Mainstreaming concepts, discounting variations?
Global policies of alcohol, drugs and tobacco

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Abstract
This chapter presents the formation of global public health rationales through problem definitions surrounding alcohol, illicit drugs and tobacco use. It discusses how this has involved certain constructs of the problems’ nature and certain ways of addressing them. The first part of the chapter contains historical accounts of the rise of the three policy areas on the global health agenda. The second part discusses concepts, worldviews and epistemologies as gathering and mainstreaming forces in contemporary times. What unfolds is a peculiar inclusive yet exclusive agenda. On the one hand, the problems have lately been increasingly conceptualised together as stemming from the same kind of disorders and circumstances. On the other hand, the conceptualisations of public health from the perspective of dealing with alcohol, drugs and tobacco are highly dominated by synchronised psy, medical and biological disciplines, which are epistemically laundered, exclusive and homogeneous. The chapter shows how the idea and rubric of dependency has been crucial for seeing a common aetiology. The worldview of this epistemic global public health framing is one where regional and cultural variations are rather disregarded, the geographical variations emphasized being mostly the ones between high and low-income countries. Another important aspect of the global polity in these areas is the one of the shared enemies of global commercial and criminal actors.

Introduction
During the twentieth and twenty-first centuries, world polities with a public health ethos have emerged in the areas of alcohol, drugs and tobacco. The road has been staked out with international treaties and cooperation strategies, underpinned by political work by international non-governmental organisations (INGOs) and the World Health Organization (WHO). The developments have looked a bit different in each of the three questions, but a conceptual epistemic mainstreaming has taken place during the past thirty years or so. The discussion in this chapter evolves around two questions: it begins by considering the historical circumstances surrounding the emergence of international collaboration in the three areas. The chapter then discusses certain ideas and concepts that in recent decades have come to mainstream and, in some respect, amalgamate the essence of the three areas as questions of global public health.

As alcohol use is legal and widespread in most parts of the world, the global public health agenda that materialised during the second half of the twentieth century has typically applied a grammar of larger epidemiologist population-based trends and patterns, construed through measures such as the societal burden of non-communicable disease (NCD) or disability-adjusted life years (DALYs). However, long before the emergences of such concepts, the nineteenth- and twentieth-century temperance movements had evolved with international alcohol policy collaboration. The population based health framing of current global health alcohol policies may have alleviated some of the moral valence associated with the historical background.
When it comes to illicit drug policy, the international political cooperation developed out of national needs to suppress criminality and work together against the spread of dangerous substances between and within national borders. As drugs have functioned as a “suitable enemy” cooperation has even tended to be more active compared to the international combatting of other types of criminality. The international cooperation surrounding illicit drugs has historically concentrated on substance-specific evaluation work and it is partly binding through international juridical agreements. Health-related drug policy objectives have, nevertheless, been too complicated to grasp, too ideologically invested and too inconsistent in their national variants for arriving at clear-cut mainstreamed global strategies with a common language. Nevertheless, through connections with other agendas, such as notably the one of HIV/AIDS, the international cooperation has been able to establish a degree of consensus regarding certain general constructs of prevention and reduction of drug-related problems.

In comparison with alcohol and drugs, the global cooperation surrounding tobacco as a matter of public health is of a later date and entails a more archetypal epidemiological narrative of discovery, mobilisation and synchronised attempts for eradication. It grew rapidly as a somewhat clear-cut issue for public health in the latter part of the twentieth century, articulated through an epistemic consensus regarding the evidence on harms caused by smoking for the smoker and their closest environment. The WHO’s own account of the history of the WHO Framework Convention on Tobacco Control is formulated as a success story involving a ground-breaking previously “unused constitutional authority” of the organisation; performances in the “art of negotiation”; accounts of “the power of process” and even some “champions” are singled out in the narration of the events.

Concepts and language use, such as the ones in the above-mentioned report on the Framework Convention on Tobacco Control, reflect the ways in which alcohol, drugs and tobacco have appeared, and been conceptualised and reproduced as phenomena of public health. For example, the current normalised cultural position of alcohol is obvious, given the fact that drug use and smoking have been associated with constructs such as ‘epidemics’ (“tobacco epidemic”, “drug epidemics”) – and with a rhetoric rarely found in documents on alcohol policy.

