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**Alcohol on the European Union's
Political Agenda:
Getting Off the Policy Roller-Coaster?**

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Preface

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Trygve Ugland

Sherbrooke, 5 January 2011

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Summary

In 2004, a European Commission official argued that political developments had put alcohol policy “high on the European Union’s political agenda”, a claim which is assessed in this report. The discussions focus on two main questions: first, why has alcohol policy ended up as a topic for the EU? Second, what status does alcohol policy have on the EU’s political agenda?

The main argument advanced in this report is that alcohol policy ended up on the EU’s political agenda because a determined group of policy “entrepreneurs” managed to draw widespread public attention to a set of shared problems pertaining to alcohol, health, and social welfare in Europe. In particular, the European Commission successfully exploited a window of opportunity for alcohol policy developments after several EU institutions, member-states and non-governmental organizations had successfully raised concerns about under-age drinking and intoxication since the mid 1990s. The Nordic countries have also played crucial roles in this process—the EU members, Finland and Sweden, through more formal policy-making processes, while Norway, as a non-member, has relied more on informal mechanisms in order to put alcohol and health more firmly on the EU policy agenda.

The attention devoted to alcohol policy by the EU has been unstable and transient. Periodic occurrences of acute awareness and concern about alcohol policy tend to quickly fade from the EU’s agenda. However, several EU forums and committees that deal specifically with alcohol policy have recently been established. This report suggests that these institutional advancements can, over time, help sustain and stabilize interest in alcohol policy and, thereby, creating a long-term commitment and approach towards reducing alcohol related harm in the EU.

Norsk sammendrag

Norges tilknytning til det indre marked gjennom EØS-avtalen som trådte i kraft i 1994, samt Sverige og Finlands medlemskap i EU fra 1995 har hatt stor betydning for alkoholpolitikken i disse landene. Deler av de statlige alkoholmonopolene har blitt avvirket, og pris- og avgiftsinstrumentet er i dag et mindre effektivt virkemiddel i bestrebelsene etter å redusere de alkoholrelaterte skadene i samfunnet som følge av tilpasninger til EU's regelverk og økt grensehandel. På den annen side har oppmerksomheten omkring alkoholpolitiske saker i EU økt over tid.

Målsettingen med denne rapporten er å øke forståelsen av *hvorfor* alkoholpolitikk har fått en mer sentral plass på dagsordenen, samt å diskutere *hvilken status* dette politikkområdet har i EU. Rapporten illustrerer at de nordiske land har spilt sentrale roller i prosessen med å sette alkohol og helse på dagsordenen, og at alkoholpolitikk i økende grad har blitt institusjonalisert i EU.

1 Introduction

Since the early 1990s, Nordic alcohol control policies have become subject to significant adaptations and changes. This development should be viewed in connection with the process in which European integration has become an increasingly more relevant and important point of reference for actors and institutions in the Nordic countries. Finland, Iceland, Norway and Sweden became partners of the European Economic Area (EEA) Agreement from 1994, and Finland and Sweden became full members of the European Union (EU) from 1995.

Since then, central aspects of Nordic alcohol control policies have become challenged by reference to the EC Treaties. The state alcohol monopoly systems have been partially abolished, and the restrictions on traveller's import allowances and the high tax levels have been put under pressure. As national policy making capacities in this area of public policy have become constrained, several initiatives have been taken to raise the awareness of alcohol related harm at the EU level. The Nordic countries have played crucial roles in this process – the EU members, Finland and Sweden, through more formal policy-making processes, while Norway, as a non-member, has relied more on informal mechanisms in order to put alcohol and health more firmly on the EU's political agenda.

Agenda-setting plays a crucial role in modern political systems because political outcomes can be influenced by those controlling the agenda. Since political agendas tend to reflect the fundamental interests and concerns of a given society, the chance of an issue ending up on the agenda will vary across political contexts. Unlike in the Nordic countries, alcohol policy – defined as all public measures pertaining to the relation between alcohol, health, and social welfare (see Babor et al., 2010) – has not figured high on the political agenda in the EU or in most member states. Despite that Europe carries a particularly heavy burden of alcohol related problems (Rehn, Room, & Edwards, 2001), alcoholic beverages have most often been treated as economic commodities to be promoted, and few systematic attempts have been made to redress adverse health and social policy consequences in the EU (Ugland, 2003a). “Alcohol policy” as a concept was traditionally not even included in the

policy vocabulary in most of the member states (Fahrenkrug, 1990). As a result, some observers concluded early that “an all-European alcohol agenda is unlikely to emerge” (Simpura, 1997, p. 40). However, this prediction has recently been challenged.

In 2004, a European Commission official claimed that “political developments now had put public health in general, and alcohol policy in particular, *high* on the Community agenda” (Commission, 2004; my italics), a claim critically evaluated in this report. The subsequent discussions are focussed on two main questions: first, why has alcohol policy become a subject of concern in the EU? Second, what status does alcohol policy have on the EU’s political agenda? The first question will be addressed by identifying factors that have contributed to bring this issue successfully on to the EU’s political agenda. The role of key actors and contextual conditions in the European environment in which these actors operate will be identified and analysed. The second question is answered with a descriptive analysis and a detailed illustration of the attention devoted to alcohol policy by the EU.

The main argument advanced in this report is that alcohol policy ended up on the EU’s political agenda because a group of determined policy “entrepreneurs”, assisted by favourable political circumstances, managed to draw public attention to a set of shared problems, pertaining to alcohol, health, and social welfare in Europe. In particular, the European Commission successfully exploited a window of opportunity for the development of alcohol policy after several EU institutions, member-states and non-governmental organizations had raised concerns about under-age drinking and intoxication in the mid 1990s.

Although the Commission initiatives enjoyed widespread support, the attention devoted to alcohol policy by the EU has been unstable and transient. Sporadic periods of alarm about alcohol consumption tend to evaporate into the ether and concomitantly fade from the EU’s political agenda. For instance, the attention appeared to decrease in the immediate aftermath of the ground-breaking alcohol policy movements in 2001. In addition, the attention seems to increase in years when Sweden – and to a lesser extent Finland – holds the Presidency of the Council because both countries have used their Presidencies to raise the awareness of alcohol policy related issues at the EU level.

However, several forums and committees that deal specifically with alcohol policy have recently been established. This report suggests that these institutional

advancements at the EU level may, in the long-term, nurture and stabilize attentiveness to alcohol policy, and thereby create a more enduring commitment and approach to reducing alcohol related harm in the EU.

Accordingly, the next section presents a theoretical overview of attention and agenda-setting in public policy with a special focus on the EU. In the following section, Section 3, the two main questions above are discussed while Section 4 discusses the prospects for a more permanent attention to alcohol policy. Section 5 presents conclusions for consideration.

This study draws on a variety of empirical sources. In addition to secondary literature and published and unpublished government documents, a series of semi-structured interviews were conducted with key policy practitioners between January 2010 and July 2010. The purpose of the interviews was to obtain new information and to bring up to date material from the written sources. One common characteristic shared by all of the respondents is that they were selected on the basis of their professional knowledge and experience with alcohol policy-making processes at the EU level.

2 The Public Policy Agenda and Agenda-Setting in the European Union

Public policy making processes can be divided into different phases, and John W. Kingdon (1995) distinguishes between four steps: (1) the setting of the agenda; (2) the specification of alternatives from which a choice is to be made; (3) an authoritative choice among those specified alternatives; and (4) the implementation of the decision. Although my primary focus is on the first step in this process, the setting of the public policy agenda, this study will also consider consequences of effective agenda-setting on policy outcomes.

“Policy agenda” refers to “the list of subjects to which government officials and those around them are paying serious attention” (Kingdon, 1995, p. 3), and agenda-setting can be understood as a conscious attempt at modifying a policy agenda. According to Kingdon (1995), agenda-setting is an activity of political entrepreneurs who are engaged in the coupling three streams: the recognition of a problem, the development of policy proposals, and a receptive political climate. Successful political entrepreneurs will therefore be engaged in activities that first raise the awareness of a problem by providing information and by pushing for specific definitions. And once the time is ripe, and a “policy window” opens, the entrepreneurs will press for their prepared proposals and solutions.

Agenda-setting will often be a matter of degree rather than a matter of simply being “on” or “off” the agenda, and much of the political struggle will therefore be concerned with moving issues higher up the agenda or pushing them down (Tallberg, 2003, p. 5). This means that the public policy agenda is highly dynamic and will be subject to constant changes. For instance, Downs (1972) illustrates, in his classic study of environmental policy, that issues tend to move “up” and “down” on the policy agenda. However, he also emphasises that the attention devoted to some issues seems to be more stable than others.

According to Downs (1972, p. 41), social problems that tend to go through an “issue-attention cycle” possess three characteristics: first, the majority of persons in a society are not suffering from the problem nearly as much as some minority. Second, the sufferings caused by the problem are generated by social arrangements that provide significant benefit to a majority or a powerful minority of the population. Third, the problem has no intrinsically exciting qualities – or no longer has them. When all three of the above conditions exist on a given problem that has somehow captured public attention, then the odds are great, according to Downs, that the issue will soon move through the entire “attention cycle”, and gradually fade from the centre stage. The role of media can also be used to explain the cycle dynamics because the mass media tends to cover a story prominently for only a short period of time before turning its attention to the next big story.

