholls (2012) argued that the success of the AHA in influencing the news agenda could be measured by the extent to which health professionals, such as Gilmore, became primary sources for new stories in the later 2000s.

But there was another crucial element in the equation. It was also recognized that whilst the AHA could prepare the ground – by building up the evidence base, setting out policy options, keeping alcohol on the political agenda – in terms of actually effecting policy change this can often come down to individual relationships. In the case of MUP, one individual, Sarah Wollaston, Conservative Member of Parliament for Totnes, Devon and former GP, was identified by interviewees as instrumental in its inclusion in the 2010 alcohol strategy:

> Let's leave the question mark aside (as to whether MUP would go ahead or not). It got there because of the Alcohol Health Alliance dripping water on a stone and going on and on about it and then something coming out of left field which was Sarah Wollaston getting the Prime Minister's attention and going to see him. Neither of them would have been effective on their own. So she was the final pathway, but it's the continued advocacy and pushing of the evidence and producing reports and so on that prepared the ground (interview #1).

> I think she's been able to exert influence on David Cameron; and the civil servants in DH and at the Home Office have been able to exert, not influence, but have been able to pass on options to ministers about licensing and public health, for example, and children and advertising, and so on (interview #4).

In a study of how industry actors attempt to influence alcohol policy, Hawkins and Holden (2014: 67) concluded that, 'the political strategy of the alcohol industry is based on building long-term relationships with policy makers in which they are seen as partners with

government in delivering policy solutions'. Further work on lobbying by McCambridge *et al* (2014) concurred with the findings and added that building long term relationships at all levels of government was the preferred strategy (although if this failed, interests were pursued through more aggressive lobbying and legal challenges). Industry's potential to influence alcohol policy through relationships was commented on also by interviewees in this study who argued that if the AHA was to have any chance of influencing policy it was crucial to establish and maintain strong relationships with policy-makers:

> But undoubtedly the thing that makes the difference is personal contact, is being able to sit in a room and look somebody in the eye and show them that what you are saying is the truth. There is absolutely no substitute for that and you can write all the reports that you like, it's actually that. I'm absolutely convinced it's that personal face to face encounter where you can actually transmit integrity – and human beings are very good at picking this up – that I think makes the difference. It's about building relationships, which of course is something the drinks industry and tobacco industry have known for a very, very long time (interview #3).

Whilst the AHA placed great store on scientific evidence as the basis of policy, interviewees acknowledged that 'facts and figures' can be disputed, baffling or a 'turn off', but that putting a human face to the science was a powerful means of engaging policymakers:

> It's a narrative commentary, it's about having stories and if all you've got is data, it's a little bit difficult to have conversations with politicians. But if you can tell them about the 23 year old that went bright yellow and died last week or the 17 year old with end stage alcoholic cirrhosis, they have immediately got a story. And you've immediately got their interest and attention and also you come across as believable. I think it's easier to transmit your integrity if you are not just talking about statistics because that tends to mystify people (interview #3).

These personal stories are also an important 'hook' for the media, and the AHA drew on its clinical networks to provide case examples for the media.

Thus activities to build the evidence base and to communicate evidence in an appealing, accessible manner to policy-makers, professionals and the general public were complemented

by efforts to strengthen stakeholder networks and mould relationships with policy actors. Re-framing the discourse tackled both the content and the form of policy communication. The strategy seemed to be successful:

> So that within four of five years I would say that we'd really had quite a dramatic impact in terms of conversation around alcohol (interview #3).

These 'conversations' with civil servants at the Department of Health, with MPs and with the media, had, in the view of some interviewees, led to a fundamental shift in the debate about the nature of alcohol harm and the policy solutions required. In particular, it was thought that prior to the launch of the AHA, it would have been impossible to have a debate in the media about using price as a solution to alcohol related harm. Interviewees stressed that the achievements were a result of pooling resources and making the most of opportunities presented to them.

At the same time, whilst the AHA is underpinned by a commitment to forwarding evidence based alcohol policy, interviewees understood that this ideal was tempered by political realities:

> As much as we'd love to see black and white evidence based policy adopted, we live in the real world where things are often a lot more political, so for example, minimum pricing – this has been a bit of a political football recently – is it, isn't it (interview #2).

> I think conversations with them (Department of Health policy team) help us to understand how potential policies fit into the wider framework, how they fit into the particular agenda of individual ministers; and we are obviously aware that more than evidence counts when it comes to persuading a Government to make a decision (interview #1).

