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THE SHIFTING
BOUNDARIES
OF ALCOHOL
POLICY

by Diana Chapman Walsh

Prologue: Every day, it seems, the mass media report a steady stream of evidence that suggests illegal drugs are America’s number one social problem. Yet alcohol, a legal drug, costs the nation far more than other drugs each year in “whatever metric applied: medical, social, economic, or public health,” stated a recent report on alcohol policy. In 1983, alcohol use and abuse cost the nation over $100 billion, according to one estimate: $71 billion in lost productivity, $18 billion in excess mortality, $14 billion in health care costs, and $12 billion in property loss and crime. These annual costs are projected to rise to $150 billion by 1995. Alcohol is implicated in as many as half of all hospital emergency room visits. So far, however, our nation has failed to formulate a comprehensive policy on alcohol abuse, ever since Prohibition was repealed in 1933. In this article, Walsh defines U.S. alcohol policy’s “shifting boundaries” and sets a context for health promotion activities related to alcohol use. “The ultimate lesson for prevention from the complex alcohol case,” she writes, “is that effective policies do need to protect the innocent and foment some moral outrage while also fostering personal accountability and internalizing protective social norms. The two sets of goals are not entirely compatible.” Walsh, who holds a master of science degree in journalism and a doctorate in health policy from Boston University, is university professor and professor of public health at Boston University and is associate director of the university’s Health Policy Institute. In 1986, she served as a faculty member of an international symposium on alcohol policy, convened in Salzburg, Austria, as the 248th session of the Salzburg Seminars. A summary of the consensus reached at that conference was published in the Summer 1989 issue of Health Affairs.
Over the past decade, impressive growth in the quantity, sophistication, and quality of empirical and conceptual work on alcohol use and abuse has increased our ability to prevent or cushion its harmful effects. Yet public tragedies, such as the oil spill from the Exxon Valdez, and private struggles (Sen. John Tower’s and Kitty Dukakis’s among the recently visible) repeatedly underscore alcohol consumption’s potential for harm. Although a great deal still remains to be learned, the alcohol case already has lessons to teach those who seek to promote the health of Americans—or who want to inspire and empower them to protect themselves.

Perhaps unique among public health problems in this century, those related to alcohol abuse gave rise to an encompassing and definitive national prevention program that has become emblematic of misguided, counterproductive social policy: Prohibition. The half-century since its repeal in 1933 has been spent discrediting its doctrinaire approach and developing alternative, more circumscribed tactics, while disavowing tendencies toward neo-prohibitionism. The lingering “shadow of Prohibition” has distorted five decades of alcohol policy.

Those who write about alcohol like to cite biblical and literary allusions to the pleasures and pitfalls of drinking, to confirm how unending and ambivalent the social reaction has been. Of many lessons to be learned from a long and polarized history, none is more salient than the complexity of the prevention challenge in a pluralistic and capitalistic society with a strong individualistic bent. Recent movement toward a public health paradigm or a systems approach in alcohol policy reflects a growing consensus that, to be effective, strategies must build—incrementally but persistently—toward a policy framework that is coherent, comprehensive, and integrated; that spans federal, state, and local jurisdictions; and that delivers a clear, consistent message at the community level to public and private behavior, interests, and values.

Efforts now under way to construct this preventive framework are harnessing what might be called the “technology of prevention”—what we know or are learning about what works for whom and when, based on empirical data from scientific research. Such work has increased exponentially since 1970, when Congress established the National Institute on Alcohol Abuse and Alcoholism (NIAAA), whose stated mission it now is “to build the necessary scientific base to develop and improve methods to prevent and treat alcohol-related problems.” But preventive efforts extend beyond science into politics, where the central task is to mobilize constituencies and power, including whatever power science confers, but also ideology, beliefs, and social norms. The deeper lesson from alcohol policy is that progress has always been strongly influenced
by “governing ideas” or definitions of the problem and its ownership, by public understandings of whose it is to suffer and solve and how responsibilities will be assigned.  