Seen in a long view, it is of a rather late date that the three questions have been conceptualised as issues related to health. As late as some hundred years ago alcohol, tobacco and opium were primarily items of trade and tools of dominance in the process of European colonial expansion. However, conceptions began to change during the following 60 years. During 1910–1970, alcohol, tobacco and drugs were increasingly conceptualised as different issues. Cigarette smoking was banalised after the First World War, and a new generation of middle-class youth adopted cigarette smoking as a generational symbol. Consequently, nicotine was separated from concepts such as inebriety and addiction. The same generation also contributed to the failure of alcohol prohibition, which forced key actors to rethink alcohol problems, redefining them from a problem located in the substance to a problem located in the “alcoholic”. This conceptualisation did not at all fit in the increasingly tighter international prohibition regime for opiates and other drugs, which focused on the drugs themselves as the problem, instead of framing them as a social problem or a disease of the will.

However, alcohol, tobacco and drugs have been reintegrated in public health politics since the 1970s. This has occurred simultaneously with a rise of a global public health agenda, its adherent infrastructure and the political manifestation of concepts of public health. As will be shown in this chapter, it can partly be seen as a result of a great global conceptual mainstreaming of diagnostic
criteria of dependence and addiction. This is a conceptual public health machinery executed by epistemic communities in medicine, psychology and pharmacology, which includes scientific policies of funding and publishing. As a result, drug and alcohol treatment (noticeably though, not tobacco) have been reorganised as a single system in many countries; intoxicants and gambling are treated together in policy strategies, and alcohol, tobacco and drug education in schools are in many parts of the world combined. At the same time, contemporary neuroscientists believe human beings can develop pathological relationships with a seemingly unlimited range of substances and activities.

In what follows, I will present a brief historical backdrop of how each of the three global policy areas arose. In the second part of the chapter, I discuss concepts, worldviews and epistemologies that have associated the three areas with health. In the end, I draw some conclusions regarding the history of ideas relevant for alcohol, drugs and tobacco.

Three global agendas

The rise of a global alcohol agenda

The roots of treating alcohol use as a social question can be traced to the Temperance Movement, which was internationally organised in the beginning of the twentieth century. The movement for worldwide prohibition was an international arena, which began to take an organisational form in 1909, when the International Prohibition Confederation (IPC) was established. In 1919, the IPC was renamed as the World prohibition federation (WPF). IPC/WPF, which was a propaganda organization distributing more than 5 million leaflets, pamphlets and other publications in less than two decades, emphasised that prohibitionists were a moral community, united regardless of race, religion, nationality, or politics. It was essentially an Anglo-American organisation, in which the Independent Order of Good Templars (IOGT) was a dominant influence. Because of economic difficulties, the Federation failed to compete with the World League against Alcoholism after the Anti-Saloon League of America had established a rival propaganda society in 1919. The World League operated in 185 countries, including European and American colonies. It was most active pushing prohibition in the early 1920s, but the peak of propaganda activities was in 1927–1930.

At the time, the international temperance movements offered platforms for the travel of ideas associated with societal progress. For instance, the American Women’s Christian Temperance Union had a great influence on the manifestation and objectives of the Australian Women’s Temperance Movement. The international platforms could also lead to substantial changes in national framings of alcohol control and treatment: the international temperance movement, for instance, influenced Finnish policy makers, who started to look more positively on compulsory treatment towards in the late nineteenth century.

The early temperance movement framed alcohol as both a social political and health-related matter. The current global public health frame occurred chiefly through the World Health Organization since its founding in 1948. A recent review of the material from the WHO Expert Committees on alcohol, drugs and tobacco shows that between 1949–1963, experts discussed intensively concepts and terminology both concerning alcohol and illicit drugs. The use of alcohol, drugs and tobacco would later be defined as common problems for the world community, drawing on a common aetiological understanding.
However, it was difficult to define alcohol and drug use as problems of the human body in a way that would allow for proper public health measures. The experts tried to find a common terminology expressing the phenomenon of ‘continuous use despite harmful consequences’ (commonly referred to as alcoholism and drug addiction). In the 1950s, the Expert Committee in Drugs Liable to Produce Addiction (ECDLPA) decided that habit forming should be replaced with addiction in all texts. Different concepts were linked to different control measures, but measures were primarily decided on nationally, outside the frame of the WHO or even outside the public health arena.\textsuperscript{22} Between 1964–1989 – around the times when ideas of New Public Health (NPH) started to surface and develop\textsuperscript{23} – the concept of dependency emerged and allowed for a combination of approaches to different substances. However, after 1990 the WHO singled out tobacco as a policy field largely separated from questions of alcohol and drugs.

