

The controversial discourse on beer in Iceland

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ABSTRACT

AIMS – This study investigates the motives and discourses around the decision taken by the Icelandic parliament in 1989 to legalise beer sales after a prohibition of 74 years. A bill was passed in 1988 that allowed the selling of beer in licensed restaurants and the state alcohol monopoly stores. **DESIGN** – The sources used for this study are mainly newspaper articles and other materials and reports published in the period 1980 to 1989. **RESULTS** – The passing of the bill was preceded by many controversial discourses in Iceland. Lobbying groups with commercial interests campaigned for the legalisation of beer, while representatives of the alcoholism movement took no formal stance on the issue, parliamentarians broke from party lines and medical doctors were split into two factions. Common questions included the plausibility of the total consumption model, various understandings of WHO recommendations, diverging interpretations of other countries' experiences of beer, and different views on how beer would affect individuals suffering from alcoholism. **CONCLUSIONS** – The changes in Icelandic alcohol policy to legalise beer were in keeping with contemporary societal processes of globalisation and modernisation, but public health arguments were given less priority. While the decision to legalise beer increased the commercial functions of the state alcohol monopoly, it also strengthened the monopoly's role as an actor in alcohol policy.

KEY WORDS – alcohol controls, discourse, medical doctors, beer, legalise, Iceland

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Introduction

For decades, prohibition of beer had been a controversial issue in the Icelandic society, when the ban on beer was finally lifted in 1989. In the course of this long debate around alcohol control measures, many important issues were raised. This process can therefore be understood as a sociological exercise of social control. Even if the repeal of the ban on beer was a blow to one of the cornerstones of Iceland's restrictive alcohol policy, the legalisation of beer also had consequences for other pillars of the alcohol control policy in various ways.

Some earlier studies have analysed the prohibition of beer from the notion of demography and symbolic law (Gunn-

laugsson & Galliher 1987; 2010; Steinsson 1996).

Another explanation emphasised that cultural specificities were disappearing and countries were moving away from a dominant beverage (Ólafsdóttir 1999). Koskikallio (1987) drew attention to the functionality of the ban on beer by comparing the two northernmost spirits-drinking countries, Finland and Iceland. He showed that after the end of prohibition in both countries, alcohol consumption followed the same pattern, with the exception of beer.

In this paper, I will attempt to analyse the rhetoric behind one of the most important alcohol policy decisions taken in

Iceland in the twentieth century, that of legalising beer. Such an analysis may contribute to an increased understanding of the process of alcohol policy creation. In the public discourse prior to the legalisation, many actors raised their voices but medical doctors were among the key contributors. Their rhetoric therefore merits particular attention.

A spirits-drinking society par excellence

With a 74-year prohibition on beer from 1915 to 1989, Iceland was a spirits-drinking society par excellence. Geographical and pragmatic reasons make Iceland not suitable for vineyards, and growing corn has also been difficult in the short summers and low temperatures. For centuries, most alcohol was imported, so economic interests related to the production of alcoholic beverages were small, but state revenue from alcohol taxes did matter.

Total prohibition of alcohol sales had been implemented in Iceland after a referendum in 1908, which resulted in 60% of the voters favouring prohibition. Voting rights were limited to men at least 25 years old. A prohibition act was passed in Althing (Icelandic Parliament), which was to take effect in two stages: alcohol imports were prohibited from 1912 and sales from 1915 (Ólafsdóttir 1999). A 1917 amendment allowed the selling of alcohol for medical purposes. Another exception to the prohibition act was made for light wines (Spanish wines) in 1922 because Spain refused any further trade in fish if the Icelanders did not exchange cod for wine.

In the following years, requests to repeal prohibition became more vigorous. A new referendum was taken in 1933. By

now women had gained the right to vote, and the voting age had been lowered to 21 years. General interest in the poll was low, with a participation rate of only 45%, and 58% of the voters were in favour of the repeal. During the discussion in the Althing following the referendum, one member proposed not to lift the prohibition of beer. His main argument was that the most negative consequences of alcohol consumption were caused by beer drinking. Beer was the route to public drinking, particularly among young men: they would start with beer, which supposedly would increase their inclination toward stronger beverages and would mark their road to abuse. A great majority of the MPs agreed on this proposal. The ban on distilled spirits was lifted in 1935. It has been argued that the issue of beer was a bargaining question to ensure the passage of the rest of the bill (Gunnlaugsson & Galliher 1987).

