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Regulating lifestyles

Europe, tobacco, alcohol and unhealthy diets

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Introduction to the emergence of a global lifestyle risk regulation agenda

In May 2013, the World Health Assembly unanimously endorsed the *Global Action Plan for the Prevention and Control of Noncommunicable Diseases 2013–2020*, which the World Health Organization (WHO) had developed over the previous couple of years.[1] The Plan follows the UN Political Declaration on non-communicable diseases (NCDs) of September 2011 in which the UN Assembly declared that the global burden and threat of NCDs constitutes one of the major challenges for development in the twenty-first century: in 2008, 36 million of the 57 million deaths globally (63%) were attributed to NCDs, including cardiovascular diseases, cancers, chronic respiratory diseases and diabetes.[2] The problem is particularly severe in Europe where, according to data collected by the Regional Office of the WHO, NCDs account for nearly 86% of deaths and 77% of the disease burden in Europe.[3] These alarming statistics have led to a growing consensus that the EU should develop a policy 'to promote healthy lifestyle behaviours'.[4] In line with the thinking of the WHO, the EU has recognized that NCDs are largely preventable and that it can contribute to

[1] Resolution WHA 66.10. The Resolution and the Global Action Plan are available at: www.who.int/nmh/events/ncd_action_plan/en/.
[2] Political Declaration of the UN High-Level Meeting on the Prevention and Control of Non-Communicable Diseases, 20 September 2011, Document A/66/L 1.
[3] WHO Regional Office for Europe, *Action Plan for Implementation of the European Strategy for the Prevention and Control of Non-Communicable Diseases 2012–2016*, available at www.euro.who.int/__data/assets/pdf_file/0019/170155/e96638.pdf.
[4] European Commission, White Paper 'Together for Health: Strategic Approach for the EU 2008–2013', 14689/07, COM(2007) 630 final.

action at global, regional and national levels by adopting a range of policies to prevent and control the surge of NCDs and reduce the impact of the four main NCD risk factors, namely tobacco use, the harmful use of alcohol, unhealthy diet and lack of physical activity. Yet the causes of NCDs are complex and the legality, design, legitimacy as well as the effectiveness of several regulatory interventions intended to promote healthier lifestyles remain highly contested. Therefore, whilst the international community places great faith in the power of law to change individual behaviour through regulatory intervention, achieving behavioural change is far from straightforward.

First, any regulatory attempt at changing consumption patterns tends to be dismissed, in the name of the principle of autonomy, as paternalistic. Thus, recent policy initiatives, such as the 'fat taxes' pioneered by Hungary and Denmark as well as New York city's plan to limit the serving size of sugary drinks, have immediately earned their proposers the nickname of 'nanny governments'. Second, the experimental nature and lack of solid empirical evidence of some of these policy interventions is an easy target for their critics. Third, the multifactorial nature of NCDs raises difficult questions not only for medicine and health policy but also for the community as a whole. In particular, social mobilization may play a crucial role in promoting the acceptance of these innovative and often experimental policies. However, unlike the area of communicable diseases, in which health activists typically have succeeded in rallying the support of society on *inter alia* access to anti-retroviral medicines to fight HIV/AIDS, NCD prevention strategies tend to be perceived as lacking similar urgency and have not (yet) succeeded in mobilizing society. Given the preventive nature of NCD action, the beneficiaries of these policies are largely 'statistical' in that they consist of either the next generation or those who will be entering middle-age decades from the present. Fourth, tackling NCDs involves a variety of short- and longer-term goals, including what may be challenging alterations to lifestyles, changes in how relevant industries formulate their products, revolutions in the way retail practices influence shopping behaviour and increases in the amount of physical exercise we engage in. Thus, it is of vital importance that behind any attempt at regulating lifestyle there is a holistic, yet realistic, understanding of the underlying phenomena when calling for action, and of the limits of intervention.[5]

[5] S. Planzer and A. Alemanno, 'Lifestyle Risks: Conceptualizing an Emerging Category of Research', 1(4) *European Journal of Risk Regulation* (2010), 337.

