Alcohol and Tobacco Control in the Philippines and Singapore: A Review of Policies and an Analysis of the Power of the Alcohol and Tobacco Industries in the Policy Process

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Thèse

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Alcohol and Tobacco Control in the Philippines and Singapore: A Review of Policies and an Analysis of the Power of the Alcohol and Tobacco Industries in the Policy Process

Doctorate Thesis

PhD in Global Health Program

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List of publications, submitted manuscripts, manuscripts in preparation, and oral and poster conference presentations during the PhD program (2018-2023)

Peer-reviewed publications included in this thesis

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Content contribution

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"Alcohol advertising in Southeast Asia," Keynote Presentation at the Global Alcohol Policy Conference 2020, Dublin, Ireland, 9-11 March 2020

"Exploring power and the alcohol industry in the Philippines and Singapore" Panel Presentation at the Global Alcohol Policy Conference 2020, Dublin, Ireland, 9-11 March 2020

"Lethal and legal: Progress and challenges in tobacco and alcohol control in the Philippines" Paper presented at the Philippine Public Policy Network Conference, Quezon City, Philippines, 21-22 November 2019

"The alcohol industry and policies on alcohol advertising, promotion and sponsorship in Southeast Asia: a preliminary review" Paper presented at the Public Health and the Global Governance of Alcohol Conference, Kettil Bruun Society Thematic Meeting, Melbourne, Australia, 30 September to 3 October 2019

Raffles Fellow Panellist in Session 1: Singapore's Role in Global Health and Achieving the Sustainable Development Goals in Health, at the 3rd Raffles Dialogue on the Future of Human Well-being and Security: Towards Resilient and Empowered Societies, Singapore, 27-28 November 2018

"Transnational alcohol corporations in Asia: (Ir)responsible business and the SDG target on reducing harmful use of alcohol" Research Poster at the 3rd Raffles Dialogue on the Future of Human Well-being and Security: Towards Resilient and Empowered Societies, Singapore, 27-28 November 2018

"Tobacco control in developing Southeast Asia: A health systems approach in assessing the progress of the SDG target on FCTC implementation," Panel on Addressing noncommunicable disease: Multisectoral approaches at the Fifth Global Symposium on Health Systems Research, Liverpool, UK, 8-12 October 2018

"Assessing tobacco control in developing Southeast Asia: A health systems approach," Research Poster at the 2018 Norwegian Global Health Conference, Oslo, Norway, 10-11 April 2018

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Abstract

Background: Alcohol and tobacco use are among the top risk factors that drive death and disability in the Philippines and Singapore across all ages and genders, and in response, both countries have recently implemented various alcohol and tobacco control policies, but these policies and the industry's role in shaping them are not well documented or analyzed. With the Philippines and Singapore as case studies, this PhD project aimed to (1) compare their alcohol and tobacco control laws and policies, (2) examine the power of the alcohol and tobacco industries in shaping alcohol and tobacco policies, and (3) identify key lessons and challenges for alcohol and tobacco control.

Methods: This PhD project consists of two studies. For both studies, we used relevant data extracted from the scientific literature, official policy documents, legislative proceedings, corporate documents, news articles, and secondary sources. The first study used the WHO Global Strategy to Reduce Harmful Use of Alcohol and the WHO Framework Convention on Tobacco Control as frameworks to develop policy scorecards for alcohol and tobacco. We then used these scorecards to assess the laws and policies in Singapore and the Philippines from a systems perspective. The second study used Lukes's three typologies of power as an analytical tool to examine the power and tactics of the alcohol and tobacco industries in influencing policies. For the second study, we also conducted 30 in-depth interviews in Singapore and the Philippines, and a thematic analysis of these interviews provided insights into key lessons and challenges for alcohol and tobacco control.

Results: The tobacco control scorecard showed that both the Philippines and Singapore scored high in tobacco control despite differences in their economic development and in their political and health systems. The alcohol control scorecard showed that alcohol control is relatively weak in the Philippines and moderate in Singapore, with both countries primarily focused on alcohol taxation. In both countries, the alcohol and tobacco industries utilized a wide range of tactics to exercise their instrumental, structural, and discursive power to influence the policy process. These industries employed lobbying, litigation or threat of litigation, revolving doors, and marketing to exercise their instrumental power. They exercised their structural power by exploiting their market dominance and public-private partnerships, by promoting self-regulation, and by benefiting from regulatory capture. These industries harnessed their discursive power through framing tactics, corporate social responsibility activities and public-private partnerships.

Because of the power of the alcohol and tobacco industries in both countries, it is difficult to institutionalize mechanisms that increase transparency and accountability in interactions between

these industries and the government, other industries, the academic community and civil society organizations.

Conclusions: Our analysis provided the first comprehensive and in-depth review of tobacco and alcohol control policies in Singapore and the Philippines, and of the industries' tactics and their impact on policymaking in these two countries. Our analysis of one high-income and one lower-middle-income Southeast Asian country provided a necessary complement to analyses of the alcohol and tobacco industries' tactics conducted in high-income countries in North America and Western Europe. While there is progress in tobacco control, the Philippines and Singapore showed relative weakness in regulating the influence of the alcohol industry. Prevention professionals need to be aware of the tactics used by these industries to exert their power and undermine health policies. As political, legal and commercial determinants of health, the alcohol and tobacco industries need to be comprehensively regulated to achieve the Sustainable Development Goals to reduce the burden of non-communicable diseases in the Philippines and Singapore. We hope our work is a useful and timely response to the sustained calls for more analysis of the power of transnational and local corporate actors in LMICs, and to calls to decolonise global health research and policy.