In the 1930s, the global prohibition wave that rose in the early twentieth century was sinking. The prohibition was repealed where it had been adopted (Schrader 2010). Iceland's keeping the ban on beer was therefore exceptional, and keeping the ban for 74 years is unparalleled in the Western world.

Among the Nordic former spirits-drinking countries, Iceland was the last to shift from spirits to beer and wine. Heavy tax rises on strong spirits in 1917 made Denmark a beer-drinking country. In Finland, the policy change in 1968/1969 was about introducing medium-strength beer in grocery stores, while in Sweden, after the rationing system was abolished, differentiating beers by strength became a significant factor of the national alcohol policy.

During World War II, when Iceland was

occupied first by the British Army and later by US forces, Icelandic breweries had gained allowances to brew beer for foreign troops. During the wartime shortages of consumer goods, alcoholic beverages were rationed as were many other commodities. In the following years the discourse on drinking mainly focused on whether to open a new monopoly store or not, a decision which was taken locally. Such ballots were carried out in connection with general elections, and there was a great resistance to open monopoly stores especially in the countryside until the 1970s. The generation born in the former part of the century had grown up in an era of low alcohol consumption. Drinking patterns changed slowly. The ban of beer was not repealed even if it was believed that a majority of the parliamentarians in the mid-1970s were in fact in favour of lifting the ban (Jakobsson 2010). Constituencies were structured in such a way that MPs from the rural areas were overrepresented in the parliament. They would not vote against prohibition and temperance values which had always had more support in the countryside than in the Reykjavik region. The continuing prohibition of beer after the legalisation of strong spirits may therefore be explained by the political structure. Examining the global prohibition wave, a recent study suggests that prohibition may be better explained by political structures than by ideological and cultural aspects (Schrader 2010).

But times were changing. General consumption increased; cultural specificities were disappearing; increased communication and travel brought influences from abroad; and local interest groups discerned financial profits in beer sales. Changes in

problem construction were also taking place, as illegal drugs were replacing alcohol as a threat to the youth.

Alcohol sales increased slowly from 2.5 to 4.3 litres of alcohol per capita per 100,000 inhabitants aged 15 and over from 1950 to 1980 (Statistics Iceland 2011). The share of spirits declined from 92% to 72% in the same period. Vodka and Icelandic aquavit were the most popular beverages, usually drunk as shots or blended in soft drinks or coffee. The first surveys of drinking frequency, carried out in 1972–1974, found that 9% of men and 27% of women aged 20–49 were abstainers and the majority were infrequent drinkers. Drinking and intoxication were mainly related to festivities. Intoxicative behaviour linked to nightlife entertainment often led to arrests for disturbing behaviour (Ólafsdóttir 2003). Therefore, this drinking pattern was of particular concern. A wide range of studies of drinking patterns have found such a pattern to be a characteristic of young or middle-aged males in the Nordic countries, Canada, the USA and the Netherlands (Babor et al. 2010).

An overview of selected alcohol-related harm indicators in the period from 1950 to 1980 showed a peak in public intoxication in 1975, followed by a decline in 1980 (Ólafsdóttir & Helgason & Tómasson 1984). In the same period, drink driving, injuries caused by drink driving and violent deaths increased. Deaths due to alcohol poisoning and alcohol dependence rose until 1975, followed by a slight decrease in 1980. This corresponds with research findings of spirits drinking being more associated with fatal alcohol poisoning and aggressive behaviour (Mäkelä et al. 2007). However, recent studies from

the US, the UK and Norway have shown that beer has most often been involved in hazardous drinking because of its cultural meaning as a recreational beverage (Babor et al. 2010). Mortality due to liver cirrhosis has followed a path of its own, peaking in 1960, but decreasing in the following years. The discrepancy between liver cirrhosis mortality and the total consumption of alcohol has not been fully explained (Ólafsdóttir 2007).

Because alcohol-related harms were caused by spirits and intoxicative drinking, some of the advocates for introducing the sale of beer considered beer to have qualities that would lead to new drinking patterns. They argued that beer could be legalised because it would then become a useful instrument in changing the drinking culture. Others were not so concerned about this distinction between light and strong beverages. Rather, they saw beer as a new beverage and as a sign of modernity.

