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The governance of addictions at the international level

Robin Room[1,2,3] and Jenny Cisneros Örnberg[1]

[1]Centre for Social Research on Alcohol and Drugs, Stockholm University;
[2]Centre for Alcohol Policy Research, Turning Point Centre, Fitzroy, Victoria, Australia;
[2]Melbourne School of Population and Global Health, University of Melbourne

SUMMARY

This chapter considers the governance of addictions in am international perspective, focusing on structures and actions at a global level and within the European Union (EU) in the fields of drugs, pharmaceuticals, alcohol, tobacco and gambling. Both at a global level and within the EU, there is great disparity between different addictive substances and behaviours in the extent of and priorities in international governance of markets and their customers. Nonmedical use of psychoactive substances under international drug control treaties is subject to a strict prohibitory regime, and at the EU level implementing that regime has been a political project of unification. In contrast, alcohol and gambling are subject to no public health-oriented international regulation, and trade treaties and agreements have been used as instruments to weaken national and local control regimes. Tobacco and psychopharmaceuticals (along with other medications under prescription regimes), are at intermediate positions. At the EU level, court decisions on trade and national control issues have paid substantial attention to considerations of public health and interest. But at the global level, international trade and investment law has fairly systematically operated to undercut control for public health or in the public interest in all areas other than the drug prohibition treaties. Particularly globally, there has been a tendency toward a Manichean system where an addictive commodity either is forbidden entirely or is subject to free-market rules with diminishing restrictions on the market and promotion.

Introduction

In this chapter, we consider the collective governance of addictions in a global perspective. Besides the self-governance of the individual who uses psychoactive substances or engages in addictive behaviour, the individual is subject to influences, informal and formal, from within the family and in other face-to-face relationships, from the local community and government and from larger social collectives such as the state, and beyond the state through international treaties and their implementation. These influences from various interpersonal and collective levels will push in both directions, towards more use by the individual as well as less or no use, but our primary concern here is the public health interest, which usually points in the direction of less use.

The chapter's primary focus is on international structures and actions, both at the global level as reflected in the treaties and organs of the United Nations and within Europe as reflected in the institutions and actions of the European Union (EU). Our perspective is comparative, across psychoactive substances and gambling.

We start with a brief history of international controls and regulations in our topical area. We then characterise the different international regimes for the different substances and for gambling, with attention to their effectiveness from a public health perspective. The public health interest is in reducing to a minimum harm to the user and to others from the substance or behavior. Controlling use or behavior and its circumstances – not necessarily eliminating it – is thus an important element in public health-oriented harm reduction. The chapter then considers the threat from international trade and investment treaties to public health interests in controlled markets in addictive substances and behaviours. It ends with a brief discussion of current trends.

The emergence of international controls, and a typology of control regimes

Psychoactive substance use and addictive behaviours have been part of human life and commerce since before recorded history, and have been subject to collective regulation, including by states, for thousands of years. The European imperial expansion in the centuries before 1950 was a main instrument in the globalization of such use and behaviours (Courtwright, 2001), and the availability and affordability of such products as beer and spirits were magnified by the changes of the industrial revolution. The social fallout of waves of intoxication with industrialised alcoholic beverages in much of Europe and its colonies produced a counter-response of strong temperance movements in the 19th and early 20th centuries, resulting in government control regimes and even in alcohol prohibition in 13 countries (Schrad, 2010). In the late 19th century, use of opiates and other psychoactive substances also rose, with increasingly industrialized production, and temperance movements expanded their scope to press for control regimes for them.

As portable and concealable goods, psychoactive substances are easily transported and traded, and temperance movements began to press for international systems of governance, as a protection for national control regimes. Alcohol was first, with international agreements restricting the "trade spirits" market in Africa; international restrictions on opium and other "narcotics" followed early in the 20th century (Bruun et al., 1975).

In the first decades of the 20th century, then, restrictive regimes were put in place, particularly in societies under strong British or American influence, for a variety of addictive substances and behaviours. The substances – tobacco, alcohol, opium, cocaine, etc. -- tended to be regarded in a common frame by doctors specializing in "inebriety or narcomania" (Kerr, 1894), although the extent of control policies often differed according to how enculturated the substance was. In the same period, there were also heavy restrictions, enforced by criminal law, limiting the availability of gambling (Dixon, 1991).