Résumé

Contexte : L'alcool et le tabac figurent parmi les principaux facteurs de risque de décès et d'invalidité aux Philippines et à Singapour, tous âges et sexes confondus, et en réponse, ces deux pays ont récemment mis en œuvre des politiques de lutte contre l'alcoolisme et le tabagisme. Toutefois, ces politiques et le rôle de l'industrie dans leur élaboration ne sont pas bien documentés ou analysés. Avec les Philippines et Singapour comme études de cas, ce projet de doctorat visait à (1) comparer leurs lois et politiques de contrôle de l'alcool et du tabac, (2) examiner le pouvoir des industries de l'alcool et du tabac dans l'élaboration des politiques de contrôle de l'alcool et du tabac, et (3) identifier les leçons clés et les défis pour le contrôle de l'alcool et du tabac.

Méthodes : Sur la base de la stratégie mondiale de l'OMS pour la réduction de l'usage nocif de l'alcool et de la Convention-cadre de l'OMS pour la lutte antitabac, nous avons élaboré des tableaux de bord pour l'alcool et le tabac afin d'évaluer les lois et les politiques à Singapour et aux Philippines du point de vue systémique. Nous avons utilisé des données pertinentes extraites de la littérature scientifique, de documents politiques officiels, de procédures législatives, de documents d'entreprise, d'articles de presse et de sources secondaires. Nous avons utilisé les trois typologies de pouvoir de Lukes comme outil analytique pour examiner le pouvoir et les tactiques des industries de l'alcool et du tabac pour influencer les politiques. Nous avons conduit 30 entretiens approfondis à Singapour et aux Philippines, et l'analyse de ces entretiens a permis de dégager des enseignements et des défis majeurs pour la lutte contre l'alcoolisme et le tabagisme.

Résultats : Le tableau de bord de la lutte contre le tabagisme a montré que les Philippines et Singapour ont obtenu de bons résultats dans ce domaine, malgré les différences de développement économique et de systèmes politiques et sanitaires. Le tableau de bord de la lutte contre l'alcoolisme a montré que celle-ci est relativement faible aux Philippines et modérée à Singapour, les deux pays se concentrant principalement sur la taxation de l'alcool. Dans les deux pays, les industries de l'alcool et du tabac ont utilisé un large éventail de tactiques pour exercer leur pouvoir instrumental, structurel et discursif afin d'influencer le processus politique. Ces industries ont eu recours au lobbying, au contentieux ou à la menace de contentieux, aux portes tournantes et au marketing pour exercer leur pouvoir instrumental. Elles ont exercé leur pouvoir structurel en exploitant leur position dominante sur le marché et les partenariats public-privé, en promouvant l'autorégulation et en profitant de la capture réglementaire. Ces industries ont exploité leur pouvoir discursif par le biais de tactiques d'encadrement, d'activités de responsabilité sociale des entreprises et de partenariats public-privé.

En raison du pouvoir des industries de l'alcool et du tabac dans les deux pays, il est difficile d'institutionnaliser des mécanismes qui augmentent la transparence et la responsabilité dans les interactions entre ces industries et le gouvernement, d'autres industries, la communauté universitaire et les organisations de la société civile.

Conclusions : Notre analyse a fourni le premier examen complet et approfondi des politiques de contrôle du tabac et de l'alcool à Singapour et aux Philippines, ainsi que des tactiques de l'industrie et de leur impact sur l'élaboration des politiques dans ces deux pays. Notre analyse d'un pays d'Asie du Sud-Est à revenu élevé et d'un pays à revenu moyen inférieur a apporté un complément nécessaire aux analyses des tactiques des industries de l'alcool et du tabac menées dans les pays à revenu élevé d'Amérique du Nord et d'Europe occidentale. Bien que des progrès aient été accomplis dans la lutte contre le tabagisme, les Philippines et Singapour ont fait preuve d'une relative faiblesse dans la régulation de l'influence de l'industrie de l'alcool. Les professionnels de la prévention doivent être conscients des tactiques utilisées par ces industries pour exercer leur pouvoir et saper les politiques de santé. En tant que déterminants politiques, juridiques et commerciaux de la santé, les industries de l'alcool et du tabac doivent faire l'objet d'une réglementation complète pour atteindre les objectifs de développement durable et réduire le fardeau des maladies non transmissibles aux Philippines et à Singapour. Nous espérons que notre travail constitue une réponse utile et opportune aux appels répétés en faveur d'une analyse plus poussée du pouvoir des entreprises transnationales et locales dans les pays à revenu faible et moyen, et en faveur d'une décolonisation de la recherche et de la politique en santé globale.

Outline

General Introduction

Alcohol- and tobacco-related NCD morbidity and mortality in the Philippines and Singapore

Alcohol and tobacco use are among the top ten risk factors that drive death and disability in the Philippines and Singapore across all ages and genders (1,2). The number of attributable deaths and disability-adjusted life years vary widely between the Philippines and Singapore. Even with this variation, the burden of alcohol use mostly impacts those in their youth (15 to 49 years old) while the burden of tobacco use affects those 50 years old and above in both countries.