The first alcohol action plan was approved by the regional office of the WHO in 1994. The European charter on alcohol was approved in 1995 and it has been described as especially important for European countries without a temperance history, such as Portugal. These countries have had no natural reference for dealing with alcohol as a health problem at the level of the population.\textsuperscript{24} Developed by the public health community, WHO’s alcohol policy agendas were intended to constitute a fairly indisputable point of reference that would not easily be compromised by trends in national politics. Since the 1980s, the public health community sought to establish support for what was referred to as an evidence-based agenda. This agenda was epistemically speaking heavily intertwined with individualised medicalised conceptions of control of risk and danger.\textsuperscript{25}

In 2010, the international expert community had reached a consensus. At the Sixty-third Session of the World Health Assembly, it was able to adopt the resolution WHA63.13, which endorsed the global strategy to reduce harmful use of alcohol. The global strategy, which is not legally binding, focuses on ten key areas of policy options and interventions at the national level and four priority areas for global action. States the document: “WHO and its Member States are dedicated to work together to address the key areas of policy options and interventions, to interact with relevant stakeholders and to ensure that the strategy is implemented both nationally and globally.”\textsuperscript{26} This document can be viewed as the manifestation of alcohol as a political question on the global health agenda.

\textit{Illicit drugs as a global question}

Whereas the international cooperation on the alcohol question had a background in the temperance movement, the international drug cooperation had many frontlines in the fight against drug-related crime in the form of international treaties.

The first international drug control treaty, The International Opium Convention, was signed in The Hague in 1912. The Convention was implemented in five countries in 1915\textsuperscript{27} and globally in 1919, when it was incorporated into the Treaty of Versailles. The primary objective was to restrict exports instead of prohibiting or criminalising the use and cultivation of opium, coca, and cannabis (added in 1927). A revised International Opium Convention was signed in 1925 and registered in the League of Nations Treaty Series.\textsuperscript{28}

The Convention for Limiting the Manufacture and Regulating the Distribution of Narcotic Drugs was a drug control treaty promulgated in Geneva in 1931, which entered into force in 1933. It established
two separate detailed groups of drugs and its scope was broadened considerably in 1948. The Convention was superseded by the 1961 Single Convention on Narcotic Drugs.  

The Single Convention on Narcotic Drugs from 1961 (amended by the 1972 Protocol, and the Convention on Psychotropic Substances, 1971) states the protection of the health and welfare of humankind as its ultimate goal. The parties of the conventions consider “co-ordinated and universal action” required for restricting use for medical purposes and for making sure there is an opium supply for medical use. The conventions also envisage the use of public health measures to prevent and reduce health and social harm due to “abuse of drugs” The WHO is one of the four treaty bodies in the international drug control conventions; the others are the United Nations Secretary-General, the International Narcotics Control Board (INCB) and the Commission on Narcotic Drugs (CND).

The Single Convention on Narcotic Drugs and the Convention on Psychotropic Substances entrust the WHO with the responsibility of reviewing and assessing substances to determine whether they should be controlled under the conventions. A request for such a review can be initiated by parties to the conventions or by the WHO itself. The review of selected substances is carried out by the WHO Expert Committee on Drug Dependence (ECDD). The Expert Committee’s tasks include carrying out a review on the information available on substances subject to international control or exemption, reassessing the level of control of given substances, and to advise the Director-General of the WHO accordingly.  

The ECDD, which has had different names in different times, has mostly convened every two years since 1949. It has played a central role in making recommendations to the United Nations Commission on Narcotic Drugs on control measures: “[i]n contrast, alcohol and tobacco committees not needing to make scheduling decisions in relation to international conventions have met less frequently often in response to WHA resolution calling for research on particular area of emerging interest”. The frequency of responses may have strengthened the ECDD and slightly compensated for its narrow role, restricted to providing recommendations on the scheduling of drugs.

In comparison to alcohol and tobacco, the global cooperation on drug policy has involved more varied types of substances that need to be classified and standardised according to knowledge of how they affect individuals and societies. The WHO is the only treaty body with a mandate to carry out medical and scientific assessment on substances:

“The advice of the Expert Committee is based on the best available scientific, medical and public health evidence and must comply with the criteria established in the conventions. Specific rules and procedures for the evaluation of substances are published in Guidance on the WHO review of psychoactive substances for international control. The science of substance evaluation has evolved over time and the methods of the Expert Committee are continuously adapted to embrace newly emerging insights.”

Through the work of the Expert Committee, the WHO has reviewed more than 400 substances since 1949. Between 1948–1999 the number of narcotic drugs under international control increased from 18 to 118, and the number of psychotropic substances from 32 to 111.

