
Public Health in the EU: Is Europe subject to Americanization?

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Abstract

This paper examines where the European Commission obtains its ideas, validity, and legitimacy to move into areas that receive only minimal support from national political leaders and societal forces. Public health is not a major priority for European politicians and voters alike yet the EU has moved into several highly visible areas of intervention such as tobacco control and nutrition. This paper argues that the Commission took its own initiative to politicize smoking and obesity and that it received support, scientific validity, and political credibility by cooperating with the World Health Organization. In turn, the World Health Organization is highly susceptible to American definitions of public health because it relies on outside experts for information, language, and scientific input. The success of a 'global advocacy coalition' fighting against smoking and unhealthy diets mirrors the widespread influence of American federal and non-profit institutions, granting agencies, pharmaceutical industry, and research communities in the area of public health. In a circuitous way, US public health research, reports, policy, and rhetoric contribute to the growing global alarm about lifestyle diseases.

1 Introduction

Since the launching of the Single Market, the European Commission with the support of Europe's political leaders have sought to reach out to the people of Europe by promoting a "Europe of the Citizens" to neutralize the widespread disenchantment with the prevailing impression of a "Europe of Merchants". The first attempts to introduce a popular dimension to EU legislation dated from the 1984 summit at Fontainebleau where President Mitterrand of France and Prime Minister Craxi of Italy commissioned a report designed to identify areas where the EU could develop new policy dimensions closer to the concerns of ordinary citizens. In retrospect, this decision was the starting point for the gradual expansion of EU activities in the field of consumer protection, environment, and health. The EU's activities in these policy areas were given a large subsequent boost by the Amsterdam Treaty and Article 152, which extended EU competence to "promoting" in addition to "protecting" the health of EU citizens. The former Constitutional treaty did not focus on health per se, but it granted the Commission a stronger mandate to fight health threats such as tobacco and alcohol. In the new Reform Treaty Article 152 draws attention to the protection of public health concerning tobacco and the abuse of alcohol though fighting health threats, first mentioned in the defunct Constitutional Treaty has been deleted.

One way in which the EU has devoted itself to the interests of ordinary citizens has been through its forays into public health, and in particular its initiatives on tobacco control and obesity. Tobacco control emerged in mid-1980s and is still on the agenda since "tobacco is the single largest cause of avoidable death in the European Union," contributing to approximately 25 percent of all cancer deaths and 15 percent of all deaths in the EU (SANCO 2008). To address this health hazard, the European Commission has passed

scores of legislative measures, such as requiring health warnings on cigarette packs, specifying maximum tar content in cigarettes, banning advertising of tobacco products, and collecting a repository of shocking images of the harm done to the smoker.¹ It also funds professional networks to encourage smoking prevention and cessation and it works to ensure that a range of other policies are consistent with tobacco control. In January 2007, the Commission published a Green Paper “*Towards a Europe free of tobacco smoke: policy options at EU level*” in anticipation of regulations to combat indoor pollution in the workplace and public spaces (European Commission 2007a).²

Of more recent vintage is the program to promote healthy diet and nutrition in the EU. In May 2007, the European Commission published a white paper on “*A Strategy for Europe on Nutrition, Overweight and Obesity related health issues,*” which is a call for action to combat weight gain, particularly among children, and prevent future sharp increases in cardiovascular disease, hypertension, type two diabetes, strokes, certain cancers, muscular-skeletal disorders and even a range of mental health conditions due to poor diets and lack of physical activity (European Commission 2007b). The campaign began with an exploratory report, “*Eurodiet: Nutrition & Diet for Healthy Lifestyles in Europe,*” which covered health and nutrients, the translation of nutrient requirements to food-based guidelines and effective promotion of these foods and healthy lifestyles (European Commission 2000).

¹ The 42 photos can be seen at: http://ec.europa.eu/health-eu/doc/healthier_together.pdf

² In July 2008, a member of the European Parliament declared that the most effective way to stop tobacco companies from lobbying politicians is to ban all tobacco products by 2025. Leigh Phillips. “MEP calls for EU ban on cigarettes by 2025.” EUObserver (18.07.2008)

The Commission, to be sure, has not received much encouragement to extend its activities into public health. Instead, the people of Europe assign low priority to community-wide health programs while many political leaders are extremely hesitant about furthering the reach of the Commission into any novel, undefined areas. In developing its public health initiatives, the Commission has responded neither to pressure from below (e.g., emanating from health-related NGOs) nor to pressure from above from the member state governments.

On the contrary, the DG Health and Consumer Protection (DG Sanco) and more generally the Commission have themselves taken the initiative in public health matters and served as the primary framers of measures on tobacco control and obesity prevention. How has the Commission and in particular DG Sanco invested effort and political capital in promoting tobacco control and healthy nutrition when their legal mandate is thin, the salience of tobacco control and healthy diet remained low across Europe for many years, and countervailing forces opposed to European regulations were firmly established? If member state's attention to tobacco control or healthy diet was minimal, where do the Commission's ideas, knowledge, framing, and objectives come from? The current atmosphere in Europe is radically different from the hopeful and optimistic mood of the 1980s when European institution building excited and galvanized the Commission and the political leadership (Ross 2008). Where and how does the Commission think up new areas of legislation when the Europeans themselves are not crying for an expansion of EU authority in these areas?

This paper addresses these issues by examining the cases of tobacco control and healthy diet campaigns. It argues that the Commission has tried to transcend its circumscribed mandate and lack of engagement by national groups, organizations, and experts by working closely with the

Europe office of the World Health Organization (WHO), which provides not only health policy expertise but also political legitimacy. By forming a mutually beneficial partnership, the directorate general of Health and Consumer Protection appropriates the data gathering and analyses of the WHO to justify its own agenda, while the WHO has an intuitive interest in the success of DG Health and Consumer Protection thanks to the overlapping membership between EU and WHO member governments. Together WHO and DG Health and Consumer Protection form a powerful and respected advocacy team, working in tandem to solve health related harms common to all European societies.

The subsequent outcome of this collaboration resembles an advocacy coalition since the actors share strong beliefs about the efficacy of action to reduce the health impact of smoking and fatty/sugary foods. Both WHO and DG Health and Consumer Protection subscribe to core beliefs about the cause of the problem, its gravity, and potential solutions (Gutrich et.al. 2005; Sabatier/Jenkens-Smith 1999).

One unusual feature, however, is that much of the research and scientific understandings furnished by the WHO to the Commission, and *vice versa*, originally came from American public health networks and medical researchers. Joint collaboration between the WHO and EU, and the reliance on scientific knowledge to frame an agenda has resulted in the accidental ‘Americanization’ of European health campaigns. The rise of a pan European advocacy coalition is built around a consensus on priorities and action plans as the EU and WHO recognize their converging interests. But this European-global partnership is organized around a set of scientific terms and professional concepts with a distinctly American tinge.

In making this argument, it becomes clear that this paper fits into one of the two “camps” of literature on the EU’s

policy-making process. The first approach takes the view that the Commission, or more accurately officials in a particular Directorate General, craft their own proposals without much input from other agents or stakeholders. They then wait for the reaction of relevant actors such as national politicians, interest groups, lobbyists, and other governmental authorities. In this scenario, Europe's civil servants are the primary framers and take the initiative to propose laws and regulations (Jakbo 2006; Mörth 2000; Nylander 2001).

An alternative view is to trace the rise of new programs to pressures from below or above. Calls for action prompt the Commission to consider different proposals and recommendations. Member state governments may assign EU institutions the task of monitoring, supervising and implementing policy proposals, or pressures from civic groups, economic interests, and non-governmental organizations may empower the Commission to move into unexplored terrain (Eberlein/Grande 2005; Pollack 2003; Tallberg 2006).

