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A long-brewing crisis: The historical antecedents of major alcohol policy change in Ireland

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Abstract

Introduction. The Public Health (Alcohol) Act *2018 in Ireland has been hailed as a world-leading package of alcohol policy reforms. Existing studies have identified the events that led to alcohol emerging onto the high-level policy agenda in Ireland, particularly after 2009. Using policy feedback theory, this study specifically investigates the political consequences of accumulating alcohol-related health and social harms for processes of policy change prior to 2009.* ***Methods.*** *The study traces the development of alcohol policy in Ireland over the past three decades. It draws on primary documents, secondary literature and interviews with public health advocates, medical doctors, public health experts and key decision-makers.* ***Results.*** *The study documents a decades-long struggle to have alcohol recognised as a public health issue in Ireland. We identify 2008/2009 as the key turning point, where policy conditions decisively shifted in a public health direction. We show how insufficient institutional authority and the accumulation of the effects of earlier policy failures helped foster this dynamic. These two factors elevated the visibility of alcohol-related harm for key stakeholders, helping spur greater demand for major policy change.* ***Discussion and Conclusions.*** *Not acting on the population health harms caused by alcohol can produce significant societal costs, particularly when consumption is rising, and entail subsequent political consequences. Understanding of innovations in alcohol policy decision making requires an appreciation of the historical context, including earlier policy failures.* [Lesch M, McCambridge J. A long-brewing crisis: The historical antecedents of major alcohol policy change in Ireland. *Drug Alcohol Rev* 2021]

Key words: alcohol, public health, policy feedback theory, policy failure, Ireland.

Introduction

In recent decades, alcohol consumption has posed an important public health challenge for Ireland. Between 1987 and 2006, alcohol intake increased from 9.8 to 13.4 L of pure alcohol per capita [1]. Increased consumption coincided with the Celtic Tiger, a time of unprecedented economic prosperity in Ireland. Greater disposable income, and relatively stable rates of alcohol taxation, contributed to easier affordability of alcohol [2]. Following the 2008–2009 financial crisis, alcohol consumption began to decrease in Ireland [2]. By international standards, however, alcohol intake has remained high [3,4]. In 2015, Ireland ranked fourth across Organisation for Economic Co-operation and Development countries, trailing only Estonia, Austria and France in per capita alcohol consumption [5].

The relationship between aggregate population alcohol consumption and harm has been observed across a range of contexts [6]. The health and social burden of alcohol consumption has also been the subject of numerous studies by public agencies in Ireland [1,2,7–10]. This body of research helped persuade the government that a new policy approach to alcohol was required. In 2013, led by the Department of Health, a series of measures were proposed to reduce both consumption and alcohol-related harms [11]. The *Public Health (Alcohol) Act*, adopted in 2018, enacted a world-leading package of alcohol policy changes, including: (i) minimum unit pricing (MUP); (ii) the structural separation of alcohol from other products in shops; (iii) new restrictions on alcohol advertising and marketing; and (iv) new requirements for labelling.

The path to alcohol policy change in Ireland was long and winding, and also politically perilous. Previous studies have identified how different actors, including public health advocates and the alcohol industry, facilitated or impeded these reform efforts

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[12–15]. This research has tended to focus on events from 2012 to 2018, the period in which the legislation was progressing through cabinet and the legislature. Less is known about how alcohol became defined as a priority issue for the government and for public health actors (for a key exception, see [16]). Addressing this gap requires attention to earlier phases of the policymaking process.

This study draws on conceptual insights from policy feedback theory (PFT) [17–20]. Associated with historical institutionalism, the framework brings temporally-sensitive perspectives to studies of the policy process [20]. Feedback effects refer to how previous policy decisions made at T1 can 'reconfigure the political landscape' at T2, by reinforcing or undermining the political power of interests and/or ideas in the intervening period [17]. Many PFT studies identify how the provision of policy benefits can transform stakeholders' incentive structures (i.e. interests) or alter their perceptions, beliefs and identities (i.e. ideas) [21]. Feedback studies help explain why certain policy arrangements become locked-in; policies can create new powerful political constituencies. Public policies not only deliver benefits for some stakeholders; they invariably generate costs for others [19]. Policy researchers have identified how the accumulation of costs can induce policy feedback effects, and thus undermine political support for policies in the long run [19,22].