In this article, I survey the state of the field in the scientific realm—current evidence on the location and extent of alcohol problems and systematic studies of the efficacy of a range of control strategies. I then move to the political realm, as alcohol-control activists have done, and sketch the case being advanced for a community-organizing approach.

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**Locating The Alcohol Problem: ‘Theirs’ But Also ‘Ours’**

The first step in preventing a problem is to locate it, and the shift now taking place in alcohol policy began with a redefinition of where the problem lies. Two influential documents shaped that new understanding, the first issued in 1975 by the World Health Organization (WHO) and produced by a distinguished international group of eleven alcohol experts. The second, by a panel convened in 1978 by the National Academy of Sciences (NAS), expanded on the first and applied it to the United States.

A model of breadth, depth, and lucidity, the NAS report has helped recast U.S. alcohol policy into preventive terms. In part, this has involved relocating the problem by adducing evidence that “heavy drinkers typically account for less than half of the people with problems.” Because “alcohol problems occur throughout the drinking population. . . at lower rates but among much greater numbers” in moderate-drinking groups (in no sense “alcoholics”), a de facto policy of identifying and treating alcoholics misses the mark. As the authors of the NAS report noted, “If all the clinically diagnosable alcoholics were to stop drinking tomorrow, a substantial fraction of what we understand as alcohol problems would still remain.” Alcohol problems surface in the medical domain as a result of chronic abuse, but also in psychological, social, and economic manifestations along a broad spectrum of consumption rates and across a wide canvas.

Overall per capita consumption of alcoholic beverages for the entire U.S. population ages fourteen and above in 1984 was estimated at 2.65 gallons of pure alcohol (about fifty gallons of beer, twenty of wine, or four of distilled spirits), or four gallons of pure alcohol for each drinking adult. The lowest level since 1977, this represents a decline that has continued for three consecutive years (a record since Prohibition), reversing two decades of steady growth in average consumption (rates rose 74 percent from 1950 to 1980). Defining “safe” levels of consumption—for individuals or aggregates—is fraught with controversy. Early Americans...
drank much more heavily than we do (an average of seven gallons of pure alcohol per capita in 1830). The current decline in average consumption appears to reflect increasing numbers of abstainers (roughly a third of adults drink no alcohol) rather than fewer heavy or moderate drinkers and may be an epiphenomenon of the current general cultural preoccupation with fitness and health, especially among the more privileged classes. Still, an estimated eighteen million Americans over age eighteen and nearly five million adolescents—some three out of ten—are said to experience problems with alcohol. Also, emerging scientific evidence detailing hazards of alcohol (for example, fetal and reproductive effects) has been undermining confidence that a certifiably safe level of drinking exists.

**Health consequences.** Drinking is associated with a long list of medical consequences, the most serious of which include approximately 100,000 alcohol-related deaths a year from trauma (including over 20,000 highway fatalities annually); liver cirrhosis; and cancers of the liver, esophagus, and mouth. Alcohol abuse has been implicated in at least thirty diseases affecting the brain and the nervous system, the gastrointestinal tract, the liver, the muscle systems (including the heart), the kidneys, the lungs, the immune and endocrine systems, sexual functioning, and reproductive outcome (the last a special focus of research, and some contention, with identification of “fetal alcohol syndrome”). Specific relationships and mechanistic pathways remain to be fully traced, but associations between alcohol and physical harm are being studied epidemiologically. In medical care utilization studies, alcohol is believed to be a background factor in 20 to 40 percent of all inpatient hospital admissions and up to half of all visits to emergency rooms.

