From Subsidiary to Policy Networks
The Dynamic of Alcohol Discourses in Europe (1800 – 2000)

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“Why all this noise about wine and strong drink?” It is 1772, Benjamin Rush, future leader of American psychiatry, anticipating the critics, is revealing his intention to make a dent in this consensus (Rush 1772: 22). Until the end of the 19th century, alcohol was seen as a product of medicinal virtue, a social habit, a foodstuff, “a good creature of God”. Neither the growing quantities being consumed nor the frequent public displays of intoxication seemed to disturb the social order (Levine 1978). Symbolically, it is certain that this observation begins the story of problems associated with the consumption of alcohol, which until then had seemed ordinary. From then on, a new discursive field emerged, formed and developed itself, as much in the United States of America as in Western Europe.

Consider for a moment the unfolding of this long conversation from a comparative perspective. We are struck, first of all, by the similarity of evolution in western countries. In fact, from the gap opened at the end of the 18th century until the present day, alcohol related problems have followed a series of identical phases. This phenomenon reveals itself in the prevailing use of terminology specific to each era, which determines the issues on which the discourse is based. In this way, it is the excessive drinker, the drunkard, that is the focus of attention. The explanation of this behaviour is a matter of “dependence” and “sin”, two terms badly differentiated. However, do not be mistaken, since the end of the 19th century, it is no longer the state of the drinkers soul, but the social consequences of excessive drinking which are the main concerns. Very quickly, the number of drunkards will reflect the degeneration which threatens society as a whole. At the turn of the century, the drink out-shadowed the drinker; attention no longer centres on the person but on the product. The veiled threat which alcohol poses to the future of western countries and the social groups which are a part of them, clearly structures the discursive field.

The Second World War marked a downturn in the evolution of this discourse. A new type of persona asserted itself in European countries: the alcoholic; an individual suffering from an illness which corresponds to scientifically defined characteristics. Attention re-centres itself on the invisible part of the problem. Now it is inside the body itself where this drama unfolds, while nevertheless presenting itself rather noisily on the social scene of the 19th century. Alcohol is no longer the main issue, nor is the behaviour of the drunkard, rather it is alcoholism – a physical disposition towards excessive alcohol consumption.

This narrow view has, throughout the 1970's come up against competition from an intellectual offensive based around the concept of "total consumption" or "Population based model". The idea is that it is the general behaviour of the population which poses a problem to public health and which must be regulated by political measures which control the accessibility of alcohol. More recently, a new revelation is beginning to make itself felt – that

1 Translated by: Jean-Claire Flanagan, Susan Masterson and Mairéad Mullins
2 Significantly, Victorian England counts **** ways of speaking about public drunkenness
of alcohol related problems and harm reduction. The concept displays the multiplicity of discourses on alcohol. Significantly, problems are not defined, apart from these discourses.

This first look at the dominant terms in discourses on alcohol highlights the same five main issues focused on in European countries. These are the drunkard, alcohol, alcoholism, the global population and alcohol related problems (or risk). And yet (and it is the second point), the problem of each of these issues, both at the level of discourse production and its implications, can be traced back to a particular social sub-system. In this case the drunkard recovers from a moral problem whereas the new view on alcohol allows the transition towards a specifically political debate. Alcoholism succeeds alcohol as a typically scientific concept (ism) which in itself temporarily eliminated the social and political dimensions of this discourse. The latter is reintroduced, or rather solicited in the discourse on global population, although it presents itself in the manner of a technical neutrality; in order to better highlight its instrumental character the discourse establishes itself as the scientific support of a rational policy, following the typical decisionist model (Habermas 1973). Today, the political dimension of discourses on alcohol takes a different form, drained of its ideological substance, as is shown by the concept of alcohol related problems – a standard formulation of public politics inspired by new ways of governance.

Finally, we can noted at this preliminary stage of the comparison that the public sphere appears to be subjected to a series of expansions and retractions – helped in that by the variable degree of polysemy of the reference concept, and that it can be characterised at each stage by the degree of intensity of the debate. Such as, if the drunkard was spoken about by the elite without major opposition, they alone being shocked by a behaviour characteristic, quite easily identifiable and which primarily distinguishes itself, the “question of alcohol”, occupied the public sphere throughout the 19th century (so many pamphlets, novels, treaties, articles and political standpoint!) causing conflicts following lines of variable forces but leaving little space for neutrality. Now, on the contrary, the undefined character of the threat has certainly helped the social appropriation of the problem by a large spectrum of social groups.

Curiously perhaps, this debate while intense which could be resolved or transformed seems to have gradually quietened down having lost its vigour and significance in the course of the 20th century. Whereas medical discourse has progressively gained ground. Compared to the uproar which proceeded, the Glorious Thirties appeared to be years of whispering behind closed doors. The debates confine themselves to specialised fields (scientific and technocratic) and the distribution of a discursive field which is established according to a hierarchical order guaranteeing the absence of conflict: the dominant discourses deal with alcoholism; the life experience of alcoholics is left for profane discourses. Alcohol continues to be popular, but contrary to the last century, it has now become commonplace. Public discourses which have an effect are clearly advertisements. The drunkard is banished to the museum of historical mistakes, like a pre scientific thought, giving rise at best, to complacency.

Lastly, in the 1970s, there was a renewal of the debate which for the first time spread from the scientific sphere of the political world in an offensive and dualistic logic (which is what I call the « coming out » of a new « coalition » which attempts to create a new subject of concern; the « global population ». Except in Nordic countries, this conflict is essentially of an epistemic nature (Maggi 2000) and concerns exclusively the scientific, professional and political elite. Subsequently, this discussion which deals with the notion of alcohol related problems, seems to pass from the political system to society, which is the opposite to what happened in the 19th century. In terms of occupying public sphere, alcohol can boast having won some ground compared to the silence of the previous years. On the other hand, in terms
of intensity of conflict, we can detect a hardening in extreme positions, followed by a process of reconstruction of discourse coalitions based on a centre still weakly structured.

My intention is to detail and discuss this discursive dynamic common to all European countries. In fact, this evolution does not correspond to the simple expression of a growing social complexity (Luhman 1992): periods of discursive simplification are followed by periods of increasing complexity. It no longer corresponds to the model of political learning (Heclo 1974) which supposes the replacement of erroneous paradigms by a more efficient view of the problem, which can be credited to increasing scientific knowledge and to experiences drawn from past policies. On the contrary, the acceptance of a concept (e.g., alcoholism as a scientific concept) seems to depend more on its viability than its validity (Spector & Kituse 1977).

On the other hand, a coincidence can be seen between discursive structuring and the different forms that solidarity organisations have taken throughout history (Butschi/Cattacin 1994, Wilke 1991, Morand 2000). In the course of this article I will try to explore the hypothesis according to which the evolution of discourse on alcohol depends, principally the transformation of the place of the State in society, its role and its workings. In fact, the State is an important actor within the system of welfare: it is the only legitimate symbol of the unity of society. For this reason, I will leave the principal that the discursive field of an era bases itself on the public discourses, in a manner which remains unclarified.

Schematically, the first response to the social problem concerns the self-regulation of society. The State only intervenes in a subsidiary manner implementing rudimentary legal frameworks (Wilke 1991). This State, sometimes described as liberal, will, starting from the end of the 19th century, progress towards a more interventionist form. This form was to be succeeded after the Second World War by The Providence State model and its refreshing and redistributing social policies due to a means of intervention favoured during that period: money. Finally, following the crises of the 1970s (financial, legitimatisation and governing crises in an ever more complex social context), social policies tended to be conceived and implemented in a more decentralised and less hierarchical way, through policy networks. These were composed of actors of different types and in which the State plays the role of mediator or regulator. Information consequently appears as a method of intervention favoured by the State to exert pressure on society (Freiburghaus 1991, Papadopoulous 1995).

How does this advancement reflect itself in transformation discourses? In order to explore this problematic, I will concentrate on the field of study dealing with the battle against alcohol related problems. This does not mean, however, that I claim to write the history of social representations on alcohol but rather to clarify the transformations of policies regarding this matter. My approach to the tangible political field could be qualified as relational. This approach has as its most profound characteristic, the abandonment of defining the object of research as a priority, but more so as an arbitrary demarcation. This will soon be identified by “the limits of its effects or, in other terms, by the network of relations which it produces” (Bütschi/Cattacin, 1994, p.42). In a social field, a relational approach implies a change in the expression welfare state to the welfare society or (according to the terms of Evers 1990) the welfare mix. This perspective allows us to characterise the relations between actors of different types (public or private, for profit or non profit) and to interest us in the emerging effects of the relation itself.

In the same way it is possible to identify a political field I believe it possible in this relational perspective to identify a discursive field. The view presupposes some points. In effect, a brief look at the main discursive transformations on alcohol could suggest a succession of paradigms that periods of interpretative crises would have come to reassess. However, this vision of change seems to us to be over simplistic. It is thought rather, that the
discursive field as it can be characterised at a given period is not homogenous, but that it reveals at the same time both the particular agreement of a multiplicity of discourses and that of a number of power struggles. According to Hajer (1997: 44) we understand discourse as “a specific ensemble of ideas, concepts and categorizations that are produced, reproduced and transformed in a particular set of practices and through which meaning is given to physical and social realities”. From a relational perspective, the discourse is only definable to the extent where it is part of an environment in which it distinguishes itself as it deals with making sense of a physical or social reality, in relation to the number of past, present or even future discourses. It is therefore the collection of these relations which makes up the discursive field.

Methodologically, the analysis of discourse which is outlined here is based on the comparison of fourteen European examples (Germany, Austria, Denmark, Spain, Finland, France, Great Britain, Italy, Norway, Sweden, Switzerland, the Netherlands and Portugal), whose common development is put into perspective with that of the United States. It consists of reconstructing the common discursive field at a meso-level (on the basis of secondary literature and available resources) before discussing its dynamic in light of organisational characteristics of Welfare States in each phase. To proceed with this reconstruction I rely on produced and reproduced discourses, but also on institutionalised practices, which can be considered as solid expressions of the discourse. Similarly, the adoption of a form of treatment will be retained as a fragment of the medical discourse on alcohol.