Alcohol policy provides a nice illustration of how the costs of a policy change can spur feedback effects across time. For example, if a government decides to reduce alcohol taxes, this policy change can generate social and political consequences over time, through increasing alcohol consumption. The legacies of this policy change can be significant, increasing the health and economic costs for stakeholders, including healthcare systems. By their nature, many of these costs will accumulate over time. As they do, policy actors, who may have been previously indifferent to alcohol policy, may experience shifts in perceptions of acceptability and other ideas, making the prospects of policy change in the opposite direction more likely.

Methods

The study traces the development of alcohol policy in Ireland over the past three decades [23]. The analysis draws on several primary documents, secondary literature and interviews. We performed searches of online sources including government websites and the Health Research Board (HRB)'s National Drugs Library (http://www.drugsandalcohol.ie/). These searches yielded access to relevant government documents published in the past 30 years. These documents included alcohol legislation [24,25], major policy documents produced by the Department of Health [26] and numerous research reports produced by the HRB on alcohol-related health harms [2,7,8,10,27].

We also present data from 15 semi-structured interviews conducted with 17 individuals, including public health advocates and medical doctors [11], public health experts [2], former politicians [3] and a former policy advisor [1]. The interviews were conducted in-person or via Zoom between September 2019 and August 2020 and belong to a parent study of recent Irish alcohol policy developments.

Interviewees were purposively sampled, with e-mail recruitment yielding a response rate of ~55% of all those targeted. Interviewees were selected because they had either been active participants in the policymaking process (35% of sample) or possessed in-depth knowledge of alcohol policy developments in Ireland (100% of sample). The timing of interviewees' involvement in the policy process varied. Among government officials and advisors, most interviewees were involved during the legislative debate over the Public Health (Alcohol) Bill (2015–2018). Other officials' experiences were limited to the previous period, when the legislation was originally developed (2011/2012 to 2015). The public health experts included in the interview sample were not privy to many of these internal processes but were routinely called upon to offer guidance when alcohol-related issues were discussed (from mid-2000s to 2015). In the case of public health advocates, all of the interviewees were involved in the main campaign to support the legislation (2015-present). Approximately half of the advocates had some experience providing expert advice for the government or conducting advocacy work in the preceding decade.

The interviews were undertaken by the first author and were recorded with permission, and transcribed verbatim. Ethics approval for data collection was obtained from the University of York. Transcripts were initially thematically coded and analysed using NVivo 12 by the first author. The transcripts were subsequently analysed in an iterative manner, with both authors reviewing them, generating and refining thematic material, and agreeing on interpretation. We developed a broad set of themes to organise and interpret the initial data, identifying the key actors, events and institutional processes central to alcohol policy development. When the influence of earlier developments emerged as a key strand of the analysis, we re-analysed the data, identifying new themes relevant to PFT, including institutionalism, policy legacies, self-undermining feedback processes and perceptions of policy failure. Rather than testing PFT's core propositions,

we instead drew upon the framework's analytical orientation to enrich the thematic analysis. Empirically, this meant undertaking an exploration of perceptions of alcohol policy decisions made in the 1990s and early 2000s, the resulting costs and benefits, and the long-term political consequences of those decisions according to actors involved in more recent stages of the process. In particular, we were interested in exploring how the accumulation of costs over this time period influenced the desire for subsequent policy change, particularly among politicians and advocates [17].

Results

The institutional context of alcohol policymaking in Ireland

Alcohol policymaking everywhere is complex because of the multitude of ways that alcohol raises issues for policymakers [28]. Approximately 11 different government departments possess some interest in alcohol-related issues in Ireland [29]. From a policymaking standpoint though, some departments are more invested than others. The Department of Health has, until recently, lacked a legislative basis for establishing tools to influence alcohol consumption and harm [30]. The Department of Justice has been much more influential, particularly given jurisdiction over licensing. Recognition of alcohol's cross-cutting nature is longstanding in Ireland. In a key mental health policy document released in 1984, *The Psychiatric Services: Planning for the Future*, the government was urged to adopt an 'interdepartmental' approach to alcohol policy [31].