Psychological correlates of a history of chronic alcohol abuse include several classes of mental illnesses (dementia, hallucinosis, delirium tremens and other forms of psychosis, memory decrement, and cognitive impairment). Depression, the mental condition most strongly linked to alcohol abuse, is implicated in roughly 30 percent of all suicides; suicide ranks among the three top causes of death among males ages fifteen to thirty-four. In epidemiological surveys sponsored by the National Institute of Mental Health (NIMH), a lifetime history of alcohol abuse or dependence was the most common psychiatric diagnosis, reported by 13.5 percent of the adult population.

**Social consequences.** Social consequences are intertwined in a web of related factors. Drinking is implicated in a wide spectrum of injuries, crimes, and domestic violence, but studies of associations often fail to correct for the overexposure of heavy drinkers to other risks (for example, smoking or reckless driving), some related to drinking remotely if at
all. Much remains to be learned about particular health and social effects
of drinking at different levels and times and about causal relationships.

Still, alcohol has been identified convincingly as an independent risk
factor in preventable injuries and deaths related to driving, flying, work-
ing, playing, and living in high-crime areas. Because trauma affects
relatively young segments of the population, alcohol-associated injuries
account for a disproportionate share of years of potential life lost; they
are the leading cause of death for Americans ages one to thirty-four.
More than half of all fatal highway crashes are alcohol-related, and the
great majority of these involve a legally intoxicated driver.

**Economics of alcohol use.** The economic cost of alcohol use and abuse
was estimated in 1983 at over $100 billion: $71 billion in lost productivity,
$18 billion in excess mortality, $14 billion in health care costs, and $12
billion in property loss and crime.\textsuperscript{13} More recent projections suggest that
the annual costs will rise to $136 billion by 1990 and to $150 billion by
1995.\textsuperscript{14} Aggregate statistics such as these are fairly crude extrapolations
from smaller-scope studies of varying quality, but they serve to galvanize
a public response.

Many of these data on the distribution of problems need to be under-
stood, at least in part, as symbols in a drama and/or rhetorical devices in a
“strategically-crafted argument.”\textsuperscript{15} Confidence intervals and caveats tend
to slip away; problems subtly inflate in the hands of control advocates or
deflate when profits are at stake; and researchers can always find in the
crossfire more questions to occupy them. The recitation of alcohol’s
casualties becomes a protestation of commitment and concern. It is here
that the science of prevention begins to blend into politics. Yet, it remains
incontrovertible that alcohol is the proximate cause of health and social
problems on a large scale. After targets have been established, the second
step is to locate workable solutions.

**Prevention Technology: Demonstrating That Some Things ‘Work’**

A diverse array of preventive interventions has been subjected to
empirical research, the volume of which has accelerated rapidly in the
past two decades. This literature is regularly synthesized; the NAS study,
NIAAA’s periodic reports to Congress, and several recent scholarly re-
views have critically assessed the evaluation research literature for evi-
dence of the effectiveness of preventive strategies. This evidence includes
regulations of advertising and/or alcohol packaging; alterations in tax
policy, drinking-age laws, and laws governing drunk driving or establish-
ing other liabilities (such as those of the host or server); and education in
a wide range of settings, employing diverse techniques and media.
Elaborate and useful typologies have been developed for sorting these out. In the interest of brevity, I identify three general types: (1) legal interventions, which impose direct penalties for engaging in drinking defined as risky to oneself or others; (2) market-oriented instruments, which seek (often through the law) to adjust financial incentives along the chain from production to purchase, particularly by altering prices through tax policy; and (3) educational approaches, which aim to engineer knowledge, attitudes, and behavior, usually addressing high-risk drinking groups or practices. Evidence of impact theoretically should appear somewhere along a three-phase temporal sequence: (1) affecting the “choice phase” would reduce overall per capita consumption; (2) influencing the “use phase” would reduce the amount of drinking in situations embodying special risks for the drinker or others; and (3) mitigating the “consequence phase” might not change drinking patterns at all if modifications in the physical or social environment could shield high-risk drinkers and those around them from harm.\textsuperscript{16}