In the course of this article, I will try to describe the emerging discourses on alcohol at the turn of the 19th century, the structuration of the discursive space and the positioning games during the agenda setting process (1850-1930) and the impact of the first "référentiels" (1880-1930). Then, I will observe the process of diffusion and dominance of the disease model (1940-1975) and the opening of a new discursive conflict (1975-1990). In the last period (1990-2000), a redefinition of discourses and coalitions is seen. For each of these steps I consider the changing and relative role of the state in this process of (re)definition, implementation and legitimisation of policy, in the context of growing social complexity. In conclusion, I will question the correlation that is often supposed in the literature about new forms of governance: do the new policy network designs and the informative and incitating role of state observed in alcohol policy as in other social policy field (Cattacin et al. 1996, Cattacin /Panchaud 1997) really support a more open discursive space?

1. Discursive structuring in a subsidiarity context (1800-1939): from auto-regulation to public intervention

The problematisation of alcohol consumption during the 19th century and up until the Second World War effectuated itself in a discursive context dominated by the actors of civil society. Despite undeniable national variations, it is neither at the level of the private sphere and “primary” solidarities (families) nor at the State level (a non-interventionist bourgeois State) that the question of alcohol is most significantly asked. In this context, however, I have noticed an evolution in the discursive field: during this period, in fact, the moral discourse, which played a substantial part at the beginning, ceded it position to a medical and coercitive view of the problem.

Contrary to what a rapid reading of the history of ideas on alcohol could lead one to believe, it is not simply a linear conceptual evolution, and it is difficult to interpret the success of the Disease model as the simple victory of one “advocacy coalition” (Sabatier, 1998) over another. On the other hand, following the theoretic course proposed in the introduction, we we assisted effectively, until the Second World War, with a process of construction and
resolution of alcohol related problems which follows the logic of a subsidiary intervention by the State to society. Firstly, the discursive field structures itself according to the relationships between principal social groups. Then, the argumentation becomes political and bases itself on the public referential (Jobert/muller 1987); looking to justify State intervention according to its standards. Finally, the response of the latter confirms the role of State police, guaranteeing public order – and defines the relations of co-operation, complementarity and conflict which will develop with different discursive coalitions. In the historic reconstruction which follows, I propose to argue in this sense, setting out first the broad outline of relations between state and society in the course of the regulation of social problems before describing more precisely the specific evolution of the discourse on alcohol.

If it was necessary to have only one criterion to mark the birth of the 19th century in Europe, it could be, in the same way as Polyani (1983), the advent of liberalism – which manifests itself in the differentiation of the political and the economical systems, and the creation of an autoregulated market. As Louis Dumont demonstrates, this social revolution is also a conceptual revolution: “the innovation lay essentially in mode of thinking. For the first time, a particular type of social phenomenon was represented, economic phenomena as distinct from society and constituting themselves as a specific system to which other social issues had to be submitted. In a sense the economy was desocialised (…)” (Dumont, 1983: I)

The principle of autoregulation, on the basis of differentiation, signifies that the economy should be regulated solely by the markets, namely by the price. It determines in theory, the relations which the economic system will develop with the political system and the social system. In this way, a free market economy implies a market society: markets not just for goods must exist, but also for land, labour and capital. At an individual level, earnings and profits are assumed to adjust the performances in a decisive manner and to guarantee the autoregulation of the system. The relations between the political system and the economic system are based on the principle of non-intervention and the guarantee of autoregulation. Nothing should influence the workings of the markets and especially not a State intervention regarding price, supply or demand. “Only policies and measures which contribute to assuring the autoregulation of the market in creating conditions which make the market the only organisational power in economic matters are suitable” (Polyani 1983:104). This liberal vision supposes societal autoregulation following procedures concerning of economic policy.

It should be a persistent enigma, an “anomaly” so that society appears in its specificity. This takes the form of pauperism. The negative effects of industrialisation - namely the disorganisation of the traditional way of life generated by the liberalisation of work and fluctuations in trade - are not compensated for by the advantages of a market free form restrictions. Undeniably pauperism is associated with abundance - a mysterious phenomenon for its contemporaries. “When the various regions of Europe are explored, we are struck by an extraordinary sight and inexplicable appearances. Countries which appear the most indigenous are those which, in reality rank among the least destitute and where among the people, a sense of opulence is to be admired. One section of the population is required to resort to the talents of others (Tocqueille, 1935, quoted by Castel 1995:349). Countless brochures attempt to be the first to challenge liberal optimism of the 18th century. At first, the phenomenon is only continuously judged in so far as where laws for the poor have still not yet provided the right solution. The responses are eclectic and are quoted as being responsible for an either too high or too low agricultural wage, drug addiction, tea, accommodation, sheep…(Polanyi 1983:129).

Then, in the course of the first half of the 19th century, the “social question” found a new anchorage in the heart of the same liberal capitalist system which it came to directly threaten. In effect, this destitution is not a result of a lack of work, as is the surmise of the
liberal theory, but results in a new organisation of work. In this sense, it can no longer be thought of as an accident, rather as a condition forced upon a section of society, and this section is not represented by its margins depicted by the vagabond, but the spearhead of his productive mechanism. Quantitatively, the extreme poverty does not represent the same section of the population in European countries and even their extent is questionable (Castel 1995). Nevertheless, pauperism as a social construction will structure the whole of the discursive field, indicating the importance of its social significance.

This can be summarised in two points. In all European countries, the working class is considered as “dangerous” because it is poor, more than criminal or politicised. Pauperism is a threat to political, social and economic order, as far as it contradicts the autoregulation principle and sparks off fears of a desocialisation of the people. This harmony postulated by liberalism seems to be compromised, leaving an open court for conflicts or anomie.

Furthermore, pauperism shocks by the moral decline with which it is associated. The living conditions of poor stricken workers’ families appear to express the reunion of all vices: violence, male drunkenness, female prostitution, child abuse, broken families. The concept of “degeneration”, formed by the French psychiatrist Morel, was inspired by textile workers and their families interned in an asylum. It signifies a hereditary degradation of the species, but of which the origin would be found in the social environment of the individual. Similarly, expressing the fear of the nations decline, hopelessly contrasts the ideal of progress generated by industrialisation. The majority of medical thinking, psychiatric and social, of the second half of the 19th century will be influenced by the concept of progressive hereditary degeneration (Bynum 1984).

In light of the "social question", the question of state intervention in society presents itself in new terms. Here the liberal principle of autoregulation finds a specific reinforcement in the principle of subsidiarity, thematised at the beginning of the 20th century in the framework of the Christian social doctrine. It asks that the State or higher authorities worry only about tasks that cannot be accomplished by inferior units. It is therefore a principle of limitations regarding centralised competence. The well-being of the person is the measure of every action of the state. In this sense, the legitimacy of its intervention results from the incapacity of inferior social units to resolve social problems (Kissling-Naef/Cattacin 1997)

Indeed the first social measures exclude the state intervention. The liberalism of the 19th century - renouncing non-interventionism- devises new protection intended for the working class. This quickly becomes the main object of concern. Although thought as a social problem, pauperism however calls for a solution in exclusively moral terms. Initially at least the social peace proposed removes the need for a more global refocusing on the organisation of work. Three forms of protection based on an unequal relation are raised by Castel (1995), forms of which we will see the importance in the struggle against alcoholism. The first is the assistance of the poor, which supposes a personalised help according to needs. It reproduces the domination of the rich over the poor, the competent over the ignorant, the doctor over the insane. This last example is well illustrated by the domination of moral treatment within psychiatric institutions throughout the 19th century. The second protection is the incite to create societies of mutual aid which aim at training for contingencies and the development of mutual aid. Finally the latter is the moral patronage of company bosses over their workers. Social benefits offered by the company basically aim to fight against the instability of the workers. It deals with focusing the worker on his job by encouraging him to stay within the company, but to also respect the hours of work and reduce his absenteeism.

Parallel to the distribution of liberal ideology a counter-movement develops. The social question is therefore quickly ceasing to be the prerogative of the enlightened bourgeoisie. The labour movement positions itself in the discussion and re-appropriates the problem of pauperism. It aims to abolish capitalism and form a more reformist respective to
fight against its pernicious effects. Two forms of response are explored: the associative way (mutual aid societies, trade unions) and political way: the workers parties, sometimes linked with landowners, farmers, not to mention a part of the middle class also advocate the adoption of protective legislation. What is significant for me in this evolution is that the structuring of the workers movement is going to permit the contesting of the protective relation desired by a moralistic bourgeoisie in search of a social peace without the State. The failure of the assimilationist strategy, which supposes the cooperation of the party dominated to the dominant norms transforms the perception of the deviant from repentance to that of an enemy (Gusfield 1996). Coercive intervention by the state is consequently legitimised.

Firstly, the benefits of social problems manifests themselves – following the law of the State, guarantor of a certain number of liberties – by the adoption of legal measures aiming to defend the person, more particularly in the area of employment. In this sense, the limitation of working hours, the agreeing of a legal age or the setting of minimal hygiene standards represents, until the end of the 19th century, the first sign of the implementation of a social citizenship. Similarly, it is the positive law, establishing a framework for economic activity that can be considered as the first instrument of systematic intervention of the liberal State in the social field. In a general manner, the use of the law will for a long time be indentified with restraint or with punishment (Morand 2000).

