A Global Legal Instrument for Alcohol Control: Options, Prospects and Challenges

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Alcohol is the sole major psychoactive substance with a huge negative public health and social impact without some form of international control grounded in a binding treaty. While existing rules of international law, in particular in the economic field, favour liberalisation and may hinder strong national alcohol control measures, we may be witnessing a turning of the tide due to the growing mobilisation against non-communicable diseases. The Framework Convention on Tobacco Control has been a ground-breaking development in this sense, and has led policymakers and advocates in a number of countries to raise the possibility of a similar convention on alcohol control. The present contribution compares tobacco and alcohol from this perspective and considers the feasibility of a dedicated international convention. It concludes that the political prospects of a movement in this direction are very dim at the present time; however, policy developments on other health problems and theoretical models emerging from constructivist international relations scholarship may open up promising perspectives for considering normative and institutional approaches that could strengthen the existing legal framework and facilitate political processes towards stronger forms of legalisation of global alcohol control.

I. Introduction and methodology

Alcohol is the sole major psychoactive substance with a significant negative impact on health not subject to some form of international control, with the main global regulatory instrument being the non-binding World Health Organization's (WHO) 2010 Global Strategy to Reduce the Harmful Use of Alcohol.[1] The direct or indirect health impacts of alcohol consumption are massive. As recently updated in WHO's 2018 Global Status Report on Alcohol and Health:

> In 2016, the harmful use of alcohol resulted in some 3 million deaths (5.3% of all deaths) worldwide and 132.6 million disability-adjusted life years (DALYs) – i.e. 5.1% of all DALYs in that year. Mortality resulting from alcohol consumption is higher than that caused by diseases such as tuberculosis, HIV/AIDS and diabetes.[2]

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[1] WHO, Global Strategy to Reduce the Harmful Use of Alcohol (21 May 2010), 63rd World Health Assembly, resolution WHA63.13.

[2] WHO, Global Status Report on Alcohol and Health (2018) p xv.

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The global dimension of the health impact of alcohol parallels the globalisation of the alcohol market and the expansion of the reach of major multinational companies. As extensively discussed in both policy and academic literature and supported by overwhelming evidence,[3] alcohol control requires a regulatory approach and has both domestic and transboundary aspects. The most visible transboundary elements influencing alcohol availability and consumption are advertising and promotion, both through traditional channels as well as through the Internet and social media, as well as to a certain extent illicit trade and the increasing importance of e-commerce. An important contributing factor also consists of the lowering of trade and regulatory barriers brought about by the liberalisation of international trade symbolically embodied by the establishment of the World Trade Organization (WTO) in 1995, as well as by the proliferation of both free-trade agreements and bilateral investment treaties.

The health and social problems caused by alcohol consumption are part of the larger challenge posed by the veritable pandemic of non-communicable diseases (NCDs) causing massive human suffering, as well as an equally massive drain on the resources of national health systems. Both in policy debates as well as in scholarly analyses, there is a consensus that preventing NCDs requires a regulatory approach at both national as well as international levels.[4] For the purpose of this contribution, therefore, I will assume that a global normative instrument is a necessary component of a comprehensive strategy, as well as a complement and support to national strategies, to reduce overall consumption of alcohol for public health purposes, both in its own right and as part of the larger fight against NCDs.

The question as to which kind of global regulatory approach would be more effective and feasible can be studied from different and non-mutually exclusive perspectives, such as what is objectively needed from the standpoint of public health, what is the existing international legal landscape affecting alcohol availability and control, what is the political feasibility of various normative approaches given national policies and interests and the lobbying power of the alcohol industry, and what are the lessons that can be drawn from the WHO Framework Convention on Tobacco Control (FCTC) as the most proximate example of an international regulatory approach to consumer product regulation. In looking broadly at different possible directions, it is also important to consider recent international law and international relations scholarship on the apparent dilemma between “hard” and “soft” law and the dynamics underlying the processes of the formation and socialisation of new international legal rules.

II. Regulatory measures and legal and judicial landscape

There is a growing consensus that a number of regulatory options constitute “best buys” in general for alcohol control. Some of these options concern domestic measures while

[3] B McGrady, *Trade and Public Health* (Cambridge, Cambridge University Press 2011); T Voon, AD Mitchell and J Liberman (eds), *Regulating Tobacco, Alcohol and Unhealthy Foods* (Abingdon, Routledge 2014).

[4] Political Declaration of the High-Level Meeting of the General Assembly on the Prevention and Control of Non-communicable Diseases, UNGA res. 66/2 (19 September 2011).

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others address the transboundary aspects of the global alcohol market. The 2010 WHO Global Strategy summarises most of these measures, which have been implemented to a different extent in a number of countries.