The Philippines has higher tobacco and alcohol-related disease burden because of its large population. Alcohol and tobacco use are among the top five behavioural risk factors that cause death and disability among males 15 years old and above in the Philippines, a country with a relatively young population. In contrast, in Singapore, because of its ageing population, alcohol and tobacco use are among the top five behavioural risk factors among those 50 years old and above (1,2).

Figures 1 and 2 show that males bear the higher alcohol- and tobacco-related burden in the Philippines and Singapore, particularly those caused by non-communicable diseases (shown in grey for alcohol, and yellow for tobacco). While Singapore has made considerable progress in reducing the tobacco-related and alcohol-related burden of disease since 1990, there was barely any significant reduction in the Philippines since 1990.

Figure 1(A). The alcohol-attributable burden of disease in the Philippines, in disability-adjusted life years (DALYs) per 100 000, disaggregated by gender, compared across categories of causes, and between 1990 and 2019

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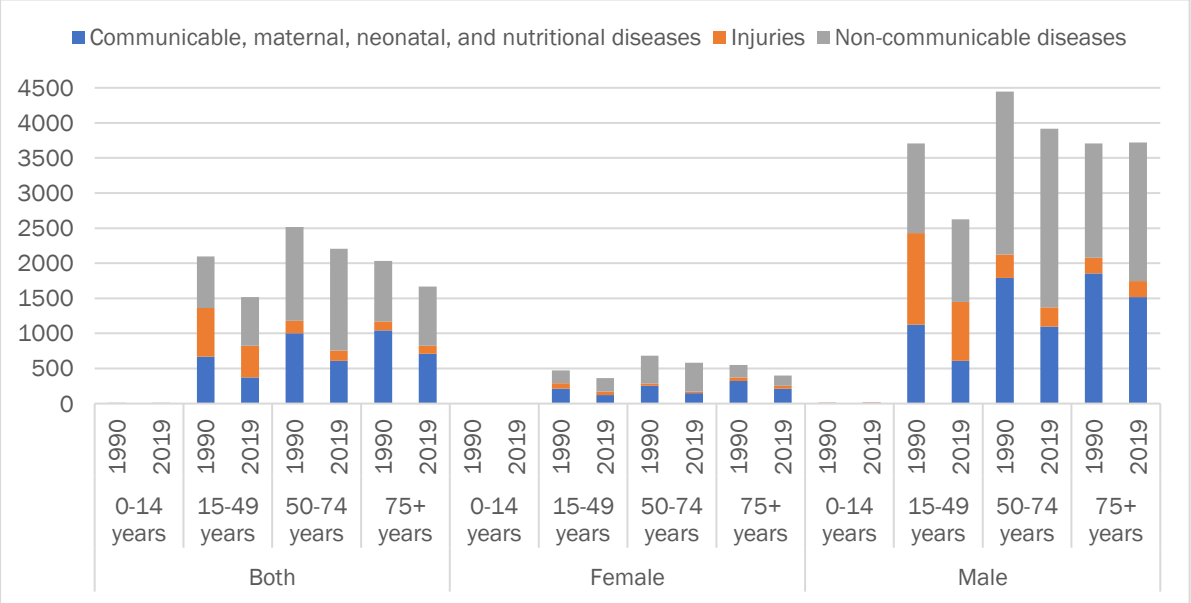

Figure 1(B). The tobacco-attributable burden of disease in the Philippines, in disability-adjusted life years (DALYs) per 100 000, disaggregated by gender, compared across categories of causes, and between 1990 and 2019

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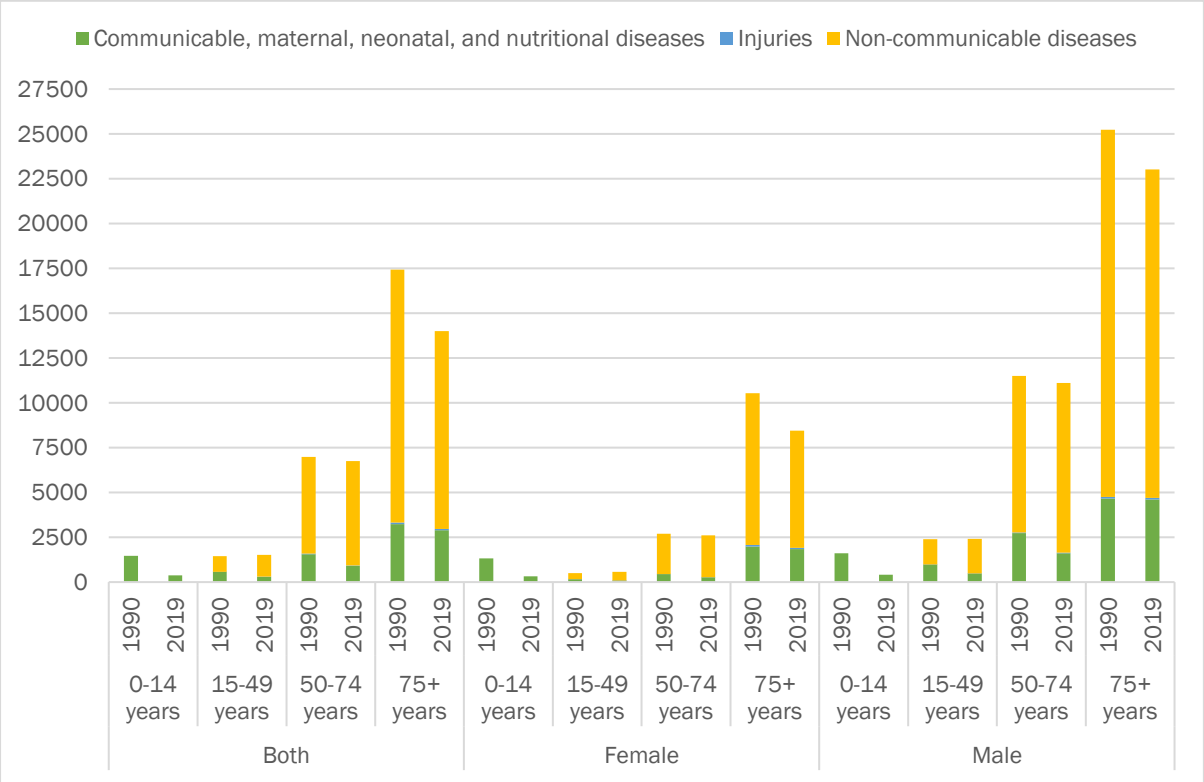