Taking charge of people “with problems” is still not yet accepted within the sphere of State intervention and no new interpretation of new social problems is provided by the State. The latter is positioned mainly as the guarantee of public order. The public force is traditionally a police force, and measures adopted are measures of coercion or punishment against individuals whose behaviour has been judged deviant. It is therefore by recourse to insane asylums and prisons that the State intervenes in social matters, should the occasion arise– responding to social problems with a strategy of exclusion. As Castel shows, “the implementation of liberal society coincides with the reactivation of total institution structures, poorhouses, prison, insane asylums or as in England, workhouses. The return to internment in its modern form and justified by the ideologies of reparation or recovery is the “solution” which suits the most resistant and desocialised groups.” (Castel 1995:383)

It can now be seen how these superficially outlined characteristics seem to play a role in the evolution of the discourse on alcohol. Up until the 19th century, the problem was not practically problematised. Distilled products are the pleasure of the rich and are presumably consumed daily by the peasants. In wine-making countries, the wine is endowed with nutritional and medicinal virtues. It fortifies children and cures illness with the blessing of the medical community. For a long time, it will, sometimes with beer, hold on to the status of “hygienic drink” (Sournia 1982).

The only discourse which breaks with the social acceptance of alcohol consumption is the church moral discourse. It stigmatises “the sin of drunkenness” or “the vice of drunkenness” and clearly condemns alcohol abuse. If the church takes care of the redemption of drunkards, the first public interventions amount only to punishment for drunkenness and the adoption of a taxation system more or less sophisticated. In the context of State police, alcohol abuse is still not interpreted as a specific deviance, drunkards are still described as “poor” or “mental ill” or “delinquent”. With regard to taxation, it simply represents a way of filling the national treasury.

With the process of industrialisation which came to Europe as America in the 18th and 19th centuries, the conditions of consumption transform themselves. The most visible phenomenon is the growing importance of the production and distribution of the distilled spirits, within the frame of a new agrarian capitalism. Strong alcohol, now affordable to all, induces new ways of consumption – notably within the popular classes. At the same time, the
nation states consolidated and democratised themselves. The arrival of an economic and political power for the bourgeoisie and the structuring of the workers parties is witnessed. Now the new standards put forward all advocate sobriety – an attitude adapted from the new emerging social order, which demands for its realisation, an outstanding worker and a rational citizen. In this sense, the social problematisation of alcohol consumption in the 19th century can be seen as part of a process of value adjustment of different social categories – repositioning first unilaterally and then mutually – in the context of a changing society. The importance of what is at stake is reflected in the extent of the debate: in Germany a bibliography is published, listing the works related to the moral, medical, scientific and social dimensions of alcohol and alcoholism and it contained no less than 504 pages! (Bynum 1984)

However, it will be seen that it is not possible to automatically attribute one discourse to each social category. The inverse is more probable: it is the social groups themselves who appropriate the discourses already available – with a view to positioning themselves socially. This discursive game gives rise to “unnatural” or, more precisely, “unintuitive” alliances. In this way, we note that the temperance movements, often qualified as conservative, are often allied with the most progressive political tendencies, such as the feminist movement: in this way, the left movement will find itself in a position to re-enforce - structurally, the industrial discourse on alcohol, or conversely to keep the same temperance discourse as the liberal bourgeoisie.

Firstly, what is at stake, is the social problematisation of a behaviour whose evaluation and regulation has until now been left to the relationship between the Church and the private sphere. This problematisation effectuates itself through the temperance discourse, a discourse which reveal the ethos of a bourgeoisie focused on the idea of self-control. Two intellectual sources align themselves with this view of the problem: the tradition of Enlightenment, concerned with distinguishing the madness of reason, and Protestant religion, principally the evangelic trend and its reference to social activism and responsibility (Roberts 1984). At the heart of the temperance discourse is the concept of addiction and that of abstinence (Levine 1984). In fact, these concepts allow the unification of scientific and religious trends. In the United States of America, the absence of differentiation, reflects itself in the expression “the physician temperance movement.”

The temperance discourse represents a break in the moral discourse of the clergy, in a sense that it displaces the burden of responsibility, from the will of the subject to alcohol, capable of producing a compulsive behaviour. The exercise of willpower did not disappear entirely, it is displaced upstream and downstream of drunkenness, and manifests itself in the practice of abstinence, or according to the case, sobriety. Abstinence appeared therefore as a means of preventing drunkenness. But also of curing what appears to be an illness: the notion of dependence illustrates well the importance accorded to the loss of control, to the annihilation of willpower. In this way, it is the discursive cohabitation between two traditions which characterise the temperance discourse: “The temperance press has always regarded drunkenness as a sin and a disease. A sin first, then a disease.” (National Temperance Society 1873, quoted by Levine 1978: 157)

Furthermore, whereas the temperance discourse distances itself from the moral discourse, it reattaches itself to the social one. Produced firstly by an elite in search of legitimisation and which aims for its own self control, it will subsequently adress the working classes, which become the principle focus of attention. Since the first decades of the 19th century, the question of alcohol amounts to the problematisation of the consumption of the lower classes. What the process achieves is problem closure. In its main version, it is a matter of the struggle against worker intemperance in order to preserve the social order. Alcohol is certainly considered as the cause of the dependence, it also becomes the cause of
all the social problems with which European countries are now confronted – problems which, as it has been seen, amount to the term “pauperism”. This causal reasoning is found in the USA (Levine 1984), in Switzerland (Bütschi/Cattacin 1994), in Sweden (Rosenqvist/Takala 1985), in Germany (Spode 1997), in France (Mitchell 1987), in Italy (Cottino 1985) and in Great Britain (Berridge 1993) to name but a few examples.

The drunkard is seen as a victim of a social practice encouraged by the markets and new ways of consumption. The consequences of drunkenness are interpreted in social terms. And yet, despite this social problematisation, what applies to pauperism also applies to alcohol related problems: the solutions formulated at the beginning of the 19th century hold onto the principle of *societal auto-regulation* and individual rehabilitation. First of all, the solutions are found exclusively at the level where the problems manifest themselves, namely at an individual level. On the whole, the discourses address themselves to programme targets. Significantly, in Great Britain, the question of alcohol will never be linked to the public health of the 19th century (Berridge 1992). Then, auto-regulation of the market is not recalled into question during this first phase: if alcohol is condemned then the solution is not in the regulation of the product but in individual moral re-education. Lastly, it is through the organisations of civil society that the temperance discourse will spread. Temperance associations multiply, first in Great Britain and in the USA, then throughout the rest of Europe, particularly Protestant Europe.

The willingness of social rehabilitation is clear in discourses on temperance movements. Their principle of action is based on *self-help*. They advocate moral persuasion and the temperance pledge. To attain their goals, these movements launch themselves into a huge campaign of spreading the good word, with the help of leaflets, conferences and in exploiting the experiences of reformed drunkards. This willingness can be found in the practices of the first specialised care institutions, most often created by temperance doctors or those in insane asylums in which “moral treatment” is applied (Baumohol/Room 1987). This temperance discourse on social accents will be raised again during the century by groups with different agendas, notably the elements of the middle classes, the working classes, but also in an American context by women and the black community. It is interesting to note in this respect that the same discourse will be instrumental both in the end of social control and the end of emancipation.

The division of the workers movement on the question of alcohol is relevant to the discursive dilemma in which it is to be found. On the one hand, it must defend a programme based on the necessity to initiate structural changes to fight against pauperism – as opposed to the dominant discourse which calls for individual morality. On the other hand, it rejoins the temperance movement of the middle class in its identification of an alcohol related problem in the popular classes, and directly concerned, is pressured to provide measures to solve it. The first position, that of Abstinents Socialists, dominates the European left. Its intention is to reform the drinking habits of the working class. If the fear of degeneration haunts the bourgeoisie and motives it to rejoin the temperance discourse, it is conversely the hope of social ascension which inspires the working class to rally itself to the same discourse and to show itself at the same time in the organisations of society and *self-help*.

From that time on, one of the only discourses which presents itself against this interpretation is the *socialist discourse*, formulated notably by Kautsky at the end of the 19th century. Inspired by Engels, it proposes to invert the relationship of causality and to consider

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3 The experiences of local and later state monopoly in nordic countries like Sweeden, Norway and Finland represents significant exceptions, wich indicate clear state interventionism. One may consider this break of the autoregulation rule as innovation in public governance - anticipating the next period. As far as the social sphere is concerned, we can obverse similar innovations concerning for exemple the adoption of the first compulsory insurances, like in Germany a the end of the XIXth century.
bad social conditions of the working class as a cause of alcohol abuse. It sees, in a quite fatalist way, the solution in the outcome of the class struggle. This discourse will succeed in imposing on the left in Germany where the workers movement remains dependent on taverns for its political meetings (Roberts 1985), likewise in Italy where a conflict between socialists and doctors, who link alcohol and criminality in the wake of Lombroso (Cottino/Morgan 1987). It is the only one to ask the question “why” the alcoholic drinks and to try to link up this phenomenon with the question of living and working conditions.

The second discourse, as opposed to the temperance discourse, is that of alcohol lobbies. Relative to the temperance discourse, it remains discreet and will only manifest itself, as such, in some countries between the two World Wars. In a general way, it represents more a referential - a dominant interpretation - than a discourse. It rejoins popular opinion and adjusts itself easily to the State referential for which alcohol stands out above all agricultural, economic or fiscal policies. In the same way, the Netherlands's liquor trade represents 23% of State revenue! (De Lindt 1981) Further, this discourse is indirectly reinforced by the criticisms that socialists can bring to the temperance discourse. Finally, it is highlighted by number of doctors. In France notably, doctors, but also the temperance movement, have linked up with the slogan: "Wine is good for you. Drink less whiskey and more wine." (Mitchells 1987). In Germany, the brewers associations are going to finance an anti-temperance organisation which publishes numerous pamphlets (Giles 1995) whereas in Great Britain the alcohol lobby addresses itself directly to the State (Weir 1984). In this sense, the discursive agitation around alcohol in the 19th century can be interpreted as a sign of weak social and political influence - apart from the members of temperance organisations.