The public health community has not been able to agree on global drug policy announcements in the same way as in the fields of alcohol and tobacco. International illicit drug policy bodies have
traditionally emerged out of treaties that answer to situations that were not manageable without the involvement of many countries’ control systems. It has been more difficult to create a worldwide polity in the area of public health. Not only has the agenda been split between substances, but views on how to approach the problems have also varied greatly. Some countries have promoted a prohibitionist approach, such as Sweden and the US, whereas others, such as Denmark and the Netherlands, have supported a harm reduction agenda ever since the beginning of the movement. Mutual understanding has been more common in questions such as dealing with international drug cartels and networks. The latest big advancement was the 2009 Political Declaration and Plan of Action on International Cooperation towards an Integrated and Balanced Strategy to counter the World Drug Problem adopted by the Commission on Narcotic Drugs. The United Nations General Assembly Special Session in New York in 2016 (UNGASS 2016) arranged a special session on “the world drug problem” with multi-stakeholder round table contemplations with topics such as demand reduction, supply reductions, human rights, children, and regional matters. In comparison with WHO’s ECDD the International Narcotics Control Board (INCB) – an independent, quasi-judicial expert body established by the Single Convention on Narcotic Drugs of 1961 – has been more influential concerning recommendations on control measures.

The WHO has been more successful in formulating a health care-oriented evidence-base to support treatment in member states. In 2009 the WHO published its Guidelines for the Psychosocially Assisted Pharmacological Treatment of Opioid Dependence. Compared to the alcohol strategy document, it is more heterogeneous in its world view, acknowledging the many different drug abuses and problems. Still, it is more clinically oriented and targeted at “health systems” – a generalised term used to cover national models for treatment supply. The readership targeted consists of policy makers and administrators, a global policy and practitioner community in health-care administration. The recommendations in the guidelines are based on systematic reviews of the available literature and on consultations with a range of experts from different regions of the world. The word “evidence” appears 179 times in the 134-page document, and the word “recommend” appears 171 times. Scientific reviews are accounted for in an appendix concerning information mostly gathered from Randomised Controlled Trials (RCT).

In the field of drugs, the international arena was long occupied primarily by meetings of and around the official international drug control system. However, as Robin Room explains, while many countries remain conservative and supportive of the drug control system, it is out of tune with progressive public opinions, and independent expert opinion has become increasingly sceptical. Under such circumstances, international sets of meetings and societies have emerged and developed a critical stance. These meetings include the International Conferences on the Reduction of Drug-related Harm, which have been annually organised by the International Harm Reduction Association since 1990. In addition, drug user movements run by active and former drug users start to become increasingly organised in international arenas.

A smoke-free world: Tobacco as a global question

In the 1960s, new evidence on the relationship between tobacco and health hazards gained public attention in the USA and in Europe. In 1962, a report from the British Royal College of Physicians was the first to document a causal relationship between smoking and cancer. In their study on Finnish and Norwegian tobacco policy developments, Matilda Hellman et al. point out three stages of
mainstreaming the tobacco policy agenda since the 1950s. The first period entailed an ontology of harm to the smoker, and harm reduction was an articulated goal. In the second stage, as of the 1970s, harm to others became an important driver in the promotion of smoke-free environments. In the third period, as of the 1990s, the focus shifted onto the problems of addiction and dependency, which entailed technical solutions and biological explanations for controlling physical cravings. Similar developments have occurred also elsewhere, which is partially attributable to the strong role of the medical profession in the anti-smoking agenda. In the collective memory of global health policy community, the process was perceived rather unique; a success story in public health mobilisation setting the example also for other lifestyle-related fields.

The tobacco question entered the WHO cooperation rather late, towards the end of the twentieth century. When Norwegian physician Gro Harlem Brundtland became Director-General of the WHO in 1998, WHO’s Tobacco Free Initiative (TFI) raised the profile of tobacco control. WHO initiated a process of developing a framework that permitted member states to adopt a comprehensive tobacco control policy, which included transnational tobacco control measures. While the ECDD had deferred tobacco for further consideration in 1996, by 1999, new evidence of greater liability for abuse brought tobacco into focus again. The WHA adopted the WHO Framework Convention on Tobacco Control (FCTC) in 2003 and put it into effect in 2005. The convention became the first international treaty negotiated under the auspices of the WHO.

The political strategies of the WHO involved a creation and validation of a collective reality to be reflected and implemented in regional and national policies. Suzanne Taylor et al. describe characterise the period 1990–2013 as a movement towards a more sustainable and combined approach to substance abuse. This was reflected in the creation of WHO’s Division of Mental Health and the Prevention of Substance Abuse’s Programme on Substance Abuse (PSA). This period was marked by the development of global tobacco control strategies.