Figure 2 (A). The alcohol-attributable burden of disease in Singapore, in disability-adjusted life years (DALYs) per 100 000, disaggregated by gender, compared across categories of causes, and between 1990 and 2019

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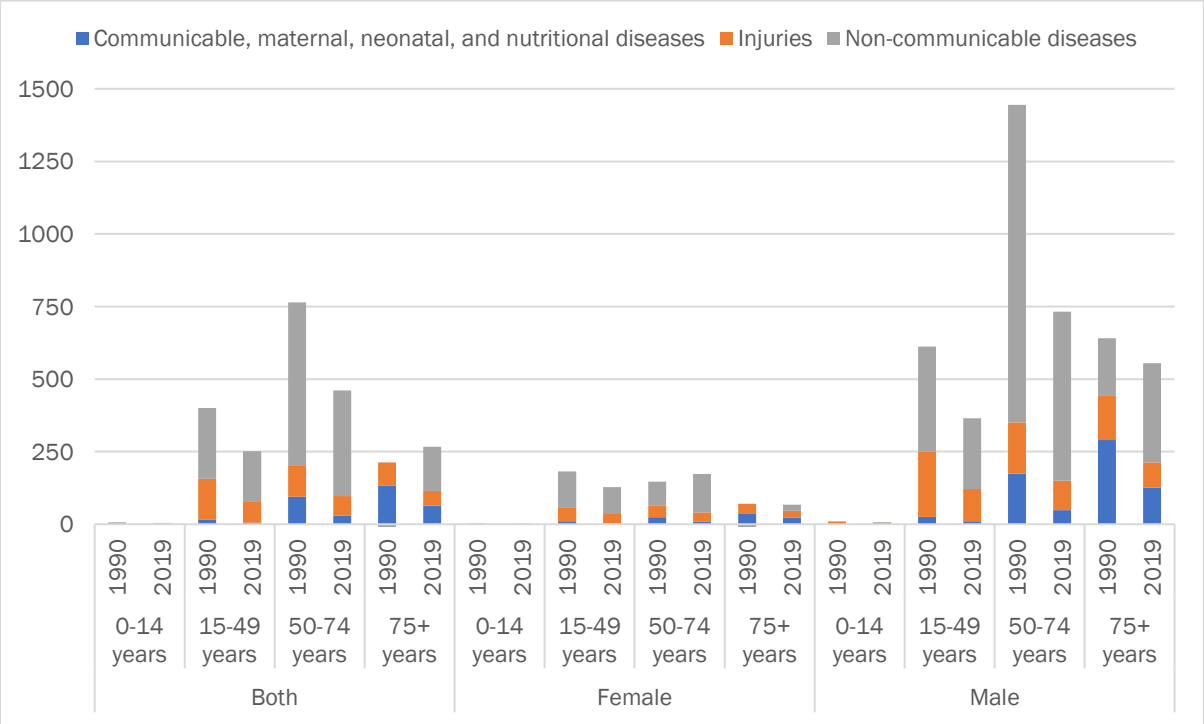

Figure 2 (B). The tobacco-attributable burden in Singapore, in disability-adjusted life years (DALYs) per 100 000, disaggregated by gender, compared across categories of causes, and between 1990 and 2019