The most prominent best buys from an international regulatory perspective are increasing the price of alcohol products through taxation (area 7 of WHO's Global Strategy);[5] restrictions and regulation of exposure to alcohol advertising and promotion across multiple types of media with particular regard to social media and the Internet, as well as transboundary advertising and promotion (area 6 of WHO's Global Strategy);[6] restrictions on the physical availability of alcohol (area 5 of WHO's Global Strategy);[7] and enacting and enforcing drink and driving policies (area 4 of WHO's Global Strategy).[8] There is less consensus on the need for dedicated measures to curb illicit transboundary trade in alcohol products (area 8 of WHO's Global Strategy),[9] as the problem apparently mostly derives from local production for household consumption rather than the massive falsification and illicit transboundary trade occurring for tobacco products.

Besides the WHO FCTC[10] and potentially the United Nations' (UN) drug control conventions (see below), the international legal landscape affecting the availability and marketing of alcohol products largely consists of trade, investment and intellectual property rules contained either in the WTO package of agreements or in regional, subregional and bilateral agreements. This is what the FCTC aimed to react against by distinguishing tobacco as a product warranting special treatment in the framework of international economic law. A recent development, which did not exist at the time of the adoption of the FCTC, is the inclusion of alcohol-specific Agreement on Technical Barriers to Trade of the World Trade Organization (TBT)-plus provisions in regional free-trade agreements that establish a special and relatively permissive set of requirements for the labelling of alcohol products. An example is Annex 8-A of the Comprehensive and Progressive Agreement for Trans-Pacific Partnership (CPTPP).[11] Particular mention should also be made of the internal regulations within the European Union given the size of its market and its importance for alcohol production and consumption. Some of the most directly relevant instruments are Council Directive 92/83/EEC[12] on excise taxes on alcoholic products, Council Directive 92/84/EEC of 19 October 1992 on the approximation of the rates

[5] WHO Global Strategy, supra, note 1, 16.

[6] ibid, 15–16.

[7] ibid, 14–15.

[8] ibid, 13–14.

[9] ibid, 17.

[10] WHO Framework Convention on Tobacco Control (adopted 21 May 2003, entered into force on 27 February 2005), 2302 UNTS 166.

[11] Comprehensive and Progressive Agreement for Trans-Pacific Partnership (CPTPP) (adopted on 8 March 2018, entered into force 30 December 2018), and Annex 8 <https://www.dfat.gov.au/trade/agreements/not-yet-in-force/tpp/Pages/tpp-text-and-associated-documents> (last accessed 25 March 2020).

[12] Council Directive 92/83/EEC of 19 October 1992 on the harmonization of the structure of excise duties on alcohol and alcoholic beverages [1992] OJ L 316/21.

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of excise duty on alcohol and alcoholic beverages[13] and Directive 2010/13/EU[14] on audio-visual media services restricting transboundary alcohol advertising. Mention should also be made of the ongoing work in the Codex Alimentarius Commission on the labelling of alcohol products, which, however, is at an early stage as of the time of writing this contribution and has not yet garnered sufficient support. Codex standards, guidelines and recommendations constitute a legally relevant standard under the WTO TBT.[15]

While the purpose of those rules is to liberalise trade and direct investments and lower non-tariff barriers, their actual impact on alcohol regulation depends to a large extent on how they are interpreted and enforced by individual states, by national and international courts and by investment dispute panels, as well as within the WTO dispute settlement system. This is due not only to the frequent indeterminacy of their content, but also to the need for countries to reconcile the obligations arising from economic law instruments with other international obligations applicable to them, including notably under international human rights law.

The prevailing assessment is that international economic law rules constrain the regulatory authority of states to impose measures to limit the availability, affordability of and exposure to alcohol products. However, there are also indications that the protection of public health can serve as a legitimate basis for trade and investment restrictions that would otherwise be treated as unlawful (provided they are non-discriminatory or with a protectionist intent). Alcohol-related examples are judgments of the European Court of Justice on advertising of alcoholic drinks and minimum unit pricing.[16] In addition, the recent successful spate of national and international litigation on tobacco control may offer important indications on the scope of acceptable national regulatory interventions.[17] At the same time, the WTO cases on the taxation of imported spirits involving Japan, Korea and Chile, respectively, show the kind of tests to which national measures may be submitted, in particular the challenge of distinguishing successfully between imported and domestic products and about the "real intent" of taxation.[18] Some of the litigation against alcohol control

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[13] Council Directive 92/84/EEC of 19 October 1992 on the approximation of the rates of excise duty on alcohol and alcoholic beverages [1992] OJ L 316, 31.