But in the remainder of the 20th century, this commonality of perspective was fragmented (for the U.S., see Courtwright, 2005). The international alcohol agreements, for instance, eventually became dead letters (Room, 2008). The result has been what Braithwaite and Drahos characterized in 2000 as "five totally separate regulatory regimes for different types of drugs":

1. an illicit drugs regime subject to totally globalized prohibition;

2. a prescription drugs regime which was globalizing slowly under US/WHO leadership until 1980 and somewhat faster under EC leadership since then;
3. national non-prescription drug regimes which are not globalizing;
4. national alcohol regulation regimes which are not globalizing (prohibition here, regulation here, deregulation there);
5. national tobacco regulation regimes, elements of which are progressively globalizing. (Braithwaite & Drahos, 2000, p. 360)

How separate all the regimes are can be argued: prescription and nonprescription drugs are often regulated by the same national authorities, and the provisions of the "illicit drugs regime" have strongly affected prescription regimes. But, while there have been some developments since 2000, the Braithwaite and Drahos typology is still recognisable today. Gambling regimes, not covered in their discussion, are national or subnational in scope, similar to non-prescription drugs and alcohol.

We shall consider first regimes which include measures on the global level, and then regimes where regulation is primarily at national and subnational levels.

Global drug control: a rigid prohibition regime

For the hundreds of substances now covered by the three international drug treaties of 1961 (as amended in 1972), 1971 and 1988, a strict prohibition regime for nonmedical use applies essentially throughout the world -- although this appears to be in the process of splintering for cannabis (Room et al., 2010; Room, 2013b; Kilmer et al., 2013).

The global drug control regime includes not only stringent controls on international trade in the substances covered, requiring criminalization of all trade not carried out under the auspices of the system, but also requires prohibition of domestic markets, and for that matter of possession of drugs, other than for authorized medical use.[1] The degree of prescription of and intervention in domestic law is unmatched in international agreements for any other item of potential consumption.

The drug control regime is also a market-planning mechanism -- an unusual form of trade treaty – in that responsibility for assuring and organizing the distribution of an adequate global supply of opium for medical use is assigned to an international committee, the International Narcotics Control Board.

Evaluations of the effectiveness of the regime have given it a mixed report (Room & Reuter, 2012). Concerning some prescription medications, such as barbiturates, the combination of international control and shifts in medical opinion appear in the long run to have restricted levels of use and harm. But for the most common plant-based drugs, derived from opium, coca and cannabis plants, as well as for some synthetic drugs such as amphetamines, it is hard to sustain an argument that the system has come anywhere close to succeeding in its aims. Meanwhile efforts to enforce the system have resulted in substantial individual and collective harm. In terms of assuring a supply of opium for medical use, the system has more or less succeeded with respect to high-income countries except in time of war, but there are wide disparities in access to pain medication globally; the WHO has estimated that 80% of the world's population lacks adequate access (WHO, 2007).

[1] As noted, the strictures of the global regime have been stretched particularly for cannabis, earlier by such phenomena as de-facto tolerance of (strictly regulated) "coffee shops" selling cannabis in the Netherlands and by U.S. state provisions for "medical marijuana" dispensaries, and are now being disregarded in two US states and Uruguay (Room, 2013b).

Particularly with the adoption of the 1988 treaty on illicit trafficking, the drug treaties and their governance and enforcement system moved more and more into the domain of law enforcement and away from public health concerns. In the mid-1990s, those in public health positions who came to play key roles in the inception of the Framework Convention on Tobacco Control were initially deterred from moving in the direction of a treaty concerning tobacco because they had "concluded that these narcotic-control treaties [...] were in the 'bad treaty' class from a public health point of view; they wouldn't help us." (Reynolds & Tansy, 2012, p. 21).

There is substantial agreement among scholarly accounts of the international drug control system that the US has long played a leading and indeed hegemonic role in it. It has had a strong influence in the Commission on Narcotic Drugs and other drug regime agencies. It also exerts influence through such means as tying its foreign assistance to its assessment of drug treaty compliance, and through an overseas-posted corps of Drug Enforcement Agency agents which outnumber the international staff of the UN Office of Drug Control (Babor et al., 2010b, pp. 214-217). However, in recent years a number of Latin American countries have been edging away from the "Washington consensus" on drug policy, in part because of heavy social costs of the policies in their countries, and in part reflecting a new self-confidence. It seems likely that the U.S. in future will be playing a less hegemonic role in the system (Youngers, 2013). In particular, the changes in cannabis policy within the US, driven from below, are making it unlikely that the U.S. can continue to act in its traditional roles concerning this drug.