The tobacco question represents a rather unique global mainstreaming of views on a problem and its subsequent policies. Consensus and conformity upheld the mandate and kept it together. Civil society engagement was important for the development of framework conventions — in particular, industry forces that were actively working against them. This institutional agenda provided a framework for activities, goals and policies. The mainstreaming and the isomorphism of tobacco policy and control can be seen as extremely functional and with a strong focus on problem-solving. Tobacco policy is a good example of a broadly shared view on a problem, whose agenda led to a rather rapid breakthrough. The Framework Convention has subsequently served as an aspired success story for other substance control agendas (alcohol policies, in particular).

Mainstreaming concepts and ideas

The framing of alcohol, drugs and tobacco as public health problems have been related to broader social developments underpinned by rationales based on science and technology. These have relied on specific worldviews, concepts and discourses, some of which follow general developments in public health discourses, whereas others have been specific to questions of substance use. In the later part of the twentieth century, collective welfare solutions in the Western countries were beginning to cover broader areas of concern, whereby public health measures, policies and discourses were also formulated. This framework enabled the institutionalisation of alcohol, drug and tobacco policies as well.
Alcohol, drugs and tobacco policies would, partly through the expanding global polity of public health, develop into a somewhat more consensual psychological and medical polity. This community sought to establish large-scale, systematic and mechanical methods for identifying problems and developing solutions. For alcohol, drug and tobacco abuse to be included in the agenda of public health problems, they have been required to involve normative, ontological and epistemological conceptions of human functioning and societal prosperity in relation to the value of health.\textsuperscript{47} The concept of health – an embodied and modifiable status – has brought the problems aetiology closer together and enabled the focus to shift away from, e.g., disagreements regarding export and import of different substances, or the moral responsibility to abstain from alcohol.

The WHO expert committees in alcohol, drugs and tobacco were active in formulating concepts and definitions in an attempt to unify the world behind the universal problems of humans and human societies. Sometimes terminology was revised several times, e.g., when the somewhat opaque term \textit{habit-forming} was replaced with \textit{addiction}. However, \textit{addiction} quickly proved to be unsatisfactory in links to control measures, after which it was replaced by \textit{dependence} and a focus on \textit{dependence-producing drugs}.\textsuperscript{48}

The WHO Expert Committee first suggested replacing \textit{addiction} and \textit{habituation} by \textit{dependence} in 1962 after which it would include dependency concepts in its International Classification of Diseases (ICD, updated since 1949). In retrospect, it can be seen as an early contribution to a larger project of combining different substances on the health agenda. The ICD serves as a problem-defining tool and a manifestation of a joint global terminology.\textsuperscript{49} The WHO emphasises the role of the ICD in identifying health trends and interpreting statistics on a global level; in short, in allowing the world “to compare and share health information using a common language”\textsuperscript{50}.

The ICD involved an understanding of the syndrome of \textit{dependence} as definable, countable and counter-actable in populations; a notion that resonated well with the rise of governance ideas of New Public Health.\textsuperscript{51} This was a rather long conceptual step from the international crime control ambitions of the Opium Convention or the morally invested social ideals of the temperance movements.

Terms such as \textit{dependence} and \textit{addiction} highlight similarities between illicit and licit substances and created an opportunity for a seemingly universal global approach to a variety of problematic behaviour. This holds true at least in the areas of research and treatment, but the psyche conceptions of dependency and addiction would entangle with and spread to popular discourse.\textsuperscript{52} On a superficial level, \textit{dependence} seems to offer a possibility to steer away from social, political and cultural complexity by concentrating on a diagnosable, health-related syndrome. This was a manageable construct familiar from the WHO’s global endeavours for communicable diseases. For example, alcohol as a \textit{dependence-producing drug} cuts across the public health spectrum, from a diagnosable physical/mental problem in the individual to the measurement of the prevalence of the problem in any given population. These goals and measures are shared by policies related to illnesses such as malaria, HIV/AIDS or hepatitis. For the global health community seeking consensus, the ‘dependency’ diagnostic tool involved important connotations. It associated severe substance use with a problem conception that was seemingly more clean-cut, technical and morally detached compared to the frail balance between the freedom of consumers to drink alcohol and health protection through limited alcohol availability.