As alcohol consumption grew in the post-war period, alcohol was identified as a key source of several health and social problems in Ireland [32]. The 1984 report underlined many of these themes, calling for an approach to alcohol rooted in public health and prevention [31]. Expert bodies, including the World Health Organization, have long advocated policies which made alcohol less affordable, available and visible. For much of Ireland's history, the government's general approach to alcohol ran counter to such advice [4,33].

In the late 1980s, prioritisation of health promotion in Ireland and elsewhere placed alcohol into sharper focus. The Health Promotion Unit within the Department of Health took responsibility for developing new policy recommendations (see Table 1). In its 1996 report, National Alcohol Policy—Ireland, it urged the government to adopt numerous 'environmental strategies' for reducing alcohol consumption, in line with World Health Organization guidance. The 1996 report was welcomed by the government but it ultimately had 'little or no practical effect' on policy [34].

In November 2000, a Commission on Liquor Licensing was appointed by the Justice Minister to review Ireland's alcohol licensing system. Early in the process, several stakeholders identified health concerns as central to any discussion about licensing (Interview A). The Commission deemed public health considerations as outside of its competence, however, and recommended a separate process be established [35]. The Strategic Task Force on Alcohol (STFA) was appointed in 2002. It issued an interim report and a final report in 2004 [36,37]. As concerns about alcohol-related harms grew, the government responded by initiating these *ad hoc* processes.

Both the 1996 and 2004 reports were informed by a public health approach. Although the STFA's two reports largely echoed the 1996 report's recommendations, the evidence had shown that alcohol consumption had continued to rise steadily. For example, between 1989 and 1999, Ireland had experienced the highest increase in consumption among EU countries [36].

In its final report, the STFA estimated that alcohol harm was costing Ireland €2 billion per year. To reduce consumption, it recommended new restrictions on alcohol marketing and promotions. The recommendations included new restrictions on where alcohol advertisements could be placed, a ban on industry sponsorship of youth leisure activities and mandatory health warnings on alcohol advertisements [36]. Despite some initial interest in following that advice, the government instead announced several self-regulatory measures with the alcohol industry [29].

A subsequent parliamentary committee established in 2006 identified key institutional weaknesses. In its review of alcohol policy in Ireland following these reports, the committee noted the lack of 'permanent management structures… to give effect to their recommendations' [38]. One public health expert echoed this sentiment:

> '*We had the first national alcohol policy in 1996 which is a wonderful study in policy-making. It should be picked apart piece by piece because the language in it is really interesting. And then we had two Strategic Task Force* [reports]. *So we have a policy that comes in and then we have these task forces. The status of those task force reports is never quite clear. They're brilliant and possibly the best things ever written on alcohol policy in Ireland, but they're not government policy. They're task force reports*' (Interview B).

The parliamentary committee went on to recommend that alcohol be included as part of the National Drugs Strategy's (NDS) remit since the latter possessed a permanent policymaking structure [38]. This

Table 1. *Key Irish policy developments 1980s to 2010s*

Time	Event
1984	A mental health policy document, *The Psychiatric Services: Planning for the Future*, is released, calling for an inter-departmental and public health approach to alcohol.
1996	Following several years of drafting and consultation, the Health Promotion Unit in the Department of Health releases the *National Alcohol Policy – Ireland*. No major policy changes are subsequently pursued by the government.
2000	The *Intoxicating Liquor Act 2000* is enacted, introducing several liberalising changes, including longer opening hours and free movement of licenses.
2002	The STFA is appointed to investigate health-related aspects of licensing changes in Ireland.
2003	The *Intoxicating Liquor Act 2003* is implemented to address some of the unintended consequences from policy reforms in 2000 (e.g. partially reversing earlier closing times).
2004	STFA releases a final report and urges the government to adopt new legislation on alcohol marketing and promotions.
2005	The government decides against acting on STFA's recommendations.
2006	A parliamentary committee identifies limited institutional capacity as a key reason alcohol-related health harms have not been adequately addressed in Ireland. The Restrictive Practices (Groceries) Order is abolished, allowing alcohol to be sold below-cost selling.
2007	The HRB releases its first major report on alcohol, identifying significant increases in health-related harms.
2008	During public consultations on the NDS, concern over alcohol-related harms is particularly prominent. Public health advocates, led by Alcohol Action Ireland, begin to mobilise groups and stakeholders concerned about alcohol harms. The *Intoxicating Liquor Act 2008* is implemented based on recommendations from the Government Alcohol Advisory Group. The new legislation includes earlier closing time for off-licences and a plan for structural separation but the government decides against implementing the latter.
2009	Government announces that alcohol will be included under NDS's remit and establishes a Steering Group on a National Substance Misuse Strategy to develop policy recommendations. The HRB releases a second report that documents increased social harms associated with alcohol consumption in Ireland.
2010	In its budget, the government announces a 20% reduction in alcohol duty.
2012	The Steering Group on a National Substance Misuse Strategy recommends several measures for decreasing consumption, including measures to influence the availability, marketing and price of alcohol.
2013–2014	Public health campaigners lobby the government to adopt the steering group's recommendations. Legislation is debated in cabinet.
2015	General Heads of the Public Health (Alcohol) Bill is released. The Public Health (Alcohol) Bill is introduced in the Irish parliament.
2018	The *Public Health (Alcohol) Act* is passed.