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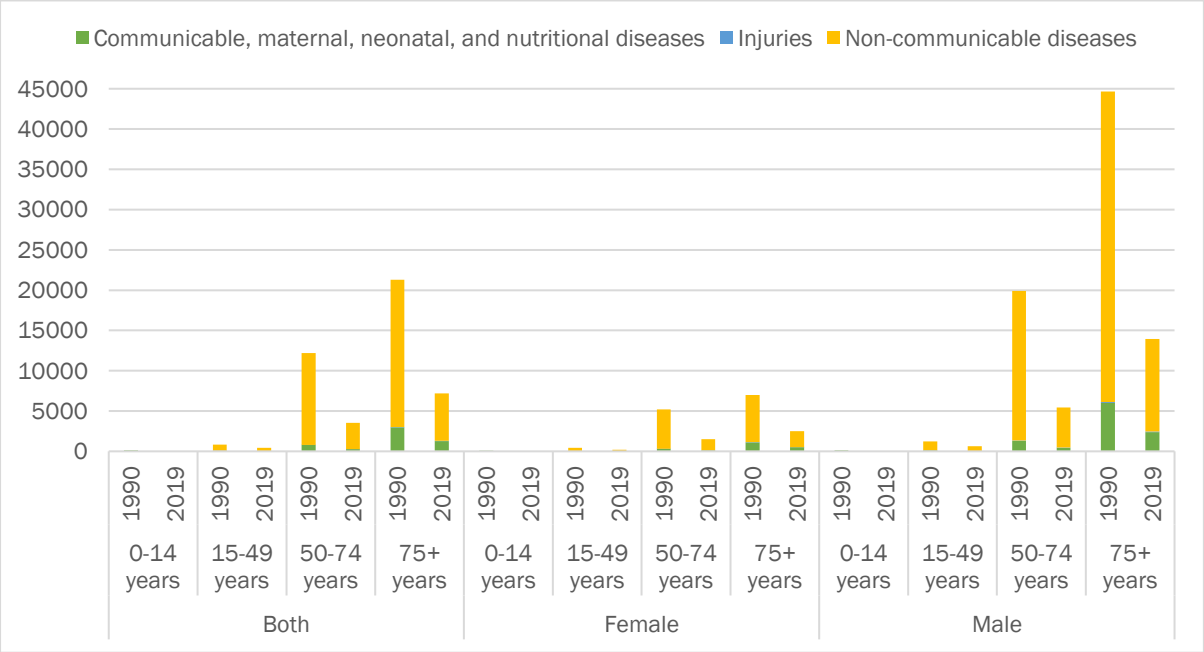


A brief history of global and regional alcohol control

At the global level

While alcohol has been a sporadic issue at the World Health Organization (WHO) since 1951 (3), it was not until 2010 that the World Health Assembly (WHA) reached consensus on a Global Strategy to Reduce the Harmful Use of Alcohol (Global Strategy), which defines priority areas for global action and proposes a portfolio of policy options for implementation at the national level. (4) (5) Scholars consider the Global Strategy as a manifestation of the public health model for alcohol policy, which has evolved since the 1970s (6). The public health model shifted the focus away from alcoholism as a disease to alcohol as a public health risk, from treatment and rehabilitation to prevention and health promotion, and from education and public awareness campaigns that promote 'responsible' drinking focused on individual behaviour to evidence-based population-level alcohol policies that include both demand and supply reduction measures.(6)

In 2015, the member states of the United Nations adopted the 2030 Sustainable Development Goals (SDGs hereafter), which included SDG target 3.5 aimed at strengthening the prevention and treatment of substance abuse, including drug abuse and harmful use of alcohol. Reducing harmful alcohol use can contribute to achieving at least six other SDGs. (7) The WHO launched the SAFER Initiative and policy package in 2018 to accelerate progress in reducing alcohol-related burden, based on the Global Strategy and the WHO's 'Best Buys' for tackling NCDs. (8)

By 2019, alcohol use caused an estimated 3 million deaths yearly and at least 93 million disability-adjusted life years globally. (9) To address the disappointing results achieved ten years after the adoption of the Global Strategy, WHO Member States adopted the Global Alcohol Action Plan at the WHA in 2022. This plan includes eleven global targets, six global action areas and proposed actions for member states, for the WHO Secretariat, international partners, civil society organisations and academia, and for the alcohol industry. (10)

However, the Global Alcohol Action Plan remains a set of non-legally binding and voluntary measures for global alcohol governance, even as it is seen as a positive development in global alcohol governance. (11,12) Scholars have also recognised that non-binding international instruments, such as the Global Strategy and the SDGs, are nevertheless norm-creating international instruments that can guide the behaviour of states. (13) However, scholars and civil society are wary of the alcohol industry's role in the Global Alcohol Action Plan, and criticised the industry's involvement in the public consultations for the Global Alcohol Action Plan, citing a conflict of interest and the alcohol industry's strategy to hinder progress in global alcohol governance. (14–16) See Figure 3 for a brief snapshot of critical milestones in global alcohol governance since 2005.

Figure 3. Timeline of milestones in global alcohol governance from 2005 to present. Source: (3)

At the regional level

The slow progress in alcohol control policies at the global level mirrors similar slow progress in reducing alcohol consumption in Southeast Asian countries. The 2018 Global Status Report on Alcohol and Health shows that among the ten of the Association of Southeast Asian Nations (ASEAN hereafter), per capita alcohol consumption ranged from less than 1 L to 10 L per year (See Figure 4). (9) Figure 4 shows that the Philippines, Cambodia, Thailand, Vietnam and Lao PDR all have higher alcohol per capita consumption than the world average of 6.2 L.(9)

Regional commitments do exist, although they are only normative and are far from being legally binding. The ASEAN Post-2015 Health Development Agenda included the reduction of harmful use of alcohol. Two of the key targets to be reached by 2025 are to implement the ASEAN Framework 2022

for Action on Alcohol Control, and to support member states in protecting alcohol control policies from alcohol industry interference and involvement, including the management of conflict of interests. (17) See Figure 4 for the key elements of the framework.