A shift of concern of alcohol problems from the public to the private sphere of life happened quickly, when a new understanding of alcohol-related problems was introduced. In the mid-1970s, a policy window opened for a group of enthusiastic individuals to push attention to alcohol problems, propose a solution and gain political receptivity. This endeavour resulted in an unprecedented volume of admittance to alcoholism treatment, followed by an increasing number of AA groups (Ólafsdóttir 2000; 2007). Drunken people were no longer seen as a policing task but in need of being admitted to treatment. This governing image of alcohol problems rejected the medical classification of alcoholism as a mental illness. Instead, all alcohol-related problems were

seen as symptoms of alcoholism, which was defined as a special, incurable disease and frequently presented as a family disease (Ólafsdóttir 2007). In this view, there was no reason to ban beer because individual characteristics rather than the beverage were to blame for alcohol-related problems. This problem construction split the drinkers in two ideal type groups; the alcoholics who were to be offered an easy access to treatment and the social drinkers who could be left to self-control. Such an approach was very similar to the changes in alcohol policy in North America, where the alcoholism movement had provided an alibi for weakening alcohol controls earlier in the century. However, some members of the Icelandic alcoholism movement expressed social concerns, supporting a more robust policy to protect their fellow members.

Theoretical background, methods and data

Both the implementation of prohibition and its repeal were validated by legislative changes. Motives behind the making of Icelandic criminal law have been classified in three main categories: societal circumstances, ideologies and increased knowledge (Thormundsson 1999). Ideological motives were no doubt strong in implementing prohibition, whereas societal circumstances can be said to have led to amendments allowing the sale of wines.

The cultural position of drinking and the rates of drinking problems in a society have been analysed and termed as a "wet" and a "dry" solution (Room 1992). While Iceland was one of the "dry" countries, intoxicative drinking caused disruptive behaviour and there was heavy drinking

over time among some of the drinkers. The "dream of a better order" was therefore appealing but in order to change the societal circumstances, lighter-strength beverages had to be made more available.

Earlier research has made much use of the dichotomy of symbolic and instrumental law (Gusfield 1963). Symbolic laws are not intended to change behaviour through direct influence on people's action, rather they are passed to appease public concern and have three basic functions: they indicate that something is being done about the problem, they help solidifying moral boundaries and they become a model for the diffusion of law to other agencies (Sample et al. 2011). Laws are declared to have instrumental effects when court ruling, legislation and public policy result in changes in behaviour and ameliorate a public problem (Grattet & Jenness 2008).

More recent studies have stressed the value of examining the interrelationship between these two ideal types (Grattet & Jenness 2008). Jenness (2004) points out that there has been a shift from focusing on changing demography and status politics to the relationship between selected social entities and actors to the underlying larger processes of institutionalisation, globalisation and modernity. She has presented a review over a number of factors to be studied that provide the impetus for criminalisation and which sustain the process over time. Her list includes the following factors: triggering events, the shape of political opportunities, individual moral entrepreneurs and experts, interest groups and interest group politics, organised social movements and diverse structural conditions. These explanatory factors have been used in many studies

on criminalisation but more seldom have they been employed in studies on decriminalisation.

In this study, where the focus is on the abolishment of legal restrictions, most of these factors are relevant, with the exception of an organised social movement. I will touch on these factors, spending more time on the notion of triggering events. The main objective is to analyse the discourse of the experts who in this case were medical doctors.

Particular attention will be paid to the following themes that were discerned in the public discourse on the issue of beer: intentions to change the drinking habits; the civilisation process; the promise of substitution; links to health and WHO guidelines; drink driving; alcohol abusers; protection of youth; drinking and everyday life; discrimination in the availability of beer; and economic interests in national beer production.

My study is based on earlier research on the topic. I have used newspaper articles selected as follows: the data had been published in newspapers, they had been written by medical doctors, and published in the period 1980 to 1989. At that time, *Morgunblaðið* (The Icelandic Daily) was the leading newspaper, which published submitted articles. This explains why all the articles were published in this particular daily. Other articles and news on the beer issue were not analysed in depth but they serve as a background material along with government and parliamentary reports.

However, a limitation of this study should be mentioned. The data may not fully cover all aspects of the medical doctors' discourse. Investigations of other

contributions and in other writings might have revealed a more nuanced discourse. The method used is a thematic analysis of text and discourses (Patton 2002).

