Multilevel Governance and the Regulation of Public Health Policies (NCDs)

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Abstract

Since the advent of the body of thought known as the New Public Health (health promotion) in the 1970s, campaigns against noncommunicable diseases (NCDs) such as tobacco, alcohol, and obesity have become increasingly common on multiple levels, ranging from the local (Mayor Bloomberg’s activities in New York City against smoking and obesity) to the provincial (public health is largely a responsibility of this level in federal systems such as the US and Canada), to the central state level (Ireland’s workplace smoking ban in 2004) to the international (EU policies on NCDs, the Framework Convention on Tobacco Control, other WHO campaigns). These policies have utilised multiple policy tools, ranging from research and public education campaigns to regulation through economic sanctions, law enforcement, and litigation. Nongovernmental actors, in the form of NGOs and policy entrepreneurs, have cooperated with government bodies in developing and carrying out several of these policies. This paper will examine how these campaigns became a global force and how the relatively successful fight to ‘denormalise’ tobacco consumption politically has become a model for other, more contested areas, such as alcohol consumption and obesity. In performing this broad survey, reliance will be placed on the five factors identified as important in policy change for this realm (agenda, ideas, institutions, networks, and socioeconomic setting). Special attention is given to the multilevel governance nature of these problems. The struggle between ‘harm regulation’ and ‘neoprohibition’ policy approaches and what policy instruments each use will be analysed in an attempt to assess the opportunities and hurdles facing the construction of further international NCD policy regimes.

You and your colleagues seem to have almost a fanatical insistence that your product’s the same as all these other products. This morning in your written statement and your oral statement, you compared cigarettes to coffee, tea, sweets, sugar, warm milk, cheese, chocolate and Twinkies. That’s quite a list. I’m struck, but what I think is a calculated attempt to trivialize the devastating health impacts of your product. You and I both know that Twinkies don’t kill a single American a year. They may not add to a healthy diet, but they don’t kill. The difference between cigarettes and Twinkies and the other products you mentioned is death.

The Problem

Health is an important dimension of social life. While health care has made tremendous strides for individuals, most of the increase in life expectancy over the past century has been because of improvements in public health rather than medical care (Nathanson 2007). As the population ages, increase in life expectancy as well as quality of life will depend even more on prevention, as health care becomes increasingly expensive. Enhanced preventative measures will be needed to alleviate these problems. While much of the improvement in life expectancy has been achieved through better prevention of infectious diseases, it is increasingly recognized that major advances now need to be made in dealing with non-communicable diseases. The recent 2014 report on cancer from the WHO makes this abundantly clear. Warning of a coming ‘cancer tidal wave’ as world population ages; five of the seven contributors listed were noncommunicable diseases (NCDs), including smoking, alcohol, and nutrition/obesity. In response, the director of Cancer Research UK stated, ‘People can cut their risk of cancer by making healthy lifestyle choices, but it’s important to remember that the government and society are also responsible for creating an environment that supports healthy lifestyles’ (Gallagher 2014).

Various levels of government, ranging from New York City under its three-term mayor Michael Bloomberg to state/provincial governments, to the central state, to international bodies such as the UN, OECD and especially WHO have now turned their attention to NCDs. Since these are consumer products, it also affects international trade and potentially the WTO (McGrady 2011). Of these issues, one is very old (alcohol), one is old but has seen a major policy shift in recent years (tobacco), and one is new (nutrition/obesity).

Increasingly, comparisons have been offered, usually tentatively, about how widespread and far-reaching problems of alcohol usage and obesity could follow the well-established pathway of tobacco policies in Western democracies (Nicholls 2009; Alemanno and Garde 2013a; 2013b; McGrady 2011; Cairney and Studlar 2014.)
From inauspicious beginnings, tobacco policy has emerged over the past half century to be considered a public health success story, with major changes in smoking behaviour occurring to substantial measured benefits in quality and quantity of life (Cairney et al. 2012). Can a similar model of population change be applied to the demonstrably increasing problems of alcohol and obesity?

While the category of NCDs have been recognised as becoming a growing and significant public health challenge, the assumptions behind easy, if tentative, can the regulatory lessons of tobacco control really be applied to other definable public health challenges of our era? This paper proposes to offer just such a comparison of the regulatory problems posed by these three issues in Western democracies, even if on a macro-level. In doing so, it will assess how well the present circumstances and development of the obesity and alcohol control problems compare to what has occurred in tobacco control. The extant analyses comparing these problems tend to be restricted to one level of government only, for instance an individual country (Cairney and Studlar 2014) or an international organization such as the EU, WHO, or WTA (Alemanno and Garde 2012; McGrady 2011).

The scope and dimensions of the problems posed by noncontagious diseases, however, are more appropriately analysed using the tools provided by multi-level governance (MLG), which involves multiple levels of government on the vertical dimension as well as recognition that policy approaches, including instrument choices, are the product of government-society interactions (governance) rather than a government acting definitively and coercively (Enderlein 2010). The multiple levels considered, however briefly, here will be international (WHO, EU), individual countries (especially the US and UK), and substate levels as devolved authorities, provinces, and local governments.

In order to cover all three substances across a number of levels, the presentations necessarily will be brief.

**Agenda setting**

In terms of agenda setting, the long process and many false starts in moving from tobacco (especially cigarette) acceptance to promotion to ever-tightening control to contemporary debates between harm regulation (snus, e-cigarettes) and neo-prohibitionism have been well documented (Studlar 2002; 2004; Cairney et al. 2012; Studlar and Cairney 2014). The issue was framed differently by various groups at different times, and, despite shocks to the existing policy subsystem, change in the dominant framing and policy occurred only slowly. Although the ‘cancer scare’ in the media of several countries after the first widely publicised Anglo-American research findings on the hazards of cigarette smoking in the early 1950s and the US
Surgeon General’s Report in 1964 contributed to agenda change from a political economy perspective on tobacco (promotion of product and behaviour) to a public health/morality one (control and denormalisation of product, behaviour, and even producers). But policy content changed much more slowly, in the 1980s-1990s in most Western democracies with the rise of concern about the health effects of secondhand smoke.