Figure 4. Alcohol per capita consumption in the Association of Southeast Asian Nations member states, disaggregated by gender, 2018

Source: (9)

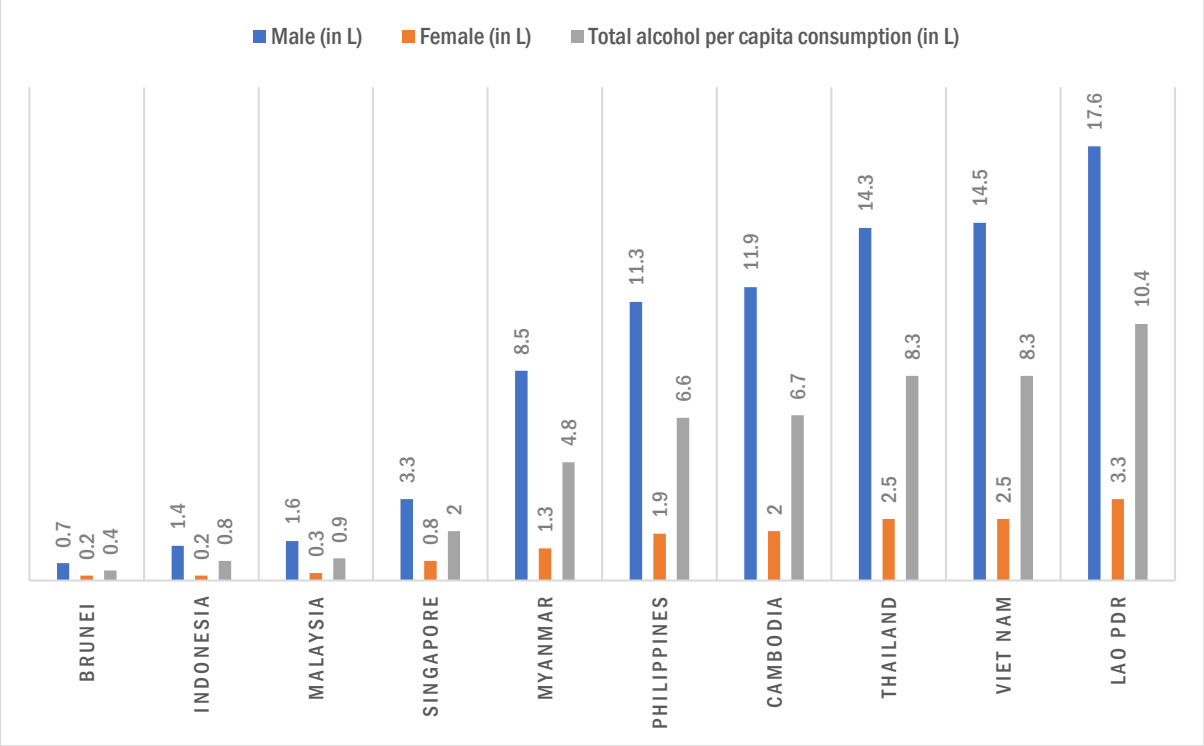
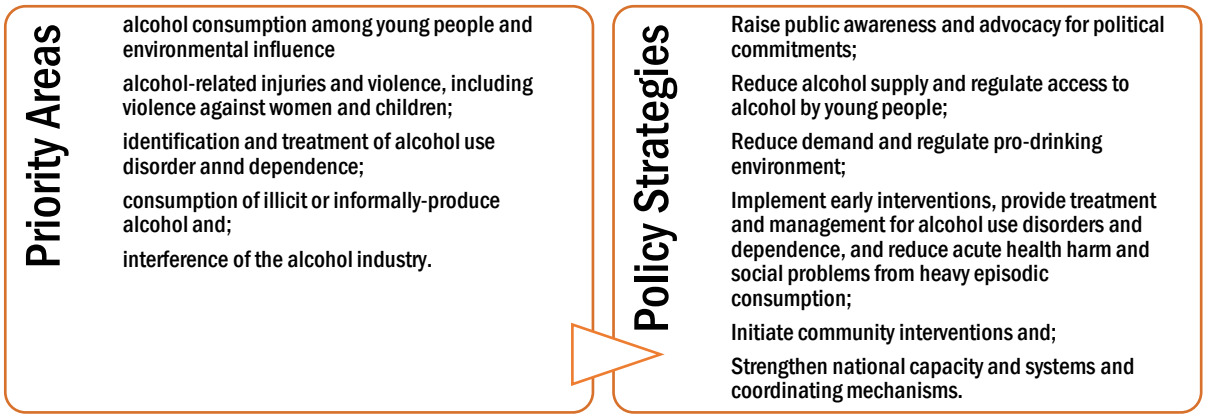


Figure 5. Priorities and policy strategies in the ASEAN Framework for Action on Alcohol Control

Source: (17)



A brief history of global and regional tobacco control

At the global level

Global tobacco governance has more than seven decades of history.(18) Global tobacco control governance peaked when the World Health Assembly adopted the WHO Framework Convention on Tobacco Control (FCTC) in 2003 and when the FCTC entered into force in 2005;(19) 182 countries are now parties to the WHO FCTC. (20) The FCTC is the first international legal instrument adopted under Article 19 of the WHO Constitution, and it is designed as a framework convention to promote global cooperation and local action against the global tobacco epidemic. (21) The FCTC emphasizes a regulatory approach to addictive substances, and includes measures to reduce demand (Articles 6 to 14) and supply (Articles 15 to 17), as well as the obligation for parties to finance the implementation of the FCTC and protect tobacco control policies from the tobacco industry interference.(22) Global health scholars have hailed the FCTC as a successful example of global health diplomacy for health promotion and as a legally binding international standard. (23)

In 2008, the WHO introduced the MPOWER package of six key measures to assist countries in implementing effective interventions to reduce the demand for tobacco. (24) The FCTC and the MPOWER package received financial resources from Bloomberg Philanthropies and the Bill and Melinda Gates Foundation, which have supported tobacco control interventions in more than 110 LMICs since 2005.(25)