[14] Directive 2010/13/EU of the European Parliament and of the Council of 10 March 2010 on the coordination of certain provisions laid down by law, regulation or administrative action in Member States concerning the provision of audiovisual media services [2010] OJ L 95/2.

[15] Codex Alimentarius Commission, Report of the Forty-fifth Session of the Codex Committee on Food Labelling (July 2019), REP19/FL.

[16] Notable examples of European Union jurisprudence, both on referral from national courts, are (1) *Konsumentombudsmannen v Gourmet AB* (2001), C-405/98, 8 March 2001, where the European Court of Justice found in favour of a Swedish law limiting advertising space for imported alcohol products to limit consumer exposure; and (2) *Scotch Whisky Association and Others v The Lord Advocate and The Advocate General for Scotland*, C-333/14.

[17] A good summary is offered in S Zhou and J Liberman, "The global tobacco epidemic and the WHO Framework Convention on Tobacco Control – the contributions of the WHO's first convention to global health law and governance", in GL Burci and B Toebes (eds), *Research Handbook on Global Health Law* (Cheltenham, Edward Elgar Publishing 2018) p 340.

[18] The links to those cases can be found at <https://www.wto.org/english/tratop_e/dispu_e/dispu_subjects_index_e.htm> (last accessed 25 March 2020).

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measures could have been tactically engineered directly or indirectly by the alcohol industry to produce a "chilling effect" on national authorities.

From the overall goal of reducing the amount of alcohol consumption and taking into account the existing legal landscape, the 2010 WHO Global Strategy is seen as largely ineffective as the main (soft) global normative instrument. It was meant as a generally agreed statement of aims and principles offering a menu of policy options to public authorities. At the same time, the strategy grants a large amount of discretion on both the measures that individual states may want to apply as well as their legal form, including "non-legal frameworks such as guidelines or voluntary restraints".[19] Recent critical literature attributes such weakness also to the non-binding legal nature of the Strategy and therefore insists that only a legally binding instrument may supply the required commitment, international harmonisation and financial resources.[20]

III. Comparison with tobacco and the FCTC: the call for a framework convention on alcohol control

The FCTC represents the closest example of an integrated global normative approach to the control of the supply and demand of an otherwise lawful product of mass consumption in view of its impact on individual and public health. It has served as the model for the mobilisation in civil society and academia in favour of a framework convention on alcohol control (FCAC).

The FCTC represents an important precedent and blueprint for global alcohol control, in particular for the following reasons:

- It strengthens the normative value of health in international law by "de-normalising" a major risk factor of NCDs and embodying the political choice that certain products or risk factors must be treated exceptionally because of their health impact and at least partially "carved out" of the general rules of international economic law through a dedicated legal instrument focused on the protection of health.
- Its negotiation and management by WHO as a public health instrument framed tobacco as a health rather than trade or agricultural policy topic. In this connection, the very fact of WHO's decision to move towards an international convention produced policy consequences with winners and losers and can be seen as an exercise by the organisation of its "epistemic authority" even before the entry into force of the convention.[21]
- It covers the package of mutually reinforcing and complementary measures generally considered as part of the basket of regulatory options to address the risk factors of NCDs, including alcohol. This approach was strengthened at the outset of the FCTC negotiations by a seminal World Bank report showing that

[19] Note 1, paras 13 and 17.

[20] DH Jernigan and PJ Trangenstein, "What's next for WHO's global strategy to reduce the harmful use of alcohol?" (2020) 98 Bulletin of the World Health Organization 222–23.

[21] J Klabbers, "The Normative Gap in International Organizations Law: The Case of the World Health Organization" (2019) 16 International Organizations Law Review 272.

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the economic gains from reduced mortality and morbidity grossly outweighed those deriving from tobacco trade and the related tax revenue.[22]

- It addresses both transboundary elements such as illicit trade and transboundary advertising, as well as national measures such as smoking in public places and sales by/to minors that can benefit from the establishment of a global normative baseline. In so doing, the FCTC aimed at empowering ministries of health vis-à-vis other national agencies and stakeholders with regards to the strengthening of regulatory policies.
- Its framework approach established a permanent institutional mechanism that enables normative development through the consensus adoption of guidelines and protocols. It also provides an institutional framework for information exchange and mutual learning, consensus building, institutionalized compliance monitoring, socialisation among stakeholders and facilitating the establishment of transboundary networks.
- It serves as the catalyst for the mobilisation of a vast civil society movement that proves instrumental in maintaining momentum and fostering accountability.
- It is playing an important role in national and international litigation, either as an obligation that courts cannot ignore or as the expression of a global consensus on necessary and effective national measures for the pursuit of legitimate health protection objectives.