This paper falls into the first "camp" discussed above. As we will see below, active lobbying from above or below - by member states or by European NGOs, health voluntaries, and the medical community - was *not* the principal driving force. Instead, the impetus for pursuing these public health initiatives came from the Commission. To overcome its lack of political clout and visibility in these issues, Commission officials joined forces with other international health organizations to elevate their standing and collect further data and analysis.

The organization of this article is as follows. I first provide an overview of why EU public health operates in a vacuum and how tobacco control and nutrition nonetheless rose to the top of the agenda. In the second section, I explore the web of connections and contacts between the World Health Organization and the American public health and medical

establishment. Third, I examine how the EU program is subject to Americanization. The final section concludes the paper.

2 Own it own: The Ascendance of Tobacco Control and Healthy Diet

As noted above, the Commission has not been subject to pressures to develop public health initiatives from above or below. Member state governments have not tried to stimulate EU-wide measures on public health for various reasons. First, providing medical services and managing the health care system has traditionally fallen to national or local authorities as part of a wider configuration of the social welfare state and funding systems. Moreover, many member states do not have a full fledged public health regime in which the main objective is to safeguard the health of the community as a whole by fostering the conditions that permit people to be healthy. For various historical reasons, apart from the UK, France, and the Scandinavian countries, most EU member states did not develop a distinct discipline of public health in medical schools once infectious diseases were no longer a threat (Cooper/Kurzer 2003; Berridge 2007; John 2001).

A second reason for member states' lack of interest in expanding the public health competences of the EU rests with the contingent nature of the problems identified, which would then require intervention (Gusfield 1981; Douglas/Wildavsky 1982). Medical science provides long lists of potential threats to health, but whether any particular danger will become the subject of policy intervention and regulatory rules is uncertain and unpredictable. Scientists may develop a consensus about the pathology of a disease and its causal pathways, but policy intervention regarding that disease is a separate

process. Judgments of the acuteness of the health risks, how to address them, and whether they fall under the responsibility of government action are subject to, contestation and stalemate (Nathanson 2007).

A third potential impediment to EU-wide public health initiatives emanating from the member states is that EU officials must rely on external authoritative advice because their own expertise and powers of persuasion are limited. Yet the EU's authority in public health may be questioned by national experts who have their own relationship to political decision making, organized interests, and cultural norms and values of the country. Furthermore, all EU initiatives must be presented to a European audience in a language that fits into conventional categories of understanding.

With regard to possible pressure on the Commission from below, European consumer groups only play a shadow or peripheral role in the formulation of new health targets suitable for EU intervention. One major impediment is that pan-European consumer groups are poorly organized at the Community level and are not the biggest movers and shakers in Brussels. With the exception of the GMO case, national and local NGOs cope with the same dilemmas as national authorities because they too struggle with competing definitions of health and conflicting interpretations of danger and the management of risk (Coen 2007; Trumbull 2006). Moreover, for consumer and environmental groups, many public health programs involve uncomfortable truths, since calls for healthy lifestyles or less risky behavior often involves dividing the population into responsible and irresponsible citizens (Strünck 2005). It seems safer to focus on collective goods that do not necessitate the passing of judgments on the behavior of certain segments of the population.

It would appear that NGOs become involved after an issue has risen to the agenda or a crisis has appeared (Greenwood

2007). They are more reactive than pro active. The European Public Health Alliance (EPHA) is a confederation of over 100 non-governmental and other not-for-profit organizations working in support of health in Europe. One third represents pan-European or international networks and the remainder consists of national or even local agencies and organizations. The diversity of member associations implies that EPHA is a public relations organization keeping its members up to date and providing ongoing commentary and feedback on Commission initiatives. It has a staff of five in Brussels and it is not in a great position to lobby Brussels' civil servants directly.

The BEUC (European Consumers' Organization) is Europe's only pan-European consumer organization. It is a confederation with a staff of 25 and it deals with a broad selection of issues including legal affairs, food safety, health, environment, safety, and economics (Greenwood 2007). Because of its organizational structure it has tended to shy away from controversies and has kept a low profile aside from publicizing in a general way the needs of consumers. Rather, most of its energies have gone into promoting greater use of informational labels to enable consumers to make educated choices about household products and nutrition (BEUC 2005; Hilton 2007).

Thus, pressures from above or below did not prompt EU action in the public health field. The initiative came from within the Commission. Originally, the European Commission became involved in tobacco control through the 'Europe against Cancer Program' (EACP) (1987), which highlighted smoking as one of the primary sources of cancer and avoidable premature death (Gilmore/McKee 2004; ASPECT Consortium 2004: 99-138). Officials relied on Art. 100 (article 95(1) of the Treaty of Amsterdam) to argue that divergent tobacco regimes impeded the free movement of goods. Since anti-smoking measures had to fit with Art. 100, the Commission drafted highly

specialized narrow directives of which seven were adopted between 1989 and 1992. Two labeling directives came into force requiring health warnings, listing of tar and nicotine, and a ban on the marketing of certain tobacco products (89/622/EEC and 92/41/EEC). The Commission also set maximum tar yields of cigarettes (90/239/EEC), minimum levels of excise taxes on cigarettes and tobacco (92/78/EEC, 92/79/EEC, 92/80/EEC), and imposed an advertising directive that banned all forms of TV advertising for tobacco products (89/552/EEC). The most controversial directive was the proposal to ban direct and indirect tobacco advertising (Directive 98/43/EC). Like the previous measures, this one as well was introduced on the basis of Article 100a of the EC Treaty, which aims to remove barriers to the completion of the internal single market. It became subject of legal challenges by industry and member states on the grounds that the measure was disproportionate relative to its single market objectives (Bitton/Neuman/Glantz 2002; Gilmore/McKee 2004; Godfrey 2000; Hervey 2001).

Concerned about the absence of 'civil society' and wanting allies in debates on smoking and tobacco control, in 1988 the Commission helped fund a small non-governmental organization to promote the formation of a network out of national cancer leagues, health voluntaries, and anti-smoking groups. The Bureau for Action on Smoking Prevention (BASP) maintained contacts with the European parliament, EU Commissioners and national and regional tobacco control groups. It laid out strategies and educated local activists in how to package the anti-smoking message and educated key actors in how to institute a ban on tobacco advertising. The Bureau also participated in the International Union against Cancer and had contacts with the WHO-Europe office and the Association of European Cancer Leagues. However, its main achievement was to issue numerous reports drawing attention to the activities of

tobacco lobbyists and singling out national officials who blocked EU legislation. Among other publications, it disclosed that the Commission allocated a paltry \$1.5m to smoking prevention while generously subsidizing a group of tobacco farmers in Greece, Spain, Portugal and France to the tune of \$883m annually in early 1990s (Joossens/Raw 1996).

The Bureau's aggressive reporting drew the ire of Directorate General of Agriculture and the cigarette industry. A coalition of British, German, and Dutch officials together with DG Agriculture mobilized to oppose a renewal of its funding in 1995, and without EU funding, BASP could not sustain itself (Watson 1995). Yet when it was forced to cease operation in 1996, popular outrage was muted. Its closure did not stir a major outcry even in broader circles of public health and cancer research (TobaccoDocuments.org 1996). Since few governments and health authorities had flagged smoking as a serious risk to health and proper target for regulation prior to the arrival of 21st century, they too did not come to the defense of BASP.

A similar story applies to the newest plan of action to improve diets and increase physical activity in EU member states. Europeans like their American counterparts are getting heavier, which is to be expected because obesity is typically associated with affluence and symptomatic of wealthy post industrialized societies. Table 1 compares rates of obesity of men and women in the EU 25 and the US and Canada. Commonly, obesity is measured in terms of the Body Mass Index (BMI). The BMI assigns a number that is a person's weight in kg divided by that person's height in meters. The rule is to consider a person overweight with a BMI between 25 and 30 and obese with a BMI higher than 30. In practical terms, this would mean that a woman with a height of 5'4" would be considered overweight at 145 pounds and obese at 175 pounds. A man

with an average height of 5'9" feet is overweight at 170 pounds and obese at 204 pounds. Even a quick glance at the first column in Table 1 leads to the conclusion that many Europeans tend to be on the heavy side. Easily, a good third of the European male population weighs too much according to this measurement, while a solid quarter of the female population is overweight.