Both the entrance and current status of alcohol policy on the EU’s political agenda will be analysed in light of Kingdon’s and Down’s perspectives. However, specific characteristics related to attention and agenda-setting in the EU will also be addressed.

The EU consists of 27 member states and 4 main institutions, the European Commission, the Council, the European Parliament and the European Court of Justice, each with their own sub-divisions. The European Commission is the main agenda-setter in most policy areas in the EU.¹ This means that the Commission is responsible for drafting legislation, which is then presented and voted on by the European Parliament and the Council. The exclusive right to put issues on the political agenda is an important source of influence. However, this role should not be overstated because the Commission tends to work closely with other EU institutions before proposing policies and legislation.

Furthermore, the Commission is in need of expertise for drafting new policy proposals and to an increasing extent, the expertise is found among various national agencies in the member states (Egeberg, 2006). Additionally, EU policy-making will normally also involve a multitude of other actors such as lobbyists, representing regional, national and international interest groups and non-

¹ The European Commission has an exclusive agenda-setting role in all areas falling under the EU’s first pillar (the European Community pillar). The Commission plays a less active role in areas covered by the two inter-governmental pillars (Second pillar: Common Foreign and Security Policy and Third pillar: Justice and Home Affairs).

governmental organizations. More to the point, the trend over that last decade has been to include more and different actors in the EU policy-making process to enhance the democratic legitimacy of European integration in the eyes of Europe's citizens. The Commission particularly welcomes European-level interests groups and organizations in its preparatory work on new legislation and in other forms of policy-making. In fact, in policy areas where these sorts of interest organizations have been lacking, the Commission has actively tried to encourage its formation (Egeberg, 2010).

Indeed, the EU is a complex policy-making system. Thus according to Greer, "the principle strategic challenge is to be able to see how to advance or oppose a given idea across many forums, some of them formal and easily identifiable (such as Council or European Parliament votes) and some of them nebulous and of doubtful value (as with the endless round of seminars and conversations in Brussels, which are collectively influential but individually often a waste of time)" (2009, p. 57). Given this complexity, it seems futile to look for one single origin of a policy initiative. This is precisely why this study focuses on the relationships among key actors in a specific policy field, EU alcohol policy.

Sebastian Princen (2007) justifies my focus by pointing out that successful agenda-setting in the EU requires a considerable degree of consensus among the actors about the need to address a certain issue. There are several ways in which such consensus can arise (Princen, 2007). First, the views of policy-makers from different member states may converge on a given approach. Such a convergence can be aided by the strategic framing of issues in ways that make them more attractive to a wider range of actors (see also Princen & Rhinard, 2006). Second, an issue may affect a wide range of member states, making it more salient for a large number of actors. These two factors may explain why alcohol policy successfully has been put on the EU's political agenda.

3 Alcohol Policy on the EU's Political Agenda

Market integration has been the predominant objective behind the post-war European integration process and the EU competencies in public health are not as fully developed as in trade, market, and economic policy. Under the principle of “subsidiarity” and given the limitations of the Treaties, the development of comprehensive health policies is primarily the responsibility of the member states. In fact, because of the sensitivity of health matters, the member states have often been unwilling to permit the EU a wider role in public health.

Nevertheless, the EU has been granted certain formal competencies in public health over the course of the time. The Treaty on the European Union (the Maastricht Treaty) in 1992 formalized the first real powers with respect to public health, giving the Community concrete legal competencies through two provisions.² Article 3(o) empowered the Community to “contribute to the attainment of a high level of health protection” for its citizens. Second, and towards achieving this objective, Article 129 delineated a rudimentary framework whereby the Community could meet this obligation. It could do so by encouraging co-operation between member states and, if necessary, lending support to their actions. The Amsterdam Treaty from 1997 revised Article 129, and several new provisions were added. Article 129 was in this connection renamed Article 152.

According to Article 152 of the Treaty of Amsterdam, the Council can adopt recommendations for the purpose of improving public health, preventing human illnesses and diseases, and obviating sources of danger to human health. Council recommendations enable the Community institutions to express a particular view to the various member states but they are not binding instruments. This implies that the party to whom a recommendation is addressed is placed under no legal obligation to behave in a particular way. The significance of these recommendations

² The Maastricht Treaty entered into effect on 1 November 1993.

is therefore not legal but they may carry political and moral weight. Furthermore, they can be used to expand EU activities into new areas because of the flexibility they offer to the member states where the national situation may differ substantially. Public health in the EU is, therefore, heavily associated with what has been referred to as the “new modes of governance”, i.e. non-binding instruments such as soft law and voluntary agreements (see for instance Héritier, 2002).

Article 152 has also been used to justify measures pertaining to advancement of new alcohol, health and social welfare measures in the EU. In 2001, the Council adopted a Recommendation on the drinking of alcohol by young people, in particular children and adolescents. The recommendation invited the Commission to follow-up, assess and monitor developments and the measures taken and to report back on the need for further actions (Council, 2001b). In its Conclusions of 5 June 2001 the Council also invited the Commission to put forward proposals for a comprehensive Community strategy aimed at reducing alcohol-related harm to complement national policies (Council, 2001a). The first EU Alcohol Strategy was adopted by the European Commission in October 2006 (Commission, 2006). This strategy addresses the adverse health effects related to harmful and hazardous alcohol consumption, and identifies five priority themes for action:

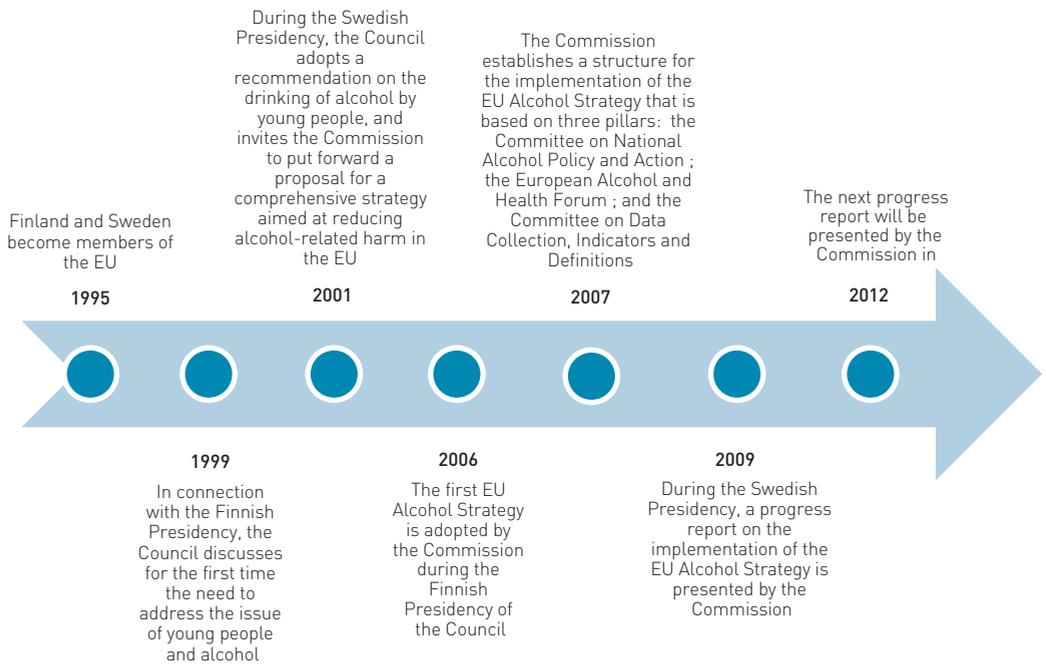
1. The first priority relates to the protection of young people, children and the unborn child and emphasises the need to address the growing problem of under-age drinking and binge drinking among young people, but also to increase the protection of children. The strategy reiterates examples of good practice from the 2001 Council Recommendation, including the need to enforce restrictions on sales and action on the availability of marketing likely to influence young people.
2. The second priority relates to the need to reduce injuries and death from alcohol related to road accidents. The strategy highlights, as good practice, the setting and enforcement of a Blood Alcohol Concentration (BAC) maximum of 0.5 mg/ml for drivers of motorised vehicles and the setting a lower limit for inexperienced and professional drivers. It also underlines the importance of awareness raising measures.
3. The third priority addresses the importance of preventing alcohol-related harm among adults in order to decrease chronic physical and mental ill health in the adult population, giving particular recognition to the impact that alcohol can have on the workplace, and workforce productivity, and the importance of the workplace as a setting for intervention. As good practice, the strategy emphasises the need to enforce, across settings, existing regulations, codes, and standards (such as licences,

server training, restrictions on alcoholic drinks promotions) as well as campaigns to raise awareness and involving health professionals to advise people at risk.

4. The fourth priority relates to the need to inform, educate and raise awareness on the impact of harmful and hazardous alcohol consumption, so as to develop knowledge in society about appropriate consumption patterns.
5. Finally, the fifth priority emphasises a continued commitment to work with partners to develop and maintain a common evidence base at the EU level, particularly in relation to the development of health indicators to monitor progress as well as studies to monitor the effectiveness of approaches.