In the context of the European Union, illicit drug issues have served as an instrument of unification. In external relations, reaching consensus on a common position on drug policy, for instance at the UN Commission on Narcotic Drugs, has been defined as part of building a united Europe. Internally in the EU, the coordination has been primarily in terms of drug enforcement, which also became "a European political project": "drug threat and the enforcement rationalized on the basis of that threat have become the basis on which to legitimize a broader set of security measures among member states while marginalizing alternative analyses and policies on drugs" (Elvins, 2003, pp. 179; 23). The emphasis on law enforcement grew in the context of agreements such as Schengen which removed border controls between most member states. The emphasis also reflected that the 1992 Maastricht Treaty established cooperation on Justice and Home Affairs as a "third pillar" of the European integration, whereas the European Commission's competence in public health matters was later and weaker, only made explicit in the 1997 Amsterdam Treaty (Elvins, 2003, pp. 76-79). The emphasis continues in the EU Drugs Strategy for 2013-2020, which identifies the emergence and rapid spread of new psychoactive substances as a new challenge which needs to be addressed, including through the strengthening of existing EU legislation. In 2013 the European Commission proposed to strengthen the EU's ability to respond to 'legal highs' – new psychoactive substances used as alternatives to illicit drugs such as cocaine and ecstasy. The proposals follow warnings from the EU's Drugs Agency (the EMCDDA) and Europol about the scale of the problem and a 2011 report which found that the EU's current mechanism for tackling new psychoactive substances needed bolstering (European Commission, 2011).

Pharmaceutical prescription regimes: internationalisation by attraction?

Many of the substances included in the drug treaties, those with medical utility, are governed also by national prescription regimes. These regimes are not directly controlled by

the drug treaties, but are influenced by them (for instance, the treaties have globalised the model of a medical prescription separated from the dispensing of the drug) (Babor et al., 2010b, p. 180).

The prescription regimes, which apply also to a variety of nonpsychoactive medications, are otherwise not subject to a formal global public health treaty or agreement, other than concerning such formal matters as generic nomenclature. The big pharmaceutical firms tend to have stayed away from opiates, including synthetic ones, and some of the other medications covered by the drug treaties, apparently considering that the risk of bad publicity is not worth it (Babor et al., 2010b, p. 83).

The global pharmaceutical industry is concentrated in the US (22 of the 50 top companies), Western Europe (16) and Japan (10), with 45% of its total revenue from the US market (Babor et al., 2010b, p. 82). The concentration of the industry is argued by Braithwaite and Drahos (2000, p. 369) to have been a reason that WHO did not succeed in "securing convergence of regulatory standards for pharmaceuticals" in the 1980s and 1990s. Instead, there were confrontations with manufacturing countries – first with the US and later with Japan. Europe, however, had a history of internationalization of standards dating back to the 19th century, and a pan-European regime was under way already after a 1975 EC Directive. Hauray and Urfalino (2009) have documented that the internationalization of the European regime was a process of "mutual transformation" under pressure from the rise of evidence-based medicine and competition particularly with Anglophone countries. Each EU Member State has its own procedures for the authorization of new medicines, within their own territory. However, the European Medicines Agency (EMA), operating since 1995, is responsible for the compulsory centralized procedure from which pharmaceutical companies, for certain medicines such at treatment of HIV/AIDS, cancer and diabetes, have to receive a marketing authorization.

Braithwaite and Drahos note that the internationalization within Europe also had wider effects: "from 1965 to 1998 Europe moved toward a system of binding regulation that applies throughout the EU", and "from this position of growing strength" enlisted first Japan and eventually the US in a program of harmonization (Braithwaite & Drahos, 2000, pp. 371-2). At the levels of production and distribution, thus, there is a global prescription medicine regime which is built around the oligopoly of a limited number of transnational corporations and the regulatory regimes of the producer countries, without any international treaty specifically on pharmaceuticals. It is clear that prescription systems, essentially a form of rationing system, with doctors and pharmacists as gate-keepers on each other and on the user, can be effective in limiting levels of use and harm (Babor et al., 2010b, pp. 179-200). A new cloud over the situation, however, is the rapid expansion in recent years, particularly in the U.S., in the volume of consumption of prescribed opioids (Fischer et al., 2008).