Triggering events

Even if the sale of beer was not legal, beer was available to a limited extent. Seamen, fishermen and flight crews had for a long time been entitled to tax-free imports of eight litres of national beer or six litres of imported beer for their own use. Home brewing and smuggled beer were another source of acquiring beer. In December 1979, Davíð Scheving Thorsteinsson, a well-known manager in the drinks industry, challenged the legislation in a memorable way. He was coming home from abroad and bought a six-pack of beer at the same time as a flight crew member. Thorsteinsson told the customs official that he intended to bring the beer into the country, stating that it was against the constitution to discriminate people according to their occupation. Following the rules, the customs confiscated the beer and told Thorsteinsson to pay a fine. This he refused, determined to bring the case to court.

However, the court case never happened because the Secretary of the Treasury found it discriminatory to ration the import of alcoholic beverages to specific occupational groups, so a new directive on travellers' allowances was endorsed. Instead of abolishing the special entitlements seamen and flight crew had been granted, the regulations were modified: all those arriving from abroad were now allowed to import a certain amount of beer. This decision authorised discrimination in the availability of beer. Frequent travellers who were likely to belong to the upper

layers of society were given legal access to imported beer for their personal use.

No political party lines

Bills on the legalisation of beer had been submitted to the parliament on a number of occasions but they had always been rejected. The prelude to the bill that was finally endorsed can be traced back to the spring of 1984 (Steinsson 1996). Four parliamentarians proposed a referendum on the legalisation of beer, followed by many other proposals in the later years. The parliamentarians, however, disagreed on the legitimacy of a referendum, and after a lengthy debate the motion was turned down.

Views on the legalisation of beer did not follow party lines. There were supporters in all political parties. At the time, alcohol issues were considered to be administrative rather than political issues, which is why they were not included in the party programmes. In Norway and Sweden, alcohol issues have long been attached to political identities and ideology, and alcohol policy argumentation has been part of the party manifestoes (Anttila & Sulkunen 2001). In this respect, Icelandic politics have been more like those in Finland, where alcohol issues and political identities have remained rather more apart.

On 28 October 1988, yet again a small group of parliamentarians submitted a bill on legalising beer sales, with the following objectives:

- to reduce the large consumption of strong spirits
- to change drinking patterns for the better
- to collect state revenue

- to bolster national production of beer and soft drinks
- to co-ordinate alcohol legislation.

The bill was submitted to numerous parties for review, but most of them opposed the bill (Steinsson 1996). The bill was somewhat amended after an extensive debate and was endorsed in the end. From 1 March 1989, it became legal to sell beer in the state alcohol monopoly stores, which brought an end to an era of prohibition in Iceland.

Such a reversal of the regulation on the sale of alcoholic beverages is rare, but it can be compared with the introduction of medium-strength beer in grocery stores in Sweden in 1965 and in Finland in 1969 (Mäkelä et al. 2002).

Even if the economic aspects of the proposed legislative changes of the Alcohol Act were predominant, the pharmacological qualities of alcohol could not be ignored. In the legislative process bills are usually submitted for hearing, where interest groups and experts are asked for their views on the matter. But who were the experts in this area? Medical doctors or the people? This question had to be answered. Was the repeal of the ban on beer a question of democracy and suitable for a referendum as had been the case when prohibition was initially implemented, and later when the ban on spirits was repealed? At an earlier stage, parliamentarians had disagreed on this matter, and the idea of a referendum was turned down.

Moral entrepreneurs and interest groups

Before the bill on beer was endorsed, the very issue of beer was widely debated in

society and the media. During this period of fermentation, there were many concurrent discourses. Moral entrepreneurs raised their voices, airing their anxieties about safeguarding the youth, temptations of alcohol abusers and drinking and everyday life. Initially, the prohibition on beer was seen in terms of protecting the young: preventive measures were particularly directed at the youth. Even if beer was considered less harmful than other alcoholic beverages, the assumption was that it would be more easily available to young people. Alcohol abusers were a central theme in the public discourse, which is no surprise given the power of the alcoholism movement. Even if the organisation responsible for the new alcoholism treatment facilities, SÁÁ National Centre of Addiction Medicine, did not take a formal stance on whether to sell beer or not, many of its members felt that beer would be dangerous for people in recovery. Heavy drinkers would fall prey to beer, unable to give up drinking.

Drinking as a part of everyday life was another prominent theme in public debate. It was feared that beer would lead to new habits such as drinking beer at lunchtime and in the workplace and increased drink driving.

Those in favour of legalising beer were especially keen to point to the discrimination in the availability of beer, which was a violation of civil equality. Other themes included comparisons with other countries, paternalism, and the belief that beer would become a substitute for spirits.

