An international legal strategy for alcohol control: not a framework convention—at least not yet

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ABSTRACT

Aims The perceived success of the Framework Convention on Tobacco Control (FCTC) in influencing national and global public health policies has led to growing interest in promulgating new international legal instruments to address global health issues—including calls for a Framework Convention on Alcohol Control (FCAC). Methods Despite broad support in the public health community, the authors caution that an analysis of the value of lawmaking for alcohol control cannot rest solely on the character of the underlying public health challenge and the similarities between alcohol control and tobacco control. Other factors must be considered, including the relative political feasibility for global health lawmaking. The potential contribution of non-binding international legal instruments to advancing global alcohol control, in particular, deserves strong consideration. Results The authors propose a gradual international legal strategy for alcohol control, starting with a non-binding code of practice focusing on areas of critical concern with wide political consensus, leading over time to a comprehensive binding treaty. Although often dismissed as ineffective relative to treaties, non-binding international legal instruments have particular strengths and can create both norms and processes that impact the behavior of states and other actors, overcoming a number of limitations of more rigid legally binding strategies. Conclusions Ultimately, the authors contend that the negotiation and adoption of a non-binding international legal instrument as a first step in a long-run legal strategy offers a more politically realistic, and potentially superior, alternative to immediate efforts to achieve a Framework Convention on Alcohol Control.

Keywords Framework Convention on Alcohol Control, international law, non-communicable disease.

INTRODUCTION

The perceived success of the Framework Convention on Tobacco Control (FCTC) in influencing domestic and global policies on tobacco control has given rise to expanding interest in promulgating new international legal instruments to protect populations world-wide from the globalization of other important health-related risk factors. Numerous commentators have called specifically for a Framework Convention on Alcohol Control (FCAC), and the drumbeat for codification is intensifying among the public health community. During the last 5 years the World Medical Association [1] and the American Public Health Association [2] have both formally recommended a FCAC and influential journals, such as the British Medical Journal [3] and the Lancet [4], as well as leading scholars [5], have joined the chorus in support of codification of such a treaty. Alcohol’s recent inclusion as part of the non-communicable disease (NCD) agenda—although its contribution to the global burden of disease is far from limited to NCDs—has made the call for a FCAC further prominent.

Inspired by the apparent success of the World Health Organization (WHO)’s first treaty, the 2005 FCTC, supporters of a FCAC argue that the time is ripe for a similar legal strategy to stem the harmful use of alcohol world-wide. At first glance, the parallels between the contemporary challenges of global alcohol control and the core factors giving rise to the idea of the FCTC in the early 1990s are striking [6]. Like tobacco, alcohol is a major

global health problem that contributes to health inequities among and within countries [7]. As in the case of tobacco, the harm to health from alcohol abuse is not limited to those consuming the product but also extends, through injuries, to others. The public health parallels are marked further by the similarities between the alcohol and tobacco industries in aggressively marketing a potentially addictive and lethal substance to children [8] and in seeking to prevent or delay effective public health measures [9]. In addition, similar to tobacco control, many strategies designed to limit the harmful use of alcohol are amenable to legislative interventions, including regulation of marketing, restrictions on availability and reduction in demand through tax and price policies. Moreover, the challenges of alcohol control, like tobacco control, are increasingly transnationalized, including issues relating to trade liberalization, foreign direct investment and global marketing and advertising. As in the case of tobacco, alcohol cannot be addressed by one country acting alone: the harmful use of alcohol is clearly a global problem calling for a global response.

LESSONS FROM THE FCTC

Despite the apparent similarities between the global public health challenges of alcohol and tobacco, an analysis of the value of lawmaking cannot rest solely on the character of the underlying public health challenge, as has been suggested by some commentators, but must also consider other factors, including the relative political feasibility for global health lawmaking. Consequently, despite the public health parallels between global alcohol control and global tobacco control, in our view the call for a FCAC is premature and deserves more careful consideration.