However, in accordance with the principle of subsidiarity, it is indeed a real failure of the first approach to the problem by societal auto-regulation which brought the social actors to ask for and legitimise public intervention. In most countries, a second temperance movement develops in the mid 19th century calling for the adoption of a restrictive legislation. The discursive stake is now to transform from what appeared to be a social problem into a political problem. To do this, the question will be reconstructed as a function of a political referential which, as we have seen, is principally based on public order and the regulation of society by laws. However, these new discourses bring a sense of innovation, and in a way, anticipate new modes of State intervention which will consequently develop, mainly after the Second World War.

Concretely, the demand for State action splits the temperance discourse in two: on the one side, a prohibitionist discourse is formulated (calling in a more or less radical way for a regulating of the production, distribution and consumption of alcohol). On the other side, an autonomisation of the medical discourse is observed, which in itself calls on the State, but to guarantee the finance for a system of specialised treatment. According to the countries, the relations between these two discourses heighten the competition (such as in Great Britain where doctors are trying to distinguish themselves from those who support pub closure on Sundays. (Berridge 1993) ) or the complementarity (such as in Sweden where doctors play an important role in the promotion of a restrictive system for the regulation of alcohol - defending the approach according to which alcoholism is not a sickness and developing a system of care based on enforced treatment. (Sutton 1998)

Simply for information, the impact on the discourses of subsidiary recourse to the legislation can be well illustrated by the example of the United States of America. The cultural conflict symbolised by the consumption of alcohol, is in effect exacerbated by successive waves of Catholic Irish and Lutheran German immigrants, attached to the beer and bars, and who seem resistant to all moralisation. From then on, among the Protestants of the middle class, a passage from assimilationist reform to coercion can be observed. To concentrate on the promotion of the prohibitionist discourse, the new temperance movement
will completely distance itself from the concept of dependence previously dominant in its discourse. This discursive strategy explains the eclipse which subjects the medical vision of the problem and the tendency to the tightening of positions; within the framework of a polarised debate

In Europe, temperance organisations themselves become political forces and following the evolution of the States of which the centre reinforces itself progressively, they organise themselves on a national level. More than in cultural terms the problem was posed in terms of social classes. However, it is seen that a problematisation in social terms is not sufficient, in the context of the liberal State, for the elaboration of a social policy. Putting the “question of alcohol” on the agenda necessitates a discursive adaptation. It will require that the discourses include the national preoccupation around which public discourse organises itself. This is made possible thanks to recourse to a degenerationist paradigm which makes a type of link between medical and prohibitionist discourses in its European version.

The degenerationist paradigm serves a double purpose. At a scientific level, it undeniably helps the constitution of alcoholism as a specific object of study, as it appears to lend itself well to research, the cases are easily spotted, quantifiable, permitting the constitution of statistic series and, relative to the stagnation of experiences based in the asylums, seems to offer therapeutic perspectives (Bynum 1984). At a political level on the other hand, it expresses the fear of social degeneration and of the end of a nation, in a context of war or of rivalry between nations. This double characteristic allows the explanation of its importance in the literature between 1860 and 1910. Nevertheless its impact will be more political than scientific. However, from the beginning of the 20th century its argument begins to deconstruct and loose its importance as an issue within the medical profession, notably under the influence of Freud’s work. Its total disappearance from the political and scientific discursive field after the Second World War, nevertheless comes about more from discreditation than falsification.

Likewise, the medical view of alcoholism develops itself within the degenerationist paradigm. The medical discourse on alcohol seeks especially to distinguish itself from the rest of the medical community by trying to define alcoholism as an illness in order to make a specialised niche within a structuring profession. Nevertheless it remains relatively insignificant, both in the whole discursive field and within medical discourse. Except in countries with a strong tradition of State intervention, in which the recourse to forced care is envisageable –as in Nordic countries (Rosenqvist/Takala 1985) or in Austria (Eisenbach-Strangl 1992), it does not find sought alley in public power. In a general manner, alcoholism remains treated in the category of mental illnesses and has not yet attained the recognition of its specificity.

Regarding the second temperance movement, it seeks to legitimise the prohibitionist discourse by referring to science and research. In that perspective, the degenerationist paradigm serves different political purposes. In France for example, the fear of the end of the century is that of depopulation, in relation to neighbouring Germany (Mitchells 1987). The link is drawn between alcohol and reproduction, from a natalist perspective. In Great Britain, medicine and temperance movements join together to problematise national efficiency, notably in the context of the Boer War and then of the First World War. It is the national crisis that allows the adoption of laws restraining accessibility of alcohol (Weir 1984). In Germany, integration of alcohol in the degenerationist paradigm will slow down the development of the medical view with which it is directly linked. In fact, the interpretation in biological terms quickly dominates the discursive field. As a result, alcoholism becomes a

4 It is interesting to note that the concept of addiction has not completely disappeared from the discursive field, but it has, in a way, been transferred from the question of alcohol to opium
consequence of social problems: from then on the question of alcohol becomes a “racial problem” (Giles 1995)

Likewise, during this long period, ending with the Second World War (regardless of the direction followed by European countries that I am not elaborating on here), reference to public order dominated State intervention, which only invests itself in a relatively marginal manner in the areas of care or prevention - areas left to civil society organisations. If the problem had been clearly defined as a social problem at the level of discourse produced in society, the first public responses still only address themselves to individuals in terms of what is forbidden. Laws which are specifically related to alcohol make reference in this way to traditional interpretation, namely public or social order. The new functions of the state in society are agricultural or economic. No public discourses make up a social or health policy.

This public intervention manifests itself by two series of measures. The first addresses the deviant behaviour and reveals itself by recourse to insane asylums or prisons. Furthermore the majority of European countries criminalise drunkenness. Finland is an exemplary case of this repressive perspective. Until 1950 in fact, alcohol-related problems were treated by police intervention, prisons and enforced care (Mäkela 1984: 41). The second is the implementation of a legal framework limiting accessibility to alcohol, but which does not necessarily imply coercive measures vis-à-vis the individual. Similarly at the beginning of the century Great Britain installed a system of restriction concerning days and hours of sale, legitimised also by reference to social order (Berridge 1992), without ever authorising forced treatment as such. Moreover, regulations for taverns, in Italy for example are possibly more a cause of the problematisation of order (taverns are perceived as a place of revolutionary fomentation) than of public health.

Significantly, the first responses of the State consecrate it’s role of subsidiary intervention in the debate. The state arbitrates social conflicts, producing, under the pressure of civil society, laws which legitimise one or another of present parties and reinforce its domination in the discursive field. However it does not intervene in a direct manner in the construction of the problem or the solution, which remains within the capabilities of private organisations of society. This dynamic seems to push the debate to its extremes. Between the two wars drastic laws were adopted – such as the prohibition in the USA and also in Finland, or the sterilisation of alcoholics in certain Swiss cantons or in Germany. The effect of these laws on the discursive field will, in the long term, discredit the discourse which they had aimed to legitimise (the temperance will be discredited by prohibition, degenerescence by the eugenic experience) – opening, but only now, the way of recognition of an interpretation which is not coercitive and does not rely on moral presuppositions: the medical model.


Progressively, starting between the two World Wars, the State substituted itself for society actors in the process of defining the problem. This occurs with a price: the reduction of the complexity of the discursive field. This process, in fact, accompanies the diffusion of the medical model in the domain of alcohol, the Disease model, which will dominate the discursive field until the middle of the 1970’s. During this period, the discursive dynamic is characterised by domination of this quasi-monopolistic discourse – whose power is re-enforced by its institutionalisation.

What stands out, relative to the previous period, is the absence of social debate in European countries – the certitude that, in some way, the “question of alcohol” had been resolved. Likewise, for example, in 1931, the Royal Commission on Licensing concluded that the problem of alcohol in Great Britain is no longer a “gigantic evil” (Weir 1984:93). This
optimistic perspective seems correlated by a drop in consumption – particularly of distilled products, recorded in Europe between the turn of the century and the Second World War. (Edwards et al 1995). However, I would like to suggest here the hypothesis according to which the reinterpretation of the question of alcohol taking place between the 1930’s and the 1970’s is not so much a process of social learning (as it happens, a right measure of the evolution of the level and modes of alcohol consumption – therefore an adjustment to an “objective” situation) but participates in a more general transformation of relations between the State and society, which gives rise to a “re-framing” (Breton 1996).

In fact, on one side, the traditional methods of State regulation have been discredited by the experiences of prohibition and eugenism, with which it is globally associated. In response, alcohol is restored to the discourse with attention to new solutions and thus to new problematics. On the other hand, the growing influence of State has an impact on the discursive field: in the discourse, the problem had not disappeared, but it is re-defined in a new referential. In fact, it can be assumed that the Welfare State – in development – now legitimises itself not only by the failure of civil society to resolve the problems, but also thanks to its own success. In the sense, it is the solution which determines the problem. As will be seen, the medical model of alcoholism will be openly contested, starting in 1975, by a vision inspired of New public health. In this case also, we can observe a process of refocusing which can be linked to a crisis of legitimacy, concerning, this time, the model of the Welfare State.

I shall now retrace in broad strokes the evolution of relations between the State and society in social questions during this period. Then I will attempt to describe the transformations of the discourse on alcohol in order to show the similarities between these two dynamics.