Interest groups also campaigned for their cause. Two breweries, Ölgerðin Egill Skallagrímsson in Reykjavík and Sanitas in Akureyri, produced beer for sale at

the Keflavik airport where Icelanders coming home from abroad could buy duty-free beer on arrival. At the airport, the breweries had to compete with foreign brands of beer, which made a larger home market all the more alluring. Also, many restaurant keepers were enthusiastic about the possibilities that would follow the legalisation of beer. The Chamber of Commerce endorsed the legalisation proposal for economic reasons.

Experts: division among the medical profession

In the spring of 1987, the Minister of Health put forward a national health plan to the parliament. One of the aims was to reduce alcohol consumption. This was in harmony with WHO recommendations which had encouraged that all nations reduce their total consumption of alcohol by 25% before the millennium. But this policy did not tally with the motion to legalise beer. The interrelationship was problematic and dealt with in differing ways by those involved in the debate.

The most active group of experts in the debate on beer were medical doctors. They framed the issue similarly to their Swedish colleagues, constructing alcohol problems as social issues, which was different from the medicalisation angle of alcohol problems endorsed by medical doctors in North America. Swedish doctors had acted as experts and played pivotal roles in alcohol policy discussions throughout the whole twentieth century (Sutton 1998).

In 1987, there were 665 physicians licensed to practise in Iceland. As many as 40% of all physicians publicly expressed their opinion on the issue of legalising beer (Directorate of Health 2011). They

were, however, divided into two main factions: those that opposed the motion, and those in favour of the legalisation. Tómas Helgason, professor in psychiatry and chief physician at Landspítalinn, National University Hospital, was a vigorous opponent of the bill and well-known both in Iceland and internationally for epidemiological studies of psychiatric disorders. His surveys on alcohol consumption and alcohol abuse were the first of their kind in Iceland. In December 1987 he opened the debate in an article asking whether the parliament was to exacerbate the alcohol problem (Helgason 1987). He encouraged the parliament to put more money into preventive measures and reject the bill on the repeal of the beer ban. His rationale was that the introduction of beer sales would increase the total consumption of alcohol. This, his main reason for opposing the motion, was further stressed in the polemics with a group of his medical colleagues (Helgason 1988).

Helgason claimed that the bill stemmed from pressure from drinks producers and those selling alcohol. What they were after was their share of the profits. He pointed out that because one of the objectives was to increase state revenue, this necessarily entailed increased sale of alcoholic beverages. Furthermore, as the purpose of the bill was to change drinking patterns and to encourage drinkers to shift from spirits to beer, beer would have to be priced lower than spirits. There would be no increase in state revenue unless there was an increase in the total sales of alcohol. Helgason argued that drinking patterns should be changed by changing attitudes to drinking, not by introducing a new beverage. His stand on the tax-free

imports of beer by travellers and crews was quite clear: such offences should be stopped rather than legalised.

It was of great concern, Helgason stated, that the parliament was not willing to follow the warnings issued by the WHO or the advice by Icelandic doctors about alcohol-related harms. Neither were they willing to heed WHO recommendations to cut down total alcohol consumption by 25%. Helgason cited his own epidemiological studies which showed that alcoholism was no more frequent in Iceland than elsewhere, even if Icelanders tended to favour intoxicative drinking. Rather the contrary might be the case. As intoxicative drinking was often followed by a hangover, self-medicalisation could tempt drinkers to have a beer as a relief. Such a pattern would shorten their way to alcoholism. Those who already were heavy drinkers would therefore probably drink even more if beer was to become available.

Medical professors' declaration

Not all, but as many as 16 out of 20 professors at the Faculty of Medicine, University of Iceland, wrote a declaration on the issue of beer (*Morgunblaðið*, 2 December 1987, 4). They supported Helgason's view that the sale of beer would increase the total consumption of alcohol and would have more bearing on national health than most other bills on health issues. Their central reasoning was that all alcohol-related harms – alcoholism included – would increase in the wake of increased alcohol consumption. Moreover, they argued that other diseases, casualties, suffering, disability and mortality could be attributed to alcohol abuse and would increase with a

rising consumption of alcohol. This would lead to soaring costs in health care. Social consequences, such as lost working days, domestic violence, mental and physical abuse and neglect of children and spouse would follow. The professors also drew attention to obstetrics, warning that a mother's drinking, even light drinking, could harm a foetus. Because beer seemed a more innocent form of alcohol, there was an increased risk that the addictive and blunting effects of alcohol were forgotten.