HRB, Health Research Board; NDS, National Drugs Strategy; STFA, Strategic Task Force on Alcohol.

call to action again fell on deaf ears. Yet in 2008, during NDS public consultations, the government could not avoid mounting public concern about inaction on alcohol (Interviews C-1, C-2 and C-3). As one advocate recalled:

> '[Government officials] *did a country roadshow ahead of the announcement of the next National Drug strategy… everywhere they went they had community meetings and town hall meetings…* [and] *were absolutely gobsmacked how many people actually highlighted alcohol as being the major concern… Everywhere they went, everyone… spoke about the impact of alcohol*' (Interview C-1).

A similar sentiment was expressed by two of the three politicians interviewed. Both recalled how access to cheap alcohol became a major issue of concern during this time (Interviews D and E). By the late-2000s, then, there was growing acknowledgement that alcohol was a major and growing problem, yet Ireland lacked sufficient institutional structures for responding to this concern.

Growing recognition of alcohol policy failure

The Irish government's laissez-faire approach to alcohol conflicted with accumulating evidence of growing harms. Several studies documented sharp increases across several social and health indicators (Interview D). Much of this research was summarised in two reviews prepared by the HRB [7,10]. The reviews garnered significant attention in the public health community and the press (Interview A). Between 2000 and 2004, it was estimated that over 4% of deaths in Ireland

had been caused by alcohol. These included deaths from chronic alcohol-related conditions such as liver disease, as well as alcohol-related accidents and non-accidental deaths [39]. The age profile also began to shift. Among young adults, liver disease had increased by 247% for those aged 15–34 years and by 224% for those aged 35–49 years [9]. Alcohol was also linked to an increase in suicides, particularly among young men. Between 2000 and 2004, it was estimated that alcohol was a major contributing factor in 823 suicides in Ireland, which were at a high level by international standards [39]. These data also challenged stereotypical ideas about the nature of alcohol problems.

Interviewees consistently described perceived relationships between increasing harm and the limited effects of government policy. As one public health expert explained:

> '*With the big increase in alcohol consumption that we had in the 1990s, by the time we came to the mid-2000s, a lot of the legacy of that was coming through in terms of the massive increase in terminal liver disease and so on… There was this lag between the consumption and the harms but the harms came out really strongly*' (Interview B).

Rises in consumption and harms were also driven by economic forces as disposable incomes increased. According to one politician, a range of policy decisions also removed traditional barriers to alcohol (Interview E), and thus promoted greater consumption. These shifts began in the late 1980s and continued for the next 20 years. The *Intoxicating Liquor Act* 1988, for example, extended opening hours for pubs on Sundays, while also enabling restaurants to have full liquor licences [24]. The legislation was updated in 2000, further liberalising licensing regulations as well as extending pub opening hours [25]. Some of these changes, including on pub opening times, were partly reversed in 2004 while the neighbouring UK continued to remove licensing restrictions [40].

There were also key changes to policies governing alcohol pricing. The surge in consumption had been briefly tempered in 2003 after an increase in alcohol taxes was imposed [41]. For most of the 2000s, however, various efforts sought to make alcohol less expensive. In 2006, the Restrictive Practices (Groceries) Order was abolished, allowing alcohol to be sold below-cost [42]. In its Budget 2010, the government reduced excise duty on alcohol by 20% [43]. Notwithstanding the tax increase in 2003 and the modest licensing policy reversal in 2004, alcohol became increasingly affordable and accessible in Ireland.