This strategy was endorsed by all EU institutions indicating that a broad consensus had been achieved on the approach to tackle alcohol related harm. A progress report on the implementation of this strategy was presented by the Commission in September 2009 and the report concludes that: “the recent activity makes for a promising start, but more needs to be done by all in the framework of the consensus strategic approach” (Commission, 2009c, p. 3). As illustrated in Figure 1, the next progress report will be presented by the Commission in 2012.

Figure 1 Alcohol on the EU’s Political Agenda



3.1 Why has Alcohol Policy Ended Up as a Topic for the EU?

A number of different actors, including EU institutions, member-states, inter-governmental and non-governmental organizations, have contributed to placing alcohol policy as a priority item on the EU's political agenda. However, Kingdon's (1995) framework can be used to reduce the complexity, and this particular agenda-setting process will here be seen as a product of the activity of a few political entrepreneurs who successfully managed to couple three streams:

1. The recognition of alcohol as a problem
2. The development of alcohol policy proposals
3. A receptive political climate for alcohol policy initiatives

3.1.1 The European Commission and the Directorate General for Health and Consumers (DG SANCO)

The political leadership of the European Commission is served by the Directorates-General (DGs), which are roughly equivalent to the administrative components of national government departments and which now cover almost all possible policy fields (Egeberg, 2010). As illustrated below, the European Commission, represented by Directorate General for Health and Consumers (DG SANCO), played a key role in the process of putting alcohol on the EU policy agenda. As a political entrepreneur, DG SANCO first identified, and then acted upon, a window of opportunity for alcohol policy developments. But in order to gain the widest support possible, the agenda-setting initiative from DG SANCO was framed in relation to young people's alcohol habits often characterised as "binge drinking", an urgent concern that had been raised previously by several member states and by the European Parliament.

The justification presented in the Council Recommendation on the drinking of alcohol by young people illustrates this strategy. The Commission's proposal, presented on 27 November 2000, deals directly with the question of why the issue of young people and alcohol should not remain the preserve of the member states (Commission, 2000). The Commission's justification for Community action in this case is based on three arguments by presenting the drinking of alcohol by young people as:

- a problem with important health implications;
- a problem of international character; and finally
- a problem which requires coordination.

Citing relevant research in relation to the first point, the Commission states that alcohol is one of the most important risk factors for human health, not only for the member states, but also within the EU as a whole. It is argued that drinking by young people does have special characteristics and that there are good reasons for specific measures to address associated problems associated. For instance, young people are said to be more vulnerable than adults to the adverse effects of alcohol, both within a short- and a long-term perspective. Secondly, the Commission argues that Community action is called for due to the increasingly international character of youth culture and the decreasing significance of national borders with regard to the transmission of this culture and products associated with it. The Commission specifically points to research, contending that regular alcohol consumption begins at a younger age than it used to and that drinking to intoxication has become increasingly common among very young people in all member states for which comparable data are available.

An important aspect is here said to be a “growth in Nordic drinking patterns among young people in the wine producing countries” (Commission, 2000). Thirdly, the Commission claims that all member states pursue measures in order to reduce alcohol related harm among young people but it is also observed that their approaches and strategies differ substantially. According to the Commission, there are lessons to be learned from these differences and the Community is said to be in a good position to promote a coherent overall strategy to combat alcohol related harm. It is further argued that Community action will improve data collection on a consistent basis, and facilitate the exchange of information regarding best practices in health education and in other preventive strategies.

These three arguments are applied to illustrate the Community dimension of the issue of young people and alcohol, and they are further backed up with references to Article 152 of the Amsterdam Treaty which legitimises common actions in the area of public health. The Commission is in its proposal illustrating the *added value* of common action compared with letting the issue of young people and alcohol abuse fully remain the preserve of the individual member states.

The Commission acknowledged that it would have broad support on the issue. The introduction of “alcopops”, the sweet-tasting alcoholic drinks, which from the second half of the 1990s became increasingly popular among very young Europeans, dramatically demonstrated the potential harmful effects of under-age drinking and intoxication. Calls for stricter regulations on the marketing,

promotion and sales of these products were made by politicians and broad spectres of the general public in a number of European countries, including countries that are not usually associated with restrictive alcohol control policies. In this process, under-age drinking and intoxication was increasingly viewed as a pan-European problem, which is clearly evident in the World Health Organization (WHO) European Charter on Alcohol which was adopted by all EU member states in 1995. The European dimension of the problem was further highlighted through the ESPAD (European School Survey Project on Alcohol and other Drugs) studies, which since 1995 have provided comparable data on alcohol and drug use in student populations in different countries (see Hibell and Andersson, 2006). Young people's alcohol use had also been subject to much attention in the European Parliament. In 1997, more than 200 members of the European Parliament supported a campaign to clamp down on "alcopops" (Ugland, 2002). All in all, this created an atmosphere – a window of opportunity – for common action at the EU level, and the cultural, historical and economical differences that exist between the various member states with respect to alcohol and alcohol control seemed to become less relevant.

The driving forces behind the alcohol policy initiatives from DG SANCO can be seen as a combination of institutional interests on behalf of the Commission to widen its scope of agency vis-à-vis the member-states, but also as a problem-solving measure to improve the public health situation in Europe based on its newly defined mandate.³

However, the Commission was not the only political entrepreneur behind the promotion of alcohol policy at the EU level. Finland, and more especially Sweden, who became EU members in 1995, viewed the initiatives from the European Commission in the area of alcohol and young people as a window of opportunity to promote a wider strategy to combat alcohol related harm – a process that led to the adoption of the EU's Alcohol Strategy.

3.1.2 The Finnish and Swedish Presidencies of the Council

Finland and Sweden share a long history of restrictive alcohol policies in which a wide range of preventive strategies have been adopted to reduce the prevalence of both acute and chronic harm, resulting from alcohol consumption (Holder et al.,

³ DG SANCO was established in 1999 to improve quality of life in the European Union (EU) through policies, laws and programmes in its three main areas of activity: public health, food safety and consumer protection.

1998). Although Sweden can be described as being more active than Finland (Karlsson & Tigerstedt, 2004, Karlsson, 2008), I argue that the difference is one of degrees, rather than a categorical one. In fact, both countries have played key roles in bringing this issue on the EU agenda. Furthermore, it will be illustrated that the two countries often have acted together in pursuing this objective.

The Council Presidency, which is held on a six-monthly basis by the member-states in rotation, performs various functions. However, the existing literature is generally sceptical about the capacity of the Council Presidency to shape the EU's political agenda due to its weak formal position, its exposure to disruptive external events, its required attention to inherited agenda, and its obligation to be neutral (see for instance Hayes-Renshaw & Wallace, 1997). However, Tallberg (2003) disagrees on both theoretical and empirical grounds. He contends that the Council Presidency enjoys a wide repertoire of means for influencing the EU policy agenda and that these means are often used by member states to advance political issues. He argues that agenda-setting by the Council Presidency primarily takes three forms: first, the Presidency can shape the policy agenda by raising the awareness of problems hitherto neglected in European co-operation and initiating debate on how these may be addressed (Tallberg, 2003, p. 6). Second, the Presidency can develop concrete proposals for action in response to recognized problems (Tallberg, 2003, p. 7). Third, the Council Presidency can engage in a specific form of institutional entrepreneurship by developing new institutional practices that structure future co-operation and decision-making (Tallberg, 2003, p. 8).

In the case of alcohol policy, the Finnish (1999 and 2006) and Swedish (2001 and 2009) Presidencies were all used to raise the awareness of issues pertaining to alcohol, health and social welfare. Several different methods were used: first, the issue was highlighted in each of the four work programmes that the Finnish and Swedish governments presented for their six-month periods at the helm (Council, 2005; Finland, 1999; Sweden, 2001, 2009). The work programmes contain an overview of priority issues for the Presidency over the six-month period. According to one of my respondents, the inclusion of alcohol policy in Presidency work programs is a priority because it implies that the issue has already been placed on the agendas vis-à-vis other EU institutions and member-states (Interview). Second, the Finnish and Swedish presidencies also exploited their rights to include alcohol policy issues in informal meetings, both at ministerial and working-group levels. These initiatives eventually led to the adoption of policy proposals for action which were produced in close co-operation with the European Commission.

In a meeting held in connection with the Finnish Presidency of the Council in 1999, the Council of Ministers of Health discussed for the first time the need to address the issue of young people and alcohol through a Council recommendation (Finland, 1999; Ugland, 2003b). This initiative was a direct result of cooperation between the Finnish and Swedish governments. It has been documented elsewhere that the two governments had already exchanged letters in 1997 about the possibility of launching the EU funded ECAS (European Comparative Alcohol Study) project in connection with the Finnish Presidency in order to build support for EU alcohol policy measures (Örnberg, 2008).⁴ However, the break-through for putting alcohol policy on the EU political agenda came during the Swedish Presidency of the Council in 2001 (1 January – 30 June) when both the Council Recommendation on the drinking of alcohol by young people (Council, 2001b) and the proposal for a comprehensive Community strategy, aimed at reducing alcohol-related harm to complement national policies (Council, 2001a), were adopted.