Since the 1930’s, the relations between the State and society, which until then had been based on the principle of auto-regulation and on subsidiary public intervention through the law, is called into question. In fact, neither the private actor nor the “Etat de droit” are in a position to respond to the growing demands for the resolution of social problems – demands which are expressed through trade unions and, in a general way, by the extension of the means of democratic participation. In this regard, the crisis of 1929 represents a crucial event, which allows the Welfare State to gain legitimacy. But the development of a more visible and active State is also stimulated by the radicalisation of social confrontation (which requires a conciliatory intervention), two World Wars (which stem from modern bureaucracy and large scale social programmes) and technological innovations (which allow rational intervention in society). (Cattacin 1996)

During the period between the 1950’s and the 1970’s, the development of the Welfare State model can be seen in all European countries. The traditional public referential, in terms of social questions – based as has been seen on social order – is thus modified, or rather completed, by elaboration of the first social and health policies. The repressive attitude and regulation by the law remain important. However, reparational policies, addressing themselves directly to the effects of social problems, join these first forms of intervention in a manner more juxtaposed than integrated. It is a matter of compensation for the negative effects of a growth by a corresponding increase in expenditure. The principle of social risk insurance spreads (Ewald 1986) and the response to problems is medicalised (Gehradt 1991). Moreover, psychosocial intervention, also professionalised, highlights more specialised institutions, in order to enlarge the medical field.

The State intervenes more and more directly, it develops existing public institutions, creating new and assimilating (by means of large subsidies) private organisations whose logic of function corresponds to its standards, whereas others are marginalised. This process of
substituting private and exclusive actors with public actors is illustrated by the development of obligatory social insurance (illness, pension, unemployment and accident) particularly after the Second World War, and likewise by the institutionalisation of conflicts by means of a legislative arsenal which organises the way private groups can participate in the political system. Progressively, we see the institutionalisation of organisations in society and their neutralisation. (Catacin/Giuni/Passy 1997)

From then on, the solution to social problems from the point of view of organisation is elaborated and implemented in two ways. Firstly, by the State actor. The principle instrument is planning (such as hospital planning during the 1960’s) which bases itself on the expertise of the social and health professions. The logic of action is bureaucratic action. Next, measures are often adopted, as a result of negotiations between social partners which revolve around the redistribution of material resources and in which different interests make themselves felt according to their political power. (Cattacin 1996)

But this phenomenon is also visible in the discursive field. In this model, civil society is now relegated to audience status and the debate is taken inside the State by political parties and, at the level of programme elaboration, by the experts of scientific and interest associations. As Claus Offe shows: “The implicit sociological premise, which underlined the constitutional accords of the liberal Welfare State, was that the models of “private” life of the family, work and consumption, would absorb the energy and aspirations of the majority of people and that the participation in public life, as well as the conflicts, concerning them, had as a result only a marginal importance in the life of the vast majority of citizens. This constitutional definition of actions, respective of capital and labour, of the State and civil society, was correlative to the centrality of values which represented the growth, the prosperity and the redistribution of resources.” (Offe 1997:101)

In this way, the function of defining the problems is transferred to the State control sphere. The political parties acquire the monopoly on the formation conflicts at the cost of an important reduction in the diversity of formulated problems (Wilke 1991). On the other hand, the State taking responsibility for social questions guarantees universality in response and the development of service on the whole territory. The result is a de-politicisation of social stakes and a de-differentiation of problems and solutions.

In the course of the 1970s, this development model of State interventionism reached its limits. This is manifested by an observation: the increase in public expenditure has consequently no longer a corresponding growth in well-being. Different criticisms raised themselves, from the left and from the right, to question the Welfare State. They specifically allowed the obstacles related to the growing complexification of society to be highlighted. They are listed frugally. In so far as where these obstacles could have consequences at discursive field level.

Following a systematic approach, we could understand the social complexity, as the result of a differentiation process of society (Luhman 1982). This differentiation could respond to a growing necessity of specialisation or express itself in a pluralisation of life forms. Consequently, the political system environment becomes more and more unknown. In other words the different autonomous spheres link up specific competencies which the State does not understand. Furthermore, the environment of the political system seems to be always more unpredictable. The effects of direct State intervention on a social sub-system are notably undetermined, from the point of view of the consequences –sometimes negative- in other sub-systems. Finally, it has been seen that this model is characterised by the growing autonomisation of the State in relation to the society into which it wishes to intervene. The decisions are taken by the administration which relies on expertise, and management carried out according to a bureaucratic logic. This means a routinisation of action, which implies difficulties in adapting to a changing environment, and uniformisation of problems to be
treated. In the context of growing social complexity the development of this type of response no longer appears satisfying and the gap widens, between the expectations of the citizens – which are not echoed at the level of the political system – and the responses of the State which follow a different rationality. The social acceptability of the measures diminishes and the State discourses, which until then dominated the discursive field, cross over to a legitimacy crisis.

Let us now look at how this evolution finds itself in the structuring of discourses on alcohol. The first process which can be highlighted is a reaction of rejection vis à vis the temperance discourse and everything which is associated with it. It will have an impact both at a scientific and political level.

In 1933, the repeal of prohibition in the USA is followed by a reinterpretation of the problem characterised by its opposition to previous discourses. This willingness to break with the past allows explanation for why the medical discourse dismisses knowledge highlighted since the beginning of the century. In fact, the majority of health problems relating to alcohol, for example, cirrhosis of the liver and cancer of the oesophagus are therefore minimised because they were assimilated to previous temperance discourses formulated in the name of science. Two phenomena reinforce this “eclipse of knowledge” (Katcher 1992). Firstly, alcohol is socially rehabilitated, and this excludes the causal link between the product and a whole series of problems, a link which characterised the discourse of the first period. On the other hand, the dominant medical paradigm changed. Now it is inspired by a microbiological approach to illness. Contrary to the degenerationist paradigm, this new view has difficulties in interpreting the problems relating to alcohol. On the other hand, we are assisting in a “rediscovery” of the addiction and in the diffusion of the idea that alcoholism is an illness in itself.

This idea is diffused in the form called the “Disease Model”. The characteristics of this discourse have been highlighted by numerous actors and Robin Room proposed the following summary:

"1. There is a new scientific approach to alcohol issues which replaces the old moralistic approach.
2. This approach involves the recognition that there is a well-defined singular entity called "alcoholism" which some people have and others don't.
3. Those who have "alcoholism" will always be different in their drinking from the "normal" drinker and therefore should never drink again.
4. The entity should be thought of as a disease in itself (and not, for instance, as just a symptom of another underlying disease) which the alcoholic suffers from involuntarily.
5. It is therefore both rational and humane to help and treat alcoholics as sick, rather than as immoral or criminal.
6. Providing treatment for alcoholism is the most urgent priority for and most adequate method of handling society’s alcohol-related problems. " (Room 1983: 54)

In European countries, discourses on alcohol follow this discursive dynamic. This means mainly that alcohol as a product of consumption is no longer to blame: it causes only certain people to become more dependent than others, (“the ill”), for reasons which are still unknown. However the source of dependence is now situated within the body of the individual. As at the beginning of the 19th century, the addiction concept is used in order to name a mystery: the pursuit of a behaviour, despite the evidence of its negative consequences (Room 1996). Similarly, the loss of control remains an essential element of the concept. In addition, the treatment or the recovery are always associated with the notion of abstinence. In this sense, the Disease model, which is meant to be at odds with the temperance discourse – in that it dismisses every moral connotation – could, despite all be placed in the continuity of
19th century discourses on dependence (Levine 1978). It is indeed with the help of this concept that the temperance movement, against the moral discourse of the Church, paradoxically popularised the idea that alcoholism was an illness.

In the same way, the temperance discourse is loosing its legitimacy among civil society organisations and within the medical profession, which, on the contrary look to distance themselves from it by referring to a scientific discourse. A similar phenomenon can be seen concerning the State’s control measures which are discredited a priori as a support mechanism for social control. Regulation or repressive measures do not disappear completely during this period, but they lose their importance in the field of alcohol and are only interpreted using socio-economic criteria. Alcohol is in fact integrated in the regulation of foodstuffs.

Generally, the taxation of alcohol recedes (due to pressure from industrial lobbies, State financing from revenue, and the enlargement of the European Community), and the system of licence granting becomes more liberal (due to development of tourism, supermarkets, and increase in the number and diversification of points of sale). Public drunkenness for example, is decriminalised. The only matter to be problematised in terms of public order is drink driving. In all European countries the progressive introduction of controlling the level of alcohol in the blood of drivers, and the reinforcement of penalties relating to driving in a drunken state (in Norway from 1936) are both noted.

This anti-temperance and anti-control reaction will open the discursive field to the commercial and promotional discourses which appears legitimate and benefit from institutional conditions favourable to their circulation. In the Disease model, only the small percentage of the ill is problematised. The other part of the population, being social drinkers, are now exclude of the scientific discourses. This evolution coincides with the transformation of ways of drinking. They become homogenised with the circulation of new products and lifestyles, and the consumption by the population increases. It also begins to transcend socio-professional categories (Mäkela 1981). Clearly, the healthy/ill dichotomy has replaced the identification by social category.

A second discursive process can be highlighted during this period. European countries seem in fact to be carried along by a common factor: the per capita production and consumption, sometimes climbing to a level reached in the 19th century (Edwards et al. 1995), while the majority of indicators of health problems related to alcohol make progress (Mäkelä 1987). Yet, it is the State which assures equivalence between the two factors in this equation: the Disease model makes alcoholism an identifiable illness, concerning an identifiable population and for which it is possible to identify a treatment, according to criteria which the experts of the medical field are in a position to determine and which the State is in a position to implement throughout the development of health policy. In this sense, the problem is now redefined according to the logic of technocratic management characterising the Welfare State. We could say: according to the solution! This certainly explains not only the spread of the concept after the Second World War, but also its institutionalisation. Let us look quickly at these two points.