It was not transnational activists and national NGOs that were instrumental in persuading the Commission to take on the issues of diet and nutrition. For one, most countries had not yet zeroed into weight as an important health issue. Instead, officials in the Commission first drew attention to the issue in 2000 in a White Paper with recommendations on the potential health impact of obesity on European society and medical care (Mayor 1999). The Council acted on the report and passed a resolution on health, nutrition, and physical activity.³ In December 2003, the Council went a step further and approved a resolution giving the Commission permission to gather information and draft an action plan to improve the overall health of Europeans.⁴ In turn, in 2005, the Commission published a Green Paper, "*Promoting healthy diets and physical activity: a European dimension for the prevention of overweight, obesity and chronic diseases*" after the Council invited the Commission to contribute to promoting healthy lifestyles, and to study ways of promoting better nutrition within the European

³ Council Resolution of 14 December 2000 on health and nutrition (2001/C 20/01) - Official Journal of the European Communities C 20/1 of 23.1.2001 http://europa.eu.int/comm/health/ph_determinants/life_style/nutrition/documents/ev_20050602_en.pdf

⁴ Council Conclusions of 2 December 2003 on healthy lifestyles: education, information and communication 2004/C 22/01) - Official Journal of the European Union C 22/1 of 27.1.2004.

Union, if necessary by presenting appropriate proposals to that end.⁵

Table 1: Overweight and obesity among adults in the European Union - 2005 (% of population)

Overweight Population
Obese population 25<BMI<30 BMI>30

	Female	Male	Female	Male	Total Overweight/ Obese Female & Male
Austria	21.3	45.3	9.1	9.1	58.4
Belgium	24.4	38.7	13.4	11.9	44.1
Czech Republic	29	42.5	17	18	52
Denmark	26.4	40.9	11.8	11	44.6
Britain	32.1	42.6	24.2	22.1	60
Finland	26.6	44.8	13.5	14.9	49.2
France	19.6	31.1	9.3	9.8	34.6
Germany	28.7	43.5	12.8	14.4	49.6
Greece	29.9	41.1	18.2	26.0	57.1
Hungary	29.8	28.7	18.0	19.6	52.8
Ireland	25	41	12	14	47
Italy	26.2	43.9	9.7	10.2	44.6
Netherlands	28.2	40.5	11.4	9.9	44.9
Poland	26.6	39.5	12.5	12.6	45.3
Portugal	31.8	42.3	14	11.4	49.6
Slovak Republic	24.9	42	15.6	15.2	47.6

⁵ Brussels, 08.12.2005 COM(2005) 637 final http://europa.eu.int/comm/health/ph_determinants/life_style/nutrition/documents/ev_20050602_en.pdf

Spain	27.6	43.5	13.4	12.9	48.4
Sweden	25.9	40.7	10.3	11.1	44
US	28.6	39.7	33.2	31.1	66.3
Canada	24.7	39.3	19	17	49.9

Source: OECD Factbook: Quality of Life – Health. Paris: OECD 2008, 239

DG Health and Consumer Protection brought together stakeholders, which included the food industry, the advertising industry, retailers, the catering sector, NGOs and consumer organizations, local, regional and national governments, schools and the media. To formalize the ongoing participation of the stakeholders, SANCO created the European Platform for Action on Diet, Physical Activity and Health to discuss and explore various action programs at local, regional, national and European levels. The stakeholders meet at conferences and workshops where they discuss best practices, policy action, legislation, and treatment. The European Parliament has also been on board virtually from the beginning and applauds the Commission's effort to raise awareness and foster a joint European approach. It believes that the fight against bad diet and nutrition is a 'political priority' that should receive the highest attention of the Commission and the member states. The EP committee on Health, Environment, and Food Safety has urged the Commission to bring Community policies into line with ordinary people's everyday concerns regarding health and the quality of life in general. It passed a resolution in early 2007 based on its own initiative report drawn up by the EP Committee on Environment, Public Health, and Food Safety. The resolution was adopted by 620 votes in favor, 24 against and 14 abstentions (European Parliament 2007).

Nevertheless, it is important to point out that the Platform and the European Parliament became part of the campaign

only after the Commission had made the first steps. Outside forces did not push the Commission to move into this area but rather the Commission went after healthy diets because it identified a void in national legislation and domestic programs. The fact that the initiative came from within the Commission put additional pressure on the officials in Brussels to build a watertight case based on scientific facts, ample research evidence, and balanced prescriptions. In both tobacco control and diet programs, officials at the Commission increasingly benefited from close ties and exchanges with the World Health Organization (WHO). Acting in concert brought benefits to each body. First, they were able to share critical resources of expertise and evidence which health policy proposals require. Neither the EU nor the WHO had the ability to gather scientific findings and deconstruct medical trends without the input and participation of member organizations and research networks. Second, both the Commission and the WHO carry more political weight and media visibility if they can point to a joint mission based on common perceptions of harm and threat to the wellbeing of European citizens. In the Commission's case, it was more likely to win over a skeptical audience of national authorities and citizens' groups with the WHO's backing.

Finally, although lobbying and grassroots mobilization have been minimal, experts and specialists are natural allies of international public health organizations (Sabatier/Jenkins-Smith 1999). Thus, public and private actors with specialized knowledge on smoking and diet seek access to the policy process and were likely to target both the WHO-Europe desk and DG Health and Consumer Protection.

3 Global Public Health and the American connection

Forming an advocacy coalition with the WHO brought the Commission into contact with other public health agencies at the global level. In the process, the Commission's framing of the tobacco and obesity issues and indeed its very policy proposals underwent a certain degree of "Americanization". This term refers to two distinct dimensions. As others have noted, the US goes through periods of intense public scrutiny of certain habits that are deemed dangerous, unsound, inappropriate, and anti-social (Gusfield 1981; Meier 1994; Morone 2003). The popular obsession with "lax mores" inevitably results in public demands for measures to impose greater restraint on individuals who apparently cannot make 'safe choices'. American worries about excessive pleasure seeking - overeating, smoking, drinking, drug use - are usually attributed to the founding principles of the American republic, which were built on a legacy of puritanical Protestantism. According to this worldview, most people lack discipline or willpower and are easily seduced by shameful pleasures and wasteful activities. This becomes a public predicament once many individuals go in pursuit of pleasure seeking activities, thereby undermining the moral fabric of society. Civic action groups, social movements, experts, media outlets, and opinion leaders expect the political class to step in to protect and preserve the moral fiber of the polity.

However, at the same time, Americanization also refers to another and offsetting trend, which regards individuals who overindulge in unwholesome activities to be in need of professional care and attention. The argument often heard is that the person who smokes or consumes large amounts of calorie-dense food products is sick and that the disorder is treatable, if not curable under the supervision of the medical establishment. This view came into fore in the 1970s during the heyday of the medical profession and first wave of discovery of psychotropic drugs to treat certain

forms of social behavior. Currently, medicalization - defining a problem in medical terms usually as an illness or disorder or using a medical intervention to treat it - is driven by a coalition of pharmaceutical companies, biotechnology inventions, managed care insurance companies and, to be sure, consumers. The latter have become involved thanks to new federal legislation (1997) permitting drug companies to advertise directly to consumers (Busfield 2006; Conrad 2005). The results have led to a plethora of 'new' drugs to treat previously underdiagnosed or unknown disorders. Insurance companies are pressured by consumer advocates to cover diseases that have been defined and labeled by pharmaceutical companies (menopause, allergy, heart burn, arthritis, erectile dysfunction, social anxiety, short stature). Smoking and overeating in the US fall into the category of disorders, necessitating prescription drugs or drastic surgery in the form of gastric bypass operations.