A growing body of behavioural research shows that as people and their environment interact, the focus of intervention should not be exclusively on the critical product, but also on the context within which the individual evolves.[6] In other words, context matters and, as such, by contributing to determining behaviour, it carries the potential for behavioural change. Mounting evidence suggests that it is more difficult to make healthy choices in certain environments than in others.[7] These studies illustrate the considerable psychological effort needed to combat the temptations of an unhealthy lifestyle, as well as cultural norms, social and commercial pressures, and how freedom of choice can, perhaps counterintuitively, make it more difficult to resist temptation. Moreover, a key feature of behaviours that promote public health is that they will only deliver gains for the individual and for the population if maintained in the long term. These research findings should lead societies to question their frequent portrayal of people leading unhealthy lifestyles as lacking personal willpower.[8] For example, it is often assumed that one gets fat because one keeps eating too much and fails to engage in enough physical activity. Nevertheless, weight gain and obesity is a much more complex phenomenon than this over-simplistic approach suggests. The role of genetic and epigenetic influences, and the crucial role of societal and environmental factors over which individuals have little control, support the view that obesity is not exclusively a question of personal responsibility. Responsibility is shared between, on the one hand, individuals, who should strive to adopt a lifestyle adequate to protect their health and that of their children, and, on the other, policy-makers and society, who must create environments that better suit human biology and support individuals in developing and sustaining healthy lifestyles.[9]

[6] The literature on the integration of behavioural research into policymaking is vast. For a popular treatment, see, e.g., D. Kahneman, *Thinking, Fast and Slow* (Farrar, Straus and Giroux, 2011); D. Ariely, *Predictably Irrational: The Hidden Forces that Shape Our Decisions* (HarperCollins, 2008); R. Thaler and C. Sunstein, *Nudge: Improving Decisions About Health, Wealth and Happiness* (Yale University Press, 2008). For a more complete treatment of the potential of behavioural sciences in NCD prevention, see Chapter 15 of this volume.

[7] See, e.g., C. Sunstein, 'The Storrs Lectures: Behavioral Economics and Paternalism', 122 *Yale Law Journal* (2013), 1826.

[8] Foresight Project Report, *Tackling Obesities: Future Choices* (London: Government Office for Science, October 2007), at 64. See also K. Brownell et al., 'Personal Responsibility and Obesity: A Constructive Approach to a Controversial Issue', 29 *Health Affairs* (2010), 378.

[9] D. King, Chief Scientific Adviser to the UK Government and Head of the Government Office for Science, Foreword, Foresight Project Report, *Tackling Obesities*, at 1.

The adoption of behaviourally informed public measures raises a series of concerns related to both their legitimacy and their legality.[10] In particular, an objection commonly raised is that these measures could conflict with the principle of autonomy, i.e. the ability to order our lives according to our own decisions.[11] However, it is counter-argued that autonomy cannot be an end in itself but merely a means to an end. While it is true that people may know what their ends are, sometimes they go wrong when they choose how to attain them. According to this line of thought – which may be defined as 'new paternalism' – if the benefits stemming from regulatory intervention justify the costs, society should be willing to eliminate freedom of choice, not in order to prevent people from obtaining their own goals but to ensure that they do so.[12] Interestingly, if we allow public authorities to make (certain) decisions for us, we gain not only in personal welfare but also in autonomy.[13] In sum, health should become 'the easier, default option rather than being agonizingly difficult'.[14] It is only by revealing the suffering of people and of society as a whole which is caused by the burden of NCDs that civil society will eventually mobilize and refuse to accept the growing health inequalities existing between rich and poor, uneducated and educated, the unfortunate and the privileged.

Aim of the volume

While the literature on the contribution that law can make to the NCD prevention and control agenda is growing,[15] it remains highly

[10] A. Alemanno and A. Spina, 'Nudging Legally – On the Checks and Balances of Behavioral Regulation', Jean Monnet Working Paper, New York University School of Law, vol. 6, 2013.

[11] See, e.g., R. Rebonato, *Taking Liberties – A Critical Examination of Libertarian Paternalism* (Palgrave Macmillan, 2012).

[12] See, e.g., S. Conly, *Against Autonomy – Justifying Coercive Paternalism* (Cambridge University Press, 2013). More generally on legal paternalism, see A. Ogus and W. Van Boom (eds.), *Juxtaposing Autonomy and Paternalism in Private Law* (Hart Publishing, 2011).

[13] Ibid.

[14] B. Thomas and L. Gostin, 'Tackling the Global NCD Crisis: Innovations in Law & Governance', 16 *Journal of Law, Medicine & Ethics* (2013), at 25.

[15] See A. Garde, *EU Law and Obesity Prevention* (Kluwer Law International, 2010); G. Howells, *The Tobacco Challenge: Legal Policy and Consumer Protection* (Ashgate, 2011); G. Lien and K. Deland, 'Translating the WHO Framework Convention on Tobacco Control (FCTC): Can we use Tobacco Control as a Model for Other Non-communicable Disease Control?', 125(12) *Public Health* (2011), 847;

insufficient given its importance to the debate.[16] It is against this backdrop that this volume adds to the existing literature by examining both the opportunities that legal instruments offer for NCD control and their inherent limitations.