8
Drawing on Law’s concept of collateral realities, Suzanne Fraser et al. scrutinise the literature that influenced and formed the basis of the dependency concept, which would turn out important for the construction of a commonality between alcohol, drug and tobacco policies. Clinical knowledge and the need for addiction treatment have depended on such a conception of the problems. The dependence syndrome, as introduced by the WHO, can also be seen to have marked a globally accepted definition for a phenomenon embracing compulsive acts or thoughts beyond those directly related to drugs. It illustrates an emerging contemporary interest in linking addiction to a spectrum of other behaviours. Important for this conceptual trend has been that “[t]he ‘dependent person’ is a pre-constituted subject whose diseased condition improves or worsens according to the impact of external social processes.”

In all areas of epidemiology, international measurement synchronisation and diagnostic criteria constitute mainstreaming forces on the global level. They define problems and lay the grounds for how the prevalence and solutions are formulated. Concepts of addiction and dependency have been propelled and underpinned by transnational discourses by epistemic communities and organisations. The construction of dependence allows for expertise to reign over a broad spectrum of behaviours. At the same time, the repertoire of solutions is sealed within the concept’s epistemologies and the professions executing and reproducing their rationales. Its connotation thus inherently creates an ambivalence. While it formulates a core shared by a variety of problems – excessive alcohol use, gambling, eating or any other behaviour thinkable – it excludes, by definition, non-diagnosable and fuzzy problem variants and their surrounding realities. These variants and realities are bound to prevail on a larger scale than the ones that fit the criteria of ‘dependency’.

While the forthcoming ICD-11 has retained dependence, the American Psychiatric Association has replaced dependency in its diagnostic manual DSM-5 of 2013 with “Substance-Related and Addictive Disorders”. Both ideas fit agendas underpinned by medical, epidemiological and psychiatric expertise. At the same time, the large neurobiological-ontological endeavour, commonly referred to as the BDMA (Brain Disease Model of Addiction), has pushed this project further by looking for supportive evidence in line with the diagnostic constructs. Its proponents claim the moral extra bonus of avoiding stigmatisation by sticking to physical expressions, and excluding individual self-interpretations of the problems. At the same time, the brain disease model is largely intertwined with systems of psy science in order to manifest itself in practice. The BDMA is an epistemic project of which knowledge on socio-political and ethical consequences is urgently needed.

The concept of the world as one single place, in which problems of dependency and addiction appear and are dealt with, is embedded in an international normative regime operating with common concepts, words and ideas. The norms of this global culture will inevitably reflect the interests of the elites who champion them. In the case of global addiction policies during the past forty years or so, the elite has primarily consisted of experts in pharmacology, medicine and epidemiology. The epistemic globalisation of conceptions and standards is an ongoing rationalisation in which dependence, addiction, and substance use disorder are only a small part of the picture. More contemplative literature on concepts in the area seems to be mushrooming, and the problems with implementing concepts in different cultures is being acknowledged.
Discourse on threats and enemies

An inherent discursive objective of the global health policy documents on alcohol, drugs and tobacco is to gather the world community behind a worldview that calls for national action, political processual collaboration and joint action. Such ideas materialise through arguments that highlight the urgency of the project by emphasising threats to humankind and its societies. Health risks and threats typically involve notions of the problems’ scale and their fatal consequences. For example, the Framework document 1997 program for substance abuse is declared to address “the substantial health, social and economic costs related to the use of psychoactive substances, which have become a major global health concern, affecting millions of people throughout the world.”62 The guidelines for the psychosocially assisted pharmacological treatment of opioid dependence state:

“the costs of ill health and loss of lives are calculated UNODC estimates that there are 25 million problem drug users in world, of whom 15.6 are problem opioid users and 11.1 problem heroin users (approximately 0.3% of the global population). The cost of this epidemic is counted in the millions of lives lost each year and the billions of dollars spent.”63

Typically, the widespread nature of the problem is emphasised by tying in questions that overlap and attribute to the problems. In the global alcohol strategy from 2010, the harmful use of alcohol is estimated to cause 2.5 million deaths every year, and alcohol use is named as the third leading risk factor for poor health globally:

“The harmful use of alcohol is one of the four most common modifiable and preventable risk factors for major noncommunicable diseases (NCDs). There is also emerging evidence that the harmful use of alcohol contributes to the health burden caused by communicable diseases such as, for example, tuberculosis and HIV/AIDS.”64

The alcohol strategy also involves another typical element of current global health rationales, namely, a focus on world inequalities. While reducing health inequalities on a global scale has been an embedded objective of the WHO from the start, globalisation has further sharpened this focus.65 According to Andrew McMichael and Robert Beaglehole, due to globalisation, “[c]ontemporary public health must encompass the interrelated tasks of reducing social and health inequalities and achieving health-sustaining environments.”66 The expansion of the scope involves a general mainstreaming of the concept of globalization (referring to ‘the way in which the world is collectively going’), as well as acknowledging that a global perspective nevertheless involves different realities (e.g., poorer and richer countries; good and less favourable circumstances for implementing and upholding good health).