The rise of seemingly domestic issues on international agendas has often been explained with reference to the political activism of domestic groups and officials that turn to the European level in order to overcome domestic political constraints (Princen, 2007). However, this activism does not seem to be the main motive behind the Nordic initiatives in this area. Instead, the Finnish and Swedish governments' promotion of alcohol policy on the EU political agenda seems to be related to the exigencies of protecting their own restrictive laws and policies from the influence of more liberal policies in other member states. Central aspects of Finnish and Swedish alcohol policies had namely become challenged in the encounter with the EU.

As a result, the state alcohol monopoly systems had been partially abolished, and the restrictions on traveller's import allowances and the high tax levels were under pressure. In this context, Finnish-Swedish co-operation seemed to increasingly replace the discord from the European Area Agreement (EEA) and accession negotiations earlier in the decade (Ugland, 2002). Furthermore, Swedish activism had replaced the original passive "let sleeping dogs lie" strategy that was used when the state alcohol monopoly systems were put under pressure (Ugland, 2002, p. 110). Despite significant administrative-organisational, economic, and cultural contrasts between the various

⁴ Although the ECAS Project initiative was taken by the Swedish Ministry of Health and Social Affairs, the Finnish National Research and Development Centre for Welfare and Health and the Swedish National Institute of Public Health were the two main institutions responsible for the execution of the project.

member states, serving as major obstacles to forming common EU alcohol policies, Finland and Sweden recognized the need for positive activist reform (Ugland, 2000). In order to succeed, the Finnish and Swedish governments exploited the international environment's concerns about young people's dangerous alcohol habits and "binge-drinking" in order to raise the attention about alcohol policy.

In addition to the Commission (represented by DG SANCO) and the Finnish and Swedish Presidencies of the Council, several other actors have contributed to put alcohol policy on the EU's political agenda. The role of the European Parliament and its 1997 vote on "alcopops" has already been mentioned. Additionally, the European Court of Justice has also confirmed on several occasions that reducing alcohol related harm is an important and valid public health goal.⁵

European lobby groups in the area of public health have also played key roles. The European Alcohol Policy Alliance (Eurocare), which was established in 1990 as an alliance of voluntary and non-governmental organisations concerned with the impact of the EU on alcohol policy in the various member states, has been particularly active. Starting with 9 member organisations in 1990, it now includes some 50 organisations across more than 20 countries in Europe. Eurocare has maintained a Secretariat in Brussels since 1996, which acts as the central contact point for member organisations as well as other bodies concerned with alcohol related issues. Eurocare also presents the views of its members to the European Commission, the European Parliament and to the decision-making institutions of the member states.

Eurocare also works actively in order to encourage incoming Council Presidencies to include alcohol policy in the work programs. According to a representative from Eurocare, it is "very easy" to promote alcohol policy in the EU during Swedish Presidency periods (Interview). This statement and the general strategies of Eurocare illustrate clearly that the various actors that have contributed to bringing alcohol policy on to the EU's political agenda should not be viewed in isolation from each other. For instance, the Nordic governments have worked closely with the Commission in this process. In fact, at a meeting in June 2004, the European Commission's Matti Rajala, who prior to his Commission employment worked in the Finnish health administration, paid tribute to the Swedish government for

⁵ This is confirmed in the following cases: Franzen case (C-89-95), Heinonen case (C-39/97), Gourmet case (C-405/98), Catalonia (joined cases C-1/90 and C-179/90) and Loi Evin (C-262/02 and C-429/02).

playing an important role in the process leading to the 2 June 2004 adoption of the new Council Conclusions on alcohol and young people (Commission, 2004).

In addition, the Swedish government seconded (or transferred) a national alcohol policy expert to DG SANCO in order to advance the work on the EU's Alcohol Strategy in 2004.⁶ In fact, several central actors with past experience in the Finnish and Swedish ministries, responsible for alcohol policy, have worked on this portfolio for DG SANCO during the past decade.

The links between the WHO and the EU on alcohol policy have also been important from an agenda-setting perspective. The European Ministerial Conference on Young People and Alcohol, held in Stockholm in February 2001, was organized in close collaboration between the WHO Regional Office for Europe and the Commission. Significantly, this conference also formed an important part of the Swedish Presidency of the EU.

Although several actors have been involved in this process, this study highlights the importance of the European Commission and especially the Swedish government through its Council Presidencies as political entrepreneurs in advancing alcohol policy to the EU's political agenda. While the European Commission exploited the first window of opportunity to promote alcohol policies directed towards young people, Sweden – and to a lesser extent Finland – have also used their Presidencies as windows of opportunity to follow up on the Commissions initiatives and to promote a wider alcohol strategy for the EU. In this sense, the policy-making process can be depicted as a case of “bottom-up Europeanization”, in which member states (Finland and Sweden) upload their domestic preferences (alcohol policies) to the EU level.⁷

⁶ In addition to the staff paid by the Commission, the Commission services include approximately 1000 officials seconded from member governments to assist with policy-making and policy management. These seconded officials have their salary paid by their national employer. According to Egeberg (2010), seconded officials from member governments or the so-called ‘detached national experts’, are often used to provide additional expertise on particular policy issues that are under consideration. The official that was seconded to DG SANCO by the Swedish government fits this description nicely.

⁷ An EU member state can be seen as a successful uploader if it manages to make its preferences heard so that an EU policy, political process, or institution reflects its interests (Börzel and Panke, 2010, p. 412). Bottom-up Europeanization can be contrasted with top-down Europeanization, which explains how the EU triggers domestic change in the member states’ policies, political processes or institutions.

However, as Princen (2007) points out, it may be easy to get *someone* at the EU level to consider an issue but it is more difficult to get an issue *high* on to the political agenda of the EU, as a whole. The next section discusses the status of alcohol policy on the EU's political agenda.

3.2 What Status does Alcohol Policy have on the EU's Political Agenda?

The status of alcohol policy on the EU's political agenda has varied over time. As a subject of public attention it appears to be characterized by roller-coaster dynamics. After having been a non-issue for the EU for an extensive period of time, health and social oriented alcohol policy has moved “up” and “down” on the policy agenda. The pattern can be demonstrated by examining two time-periods, the period before and the one after the “break-through” year for alcohol policy in 2001.

3.2.1 An Incremental Process of Increased Attention Until 2001

In the EU, alcohol has traditionally been treated as an ordinary economic commodity and largely considered in relation to agriculture policy, tax policy, and the internal market for the free movement of goods. The need to tackle problems related to harmful and hazardous consumption of alcohol first entered the agenda of the European Community in connection with the “Europe Against Cancer” programme from 1986 (Council, 1986). However, the initiative did not lead to concrete measures pertaining alcohol, health and social welfare, and alcohol policy seemed to disappear from the EU's political agenda.

However during the 1990s, the awareness of the potential detrimental health and social effects that can be associated with alcohol consumption appears to increase in the EU and many of its member states. It has been indicated that both southern and central EU member states adopted stricter and wider alcohol control measures between 1990 to 2000 (Karlsson & Österberg, 2001). It was no coincidence that during that period the European Commission placed alcohol on the EU's political agenda. The 1995 enlargement also implied that the EU got two new member states that had long traditions with a restrictive alcohol policy at the national level. Although both Finland and Sweden supported the Commission in its work on the recommendation on alcohol and young people, both countries have also promoted a wider approach to alcohol control.

In the context of the upcoming Finnish Presidency in the second half of 1999, the need for a common alcohol strategy for the EU was expressed for the first time in a Council of Ministers for Health meeting in June 1999. This process accelerated through the proposal for a Council recommendation on “Drinking of alcohol by children and adolescents” that was presented in December 2000. The Commission here claimed that “Alcohol, being one of the most important risk factors for human health, it will remain an issue of utmost importance, not only for the Member States, but also at the European Union level” (Commission, 2000). The process culminated during the Swedish Presidency of the Council in 2001 (1 January – 30 June) when both the Council Recommendation on the drinking of alcohol by young people (Council, 2001b) and the proposals for a comprehensive Community strategy, aimed at reducing alcohol-related harm, were passed to complement national policies (Council, 2001a).

According to then Swedish Minister of Health and Social Affairs, the EU approach to alcohol policy changed during the Swedish presidency: “Previously, alcohol-related issues were primarily regarded as a single-market, and agricultural concern. However, all the Member States now agree that alcohol should be regarded as a public health issue as well”.⁸ Despite his optimism, attention towards alcohol policy has been unsteady since 2001. The issue seemed to fade from the EU’s political agenda after the adoption of the Council Recommendation and the invitation to develop an EU Alcohol Strategy in 2001.

3.2.2 Down and Up with Alcohol Policy Post 2001

The decreasing attention devoted to alcohol policy after the break-through year of 2001 is evident by the activities of the European Commission and the DG SANCO and its virtual neglect by Council Presidencies succeeding the 2001 Swedish Presidency. In short, alcohol policy did not seem to rank high on the political agenda. Few initiatives were taken by the DG SANCO in order to transform the EU Alcohol Strategy from project to reality and alcohol policy was excluded from the work programs of the successive seven presidencies.⁹

⁸ Press release from the Swedish Presidency: “EU Health Council proposes common alcohol strategy”, 5 June 2001 in Luxembourg.