More specifically, it focuses on the role the EU should play in promoting healthier lifestyles, in light of the moral, philosophical, legal and political challenges associated with the regulation of individual choices. The EU has recently recognized the growing impact of NCDs on the EU's economy and the wellbeing of its citizens and has consequently started to develop policies intended to tackle the four main factors to which NCDs are linked (tobacco use, harmful use of alcohol, unhealthy diets and lack of physical activity). However, if common themes emerge between the different EU policies intended to promote healthier lifestyles, no attempt has yet been made to systematize them. Thus, this volume endeavours to identify horizontal, common themes and determine whether and, if so, to what extent, the lessons learned in relation to each area of EU intervention could be transposed to the others. By focusing on the EU, we intend to highlight both the opportunities that legal instruments offer for the NCD prevention and control agenda in Europe, and the constraints that the law imposes on policymakers. It is only if one understands these constraints that opportunities can be maximized. While law is not a panacea for tackling the crushing burden of NCDs, legal interventions inspired by common sense and based on sound evidence can potentially help reverse current NCD trends and trace a new path in addressing self-destructive behaviours induced in great measure by market integration. This contribution hopes to place EU lifestyle risk regulation more firmly on the agenda of both policymakers and academia. It also attempts to define what role the EU could (and should) play in promoting healthier lifestyles, without however purporting to provide an exhaustive analysis of the EU tobacco control, fight against harmful alcohol use and obesity-prevention policies.

To set the scene for the rest of the volume, this chapter briefly explains how the EU has started to develop what we consider as a lifestyle

A. Alemanno and A. Garde, 'The Emergence of an EU Lifestyle Policy: The Case of Alcohol, Tobacco and Unhealthy Diets', 50 *Common Market Law Review* (2013), 1745; A. Alemanno and A. Garde, 'Regulating Lifestyle Risk in Europe: Tobacco, Alcohol and Unhealthy Diets', SIEPS Policy Report, 6/2013; T. Voon, A. Mitchell and J. Liberman (eds.), *Regulating Tobacco, Alcohol and Unhealthy Foods: The Legal Issues* (Routledge, 2014).

[16] As denounced by B. Thomas and L. Gostin, 'Tackling the Global NCD Crisis: Innovations in Law & Governance', 41 (1) *Journal of Law, Medicine & Ethics* (2013), 16.

risk regulation strategy to tackle NCDs. After briefly presenting the key features of the three policy areas of EU intervention in the field of NCD prevention and control, we will then turn to a presentation of the structure of the book and the individual chapters contained therein.

Towards the development of an EU NCD prevention and control strategy[17]

The EU's awareness of the threat posed by the growing burden of NCDs to the EU economy and the wellbeing of its citizens is relatively recent.[18] This stems in particular from the powers the EU derives from the EU Treaties in the field of public health (the introduction of a chapter on public health in the early 1990s marking a turning point in the EU's approach to public health issues), together with the growing rates of NCDs and the rapid spread of their main risk factors more specifically.

From a few ad hoc measures. . .

A few measures were adopted in the early days of the European Community, before the Member States explicitly granted some competence to the EU in the field of public health. In particular, the first food-labelling laws adopted at EU level may have had some (though a limited) impact on the burden of NCDs. For example the Food Labelling Directive[19] and the Nutrition Labelling Directive[20] required that ingredients of foodstuffs be listed on most pre-packaged foodstuffs, and regulated how nutrition information should appear on food labels. These measures have since been replaced by the Food Information Regulation.[21] However, at the time of their adoption, these two directives could only be characterized as by-products of the internal market: they were incremental rather than a systematic attempt to address the major NCD risk factors and therefore promote healthier lifestyles within the EU.

[17] This section draws on two previous publications: Alemanno and Garde, 'The Emergence of an EU Lifestyle Policy', and Alemanno and Garde, 'Regulating Lifestyle Risk in Europe'.
[18] S. L. Greer and P. Kurzer, *European Union Public Health Policy: Regional and Global Trends* (Routledge, 2013).
[19] Directive 79/112, OJ 1979 L 33/1. [20] Directive 90/496, OJ 1990 L 276/40.
[21] Directive 1169/2011, OJ 2011 L 304/18.