International control of tobacco: globalization in baby steps

The Framework Convention on Tobacco Control was adopted in 2003, came into force in 2005, and has been acceded to by 177 countries. It is the first treaty negotiated under World Health Organization auspices. As a Framework Treaty, it is intended to be supplemented by protocols, and the first of these, a Protocol to Eliminate Illicit Trade in Tobacco Products, was agreed on in 2012 but has not yet entered into force.

The Framework Convention sets a number of standards concerning taxes and other measures to reduce demand, regulation of contents and emissions, packaging and labeling, limiting passive smoking, and banning advertising. But, unlike the drug treaties, most of the

provisions are stated in terms of goal-setting and exhortation, rather than of imperatives. A number of Guidelines on implementation of articles of the treaty have been adopted and others are in preparation, although their legal status in case of disputes is not clear. A review of progress at national levels five years after the convention came into force showed progress in some areas but less in others (Nikogosian, 2010).

In the context of the European Union, tobacco is an unusual case. The EU took an active role in the process leading to the FCTC and reducing the harm from smoking is today one of the top public health priorities within the Union. Over the past two decades there has been shared responsibility between the EU and member states for tobacco control policies, where the EU has the capacity to coordinate, complement, and support public health efforts (Studlar, 2012). Nevertheless, as Alemanno and Garde (2013:18-19) remark, "EU tobacco control efforts are marked by a strong regulatory involvement from the EU.... As a result, this field of EU policy has been at the forefront of a 'federal' experimentation, helping delineate the limits of EU competences and the relevance of the principles of subsidiarity and proportionality for EU law and policy making". Thus the 2003 EU prohibition against advertising and sponsorship of tobacco products was adopted on the legal basis of the requirement for equal treatment in the "internal market" (Directive 2003/33). Germany has twice challenged the validity of this directive, at first successfully, arguing that it in reality it is a disguised public health measure which does not contribute to the establishment or the functioning of the internal market (see Case C-376/98 and Case C-380/03). Since health considerations, rather than the promotion of free movement of tobacco products, have constituted a decisive factor in the adoption of both the Tobacco Advertising and the Tobacco Products Directives, the approach has created serious tensions around the legitimacy of EU regulatory interventions (Alemanno & Garde, 2013).

International control of alcohol and of gambling: a blank slate

On alcohol, there is still no binding international agreement from a public health perspective, despite a number of calls for a Framework Convention on Alcohol Control (e.g., Anonymous, 2007). WHO has adopted a Global Strategy to Reduce the Harmful Use of Alcohol, but the resources devoted to its implementation are very scanty (Room, 2013).

The United Nations and WHO are presently engaged in developing global plans to tackle Non-Communicable Diseases (NCDs, such as heart disease, cancer, chest diseases, diabetes) on a basis as intensive and urgent as campaigns have been against infectious diseases. Alcohol has been included as one of the four main risk factors for NCDs, to be tackled and reduced in the Global Action Plan for NCDs 2013-2020. The voluntary global targets agreed on for risk factors include 30% relative reductions in tobacco use and in salt intake, but a 10% relative reduction in harmful use of alcohol. There is also a further restriction on the alcohol goal: "as appropriate, within the national context". The Action Plan sets out a variety of "policy options for member states" concerning each of the goals. The options set out for tobacco control include a number of specific measures, such as raising tobacco taxes, legislating tobacco-free environments, and comprehensive bans on tobacco advertising, promotion and sponsorship, all keyed to recommended actions in the Framework Convention on Tobacco Control. For alcohol, there is no specificity in the policy options: the ten headings of the Global Strategy are reproduced, without elaboration, and otherwise governments are asked to "formulate public health policies and interventions to reduce the harmful use of alcohol based on clear public health goals, existing best practices, best-available knowledge and evidence of effectiveness and cost-effectiveness generated in

different contexts" (WHO, 2013). The relatively low target and lack of specific actions was the compromise solution after hard lobbying by the global alcohol industry, influencing the position of national delegations.