One of the interviewees, a former senator, recalled the dramatic nature of change in availability:

> '*When I was in the Senate, there was the loosening of the regulations around* [the] *availability of alcohol*. [This coincided] *with the boom… Now alcohol was available in garages, in supermarkets… you* [went] *into a supermarket at Christmas, like a small supermarket* [and] *the place* [was] *stacked to the ceiling with* alcohol' (Interview F).

Another former senator suggested the deregulation of the alcohol retail sector induced a major cultural shift:

> '*If you walk into any small local shop over the last 20 years, you… see the growth of alcohol sales. You can see the amount of shelf space they're being given… it's beside the bread or… the nappies. It has just become so normalised*' (Interview N).

A consensus emerged first within civil society, and then later within government, that this shift had invited a new host of problems. As one advocate put it:

> '*We opened a can of worms by liberalising availability by allowing alcohol to be sold in every corner shop… The pendulum had swung too far*' (Interview G).

This sentiment was shared by a former politician, who said:

> '*The deregulation of the availability of alcohol … was such a victory for the industry … alcohol consumption went right up during the boom … I think there probably was a view* [within] *public health circles … and the Department of Health* [said], "*oh, my God, this is too much*"' (Interview F).

Civil society groups that had not previously been as engaged on alcohol-related matters also became increasingly concerned about alcohol availability and promotion (Interview C-1). As one interviewee explained:

> '*It's now quite easy for young people to get access to alcohol. It's relatively cheap with the low-cost selling and then with just the explosion of multimedia young people are being bombarded everywhere* [by] *alcohol*' (Interview G).

Others went further, linking particular policy decisions and specific harms. According to one expert:

> '*I think a lot of* [the public disorder] *came about due to the changes in our licensing laws that would have started around the 2000s*' (Interview A).

Thus the number of stakeholders affected by the costs of these decisions was growing over time. This provided incentives for these new opponents of alcohol harms to politically mobilise in favour of policy change.

Mounting concern about the availability of alcohol garnered the attention of the government as well (Interview E). In January 2008, the Justice Minister appointed the Government Alcohol Advisory Group and asked it to examine the growth of off-licences, among other issues. The group recommended the introduction of "physical separation of alcohol products from non-alcohol products in mixed trading premises" [44]. The government accepted several of these recommendations and enacted changes to the *Intoxicating Liquor Act* in 2008. Despite the inclusion of structural separation in the legislation, the government chose against implementing the provision (Interview E). As one advocate recalled:

> '*On the very day that the Act was brought in… the Minister for Justice… stood on the steps of government buildings and said, "we're not going to implement that at this time". So they went through the process of bringing it through all of the stages of legislation, they signed off on it, and then they fell back to self-regulation… and they said, "we'll keep an eye on that and we'll see if the industry is managing on their own"*' (Interview C-1).

By 2009, there were clear signs over the longer term that overall alcohol consumption was creating a significant health and social burden, as well as a broader recognition that the government lacked adequate institutional structures for addressing the issue.

Economic growth meant that consumers had more disposable income, making alcohol more affordable [34,36]. The financial crisis did not immediately serve as an impetus for making major changes to alcohol policy, as there were other policy priorities, and overall consumption reduced:

> '*With the recession and austerity… consumption did go down… but it was going back up again as the economy recovered*' (Interview F).

The political consequences of institutional problems and policy failure

Inadequate institutional responses coupled with growing attention to alcohol-related harm, including perceptions that the broad policy approach was contributing to accumulating levels of harms, spurred activity among the public, experts and civil society. By the late 2000s, there was a clear sense that doing nothing or leaving it to industry to self-regulate was not viable (Interviews D and E). As a former junior health minister explained:

> '*This sort of stuff has been bubbling up now for 20 years… a lot of people saying to politicians… the famous phrase: 'something has to be done, something has to be done'… So I think there was public pressure to do something*' (Interview D).

One public health expert described a similar public opinion shift:

> '*In 2009, I think there was a lot of pressure that something had to be done about alcohol. It was just there, it was a problem, and I think* [the government] *couldn't really ignore it anymore*' (Interview A).