**Legal Controls**

Legal interventions directed at the choice phase involve regulating the physical, economic, or social availability of alcohol. Paradoxically, the most important scientific “fact” about alcohol is patently obvious yet long contested: availability matters. Contrary to conventional wisdom, Prohibition did reduce alcohol consumption and related problems to the lowest point ever in U.S. history. Periods of rationing or strikes have had similar effects around the world.\textsuperscript{17} Less dramatic regulations of the distribution system—natural or enforced changes or differences in times of sales; numbers, types, and locations of retail outlets; and selling practices (such as sales of liquor by the drink for on-premises consumption)—have been studied fairly extensively with mixed results, mostly ascribed to methodological deficiencies and dilemmas.

The conclusion generally reached is that regulating the physical availability of alcoholic beverages can reduce consumption and some problems, but the relationships are complex, entwined in larger cultural and economic matrices, and difficult to unravel with precision. Resistance by the alcoholic beverages industry to policies designed specifically to erode sales complicates the picture and deflects attention from availability oriented strategies.

**Controls on use of alcohol.** The fallback position is to the use phase, targeting high-risk drinking situations or groups rather than consumption directly. Here, by far the greatest attention has been devoted to the problem of drinking and driving. Laws specifying the minimum legal
drinking age for the purchase, possession, or use of alcohol are one part of the drunk-driving story.

Such laws date back some 200 years and are among the longest-standing alcohol availability policies. After Prohibition, all states moved to enact restrictive laws (most foreclosing any drinking by minors under age twenty-one). Then, in 1970, mindful of the Vietnam War, Congress attached the Twenty-sixth Amendment to the U.S. Constitution, lowering the voting age to eighteen. States correspondingly began to loosen their drinking-age laws: between 1970 and 1975, twenty-nine states reduced the minimum age for legally purchasing some or all types of alcoholic beverages. But, a “dramatic increase” ensued in alcohol-related automobile crashes involving eighteen- to twenty-year-olds, and, within the next decade, all but five of the twenty-nine states restored their higher drinking-age limits. This volatility in the laws created opportunities for natural experiments. Thus, minimum drinking-age laws are among the most thoroughly researched policy options.

The weight of the available evidence argues for higher minimum drinking-age laws. Magnitudes of impact and specific effects (especially on consumption levels) are still in some doubt, and it is certainly not known what the ideal cutoff age would be (some argue for a graduated approach, affording increased flexibility with advancing age or skill) or how best to combine drinking-age restrictions with supportive policies. However, available evidence does suggest that elevating the minimum drinking age is a highly effective measure for reducing motor vehicle crashes.

While this evidence was accumulating, anti-drunk-driving groups, backed by the U.S. National Transportation Safety Board and a special Presidential Commission on Drunk Driving, were able to stimulate federal legislation, passed in 1984, that required all states to set their minimum purchase age for all beverages at twenty-one by 1986 or lose some federal highway funds. Most have complied. The research adumbrates that this policy change will have a small but appreciable impact on highway crashes and deaths among young people ages eighteen to twenty-one; a 5 to 28 percent reduction in fatal crashes is the best estimate. A few studies have hinted that there may be spillover effects to younger cohorts, and the potential for improvement in other drinking-related indicators (delinquency, crime, school problems) has been posited but not yet demonstrated.

Drinking-age laws target a small segment of the driving population (eighteen- to twenty-year-olds) and are easily and frequently evaded. The real energy of the “drunk-driving movement” has gone into generic drinking-and-driving laws, initially inspired by international experiences.
modeled after the 1967 British Road Safety Act. In the 1970s the U.S. National Highway Traffic Safety Administration supported a large-scale demonstration project of which a major goal was to enhance coordination among the often disjointed activities of officials responsible for enforcement, licensing, adjudication, and public information. Evaluations documented reductions in nighttime fatal crashes in twelve of the thirty-five communities involved but no national-level impact on rates that continued to climb.