Within the EU, also, the alcohol area has been marked by a relatively weak approach to any regulation at the international level. The first EU Alcohol Strategy was adopted by the European Commission in 2006 in response to the growing recognition of the health impact of harmful and hazardous alcohol consumption in the EU. The development and continuation of the alcohol strategy can be considered a significant step in EU alcohol policy development. However, the difference at the EU level in handling between tobacco and alcohol is striking; whilst EU tobacco control has preferred a traditional command-and-control approach, the Alcohol Strategy has embraced self-regulation. The 2006 EU Alcohol Strategy acknowledges that "in some cases, where there is a cross border element, better coordination at, and synergies with, the EU level might be needed" (Commission of the European Communities, 2006). However, as Allemano and Garde (2013: 19) summarise it, "very few EU harmonizing rules have been adopted to date to combat alcohol-related harm". Given the importance attached to subsidiarity in health matters, the idea of so-called added value – would EU intervention add value to the initiatives contemplated by member states if they had acted alone? – has been presented as a criterion for EU actions and policies (Randall 2001), and de-facto mostly answered negatively. The Audiovisual Media Services Directive (AVMS Directive) constitutes an exception, in that it lays down rules on the content of alcohol promotions in AVMS. These provisions are nonetheless extremely weak, and most Member States have relied on the minimum harmonization clause contained in the Directive to adopt stricter measures to protect the health of their citizens better – leading in turn to a high degree of fragmentation of the internal market. Furthermore, the EU has so far failed to seize the opportunities offered by the EU Treaties for effective regulation of marketing practices which promote the harmful use of alcohol (Allemanno & Garde, 2012, p 50). On the other hand, the CJEU has accepted rather far-reaching public health measures at the national level when it comes to alcohol such as retail monopolies on alcohol and the Loi Evin -- the French law on alcohol advertising – which are clear interferences in the open market.

There has been little attempt to regulate gambling at the international level, although the rise of internet gambling has brought the issue to the fore. However, some individual nations have made energetic efforts to bring commercial internet gambling based outside their territory but involving national customers under control. Thus the U.S. has forbidden credit card companies and other financial institutions operating in the U.S. to pay attempted money transfers to gambling websites, though with limited success (Lester, 2008; Owens Jr., 2010; PR Newswire, 2013).

Within the EU, national restrictions and gambling regulations have been questioned in the name of free markets, and the legality of preventing foreign actors entering the market is contested in many member states. Increasing opportunities for cross-border gambling have facilitated the development of a global gambling market beyond easy state control (Cisneros Örnberg, 2006). As with EU alcohol policy, the European Commission has, in accordance with the subsidiarity principle, defined its tasks in the gambling area primarily as supplementing national control regimes, ensuring for example , compliance of national regulatory frameworks with EU law, efficient enforcement and the protection of consumers, minors and vulnerable groups, and the prevention of fraud and money laundering (European Commission, 2013).

International law as a threat to public health: trade and international investment law

The capacity of nations to control and reduce harm from psychoactive substances or gambling is substantially limited by treaties and legal decisions concerning international trade and investment. We have already mentioned the European Union's single market provisions; trade law restrictions through the World Trade Organization or bilateral and regional trade treaties are potentially a greater threat to public health measures. Both WTO and EU law start from the premise of trade liberalization. They also recognize that Member States should be able to invoke public interest objectives, including public health protection, but provide that trade restrictions on public health grounds must be proportionate, i.e. legitimate and no more restrictive than necessary to protect public health (Alemanno och Garde, 2013; Anonymous, 2002). The problem with the "proportionate" principle is applying it in practice; it usually only applies if there is no other way with less interference in the market by which the public health goals could be attained. Typically, the measure which is in dispute is but one among a number of measures which have been or could be taken, and the results of each, including the one in dispute, will be a relatively small improvement. The motivation for the measure is also often mixed, with local vested interests intermingled with public health concerns. In this situation, decisions by dispute resolution panels, often expert in trade law but not in public health, commonly go against the public health interest (Babor et al., 2010a, pp. 88-90).

There is no specific provision in the international drug control treaties which would override trade treaties. But one advantage of their privileged status in international law is that they seem informally to act as a protection from trade agreements and disputes: there has never been a World Trade Organization trade dispute concerning any of the substances the drug treaties cover.

There is no provision either in the Framework Convention on Tobacco Control concerning resolution of conflicts with trade laws, but this convention has certainly not afforded any de-facto protection against such disputes. Thus there are pending disputes with Australia and Uruguay on impairment to a property right in trademarks inherent in a plain-packaging or warning label requirement on cigarette packs (Vadi, 2012). There have also been trade disputes in diverse circumstances concerning alcohol (Grieshaber-Otto et al., 2000). A substantial list of high-income countries have lined up with their alcohol industries, for instance, to complain about proposed warning labels on alcohol beverages in Thailand (O'Brien, 2013). Similarly, the U.S. and Canada sued each other under the General Agreement on Tariffs and Trade (forerunner to WTO) concerning unequal treatment of alcoholic beverages under provincial and state liquor control regimes (Room et al., 2006).