In short, Americanization refers to two discrete phenomena. Culturally, there is a tendency to blame individuals for certain character failings which results in overeating or smoking. At the policy level, the tendency is to resort to biomedical solutions and provide answers in the form of pharmaceuticals or hospital treatment. The American definition of public health in which individuals carry responsibility to conduct their lives in such a way that they refrain from 'unwholesome' activities and remain healthy has been adopted by international health organizations in the era of rising mortality due to non-communicable diseases (cardio vascular disease, stroke, cancer, diabetes). Since the 1980s, the WHO has been drawn into documenting and discussing how political leaders and experts should cope with the advent of what is often called 'lifestyle' diseases, namely illnesses related to smoking, calorie-dense diets, recreational drugs, and alcohol.

By the late 1980s, the WHO had undergone years of turmoil and criticism as it struggled under bad leadership, charges of cronyism, and the fragmentation of its programs, many of them funded outside the regular budget. In the 1990s, WHO leadership sought to reposition itself as a credible and highly visible contributor to the rapidly changing field of global health. One way to accomplish this was to monitor and influence the agenda of other actors on the global scene. The WHO established many joint committees and public-private partnerships to play a more forceful and visible role in health of the developed and developing world (Brown/Cueto/Fee 2006).

Soon after the EU signed off on the 'Europe against Cancer Program,' the WHO identified smoking as a major threat to health of people and wellbeing of society. The World Health Assembly began to pass the first wave of anti smoking resolutions in 1986 and soon followed up with the publication of many reports (Studlar 2006; WHO 1986, 1998, 1999, 2000, 2001; Sasco/Dalla-Vorgia/Van der Elst 1992; Bettcher/Subramanian/Guindon/Perucic 2003). In the mid 1990s, it began to advocate a tobacco free world.

At around the same time, another program desk at the WHO issued its first report on obesity, claiming that increased weight exposed its carriers to a host of diseases such as cardio-vascular, cancer, and diabetes. Both unhealthy diets and smoking are factors in the rise of non communicable diseases (NCD), which have replaced older killers such as infectious diseases. Starting in 1997, the WHO produced numerous reports about obesity: *Obesity: Preventing and Managing the Global Epidemic* (1997); *Obesity and poverty: a new public health challenge* (2000) *Diet, nutrition and the prevention of chronic diseases* (2002), and *Using domestic law in the fight against obesity: an introductory guide for Pacific countries* (2003). Moreover, WHO Europe office has published separate reports in which it assembles policy prescriptions

(Branca/Nikogosian/Lobstein 2007; Thommen Dombois 2007; WHO 2008).

The staff at the WHO is dependent on external advice, analysis, fact gathering, and support in ways strikingly similar to how the Commission relates to expert and advisory committees. Not surprisingly, the most influential group of outside advisers and consultants are American public officials, American health NGOs, and American-based researchers. Aside from the fact that the US is the largest contributor to the WHO budget, it also possesses the largest medical and scientific concentration of public health experts and epidemiologists. In terms of tobacco and healthy diet, it seems beyond doubt that the US can claim the largest, deepest, and widest expertise in political mobilization, regulatory legislation, medical knowledge, and treatment experience. Funding for this kind of research came from many different sources such as the US federal government, universities, and health philanthropies (Robert Wood Foundation) while research took place at the National Institutes of Health, National Cancer Institute, Centers for Disease Control and Prevention, American Cancer Society, and research centers affiliated with medical schools (Bayer/Colgrove 2004; Brandt 2007; Studlar 2002; Wolfson 2001).

American researchers, scientists, physicians, and funding agencies or donors form a relatively cohesive group and they travel the world to serve in professional associations, attend workshops, and participate in conferences (Farquharson 2003). Thus American public health professionals employed by the American Cancer society are active in the International Union against Cancer, which in turn supplies information and collects data for the WHO. Prominent American policy officials serve on the International Liaison Group on Tobacco or Health (ILGTH) created by WHO, which oversees the organization of the now bi-annual World Conference on

Tobacco Or Health (WCTH). The Secretariat for the ILGTH is partly staffed by the UICC, which has strong ties with the American Cancer Society and the WHO. Aside from researchers and policy officials, the American corporate sector is also highly visible since it funds research directly as well as indirectly (Proctor 1995). The net result is a lengthy process of policy diffusion as numerous American experts representing official government agencies as well as non governmental health organizations participate in the international assessment and evaluation of policy measures, scientific findings, and the role of legislation.

Evidence for the transmission of ideas and concepts from American anti-tobacco and anti-obesity advocates to the WHO are found in the various reports published by WHO. The WHO takes a page from the victories of the US non-smoking movement in its publication: *Confronting the epidemic: a global agenda for tobacco control research* (1999). Officials at the WHO explain that the American tobacco control community succeeded because it integrated grassroots activism with medical findings and legislation. They uphold the American non-smoking movement as a template for others because it grew from the idea that close coordination between activists, researchers, and public agencies improves the effectiveness of health campaigns. In turn, American officials and private foundations have pushed for the internationalization of tobacco control and perceive the WHO - rightly - as one of the vehicles to achieve that. A tight circle of American professional networks collaborate with the WHO in disseminating research, science, and public activities (Lando 2005; Lando 2006).

In the case of obesity, the WHO has a close relationship with the International Association for the Study of Obesity (IASO). A group of researchers started to study obesity in the 1960s when health officials first began to warn of a

rising incidence of obesity. In the 1980s, the study of obesity grew and more conferences were held in different parts of the world. In the mid 1980s, the International Association for the Study of Obesity (IASO) was created with a board of international researchers many of whom were American. It created a European offshoot in the 1990s, which became the European Association for the Study of Obesity (EASO). In addition, several obesity researchers founded the International Obesity Task Force (IOTF) in 1995, which is a branch of the IASO. Its members represented leaders of the mostly academic and medical community.⁶ All three organizations (IASO, EASO, IOTF) share the same office address in London, a testimony to their common origins and overlapping membership. The International Obesity Task Force is a global network of experts and the advocacy arm of the International Association for the Study of Obesity. It works closely, very closely with WHO in defining, explaining, and communicating the particular issues related to obesity and it operates both like a research think-tank and policy advocate.⁷

As was the case for tobacco control efforts, American experts of various sorts are at the forefront of international efforts to address obesity. The IOTF was originally set up with the help of American and international drug companies with facilities in the US with the express purpose of promoting obesity prevention. The members of the task force are mostly working in the weight loss field as

⁶ www.iaso.org/history.asp.

⁷ For example, the chair of IOTF also chaired the UN Commission on the Nutritional Challenges of the 21st Century, which projects that by 2015 2.3 billion adults will be overweight, including 700 million obese. AlphaGalileo: World leaders challenged to agree a global pact on obesity and healthy nutrition at AAAS conference in Boston (February 17, 2008). <http://www.alphagalileo.org/index.cfm?fuseaction=readrelease&releaseid=527181>

surgeons, dieticians, nutrition researchers, physicians, and other specialists and large pharmaceutical companies such as Abbott Laboratories and Hoffman-La Roche release grants to fund different studies and trials. In addition, the drug industry also sponsors conferences, hands out prizes to honor scientists, and of course gives access to drugs and technology so that weight loss researchers can test treatment programs for obesity (Marsh/Bradley 2004; Moynihan 2006; Oliver 2006). Most of the obesity experts (and highest concentration of obesity) are residing in the US. Not only are American medical scientists, researchers, nutritionists, weight loss specialists, and bariatric surgeons prominent players in the global discourse on obesity, but US federal officials have been instrumental in introducing standardized definitions and parameters for the diagnosis of obesity and treatment

4 Americanization of EU health programs

As the above section indicated, the WHO has worked intensively on tobacco control and anti-obesity efforts. American experts and officials have been at the core of these efforts, and American research findings and policy examples figure prominently in WHO treatment of these issues. As this section will detail, the EU approach has absorbed progressively “American” concepts in these areas through its cooperation with the WHO.