⁹ Belgium (1 July – 31 December 2001), Spain (1 January – 30 June 2002), Denmark (1 July 2002 – 31 December 2002), Greece (1 January – 30 June 2003), Italy (1 July – 31 December 2003), Ireland (1 January – 30 June 2004) and Netherlands (1 July – 31 December 2004) (Denmark, 2002; Ireland, 2004; Italy, 2003; Netherlands, 2004).

The neglect also confirms, as one respondent put it that “It is not a *given* that alcohol policy is on the EU policy agenda. You have to work hard for keeping it there” (Interview). Somehow, the incremental process of increasing attention to alcohol policy seemed to end after the break-through year of 2001. However during 2004–05, the Commission, represented by DG SANCO, seemed to take a more aggressive stance again devoting considerable attention to alcohol policy. In particular, a more systematic approach is taken vis-à-vis the work on the common Alcohol Strategy. Several of my respondents, representing national governments and international NGO’s, linked the revival of alcohol policy on the EU’s political agenda to several personnel changes taking place in DG SANCO in 2004. The appointment of a new Director General and the secondment of a Swedish alcohol policy expert to advance the work on the Alcohol Strategy seemed to be particularly important. As one respondent put it, “The EU system within the area of health is very small, and when it comes to alcohol policy, it is even smaller – so, individuals are important” (Interview).

These developments within the Commission coincide with the inclusion of alcohol policy in the joint work programme for the 2005 Presidencies held by Luxembourg (1 January – 30 June) and the United Kingdom (1 July – 31 December). Under the sub-title “Health” the program emphasized that “Other issues on which action may be taken are patient safety, epidemics, bioterrorism and alcohol” (Council, 2004, p. 22). The wording is more precise in the joint work program formulated prior to the forthcoming 2006 Presidencies, held by Austria (1 January – 30 June) and Finland (1 July – 31 December): “Other issues which will be addressed are the Communication on nutrition and physical activity, the Alcohol Strategy Communication, mental health, adult-onset diabetes, women’s health” (Council, 2005, p. 30). These statements are followed up by concrete initiatives and again, the link between the Commission and the Council Presidency is again important. In October 2006 during the Finnish Presidency, the European Commission adopted a Communication on an EU strategy to support member states in reducing alcohol related harm (Commission, 2006). This strategy was in turn supported by the Council in its meetings on 30 November – 1 December 2006 (Council, 2006).

Since the adoption of the Alcohol Strategy in 2006, there has been considerable activity on the part of DG SANCO (Commission, 2007b). Most importantly, in 2007 DG SANCO established an institutional framework to support the implementation of the Alcohol Strategy. The framework is based on three pillars: the Committee on National Alcohol Policy and Action; the European Alcohol and

Health Forum; and the Committee on Data Collection, Indicators and Definitions. Although alcohol policy disappeared again from work programs for the next five Presidencies,¹⁰ this institutional framework kept alcohol policy on the agenda until Sweden took over the Presidency again during the second half of 2009.

The Swedish work program had a strong emphasis on alcohol policy. Under the title, “Full Employment and Good Health”, the program stated that “Another issue is the implementation of the EU alcohol strategy. The Commission is due to present its first progress report on the implementation of the strategy at national and European level. The ambition is to establish long-term prevention efforts for alcohol-related harm” (Sweden, 2009, p. 28). Indeed, 2009 was a very active year for EU alcohol policy. The Commission published a first progress report on the implementation of the common alcohol strategy in September 2009 (Commission, 2009c) and the Council invited the Commission and the member states to keep alcohol policy high on the EU political agenda until the second progress report is presented in 2012 (Council, 2009).¹¹

Despite an incremental increase in attention to alcohol which led up to the breakthrough year in 2001, attention devoted to this issue has since vacillated between highs and much like a roller-coaster. However, the need for stable attention has been recognized by more and more policy actors. At the Employment, Social Policy, Health and Consumer Affairs Council meeting on 1 December 2009, towards the end of the Swedish Presidency period, the Council invited the Commission and member states to “keep public-health-based alcohol policy *high on the agenda* towards 2012 in order to build sustainable and long-term commitments to reduce alcohol-related harm at EU level” (Council, 2009a, p. 5; my italics).

This may not be easy and concerns about the future of alcohol policy at the EU level were recently raised by the European Alcohol Policy Alliance, Eurocare, which

¹⁰ Germany (1 January – 30 June 2007), Portugal (1 July – 31 December 2007), Slovenia (1 January – 30 June 2008), France (1 July – 31 December 2008) and Czech Republic (1 January – 30 June 2009) (Czech Republic, 2009; France, 2008; Germany, 2007; Portugal, 2007; Slovenia, 2008).

¹¹ In this respect, it is interesting to note that alcohol has not been included in the 6 month work programs of the Spanish and Belgian Presidencies of the Council between 1 January and 30 June 2010 and 1 July and 31 December 2010, respectively (Spain, 2010; Belgium, 2010). However, alcohol is mentioned under “Public Health” in the common 18 month program of the Spanish, Belgian and Hungarian Presidencies covering the period 1 January 2010 to 30 June 2011 (Council, 2009b).

stated that “There is a concern for what will happen in the coming five years with a new European Parliament, new Commission and expected changes internally within DG SANCO – will the support be continued? (Eurocare, 2009, p. 11). These concerns seem justified given previous roller-coaster dynamics. However, I maintain that the institutional framework set up by European Commission and DG SANCO has made alcohol policy an area of significant activity at the EU level which may eventually contribute to the stabilization of substantial attention towards alcohol, health, and social welfare while, most importantly, keeping the issue high on the public policy agenda.

4 Towards a More Permanent Approach to Alcohol Policy in the European Union?

On the surface, alcohol, as an object of social concern, possesses qualities that can make it an easy victim of a so-called “attention cycle”, cyclically and gradually vanishing from its alternating positions as center of attention (Downs, 1972). First, although alcohol’s contribution to the burden of illness carried by individuals and societies, and alcohol’s harmful effect on the social fabric of families, communities, and nations is significant (see Babor et al., 2010), the general perception is often that the majority of persons in a society are not suffering from alcohol related problems nearly as much as a particular minority. It has for instance been extensively documented that most of the alcohol in a society is consumed by a relatively small minority of drinkers (Babor et al., 2010). Because a vast majority can be classified as “social moderate” rather than “heavy problem” drinkers and “abusers”, most people will therefore not be continually reminded of the problem by their own suffering from it.

Second, the sufferings caused by alcohol problems are generated by social arrangements that provide significant benefits to a majority or a powerful minority of the population. The production and sale of alcoholic beverages is an important part of the economy of many countries. It generates profits for a powerful minority of alcohol producers and retailers but it also generates tax revenues for the government that will benefit the entire society. Further, moderate drinking is often portrayed in media as a social act with potential benefits for the drinkers, a view that is backed by powerful alcohol lobby groups. Reducing alcohol consumption through the implementation of effective alcohol policies will therefore require fundamental changes to social institutions and behaviour while threatening powerful interests in society. Accordingly, keeping alcohol policy high on the political agenda is therefore associated with severe obstacles.

However, the third characteristic identified by Downs (1972) may have a stabilizing effect on attention devoted to alcohol and its place on the public policy agenda. Alcohol seems to possess exotic qualities that make it sufficiently dramatic and exciting to generate and sustain public interest. In this regard, the role of the media is crucial. According to Gusfield (1995), the portrayal of alcohol issues in news media tends to be simplistic, sensational, and dramatic. The use and abuse of alcohol by young people, in particular, seem to captivate the media. European news media reports on the use of “alcopops” played an important role in bringing alcohol to the EU’s political agenda. However, when it comes to breaking the “attention cycle”, the newly established structure for the implementation of the EU Alcohol Strategy may contribute to institutionalizing high public attention and keeping alcohol on the political agenda.

4.1 Institutionalization of Alcohol on the EU’s Political Agenda

According to Johan P. Olsen, institutionalization, as a process, implies that an organizational identity is developed and that its acceptance and legitimacy in a culture (or subculture) is built (2009, p. 10). To be sure, alcohol policy has been increasingly institutionalized at the EU level. This process is characterized by an increasing consensus that alcohol is not an ordinary consumer commodity and that its adverse health effects related to harmful and hazardous alcohol consumption should be addressed by the EU. Further, an organizational framework has been set up at the EU level that promotes the development of shared conceptions and increased clarity and agreement about the relation between alcohol, health and social welfare.

In order to promote legitimacy and good policy-making, the EU offers opportunities for policy participants to promote and discuss ideas on the European stage. To this end, the European Commission chairs and sponsors a wide range of relevant forums, working groups, and committees. In return, the Commission hopes that these informal networks can offer possibilities to expand EU activities into related policy areas (Héritier, 2002). In the area of health, DG SANCO is responsible for establishing consultative networks and since the adoption of the EU Alcohol Strategy in 2006, there has been considerable activity on the part of the Commission in this area. DG SANCO has established a structure for the implementation of the EU Alcohol Strategy that is based on three pillars: the Committee on National Alcohol Policy and Action; the European Alcohol and Health Forum; and the Committee on Data Collection, Indicators and Definitions.