It is from the USA that the Disease Model spread to Europe. Three converging discourses practically monopolise the discursive field of this period. I will briefly mention them. Firstly, there is the work of Yale Research Centre of Alcohol Studies, circulated by the bias of The Quarterly Journal of Studies on Alcohol, founded in 1940. In this context, the slogan "Alcoholism is a disease" was introduced with the specific intention of “de-moralising” the political debate on alcohol consumption (Conrad, Schneider 1980). Secondly, Alcoholics Anonymous, founded in 1935 grew quickly in the United States and then Europe (see Mäkelä 1996). Their discourses are also based on the interpretation of alcoholism as an illness and the necessity of abstinence. Finally, the work of Jellineck which characterise the stages of
alcoholism (Jellineck 1952) contribute to the identification of the illness. Symbolically, this new definition of the problem is sanctioned by the adoption of the Disease model by the WHO in 1951. An epistemic community is formed at international level, which will contribute to the circulation of the medical view in European countries.

At the same time a process of institutionalisation of this discourse is witnessed. Health systems in full development integrate the question of alcohol in their individual curative approach. From the 1950’s onwards, the majority of countries cover treatment fees of recognised “alcoholics”. The medical field specialises in a new science: “alcohology”. The model is in fact perfectly adapted to insurance and reparational policies of the post-war period. Private organisations, the most common issues of temperance movements, become professionalised or decline (including in Nordic countries), not to say disappear completely. In fact, the discursive field becomes homogenised. The State now plays and active part in the production of discourses on alcohol. It is the State who, (in collaboration with experts on the medical sector), defines the problem of alcoholism and how it should be resolved – while the implementation of reparatory policies contribute to assuring the hegemony of discourse in the field and assure the reorientation of individuals “with a problem” towards the health system.

Contrary to the politicisation that has been seen at the end of the 19th century, the organisation of the discursive field during the Glorious Thirties sanctions the depolitisation of the problem of alcohol by scientific and technocratic experts - taking responsibility at a discursive level. Other possible considerations relevant to the problem in a way relate back to the private sphere – in the field of the “irrational”. In the same time, civil society organisations bring their discourses in line with that of the State or disappear, lacking credibility.

Generally, the Disease model can be characterised by its discursive resistance ability. During the period when it dominated this field (until the mid 1970’s) the critical discourses emanating from the scientific community are not accepted and subject a violent counter-attack of public order (Room***). Likewise, for example, alcoholics are assumed to be insensitive to price variations and accessibility of alcohol, which in advance discredits control measure. On the contrary consumption by the rest of the population is supposed to react to these variations, but social drinkers are exempt from problem. From then on, every questioning of this perspective in the name of prevention or public health is in fact assimilated to the come back of the temperance discourse and immediately discredited. The approach of total consumption, proposed by the Frenchman Lederman in the 1950’s has not been echoed at this time.

Therefore, the alternative discourse is elaborating itself outside of the public debat, in a discreet manner. If it supported by a new coalition of researchers, particularly inspired by the results of epidemiologic research. This fulfils its “coming out” in 1975, with the WHO’s publication of a study entitled: Alcohol Control Policies in a Public Health Perspective (Bruun et al. 1975). This is particularly based on Ledermann’s model, which suddenly makes sense. The actors, the majority of whom originate from Nordic countries, attempt to defend a new control policy concerning the accessibility to alcohol, following the Norwegian, Swedish and Finish experience model. The legitimacy of this new discourse wants to be exclusively scientific. However, its point is political and this discourse is supported by a new coalition discursive agreed on by researchers, but also doctors, workers, private organisations and members of the police and justice (******)

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1 To cite a few examples in France, the High Committee for Study and Information on Alcoholism is created in 1954. In Sweden, two governmental Commissions carry out research which will be published and which will have a considerable political influence (Armyr 1982). In Switzerland during this period the federal Commission against alcoholism is created, with the specific goal of remedying the unilateral functioning of the federal authority of alcohol, which is above all a management unit.
Since then, what makes the argument credible, what permits its consideration, is the legitimacy crisis into which the model of the Welfare State is entered. Undeniably, the proportional growth of health expenditure does not correspond to an improvement in well being. The system of treating alcoholism excludes a series of cases and problems which are not even conceptualised within the Disease model. Finally, the medicalisation of alcoholism shows its limits and the question of recovery is also called into question. This crisis of legitimacy is evidently re-enforced by the financial crisis. In a general way, the tendency is towards the development of policies no longer reparatory, but anticipatory (*****). In this new context, prevention acquires a growing importance. It is in this climate of calling into question the technocratic model – incapable of adapting to a complex society, that the emergence of a new discourse on alcohol can be best understood – discourse which tries to anchor itself conceptually in the paradigm of the New public health.


With the crisis of the Welfare State, it is the place and the role of the State in the production of welfare which is called into question. This re-evaluation of public functioning is noticeable at the level of production of discourse on alcohol. After a period of relative consensus, the discursive field appears divided: the supporters of public health versus the supporters of freedom of consumption. This debate, which essentially mobilises the epistemic community, follows the contested diffusion of the neo-liberal ideology in Europe (Jobert 1994). In fact, on one side the arguments in defence of the Welfare State against the assaults of liberalised economy can be found, on the other, the anti-temperance and anti-coercion arguments, which clearly make up the area of the alcohol industry.

However, from the 1990’s, a willingness to pass over the divisions and the binary interpretations of good and bad can be noticed. It will be seen how the outline of this new consensus can be linked to the transformations of the State regulation, notably with a growing tendency towards networking actors and the influence of the new instruments of public action – information and persuasion. Once again, conciliatory intervention by the State seems solicited. But in the actual context, it positions itself neither in a subsidiary manner or as an arbiter in the case of social conflict, nor as the only legitimate formulator of problems and solutions in a reconciled and uniformed society; but rather as a mediator, seeking to make compatible the discourses whose diverse logic inversely expresses the societal complexity.

For the last time, I will succinctly consider the changes in the relations between States and society, before retracing the evolution of the discourses on alcohol – in order to suggest that these two dynamics can, here again, be related.

The “crisis” overcome by the European countries has been interpreted as a crisis of capitalist economic reproduction (Meadow 1972), a crisis of governability (Crozier et al. 1975), or a crisis of the Welfare State and its objectives (Habermas 1985, Rosanvallon 1981). At the beginning of the 1990’s, neoinstitutionalist comparative researchs have, conversely, underlined the resistance of the Welfare State wich developed during the Glorious Thirties (Pierson 1994, Esping-Anderson 1996). Social policies reforms, in that perspective, could be only adjustments.

In a more general way, it is undeniable that the place of the State in society, its role and its methods of action are in the process of transforming. This evolution follows different methods according to the country, but the tendency is however common to all Western Europe. Inspired by Kenis and Schneider (1991), the main changes in the evolution of policies can be summarised as follows: growing importance of the organisation of civil society,
blurring of borders between public and private and correlative transformation of state instruments (see for example the concepts of the "animator State" (Donzelot 1994), "reflexive State" (Willke 1992), “propulsive State” (Morand 1991), “incitator State” (Bütschi/Cattacin 1993); the loss of state centrality and pluricentralisation of political and social processes; fragmentation of the State, which no longer appears as a monolithic but as a ensemble of relatively independent institutions; functional differentiation (policies, programmes, State agencies which tend to specialise); growth of the State intervention sphere: in the social domain, this phenomenon corresponds to the propensity of modern society to transform the stakes which until then were private or familial into public problems (Gusfield 1996), internationalism and interdependence of national stakes, growing recourse to information – notably scientific expertise.

From this balance, it is possible to extract two elements allowing the characterisation of the transformations of European politics since the end of the 1970’s in terms of the relations between the State and civil society. It is about the new role played by information (or more generally, the argumentation and the discursive strategy of the State) and by political networks in the context of a growing societal complexity. The actual coincidence between societal complexity and internal complexity of State components likewise, constitutes the principle problem with which confronts the current Welfare State (Wilke 1992)

Firstly, it is information which today appears as a public instrument of action is more suitably adopted to a complex society (Frieburghaus 1991). In a more general manner, the negotiation, persuasion, co-ordination and the recourse to discursive strategies solely permits the State to influence the more autonomous functioning of the sub-systems. This form of regulation situates itself between planning and autoregulation through various types of markets (Wilke 1991). Furthermore, the traditional legitimisation of policies by democratic institutions should be completed by a “secondary legitimisation”, which aims to convince the partners and citizens concerned, of well-founded resolutions in order to guarantee the success of their implementation (Benninghof 1997). Moreover, a growing recourse develops to expertise, so that the State acquires its knowledge of the system which it wants to exert influence over and understands the functioning of its logic. An expertise which evolves itself and attempts to integrate the complexity or on the contrary to overtake it (the new expert is a “mediator”or a “sage”. Finally, the State actor can also, notably in a period of growth, replace the problem of knowledge with that of compatibility between different codes. It attempts to find a compromise satisfying different interests by negotiations with representatives of each sphere concerned, widened negotiations which attempt to account for the growing complexity (Papadopoulos 1996)

Secondly, an accentuation of the relational characters of policies is noted, also of the law (on the soft law see Morand 2000). Recourse to the civil society in this perspective does not represent a renewal with autoregulation in a neoliberal perspective. Rather, it is about the the legitimacy deficit and about efficiency of the Welfare State, transferring the process of definition and resolution of social problems to a level, which Beck calls the “sub-politics”, or spheres of plural expression of society Without question, public intervention will rely on private organisations. The newness relative to the autoregulation of the previous century comes to the fact that the State, principally in its administration, wants to retain an active role in social politics. In order to do this, it relies on the resources available (information and communication) to intervene in society. The command ability of these stakes by management is therefore a necessary condition for this new form of regulation.

The result sought here is not an adjustment between different sub-systems, rather an improved social acceptance of State intervention. We see the promotion of discussion forum by State, intense activity of spreading information, but also the active participation of private organisations in the elaboration and implementation of programmes ensuring that the social
pluralism is taken into account. The State is no longer at the centre of producing well-being, which is the result of networks in its group. Similarly, it is no longer the production of a monopoly of legitimate discourses on well-being. However, it holds onto a *leadership* in the domain. Effectively, these are the political networks which, today, appear more like the place of creation and the implementation of policies. These political networks are characterised by the dominance of informal, decentralised and horizontal relations. According to Volker Schneider: “In the context of policy making, this means that a policy emerges not from a centrally concerted or programmed action but from the autonomous interaction of a plurality of interdependant organizations or individual (Schneider 1992: 110). Concerning the structuring of discourses, this report appears valid. In a sense, it is this new political context which allows the explanation of the pertinence of *the argumentative turn in policy and planning* (Fischer/Forester 1995).