According to the 2010 alcohol strategy:

“Reducing the harmful use of alcohol by effective policy measures and by providing a relevant infrastructure to successfully implement those measures is much more than a public health issue. Indeed, it is a development issue, since the level of risk associated with the harmful use of alcohol in developing countries is much higher than that in high income countries where people are increasingly protected by comprehensive laws and interventions – and by mechanisms to ensure that these are implemented.”67 (My emphasis.)
The statement above portrays alcohol as more than merely a public health issue; it is represented as a structural problem that goes beyond the health scope. In the world health polity, a responsibility over low-income countries has developed into an ethical premise. There is not enough room (political mandate and economical resources) to involve the structural dimensions relating to poverty and equality that were already raised by the temperance movement in the nineteenth century. In the twenty-first century world health polity the structural problems are often articulated through a linear narrative on countries’ different extent of resources and of evidence-based policy implementation. Political and ideological explanatory factors and themes related to, e.g., labour, gender equality or systemic social marginalisation might be overlooked. The international cooperation under the temperance umbrella may have been a better platform to spread such ideas.

As mentioned above, modern global health policy agendas have perceived inequality as a central theme already before the emergence of current globalisation forces. Partly due to the increasing AIDS/HIV awareness, the Ottawa Charter for Health Promotion of 1986 expanded definition(s) of public health and strived for a broader cross-sectional social perspective. While the initiative enabled a more contextual framing of public health issues, it has later on been seen as too wide a scope for the WHO, an organisation with specialised epistemic views and limited resources. As mentioned earlier, the period between 1964–89 has been characterised as the era when New Public Health ideas were emerging and consolidated – of which the Ottawa Charter is an important manifestation. During this period, the WHO Expert Committees on alcohol, drugs and tobacco also introduced and established the concept of dependence. The Ottawa Charter did not entail new social framings for questions regarding alcohol and drugs, which both had different contextual and conceptual backgrounds compared to epidemiology and public health. However, its zeitgeist perhaps constituted a welcomed reminder of the complex overall picture of the problems’ nature as well as social dimensions that went beyond aspects of health.

In 1984, an advisory group for European WHO member states outlined Health for All targets for the European region. One set of the targets promoted “a social model of health” through a package of five lifestyle and health targets that addressed healthy public policy, social support systems, knowledge and motivation, positive health behaviour, and health-damaging behaviour. While the advisory group still addressed individual behaviour, it focused on the interactions between individuals and their environments as well as the political instruments needed for addressing health determinants.

In line with the growing epistemic movement on social contextualisation of the 1970s and 1980s, the advisory group sought to expand the territory of health into other policy arenas and emphasised the complex political and social processes necessary for achieving changes in health.

The Ottawa Charter thus initiated an attempt for redefining and repositioning institutions, epistemic communities and actors at the ‘health’ end of the disease–health spectrum. By abandoning an individualistic conception of lifestyles and instead highlighting social environments and public policy, health promotion sought to shift the focus from the modification of individual risk factors or risk behaviours to the “context and meaning” of health actions and health-supporting determinants. In its Health for All strategy, the WHO framed health as a core value of development policy. Furthermore, it defined the goal of health policy as “providing all people with the opportunity to lead a socially and economically productive life.” Governments were seen accountable not just for the health services they provided, but for the health of their populations.
In the 1980s, the scope of the political project for world health was actively aiming to expand, demanding greater national governmental involvement. The initially global project began resembling a national political programme. Lifestyles were understood as collective behaviours deeply rooted in structural contexts—but how were these shifting conceptions to be translated into policies of alcohol, drugs and tobacco, particularly as the concept of dependence was rising? As the complexity and width of public health policies were being acknowledged, it was also acknowledged that many issues were difficult to address to a satisfactory degree through a global agenda.

Since the Ottawa Charter, the world has witnessed a globalisation which could not have be foreseen at the time. Solidarity between low- and high-income countries has become an even more central goal of the WHO, although perhaps less structurally defined in comparison with the 1980s. This solidarity is, indeed, one of the most frequently raised ‘geographical’ variations acknowledged in WHO documents on alcohol, drug and tobacco policies. It reflects a solidarity among the world polity, calling for collaboration in order to deal with world inequality. The potential partners and promoters of the global agenda are state governments, INGOs, and the private sector.