Such a definitive shift has not yet occurred recently in any Western jurisdiction on alcohol or obesity although there have been some signs of this, perhaps most advanced in the WHO (McGrady 2011; Alemanno and Garde 2013b). Similar to tobacco, however, actually alcohol policy is an old problem, in fact a major subject of political controversy in the late nineteenth and early twentieth century (Schrad 2010). But unlike tobacco, which has seen similar frame changes across many countries within a relatively similar period of time, the alcohol agenda varies considerably, depending on the history of different jurisdictions as alcoholic drink producers, which forms of alcohol they produce, the impact of public health considerations, and the ‘culture’ of drinking in those jurisdictions. The result is a plethora of framings and policies, both across countries (Norström 2002) and even over time in the same country as various definitions of the issue change (for analyses of this in the UK, see Berridge 2013; Thom 1999; Greenaway 2003; Nicholls 2009). For instance, framing of alcohol policy in some jurisdictions may focus on economic benefits in (tourism, exports, the ‘nighttime economy’, and taxation, to cite a few) while in others there is more concern about morality, public health, addiction/abuse, and safety/crime (Peele 2010). Part of the longstanding conflict over British alcohol policy is over what should be the dominant frame. Furthermore, different jurisdictions within the same country may pursue different agendas. Alcohol prohibition in the US did not end in 1933; the option still remained for states and localities, and it became a longstanding norm in vast swaths of territory in the US (Freidreis and Tatalovich 2010).

The problem of obesity is both a relatively recent problem and also subject to multi-faceted framing. Historically humankind has suffered from lack of adequate food of whatever rather than an overabundance of consumption of food compared to physical activity. Obesity is a complex problem. It can be defined as a product of genetics, lack of physical activity, various nutritionals ingredients (food security), lack of education, or the socialisation of industrial and media practices. If it is a nutritional problem, then what substances contribute most to the condition? Depending on how the problem is defined, the preferred solution may lie more in education and individual choice by consumers and/or producers or, as in the case of tobacco, greater public regulation of the product. But the language around this issue among proponents of greater regulation has changed in ways familiar to the tobacco controversy, with claims of an obesity ‘pandemic’ and the manufacturers serving as ‘disease vectors’ (Alemanno and Garde 2013b). The increasingly contested agenda status of obesity and alcohol, however, is due at least in part to the rise of the New Public Health, or health promotion, from the 1970s, which is discussed later.

The WHO, which previously has given early and persistent warnings about smoking and alcohol, now has turned its attention to obesity as well. As noted previously the WHO’s World Cancer Report 2014 warned of a ‘tidal wave’ of cancer on the horizon, mainly because of noncontagious diseases. The report urged
preventive action in the form of regulations on alcohol and sugar. The WHO also has pointed out that the dangers of contagious diseases are overall declining while those from noncontagious diseases are rising (Gallagher 2014). While a few, including countries and even the EU, have taken some steps to address ‘lifestyle’ problems, thus far there has not been a concerted effort at policy change. Protecting children from developing obesity does seem to be a consensual rallying point, however.

**Socioeconomic Conditions**

Although the causal relationship between socioeconomic conditions and tobacco policy is far from settled (Cairney et al. 2012; Pacheco, 2011; Bogart 2011), they both changed dramatically over the past half century, allowing toward more restrictiveness. Alcohol and obesity have yet to see this ‘co-production’ in terms of prevalence and public opinion. In prevalence, alcohol consumption has increased overall over past decades, and obesity is a growing problem. While the public demonstrates more concern, in most countries there has been no large shift to support changes in policy.

During the mid-twentieth century, approximately 50 percent of the population regularly smoked in Western democracies, men more than women. The popular culture rarely questioned or restricted this practice seriously, despite brief reductions in smoking prevalence after the cancer scare of the early 1950s and the cautionary reports of the Royal College of Physicians in the UK and the US Surgeon General in 1964. Eventually smoking prevalence began a slow but largely persistent decline. Since we now know that nicotine is addictive, it’s a difficult behaviour to change. Smoking first declined in more educated and professional groups, becoming more concentrated in the working class over time. As a result of the tobacco companies’ advertising exploitation of women’s greater capacity for independent behaviour from the 1960s, the lessening of smoking among men was compensated somewhat by more consumption by women. While public opinion never clamoured for policy change, once changes began to be implemented, the public became increasingly supportive of restrictions on tobacco, a case of ‘permissive consensus.’ (Cairney et al. 2012) This was contrary to the fears of several political figures, who were reluctant to introduce more restrictive policies because of fears of electoral repercussions from smokers, especially in working class constituencies in the UK and tobacco-growing areas in the US (Cairney et al. 2012; Califano 1981). In fact, eventually tobacco control has become popular enough to be a cross-partisan issue in most countries (Cairney et al. 2012).

As one might expect from the variety of alcohol policy regimes across Western democracies, the socioeconomic conditions pertaining to this issue vary considerably as well. In the early twentieth century, it was mainly English-speaking and northern European countries, more spirit and later beer-drinking, that found alcohol consumption problematic and moved to curtail it in various ways, including prohibition (Schrad 2010). Higher concern about alcohol-related problems and more restrictive policies have continued to be more prevalent in those same countries (Norström 2002; Peele 2010). The ‘saloon culture’ that provoked the temperance movement did have demonstrably deleterious effects on family life, crime, and disease morbidity and mortality, but the extent of these problems, and the response to them, varied considerably. Alcohol, especially wine was woven more into the
cultures of continental, largely Roman Catholic, countries. In contrast to tobacco, however, the effects of alcohol consumption became problematic in wartime, both for military efficiency and alternative economic production purposes, and serious restrictions were imposed in several countries, starting in World War I. Some of these restrictions were retained after the war, most famously limits on ‘opening hours’ in the UK. In general, however, each country settled into a set of regulations on alcohol after World War I which persisted for decades, ranging from local option (including prohibition) to government monopoly to temperance to minimal regulation (Norström 2002; Greenaway 2003).

Similar to cigarettes, heavy taxation of alcohol in some jurisdictions removed the responsibility for control from public officials to the thirsty public in a market-based solution. One could choose to consume the product, but in doing so, one had to pay a government-imposed ‘sin tax’. Consumption rates stabilised in many countries for decades. In contrast to the pre-war period, alcohol rarely became a major issue on the general public agenda after World War I, in contrast to the pre-war period. After the perceived failure of prohibition regimes, the public largely seemed content to have consumption left to individual choice under regimes of lighter or heavier regulation, except for criminally behaviour related to consumption (alcohol abuse). Overall levels of alcohol consumption across Europe have converged. Europe has the highest proportion of drinkers in the world, the highest levels of alcohol consumption per capita and a high level of alcohol-related harm, 15% of all ill health and early deaths among men and about 4% among women (European Parliamentary Research Service 2014). Some countries, such as the UK, have become concerned with binge drinking, especially among the young (Nicholls 2009) and increases in specific diseases that are alcohol-related, such as liver cancer (Tiggle 2012). While alcohol consumption never became quite as bipartisan an issue as tobacco, it was not one on which parties were eager to campaign (Pennings 2010). With the amount of behavioural and attitudinal fragmentation across groups and countries, the EU has preferred market-based rather than regulatory policies, in contrast to tobacco (Princen 2009).