Interviewees had different explanations for the public's demand for policy action. One doctor described how the personal costs of alcohol consumption may have been instrumental:

> '*Sometimes it has to come to your door in order for everyone to get that idea that this is a real thing. Here I'm having to tell this 50-year-old, who's been drinking wine seven days a week that her liver is gone and that she's on the list for a transplant. That's real to that person at that time*' (Interview B).

Others described how vivid signs of policy failure were important in provoking the government's attention (Interviews A and J), including increases in antisocial behaviour outside of pubs (Interview A).

One advocate recalled a prevailing sense that things had "just got completely out of control" and the government realised that it "had to do something" (Interview J). As pressure was mounting on the government, key public health advocates, particularly Alcohol Action Ireland (Interviews J and N), started mobilising key constituencies, including liver specialists (Interviews H and I) and psychiatrists (Interviews K and L), who had grown increasingly concerned about alcohol-related harm [45]. As a previous policy advisor in the Department of Health explained:

> '*At the tail end of* [the 2000s], *the Department of Health … recognised that… much of what we had put in place wasn't effective, it wasn't working and* [and so it] *set about establishing the rounds for what we now know as the National Substance Misuse Strategy*' (Interview D).

In 2009, the government created a steering group for the National Substance Misuse Strategy and tasked it with developing alcohol policy measures that could be integrated with the NDS. The steering group was highly diverse, comprising officials across government departments, major health NGOs, civil society groups and representatives from the alcohol industry. The group was established to specify measures that could be used to 'tackle the harm caused to individuals and society by alcohol use and misuse' [46]. The creation of the steering group, then, represented progress for public health advocates.

The group's final report, released in February 2012, identified 'price, availability and marketing' as the drivers of alcohol consumption and urged the government to adopt stricter alcohol policies [46]. The report thus adopted the key tenets of a public health perspective on actions that could be taken. The representatives from the alcohol industry refused to endorse the report and released two minority reports in protest [47,48]. Efforts by the alcohol industry to undercut the majority's work were ultimately unsuccessful (Interviews B and H). Several interviewees explained that many of the conclusions reached by the steering group were 'well-established within public health circles'. (Interview M). As one advocate explained:

> '*The steering group's report… stood on the shoulders of two…* [STFA] *reports that go back to the 2000s… The groundwork, politically, had been done in an iterative way. But the story doesn't start with that group in* [2009], *it goes back to that first report of the* [STFA]' (Interview H).

The willingness of the government to listen to expert advice, then, shifted in this period. Public pressure and the mobilisation of key civil society groups were the key differences from the earlier period (Interviews J and N).

Six years elapsed between the steering group's final report and the eventual passage of the *Public Health (Alcohol) Act* in 2018. The government succeeded in charting a new path for alcohol policy that faced numerous challenges along the way. Some of the advertising restrictions were implemented in 2019 and structural separation fully commenced in 2020. Other aspects of the bill, including MUP, product labelling and other advertising restrictions, have yet to commence but are slated for implementation at a later date. In the case of MUP, there has been a long-standing desire to coordinate implementation with Northern Ireland. This, however, has been subject to several delays. Recently the Irish government announced it would be going alone on MUP and expects to have the policy in effect by December 2021.

Discussion

The *Public Health (Alcohol) Act* 2018 represented a major victory for public health interests after a - decades-long struggle to have alcohol recognised as a public health issue. This was secured as alcohol was becoming more problematic for society, in part because of weaknesses in institutional and policy decision-making processes, and also because of the dominant approach of liberalisation. Our analysis shows how policy conditions were decisively changed in 2008/2009 in ways influenced by earlier developments.

First, we document how the government largely overlooked the health harms associated with alcohol consumption and then explore the potential consequences of this ignorance over time. Our analysis suggests that Ireland's failure to establish adequate institutional structures for exploring and continuously monitoring the health and social impacts of alcohol consumption likely played a role in this inattention.

Second, we examine how several policy decisions that deregulated the alcohol sector (and non-decisions that made alcohol more affordable) were then followed by subsequent increases in alcohol consumption. Although the research design limits our ability to draw causal connections between these factors, our results reveal how government policy created a policy context that made consumption easier and thus likely contributed to higher incidence of alcohol-related harms. This narrative of policy failure is firmly established as representing the history of Irish alcohol policy development according to actors who were later involved in policy change.