In the past, ties between EU and WHO were not very close and they did not collaborate much from the 1950s until 1970s (Lucas/Ugland 2004). Since then, an overlapping consensus has emerged on scores of public health issues. The Commission strengthened its links with the WHO since all EU member states are members in the WHO while each organization benefits from the sharing and borrowing of ideas and data. But the relationship between WHO and

DG Sanco became especially close after the WHO decided to undertake the ambitious goal of drafting the first international public health treaty in the form of a World Health Organization Framework Convention on Tobacco Control. Launched at the 49th World Health Assembly in May 1996, Commission officials gave critical input on how to structure this international organization and what it should encompass. In late 1999, the Commission sought and obtained from the Council of Ministers a formal mandate to participate on behalf of the Community in the negotiations for those matters falling within EU competence. The mandate was granted on the basis of Article 300.1 of the Treaty. Thus, the Commission became an active contributor to secure the success of the FCTC.

On top of the FCTC, the two organizations also frequently interact at conferences, workshops, and meetings in which they discuss challenges of mutual concern. The WHO-Europe press office describes the relationship as “partners at different levels.” Globally, they synchronize their work on health threats, health security, health and development, and achievement of the health-related Millennium Development Goals. Regionally, their collaboration is more focused as they share the same goals in responding to the needs of their 27 common member states. In their joint statement, they announce that improved and synchronized support will lead to better health outcomes for EU citizens - one of the key goals of the Lisbon Strategy. The WHO has also contributed in developing the future EU Health Strategy.⁸ Growing from this partnership is the European Strategy for Tobacco Control (managed by the EU).⁹ It holds workshops and manages a data bank on progress with the help of national governments and European agencies (Princen 2007).

⁸ http://www.euro.who.int/PressRoom/pressnotes/20070613_1

⁹ <http://www.euro.who.int/tobaccofree>.

In the area of obesity, virtually from the moment that the Commission decided to highlight the harms to health flowing from bad diets and sedentary lifestyles, the cooperation with the WHO has been extremely close. The WHO-Europe office held the European Conference for Health Ministers to discuss measures to combat obesity in November 2006. The outcome of the meeting was a charter, signed by all EU member states acknowledging the scale of the problem and presenting a strategy to tackle obesity as one of today's most serious public health challenges (WHO 2006). The European Commission followed through with a specific European action plan covering nutrition and physical activity translating the charter's principles into practice and establish monitoring mechanisms (Groves 2006; Watson 2006).

Why does it matter that the EU and the WHO have established a productive working relationship? Since the WHO is influenced by American health ideas, the EU is indirectly exposed to American thinking about lifestyle choices and diseases. American approach to health reflects a 'secular morality' upholding a distinct view of what is appropriate behavior in society and what is not. Nevertheless, 'treatment' is routinely offered as a surrogate for the erstwhile Christian-driven campaigns promising hell and damnation for those who do not step in line with mainstream white middle class norms and habits.

In the case of smoking, American influence is found in several areas. First, it is found in the language the Commission now uses. Commission officials speak of the 'smoking epidemic' but smoking is not a disease like the 'flu pandemic.' By designating smoking as a disease it follows that policy measures are supposed to cure 'smoking' and vanquish the 'plague.' It has fueled a sense of crisis and the only legitimate type of research is research that contributes to tobacco control and to anti-smoking measures (Mair/Kierans 2007). Yet socio cultural factors

influence smoking habits as much as addiction to nicotine does. Increasingly, smoking is indicative of a rebellious streak and anti middle class behaviors (Katainen 2006; Tulloch/Lupton 2003). Smoking also tends to cluster in poor disadvantaged neighborhoods and family households. Yet tobacco control adopts the same language as the campaign to eradicate malaria or polio, while the growing socio economic association between 'risky' lifestyle choices and poverty or underprivileged social status. Campaigning on a platform of 'personal responsibility' makes no impact on those who do not prioritize balanced lifestyles by seeking to avoid premature death or chronic disease.

The second example is the right to smoke-free public places. The danger of second hand smoke or environmental tobacco smoke was first raised by American activists and authorities and became the battle cry of the non smoking movement in the US in the 1970s when local authorities (Berkeley, CA) and the Civil Aeronautics Board (1973) imposed restrictions on smoking in public spaces. In the early 1980s, new biomedical studies appeared pointing to increased health risks to non-smokers who are exposed to sustained second hand smoke. In 1986, the US surgeon general and the National Academy of Sciences issued reports calling on a ban on smoking. However, what nailed the debate and ushered in fresh waves of legislation was the 1992 report of the Environmental Protection Agency *The Respiratory Health Effects of Passive Smoking: Lung Cancer and Other Disorders*, which concluded that the widespread exposure to second-hand smoke presented a serious and substantial public health impact (Bayer/Colgrove 2004; Kluger 1997).

The emergence of passive smoking and the protection of innocent citizens from second hand smoke catapulted tobacco into the domain of public policy. Instead of protecting the self governing individual from risky choices,

the attention on passive smoke has turned the smoker into an anti-social being endangering the health of others. It has delegitimized smoking in that tobacco use endangered the health of others. This philosophical rephrasing is critical for understanding the success of the tobacco control movement in the Western world. By sidestepping the reliance on moral suasion and normative rhetoric, it was able to elevate the issue into a medical problem with public health ramifications. By shifting the focus from restraining the choices of the self governing individual to a public health threat, tobacco control advocates diffused the counter claims of industry that upheld the right to smoke as a matter of individual freedom.

Science, especially the science based on aggregate epidemiological studies, must be translated into layman's language. Passive smoke is one of these scientific discoveries that became a 'fact' and thus subject of legislation only in the late 1980s in the US. The appearance of innocent victims damaged by the smoke of others widened the debate to include the entire population and justified new legislation (Beveridge 1999; Brandt 1998; Nathanson 2007). However, until recently, the 'science' of ETS was not widely recognized in EU member states (Grüning/Strünck/Gilmore 2008; Studlar 2006: 384).

Thanks to the diffusion of American public health concepts and supporting science the Commission proposed a green paper on indoor pollution and second hand smoke. It is hard to imagine a scenario where the Commission would have pressed for comprehensive European-wide rules were the 'global' health community not united to the idea that smoking should be de-normalized. However, many European member states have been reluctant to adopt an 'American' perspective and have hesitated to endorse a blanket call for smoke free public spaces for different reasons (Thyrian/John 2006).

However, the most striking impact of American concepts on EU public health programs manifest itself in the current debates on obesity. Surgeon General, David Satcher issued his “Call to Action” in 2001, claiming that obesity would soon cause as much preventable disease and death as cigarette smoking. Describing this event as an epidemic, federal officials, medical experts, journalists, and public interest groups quickly picked up the debate and obesity rose to the top of the political agenda. It has dominated the US media outlets and popular health publications since late 2001. In 1980, 62 articles with the headline ‘obesity’ appeared in US news sources. In 2004, 6500 articles appeared with the heading ‘obesity’. Since 2002, at least a 1000 articles per quarter have appeared with alarming news items about obesity in the US and in the rest of the world in US media outlets (as indicated by Lexis-Nexis US News Sources).