Obesity has literally become a growing issue in the Western world, led by the US. Although varying by country, indicators are that people in general and children in particular have become increasingly overweight over the past few decades, leading to multiple morbidity problems. The US leads the world in measured obesity, with two-thirds of its citizens overweight or obese and 60 percent not getting enough physical exercise. Other parts of the economically developed world, however, are not far behind, with rates above 25 percent (OECD 2013). There has been a 'nutrition transition' over the past decades. There is less nutrition from fresh fruit and vegetables and increasing consumption of carbohydrates, especially through fast-energy producing but low nutrition foods, especially those laden with sugar, salt, and fat (McGrady 2011: 17). Despite controversy, recently sugar has been the focus of attention, including claims that it is an addiction (Lustig 2013). There are indications that the public may be willing to accept government-mandated measures to reduce sugar, especially in foods aimed at children (BBC News Health 2014a).
Groups organize to advocate and resist change in lifestyle policies. As indicated previously, they work in combination with socioeconomic factors; in the long run groups have difficulty in combating unfavourable economics, culture, and public opinion, especially if the latter is mobilised rather than passive. As the tobacco economy declined in the West, both in terms of domestic leaf producers losing market share to overseas growers and smoking prevalence in the West declining, the tobacco industry, once a mighty sector of the economy, gradually lost political clout to the rising pro-health forces in opposition. Anti-tobacco groups moved from the margins of the debate increasingly into the centre of it, aided by sympathisers inside government and in other sectors of society such as sections of the media and academia. The political economy framing of tobacco emphasised government subsidies, domestic and international, for growing, manufacture, and distribution of cigarettes to support general economic growth and even military morale in wartime. Tobacco farmers, workers, manufacturers, and retailers benefited from this, along with collateral groups. Despite fierce political and legal resistance from the tobacco lobby and its allies, anti-tobacco groups, both those more medically/scientifically based and those of a more campaigning bent, increasingly have made public health the dominant frame. For instance, second hand smoke has gone from a ‘nuisance’ issue to a life-threatening condition in the past 30 years, providing impetus for groups long campaigning against it. In social construction terms, few groups have fallen as much in political prestige over the past half century as tobacco industry groups (Schneider and Ingram 1993). The image of tobacco companies shifted from patriotic providers of pleasure to ‘Big Tobacco’, the deceptive and dangerous colossus in the room. While still rich and well-connected, tobacco companies increasingly have to work behind the scenes politically rather than in public view. Furthermore, in several countries industry experts have lost prestige and access to government officials as their findings and recommendations are considered self-serving and fallacious (Cairney et al. 2012).

In contrast, alcohol producers have managed to a consultative position with government in most countries. This has occurred through a combination of self-regulation, concessions on some issues, and defining the alcohol problem as one limited to a small section of abusers and criminals rather than as a broader public problem. They have been opposed by a disparate array of groups because of the uncertain definition of the policy problem—health professionals, police officials, and victims of alcohol, including both drinkers and non-drinkers. In contrast with the strategy of absolute denial pursued by the tobacco industry, especially in the US, for many years, the alcohol industry has engaged in voluntary self-regulation, touted its social responsibility, and been willing to endorse government addressing problems resulting from abuse and criminality. In the US the industry has been able to rely on the bad reputation of the experience of countrywide prohibition to support its platform of ‘responsible drinking’. In the UK, without that traumatic prohibition experience, health groups increasingly have challenged the ‘minority abuse’ claims with a public health perspective emphasising broad public health harms to society and making the analogy to tobacco, including even ‘second-hand drinking’; (Nichols, 2012; Peele 2010; McCambridge et al. 2013). But this more public health perspective on alcohol use, led by medical personnel including chief medical officers in various jurisdictions, has thus far make little headway in changing policy or removing alcohol-related groups from the consuls of state.
While Western countries traditionally have consumer protection laws regulating food, especially what can be sold to children, recent concerns about nutrition/obesity have pitted health and children’s advocacy groups against food producers. Major food producers, similar to tobacco giants, are some of the largest corporations operating in each country. Again similar to tobacco, if they often are supported by food growers and various retailers in the supply chain for existing products. The corporations are disinclined to make major changes beyond minor labelling ones on their products. They resist most advertising restrictions and dispute research that finds individual substances to be at fault in nutrition deficiencies. Obligations beyond general guidelines and educational instruments are considered to be ‘nanny state’ regulations, legally resisted if political influence fails, as in Mayor Michael Bloomberg’s New York City policies (Gostin 2013). On the other side, a growing chorus of consumer affairs associations and nutritious food producers as well as health and children’s groups have attempted to shift policy through more stringent regulations. Recently the appellation ‘Big Food’ has appeared (Bittman 2014) in an attempt to rival the social construction of ‘Big Tobacco’. Thus far there is no ‘Big Alcohol’.

Institutions

On all three of these issues, the governmental institutional configuration of forces is similar. On the one hand, there are the departments that act as promoters for the products---agriculture, commerce/industry, and finance (taxation). On the other, there is the health department and sometimes consumer protection, whose priorities are different. What happened in tobacco was that over time health interests inside and outside government were able eventually to challenge successfully the framing of the issue, to their advantage. While the same process may have begun in the cases of alcohol and obesity/nutrition, these have not progressed very far in most jurisdictions. In some, such as the UK, the health department has been unable to gain institutional predominance over the issue of alcohol (Cairney and Studlar 2014). On obesity, departments mainly concerned with food production still hold sway almost everywhere, giving ground only grudgingly to health considerations.