Finally, we show how insufficient institutional authority and the accumulation of the effects of policy failure may have increased the visibility of alcohol harm to stakeholders over time. This seems to have begun with experts, who could see evidence of alcohol-related health problems on the rise, and then civil society organisations, both of whom perceived the impacts that increasing alcohol consumption was having on the communities they served. There is also evidence of influential shifts in sentiment on the acceptability of alcohol harms in the general public. These forces placed significant pressure on the government, leading first to the inclusion of alcohol under NDS and eventually to the enactment of the Public Health (Alcohol) Bill in 2018. Thus, our findings reveal how the series of political contests that unfolded between 2012 and 2018 had deeper historical roots.

Other policy process theories, including the Multiple Streams Approach and the Advocacy Coalition Framework, provide alternative frameworks for analysing such policy changes. These accounts identify the role

of policy entrepreneurs or timing (Multiple Streams Approach) and actors' beliefs and/or political resources (Advocacy Coalition Framework) in spurring policy change [49,50]. Recent studies have applied these frameworks to the Irish case study [12–14,16]. The focus of such research has been close to the events under study, providing snapshots of policy actors' activities in the policy process, in ways similar to alcohol policy investigations elsewhere (including by us [51–53], though see [16]). One limitation of such temporally circumscribed analyses is that they may obscure the influence of earlier antecedents. This study addresses this gap by exploring the development of alcohol policy over time and benefitting by being informed by a distinct analytical orientation. The approach used here is different from longer-run historical scholarship [16,54,55] in seeking to apply policy analytic approaches within shorter timeframes [13,56].

Another policy process theory, Punctuated Equilibrium Theory, may provide a different way to think about the findings. Punctuated Equilibrium Theory presents a model of policymaking where stable policy processes are occasionally punctuated by seminal departures from past policy practices. According to this framework, decision-makers engage in disproportionate information processing; they under-attend to a particular issue until a crisis focuses their attention [57]. Some of the findings presented are consistent with this model of policymaking. Although signs of institutional and/or policy failure were evident during the 1990s and 2000s, these indicators were largely overlooked by key decision-makers. Only when they reached crisis levels (and critically, when these were highlighted by a coalition of advocates, experts and the public) did the government feel the need to prioritise institutional reform and major policy change. These developments were reinforced in the aftermath of the financial crash, when rising health-care costs and acceptance of the major role that alcohol played, became prominent in an era of austerity politics.

A strength of this study is the use made of informant interviews to generate key inferences about alcohol policy development in Ireland, and relatedly about drivers of salience, and how perceptions of history inform political ideas. Previous studies have most commonly drawn on primary documents and/or newspaper coverage to capture the process. We show how policy participants possessing a wealth of knowledge and insight may articulate their perspectives on the influence of longer running historical processes on more contemporary issues. Fine-grained analyses need to situate informant interviewees in relation to the matters being discussed. Long-standing participants in the policy process have obvious value for testing rival explanations after taking account of recall and positionality issues, as well as in identifying other patterns that might not be uncovered in documents. Contemporary actors not directly involved previously may nonetheless contribute to efforts to better understand how earlier events shape later events by tracing how their accounts of the past shape their motivations and actions.

The findings have broader implications for the study of alcohol policy. Ireland is far from the only Anglophone country that liberalised alcohol regulation in the 1990s and 2000s. England, New Zealand and several Canadian provinces underwent similar policy changes [16,40,58,59]. In none of these contexts, however, has there been anything akin to the *Public Health (Alcohol) Act*. This might be because liberalisation was pursued further in Ireland, and/or because the earlier policy making institutions were weaker, and so generating costs more easily. It also might be the case that the feedback processes (i.e. costs) were met with incremental policy changes by governments elsewhere, though this is not obviously so. Future work could consider how feedback processes have played out in different contexts. This approach could also be taken to policy implementation at lower levels in policy systems (e.g. restricting outlet density and opening times in Australia) [60,61]. This study shows that alcohol policy decisions and their consequences are inviting of these types of analyses, which have clear capacity to deepen our understanding of alcohol policymaking.

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Conflict of Interest

None.

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