Unlike smoking, the link between nutrition, obesity, and premature mortality is woolly and open to interpretation. There is no medical or scientific evidence that a BMI of 27 shaves off years in life expectancy and there is no evidence that a BMI of 31 (obese) is more damaging to health and life expectancy than a BMI of 29 (overweight). The increased health risk of smoking is firmly documented and the reported lung cancer risks for smokers are typically 10-15 times higher than for non-smokers. The death risks for overweight and obese people are in many instances closer to 0.5-1.75 above those for people with normal weight and hardly worthy of the current panic about weight gain (Flegal/Graubard/Williamson 2005; Gronniger 2006). While a sizable body of conclusive science shaped the message on smoking, informed opinions delineate the debate on diet. Even at the level of associational rather than causal analysis, many studies seem to suggest that individuals who are overweight and mildly obese face no or very little increased mortality risk relative to normal weight

individuals (Adeyi/Smith/Robles 2007; Gregg et.al. 2005; OECD 2007).

Possibly, the whole panic about an obesity epidemic is exaggerated (Gard/Wright 2005; Kersh/Morone 2005; Oliver 2006). Fat turned into a political controversy with corresponding competing suggestions on how to 'cure' this disorder rather suddenly and without much evidence based studies that obesity is a fatal condition (Schlesinger 2005; Schwartz 1986; Stearns 1997; Clifford Engs 2000). In spite of the onslaught of media attention on obesity, US federal agencies have been reluctant to restrict the marketing freedoms of the powerful industry or business sectors so that the most innovative policy measures are undertaken by state and local government authorities to counter the obesity trend. Many school districts have banned vending machines, are serving more nutritious lunches while promoting physical education. Different state governments allow recipients of food stamps to purchase fresh fruits and vegetables. Local state officials, consumer advocates, and health professionals have put pressure on various insurance companies to remove weight loss surgery as 'elective' so that it is covered by the insurance policy of the patient. Seeing the writing on the wall, the American food and beverage industry is volunteering to refrain from advertising to young children. However, the federal government plays mostly the role of funding biomedical research and publicizing its findings through the Center of Disease Control or National Institutes of Health.

The absence of a frontal attack on 'obesity' is partly due to the ideological position of the Bush administration, the power of the food and beverage industry, vested interests of other sectors of the economy benefiting from food and beverage marketing, and collective doubts about restricting consumer lifestyle choices. Equally, the lack of a clear cut policy prescriptions flow from the fact that in the end obesity is not a disease and that the frantic discussion says

more about a particular mix of science, morality, and ideology than its challenges to the health and life expectancy of Americans or Europeans.

It could be that the US biomedical community rallied against obesity owing to the profits earned from treating extreme weight gain. Pharmaceutical companies and the weight loss community consisting of physicians, nutritionists, surgeons, dieticians, exercise coaches, weight loss programs stand to earn from the panic about obesity and its health costs.

And this panic has been imported into the EU thanks to its ties with the WHO and the latter reliance on the American health community and Big Pharma (Basham/Luik 2008). The pharmaceutical industry is the nerve center against the fight against obesity. Virtually all established researchers have ties with different pharmaceutical companies or are spokespeople for particular drugs or forms of intervention pushed by the drug companies. There is basically no prominent American-based obesity researcher without ties to the weight loss industry. Moreover, many of them support or participate in the IOTF, which in turn co authored the 1995 report of the WHO that first set out the idea that a person is overweight with a BMI of 25 (Campos, et.al. 2006). Thus, the WHO is supported by an inclusive group of obesity researchers with financial links to 'Big Pharma' while the Commission relies on the WHO to design its own case in favor of Community action. The Commission borrows figures, data, and trends from WHO reports in order to repeat the claim that the biggest challenge of the 21st century is to prevent an obesity calamity with corresponding catastrophic consequences for the wellbeing and health of European citizens. The European parliament also regurgitates this language inflaming further passions with its war declaration on fat.

It could be that this whole debate is a vehicle for a network of divergent stakeholders to make a profit from 'treating'

this condition. Obesity researchers have an interest in defining unhealthy weight as broadly as possible, by overstating the hazards of obesity, and thus providing justifications for regulatory approvals, as well as for government and insurance industry subsidization of their products. Many conferences, reports, treatment trials have been largely funded by pharmaceutical and weight-loss companies. Government health agencies, like the Centers for Disease Control and Prevention in the United States, have insisted on the urgency of tackling the obesity predicament while lobbying for greater program funding and policy setting authority. It is probably more than a coincidence that as soon as tobacco control faded into the background because it became uncontested and legitimate, the public health community identified another target. It may also be more than a coincidence that a fall in smoking prevalence rates accompanied a rise in weight gain!

Since treating 'fat' is more complicated than curbing tobacco consumption, most European governments have not sprung into action. Tackling obesity is complex since many different variables and structural developments – sedentary lifestyles, eating out, snacks, sugared beverages, advertising, packaged/processed foods – contribute to weight gain, while the pathway to early death is circuitous and difficult to capture. Eating is a necessity for life in contrast to smoking, which is an elective activity that meets certain cravings for nicotine or cool behavior. Discussions about weight as a health risk tend to treat it as a health behavior, akin to smoking. Yet the relationship between behavior and weight is complex, and intertwined with immutable factors such as genetics, and body build and shape. The average individual's control over his or her weight is limited at best. What smoking and obesity share, however, is that neither smoking nor diet are 'diseases' and their medicalization has problematic repercussions for mapping out exactly how to address the marketing of a

legal product with lethal health consequences and the surfeit of fatty and sugary food products on the market.

5 Conclusion

The purpose of this paper has been to trace how the European Commission became involved in tobacco control and healthy diets when political support for such initiatives is minimal. The answer I provided is that Commission officials in the relevant directorate general proposed these programs without much input from below or above. But they transcended these limitations by partnering with the WHO. However, international non-governmental organizations face the same obstacles as the European Commission in that they need to cultivate external sources of expertise to become familiar with the policy field and acquire the necessary skills to draft an action program. They also need outside validity and a conduit for diffusing their own findings once they have drafted a position.

Knowing that international health organizations depend on the scientific input and research credentials of health and medical scientists working in the member countries, professionals in the field seek out the WHO and the Commission. Since the largest most professional and wealthiest public health community is found in the US, it follows that the staff of the WHO has ongoing exchanges with American biomedical institutes, professional associations, non governmental agencies, health officials, and medical practitioners. During the course of this ongoing exchange of ideas, research findings, and policy suggestions, the WHO internalizes the principal concepts determinant of the American approach to public health. This approach sees lifestyle choices i.e. consumption of fatty or sugary foods and tobacco as a 'disease' which requires a collective efforts to annihilate this 'scourge'

while the popular rhetoric exhibits a fair dose of ‘moral fervor’ by castigating smokers and overweight individuals for their apparent lack of willpower and restraint.

In turn, the Commission incorporates WHO research findings and framing and thus indirectly adopts the line of thinking promulgated by American authorities and researchers. In the field of tobacco control, the Commission has, after years of resistance and disappointments, achieved its main goal. In virtually all EU member states it is understood that smoking should be curbed, restricted, discouraged or banned. What is still open to debate is whether second hand smoke poses a genuine health hazard requiring further indoor pollution legislation.

Healthy diet is a newer area, and unlike tobacco, it is probably more challenging to draft meaningful legislation to reduce the intake of excessive calories. Both American and European policy officials face the plain and simple catch that a mixture of demand as well as supply factors contributes to the rising consumption of calorie-dense food products. The Commission more so than American officials recognize that one of the factors is socio economic status and that the consumption of fresh fruits and vegetables and unprocessed food varies across income and education. Secondly, the EU must rely upon the participation of a large casts of stakeholders in order to achieve any results. Its mandate and repertoire of policy tools are ultimately limited and modest. However, in both the US and EU, decision making structures are strewn with hurdles and the international advocacy coalition must overcome wide and broad resistance raised by powerful interests such as the food and beverage industry against dramatic efforts to wean consumers away from calorie dense food products.