Furthermore, there is multilevel regulation of each of these issues. This allows for greater experimentation on the one hand, but also lack of policy coordination. Central governments have varying amounts of authority over these policies. In the US, control of alcohol policy has mainly been devolved to the state and local government level since the end of national prohibition in 1933 (Frendreis and Tatalovich 2010). Food regulations are the preserve of local authorities in the US, where some progressive ones have taken action. Even in the UK, alcohol policy involves devolved authority, and Scotland has taken the earliest action on minimum pricing of alcohol, although now stalled in the courts (BBC News 2013; McCulloch 2014). Famously, it was coordinated judicial action by US state governments, not the central government, that brought about a more uniform tobacco regulatory policy through an out-of-court negotiation with the major tobacco companies (Studlar 2002), but this was an unusual circumstance that is not likely to be repeated. In various dimensions on all of these issues, including tobacco taxation, US states remain uncoordinated.
The EU has become involved in all three of these policies in recent years, what some call EU ‘lifestyle policy’. See Table 1 and Table 2. Leading legal analysts of this process conclude that EU involvement in policy change has occurred to varying degrees—greatest on tobacco (command and control) and least on alcohol (soft governance, best practices, and self-regulation), with obesity somewhere in between. Thus far EU obesity policy has been closer to its market-based, soft governance role on alcohol than to the stronger one on tobacco but there are signs of change, especially in the increasing concern shown over this particular issue, and more generally for NCDs, over the past two decades (Alemanno and Garde 2013a; 2013b). As with the US states, the conditions to develop a harmonized, more restrictive policy on tobacco took years to develop and may be exceptional. Furthermore, as indicated above, the EU traditionally taken a more permissive view towards alcohol, viewing it mainly as a free trade rather than a health issue. Its view of food is even more complicated since it is tied to the ongoing dilemmas of price supports in the Common Agricultural Policy.

There is a fourth level of government involved in these public health issues, namely the broader international one, mainly through WHO, including the WHO regional office in Europe, but also the UN more broadly (see Table 2) and the World Trade Organisation (WTO). Increasingly the WHO has made recommendations on alcohol, tobacco, and obesity (see Table 2). Normally the WHO depends on the willing cooperation of its sovereign state members. As a result, the strength of WHO regional affiliates varies considerably, with the European one being one of the more aggressive, especially on tobacco and alcohol issues (Princen 2009). The passage of the FCTC as the world’s first public health treaty through the leadership of the Norwegian WHO Secretary-General and its continuous implementation meetings subsequently (Mamudu et al. 2014) indicate that WHO has considerable persuasive power, including incorporation of the EU as well as member states as full adherents to the FCTC (Mamudu and Studlar 2009). Thus far it has not developed a similar amount of consensus for a similarly upgraded approach to alcohol and obesity, however.

The WHO has increasingly been recognized the problems of alcohol and nutrition/obesity are growing and extend beyond the borders of individual countries. Although the WHO has taken an interest in alcohol regulation since 1949, Bruun et al. (1975) document the ‘diminishing control’ of international organizations over that substance. Yet the recent WHO Global Strategy on to Reduce the Harmful Use of Alcohol (2010) covers such topics as the response of health services, strengthening drunk driving laws, and harm minimization in social settings, but also possible measures to restrict product availability through marketing and cost in terms of prices and taxes (McGrady 2011). The similarly nonbinding WHO Global Strategy on Diet, Physical Activity, and Health (2004) puts forward a number of recommendations designed to reduce risk factors and improve access to healthy food. Some of the policy instruments offered in both of the latter documents are those first used in tobacco control, including the FCTC although the full repertoire of measures developed over the years for tobacco (McGrady 2011; Studlar and Cairney 2014) are not advocated. In an organized albeit tentative attempt to

(Tables 1 and 2 about here.)
address ‘lifestyle issues’ (alcohol and nutrition/obesity), the EU also has made similar recommendations (Alemanno and Garde, 2013a; 2013b).

The market-friendly WTO as an adjudicator of what is allowable under international trade agreements looms as a potential venue for NCD regulation by states or other international bodies as well. As McGrady 2011:4) indicates, it was the new conceptualisation of public health described below that included noncommunicable diseases generated by cross-border consumer products, beginning with tobacco, that pose a dilemma for the WTO, one that was not foreseen in either the 1947 GATT agreement or even the 1994 incorporation of GATT into the WTO. Already on its agenda are cases concerning alcohol labelling similar to that for tobacco in Thailand and ‘front-of package’ alcohol labelling in Brazil (McGrady 2011). The critical contest, however, is over of Australia’s (and possibly other countries’) plain packaging mandate for cigarettes.

One of the unrecognised factors in these policy disputes is that the tobacco manufacturers often pursue ‘die hard’ litigation strategies when they lose in the executive and legislative branches as well as in arising court cases. This has occurred in the US, Canada, Australia, and the EU. The industry usually loses these cases to governments. Now, however, the strategy has moved to the international level. Having lost domestic lawsuits against the Australian law on plain packaging of cigarettes, the industry is now taking its case to the WTO. A decision against plain packaging there as an unjustified interference in trademarks might have a chilling effect not only on tobacco regulation, but more broadly on using strict regulation as an instrument for fighting against the consumption of dangerous products.

Ideas (1): Scientific information

Scientific information is critical for policymaking on all of these issues. While public health practitioners may see the implications of findings about morbidity and mortality associated with consumption of these products as straightforward, some NCDs, such as alcohol and obesity, have longer lines of causality, allowing for considerable dispute as to which factors are more important. This allows delays and differential framing. Furthermore, starting with tobacco, industry-sponsored denial of scientific findings, often based on dubious research, selective evidence, and propaganda, has become a major factor in resistance to possibly intrusive, public-health based policy changes (Oreskes and Conway 2011; Michaels 2008). It took decades to get major tobacco control policies enacted in most Western countries despite the clear evidence in mid-century of the health hazards of smoking. The 1964 US Surgeon General’s report only summarised what was known. Other sources, both genetic and environmental, had to be eliminated. The rise of more socialised concerns about the scientific effects of second hand smoking in the 1980s shook resistance, and cigarettes became the focus of the problem. Even then, many jurisdictions had their own expert investigations of the effects of second hand smoke before passing policy change (Aspect Consortium 2004).