Interviewees could see the advantages of a pragmatic approach, taking into account both political and public sensibilities. As one interviewee reflected, advocacy needed a strategic approach based on an understanding of how policy change comes about:

> You can either work slowly incrementally behind the scenes or you can try and take Government on in a very direct way or all sorts of policies in between, and I think we've varied strategy and tactics depending on the situation (interview #1).

Conclusion: Shifting national policy through advocacy alliances

The alcohol arena is populated with a large number of heterogeneous groups holding very different policy positions, and even within the policy sub-system of those concerned about the social and health harms associated with alcohol consumption, there are differences of opinion regarding the priorities for action and appropriate policy interventions. This account of the emergence and early development of the Alcohol Health Alliance highlights some of the mechanisms used by groups of policy actors jostling to position and gain attention for competing views of a policy issue, in this case alcohol-related harm. The initiation and launch of the AHA was indicative of a growing unease with the direction of national policy which was seen to reflect economic rather than health and social welfare interests and to place too great an emphasis on criminal justice harms at the expense of alcohol-related health harms. Those concerned with health felt relatively powerless to influence the direction of policy or to get their views across to the public. The formation of the AHA rested on 'behind the scenes' activity by stakeholders, individuals and organizations such as the NHF, which paved the way for collaborative efforts and offered a model (ASH) for the new alliance. The policy context was right; there was direct opposition to the government's Responsibility Deal, there was concern about neglect of growing evidence that population-wide intervention was an effective way to managing alcohol-related harms, and there was a perception that health concerns had taken a back seat to concern about alcohol-related crime and problems of the night time economy. The identification of a credible figurehead located within an influential medical institution provided the necessary hub around which to mobilize and structure an alliance of like-minded individuals and organizations. Careful selection of the membership

ensured consistency of core policy beliefs, so that the new alliance began with a strong consensus about the aims of the alliance and the policy shift it was hoping to achieve. Central to their strategy was the ambition to adjust the perceived policy imbalance between health and criminal justice priorities, to re-frame perceptions and debates around alcohol and to shift policy in the direction of adopting evidence-based population measures to address alcohol-related health harms. Advocacy around the introduction of minimum unit pricing took centre stage in much of the campaigning; it was timely and fitted with a more widespread rise in debate and attention to MUP as a possible intervention to address the most problematic aspects of consumption (McKee, 2012).

The AHA successfully positioned the group as an influential stakeholder within the policy sphere and had considerable impact on re-framing the discourse around alcohol. For a time, they appeared to be gaining ground in raising awareness, in stimulating wider interest in the health aspects of alcohol consumption and in reaching the centres of decision-making, at least in the health arena. Examination of the success of the AHA in achieving a lasting shift in policy thinking is outside the scope of this paper. However, a number of changes were underway which raise questions regarding the evolution of alliance groups beyond the mobilizing and early action phases and, in this particular instance, point to the entrenched nature of established policy approaches which new alliances may find difficult to disrupt. Changes in the organizations that provided initial support and resources, and in the wider political climate may affect the positioning of the coalition in the policy arena. In the longer term, internal policies may also prove disadvantageous. The fact that the AHA restricted its membership to a tightly knit group, useful in the early years of mobilization, in the longer term may restrict access to resources, expertise and a wider following. The decision not to include the police may, in the long run, perpetuate a health/crime divide rather than bring the two areas of interest into closer alliance. Finally, the government's decision not to take action

on MUP hit at a fundamental element in the AHA's argument and one in which they had, possibly, invested too much faith at the expense of other ways of achieving their aims. The full story of the politics of MUP and of attempts to shift national policy towards the adoption of a population approach to addressing alcohol-related harms remains to be written. The formation of the AHA has demonstrated the role of advocacy coalition to contribute to re-framing policy and public discourse; but it remains to be seen whether such an alliance can maintain its initial impetus in opposition to more firmly entrenched policy beliefs and approaches supported by competing powerful interests and maintained through long established relationships and consultation processes.

Notes

1. From April 2013 the National Heart Forum became UK Health Forum, 'Our new name reflects the wider focus of our work today, both within the UK and internationally, across the range of preventable non-communicable diseases that share common risk factors and determinants' (http://www.ukhealthforum.org.uk/who-we-are/, accessed 5th December, 2013).

2. These policy briefings (dated 2009) were downloaded from the website by the research team but they have now been removed. [accessed, March 2013].

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