Through the late 1970s and early 1980s the government, citizens’ groups, and the media propelled substantial increases across the nation in legislation, arrests, convictions, sanctions, and educational programs for alcohol-impaired driving. In the early 1980s more than 400 anti-drunk-driving groups came together in grass-roots organizing; media coverage of the problem jumped fiftyfold; and states made 729 changes in their drinking-and-driving laws. Between 1980 and 1985, the number of highway fatalities declined 16 percent (from 45,284 to 39,168). But once the intense interest and activity leveled off, alcohol-related highway fatalities began to increase. Government officials and others called for renewed enforcement of existing laws and for more research on how to sustain success over time.

A legal deterrence model. Strategies have coalesced around a general deterrence model, based on English utilitarian philosophy and comprising two major parts: short-term simple deterrence, with which people are expected to comply to avoid punishment, and a subtler, delayed process of self-regulation, as people gradually internalize social norms espoused or symbolized by the law. Attempts are being made now to specify that model in greater detail.

Simple deterrence is believed to hinge on penalties that are certain, swift, and severe; many states and several countries have passed new or amended laws designed to increase the probability of detection and punishment and to sharpen their sting. The severity of punishment seems to interact with its certainty. More draconian penalties (such as lengthy mandatory jail sentences for first offenders) fail when they are halfheartedly or ineptly enforced, but a recent study indicated that mandating jail or community service can achieve a modest but measurable effect.

Speed of punishment is enhanced by provisions that move the offense out of the criminal courts and into a more streamlined civil or administrative authority empowered to suspend or revoke drivers’ licenses. This approach, too, finds limited support in some of the published research. Certainty of detection is largely a function of enforcement activity by the police and the latitude the laws give them in apprehending and testing potential offenders. Police used to test for alcohol impairment when they
noticed someone driving erratically or violating traffic laws. “Per se” laws make it a legal offense to drive (no matter how competently) with a blood alcohol concentration (BAC) above a specified level (0.05 percent BAC is viewed as the threshold at which impairment begins, but most states define “driving under the influence” at the more permissive 0.10 percent BAC). Intensive crackdowns in enforcement, whether through traditional observational procedures or through sobriety checkpoints and roadblocks facilitating random breath testing for BACs, have produced short-term reductions in rates of alcohol-related crashes. These campaigns are expensive, and their relative cost-effectiveness still needs to be established, as do optimal levels and styles of enforcement.

**Effects of legal deterrence.** Deterrence efforts can be directed at the general population or at special subgroups. Roughly one-quarter of drunk-driving fatalities involve repeat offenders, who particularly draw the fire of citizen activists. Recidivism among convicted drunk drivers has been reduced to some extent by revoking or suspending their licenses, even though many persist in driving illegally. Enforced education or rehabilitation programs have been judged less effective than legal sanctions.

**Interaction of social and legal sanctions.** Fear of legal sanctions may be less potent or enduring as a motivator than are concerns about social opprobrium or disjunctions with one’s sense of personal integrity. Surveys in Sweden and Canada found that driving after drinking was influenced by overall drinking habits, support for drunk-driving laws, and beliefs about the appropriateness of alcohol-impaired driving, not by respondents’ perceptions of the threat of arrest. Annual surveys in Massachusetts between 1981 and 1985 revealed a 13 percent drop (from 25 to 13 percent) in drivers reporting that they “would not care at all if their best friends found out that they had been arrested for drunken driving.” During this same period, the rates of reported driving after heavy drinking (five or more drinks) declined appreciably, as did the number of fatal crashes in the state. The law may perform its most important role as an element in the process of social change, signaling, legitimating, and cementing the community’s moral commitments. The utilitarian effectiveness of the law—unproven for the long term—may in the end be less important than the function it serves as a powerful form of communication about what society wants us to be.

