Commentary

“It’s the Population, Stupid”: Why Changing
the Policy Frame Should Help Scotland
Tackle Its Problem with Cheap Alcohol

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AFTER A BRUISING PRIMARY CAMPAIGN, BILL CLINTON STARTED the 1992 presidential election well behind in the polls. That spring, he trailed both the incumbent Republican president, George H.W. Bush, and the independent, Ross Perot. Before too long, however, the euphoria of Operation Desert Storm began to fade and was replaced by widespread concerns over a faltering American economy. At this late date, everyone knows how the story ended: the self-proclaimed “Comeback Kid” dominated election day and won the presidency by carrying 32 states and the District of Columbia.¹

The man whom many credit with this victory, political strategist James Carville, reportedly hung a sign in Clinton’s campaign headquarters making 3 points: (1) the importance of emphasizing change versus the status quo, (2) the even greater importance of health care reform, and (3) the centrality of the economy. Originally intended as a quip in an internal memorandum, his statement “It’s the economy, stupid” soon became the informal slogan of the Clinton/Gore campaign. Reframing the debate from one of military success to one of economic failure changed the election and, with it, contemporary American history.²

In this issue of *The Milbank Quarterly*, S.V. Katikireddi and colleagues discuss political reframing in the more focused, but never the less important, context of alcohol policy.³ Drawing on their detailed study of parliamentary records and an analysis of extensive interviews with relevant participants, they explore the case of my homeland Scotland and its success in becoming the first country in the world to pass legislation introducing a minimum unit price (MUP) for alcohol.⁴⁻⁶

The context of this work is important to explain. Until recently, Scotland attracted the unwanted sobriquet of “the sick man of Europe.” Our premature death rates were excessive, even when postindustrial

socioeconomic stagnation was taken into account. Our health inequalities were shameful. But in recent years, something rather remarkable has begun.⁷ Drawing on the increased powers delivered by political devolution, the Scottish parliament has started to forge its own public health path.⁸ Introducing a ban on indoor smoking ahead of other parts of the United Kingdom—despite intense opposition from London, for example—reduced hospital admissions for coronary events by 17%.⁹ Political reframing was key to achieving that public health victory. Opposition to public-smoking bans focused on passive smoking as a nuisance. Government-backed public service announcements, however, correctly recast it as a killer.¹⁰

With alcohol, the challenge was different. The alcohol industry tends to focus on the problem of specific groups: the heavily addicted or alcoholics, drunk drivers, pregnant women, and drunk and disruptive youth. It is a smart strategy. No one is in favor of drunk drivers or pregnant women drinking (at least more than minimally). The heavily addicted who live on our streets or inhabit our jails elicit only limited sympathy, and drunk, disruptive, and, by inference, dangerous youth scare “respectable” middle-aged men and women. Yet none of these “targeted” customers are in any way central to the alcohol industry’s profits. The industry can well afford to be against those who spend relatively little on its product and whose antisocial antics cost so much in terms of both these companies’ reputations and society at large. What it cannot (or at least feels it cannot) allow to happen is for the debate to shift its focus to the mainstream, nonaddicted, but quietly self-damaging chronic drinker; indeed, that is precisely with whom every distillery’s and alcohol producer’s sales and profits lie.

Scotland’s alcohol problem was never one of legions of drunk drivers or gaggles of drinking pregnant women any more than it was the sad cases that occupy doorways or drunk cells at night. It was always far more about the quiet, excessive, deeply physically damaging consumption of overly cheap alcohol, often bought from supermarkets or local off-license shops, that is consumed at home each night, producing ever-younger patients suffering cirrhotic livers and premature death.¹¹ In other words, “It’s the population, stupid.”

That is why the work of Katikireddi and his colleagues matters so much. They delved into the political and lobbying process to analyze the positions taken and identified the crucial importance of reframing the issue of excess alcohol consumption from one that marginalized

economically disposable consumers to one that tackled the very heart of the issue: Alcohol sold in Scotland was far too cheap, and as a result we all were consuming too much and injuring our collective health.

Sadly, the alcohol industry continues to fight this issue. Thus far, it has managed to delay the legislation's implementation through a series of legal challenges. The use of the Scotch Whisky Association¹² to front that challenge is opportunistic and cynical, and its intransigence is backward looking and shortsighted.

The industry could, and should, take another tack. As the deputy chief medical officer for Scotland at the time we envisaged the original MUP approach, I met with industry representatives and took great pains to make it clear that we were not against their businesses, trade, or profits. To the contrary, my colleagues and I agreed with the alcohol producers that their financial success was a boon for the Scottish economy and, within reason, good for the public's health. But as health officials, we reminded these companies that we were seeking just one thing: to decrease the total amount of ethanol consumed by the Scottish population so that it did not cause so much damage to its collective health.