While the theme of inequality theme received more space, the enemy has become more pronounced: the global alcohol and tobacco industry, as well as producers and sellers of drugs who recruit consumers in low-consumption or traditionally abstinent geographies. Globalised health challenges along with global scopes and agendas for dealing with them have led to a more severe polarisation between public health and industry interest, which resembles a new left–right constellation.

The health versus industry constellation involves tremendous competition among global and national stakeholders to legitimise their own standpoint in order to get people’s beliefs to conform with their own agendas. One of the most aggressive intrusions of the global alcohol industry in politics is the brewery SABMiller and the industry-funded International Center for Alcohol Policies formulation of official National Alcohol Policy draft documents for Lesotho, Malawi, Uganda and Botswana. The industry is a very real, yet no doubt a gathering and convenient enemy, in the world view of the global epistemic order of alcohol and tobacco policies. A strong global industry entail various problems, from scientists with funding from vested interests to industry intrusions into policy-making. Global public health and global industries are both entwined with each other’s modus operandi.

The world health polity has not only brought more and more issues into its purview, globalisation has also increased the odds of finding an elite ally for any given movement. The global NGO networks in questions regarding alcohol, drugs and tobacco are involved in influencing and implementing agendas and frame conventions of the WHO or the UN, aiming for these to become, partly or fully, integrated in policy and praxis all over the world. Transnational NGOs have been referred to as “the citizen sector” and agents of accountability. Aileen O’Gorman and Kerri Moore have reviewed and mapped over 200 EU-based drug policy advocacy organisations showing that NGOs and large-scale CSOs have great capacity to access and engage in governance spaces at national, EU and UN levels.

**Conclusions**

In this chapter, I have discussed the background for the appearance of alcohol, drugs and tobacco on the world polity’s health agenda. The nineteenth-century temperance movement was the first to engage in international cooperation regarding the social aspect of alcohol. The international
cooperation concerning drugs, for its part, has mostly focused on aspects of criminality and on categorising substances, partly due to a lack of political consensus. Finally, in current times, tobacco has rapidly risen as a clear-cut question of public health.

The chapter has also suggested some mainstreaming forces that have enabled seeing alcohol, drugs and tobacco policies as involving similar core problems, as well as mainstreaming forces that have emphasised them as global problems, hence to be addressed in a world polity. The word dependency and the idea of this phenomenon (also in terms of addiction and substance use disorders of the DSM) have supported both of these mainstreaming objectives.

The worldview that materialises in the account of this global health policy sphere on alcohol, drugs and tobacco largely disregards regional and cultural variations. The emphasised structural and geographical variations are those between high- and low-income countries, which reflects a solidarity project. This chapter suggests that this project became more articulated due the rise of an interest in societal and contextual framings of problems – e.g., through the Ottawa Charter in the 1980s, or other global health challenges, such as AIDS/HIV. The focus on balancing out resources between low- and high-income countries by spreading good practices reflects a moral project that sometimes resembles a welfare state idea in the aims to overcome inequalities between people. To some extent, it involves a positivist view on low-income countries as simply being in more earlier stages of implementing the ‘right’ kind of evidence-based interventions. Another important element of this ontology is shared notions of enemies and threats regarding ill health, criminality, and a demoralised global industry.

Drawing on a strong evidence-based movement (EBM) and disciplines such as medicine, pharmacology, public health and epidemiology, the global epistocracy in these areas of public health have entangled roles of political activists and researchers. This epistemic project is morally invested. In its raison d’être, EBM pursues a moral imperative in producing interventional efficacy and therefore better health, a largely uncontested moral good. At the core of this project lies the ontological idea of a controllable reality (within the individual body, or the evidence-based policy task), i.e., an external reality that might influence health status, but is seldom formulated in within cultural and societal frameworks. How this is reproduced in the mainstream of addiction science is an urgent research task.

What has unfolded in this chapter is the narrative of a simultaneously inclusive and exclusive agenda. On the one hand, the problems are seen as stemming from similar disorders and circumstances. On the other hand, the narrative is highly dominated by somewhat synchronised ontologies of the psy, medical and biological disciplines. Some large ethical concerns for the enormous projects covered in this study reflect attempts to homogenise or to see heterogeneities. In the future, the question of the scientific community’s different roles in relation to science production and policy needs to be scrutinised and discussed more thoroughly.

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