A set of innovative strategies, designed to target the consequence phase by building safeguards into drinking environments, combine under the rubric of server intervention programs. These programs are rooted in the legal doctrine of dram shop liability, believed to supply the underlying motive for commercial servers and social hosts to adopt a broad set of
hazard-reducing measures. They seek to operate through economic incentives, education, and community support. Server interventions are being evaluated, appear promising, and are certain to continue to stimulate attention and experimentation.

Economic Measures

Economically driven measures are often introduced through laws, so the distinction is somewhat arbitrary. Here again, though, compelling evidence supports the utility of policies designed to moderate alcohol use. Studies have established that the relative price of alcohol (or what has been labeled its “economic availability”) varies inversely with rates of consumption and associated problems, notably liver cirrhosis mortality and highway fatalities. The magnitude of the relationship differs across studies and by beverage type (alcohol in distilled spirits is taxed at a much higher rate than that in beer and wine; distilled spirits seem most clearly price-sensitive, beer next, and wine least). Young people (ages sixteen to twenty-one) are influenced by the price of beer (the form of alcohol they purchase most). Econometric studies estimating the separate and combined effects of hypothetical excise tax policies that would index beer taxes to inflation or upgrade the alcohol tax on beer to that on distilled spirits show substantial dampening effects on the numbers of youthful drinkers, the amount and frequency of their drinking, and their deaths on the roads.

Alcohol tax policy appears to be more cost-effective as a countermeasure against highway fatalities than are drinking-age laws. In fact, price control may be the single most important policy instrument available for the prevention of alcohol problems, although this assertion, as are most in the field, is open to dispute.

Despite the robust case for strong tax controls, state and federal tax policies since the mid-1960s have, by default, gone the opposite way, allowing alcoholic beverage prices to erode relative to inflation. From 1960 to 1980, real prices of liquor, beer, and wine dropped 40, 27, and 20 percent, respectively. In some jurisdictions now, beer and wine products are competitively priced with soft drinks. Efforts have been made to reform alcohol taxes by indexing them to inflation or equalizing the tax rate (at the high end) for all alcoholic beverages.

A number of other potential tax policies include changes in rules on the depreciation of capital assets, on tax credits for investments, and on the deductibility of business-related alcohol expenses (a $4 billion federal tax subsidy in 1979). These have mostly fizzled because of shallow support, while the industry’s opposition is highly focused and strategic. If
the notion of a “sin tax” proves politically viable, it might appeal to legislators who are struggling to balance state budgets but for whom raising alcohol taxes has been politically infeasible.

In seeking to control alcohol use, drunk-driving campaigners can place the burden on the “impaired driver,” who generally lacks representation as such in any organized interest group and who can easily be characterized as an antisocial public menace. Tax policy, in contrast, treads on the marketing toes of a diversified and profitable industry, with power concentrated in a few global megacorporations that generated some $170 billion in worldwide sales in 1980. This difference probably explains the relatively greater political emphasis that has been placed on the drunk-driving arena.

**Education And Communication**

An abiding American faith in the liberating power of information persists in the face of evidence that is stubbornly equivocal. Over the years, educational campaigns have fared poorly in critical reviews of research on the primary prevention of alcohol problems. Studies have sought to document the impact of a wide variety of educational campaigns—in schools, colleges, worksites, and communities; with children, parents, teachers, health providers, bartenders and waiters, and convicted drunk drivers; and in the mass media, through public service and/or paid advertisements and efforts to alter other mediaborne public images of alcohol use (advertising, billboards, sponsorship of sporting events, and the like) that determine the social availability of alcohol.