4.1.1 The Committee on National Alcohol Policy and Action

The Committee on National Alcohol Policy and Action was established by DG SANCO in 2007, following the adoption of the Commission's Communication on the EU alcohol strategy (Commission, 2006). According to its mandate, the Committee is intended to play a major role in the implementation of the strategy by promoting coordination between national and EU alcohol polices and by contributing to further policy development in reducing alcohol-related harm.¹²

The Committee is composed of delegates from the member-states, who are appointed, upon request from the Commission services, by their governments. The Committee also includes observers from the European Free Trade Association (EFTA) and EU candidate countries, as well as observers from the WHO. Normally, one delegate will represent a member-state or serve as observer for an international organization at the meetings of the Committee.

The Committee on National Alcohol Policy and Action has been relatively active since its inception. It met for the first time in November 2007 and has since met six times (April 2008, October 2008, February 2009, June 2009, January 2010 and September 2010). Participation can be characterised as "good" because the meetings are consistently attended by representatives from approximately 20 member states, supplemented by a large group of observers from non-member states and international organizations (Commission, 2007a, 2008b, 2008c, 2009a, 2009b, 2010a, 2010c). However, concerns have been raised about the lack of consistency with regard to the national representation. According to Eurocare, member-states tend to be represented by different officials at the various meetings (Eurocare, 2009). Further, the European Commission is said to be consistently represented on a lower level and with few representatives from other units than Health Determinants (Eurocare, 2009). Be that as it may, the Committee on National Alcohol Policy and Actions contributes to the institutionalization of alcohol policy at the EU level.

4.1.2 The European Alcohol and Health Forum

The European Alcohol and Health Forum, which was established by the European Commission in June 2007, is composed of more than 60 non-governmental organisations and economic operators (alcohol producers, retailers, advertisers and publishers). The forum is scheduled to meet twice a year and the overall objective is

¹² Committee on National Alcohol Policy and Action: Mandate, Rules of Procedure and Work Plan (http://ec.europa.eu/health/ph_determinants/life_style/alcohol/documents/committee_mandate_en.pdf).

to provide a common platform for all interested EU stakeholders that pledge to step up actions relevant to reducing alcohol-related harm, notably in the following areas:

- Strategies aimed at curbing under-age drinking;
- Information and education programmes on the effect of harmful drinking and on responsible patterns of consumption;
- Possible development of efficient common approaches throughout the Community to provide adequate consumer information;
- Actions to better enforce age limits for selling and serving alcohol;
- Interventions promoting effective behavioural change among children and adolescents; and
- Cooperation to promote responsibility in and prevent irresponsible commercial communication and sales.

The European Alcohol and Health Forum is chaired by the Director General of DG SANCO, and it has been involved in much activity. The first plenary meeting of the Forum was held in October 2007 and has since met six times (April 2008, November 2008, March 2009, November 2009, March 2010 and November 2010). The plenary meetings are well-attended and more than 80 representatives, ranging from the “Brewers of Europe” and the “Scotch Whiskey Association” at one end of the spectrum to the “Estonian Temperance Union” and the “European Association for the Study of the Liver” at the other, participated in the March 2010 meeting (Commission, 2010b).

In addition to the plenary meetings, an Open Forum is held once a year in order to give interested non-member bodies and organisations from the EU and beyond an occasion to follow the work of the Forum and to make their opinions known. Further, the Forum has established two task forces, Task Force on Youth-Specific aspects of Alcohol and Task Force on Marketing Communication, and a Science Group, mandated to provide scientific guidance to members of the European Alcohol and Health Forum.

In addition to the seven plenary meetings that have been held, three Open Forums have been convened. The Task Force on Youth-Specific aspects of Alcohol, the Task Force on Marketing Communication and the Science Group have met four, six and seven times, respectively. Thus, a total of twenty-seven meetings have been held in the framework of the European Alcohol and Health Forum since 2007 which contributes significantly to the institutionalization of alcohol policy at the EU level.

4.1.3 The Committee on Data Collection, Indicators and Definitions

The Committee on Data Collection, Indicators and Definitions shall contribute to the establishment of reliable and comparable data on alcohol consumption, drinking patterns and harm, as well as of common indicators and definitions. It is composed of representatives from the member-states, the European Commission, WHO, ESPAD (European School Survey Project on Alcohol and Other Drugs), EMCDDA (European Monitoring Centre for Drugs and Drug Addiction) and other relevant bodies/organisations.¹³ Two meetings have been held since its establishment in 2007 and a majority of the participants at these meetings represented the European Commission (Commission, 2008a, 2009d).

Combining the activities of the various committees, 36 meetings have been held at the EU level between 2007 and 2010 to address the adverse health effects related to harmful and hazardous alcohol consumption. These meetings have certainly contributed to put alcohol policy on the EU political agenda.

Apart from stabilizing attention to the issue, what role do these meetings serve when it comes to the implementation of concrete measures on the relation between alcohol, health and social welfare? Again, it is important to emphasize that the role of these networks of EU officials and policy advocates are mostly informal and consultative due to the limited legal status of these issues in the EU. Ultimately, member states will have to press for more EU competencies in the area of public health in order for a binding EU alcohol policy to emerge. Nevertheless, a trend has been started and alcohol policy has succeeded in rising from a non-issue to an issue of importance to the EU. The former Director General of DG SANCO, Robert Madelin, who played a central role setting up the alcohol policy networks at the EU level, puts it this way:

“...the officials who come to the alcohol policy meetings seem encouraged by the fact that they have an EU level benchmark against which to push. But that’s very much at working level. What we lack, I think, is a big enough focus on public health promotion as a component of health responsibilities in most if not all Member States. So the existence of the Forum and the existence of the group of officials is not, in itself, delivering that and I don’t think it can. I don’t think the EU can tell Member States to rebalance towards more public health promotion, but the trend is there...” (Globe, 2009).

¹³ The EMCDDA was set up by the EU in 1993 in order to provide EU and its member states with a factual overview of European drug problems and a common information framework to support the drugs debate. Eurocare has promoted the establishment of a similar center in the area of alcohol (Eurocare, 2009).

The Commission is likely to include as many relevant actors as possible into policy networks in order to be seen as legitimate. Broad and flexible integration of groups and interests into policy networks can sometimes create rather oddly disparate compositions in the various forums, working-groups, and committees. For instance, the forum on Diet, Nutrition and Physical Activity incorporated actors as dissimilar as McDonald's and the European Health Forum (Greer, 2009). Similarly, DG SANCO invited representatives from the alcohol industry and public health advocates to participate in the European Alcohol and Health Forum.

In general, Commission networks are exceedingly open to participants from divergent perspectives because its objective is to become the central venue for health policy debate in Europe. Openness is legitimized further by the inclusion of non-member states. For instance, the European Free Trade Association (EFTA) members, Norway and Switzerland, have been formally granted observer status in the Committee on National Alcohol Policy and Actions. The Norwegian case is special. Although central components of Norwegian alcohol policies have been significantly impacted both directly and indirectly by the EU, Norway as a non-member is excluded from all formal decision-making processes. Norway has therefore relied more on informal mechanisms in order to put alcohol and health more firmly on the EU policy agenda. For instance, financed by the Norwegian government, the Norwegian Policy Network on Alcohol and Drugs (ACTIS), which is an umbrella organisation that brings together 26 NGOs, networks and foundations active in the field of alcohol and drug problems, has maintained a permanent lobby office in Brussels since 1995. The dual task of the Brussels office is to gather information about political developments concerning alcohol and drugs at the EU level, and to promote these issues vis-à-vis the EU institutions.

All in all, the institutional framework presented above was established by DG SANCO in order to implement the EU Alcohol Strategy. Although it is too early to formally evaluate the EU Alcohol Strategy, the various committees and forums supporting the implementation have been characterised by much activity and this organizational framework has contributed to the maintenance of a consistently acute awareness of alcohol issues and alcohol policy in the public domain while keeping alcohol as critical issue on the EU's political agenda.

5 Conclusion

Contrary to what many observers predicted, a European Union alcohol policy agenda has emerged. This report discusses why alcohol policy ended up as a topic for the EU and the status of alcohol policy on the EU's political agenda.

It is concluded that alcohol policy ended up on the EU's political agenda because a group of determined policy entrepreneurs, abetted by favourable political circumstances, managed to draw attention to a set of shared problems pertaining to alcohol, health, and social welfare in Europe. In particular, the European Commission successfully exploited a window of opportunity for alcohol policy developments after several EU institutions, member-states and non-governmental organizations raised concerns about under-age drinking and intoxication in the mid-1990s. Despite increased awareness, attention devoted to alcohol policy by the EU often seems to be unstable and transient. After periods of intense attention, alcohol policy seems to sooner or later drift away from the EU's political agenda. However, several forums and committees that deal specifically with alcohol policy have recently been established at the EU level. Policy-making in the EU will remain complex and it is difficult to predict the outcome of institutionalized processes. However, it is reasonable to assume that institutional advancements can, as they have in the past, continue to contribute to stabilizing a high level of alertness for the need of an effective alcohol policy to reduce harm in the long-term.