On this basis, and despite the challenges summarised in the following section, academic literature and policy discussions have focused on a FCAC modelled on the FCTC as the most rational normative choice to address in an integrated manner the various dimensions of alcohol control and to aim at the same public health and policy goals as the FCTC.[23]

IV. A FCAC as the most rational normative choice?

From a functional and rational choice perspective, and despite the weaknesses and shortcomings of the FCTC, I am also of the view that a FCAC negotiated within WHO and building on the precedent of the FCTC would be the most effective approach from a substantive and institutional perspective in terms of a global regulatory instrument.

Most of the considerations summarised above for tobacco and the FCTC apply in my view to alcohol control as an urgent area of public health intervention warranting a similar international legal approach. There are obvious similarities in the package of regulatory measures, validated by the similar directions adopted in the WHO 2010 Global Strategy, and in the kind of public sector interventions required to tackle the problem. The imperative of framing alcohol as a health issue counterbalancing the application of

[22] This approach was validated from an economic perspective by an influential World Bank report published at the outset of the FCTC negotiations: World Bank, *Curbing the Epidemic: Governments and the Economics of Tobacco Control* (Washington, DC, World Bank 1999).

[23] R Room, "International control of alcohol: alternative paths forward" (2006) 25 Drug and Alcohol Review 581.

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international economic law rules through a dedicated instrument is also similar to the discourse around tobacco control and of decisive political importance.

A potential future FCAC, however, must also learn from the weaknesses of the FCTC. For example, the content of the latter's text is uneven and at times vague, ineffective (eg Article 19 on liability or Article 27 on settlement of disputes) or largely hortatory (eg Article 6 on taxation). Critical views note that direct transboundary aspects – which would more plausibly justify negotiating a new treaty – are less prominent in the case of alcohol as compared to tobacco and thus decrease the relevance and even the perceived need of a treaty as an effective tool for decreasing alcohol consumption. Direct transboundary factors mainly consist of transboundary advertising and promotion, where the FCTC has proved of limited value due to the resistance of powerful states during the negotiations, the failure of establishing an absolute ban of tobacco advertising and promotion and the resulting weakness of Article 13.[24] The difficult negotiation of the protocol on the illicit trade of tobacco products also shows the challenges arising from the choice of a framework convention approach, even though scholars point out that the FCTC can and should be implemented in its own right without the need for additional protocols.[25] Finally, the development of new products such as tobacco-free electronic cigarettes and supposedly safer products such as non-combustible cigarettes has created legal and policy challenges for the scope of the FCTC.[26]

V. Feasibility of a FCAC

How feasible is it to arrive at a health-orientated FCAC negotiated within WHO? There are two main groups of considerations, both pointing to a negative conclusion in my view, at least for the moment.

The first set of considerations concerns the political feasibility of achieving a FCAC that does not just represent a political statement, but rather an effective and dynamic public health tool gathering sustained political and financial commitment for its implementation and making a difference for individual states parties. The challenges concerning alcohol products as opposed to tobacco and tobacco products, which decrease the political appetite of WHO's membership to embark on negotiating a new treaty, include the following:

- A more difficult health message about the dangers of alcohol as compared with tobacco, as shown by the framing of the problem as the "harmful use" of alcohol, with the industry focusing on the benefits of moderate drinking and pointing to consumers as the problem rather than the products and their commercialisation.
- A different positioning of the industry, without the stigma of the tobacco industry and therefore a more legitimate stakeholder in the policy discourse. From this

[24] Interview with a senior WHO official, 12 July 2019.

[25] J Liberman, "The Power of the WHO FCTC: Understanding Its Legal Status and Weight" in AD Mitchell and T Voon (eds), *The Global Tobacco Epidemic and the Law* (Cheltenham, Edward Elgar Publishing 2014) pp 48–63.

[26] Conference of the Parties to the WHO Framework Convention on Tobacco Control, "Control and prevention of smokeless tobacco products" (28 May 2014) FCTC/COP/6/9.