In 2015, UN member states included strengthening the implementation of the FCTC among the targets of the Sustainable Development Goal on health. The inclusion of the FCTC in the SDGs has facilitated financing for LMICs in the implementation of the FCTC.(26)

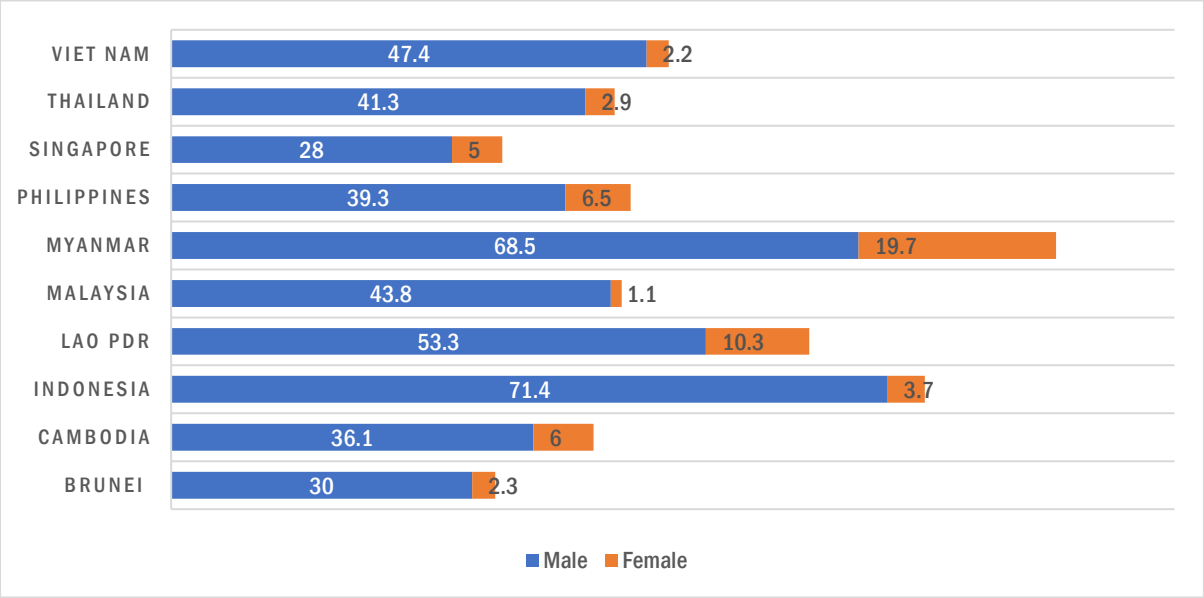
In 2018, the adoption by the FCTC Conference of Parties of the Global Strategy to Accelerate Tobacco Control 2019-2025 led to the launch of two investment funds for sustainable tobacco control financing: the WHO FCTC Investment Fund and the Investment Fund for the FCTC Protocol to Eliminate Illicit Trade in Tobacco Products. (27–29)

At the regional level

ASEAN member states have included the reduction of tobacco consumption in their health priorities as part of the post-2015 ASEAN Health Development Agenda. This priority to promote healthy lifestyles included targets to accelerate the implementation of the FCTC and national tobacco control policies, and to help ASEAN member states protect tobacco control policies from industry interference. (14) All ASEAN member states, except Indonesia, have ratified the FCTC. (30) Tobacco control remains a challenge in ASEAN, the prevalence of tobacco use in ASEAN member states ranged from 28 to 71 per cent among males, and 2 to 19 per cent among females in 2020. (31)

Figure 6. Age-standardised prevalence (%) of tobacco use among 15 years old and older in ASEAN member states, disaggregated by gender, 2020

Source: (31)



Context: Alcohol and tobacco industry tactics in the Philippines and Singapore

Tobacco industry interference has been documented both in the scientific and the grey literature covering the Philippines and Singapore, and it has been included in regional case studies or as country cases. Considerable literature has been published on the tobacco industry tactics in Southeast Asian countries for the past two decades (32,33), including the Philippines (34) and Singapore (35,36), including my own work that is not included in this PhD project.(37,38) The Truth Tobacco Industry Documents (39) and civil society monitoring (40,41) have contributed significantly to this literature and towards understanding the tobacco industry's tactics in low-and middle-income countries. For example, scholars documented how the tobacco industry circumvented marketing restrictions (36) and used its sponsorship of the arts, education and the media to avoid smoke-free legislation in Singapore. (35) In the Philippines, the tobacco industry was considered the 'strongest tobacco lobby in Asia' (34), managing to obtain permanent representation in a tobacco policy making body (42). Given recent tobacco policy developments, the role of the tobacco industry in the policy process in the Philippines and Singapore required further examination.

In contrast, there remains a dearth of scientific literature on alcohol industry tactics to influence policies in the Philippines and Singapore. Apart from my own published review of alcohol marketing in Southeast Asia, which highlights the expansion of the alcohol industry's in the region and the promotion of voluntary advertising codes (43), and from a case study in the grey literature on the role of the alcohol industry in road safety initiatives in the Philippines(44), specific case studies on the role

of the alcohol industry in the policy process in the Philippines and Singapore have yet to be published. The recent introduction of alcohol policies in the Philippines and Singapore's offered an opportunity to take a closer look at the role of the alcohol industry in the policy-making process.