Scientifically-based policy change has not reached that point on alcohol and obesity as of yet. As indicated above, despite the manifold indicators of the health hazards of alcohol, there is still a policy consensus that ‘moderate drinking’ can be beneficial. Despite some prominent dissents, especially from scientists, medical
officials, and the public health community (Bauld 2013; Nutt 2010), the problem has generally been framed as ‘alcohol abuse’, a construction favourable to corporate interests (Princen 2009). The policy debate over alcohol in the UK is a good illustration of these two tendencies (Cairney and Studlar 2014). In other words, the dominant approach to alcohol in most of the world, including the EU but not WHO (Princen 20090 remains one of ‘harm regulation’ (harm minimisation). This also was an approach pursued by UK and US governments through attempts to encourage ‘safe cigarettes’ at least until the 1970s (Berridge 2004; Studlar 2014) when neo-prohibitionism became the norm for those advocating action against tobacco. Furthermore, the mix of products, with different levels of alcohol content, makes it difficult to agree on suitable policy instruments. This was a problem that bedevilled even alcohol prohibitionist regimes which products to include in the ban and what levels of content to allow (Schrad 2010). Attempts to include the broader social damage of alcohol into consideration, recently in the form of ‘passive drinking’ in the UK, have not succeeded (Burgess 2009).

Obesity is an even more complex issue scientifically. Nutrition is a complicated issue, with conflicting research findings about the causes of obesity appearing regularly. There is increasing focus, however, on sugar consumption as an important source of the problem. Ironically, the rise of the obesity epidemic coincides with 1980s admonitions to avoid fat in foods. In an attempt to maintain calories and energy at a cheap price, this led to increased consumption of the sugar added to offset the loss of taste through the removal of fat. The production of high-calorie fructose to add to foods in Japan, the US and Canada compounded the problem. But now it is argued that ‘not all calories are the same’, and the consumption of sugar, especially by children in the form of candy and carbonated drinks, is a major driver of obesity (Lustig 2012). Thus a scientific consensus may be forming, as it did in tobacco, on a single source of the problem. In principle, a simplified diagram of cause-and-effect should make framing and adoption of policy easier. But in the case of obesity, there is ‘Big Food’, the vested corporate industrial-agribusiness complex, which is primed with its own researchers, publicists, and lawyers to resist reduction of its profits. Recently there have been complaints from corporate scientists about the ‘demonisation’ of sugar on ‘simplistic’ grounds (BBC News Health 2014a) reminiscent of earlier controversies over tobacco (Studlar 2002).

Ideas (2) The New Public Health

Underlying this dispute over the evidential basis for policy change on various NCDs, however, is a broader movement of ideas, usually labelled the New Public Health, health promotion, or Healthy Public Policy. This arose in the 1970s from concern that the barriers to increased life and health largely lay in individual and social behaviour (non-contagious diseases) rather than in infectious diseases and improved health care. The founding document of the movement was produced by the Canadian Health and Welfare Ministry, A New Perspective on the Health of Canadians (1976, commonly called the Lalonde Report after the sitting health minister), but it quickly spread elsewhere, and some of its most ardent advocates have been in the US, where the Department of Health periodically produces ‘healthy public policy’ goals (Studlar 2002). Some have labelled this a ‘secular morality’ concerning the body and lifestyle (Brandt and Rozin 1997; Studlar 2008).
advocating public policies for this purpose, the New Public Health becomes intrusive into individual lifestyle choices (Leichter 1991), but its practitioners unabashedly seek changes through various means in the interests of improved collective health and wellbeing. Tobacco was the first major success of this movement as the epistemic community organised to promote stronger regulatory policies (Mamudu et al. 2011). While the epistemic communities are not as institutionalised around alcohol and nutrition/obesity, they show signs of becoming so.

Ideas (3) Diffusion

One of the major factors leading to convergence of policies on tobacco and the FCTC was the diffusion of information and policy across international boundaries. Faced with a new but similar problem and a formidable opponent, both NGOs and countries followed, however unconsciously, the precedent of tobacco companies in developing global communications networks as well as others that crossed jurisdictions (Cairney et al. 2012; Hiilamo et al. 2014). From the first small (a few dozen people, mainly from the US and UK) World Tobacco or Health conference in 1967, this epistemic community grew to a broad international group of thousands attending in 2013. There is now a periodic European Conference on Tobacco or Health as well. Similar organisations were based on the internet.

Diffusion on the other two issues has not progressed nearly as far or as fast although, as noted previously, WHO and the EU have attempted coordinating roles. Alcohol policies are so different and so embedded historically that international information and lesson drawing, while extending back into the 19th century (Schrad 2010) has had difficulties in converging, especially after the failure of early 20th century countrywide prohibitionist policies (Bruun et al. 1975; Schrad 2010). As noted, even the EU has done much less to curb alcohol than tobacco (Princen 2009).

Even though international diffusion on obesity has only occurred over the past two decades, it seems to have gathered strength faster than recent attempts on alcohol. While food consumption patterns, even in industrialised democracies, vary greatly as well, obesity is a recently increasing ‘food harm’ that is amenable to scientific analysis, even if there is not complete agreement on causative factors and policy changes. In principle, ameliorative measures could be transferred from one jurisdiction to another, especially if they proved to be effective although there is only limited evidence of this thus far (Gostin 2013; Emanuel and Steinmetz 2014; Alemanno and Garde 2013b).

Policy Approaches and Instruments

(Table 3 about here.)

Now that the factors affecting these three NCD issues have been broadly outlined, one can assess the current status of policy debate on them, especially in regard to potential policy options and instruments. Since tobacco is the best established policy and has a trajectory toward more restrictiveness over the past half century, I shall use this as a base. Studlar and Cairney (2014) present a comparative
chronological table showing the broad sequences of policy instruments in this field, moving from educational ones, self-regulation, and limited advertising restrictions toward increasingly coercive instruments involving fines, legal sanctions, and even-more-rigid restrictive calibrations of instruments, to the extent of graphic warning labels and plain packaging (Cairney et al. 2012). See Table 3. Within this realm, the UK and US overall are considered two of the most restrictive jurisdictions in the world, even if there is some variation within them as well, especially in the US (Joossens and Raw 2014; Cairney et al. 2012). The EU, through its tax harmonisation schemes, advertising and products directives, sponsorship of anti-tobacco NGOs, and accession requirements for new members, also has become increasingly restrictive.

Analysts have drawn different lessons from the tobacco experience. While many see tobacco policy, including the FCTC, as a useful precedent, some decry the fact that not more has been done to confront alcohol and obesity problems (Klein and Dietz 2010; Lien and Deland 2011; Kersh and Marone 2002; 2005; Weiss and Smith 2004). Emanuel and Steinmetz (2014), however, argue that if one considers the slow pace of tobacco policy change, there actually has been faster action, in multiple venues, against obesity since the issue was first raised in the 1980s than historically against tobacco.