The Nordic countries have played central roles in the process of putting alcohol and health more firmly on the political agenda in the European Union. However, the EU Alcohol Strategy which is currently under implementation differs fundamentally from the comprehensive and formalised network of statutory regulations that have been used to control the total consumption of alcohol in the Nordic countries. Noticeably, the two main pillars of Nordic alcohol policies – the state alcohol monopoly systems and the high taxes and prices on alcoholic beverages – are not incorporated in the EU Alcohol Strategy, which instead rests and relies largely on informal, self-regulatory and self-imposed codes of regulations. However, what this report illustrates is that the need for actions and initiatives in

the area of alcohol and health is now increasingly shared among member states and EU institutions. Substantive debates in the EU about *if* alcohol should be regulated have been replaced by procedural debates about *how* alcohol should be regulated. The Nordic countries are likely to be at the forefront in the future discussions on levels and degrees of regulations of alcohol at the EU level.

All in all, during the last two decades the awareness of alcohol related problems, an issue that to a large extent had been neglected, has been raised significantly in the EU. Debates about how alcohol problems may be redressed have been initiated and several concrete proposals for actions in response to these problems have been developed and agreed to. These initiatives are supported by newly developed institutional practices that will contribute to structure co-operation and decision-making in the future. To be sure, the EU has taken important steps towards addressing Europe's heavy burden of alcohol related problems.

References

Babor, T., Caetano, R., Casswell, S., Edwards, G., Giesbrecht, N., Graham, K., et al. (2010). *Alcohol: No Ordinary Commodity: Research and Public Policy*. Oxford: Oxford University Press.

Belgium (2010). *Work Programme: Belgian Presidency of the Council of the European Union, 1 July – 31 December 2010*. Retrieved from http://www.eu2010.be/files/bveu/media/source1854/documents/27_782_PL_SPF_UK.pdf.

Börzel, T. & Panke, D. (2010). Europeanization. In M. Cini (Ed.), *European Union Politics* (pp. 405–417). New York: Oxford University Press.

Commission. (2000). *Proposal for a Council Recommendation on drinking of alcohol by children and adolescents, COM (2000) 736 Final, 27 November*. Luxembourg: Office for Official Publications of the European Communities

Commission. (2004). *Draft Minutes of the Meeting of the Working Group on Alcohol and Health, 9th and 10th June 2004, Luxembourg*. Retrieved 20 January, 2010 from http://ec.europa.eu/health/archive/ph_determinants/life_style/alcohol/documents/ev_20_040_609_mi_en.pdf.

Commission. (2006). *Communication from the Commission of 24 October 2006, “An EU strategy to support Member States in Reducing Alcohol-Related Harm”, COM(2006) 625 final*. Retrieved 27 January, 2010 from http://ec.europa.eu/health/ph_determinants/life_style/alcohol/alcohol_com_en.htm.

Commission. (2007a). *Committee on National Alcohol Policy and Action – Summary Report from the 1st Meeting in Luxembourg, 5 November 2007* Retrieved 29 April 2010 from http://ec.europa.eu/health/archive/ph_determinants/life_style/alcohol/documents/ev_20_071_105_en.pdf.

Commission. (2007b). *Speech by Markos Kyprianou, European Commissioner for Health: “The Fight against Alcohol-related Harm: Launch of the Alcohol and Health Forum”, 7 June*. Retrieved 29 April 2010 from <http://europa.eu/rapid/pressReleasesAction.do?reference=SPEECH/07/372&format=HTML&aged=1&language=EN&guiLanguage=en>.

Commission. (2008a). *Committee on Data Collection, Indicators and Definitions – Summary Report from the 1st Meeting in Luxembourg, 4 December 2008*. Retrieved 30 April 2010 from http://ec.europa.eu/health/archive/ph_determinants/life_style/alcohol/forum/docs/ev_20_081_204_mi_en.pdf.

Commission. (2008b). *Committee on National Alcohol Policy and Action – Summary Report from the 2nd meeting in Barcelona, 2 April 2008*. Retrieved 29 April 2010 from http://ec.europa.eu/health/archive/ph_determinants/life_style/alcohol/documents/ev_20_080_402_en.pdf.

Commission. (2008c). *Committee on National Alcohol Policy and Action – Summary Report from the 3rd meeting in Luxembourg, 13–14 October 2008*. Retrieved from http://ec.europa.eu/health/archive/ph_determinants/life_style/alcohol/forum/docs/ev_20_081_013_mi_en.pdf

Commission. (2009a). *Committee on National Alcohol Policy and Action – Summary Report from the 4th meeting in Luxembourg, 17–18 February 2009*. Retrieved from http://ec.europa.eu/health/archive/ph_determinants/life_style/alcohol/documents/ev_20_090_217_mi_en.pdf

Commission. (2009b). *Committee on National Alcohol Policy and Action – Summary Report from the 5th meeting in Luxembourg, 24–25 June 2009*. Retrieved from http://ec.europa.eu/health/archive/ph_determinants/life_style/alcohol/documents/ev_20_090_624_mi_en.pdf

Commission. (2009c). *First Progress Report on the Implementation of the EU Alcohol Strategy*. Retrieved 27 January 2010 from http://ec.europa.eu/health/archive/ph_determinants/life_style/alcohol/documents/alcohol_progress.pdf.

Commission. (2009d). *Committee on Data Collection, Indicators and Definitions – Summary Report from the 2nd Meeting in Luxembourg, 1 September 2009*. Retrieved 30 December 2010 from http://ec.europa.eu/health/indicators/events/alcohol_committee_mtg_2_2009-09_minutes_final.pdf.

Commission. (2010a). *Committee on National Alcohol Policy and Action – Summary Report from the 6th Meeting in Luxembourg, 27–28 January 2010*. Retrieved from http://ec.europa.eu/health/alcohol/docs/ev_20_100_127_mi_en.pdf

Commission. (2010b). *European Alcohol and Health Forum – Summary Report from the 6th Plenary Meeting in Brussels, 11 March 2010*. Retrieved 29 April 2010 from http://ec.europa.eu/health/alcohol/docs/ev_20_100_311_mi_en.pdf.

Commission. (2010c). *Committee on National Alcohol Policy and Action – Summary Report from the 7th Meeting in Luxembourg, 14–15 September 2010*. Retrieved from http://ec.europa.eu/health/alcohol/docs/ev_20_100_914_mi_en.pdf

Council. (1986). *Resolution of the Council and of the Representatives of the Governments of the Member States, meeting within the Council, of 29 May 1986, on alcohol abuse (OJ C 184, 23.7.1986, p. 3)*.

Council. (2001a). *Council Conclusions of 5 June 2001 on a Community strategy to reduce alcohol-related harm (OJ C 175, 20.6.2001)*.

Council. (2001b). *Council Recommendation of 5 June 2001 on the Drinking of Alcohol by Young People, in Particular Children and Adolescents, 2001/458/EC (OJ L 161, 16.6.2001, p. 38)*.

Council. (2004). *Operational Programme of the Council for 2005 submitted by the incoming Luxembourg and United Kingdom Presidencies*. Retrieved 25 January 2010 from http://www.eu2005.lu/en/presidence/priorites_et_pgm/programme_pres/Operational_programme_2005.pdf.

Council. (2005). *Operational Programme of the Council for 2006 submitted by the incoming Austrian and Finnish Presidencies*. Retrieved 25 January 2010 from http://www.eu2006.fi/THE_PRESIDENCY/EN_GB/WORK_PROGRAMME/_FILES/75_197_089_060_421_975/DEFAULT/ST16_065_EN05.PDF.

Council. (2006). *Council Conclusions on EU Strategy to Reduce Alcohol-Related Harm, 30 November – 1 December 2006 (16 165/06)*.

Council. (2009a). *Council Conclusions on Alcohol and Health, 2980th Employment, Social Policy, Health and Consumer Affairs Council meeting, Brussels, 1 December 2009*.

Council. (2009b). *Draft 18 Month Programme of Prepared by the Spanish, Belgian and Hungarian Presidencies (1 January 2010 – 30 June 2011), Brussels, 27*

November. Retrieved 28 July 2010 from http://register.consilium.europa.eu/pdf/en/09/st16/st16_771.en09.pdf.

Czech Republic. (2009). *Work Programme – Czech Presidency of the Council of the European Union, 1 January – 30 June 2010*. Retrieved 25 January 2010 from www.eu2009.cz/scripts/file.php?id=6226&down=yes.

Denmark. (2002). *Work Programme: Danish Presidency of the Council of the European Union, 1 July – 31 December 2002*. Retrieved 25 January 2002 from <http://www.fco.gov.uk/resources/en/pdf/pdf2/danishpresidencyprogramme>.

Downs, A. (1972). Up and down with Ecology – the “issue attention cycle”. *Public Interest*, 26 (Summer), 38–57.

Egeberg, M. (2010). The European Commission. In M. Cini (Ed.), *European Union Politics* (pp. 125–140). New York: Oxford University Press.

Egeberg, M. (Ed.). (2006). *Multilevel Union Administration: The Transformation of Executive Politics in Europe*. Basingstoke: Palgrave Macmillan.