Their conclusion was pragmatic: when they were known, the causes of a disease should be prevented. According to the national health plan and WHO recommendations, preventive action should be taken. While one of the aims was to decrease the total consumption of alcohol, the motion on beer was contrary to this objective and it should therefore be rejected.

Clinicians' statement against beer

Medical doctors working in the alcoholism treatment system obviously had good reasons to be concerned about the proposed legalisation of beer, which led to them issuing a statement against the bill (*Morgunblaðið* 30 January 1988, 11). They endorsed the theory of total alcohol consumption and the relationship with alcohol and harms, presenting evidence of Sweden's introduction of medium-strength beer and of increased availability of beer in Finland. As far as they could see, beer would become widely available in Iceland as it would be sold in both monopoly stores and in public venues. The doctors presumed that alcohol abuse would become more common if the ban on beer was lifted. According to them, it had been the prohibition of production and the

ban on the sale of beer that had kept the total consumption of alcohol at a low level. Maintaining low consumption levels conformed to WHO recommendations, they declared, concluding that alcohol was a health risk. Parliamentarians should use their time to discuss alcohol policy in its entirety in relation to the national health plan and the WHO alcohol action plan before making a decision to lift the ban on beer.

138 medical doctors sign resolution

More medical doctors – professors of medicine and the medical doctors working in the treatment of alcoholism – joined forces with Helgason. A total of 138 physicians signed a resolution urging the parliament to reject the proposed bill on the repeal of the ban on beer (*Morgunblaðið*, 26 March 1988, 57).

Not in the name of the medical profession

Another tone was struck in a resolution by 133 hospital doctors and general practitioners (*Morgunblaðið*, 17 December 1987, 30–31). Theirs was a reaction against the declaration of the 16 medical professors warning against the legalisation of beer. The doctors claimed that the professors were not entitled to speak in the name of the medical profession. The resolution by 133 doctors pointed out that the dispute on beer seemed to be about whether to sell alcohol or not. In reality the question was whether to allow the sale of the mildest alcoholic beverage, beer, or only to permit the selling of the strongest alcoholic beverages. Nothing, they said, indicated that beer drinking was more harmful to health than

were other types of alcohol. The opinion that the consumption of beer would add to the total consumption of alcohol was arbitrary, as experiences from abroad did not show that there would be changes in the total consumption levels providing that beer was sold in the same way as other alcoholic beverages. Consumption would probably move from stronger to weaker beverages. WHO maintained that the most effective measure to control the total consumption of alcohol was price policy and limited availability, not a ban on specific types of alcohol. Several studies also suggested that the relationship between total consumption of alcohol on the one hand and physical and social harms of alcohol abuse on the other were not as straightforward as indicated in the professors' resolution. Rates of liver cirrhosis, both in the USA and Iceland, had declined even though total alcohol consumption had increased. Epidemiological studies of alcohol abusers showed a similar proportion of alcohol abusers in Iceland and the USA even if US consumption was somewhat higher. The proportion of alcohol abusers in Iceland was on par with that in Sweden and Norway, where beer was sold. There was therefore no reason to assume that Icelanders would fare badly even if the sale of beer were permitted in the alcohol monopoly stores.

Two of the 133 medical doctors, psychiatrist Grétar Sigurbergsson and chief pathologist Þorvaldur Veigar Guðmundsson wrote two long newspaper articles on beer (Sigurbergsson 1988; Guðmundsson 1988). They maintained that the legalisation of beer was not a matter for physicians, but rather an issue of democracy. Both approved of the connection between the total consumption model of alcohol

and alcohol-related harms with the exception of alcoholism. Here, they saw only a weak link, and perhaps it was the case that alcoholism followed altogether different principles.

In their articles, the authors compared alcohol sales in Iceland with those in other countries, particularly the other Nordic countries. They had found that in the Faroe Islands, an increased availability of beer had led to a decreased consumption of other alcohol beverages and that when the sales of strong beer in Sweden increased, the consumption of spirits diminished, bringing down the levels of total alcohol consumption. Referring to evidence from other countries, the authors argued that experiences from, for example, Germany, Austria, Belgium, Denmark and Australia indicated that drinking in workplaces was not as common as the opponents of beer argued.