One policy debate that has raged across all three areas over the years is neo-prohibitionism versus harm regulation. Since the abandonment of countrywide alcohol prohibition, most famously in the US, in the early twentieth century, there are few calls for legal prohibition except in highly demographically homogenous local areas. But neo-prohibitionism, or driving down consumption of a product to as near zero as possible, has flourished in tobacco control; in fact by the 1980s it had become the major goal, hence the stated goal of being ‘tobacco free’. Harm regulation, however, has been the dominant goal in most alcohol policies, and it has also dominated in obesity/nutrition.

But harm regulation was an elusive goal in tobacco policy for many years, and now has returned in the debate over how to regulate e-cigarettes, snus, and instruments designed to allow seriously addicted smokers to satisfy their nicotine cravings under conditions of limited sales venues, such as ‘state stores’. The earlier attempts at harm regulation involved the search to modify cigarettes to make them less hazardous and addictive, ranging from the manufacturing attempts to lessen harm through filters to government-sponsored research in both the US and UK, in consultation with industry, to make safer cigarettes. Harm regulation was also part of government attempts to limit the ingredients of cigarettes, which were printed on packages. But human ‘compensatory smoking’ to achieve the desired nicotine absorption defeated some of these schemes, and it is now settled doctrine that ‘every cigarette does you damage’, no matter in what form.

The debate over regulation of e-cigarettes and snus is whether the aim should be ‘harm regulation’ since these sources of nicotine are demonstrably less harmful in individual consumption than cigarettes. On the other hand, neo-prohibitionism argues that they do not represent zero harm, may have unknown dangers, and also may be ‘gateways’ to regular smoking. Essentially, the neo-prohibition advocates in
tobacco control argue that here is an opportunity to achieve what was not done earlier with cigarettes, namely to quell their use before they gain a large market share, with potentially disastrous health consequences. Hence they argue for similar regulatory regimes for e-cigarettes and snus as for cigarettes. The 2014 EU Tobacco Products Directive does that while the US FDA considers its response. In only two EU-regulated states, Sweden and Norway, is snus legal.

Neo-prohibitionism is not yet the norm for alcohol and obesity. Instead a harm regulation regime has obtained, a lighter one for food than for alcohol since the latter has always been considered, to some degree, dangerous. The major instruments for alcohol control are age limits on sales, taxation, licensing and inspection, education, advertising limits, and sometimes minimal labelling. Alcohol abuse, such as public drunkenness, drunken operation of a motorised vehicle, and other violent or life-threatening activity as a result of alcohol consumption can be prosecuted as crimes, with the effective penalties vary by local jurisdictions. Until recently, in most US states taxation of alcohol was much greater than that on cigarettes. Aside from stricter licensing and sanctions for abuse, the regulation of alcohol is generally lighter than that for tobacco. Advertising and sponsorship restrictions and labelling are less intrusive. Most jurisdictions have large amounts of self-regulation.

If one considers the wide range of jurisdictions involved, regulations for food are surprisingly diverse (Bogart 2013). Nevertheless, the minimum standard is to meet labelling standards concerning contents. Traditionally, unhealthy as well as healthy foods are taxed at the same rate or perhaps not at all, advertising even in children’s programming is often self-regulated, and there are no few government-imposed warning labels. Now there has begun to be discussion and some action on warning labels (including ‘traffic light’ measures of nutritional acceptability), advertising limits for children’s television programming, heavier taxation, and even banning of sugary drinks above a certain size (McGrady 2001: 285; BBC News 2014a; 2014b; Alemanno and Carreño 2011; Alemanno and Garde 2013a; 2013b; Gostin 2013). Thus far regulatory initiatives in these areas often have been challenged and sometimes revoked through legal or political means (Gostin 2013). This is not an unexpected outcome when new forms of regulation of a product are attempted; it happened to regulation of cigarettes, including some early attempts at warning labels as well (Hillamo et al. 2013).

This is a familiar pattern, in two ways. First, governments are reluctant to take on regulation of new products if there are not established procedures and agencies to deal with this, plus there is always a struggle for reorganisation and adequate budgets for new tasks. Thus, the first response is to try to institute a harm minimisation regime, involving such instruments as voluntary self-regulation, education, and perhaps a few other nonburdensome limits, plus research into how to make consumption of the product safer. But these measures may not be adequate for the task at hand. Obviously this did not work for tobacco. In the case of nutrition, one explanation for the obesity epidemic is that it was an unintended consequence of focusing harm regulation on another nutrition issue, namely fat consumption, in the early 1980s after obesity emerged as an issue. While the US government reduced salt and saturated fat in federally-financed school lunches in the 1990s, sugar was ignored. In the words of former US President Bill Clinton, who announced the new guidelines, ‘We blew it’ (Bittman 2014; Emanuel and Steinmetz 2014).
The United Kingdom in particular favours ‘self-regulation’ as a policy response (Vogel 1986). In tobacco, this was utilised for decades, first with warning labels and then subsequently with indoor smoking limits; eventually both were abandoned (Berridge 2013). But such ‘responsibility agreements’ are still continuing with alcohol and nutrition/obesity, despite criticism from public health advocates (Gilmore 2011; McCambridge et al. 2013; Hastings et al. 2010; Sharma et al. 2010). The EU as well has instituted multi-stakeholder forums on alcohol and nutrition/physical activity in which participants undertake at least one commitment to aid the health problems generated by these products. There also a High Level groups on alcohol and nutrition, composed of representatives of EU member states, plus Norway and Switzerland, that meet both separately and with the respective Forum to exchange ‘best practice’ ideas (Allemanno and Garde 2013a).

Second, when light regulation proves inadequate for the problem, stronger forms may result. As indicated in Table 3, early forms of regulation of cigarettes included education, age limits on sales, and some advertising limits, especially on broadcast media. The scope widened and the restrictiveness and application of coercion increased for regulations over the years. What is the likelihood of a similar process occurring for alcohol and obesity?