The two things are not, and never were, incompatible. Alcohol companies constantly reformat, rebrand, and remarket their products. Many are profitable global companies with the very best brewing, distilling, and marketing talent at their disposal. If they wanted to make and promote products containing less alcohol, they could. If they wished to engage with the government on maintaining profits while reducing harm, they could. Their adoption of a path of opposition and obstruction makes them seem increasingly like a new incarnation of the tobacco industry. Perhaps it is that case, then, that should attract the attention of the alcohol companies' chief executives and their shareholders. The first class-action suits for alcohol damage will not come from those marginal groups that they currently seek to demonize. Rather, they will emerge from local and national governments, with popular backing, seeking redress against the excess costs and personal damage they incur.

As for the Clinton-Carville phrase, it has long since taken on a life of its own as a political snowclone, "a multi-use, customizable, instantly recognizable, time-worn, quoted or misquoted phrase or sentence that can be used in an entirely open array of different jokey variants by lazy journalists and writers."¹³ While I have no desire to be rhetorically lazy, it is my hope that the Clinton-Carville phrase may soon take on a new variant when explaining what must drive governmental alcohol

policy in the 21st century. To put it quite simply, “It’s the population, stupid!”

References

1. Federal Election Commission. Federal elections 92: election results for the US president, the US Senate and the US House of Representatives. June 1993. <http://www.fec.gov/pubrec/fe1992/federalelections92.pdf>. Accessed February 27, 2014.
2. *New York Times*. October 31, 1992. <http://www.nytimes.com/1992/10/31/us/1992-campaign-democrats-clinton-bush-compete-be-champion-change-democrat-fights.html>. Accessed February 24, 2014.
3. Katikireddi SV, Bond L, Hilton S. Changing policy framing as a deliberate strategy for public health advocacy: a qualitative policy case study of minimum unit pricing of alcohol. *Milbank Q*. 2014;92(2):250-283.
4. Katikireddi SV, Bond L, Hilton S. Perspectives on econometric modelling to inform policy: a UK qualitative case study of minimum unit pricing of alcohol. *Eur J Public Health* [published online December 23, 2013]. <http://eurpub.oxfordjournals.org/cgi/pmidlookup?view=long&pmid=24367068>. Accessed February 24, 2014.
5. Hilton S, Wood K, Patterson C, Katikireddi SV. Implications for alcohol minimum unit pricing advocacy: what can we learn for public health from UK newsprint coverage of key claim-makers in the policy debate? *Soc Sci Med*. 2014;102:157-164. <http://www.sciencedirect.com/science/article/pii/S0277953613006539>. Accessed February 24, 2014.
6. Wood K, Patterson C, Katikireddi SV, Hilton S. Harms to “others” from alcohol consumption in the minimum unit pricing policy debate: a qualitative content analysis of UK newspapers (2005–12) [published online November 27, 2013]. *Addiction*. doi: 10.1111/add.12427.
7. Fox D. Health inequality and governance since 2007. *Public Health*. 2013;127(6):503-513.
8. Smith KE, Collin J. Scotland and the public health politics of independence. *BMJ* 2013;347:f7595. doi: <http://dx.doi.org/10.1136/bmj.f7595>.
9. Donnelly P, Whittle P. After the smoke has cleared—reflections on Scotland’s tobacco control legislation. *Public Health*. 2008;122(8):762-766. doi: 10.1016/j.puhe.2008.03.003.

10. Pell JP, Haw S, Cobbe S, et al. Smoke-free legislation and hospitalizations for acute coronary syndrome. *N Engl J Med*. 2008;359:482-491. doi:10.1056/NEJMsa0706740.
11. Leon DA, McCambridge J. Liver cirrhosis mortality rates in Britain from 1950 to 2002: an analysis of routine data. *Lancet*. 2006;367(9504):52-56.
12. Institute of Alcohol Studies. Scotch whisky industry challenges minimum pricing of alcohol. *Alcohol Alert*. 2012; Issue 2. <http://www.ias.org.uk/What-we-do/Publication-archive/Alcohol-Alert/Issue-2-2012/Scotch-whisky-industry-challenges-minimum-pricing-of-alcohol.aspx>. Accessed February 24, 2014.
13. Pullum, GK. Phrases for lazy writers in kit form. Published on Language Log website, October 27, 2003. <http://itre.cis.upenn.edu/~myl/languagelog/archives/000061.html>. Accessed February 24, 2014.

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