. . . to the introduction of a chapter on public health in the EU Treaties

The momentum to address the burden of NCDs at EU level gathered in the 1990s, as a result of both the pressing warnings of the international and the scientific communities and the express acknowledgment that the EU had an important role to play in public health matters.

Since the entry into force of the Maastricht Treaty in 1993, the EU Treaties have contained a specific chapter on public health which is now to be found in Article 168 TFEU. The first paragraph of this provision has imposed an obligation on the EU to ensure a high level of public health in all its policy areas. It is precisely with a view to implementing the Union's mainstreaming obligation that the Council emphasized, in its Conclusions of 8 June 1999, the necessity to integrate health protection requirements in all EU policies.[22]

Mainstreaming implies, at its core, that a high level of public health protection should be pursued not only via earmarked, distinct policies, but must be incorporated in all policy areas. One could reason by analogy and rely on Olivier De Schutter's argument on the mainstreaming of fundamental rights: 'fundamental rights . . . should be seen . . . as an integral part of all public policymaking and implementation, not something that is separated off in a policy or institutional ghetto. Mainstreaming is transversal or horizontal'.[23] Assessing the impact of policies on public health requires, in turn, that a careful balancing exercise is carried out between competing interests at all stages of the policymaking process, from the first Commission proposal, to the adoption by the Council and the European Parliament of a given measure, to its application by all parties to which it is addressed, to its monitoring and evaluation. The practical difficulties involved in assessing how a high level of public health protection could best be ensured should not stop the EU from taking seriously into account the mainstreaming obligation laid down in Article 168 TFEU – the challenge is to design an effective and transparent mechanism to ensure that this constitutional obligation is duly upheld.[24]

[22] OJ 1999 C 195/4.

[23] O. De Schutter, 'Mainstreaming Human Rights in the European Union' in P. Alston and O. De Schutter (eds.), *Monitoring Fundamental Rights in the EU: The Contribution of the Fundamental Rights Agency* (Hart Publishing, 2005), at 44, citing C. McCrudden, 'Mainstreaming Equality in the Governance of Northern Ireland', 22(4) *Fordham International Law Journal* (1998), 1696.

[24] Garde, *EU Law and Obesity Prevention*, at 74.

The EU's duty to mainstream health in all policies was further reinforced with the introduction, by the Lisbon Treaty, of Article 9 TFEU which confirms that:

> in defining and implementing its policies and activities, the Union shall take into account requirements linked to the promotion of a high level of employment, the guarantee of adequate social protection, the fight against social exclusion, and a high level of education, training and protection of human health.

The introduction of EU powers in the field of public health led to the adoption of two successive programmes of EU action in the field of public health for the periods 2003–2008[25] and 2008–2013.[26] They both shared the objective 'to promote health and prevent disease through addressing health determinants across all policies and activities',[27] not least 'by preparing and implementing strategies and measures, including those related to public awareness, on lifestyle related health determinants, such as nutrition, physical activity, tobacco, alcohol, drugs and other substances and on mental health'[28] and 'by tackling health determinants . . . creating supportive environments for healthy lifestyles and preventing disease'.[29] The Lisbon Agenda on Growth and Competitiveness further strengthened the economic and social case for EU intervention by stressing that, in addition to good health being a valuable goal in itself, it also leads to better economic results and increased social cohesion, and consequently makes the European economy more competitive.[30] Moreover, the European Commission emphasized that tobacco, harmful use of alcohol, unhealthy diets and lack of physical activity result from differences in socioeconomic determinants giving rise to health gaps inconsistent with EU core values of solidarity, equity and universality.[31]

[25] Decision 1786/2002 of the European Parliament and of the Council, OJ 2002 L 271/1.
[26] Decision 1350/2007 of the European Parliament and of the Council, OJ 2007 L 301/3.
[27] Article 2(2)(c) of Decision 1786/2002, OJ 2002 L 271/1.
[28] Para 3(1) of the Annex of Decision 1786/2002, ibid.
[29] Article 2(2) and point 2.2 of the Annex of Decision 1350/2007, OJ 2007 L 301/3. See also the White Paper 'Together for Health'.
[30] European Council Conclusions, Lisbon, 23–24 March 2000.
[31] White Paper 'Together for Health'. The EU has also set up an Expert Group on Social Determinants and Health Inequalities to reflect its growing awareness of the need to tackle NCDs more comprehensively; see http://ec.europa.eu/health/social_determinants/policy/index_en.htm.