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particular perspective, the longstanding policy of WHO to exclude solely the tobacco industry from any contact or consultation may have deprived the organisation of leverage in reacting to the questionable corporate practices of the alcohol industry similar to those of the tobacco industry.[27]

- Effective industry lobbying combining chilling litigation, corporate social responsibility initiatives, sympathetic politicians in senior positions in key countries and organisations as well as in many national parliaments, etc.
- A higher and more diffused level of cultural acceptance of alcohol as compared to tobacco, which makes pushback against "nanny" states and WHO more likely with regards to regulatory measures similar to those included in the FCTC. In most countries, politicians and public figures are more easily portrayed to consume alcohol than tobacco products. Tobacco has gradually come to be associated with a lower social and cultural status, while wine and spirits have been successfully promoted as sophisticated products that can be consumed in moderation to achieve both aesthetic and personal enjoyment and to confirm social status.[28]
- A more diversified and fragmented market situation as compared to tobacco, with wine, beer, spirits and traditional drinks driving different economic interests in various countries and regions and making agreement on general measures more challenging.
- Inconsistent political support from within different WHO regions, with the Eastern Mediterranean Region, for example, being afraid to weaken religious prohibition against alcohol through a regulatory instrument that would somehow legitimise its presence on the market.
- The lower relevance of transboundary factors as compared to tobacco may militate against a dedicated treaty, as noted above. Moreover, the main immediate transboundary factor of alcohol control from a regulatory perspective is advertising and promotion; from this standpoint, the FCTC has not been particularly successful due to the weakness of its provision (Article 13) and to the move by the industry of a great part of its promotional activities to the unregulated area of social media and Internet services.[29]
- A less influential and organised civil society mobilisation as compared to tobacco that has not been able to exercise the level of pressure and influence witnessed for other health issues such as tobacco control, breastmilk substitutes or access to medicines. It should be noted, however, that the argument can be reversed; the FCTC constituted since the beginning of its negotiation a strong catalyst for

[27] This ideological approach is reflected in the Framework of Engagement with Non-State Actors, adopted by WHO in 2016: WHO, 69th World Health Assembly, "Framework of Engagement with Non-state Actors" (28 May 2016) WHA69.10.

[28] Room, supra, note 23, 581.

[29] See, in the present issue, J Kelsey, "Digital Trade Agreements and Regulatory Autonomy".

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focused and organised civil society mobilisation and the establishment of a "Framework Convention Alliance".[30]

- WHO's membership and secretariat seem systemically resistant to considering hard international law as a priority tool for carrying out WHO's mandate,[31] as shown recently in other areas such as the regulation of international pathogen sharing[32] and the review of the International Health Regulations (2005) after the 2014–2016 Ebola crisis.[33]

The second set of considerations concerns theoretical approaches to help with conceptualising the conditions that militate in favour of norm creation at the international level, as proposed by constructivist international relations scholars Martha Finnemore and Kathryn Sikkink. One of their main arguments[34] is that international norms follow a cycle of emergence, cascading and internalisation. Emergence requires the engagement of "norm entrepreneurs" that are able to challenge the status quo with a logic of contestation and to frame issues in a way that facilitates their legalisation. Norm entrepreneurs can be states, individuals, international organisations, non-governmental organisations or mixed coalitions thereof. In so doing, they use organisational platforms (often international organisations) that mobilise advocacy, provide expertise, knowledge and training, socialise the emerging norms and institutionalise them within their structures and procedures. Once new norms (eg a new treaty) are accepted by a critical mass of states, they reach a "threshold" or "tipping point" that accelerates their further acceptance, diffusion and eventually internalisation in the domestic legal systems of states parties.

If one subscribes to this theoretical model, the question is whether there are norm entrepreneurs and organisational platforms that can advocate for and support the successful negotiation and ratification of a FCAC at this time. The answer seems to be negative even though political conditions are not static and can change, as was the case for other apparently "missions impossible" such as the prohibition of anti-personnel landmines or international criminal law. There do not seem to be at this time "champions" among states that are willing to invest financial and political resources, catalyse the creation of transboundary coalitions and effectively galvanise and sustain commitment towards a FCAC; civil society organisations are also less aggressive, organised and well-funded than was the case for tobacco. WHO, under the current leadership of Dr Tedros Adhamon Ghebreyesus, does not have alcohol as a priority, and secretariat resources are very limited. The COVID-19 pandemic has also inevitably focused WHO's leadership in a single direction. All of this contrasts with the push towards the FCTC, where WHO, under the leadership of Director-General

30 <https://www.fctc.org/about-us/> (last accessed 31 July 2020).

31 GL Burci and C-H Vignes, *World Health Organization* (Alphen aan den Rijn, Kluwer Law International 2004) p 155.

32 GL Burci, "Health and Infectious Disease", in TG Weiss and S Daws (eds), *Oxford Handbook on the United Nations* (2nd ed, Oxford, Oxford University Press 2018) pp 679–94.

33 WHO, "Report of the Review Committee on the Role of the International Health Regulations (2005) in the Ebola Outbreak and Response" (13 May 2016) A69/21.

34 M Finnemore and K Sikkink, "International Norm Dynamics and Political Change" (1998) 52 International Organization 887.

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Gro Harlem Brundtland, was at the same time a norm entrepreneur (together with a sizable and determined coalition of states and an equally fiercely dedicated coalition of non-governmental organisations), institutional platform and forum for institutionalisation.