To conclude, therefore, the international advocacy coalition consisting of the WHO and Commission managed to draw attention to non communicable diseases related to post-industrial lifestyles. They shaped the discourse, imposed a

framework, and generated broad discussion in Europe. Whether they can move forward and draft an action program will have to be seen. For one, the decision making structures in the EU make it easier to block proposals than to pass them. Second, while a host of interests have rallied behind healthy diets and anti-smoking, their motivation, perception, and final objectives may in fact diverge. It is easy to proclaim that people should consume balanced diet and increase physical activity. It is much harder to agree on how such goals ought to be achieved and what instruments or tools will be most effective.

References

Adeyi, Olusoji/Smith, Owen/Robles, Sylvia, 2007. Public Policy and the Challenge of Chronic Noncommunicable Diseases. Washington DC: World Bank.

ASPECT Consortium/European Commission Directorate-General for Health and Consumer Protection, 2004. The development of European tobacco-control policy. *Tobacco or Health in the European Union. Past, Present and Future*. Luxembourg: Office for Official Publications of the European Communities. http://ec.europa.eu/health/ph_determinants/life_style/Tobacco/Documents/tobacco_fr_en.pdf

Basham, Patrick/Gori, Gio/Luik, John, 2006. Diet Nation: Exposing the Obesity Crusade. London: The Social Affairs Unit.

Basham, Patrick/ Luik, John, 2008. Head to Head Is the obesity epidemic exaggerated? Yes. In: *BMJ* 336:244

Bayer, Ronald/Colgrove, James, 2004. Children and bystanders first: the ethics and politics of tobacco control in the United States. In: Eric A. Feldman/Bayer, Ronald eds. *Unfiltered: conflicts over tobacco policy and public health*. Cambridge, MA: Harvard University Press.

Berridge, Virginia, 2007. Multidisciplinary public health: What sort of victory? In: *Public Health* 121:404-8.

Bettcher, D./Subramanian, C./Guindon, E./Perucic, A./et al. (eds.), 2003. *Confronting the Tobacco Epidemic in an Era of Trade Liberalization*. Geneva: WHO.

Beveridge, Virginia, 1999. Passive Smoking and Its Prehistory in Britain. Policy speaks to Science? In: *Social Science and Medicine* 49: 1183-95.

Bitton Asaf/ Neuman, Mark D./Glantz, Stanton A., 2002. Tobacco Industry Attempts to Subvert European Union Tobacco Advertising Legislation. San Francisco: Center for Tobacco Control Research and Education University of California. <http://repositories.cdlib.org/ctcre/tcpmi/EU2002>.

Branca, Francesco/Nikogosian, Haik/Lobstein, Tim, 2007. The Challenge of Obesity in the WHO European Region and the Strategies for Response. Geneva: WHO.

Brandt, Allan, 1998. Blow Some My Way: Passive Smoking, Risk, and American Culture. In: Stephen Lock/Reynolds, Lois/Tansey, E.M. eds. *Ashes to Ashes: The History of Smoking and Health*. Amsterdam: Rodopi.

Brandt, Allan M., 2007. *The Cigarette Century: The Rise, Fall, and Deadly Persistence of the Product that Defined America*. New York: Basic Books.

Broscheid, Andreas/David Coen, 2007. Lobbying activity and fora creation in the EU: empirically exploring the nature of the policy good. In: *Journal of European Public Policy* 14: 346 - 365.

Brown, Theodore M., Cueto, Marcos, Fee, Elizabeth, 2006. The World Health Organization and the Transition From "International" to "Global" Public Health. In: *American Journal of Public Health* 96: 62-72

Busfield, Joan, 2006. Pills, Power, People: Sociological Understandings of the Pharmaceutical Industry. In: *Sociology* 40: 297-314

Campos, Paul/Saguy, Abigail/Ernsberger, Paul/Oliver, Eric/Gaesser, Glenn, 2006. The epidemiology of overweight and obesity: public health crisis or moral panic? In: *International Journal of Epidemiology* 35:55–60

Clifford Engs, Ruth, 2000. *Clean Living Movements: American Cycles of Health Reform*. Westport, CT: Praeger.
Coen, David, 2007. Empirical and theoretical studies in EU lobbying. In: *Journal of European Public Policy*, 14: 333-45.

Cooper, Alice/Kurzer, Paulette, 2003. Rauch Ohne Feuer: Why Germany Lags in Tobacco Control. In: *German Politics and Society*, 21: 24-47.

Douglas, Mary/Wildavsky, Aaron, 1982. *Risk and Culture: An Essay on the Selection of Technological and Environmental Dangers*. Berkeley and Los Angeles: University of California Press.

Eberlein, Burkard/Grande, Edgar, 2005. Beyond delegation: transnational regulatory regimes and the EU regulatory state. In: *Journal of European Public Policy*, 12: 89-112.

European Commission, 2000. *Eurodiet Core Report: Nutrition & Diet for Healthy Lifestyles in Europe*. Brussels: University of Crete School of Medicine/European Commission-Sanco.

European Commission 2007a. *Green Paper: Towards a Europe free from tobacco smoke: policy options at EU*

level. Brussels: Directorate C - Public Health and Risk Assessment COM(2007) 27 final

European Commission, 2007b. A Strategy for Europe on Nutrition, Overweight and Obesity related health issues. Brussels: Commission of the European Communities COM(2007) 279 final

European Parliament, 2007. Promoting healthy diets and physical activity: a European dimension for the prevention of overweight, obesity and chronic diseases. ENVI/6/33971. <http://www.europarl.europa.eu/oeil/file.jsp?id=5386462>

Farquharson, Karen, 2003. Influencing Policy Transnationally: Pro-and Anti-Tobacco Global Advocacy Networks. In: Australian Journal of Public Administration, 62: 80-92.

Flegal KM/Graubard BI/Williamson DF/Gail MH, 2005: Excess deaths associated with underweight, overweight, and obesity. In: JAMA, 293:1861-7.

Gard, Michael/Wright, Jan, 2005: The Obesity Epidemic: Science, Morality and Ideology. New York: Routledge.

Gilmore, Anna/McKee, Martin, 2004: Tobacco-control policy in the European Union. In: Feldman, Eric A./Bayer, Ronald Eds. Unfiltered: Conflicts over Tobacco Policy and Public Health. Cambridge: MA: Harvard University Press.
Godfrey, Frank. 2000. An overview of European Union tobacco control legislation. In: Central European Journal of Public Health, 8:128-31.

Greenwood, Justin, 2007. Interest Representation in the European Union. New York: Palgrave Macmillan.

Gregg EW et al., 2005. Secular trends in cardiovascular disease risk factors according to body mass index in US adults. In: JAMA, 293:1868-74

Gronniger, Jerome, 2006. A semi-parametric analysis of the body mass index's relationship to mortality. In: American Journal of Public Health, 96: 173-178

Groves, Trish, 2006. Pandemic obesity in Europe. In: BMJ, 333:1081-85.

Grüning, Thilo/Strünck, Christoph/Gilmore, Anna, 2008. Puffing Away? Explaining the Politics of Tobacco Control in Germany. In: German Politics, 17: 140-164.

Gusfield, Joseph R., 1981. The Culture of Public Problems: Drinking-Driving and the Symbolic Order. Chicago: University of Chicago.

Gutrich John, et.al. 2005. Science in the public process of ecosystem management: lessons from Hawaii, Southeast Asia, Africa and the US Mainland. In: Journal of Environmental Management, 76: 197-209.

Hervey, Tamara, 2001. Up in smoke? Community (anti)-tobacco law and policy. In: European Law Review, 26:101-25.

Hilton, Matthew, 2007. Consumers and the State since the Second World War. In: The ANNALS of the American Academy of Political and Social Science, 611: 66-81.

Jabko, Nicolas, 2006. Playing the Market: A Political Strategy for Uniting Europe, 1985-2005. Ithaca: Cornell University Press.