This debate has been joined on the basis of supply-side versus demand side policy approaches. Demand-side policies emphasize ‘informed consent’ by adult buyers, with minimal government regulation. On the other hand, supply-side solutions are what some critics call ‘the nanny state’—restrictive policies designed to limit individual choices. Warning labels are designed to do that, as are advertising limits, product placement restrictions, and content specifications, backed by the possibility of fines and litigation. These differing perspectives have been joined in the UK in the outbreak of a debate about the Labour party’s proposals to impose supply side solutions to the problems of drinking, and junk food, limitations on salt, sugar and fat in children’s foods, stronger regulations on televised advertising and product placement in stores, prohibiting alcohol sponsorship of sport, and other measures such as minimum pricing of alcohol, to discourage consumption of unhealthy food, beer, and wine. These instruments are familiar from the history of tobacco control policy. Cries of ‘nanny state’ immediately were voiced by pro-business spokespersons (Walters and Owen 2014). To anybody familiar with the history of tobacco control policy, this proposed move towards more regulation is familiar. .

The problem with relying on the demand side in combination with light regulation is that, despite widespread availability of information, the public may not be able to apply it to purchases of dangerous consumer products. Nutrition information is complex and confusing, the effects of different forms of alcohol on the human body are complex and vary among individuals, and even smoking provides some compensatory benefits for its hazards, as well as being addictive. Focusing on ‘informed consent’ by adults by limiting age for purchasing products may help, but enforcement is not easy. In the case of obesity, effective regulation is likely to focus on eating habits acquired in childhood, but, as in smoking, any self-regulation would conflict with the industrial need to acquire lifetime customers of the product at this age. Thus while limits on purchase age seem to be a measure on which jurisdictions can readily agree, it will be even more difficult to enforce than such restrictions for alcohol and food. If the results are weak, the temptation will be to regulate more
severely through ingredients bans, which should work better for food products than for cigarettes. But harm regulation as a goal is not likely to be abandoned in either obesity or alcohol. In the latter, the struggle between public health/medical practitioners, especially Chief Medical Officers in the UK, and politicians supporting growers, manufacturers and sellers of these products is likely to intensify (Nicholls 2012).

Based on the tobacco policy experience, there are four key factors in developing a stronger government policy response to other NCDs. The first is to establish a plausible case scientifically for causality of particular ingredients, which is more difficult for obesity. The second is to establish addiction, thus diminishing individual responsibility for behaviour and emphasising that of the producers. The third is to consider second-hand effects beyond the individual consumer. This was a key turning point in tobacco regulation, has had some limited effect in alcohol policy, but is only in the early stages in nutrition/obesity. The fourth is to develop a multi-factorial in policy response, not placing too much emphasis on one instrument to the exclusion of others. Nonetheless, alcohol and obesity are likely to remain within the realm of harm regulation rather than neo-prohibitionism.

Conclusion

For many years, voices have been heard that other serious public health problems such as alcohol consumption and obesity should be treated by government in similar fashion as tobacco has been. The reduction of the smoking rate in most industrial countries over the past half century is generally considered a major public health achievement. While some moves to proceed in this direction have occurred in some jurisdictions, overall tobacco still stands *sui generis* in both its output and outcome among these three products. Nevertheless, what this paper has demonstrated is that the political struggle over both alcohol and nutrition can be analysed with the same theoretical framework employed for tobacco, considering several relevant general factors as well as the repertoire of policy instruments utilised. When one does this, both similarities and differences appear. But in principle, the regulation of all three of these products through the MLG policy process is similar in terms of the opportunities and constraints present. Tobacco control started later than alcohol control, but it has proceeded further along a path towards stronger regulation. While food in general has a long regulatory history, only recently has this focused on the obesity problem. Considering the relatively short period of time that obesity has been defined as a problem with a potential policy solution, it has moved in a more consistent, even if protracted, manner towards stronger regulation than has alcohol policy, with its checkered and varied history of regulation in different countries. In fact, some policy analysts argue that it has more moved more swiftly than tobacco policy (Emanuel and Steinmetz 2014). With a common analytical framework in place, we are capable of understanding potential policy developments in regulation of all three of these products, however varied the specific inputs might be.

While these struggles over the future direction of policy will be carried on in jurisdictions within individual countries, there is the possibility not only that international organisations will influence them, but even ultimately help decide the outputs. If broader, more restrictive, and more coercive policies develop within a few
leading countries and/or a broader consensus seems to be emerging, the WHO and the EU may take leadership roles, as they have on tobacco. But as indicated previously, the World Trade Organisation (WTO) may emerge as a critical actor because of its role in the Australian plain packaging case.

Table 1: Chronology of Tobacco Policy in the EU

<table>
<thead>
<tr>
<th>Year</th>
<th>Event</th>
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<tbody>
<tr>
<td>1970</td>
<td>Tobacco growing subsidized in Common Agricultural Policy countries (CAP)</td>
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<tr>
<td>1972</td>
<td>First attempts at harmonization of cigarette taxes</td>
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<tr>
<td>1985</td>
<td>First European anti-tobacco campaign announced</td>
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<tr>
<td>1987</td>
<td>Single European Act</td>
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<tr>
<td>1989</td>
<td>First EU health warnings; Television ad ban; Limits on product labeling; First EU nonbinding resolution on tobacco control, second hand smoke</td>
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<tr>
<td>1990</td>
<td>First limits on toxic ingredients;</td>
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<tr>
<td>1992</td>
<td>Tax harmonization for cigarettes becomes renegotiated every few years; smokeless tobacco banned (later exceptions for Sweden and Norway)</td>
</tr>
<tr>
<td>1993</td>
<td>Maastricht Treaty expands EU role in health, also emphasizes markets and subsidiarity; EU-level tobacco industry became more organized</td>
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<tr>
<td>1994</td>
<td>First EU financing of NGO capacity-building projects</td>
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<tr>
<td>1995</td>
<td>First advisory body on tobacco control, BASP, ends, eventually replaced by ENSP (1997)</td>
</tr>
<tr>
<td>1996</td>
<td>First general EU statement on tobacco control policy (others 1999, 2002)</td>
</tr>
<tr>
<td>1997</td>
<td>First EU general ad ban approved (TAD1)</td>
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<tr>
<td>1999</td>
<td>Amsterdam Treaty, Article 129, “A high level of human health level protection shall be assured in the definition and implementation of all Community policies and activities.” EU recommended policies for member states</td>
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<tr>
<td>2000</td>
<td>ECJ strikes down TAD1; Lisbon Process</td>
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<tr>
<td>2001</td>
<td>Larger health warnings: Bans on “light and mild” descriptors</td>
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<tr>
<td>2002</td>
<td>EU sues tobacco companies for smuggling in the US: Council recommendation on improving tobacco control.</td>
</tr>
<tr>
<td>2003</td>
<td>Revised EU print, telecast, and internet ad and sponsorship ban (TAD2): Graphic warning labels approved;</td>
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<tr>
<td>Year</td>
<td>Event</td>
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<tr>
<td>2004</td>
<td>EU signs FCTC; ten new accession countries join EU</td>
</tr>
<tr>
<td>2005</td>
<td>Agricultural price support for tobacco reduced, to end by 2010; 10 Accession countries given delays for <em>acquis</em> on tobacco tax; Ratification of FCTC</td>
</tr>
<tr>
<td>2006</td>
<td>Commission refers Germany to the ECJ for lack of advertising ban transposition; Finnish Presidency emphasizes health in all policies, including tobacco.</td>
</tr>
<tr>
<td>2007</td>
<td>Green Paper on second-hand smoke restrictions; Two new accession members EU mandates fire-safe cigarettes</td>
</tr>
<tr>
<td>2009</td>
<td>Council Recommendation on Smoke-Free Environments</td>
</tr>
<tr>
<td>2010</td>
<td>Revised tax harmonization for tobacco products</td>
</tr>
<tr>
<td>2011</td>
<td>Fire-safe (reduced ignition propensity, RIP) cigarettes approved as safety standard</td>
</tr>
</tbody>
</table>