Also for these reasons, parallels between the FCTC and a putative FCAC have to be taken with great caution, and the policy conditions to imagine a determined push towards a new convention do not seem to be present. It is unlikely that this stalemate will change in the short to medium term.

VI. Alternative frameworks and approaches

The empirical accuracy of the forecast above has been confirmed by the WHO Executive Board in January 2020. In its decision EB146(14), the Board requested the Director-General to "develop an action plan (2022–2030) to effectively implement the global strategy ... as a public health priority" to be considered by the World Health Assembly in 2022.[35] The Director-General was also requested to develop a "technical report on the harmful use of alcohol related to cross-border alcohol marketing, advertising and promotional activities ... which could contribute to the development of the action plan". Finally, the Board decided to review the Global Strategy in 2030, thus adopting a long-term perspective for a possible discussion on a different normative approach.

From a theoretical perspective, a broad spectrum of models and frameworks is conceivable in terms of potential normative effectiveness and political feasibility, at least with regard to some aspects of the problem. This also resonates with powerful conceptual models developed by constructivist international relations scholars that have proved influential and insightful in theorising and predicting the calculations and trade-offs that states engage in when considering avenues for international legalisation. From a political and governance perspective, it is important to adopt a broad and holistic approach that includes various forms of rule-making and institutional governance and not to reduce the analysis to the binary debate between "hard and soft law" that, in my view, affects some of the literature on the need for a FCAC. Non-binding instruments and international institutions have empirically proved effective in inducing compliance in a variety of situations and should not be discounted on the basis of formal legal considerations.

In terms of hard legalisation, a proposal that has been considered in the public health literature,[36] as well as within the UN, is adding alcohol as a controlled substance under the 1971 UN Convention on Psychotropic Substances.[37] Article 2 of the Convention, in particular, stipulates that a substance can be subject to international control if WHO finds that it has the capacity to produce: "... a state of dependence, and ... central

[35] WHO Executive Board, "Accelerating action to reduce the harmful use of alcohol" (7 February 2020) decision EB146(14).

[36] Room, supra, note 23, 590–91.

[37] Convention on Psychotropic Substances (adopted 21 February 1971, entered into force 16 August 1976) 1019 UNTS 175.

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nervous system stimulation or depression … and that there is sufficient evidence that the substance is likely to be abused so as to constitute a public health and social problem warranting the placing of the substance under international control".[38] While alcohol is objectively a psychoactive substance and can produce the effects contemplated in Article 2 of the Convention, such an inclusion would change drastically the nature and perception of alcohol from a consumer product to a medical substance, and it is unlikely that there will be political consensus on such a drastic reframing. It would also probably require an amendment or a very creative interpretation of provisions such as Articles 5 and 9 that regulate the possession, supply and prescription of controlled substances for therapeutic or scientific purposes.

The scholarly literature that can help with framing the international normative models for alcohol control focuses on the meaning and mechanism of legalisation in international governance. In a seminal contribution published in 2000 in *International Organization*, Kenneth W. Abbott and Duncan Snidal conceived of legalisation as a process developing along a continuum of soft and hard law.[39] Softness and hardness, however, are not mutually exclusive concepts; nor do they only depend on the formal nature of an instrument, but rather they are based on a matrix with three axes: obligation (the binding force of an instrument), precision (the general or detailed formulation of an instrument or of particular provisions therein) and delegation (whether or not third parties or international bodies can interpret, adjudicate, monitor and/or enforce the instrument). The theoretical assumption is that international legal instruments (regardless of their labels) position themselves on a curve ranging from "very hard" to "very soft" depending on the combination of those three factors. Besides the more intuitive aspect of the formal legal nature of the instrument, it seems conceptually and empirically plausible to assume that a highly detailed instrument as well as one that delegates interpretation and enforcement to an international body would produce a stronger "compliance pull" than an instrument exhibiting the opposite features. Depending on a number of variable parameters such as the subject matter at hand, the immediate and long-term goals (including reputational goals), the messages being sent to other states as well as to domestic audiences, the perceived sovereignty and transaction costs and other similar considerations, states aim at case-by-case permutations along the three axes in order to seek an acceptable negotiated balance.

Harder forms of legalisation, with the hardest form represented ideally by a precise, prescriptive and detailed treaty with strong institutionalised mechanisms for interpretation, compliance monitoring and adjudication, seem particularly warranted (according to Abbott and Snidal) in a number of circumstances that resonate with the challenges raised by international alcohol control.[40] The credibility of hard commitments, for example, is of particular value for the creation of "clubs" of shared values, on the assumption that only sincerely committed states would accept binding

[38] ibid, Art 2.