Any assessment of a FCAC’s political feasibility should recognize that the lessons and experience of the FCTC must be taken into historical context. As WHO’s first treaty-making endeavor, the process of negotiating and adopting the FCTC faced some extraordinary challenges including, at first instance, an effort by the WHO Secretariat to extinguish the tobacco lawmaking process at WHO by suppressing the commissioned paper [10] that first called for the negotiation of a FCTC at WHO [11].

Once the 1996 World Health Assembly adopted the legal mandate to develop the treaty under WHO auspices there were enormous hurdles to reaching agreement on the text, principally because of the sheer lack of treaty-negotiating experience among relevant actors [12]. As WHO had never served as a platform for treaty negotiations, its performance was considered widely at best cumbersome and slow. In addition, many Member State representatives to the negotiations, particularly from lower-income countries, were from health ministries, had never participated in a treaty negotiation process and were unfamiliar with the process of international lawmaking. Finally, civil society was ill-prepared to participate fully and effectively in the international lawmaking process. Most of the hundreds of civil society representatives who participated during the course of the FCTC negotiations came from national and local tobacco control organizations and, while there were distinguished lawyers from civil society active in the negotiations, there was not a single lawyer with experience in international lawmaking. Overall, the FCTC lawmaking process was an immense learning process for almost all the actors involved. Subsequent lawmaking efforts at WHO have benefited from this learning experience.

Despite the tremendous hurdles involved in negotiating the FCTC, the challenges potentially involved in seeking consensus to negotiate a new FCAC are far more problematic. In the case of tobacco, being the first treaty was not only a difficult challenge, but also a remarkable advantage because those interests opposed to effective regulation did not take the international legislative process seriously until it was essentially too late to stop. After overcoming the hurdle of a reluctant secretariat, a binding legal mandate to negotiate the treaty was achieved with relative ease. It took years for the tobacco industry to pay attention and try to interfere with the negotiation process. Further, states representing or having major tobacco interests did not seriously try to object to the treaty negotiations before formal commencement of the negotiation process. However, some state and industry interests did seek to limit the scope of international tobacco legal commitments under the FCTC once the formal negotiation process was underway until the treaty was adopted in 2003.

Alcohol does not have the advantage of being the first treaty proposal off the public health block, and the probability of achieving multilateral agreement on a FCAC at the current time is slim. Industry and powerful state interests are acutely aware of interest in international lawmaking and are prepared to rigorously oppose international regulation. In addition, achieving multilateral agreement is especially challenging in the context of alcohol due to industry influence and competing evidence, disparate social and religious relationships with alcohol and associated political sensitivities. Mobilizing the political will for the development of rational science-based alcohol policies, particularly in relation to regulation of price and availability, is significantly more difficult than with tobacco [13]. The absence of an active and effective global coalition of non-governmental organizations advocating for strengthened global alcohol policies makes the mobilization of widespread public and political will in support of binding international legal action further challenging.
The limited outcome of the high-level meeting of the United Nations General Assembly on the Prevention and Control of Non-Communicable Diseases (NCD Summit) speaks to the current state of political antipathy towards the development of an alcohol treaty. Despite overwhelming support in the public health community, the NCD Summit’s Political Declaration, an expression of political will at the highest level, makes no call for a global legal framework to advance alcohol control. The ongoing uncertainty in the global economy, with industry performance and job creation gaining further primacy over health and environment concerns, makes the prospect of a FCAC in the foreseeable future all the more remote.

**STRENGTHS AND LIMITATIONS OF INTERNATIONAL LAW AS A TOOL FOR GLOBAL HEALTH GOVERNANCE FOR ALCOHOL CONTROL**

Although there is broad support for a FCAC among the public health community, supporters of a treaty are conspicuously sparse on the details of how such an instrument could contribute to global efforts to stem the harmful use of alcohol [14]. In some respects, the recent widespread support in codifying a framework convention on alcohol control reflects the public health community’s recent interest in international lawmaking as a tool to advance global health cooperation. Although health has traditionally been a highly neglected realm of international lawmaking [15], since the adoption of the FCTC interest in global health lawmaking has skyrocketed.