At the same time, (in the framework of these new relations between the State and society) a tendency to develop new discourses by overlapping consensus. This process represents the strong element of this type of reaction, that of an integrated society, seeking identification with the promoted programmes. It is also it Achilles heel however, in so far as it blocks action when positions are irreconcilable. Nevertheless, the advantages of this type of regulation are nevertheless clear: taking charge of problems by groups directly affected and by established organisations resolves the issue of legitimisation towards the partisan political arena, and furthermore, towards the groups of the population to which the programmes are addressed (Cattacin/Lucas 1999).

In this context, health policies in Europe have shifted during the seventies and eighties from a medical and curative approach to a more preventative and social perspective. After public order and individual health it is now in the name of public health that the State legitimises its intervention in the social field. This discourse, succinctly summed up, organises prevention around three elements: the host, the environment and the agent (Holder 1994). It has been seen: this transformation has social, scientific and financial reasons. Citizens ask for more psycho-social and preventative measures, the research community provides arguments for a more information based health system, and the politics search for a strategy to reduce the costs of the health care system. Prevention represents an important alternative to the medicalisation of individuals, to the uniform system of treatment, and, finally to expensive expansion of the care sector (hospitals a.s.o.)

Nevertheless, this discourse on prevention (developed within the international epistemic community) can have different effects, depending on whether it is formed and interpreted later in the framework of a neo-liberal theory of the social state, in the defence of a providence interventionist State, or in the framework of research of alternative management solutions in the face of the growing complexity of society. In the first case prevention is associated only with information campaigns and public awareness. The type of discourse is taken up notably in countries in the South of Europe, often in symbolic innovative policies, as in Italy or Spain. In the second case, prevention means either secondary prevention, namely early detection in a system of treatment sufficiently capable to re-appropriate the notion (this is the case in France) or the reinforcement of detection and control measures, in the framework of a State with a strong coercive tradition (as in Nordic countries). Finally, in the last case, the prevention is assimilated to the notion, developed in the field of illegal drugs, of "harm reduction". It implies the recognition of a variety of health or social situations, and the organisation of multiple solutions adapted to this diversity. This is the case in countries which have a long tradition of co-operation between the State and civil society in the field of social policy, such as in the Netherlands.

We can generally distinguish between two periods in the evolution of policies on health. The eighties are characterised firstly by the existence of models of diversified welfare,
wich act without a plan, wich add (in an ad hoc manner) new measures to traditional programmes or which reinforce the societal element of their response to social problems. These three types of actions can be partly explained by the State practices developed during the diffusion period of the Welfare State. In a way, it calls back tradition in order to counteract the effects of the crisis. Weak Welfare States are in this case strengthened to a degree. Countries that traditionally construct policies “from top to bottom” (in a federalist manner, following the subsidiarity principle or in respecting the “pillars” of society) are on the other hand at an advantage. In fact, they are in a position to be able to mobilise, all by modernising these traditionally legitimate practices. Finally, strong Welfare States follow a process of slow adaptation of the constraints generated by the 1970’s. They mobilise their action mechanisms in the social field in order to respond to new problems.

The second period begins with the 1990’s. It seems in fact that discursive elements involved in the new approach to health policies presented above are indeed in the process of circulating in all western European States and are finding a political translation. Among those prevention campaigns regarding drug addicts (including legal and illegal drugs), progressive integration of different forms of dependencies in a view of public health, the “detechnocratisation” of solutions to social problems, the willingness to involve communities in the working out and the realisation of public problems can be mentioned. Discourses on the promotion of health are also found in the majority of administrations, as a means of policy rationalisation (to improve the quality of life and reduce the costs of reparative intervention).

In this context, how has the discursive field about alcohol evolved? In a general way, since 1975, the integration of this question has been assisted within the paradigm of public health. This re-interpretation of problems implies three conceptual shifts (Mosher/Jernigan 1989). In the first place, attention is no longer centred exclusively on the alcoholic, but on the population in its entirety. This new perspective follows the results of epidemiologic research on the implications of global consumption on public order, health or security. The new statistic data suggests that although the majority of the population is not alcohol dependent, their consumption, at an aggregate level can be linked to the national level of social and medical problems related to alcohol.

Secondly, new consideration is given to the consequences of alcohol consumption on health. It has been seen that this research field has been left behind following the experience of prohibition and the dominance of the Disease model, centred on individual dependence. The integration of the question of alcohol into the paradigm of public health allows a resumption of the study of problems such as cirrhosis of the liver, or the long term results of consumption, such as cancer. In this perspective, the consumption of alcohol is problematised as a risk factor.

Finally, the political consequence of these new arguments in terms of alcohol related problems is promotion of prevention based on total consumption, the Population based model. It will be seen that it is not the only possible conclusion which can be drawn from these premises, and an alternative can be noticed today, which we called the discourse on harm reduction. However, it is clear that at the beginning, the scientific argument is used to legitimise measures of accessibility control or the increase of taxes. This perspective, as we have seen, was difficult to support during the Glorious Thirties. Since 1975, the attention of researchers has been concentrated on the consequences of political control measure. A growing amount of literature allows scientific arguments in favour of this type of instruments (Giesbrecht 1995). In 1995, a second book came to follow the reasoning broached in 1975 by Kettit Bruun. Alcohol Policy and the Public Good (Edwards et al 1995) presents the result of the research and tries to legitimise, in the name of scientific objectivity, a restrictive policy.
In a general manner, the new discourse, which I called the Population based model is the object of a consensus within the international epistemic community, composed of researchers and public health administrators and professionals. This community is supported by the World Health Organisation (WHO), which has developed since 1992, a plan of action for Europe, directly inspired by its discourse: the European Alcohol Action Plan (WHO 1993). One of the objectives of this plan is the reduction of global alcohol consumption. This new discourse exists alongside the Disease model, which can be ignored or integrated into this global perspective: alcohol dependence, since then, being conceived as one of the multiple alcohol related problems. It is interesting to note that this new discourse is clearly positioned as a (scientific) tool in the service of policy, as is shown by the title of another work: Making the Science and Policy Connection (Edwards et al 1993). The implied researchers are aware of leading a type of new crusade. A new consensus has been created, but aside from Nordic countries, this perspective based on total consumption has not succeeded in spreading outside the circle of the concerned elite.

In most countries, this model will be institutionalised in the 1980’s in political preventive measures based on information. The aim is to reduce average consumption (the problematic of alcohol being included into what are, more generally, the daily risks linked to foodstuffs and a healthy life) or to focus on precise problems (wich are note subject to conflict) such as drink-driving. On the other hand, the option of a restriction on the accessibility to alcohol is a relative failure.

At an argumentative level, the process of diffusion and legitimisation of this new discourse is the same as that which allows the alcoholism movement to imposed itself some forty years previously. The following quote is an extract from what is considered to be the first manifest in favour of the Disease model, and could have been formulated by the supporters of the Population based Model. "The chief obstacle to the progress in the scientific solution of problem lies in the existence of prevailing body of public opinion which is apathetic to this approach. One would think that science could do without public opinion, but it can not. This is especially true when the subject requires organized research and, further, calls for popular acceptance of the results of research" (Anderson 1942, quoted by Room 1983: 48).

In fact, the discursive dynamic which has been observed since 1975 is the re-opening of and interpretative conflict. The hegemony of the Disease model, its institutionalisation, its re-enforcement by commercial discourse and its tacit acceptance by public opinion, obliges the new discourse to position itself in an offensive manner against the dominant interpretation. Against the vision of alcoholism as an illness first, but more significantly against its implications in political terms. In looking to problematise social drinkers, the discourse on public health encroaches on the terrain which was until then, as has been seen, monopolised by the industrial discourse and the alcohol trade.

Industry was staged in the course of the 1980s, financing research projects offering an alternative to discourses on control policies. For example, in 1989, the Portman Group was founded as the most important drinks distributor in the United Kingdom, officially, “with regard to promoting a reasonable usage of alcoholic beverages, to reduce damages caused by alcohol and to develop a better awareness of “alcohol abuse” (Communication 1995). This discursive strategy allows the industry to position itself on equal footing with advocates of public health and to thus directly combat their arguments. Thus, the Portman Group in this case seeks to combat the WHO plan of action, critised especially for not concentrating on “the abusers of alcohol”. Another very influential international group is the Amsterdam Group, founded in 1990. In 1993, it published a report entitled Les Boissons Alcoolisée et la Société Européenne (Alcoholic Drinks and European Society) (Amsterdam Group 1993) qualified as an "demolition of objectives and methods of the WHO plan of action" by the Eurocare
Association 1995. This association regroups active private European organisations in the domain of the prevention of drug and alcoholism. In joining the discursive war, it produces its own report significantly entitled: *Contrebalancing the Drink Industry*. This battle gives way to several articles, particularly in the British press, which spread doubt on the credibility of scientific research financed by the alcohol industry (Lemmens 1997). Publicity, in this incident contributes to the process of demonisation of all discourses produced with the downhill/down stream part of alcohol interests.

Thus in the same manner as the Disease model imposed itself against the temperance discourse, the Population based model finds itself an enemy: in discourses of the advocate of public health, commercial discourses represent the Bad: "Alcohol producers are engaged in a campaign to capture the heart and mind of alcohol research and public health people, as part of a major effort to win the war of ideas that shapes alcohol policy at national and international level" (Editorial, *Addiction* 2000 (95) 2: 179). Therefore, in the middle of the 1990s, the discursive field can be characterised by its dualistic structure: two sole sides are envisaged and each discourse which does not exactly reproduce the argument of its side is immediately accused of playing the enemy game. In addition, another characteristic is the international aspect of the debate, which occurs on an epistemic community level.