[39] Main reference here is to KW Abbott and D Snidal, "Hard and Soft Law in International Governance" (2000) 54 International Organization 421. Their approach is confirmed and developed in G Shaffer and M Pollack, "Hard and Soft Law", in JL Dunoff and MA Pollack (eds), *Interdisciplinary Perspectives on International Law and International Relations* (Cambridge, Cambridge University Press 2013) p 197.

[40] Abbott and Snidal, supra, note 39, 426–34.

obligations that would decrease the profitability of their industries. It also increases reputational costs and liability risks in case of breach and, most importantly, internalises obligations and binds internal actors, decreasing later transaction costs during implementation and deterring breaches. The delegation of interpretation and enforcement powers to common institutions, moreover, can help in handling problems of incomplete contracting (ie in the case of general or imprecise provisions). This is the case of the FCTC, where the Conference of the Parties to the convention has clarified and made more specific a number of provisions through the adoption of guidelines.[41] Soft forms of legalisation instead – again, with a range of models and options decreasing the prescriptiveness of an instrument, limiting its content to general provisions and establishing only weak and/or *inter partes* mechanisms for interpretation, monitoring and/or enforcement – may be pursued to lower contracting costs of negotiation and internalisation and sovereignty costs in more politically sensitive areas. Softer forms of legalisation may also help with managing uncertainties, facilitating compromises as well as agreement in case of domestic political controversies.[42] It is not possible to go beyond these few examples in this contribution; however, the theoretical model introduced by Abbott and Snidal seems very insightful and can help with considering forms of international legalisation of alcohol control that, while short of a full-fledged dedicated international convention, may represent a step forward from the current situation. Legalisation should also be seen as a dynamic process, where policy and normative choices may constitute steps generating evidence, consensus and political dynamics that, in turn, lead to subsequent developments.

Given the constraints imposed at a policy level by the directions imparted by WHO's Executive Board in the above-mentioned decision, immediate prospects to strengthen the global normative framework for alcohol control must focus on the plan of action to be developed by the WHO Secretariat for 2022, including the report on cross-border advertising and promotion. The plan of action will be primarily the implementing tool of the Global Strategy; therefore, it can be assumed that the secretariat will focus on developing and elaborating the actions sketched in the latter and highlighting the main challenges that states have encountered in its implementation so far. The Executive Board has not requested the Secretariat to explore alternatives to the current strategy, thus the intention to continue to rely on a "soft" normative approach seems clear. However, the structure and terms of the strategy arguably leave space for strengthening its normative pull from the other two perspectives identified by Abbott and Snidal: namely, increasing the level of detail and specificity of the measures and actions and creating new institutional tools to increase the accountability of states with regards to their level of compliance. The plan of action could also build on paragraphs 46 and 48 of the Global Strategy and introduce practical measures to involve civil society, research institutions and professional associations in the implementation and monitoring of the Global Strategy while avoiding a closer

[41] The text of the guidelines can be found at <https://www.who.int/fctc/treaty_instruments/adopted/guidel_2011/en/> (last accessed 25 March 2020).

[42] Abbott and Snidal, supra, note 39, 434–50.

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involvement of industry, as well as create forums and mechanisms to promote networking for mutual learning and support. A precedent that can provide some useful guidance in this connection is the non-binding 2010 Global Code of Practice on the International Recruitment of Health Personnel.[43] The Code, firstly, is addressed to all relevant stakeholders and not only Member States; it therefore promotes and legitimises their participation, strengthens their role and makes them part of the monitoring mechanism of the Code, thus increasing the accountability of Member States.[44] Secondly, it establishes a relatively detailed process to monitor implementation that involves non-state actors and provides for periodic consideration by the Health Assembly. Since this process is in essence a form of peer review, the plan of action could introduce alternative or complementary mechanisms, such as ad hoc expert or intergovernmental bodies to consider in detail developments and challenges, provide guidance and make recommendations to WHO's governance or directly to member states.