**Educational approaches.** Along the continuum presumed to connect knowledge, attitudes, and behavior, virtually all conscientious education and communication interventions can measurably affect knowledge, fewer influence attitudes, and only the exceptional delay the onset of drinking behavior or change it to a meaningful degree. Three theoretical models implicitly underlie most of the educational research. Early work built upon a knowledge/attitudes model, which assumes that sounder information about the hazards of alcohol will alter attitudes and, in turn, rechannel behavior in health-enhancing directions. More recent intervention studies have attended more closely to nuances of the social milieu within which information may or may not influence behavior. A values/decision-making model emphasizes self-esteem, responsible decision making, and clarification of personal values and goals. A social competency model draws on social learning theory to teach psychosocial skills by offering examples of (or modeling) desired behaviors, discussing reasons and techniques for “saying no,” providing instruction in commu-
nication and coping skills, and sometimes also socially inoculating students to recognize and resist the influence of advertising and other environmental pressures to drink.

Based on evolving psychological theories of the dynamics of behavioral change, the more contextualized models, together with tighter study designs, are moving the alcohol education field in a more promising direction. Large-scale studies that can tease out interaction effects between programs and audiences and studies that incorporate strong process evaluations, to capture differences in the degree and quality of actual program implementation, should in time yield more finely grained pictures of approaches that really do work in specific circumstances for particular subpopulations. Studies of smoking and other health education programs in the schools may harbor lessons that will extrapolate to alcohol, but the smoking message (lifetime abstinence) is simpler to convey than are the mixed, time-sensitive, contingent, and culturally relative messages defining “responsible” use of alcohol. The applicability of analogies from smoking education to alcohol use will have to be tested more fully before smoking successes can safely be generalized.

When educational approaches are judged against a larger backdrop, attention can be paid to their synergies with legal interventions and other efforts to alter social norms, their agenda-setting potential, and their contributions to public support for policies of alcohol control. From this vantage point, outcome measures in short-term studies are often too limited to capture fully the contributions that sophisticated educational programs can make, if they are well integrated into a wider community matrix. Research with a longer time horizon may identify recognizable stages in a process of “diffusion of innovation” and allow alcohol education strategies to be tailored accordingly.

Alcohol warning labels. Alcohol warning labels rest on a case that was built inferentially from experience with other health risks, especially tobacco products, which have carried warning notices since 1965. As of November 1989, all sealed containers of alcoholic beverages manufactured, imported, or bottled for sale or distribution in the United States must state: “Government warning: 1. According to the Surgeon General, women should not drink alcoholic beverages during pregnancy because of the risk of birth defects. 2. Consumption of alcoholic beverages impairs your ability to drive a car or operate machinery, and may cause health problems” (P.L. 100-690).

NIAAA has solicited proposals to study the effects of the warning labels, stressing continuities and discontinuities with experience in labeling tobacco and food, which has been studied in controlled, laboratory like situations and in field experiments. There is some limited evidence to
suggest that cigarette warning labels, together with other factors, have helped reduce the prevalence of smoking, but almost nothing is known about the potential impact of alcohol warning labels.

**Repoliticizing Prevention By Mobilizing Communities**

Some activists are convinced that the cultural position of alcohol is in fact unstable and are inspired both by the social movement organized to stiffen drunk-driving laws and by the underlying wave of new temperance sentiment attached to the “wellness revolution.” Granting the difficulty of the challenge and the research remaining to be done, these activists nonetheless assert that sufficient knowledge is already at hand to move the field into a new implementation stage, involving politically astute community organizers and self-conscious agents of change.

This call to arms explicitly identifies the vocal and well-funded alcoholic beverages industry as the opposition. Public health successes against the tobacco industry are cited as encouragement that the struggle can be won with a concerted effort. And, numerous public and private organizations (government agencies, large foundations, citizens’ lobbies, health groups, and universities) on the national, state, and local levels are identified as recent converts to environmentally based prevention strategies.

At the heart of the campaign is a systems perspective on alcohol, which defines a web of relationships between legal, economic, cultural, social, and health factors in a community’s social environment that mediate the availability, use, and impact of alcohol. An elaboration of classic public health thinking, the systems approach overtly states that problems exist on several levels, have multiple causes, and are linked to their context. This perspective again widens the framework and broadens the prevention agenda. Uncertainty about whether advertising or education immediately affects consumption, for example, matters little in the systems framework, because their important role is to enhance the consistency of messages about alcohol consumption that permeate every level of the social environment.