Source: Adapted from Asare et al (2009); Studlar (2012)
Table 2: Chronology of International Government Actions on Alcohol and Obesity

1980 WHO-Europe Health for All in Europe

1986 WHO Tobacco or Health Programme launched through resolution of World Health Assembly

1987 WHO-Europe A 5-year Action Plan, Smoke Free Europe

1989 WHO (World Health Assembly) adopts 1988-1995 Tobacco or Health Action Plan

1993 WHO-Europe European Alcohol Action Plan

1995 WHO-Europe European Charter on Alcohol

2000 WHO-Europe European Alcohol Action Plan

2000 EU, European Council Conclusion (Lisbon Agenda on Growth and Competitiveness)

2000 WHO World Health Assembly Global Strategy for the Prevention and Control of Noncommunicable Diseases

2001 WHO-Europe, Declaration on Young People and Alcohol

2001 EU, Council of the EU recommendation on the drinking of alcohol by young people, in particular children and adolescents

2001 EU, Council of the EU Conclusions on a Community strategy to reduce alcohol-related harm


2004 WHO Global Strategy on Diet, Physical Activity, and Health

2004 EU, Council of the EU Conclusions on alcohol and young people

2004 EU, Council of the EU Conclusions on Heart Health

2005 EU, Forum on Nutrition, Health, and Physical Activity

2006 EU, Alcohol Strategy
2006 EU, Council of the EU Conclusions on Promotion of Healthy Lifestyles and the Prevention of Type II Diabetes

2007 EU, Obesity Prevention White Paper

2007 EU, Alcohol and Health Forum

2007, EU, Committee on National Alcohol Policy and Action (CNAPA): Mandate, Rules of Procedure and Work Plan

2007 EU, High Level Group on Nutrition and Physical Activity

2007 EU, Together for Health: A Strategic Approach for the EU 2008-2013

2009 EU, Council of the EU Conclusions on alcohol and health


2010 WHO Global Strategy on to Reduce the Harmful Use of Alcohol

2010 EU, Europe 2020: A European Strategy for Smart, Sustainable and Inclusive Growth


2011 EU, Council of the EU Conclusions on Closing Health Gaps with the EU through Concerted Action to Promote Healthy Lifestyle Behaviours’

2011 UN Political Declaration of the High-Level UN Meeting on the Prevention and Control of Non-Communicable Diseases (2011)


2014 EU, Third Health Programme 2014-2020
Table 3: Comparative Sequencing of Tobacco Control Policy Instruments

<table>
<thead>
<tr>
<th>Pre-1980s (6)</th>
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<tbody>
<tr>
<td>1) Increases in taxation for revenues</td>
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<tr>
<td>2) Age limits for purchase and possession (some countries)</td>
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<tr>
<td>3) Educational campaigns</td>
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<td>4) Health warnings on packages</td>
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<tr>
<td>5) Broadcast advertising limits</td>
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<tr>
<td>6) Limited smoking venues for safety reasons and in major carrier public transportation (buses, subways, trains)</td>
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<tr>
<th>1980s (9)</th>
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<tr>
<td>7) Cessation services</td>
<td></td>
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<tr>
<td>8) Capacity building for local governments and anti-tobacco organizations (selected jurisdictions)</td>
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<tr>
<td>9) Broader advertising limits</td>
<td></td>
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<tr>
<td>10) Limits on smoking in more mass public venues, private and government</td>
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<tr>
<td>11) Government reports</td>
<td></td>
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<tr>
<td>12) Cigarette contents restricted</td>
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<tr>
<td>13) Airlines Restricted</td>
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<tr>
<td>14) Promotions restricted</td>
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<tr>
<td>15) Stronger health warnings (multiple, rotating)</td>
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<tr>
<th>1990s (8)</th>
<th></th>
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<tbody>
<tr>
<td>16) Taxation for public health</td>
<td></td>
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<tr>
<td>17) Raising the age limit for cigarette purchase</td>
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<tr>
<td>18) Bans on smoking in government venues</td>
<td></td>
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<tr>
<td>19) Limits on package size</td>
<td></td>
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<tr>
<td>20) Restrictions on vending machines</td>
<td></td>
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<tr>
<td>21) Bans on smoking in private hospitality venues</td>
<td></td>
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<tr>
<td>22) Comprehensive government strategy</td>
<td></td>
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<tr>
<td>23) Restrictions on point of sale advertising</td>
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</table>

<table>
<thead>
<tr>
<th>2000s (1)</th>
<th></th>
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<tbody>
<tr>
<td>24) Pictorial health warnings</td>
<td></td>
</tr>
<tr>
<td>25) Plain packaging</td>
<td></td>
</tr>
</tbody>
</table>

Source: Studlar and Cairney 2014

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1. Lack of physical activity is often paired with nutrition as part of the obesity problem. While this is important, I do not examine that dimension directly here.

2. The position of the alcohol policy reformers in the UK is based on what is called a ‘whole population approach’ (rather than focusing on alcohol abusers only) derived from the New Public Health (Nicholls 2012).