Eurocare. (2009). *Eurocare Overview and Recommendations for a Sustainable EU Alcohol Strategy*. Eurocare.

Fahrenkrug, H. (1990). Alkoholpolitik i EG's medlemsstater. In C. Tigerstedt (Ed.), *EG, alkohol och Norden* (pp. 55–70). Helsinki: NAD.

Finland. (1999). *Work Programme – Finnish Presidency of the Council of the European Union, 1 July – 31 December 1999*. Retrieved 18 September 2002 from <http://presidency.finland.fi>.

France. (2008). *Work Programme: French Presidency of the Council of the European Union, 1 July – 31 December 2008*. Retrieved 25 January 2010 from http://ue2008.fr/webdav/site/PFUE/shared/ProgrammePFUE/Programme_EN.pdf.

Germany. (2007). *Work Programme: German Presidency of the Council of the European Union, 1 January – 30 June 2007*. Retrieved 25 January 2010 from http://www.eu2007.de/includes/Downloads/Praesidentschaftsprogramm/EU_Presidency_Programme_final.pdf.

Globe. (2009). Robert Madelin: European Commission does not support ‘an apartheid’ approach to alcohol policy making. (3), 14–17.

Greer, S. L. (2009). *The Politics of European Union Health Policies*. Maidenhead: Open University Press.

Gusfield, J. (1995). Meta-analytic Perspective on ‘Alcohol’ in American Culture In S. E. Martin & P. Mail (Eds.), *Effects of the Mass Media on the Use and Abuse of Alcohol* (pp. 31–35). Bethesda, Maryland: National Institute on Alcohol Abuse and Alcoholism.

Hayes-Renshaw, F., & Wallace, H. (1997). *The Council of Ministers*. Basingstoke: Macmillan.

Héritier, A. (2002). New Modes of Governance in Europe: Policy Making Without Legislation? In A. Héritier (Ed.), *Common Goods: Reinventing European and International Governance* (pp. 185–206). Boulder, Co: Rowman and Littlefield.

Hibell, B. & B. Andersson (2006): The ESPAD Project: Purpose, target population, data collection, economy and governance. Retrived 2 January 2011 from http://www.espad.org/documents/Espad/Documents/The_ESPAD_History.pdf.

Holder, H., Kühnlhorn, E., Nordlund, S., Österberg, E., Rommelsjö, A., & Ugland, T. (1998). *European Integration and Nordic Alcohol Control Policies* Aldershot: Ashgate.

Ireland. (2004). *Work Programme: Irish Presidency of the Council of the European Union, 1 January – 30 June 2004*. Retrieved 25 January 2010 from http://eurojournal.org/files/work_prog.doc.

Italy. (2003). *Work Programme: Italian Presidency of the Council of the European Union, 1 July – 31 December 2003*. Retrieved 15 July 2003 from http://www.euitaly2003.it/NR/rdonlyres/57F9D4ED-4498-47F5-A4ED-73FE0BF965AC/0/ProgrammaPresidenza_ING.pdf.

Karlsson, T. (2008). Finlands, Norges och Sveriges alkoholpolitiska linjedragningar sedan ”ödesåret” 2004. *Nordisk Alkohol & Narkotikatidskrift*, 25(3), 205–222.

Karlsson, T., & Österberg, E. (2001). A Scale of Formal Alcohol Control Policy in 15 European Countries. *Nordisk Alkohol & Narkotikatidskrift (English Supplement)*, 18, 117–129.

Karlsson, T., & Tigerstedt, C. (2004). Testing New Models in Finnish, Norwegian and Sweden Alcohol Policies. *Nordic Studies on Alcohol and Drugs*, 21, 71–91.

Kingdon, J. W. (1995). *Agendas, Alternatives and Public Policies* (2nd ed.). New York: HarperCollins.

Netherlands. (2004). *Work Programme: Dutch Presidency of the Council of the European Union, 1 July – 31 December 2004*. Retrieved 25 January 2010 from http://www.anacom.pt/streaming/Dutch.pdf?categoryId=119200&contentId=208151&field=ATTACHED_FILE.

Olsen, J. P. (2009). Change and Continuity: An institutional Approach to Institutions of Democratic Government. *European Political Science Review*, 1(1), 3–32.

Örnberg, J. C. (2008). The Europeanization of Swedish Alcohol Policy: The Case of ECAS. *Journal of European Social Policy*, 18(4), 380–392.

Portugal. (2007). *Work Programme: Portuguese Presidency of the Council of the European Union, 1 July – 31 December 2007*. Retrieved 25 January 2010 from <http://www.ue2007.pt/NR/rdonlyres/B9B87547-C363-43FB-A5FF-67D4D2C39B72/0/PrioridadesEN.pdf>.

Princen, S. (2007). Agenda-Setting in the European Union: A Theoretical Exploration and Agenda for Research. *Journal of European Public Policy*, 14(1), 21–38.

Princen, S., & Rhinard, M. (2006). Crashing and Creeping: Agenda-Setting Dynamics in the European Union. *Journal of European Public Policy*, 13(7), 1119–1132.

Rehn, N., Room, R., & Edwards, G. (2001). *Alcohol in the European Region – Consumption, Harm and Policies*. Copenhagen: WHO Regional Office for Europe.

Simpura, J. (1997). Alcohol and European Transformation. *Addiction*, 92(Supplement 1), S33-S41.

Slovenia. (2008). *Work Programme – Slovenian Presidency of the Council of the European Union, 1 January – 30 June 2008*. Retrieved 25 January 2010 from http://www.eu2008.si/includes/Downloads/misc/program/Programme_en.pdf.

Spain. (2010). *Work Programme – Spanish Presidency of the Council of the European Union, 1 January – 30 June 2010*. Retrieved 25 January 2010 from http://www.eu2010.es/export/sites/presidencia/comun/descargas/Spanish_Presidency_Program.pdf.

Sweden. (2001). *Work Programme – Swedish Presidency of the Council of the European Union, 1 January – 30 June 2001*. Retrieved 10 January 2001 from <http://www.eu2001.se>.

Sweden. (2009). *Work Programme: Swedish Presidency of the Council of the European Union, 1 July – 31 December 2009*. Retrieved 25 January 2010 from http://www.se2009.eu/polopoly_fs/1.6255!menu/standard/file/Arbetsprogram%20f%C3%B6r%20det%20svenska%20ordf%C3%B6randskapet%20i%20EU%201%20juli-31%20dec%202009.pdf.

Tallberg, J. (2003). The Agenda-Shaping Powers of EU Council Presidency. *Journal of European Public Policy*, 10(1), 1–19.

Ugland, T. (2000). Impact of Europeanization on Nordic alcohol control policies: a discussion of processes and national differences. *Journal of European Social Policy*, 10(1), 58–67.

Ugland, T. (2002). *Policy Re-categorization and Integration: Europeanization of Nordic Alcohol Control Policies*. Oslo: ARENA.

Ugland, T. (2003a). Adaptation and Integration through Policy Re-categorization. *Journal of Public Policy*, 23(02), 157–170.

Ugland, T. (2003b). Making Policy in the EU: The Case of the Council Recommendation on the Drinking of Alcohol by Young People. *Contemporary Drug Problems*, 30(4), 739–755

Appendix: Informants

Bernt Bull, Senior Adviser, Norwegian Ministry of Health and Care Services, Oslo, 5 February 2010.

Pieter de Coninck, European Commission, Directorate General Health and Consumers (DG SANCO), Directorate Public Health and Risk Assessment, Brussels, 22 April 2010.

Michel Craplet, Chairman, European Alcohol Policy Alliance (Eurocare), Brussels, 21 April 2010.

Claude Riviere, Head of European and International Affairs, Association Nationale de Prévention en Alcoologie et Addictologie (France), Brussels, 21 April 2010.

Ruth Ruiz, Policy and Information Officer, European Alcohol Policy Alliance (Eurocare), Brussels, 21 April 2010.

Mariann Skar, Secretary General, European Alcohol Policy Alliance (Eurocare), Brussels, 21 April 2010.

Anders Ulstein, Head of International Department, Norwegian Policy Network on Alcohol and Drugs, Oslo, 8 February 2010

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5/2010 Rossow, Ingeborg, Hilde Pape & Bergljot Bakken *Tiltak for å begrense alkoholrelaterte skader og problemer*. 74 s. Oslo 2010

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4/2006 Larsen, Elisabeth, Jostein Rise & Pål Kraft *En evaluering av tobakkskampanjen «Hver eneste sigarett skader deg»*. 53 s. Oslo 2006.

3/2006 Larsen, Elisabeth, Karl Erik Lund og Jostein Rise *Evaluering av tobakkskampanjen «Røyken tar pusten fra deg»*. 116 s. Oslo 2006.

2/2006 Lund, Karl Erik *The introduction of smoke-free hospitality venues in Norway. Impact on revenues, frequency of patronage, satisfaction and compliance*. Evaluation of public tobacco control work in Norway 2003–2007. 110 s. Oslo 2006.

1/2006 Lund, Karl Erik *Innføring av røykfrie serveringssteder i Norge. Konsekvenser for omsetning, besøksfrekvens, trivsel og etterlevelse*. 121 s. Oslo 2006.

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