**Alcohol Policy’s Social Odyssey**

The history of alcohol policy has involved a constant struggle to define the contours of a social problem and then to establish the boundaries that fix responsibilities for its solution. At the risk of oversimplifying, it is illuminating to observe how the center of gravity for alcohol control has moved, in this century, from the churches (before Prohibition), to moral
entrepreneurs (as the temperance movement built momentum), to the legal system (under Prohibition), to the medical profession (with the alcoholism movement), to private-sector representatives of “problem drinkers” themselves (as Alcoholics Anonymous took hold), to the criminal justice system again (with incarceration of public inebriates and, later, prosecution of drunk drivers), to a government/university alliance speaking for scientific rationality (with research sponsored by NIAAA), and, now, to community-based activists working to widen the framework of concern and to mobilize a public health movement against the hazards of drinking.

Vestiges of the old arrangements coexist with the new, and the shifting boundaries around alcohol policy are accompanied by subtle changes in the cultural position of the substance itself. Alcohol functions in different cultures and at different times as a thirst-quenching beverage; a nutrient; a poison; a medicine; a stimulant for work; a psychoactive drug (to one generation, mystical and liberating, to the next, malevolent and addicting); a lucrative commodity in international trade; and an emblem of sophistication, group identity, and commitment to one or another lifestyle. Changing social definitions, as much as the substance itself, infuse alcohol use with meaning, motive, and risk.

In their current efforts to rejuvenate a movement against alcohol, public health activists are careful to dissociate themselves from the teetotaling and moralistic image of earlier temperance advocates. The new generation of activists are concerned about health, not morality; protection, not prohibition. But they share with earlier movements a clear view of alcohol consumption as the core issue. Their formulation allows scope for medical, legal, and moral entrepreneurs, all rallied now under a broader public health banner. Alcoholics can still be viewed as sick people deserving forgiveness and help because individually oriented treatment programs will only be enhanced, in this view, by a social and physical environment that supports their recovery, instead of subverting it. Organizations fighting drunk driving, drinking during pregnancy, or impairment at work can foster increasingly intolerant and moralistic attitudes toward those who engage in practices felt to endanger innocent lives or incur public expense, because this, too, creates an environment conducive to health. Reminders by high government officials that taxpayers carry the costs of alcohol abuse or claims that alcohol-impaired workers compromise U.S. competitiveness in the world economy also affect the social environment.

Historians of alcohol policy have made it abundantly clear that underlying values and assumptions profoundly shape events. Alcohol researchers are developing a nuanced appreciation of the futility of coercive
controls that lack social legitimacy and support and, conversely, of the power of social norms to supply that essential legitimacy. A virtue of the new public health campaign is its community focus, which creates an opportunity for value conflicts to be aired and resolved locally. Even so, it will be crucial to bear in mind the strong backlash during cycles of anti-alcohol and/or antidrug sentiment such as the one we are entering now.

The emphasis alcohol prevention policy has placed on the refinement of legal instruments to deter and punish “deviants” should stand as a reminder that changing social norms can unleash intolerance not only of a dangerous substance but also of its users, who come to be stigmatized as themselves dangerous. Thus, in the “war” against drugs (other than alcohol), crime in American streets is blamed not on producers or pushers but on users of illicit drugs. The ultimate lesson for prevention from the complex alcohol case is that effective policies do need to protect the innocent and foment some moral outrage while also fostering personal accountability and internalizing protective social norms. The two sets of goals are not entirely compatible, and the perpetually shifting boundaries in alcohol policy signal that we have yet to discover where a stable and socially optimal balance is to be struck in allocating responsibility and implicitly assigning blame.

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NOTES

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