After several calls from the Council of the European Union for EU action on NCDs,[32] not only did the EU adopt a range of specific measures intended to curb the consumption of tobacco,[33] but it also adopted three strategies intended to tackle the major NCD risk factors more comprehensively and support its citizens in improving their lifestyles: the EU Alcohol Strategy (2006);[34] the Obesity Prevention White Paper (2007);[35] and a Council Recommendation on smoke-free environments (2009),[36] which complements the adoption of the 2001 and 2014 Tobacco Products Directives[37] and 2003 Tobacco Advertising Directive.[38]

These three areas of EU intervention have several themes in common: they are intended to promote enabling environments more conducive to healthy lifestyles, and they recognize the imperatives of adopting a multi-sectoral, multi-level, multi-stakeholder approach to maximize their chances of influencing the lifestyles of EU citizens and contributing meaningfully to the global agenda on NCD prevention and control. However, these common features should not detract from the fact that EU intervention has varied in nature, scope and intensity depending on the risk factor under consideration. One does indeed observe a gradation of EU involvement, with a strong intervention in relation to tobacco control, a lesser intervention in relation to alcohol control, and the EU nutrition and obesity prevention policy somewhere between the two.

Tobacco

EU tobacco control efforts are marked by a strong regulatory involvement from the EU, coupled with recommendations to Member States and EU-wide anti-smoking campaigns. As a result, this field of EU policy

[32] Some of these calls have focused on one specific risk factor, whilst others have tended to be more horizontal in nature, targeting all risk factors. Examples of the latter type include: the Council Conclusions of December 2003 on Healthy Lifestyles; the Council Conclusions of June 2004 on Promoting Heart Health; and the Council Conclusions of June 2006 on the Promotion of Healthy Lifestyles and the Prevention of Type II Diabetes.

[33] See in particular Directive 2001/37 on tobacco products, OJ 2001 L 194/26 (as repealed by under review), and Directive 2003/33 on tobacco advertising and sponsorship, OJ 2003 L Directive 2014/40, OJ 2014 L 127/1.

[34] COM(2006) 625 final.

[35] COM(2007) 279 final. For an assessment of the EU's obesity prevention strategy, see Garde, *EU Law and Obesity Prevention*.

[36] OJ 2009 C 296/4, as repealed by Directive 2014/40, OJ 2014 L 127/1.

[37] Directive 2001/37, OJ 2001 L 194/26.

[38] Directive 2003/33, OJ 2003 L 152/16.

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 policymaking, as discussed more fully below.[39] At this stage, suffice to say that the EU has not hesitated in this field to invoke its duty of mainstreaming public health into all EU policies in order to push the EU agenda, as illustrated by the ongoing debates surrounding the revision of the Tobacco Products Directive. The EU has also become a party to the Framework Convention on Tobacco Control (FCTC), the first international health treaty ever signed, thus becoming an actor alongside its twenty-eight Member States on the public health scene at global level.

Alcohol

Whilst the EU Alcohol Strategy entrusts Member States with the adoption of comprehensive multi-sectoral strategies, it also explicitly acknowledges that:

> studies carried out at national and EU level show that in some cases, where there is a cross-border element, better coordination at, and synergies established with, the EU level *might* be needed. Examples include cross-border sales promotion of alcohol that could attract young drinkers, or cross-border TV advertising of alcoholic beverages that could conflict with national restrictions.[40]

However, very few EU harmonizing rules to combat alcohol-related harm have been adopted to date.[41] The Audiovisual Media Services Directive (AVMS Directive) constitutes an exception, in that it lays down rules on the content of alcohol promotions in AVMS.[42] 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 for better protecting the health of their citizens – leading in turn to a high degree of fragmentation of the internal market.[43] Notwithstanding the fact that an effective multi-

[39] See Howells, *The Tobacco Challenge*; A. Alemanno, 'Out of Sight Out of Mind: Towards a New European Tobacco Products Directive', 18 *Columbia Journal of European Law* (2012), 197; Garde, *EU Law and Obesity Prevention*, Ch. 3.
[40] At 5. Emphasis added.
[41] J. Cisneros Örnberg, 'Escaping Deadlock – Alcohol Policy-making in the EU', 16(5) *Journal of European Public Policy* (2009), 755.
[42] Articles 9(1)(e) and 22 of Directive 2010/13, OJ 2010 L 95/17.
[43] O. Bartlett and A. Garde, 'Time to Seize the (Red) Bull by the Horns: The EU's Failure to Protect Children from Alcohol and Unhealthy Food Marketing', 4 *European Law Review* (2013), 498.