Guðmundsson challenged Helgason's statement that even if there was a direct relationship between total alcohol consumption and alcohol-related harms, some harms – such as alcoholism – would become more prevalent than others. Guðmundsson pointed out that this assumption was contradictory to Helgason's own research on the incidence of alcohol abuse and that the researcher seemed to conflict with the policy maker. Furthermore, he questioned the predictions of the National Economic Institute of a 30% increase in the total consumption of alcohol following the legalisation of beer which Helgason referred to in his reasoning.

Sigurbergsson was in favour of the WHO-recommended restrictions on the sale of alcohol. These included restrictions on import, production and availability,

tax regulations, educational campaigns, limitations on advertising, and the use of moral religious forces in society. He also noted that WHO recommendations said nothing about weaker drinks being more dangerous than stronger beverages. He concluded that the regulation of beer sales was the most important factor. If it were sold like other alcoholic beverages, beer was likely to reduce the total consumption of alcohol, but sales of beer in grocery stores would lead to increased total consumption. Sigurbergsson also rejected the stepping stone theory on adolescent drinking that beer drinking would pave the way for spirits or illegal drugs.

Controversial issues

In the debate among the medical doctors for or against beer, the controversy centred on the relevance of the total consumption model, the understanding of WHO recommendations, interpretations of other countries' experiences of beer, and on alcoholism. The total consumption model was the leitmotif in the rhetoric among the medical doctors opposing the bill. This group made use of the WHO's message to all member states to cut the total consumption of alcohol, later formulated under the slogan "Less is better".

The other groups of medical doctors argued that beer would substitute strong spirits or would only add to a limited degree to total alcohol consumption. This group also endorsed the recommendations of WHO on strict alcohol policy measures including restrictions on imports, production, availability and advertising as well as taxation and educational campaigns. In general, the recommendations favoured milder to stronger alcoholic beverages, but

the question in the case of Iceland was at what cost. The medical doctors were decidedly divided on the answer.

In general, the debate was unusually international for a national polemic. At one point or another, all parties drew from international experiences to support their cause. Changes in beer regulations in the Faroe Islands, medium-strength beer in Sweden and the introduction of beer in grocery stores in Finland were the most referred to, but some evidence also came from other countries.

All participants in the debate discussed whether the legalisation of beer would have consequences for alcoholics. It was widely accepted at the time that alcoholics were a special group, but there was little consensus on how the number of alcohol abusers was linked to the total consumption of alcohol. Doubts about and denial of the relationship between total alcohol consumption and alcohol abuse advocated less strict alcohol controls. Health issues and increased health costs were mentioned, but little discussed. Interestingly, two of the medical doctors arguing for the introduction of beer, Sigurbergsson and Guðmundsson, renounced their roles as experts because the issue was rather a question of democracy and equality. Parliamentarians also set the public health experts' views aside, legalising beer despite convincing evidence that this would increase total alcohol consumption. Changes in alcohol policy were therefore not based on public health arguments but followed underlying societal processes at the time, globalisation and modernisation.

In the aftermath

The amendment of the Alcohol Act which

legalised the production and sale of beer implied that beer should be sold like other alcoholic beverages in the state alcohol monopoly and in licenced taverns. Other than this, no specific procedures were announced, which meant that many questions had to be solved before the sale of beer could start. What should the tax rate be on beer or the minimal unit of sale? Should beer be sold in cans or bottles? How strong should it be? What counted as imported or nationally produced beer? How many brands should be for sale and how should they be selected? How to respond was in the hands of the Ministry of Finance and the director of the State Alcohol and Tobacco Company of Iceland ÁTVR. While the bill on beer had been passed in May 1988, the sales were to start on 1 March 1989. Nine months was a short time to adopt the multitude of necessary measures. Important decisions had to be taken quickly.

The introduction of beer broadened the commercial enterprise of the state alcohol monopoly. From 1989 to 1992, ÁTVR was responsible for wholesale and retail of beer, wine and strong spirits, control of breweries, and production and export of spirits. In the next few years, business declined to a certain extent following the privatisation of production in 1992 and of wholesale in 1994. The introduction of beer impacted not only on the commercial functions of the state alcohol monopoly, but also strengthened its role as a pillar of a restrictive alcohol policy. As the monopoly operated under the auspices of the Ministry of Finance, government fiscal interests mattered rather more than public health considerations.