With more than 170 state parties, the FCTC is one of the most widely subscribed treaties in the United Nations (UN) system. The perceived success of the FCTC in strengthening national tobacco control policies and global coordination to combat the scourge of tobacco has expanded dramatically awareness of the potential benefits of international health lawmaking and triggered interest in codifying new global health treaties. There has been a plethora of proposals for new treaties during the last 5 years. Some observers have called for treaties on specific concerns, such as alcohol, obesity, research and development or nanotechnology, while others have endorsed the idea of a comprehensive global health treaty. Overall, widespread and occasionally indiscriminate enthusiasm for new codification efforts has not always been accompanied by sound legal and political analysis of the context and circumstances.

While global health lawmaking was an effective strategy for tobacco control, international law is not necessarily an appropriate strategy for every global health problem. There is no substitute for binding international law when states want to indicate a serious commitment to international cooperation. The formalized process of legalization has important benefits. In addition to requiring commitment to a set of international norms, legalization requires state actors to engage in established legal processes and discourse. International legal commitments go through a process of national ratification, which further bolsters the credibility of binding international law. In addition, important legal and reputational consequences can attach when states fail to honor international legal commitments.

However, international law is an inherently imperfect mechanism for international cooperation, its innate weakness stemming in part from the core principle of state sovereignty [16]. The law that is made and the law that is implemented depends upon the will of states. In the treaty-making process, states agree explicitly to make rules to govern, and thereby limit, their own conduct and that of their nationals. States are generally loath to sacrifice their freedom of action through binding international commitments. A related weakness stemming from the principle of sovereignty is the general lack of enforcement mechanisms in most contemporary international agreements.

The international legislative process itself is characterized by numerous challenges and limitations. Treaties can be remarkably slow to negotiate, conclude and bring into force. The slowness of the lawmaking process makes international lawmaking a challenging prospect to address global health issues as the process cannot generally respond quickly to changes in science. In addition, the drive for universality can result in negotiation of shallow international standards, the so-called ‘lowest common denominator’ of agreement among states. The international legislative process also often suffers from severe problems of compliance. Apart from political will, there is increasing awareness that many states, particularly developing countries, face acute problems of resource limitations and the capacity to implement international commitments [17]. Finally, multilateral treaty-making is also a remarkably expensive endeavor. Negotiation of the FCTC cost an estimated 34 million dollars, excluding the cost of WHO staff and secondments [18]. Careful thought should be given to competing uses for limited public health resources before embarking upon new, costly international legislative endeavors.

Despite the conspicuous limitations of the international lawmaking process and the inherent challenges of using treaties to promote collective action, treaties can be useful for raising global awareness and stimulating international commitment and national action. The fact that many treaties tend to be well respected in practice reflects the fact that they are
generally seen as mutually beneficial for state parties [19]. As an increasing number of health threats are global in scope, binding international legal agreements are likely to increase in importance as an essential component of global health governance. This does not mean, however, that all global health problems have or should have a global legal solution.

AN INTERNATIONAL LEGAL STRATEGY FOR ALCOHOL CONTROL: FROM A CODE OF PRACTICE TO A TREATY

A sound appreciation of the underlying political reality should inform the development of a legal strategy, including the choice of legal instruments. The international legal strategy through which we propose to advance global alcohol control is a gradual one: starting first with the development of a non-binding code of practice in areas of critical concern with wide political consensus, such as the marketing of alcohol to children, leading eventually to a comprehensive binding treaty. We contend that the negotiation and adoption of a non-binding international legal instrument as a first step in a long-term legal strategy offers a more politically realistic, and potentially superior, alternative to immediate efforts to achieve a FCAC.

In a forthcoming paper, we detail our proposal for a non-binding code of practice, negotiated jointly under the auspices of WHO and the United Nations Children’s Fund (UNICEF), as a mechanism to establish global norms aimed at restricting the marketing of unhealthy foods and beverages to children [20]. Our call for a WHO/UNICEF Global Code of Practice on the Marketing of Unhealthy Food and Beverages to Children, responding to considerations of relative similarities in marketing practices as well as to that of efficiency, encompasses both alcoholic and non-alcoholic beverages. Whether or not responding to marketing of alcoholic and non-alcoholic beverages and unhealthy foods to children through a single instrument gains support—admittedly a controversial idea—we believe that the vehicle of an incremental legal strategy, starting first with a non-binding code, deserves serious consideration by alcohol control proponents.