European common market law has also been a constraint on public health provisions with respect to alcohol. Decisions concerning tobacco seem mostly to have come down on the side of public health (Vadi, 2012), but the Nordic systems of state control of alcohol production and distribution were considerably weakened by changes required to join the European Union or the related European Economic Space (Holder et al., 1998; Cisneros Örnberg & Ólafsdóttir, 2008).

On the other hand, decisions of the European Court of Justice in cases involving gambling, ironically, have tended to prod states into acting more in accordance with public health and interest, that is, in the direction of restricting gambling and associated addiction and harm. Many European Union member states have had state monopolies on gambling, with the monopoly justified as a control on the extent of gambling. The court's decisions

that in order to keep a monopoly states have to show a good-faith effort to be acting in the public health direction has tended to push states in that direction (Cisneros Örnberg & Tammi, 2011).

Conclusion

In many aspects, the markets in psychoactive substances and gambling are globalised, and control of them is increasingly concentrated. Humankind's addictions have proved to be powerful drivers of capital accumulation, whether the market in the particular addictive commodity is legal or not. In the 20th century, a sharp division was made between psychoactive substances on a global basis in terms of their legality for nonmedical use, with controlled drugs defined as inherently too dangerous to be made available on the legal market. Although the division is presently fraying at the edges, the global institutions which govern and enforce the controls remain in place, although which substances have ended up on which side of the line of prohibition is hard to reconcile with the development of knowledge (Room, 2006).

With this large exception, addictive commodities have been subject in recent decades to two conflicting trends at a global level. One has been the growth and widening of public health concerns about the governance of addictive commodities. The other has been the triumph of neoliberal free-market ideology. This has often resulted in the privileging of free markets and free trade over other public values and interests. Both in the context of the European single-market, and in a wider global trade context, this has pushed against public health strategies of using relatively mild market restrictions that nudge consumers in directions favourable to their health and wellbeing. As a result we see a trend of greater privileging of individual over collective interests. The idea that the individual should be free to make his or her own choices in behaviour, expenditure or consumption, no matter what the effects on those around him or her, finds one manifestation in the ideology of consumer sovereignty. Though the ideology is framed in terms of preferences of the individual consumer, the main proponents and beneficiaries of the ideology's application are those supplying the addictive commodity.

For alcohol and for gambling, the result in many places of market deregulation has been substantial increases in proportions of populations which are at harmful levels of consumption. For tobacco, there has been a counter-move against the two trends in high-income countries, but rates of smoking are still rising in low- and middle-income parts of the world.

The current disarray at the international level concerning cannabis prohibition (Room, 2014) may be a signal that the division between two kinds of substances and control regimes is beginning to break down. In this circumstance, there is an urgent need to move beyond a hard-and-fast division between what is to be prohibited and what is to be made available for exploitation, promotion and sale with no substantial restrictions. A way needs to be found to move the governance of addictions to a middle way of limited and regulated markets, with commitments to individual choice and to free markets mitigated by strong attention to public health concerns.

TAKE HOME MESSAGES

There is wide divergence between addictive substances and behaviours in the extent and direction of international governance over national and local control of markets and customers.

For substances controlled by the international drug treaties, a strict prohibition regime remains in place, although fraying at the edges. Trade treaties and disputes have had no impact on this regime.

For alcohol and gambling, there is no international governance on behalf of public health or the public interest. At the global level, trade agreements and disputes have acted to weaken national and local market controls.

For tobacco, the Framework Convention on Tobacco Control expresses a weak but growing intergovernmental consensus, operating primarily by recommendation. But international trade investment agreements have been used to weaken national and local controls. EU regulation is a contrary example that might serve as a positive example...

For psychopharmaceuticals, like other medicines subject to the prescription system, there is considerable de-facto convergence of regulation, initiated by and spreading from development in the EU.

There has been a tendency toward a bifurcated international governance system, where a commodity and its use is either banned, or national or local controls on supply and promotion are swept away by the enforcement of trade and investment agreements. A way needs to be developed to move at a global level beyond such a Manichean division.

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CONFLICTS OF INTEREST

None

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