John, Ulrich, 2001. Addiction research in Germany makes progress - however, it has a long way to go to contribute significantly to the international community of research and care. In: *Addiction*, 96: 679-681.

Joossens, Luk/Raw, Martin, 1996. Are tobacco subsidies a misuse of public funds? In: *BMJ*, 312:832-5.

Katainen, Anu, 2006. Challenging the imperative of health? Smoking and justifications of risk-taking. In: *Critical Public Health*, 16: 295 – 305.

Kersh Rogan/Morone, James, 2005. The New Politics of Public Health. In: *Journal of Health Politics, Policy and Law*, 30: 842-863.

Kluger, Richard, 1997. *Ashes to Ashes: America's Hundred-Year Cigarette War, the Public Health, and the Unabashed Triumph of Philip Morris*. New York: Knopf.

Lando, Harry/Borrelli, Belinda/Muramoto, Myra/Ward, Kenneth, 2006. Perspectives on the role of the Society for Research on Nicotine and Tobacco in promoting global tobacco research and reducing tobacco harm. In: *Nicotine & tobacco research*, 8: 761-765.

Lando, Harry, et.al. 2005. The Landscape in Global Tobacco Control Research: A Guide to Gaining a Foothold. In: *American Journal of Public Health*, 95: 939-945

Lucas, Barbara/Ugland, Trygve, 2004. Social Policy Formulation in a Dualistic Public Sphere: The European Union, the World Health Organization and the Alcohol Question. Unpublished paper.

Mair, Michael/Kierans, Ciara, 2007. Critical reflections on the field of tobacco research: The role of tobacco control in defining the tobacco research agenda. In: *Critical Public Health*, 17: 103-112.

Mayor, Susan, 1999. European plan to put obesity on governments' health agenda. In: *BMJ*, 318:1574-76

Meier, Kenneth J., 1994. *The Politics of Sin: Drugs, Alcohol, and Public Policy*. Armonk, N.Y.: M.E. Sharpe.

Morone, James A., 2003. *Hellfire nation: the politics of sin in American history*. New Haven: Yale University Press.

Mörth, U., 2000. Competing frames in the European Commission – the case of the defence industry and equipment issue. In: *Journal of European Public Policy*, 7: 173–89.

Moynihan, Ray, 2006. Obesity task force linked to WHO takes "millions" from drug firms. In: *British Medical Journal*, 332:1412

Nathanson, Constance, 2007. The Contingent Power of Experts: Public Health Policy in the United States, Britain and France. In: *The Journal of Policy History*, 19: 70-95.

Nylander, Johan, 2001. The Construction of a Market - A Frame Analysis of the Liberalization of the Electricity Market in the European Union. In: *European Societies*, 3: 289-314.

OECD, 2007. *Health Data 2007: Statistics and Indicators for 30 Countries*. Paris: OECD.

Oliver J. Eric, 2006. *Fat politics: the real story behind America's obesity epidemic*. New York: Oxford University Press.

Peter, Conrad, 2005. *Shifting Engines of Medicalization*. In: *Journal of Health and Social Behavior*, 46: 3-14.

Pollack, Mark A., 2003. *The Engines of European Integration: Delegation, Agency, and Agenda Setting in the EU*. New York: Oxford University Press.

Princen, Sebastiaan, 2007: *Advocacy Coalitions and the Internationalization of Public Health Policies*. In: *Journal of Public Policy*, 27:13-33.

Proctor, Robert N., 1995: *Cancer War: how politics shapes what we know and don't know about cancer*. New York: BasicBooks.

Ross, George, 2008. *What do 'Europeans' Think? Analyses of the European Union's Current Crisis by European Elites*. In: *Journal of Common Market Studies*, 46: 389–412.

Sabatier, Paul/Jenkins-Smith, Hank 1999. *The Advocacy Coalition Framework*. In: Sabatier, Paul ed. *Theories of the Policy Process*. Boulder, CO: Westview Press.

DG Sanco, 2008. *Tobacco*. Available on: http://ec.europa.eu/health/ph_determinants/life_style/Tobacco/tobacco_en.htm

Sasco, A.J./Dalla-Vorgia, P./Van der Elst, P., 1992. *Comparative Study of Anti-Smoking Legislation in Countries of the European Economic Community*. Geneva: WHO.

Schlesinger, Mark, 2005. Weighting for Godot. In: *Journal of Health Politics, Policy & Law*, 30: 785-801.

Schwartz, Hillel, 1986. *Never Satisfied: A Cultural History of Diets, Fantasies and Fat*. New York: Free Press.

Shafey O./Dolwick S./Guindon G. (eds.), 2003. *Tobacco Control Country Profiles*. Atlanta, GA: American Cancer Society/Geneva: WHO.

Stearns, Peter N., 1997. *Fat History: Bodies and Beauty in the Modern West*. New York: New York University Press.

Strünck, Christoph, 2005. Mix-Up: Models of Governance and Framing Opportunities in U.S. and EU Consumer Policy. In: *Journal of Consumer Policy*, 28: 203–230

Studlar, Donley T., 2002. *Tobacco control: comparative politics in the United States and Canada*. Peterborough, Ont.: Broadview Press.

Studlar, Donley, 2006. Tobacco Control Policy Instruments in a Shrinking World: How much Policy Learning? In: *International Journal of Public Administration*, 29: 367-396.

Tallberg, Jonas, 2006. *Leadership and negotiation in the European Union*. New York: Cambridge University Press.

Thyrian, Jochen René/John, Ulrich, 2006. Measuring activities in tobacco control across the EU. The MAToC. In: *Substance Abuse Treatment, Prevention and Policy*, 1:9 (<http://www.substanceabusepolicy.com/content/1/1/9>)

TobaccoDocuments.org, 1996. The Activist Movement. <http://tobaccodocuments.org/pm/2063589812-9824.html>

Trumbull, Gunnar, 2006. *Consumer Capitalism: Politics, Product Markets, and Firm Strategy in France and Germany*. Ithaca: Cornell University Press.

Tulloch, John/Deborah Lupton, 2003. *Risk in Everyday Life*. Thousand Oaks, CA: Sage Publications.

Watson, Rory, 1995. European antismoking group loses grant. In: *BMJ*, 311:10

Watson, Rory, 2006. European nations draw up strategy to fight obesity. In: *BMJ*, 333:1088-91

WHO, 1986. *IARC Monographs on the Evaluation of Carcinogenic Risks to Humans*. IARC Technical Report Series No 8.

WHO, 1998. *Guidelines for Controlling and Monitoring the Tobacco Epidemic*. Geneva: World Health Organization.

WHO, 1999. *Confronting the epidemic: a global agenda for tobacco control research*. Geneva: World Health Organization.

WHO, 2000. *Tobacco Company Strategies to Undermine Tobacco Control Activities at the World Health Organization*, Report of the Committee of Experts on Tobacco Industry Documents, July 2000.

WHO, 2001a. *Tobacco and the rights of the child*. Geneva: WHO.

WHO 2001b. *Public Support for International Efforts to Control Tobacco: A Survey of Five Countries*. Toronto: WHO/ Environics Research Group Limited.

WHO, 2006. Ministerial Conference on Counteracting Obesity. European Charter on counteracting obesity. EUR/06/5062700/8. Istanbul, Copenhagen: WHO Regional Office for Europe. Available at: www.euro.who.int/Document/NUT/Obesity_Charter_E.pdf.

WHO, 2008. WHO Action Plan for Food and Nutrition. 2007-2012. Copenhagen: WHO Regional Office for Europe.

Wolfson, Mark, 2001. The fight against big tobacco : the movement, the state, and the public's health. New York: Aldine de Gruyter.

World Bank, 2003. Shafey O./Dolwick S./Guindon GE (eds). Tobacco Control Country Profiles 2003. American Cancer Society, Atlanta, GA, 2003.