In the first year (1989) after the ban on beer was abolished, alcohol consumption

rose sharply but decreased in the following years because of an economic recession (Ólafsdóttir & Leifman 2002). When disposable income started to rise in 1994, the consumption of alcohol, too, began to increase substantially in the following years. Between 1988 and 2007, consumption rose from 4.5 litres to 7.5 litres per inhabitant 15 years and over. In 2007, beer accounted for 52% of total alcohol sales. We can therefore conclude that the introduction of beer made Iceland wetter, but this development was stopped by the economic collapse in 2008, which led to lower levels of alcohol consumption.

The dream of a better order did not fully come true, even if social problems and health hazards did not develop at the same rate as the total alcohol consumption in Iceland (Ólafsdóttir 2007). There have been fewer alcohol-related offences, and surveys carried out in 2001 and 2004 indicate a decrease in self-reported alcohol-related harms among men. An increase in women's alcohol-rated harms and rising interventions by child welfare authorities due to parental substance abuse indicate escalating alcohol problems among women. Morbidity and mortality rates were on the way down until 2003. Mortality due to liver cirrhosis has always been very low in Iceland and did not follow the increase in the total consumption of alcohol. However, liver cirrhosis rates were higher than ever before in the period from 2004 to 2008 (<http://www.hagstofa.is/temp/Dialog/Saveshow.asp>). Whether this is random fluctuation or a time lag remains to be seen.

The ban on beer had been the main symbol of restrictive alcohol policy measures. The symbolic role of "outdated" alcohol

control measures has since moved from the ban on beer to the question of a state alcohol monopoly. In the new discourses on the legitimacy of a state alcohol monopoly old themes surfaced again: the value of the total consumption model, disputes on impacts on alcoholics, and experiences from abroad in terms of the privatisation of alcohol monopolies in other countries. This discourse has been driven by interest groups in trading and commerce whereas expert groups such as medical doctors have hardly taken part.

Discussion

The shift from spirits to beer drinking was a result of a policy decision. It is usually societal circumstances that lead to legislation, but lawmakers can also influence societal changes by steering and following new attitudes and changes in society. Politics and societal changes have often been driven by coincidences in social life (Jóhannesson 2010; Talebs 2007). In the case of legalising beer in Iceland, the timing was triggered by a particular event.

The prohibition of beer had been instrumental in keeping alcohol consumption low – the lowest in Europe for decades. The removal of instrumental effects had consequences for the symbolic values. The historical relationship between beer and the temperance movement was seen as a symbiosis. In lawmaking it is no longer considered appropriate to maintain legislation to protect general morals or public opinion (Thormundsson 1999). However, there are reservations if a behaviour violates fundamental values of society or is morally reprehensible or harms others or the society as a whole. Legislation on garbage, hate crime and sex offender commu-

nity notification laws have proved to have a stronger symbolic than instrumental effect (Howard 1999; Grattet & Jenness 2008; Sample et al. 2011).

Care and paternalism are significant factors in modern lawmaking, protecting vulnerable groups such as children, and promoting honest competition (Thormundsson 1999). Counteracting discrimination related to race, gender and residence is also seen as a legitimate argument in legislation. Similarly, the protection of public interests has become increasingly important in lawmaking as is exemplified in tobacco legislation. This new appreciation implies an increased understanding of values such as health, well-being, environment and honest competition. In the discourse on beer, discrimination of equality in the availability of beer was used to justify its legalisation. The other option, to ban duty-free imports of beer was seen as going against the tide of modernisation and globalisation.

All in all, the rhetoric around the issue of beer focused on a number of important questions. These included democracy, equality and public interests. The role of experts, in this case medical professionals, was weakened because they were split into two factions. Classical themes in any alcohol policy debate involved vulnerable groups such as youth and people suffering

from alcohol abuse. Moreover, the validity of the total alcohol consumption theory was disputed, while WHO recommendations played an important role.

The discussion on the preference of weak or strong alcoholic beverages evolved around legislative inconsistencies. In the debate about the lifting of beer prohibition in the 1980s, the opposite argument was used: that it was inconsistent to allow the sale of strong beverages but not of the weakest type, beer. It is intriguing that in the debate on lifting prohibition in the 1930s, those in favour of the repeal of spirits prohibition argued against the inconsistency of allowing the sale of weaker alcohol in the form of wine while disallowing stronger beverages.

To aim for consistency in the legislation on the production and distribution of alcohol may, however, be too narrow a perspective. Variance may sometimes serve the public good, given that the alcohol policy measures fit the social context.

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