This is explained by the growing influence of inter or super national dynamics on alcohol policies, displacing the discursive stake at an international level. In fact, these dynamics are opposed. The integration of European countries in “the super-national State” – the European Union tends to promotes discourses in the industry, which makes alcohol a product of commonplace consumption. Indeed, this economic logic had thus forced Nordic countries to relax their methods of intervention in the domain of alcohol (Holder et al. 1998) and to reconsider their political referential (Sulkunen et al. 2000). At the same time, it is seen that WHO attempts to promote a more restrictive European policy in this area, which at least has influence on a discursive level in countries with liberal policies.

Recently, an evolution towards the constitution of a new discourse is noted, the *Harm reduction Model*. This requires a recomposition of discursive alliances for its support. This discourse was inspired by the concept of *Harm reduction*, developed in the battle against problems relating to illegal drugs and which has spread in the concerned epistemic community at the beginning of the 1990s. In political terms this new approach was characterised in the framework of our previous works on the basis of experiences of German and Dutch cities. “This model is based on a hierarchy of aims which favours the reduction of risks at each stage of the drug addiction process and in each activity domain. Faced with the complexity of the problematic, this model tries to favour and guarantee prevention and is seen to stimulate a large diversity of proposed solutions for drug addicts, as well as implicated actors, both public and private. Due to this, particular attention is attached to the co-ordination of the network. The appropriateness of this model in its environment is guaranteed by a continuous process of experimentation/adaption.” (Cattacin et al. 1994: 215). In the domain of alcohol, it is this discourse framework which promises programmes such as “Operation Red Nose”,5 in some Swiss cantons, who have come to terms with excessive consumption but seek to manage the negative consequences.

Several factors lead to the fact that the discourse on harm reduction, although still very minor in the field of alcohol, could gain in importance. In first place a scientific protest of implied presuppositions of the Population based model begins to make itself heard. The idea behind this new work is to desagregate consumption in order to focus on specific categories, more respectful of social plurality. (Stockwell et al. 1997) This discourse positions itself in the scientific field but its implications are political. This process of coming out is not without

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5 A programme organised by private associations, which allows people who have drunk too much to be taken home along with their car, by two drivers. It is a free service.
reminder of the emergence of the Population based model discourse. In fact, it is once again the political context which appears to offer to the scientific argument a formulation opportunity and a kind of recognition in its own system: the scientific one.

At the same time, researchers are also split concerning the attitude that should be held towards scientific discourses financed by the alcohol industry and towards the industry in general. Controversial initiatives are undertaken in order to elaborate a common discourse. This attempt at reconciliation is supported by two meetings of experts in two locations (in Dublin in 1997 and in Geneva in 2000), on the invitation of the National College of Industrial Relations and the International Centre for Alcohol Policies, founded in 1995 with the soul purpose of developing collaboration between the industry and actors in public health. The priority is to find a common language (ICAP 1999). The discursive result of this exercise is formulated in a series of common principles. This states the “principles of co-operation between the alcohol industry, governments, scientific researchers and public health services” (The Dublin Principle 1997). This discourse had been drafted following the principle of overlapping consensus. The strategy of wanting to overcome this discursive divide between the public health discourse and that of the industry is not shared by the whole active community in the field of prevention. Some argue in favour of an independent positioning opposite economic interests - with a purpose of credibility vis à vis the public (Lemmens 2000).

At industrial level the same tendency –from dualism to willingness to draft up a minimal consensus- is witnessed. The opposition to the discourse on the Population based model has in fact made up the first of discursive strategies. To the discourse warning against the dangers of alcohol to health, the industry responded by the financing and circulation of research pointing out on the contrary the beneficial effects of moderate consumption. To the argument consisting of reducing the global level of consumption, the industry responded with the necessity of concentrating on chronic alcoholics. This counter argument strategy continues, but it is completed now by the willingness to develop an alternative policy, which is compatible with the economic interests of the industry and contributes to its legitimacy. From this perspective, the discourse on Harm reduction allows the formation of a new coalition, between a party of researchers, the industry, supporters of public health and politicians and directors concerned.

This new discourse is formed in the framework of what is supposed to be a scientific debate (see, for example in France, the report evaluating the Evin Law published by Enterprise and Prevention 1993), but it devises more importantly in a pragmatic way. In fact, it is in the context of a social state which always resorts to more private organisations and discursive strategy, more and more cases of co-operation and direct participation of the industry in preventative projects can be seen. This situation is the most frequent in the case of seeking integration into the network of a maximum number of actors and developing programmes according to the harm reduction principle, a programme to which the industry can relate when the minimum consensus required is attained. This is the case for example in the Netherlands or in Denmark. In the Netherlands, the organisation STIVA, bringing together alcohol producers contributes to both the definition and the implementation of preventative schemes regarding drink driving. On the other hand, owing to a lack of agreement, prevention policies aiming to reduce consumption are drawn up without it.

The State, in this new context of policy development acts as a mediator, seeking to reconcile different rationalities. At management level, more co-ordination work can be seen, notably between departments following an economic or commercial logic and those in charge of promoting health. In addition, the promotion of participation of social actors has been noted, be it for profit or non-profit, in the development and implementation of policies on the issue of alcohol. It deals with a strategy serving to by-pass the blocking of action due to the
complexity of society, but also the financial limits of public intervention. This ambiguity in positioning can be found also in the case of groups representing the industry, who seek to “promote the industry’s long-term commercial interest” (Rae 1993) as is openly said by the director of the Portman Group. They can see by participation in prevention the way to reinforce their credibility and to circulate an interpretation of the question of alcohol which is favourable to them. Therefore, the attitude of the health community vis-à-vis this new possibility of discursive alliance, is a determinant for the promotion of a new consensus regarding alcohol policy.

The fundamental criticism brought to this growing dynamic is that it completely dismisses the conflicting dimension between the interests of health and those of commerce from the discursive field – a conflict that nevertheless, for all that, is not resolved – and risks simply being displaced and manifesting itself in other contexts. Furthermore, the participation of the industry in forums organised by the public actor (this was recently the case in Switzerland in the field of smoking) contributes to the legitimisation of its discourse, notably of its discourse on the promotion of health, but also, by extension, of its promotional discourse. Likewise, the State is constrained to take position, to use its influence and its capacity of diffusind information to maintain its leadership in the organisation of the auto-regulation of society, but also in the proves of re-interpreting policies, at the risk of seeing itself reduced to supporting the domination of discourses of the industry in the struggle against alcohol-related problems. However, do they means exist ? A more detailed analysis of the institutional and discursive context in which the discourses on public health and harm reduction diffuse in Europe would certainly permit the understanding of different evolutions (for this type of work, see Ferrera 1997)

IV Conclusion

In conclusion, I am content, at this stage of research, to underline certain points. This article tries to explore the hypothesis according to which the discursive dynamic in the field of alcohol can be linked to the transformations of relations between the state and civil society in the area of social and health policies. In a general way, effectively, it stands out that the evolution of the discourse in two centuries can not simply be related to a class or social groups struggle, to the growing complexity of society, to a linear advancement of scientific knowledge “illuminating” the policy, to social learning, to the victory of one advocacy coalition over another or to an internal dynamic of discourse itself. Certainly, in an empirical manner, a combination of these different processes can be found, in certain countries or in certain eras. But, alone, none of them can account for the changes in the discursive field in a wider sense.

By the way, this first outline allows the underlining of certain elements from the point of view of the content and the dynamic of the discourse. From the point of view of content firstly, we can see, the agreement and the adjustment – in the long term – between the discourse on alcohol and the global referential in terms of social policy. Similarly, the way in which relations between the State and society are conceptualised, in a general way, can be seen in the discourse on the specific question of alcohol: the way in which the problem is defined and in which the solutions are envisaged can characterise an era. Finally, the dimension of position relative to the discourse, one vis-à-vis another, seems very pertinent. The importance of re-interpreting past discourses can be seen (the case of the Disease model) and also the necessity to tactically distinguish between the discourses of other groups (the case of the socialist discourse at the turn of the century).

Next, it seems to me that the evolution of the discourse, at least at this analytical level, follows a process which depends on relations between the State and civil society. Likewise,
the discursive dynamic is not the same in a subsidiary context, within the technocratic Welfare State or in that of networking the actors of public policy. During the period of subsidiarity, the discourses are formulated principally at the level of civil society organisations. The discursive field does not structure itself as a function of social clivage however, but as a function of the way these groups relativaly positioned itself in the debate (which pleads in favour of the autonomy of the discursive dimension) and it evolves through a dynamic reflecting the principle of subsidiarity – which plays at the level of the discourse itself.

During the period of the Welfare State, the formulation of the discourse is monopolised by the State and experts. The possible recourse to *half knowledge* (Marin 1981) allows the constitution of an homogenous discursive field, in excluding alternative discourses. Moreover, the institutionalisation of the dominant discourse reinforces its hegemony and its ability to resist change. The principle dynamic does not come from the discourse itself but from a legitimacy crisis of the actor who has the monopoly on problem formulation, in this case, the Welfare State. This new situation opens the voice for discursive change.

Finally, in the context of networking, the discursive field can now be seen to be entirely made up of actors of the network, namely at the level which Haas (1982) called the epistemic community. The integration of organised civil society, relative to the previous period, does not however guarantee the democratisation of the discursive field and its opening: the discourse remains the fruit of the elite (composed mainly of actors with very diverse status), the integration is selective and, finally, the consensual dynamic which is elaborating tends to exclude the conflict *a priori* rather than resolving it. In this sense, the organisational opening could well correspond to a new form of discursive closure.
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