The foregoing analysis assumes that my interpretation of the Executive Board's decision is correct and that the secretariat will limit itself to working within the confines of the Global Strategy and its inherent weaknesses in developing the action plan. It also does not take into account, for reasons of brevity, that the action plan has to be developed "in consultation with Member States and relevant stakeholders". Besides the question of whether the reference to "relevant stakeholders" will require consultations with the alcohol industry,[45] the fact that Member States will be involved in the consideration of possible policy choices will inject a political dimension into what could otherwise be labelled as a technical exercise based on evidence and public health considerations. Depending on the evidence gathered during the forthcoming process and political dynamics that are so far hard to anticipate, it cannot be excluded that the preparation of the action plan may be turned into an opportunity to show the systemic inadequacies of the Global Strategy and to propose a broader reconsideration of the fundamental normative strategy of WHO rather than just making the best of it. The development of a technical report on cross-border alcohol marketing, advertising and promotion, in particular, could enable the Secretariat to highlight the need for binding international rules to effectively address this and other transboundary elements of crucial importance for a credible regulatory approach to alcohol control. Either approach, of course, will remain of marginal importance if it is not accompanied by a substantial increase in financial resources, which would also enable the WHO Secretariat to play a more active and impactful role in providing

[43] WHO, "WHO Global Code of Practice on the International Recruitment of Health Personnel" (21 May 2010), WHA63.16.

[44] Para 2.2 of the Code reads as follows: "The Code is global in scope and is intended as a guide for Member States, working together with stakeholders such as health personnel, recruiters, employers, health-professional organizations, relevant subregional, regional and global organizations, whether public or private sector, including nongovernmental, and all persons concerned with the international recruitment of health personnel". Moreover, para 9.4 enables the WHO Secretariat to "consider reports from stakeholders as stipulated in Article 2.2 on activities related to the implementation of the Code".

[45] This possibility should be strongly constrained and open to scrutiny by Member States under the Framework of Engagement with Non-State Actors (note 27).

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technical support and capacity building, as explicitly provided in paragraphs 49–51 of the Global Strategy.[46]

Even though the development of the plan of action provides a concrete possibility to strengthen the current normative framework or even open up a discussion on possible alternatives, the main global instrument will remain the non-binding Global Strategy for the time being. The different legal nature between the latter and existing treaty-based rules of economic law will inevitably create an asymmetry with regards to national actions that may deter the search for stronger national and international forms of alcohol control. A necessary complement to the improvement and strengthening of the Global Strategy consists, therefore, in improving the interpretation and application of the existing economic law rules. The manner in which the fierce controversies concerning access to medicines have shaped the design and implementation of international patent law[47] is a powerful reminder that existing economic law rules provide sufficient discretion to states to accommodate more stringent forms of control on the availability and promotion of alcohol products. Recent jurisprudence such as that mentioned above also points to a growing deference towards regulatory interventions by states when challenged on the basis of market and economic rules. Examples of this approach could concern taxation, regulation of advertisement, labelling and health warnings, regulation of points of sale, etc. This option, of course, would be far from satisfactory in public health terms and would strongly depend on the political will of a sufficient number of states, aggressive antagonising and "softening" of binding market rules through the use of soft instruments adopted within WHO and other international organisations with a social mandate and the attitudes of national courts and international dispute settlement bodies.[48] Still, it would help with changing some of the assumptions underpinning current economic law rules and could move political dynamics towards more stringent and self-standing forms of international legalisation.

Similar dynamics can also take place within different bodies of international law, notably human rights law. The contribution given by both global and regional human rights-monitoring bodies and courts can be very significant in this regard and can contribute to the legal and political dynamics mentioned here. Tobacco control, for example, figures frequently in the concluding observations of the UN Committee on Economic, Social and Cultural Rights under Article 12 of the Covenant; the efforts by states parties to limit tobacco-related morbidity and mortality is considered as part of their obligations to progressively realise the right to health. To my knowledge, this has not yet occurred with regards to alcohol (or not to the same extent), but such a neglect will probably change.[49]

[46] Global Strategy, supra, note 1, 21–22.

[47] The strong divide between arguments in favour of strong intellectual property protection to promote pharmaceutical innovation on the one hand and contrary arguments based on the need to better protect and promote the right to health on the other is reflected in a controversial report of a UN high-level panel: United Nations, "Report of the United Nations Secretary-General's High-Level Panel on Access to Medicines" (2016).

[48] A useful conceptualisation of the possible antagonistic relationship between "hard" and "soft" law is provided in Shaffer and Pollack, supra, note 39, 209–13.

[49] OA Cabrera and LO Gostin, "Human Rights and the Framework Convention on Tobacco Control: Mutually Reinforcing Systems" (2011) 7 International Journal of Law in Context 285.

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VII. Conclusions

The road towards an effective global legal instrument for alcohol control is clearly long, difficult and uncertain. While a dedicated international convention along the lines of the FCTC may be an ideal outcome and may enable international law to play a stronger role than it does now in turning the tide of alcohol-related diseases and human suffering, its normative and political feasibility should be critically assessed using both political considerations as well as insightful theoretical models. Those considerations could assist policymakers in considering alternative forms of legalisation that could not only help with changing the political economy of the global alcohol market, but also start a dynamic process that could eventually lead to a future FCAC.

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