While non-binding legal instruments are dismissed frequently as inferior and ineffective relative to treaties, there is growing recognition that the challenges of global governance require faster and more flexible approaches to international cooperation than can be achieved by traditional treaty strategies. Non-binding instruments, such as the proposed WHO/UNICEF Code, are flexible and can facilitate compromise and cooperation among states because states do not run the risks to reputation or countermeasures that may be involved in the breach of hard treaty obligations. Thus, it may be easier to achieve deeper commitments with stricter compliance mechanisms with a non-binding format. The utilization of a non-binding legal approach is especially useful, as in the case of alcohol, in areas where there is clear urgency for the global community to act, yet there is a lack of political will and/or evidence necessary to support a treaty. Although many non-binding standards are purely rhetorical, if designed and implemented effectively they can create norms that guide the behavior of states and overcome recognized limitations of formal legalized strategies.

A comparison of the FCTC and the recently adopted WHO Global Code of Practice on the International Recruitment of Health Personnel (‘WHO Global Code’) illustrates some of the advantages of non-binding legal instruments. The FCTC was negotiated over 6 years in six separate rounds of 2-week negotiation sessions open to all WHO Member States, while the WHO Global Code was negotiated in a fraction of that time. Moreover, while both instruments set forth a shallow substantive framework, the WHO Global Code incorporates a significantly more potent governance framework, including mechanisms for information sharing, monitoring and implementation.

A principal criticism of non-binding legal instruments is their voluntary nature. This is particularly a concern in alcohol control where, like tobacco, industry has sought to evade or suppress effective regulation. However, although technically non-binding at the international level, international codes can be codified into national law and practice. Indeed, there is significant evidence from international practice from health and other realms of international legal concern that voluntary international legal instruments have, at times, been effective in strengthening the capacity of low-income states to stand up to industry pressure and enact and enforce cogent legislation in compliance with the voluntary international standards. The International Code of Marketing of Breast Milk Substitutes, WHO’s first foray into utilizing a non-binding legal framework, illustrates this principle powerfully. Adopted in 1981, 84 countries have since enacted provisions of the voluntary code into national legislation [21]. To put this achievement into context, 42 FCTC state parties have thus far adopted new national legislation (22). Although many more countries have sought to strengthen existing national tobacco control legislation, strengthening compliance remains a major hurdle. The more recently adopted WHO Global Code is also beginning to show signs of meaningfully impacting national and international practice [23]. An internationally negotiated non-binding code of practice in the area of alcohol control, unlike the largely
ineffective voluntary national and industry developed standards prevalent in alcohol, has real potential to provide countries with effective and enforceable national legal frameworks.

There is an urgent need for coordinated multilateral action to address the global nature of the harmful use of alcohol. However, the political and economic reality suggests strongly that a FCAC is not currently feasible. The elaboration of an internationally negotiated non-binding code can comprise part of a dynamic process leading to a gradual deepening of commitment and action over time, including the eventual promulgation of a treaty on alcohol control. In addition to the direct benefits of utilizing a non-binding code, the process of development and implementation can serve to galvanize the information, public support and political will required for a comprehensive treaty. There are numerous examples in international legal practice, in areas ranging from nuclear energy control to human rights, where non-binding international standards have led gradually to binding multilateral legal agreements. Notably, the negotiation of the FCTC was preceded by the adoption of 17 resolutions over 20 years in the World Health Assembly.

CONCLUSION

The public health community’s considered selection of an appropriate legal strategy is critical to advancing global alcohol control. A failed legal strategy could delay meaningful global legal action for years to come—time that the global community cannot afford. An incremental strategy that builds on a non-binding code approach in areas of critical concern and broad consensus holds significant promise for success. This choice of legal strategy is politically achievable and has the potential to influence state, as well as industry, practice.

Declarations of interest

ISD is a former Associate Director of HealthWorkforce, Realizing Rights, a program of the Aspen Institute.

References