Identifying power in the alcohol and tobacco control policy process

Steven Lukes' three-dimensional concept of power has been widely used to study the political activities of corporate actors in global health governance.(45–48). Over time, public health scholars who recognise health as inherently political have utilised power as an analytical tool to examine corporate political activities. (49–52) Steven Lukes' three dimensions of power refers to power as decision-making (instrumental power), as agenda-setting (structural power) and as preference-shaping (discursive power).(53) We also used this approach in our study.

Rationale

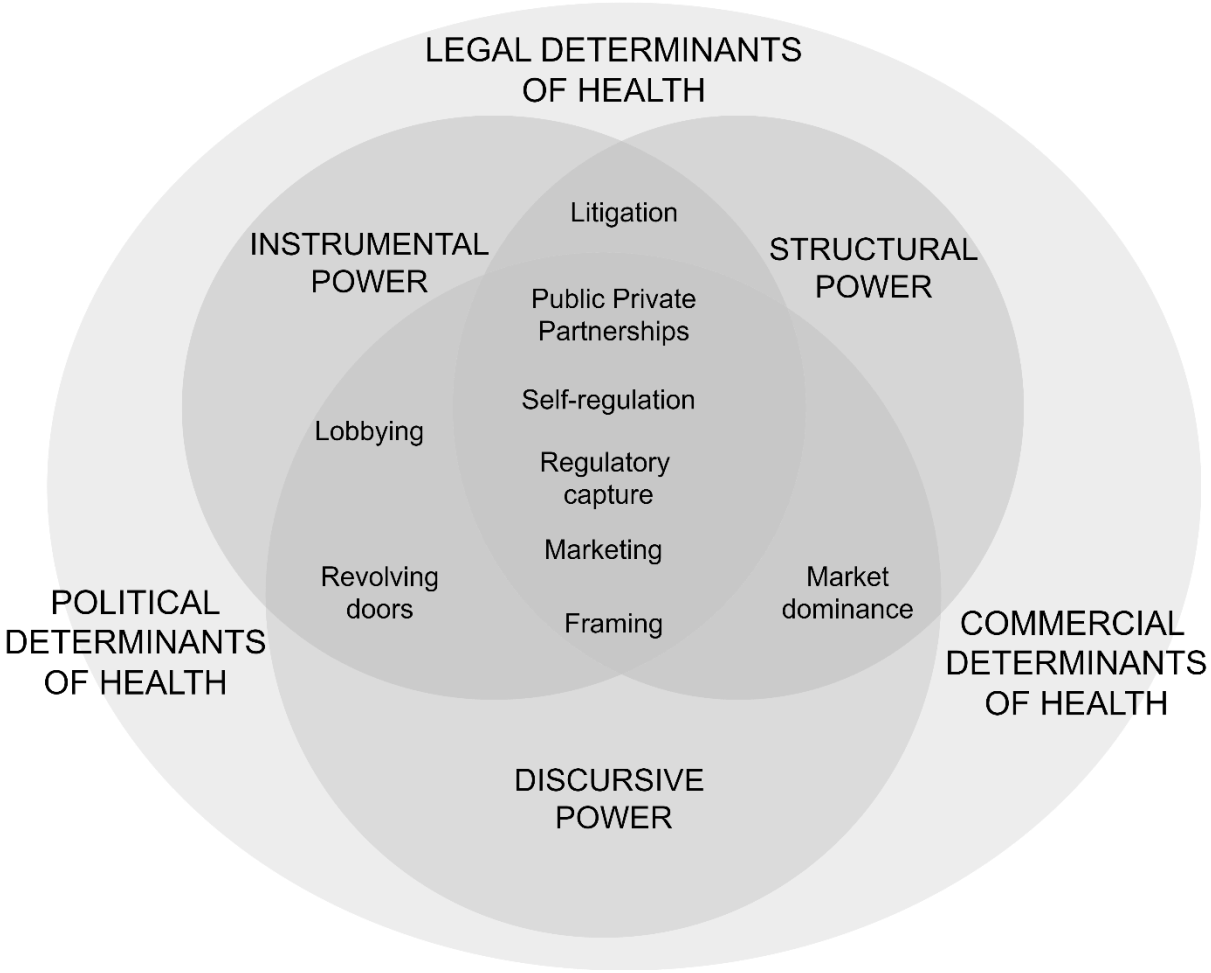
The three dimensions of power contribute to a framework of analysis for this PhD project that acknowledges the complexities in state-corporate relations in my analysis of the power of the alcohol and tobacco industries. Such relations set against the transnational nature of the alcohol and tobacco industries provides the rationale for the use of these three dimensions of power.

First, the three dimensions of power offers opportunities not only to examine the industries' resources (instrumental power), motivations and access to the policy process (structural power) but also to analyse the power of the ideas and the norms (discursive power) that they generate and perpetuate to exert political power in countries where they operate.

Second, the three dimensions of power offers a comprehensive and interdisciplinary perspective for the discipline of global health that draws from political science and international political economy (globalization studies) to the study of corporations and their activities in terms of tactics and strategies that have an impact on health policies and consequently, on public health in low- and middle-income countries.

Finally, discursive power, the third dimension of power provides the conceptual depth and breadth to examine (although difficult) how corporations legitimize and institutionalize their status as dominant political actors. Such analysis often goes missing when corporations are studied only as profit-driven economic actors based on their resources (instrumental power) and market size (structural power). See Figure 7 for the framework of analysis.

Figure 7. Framework for the analysis of the power and tactics of the alcohol and tobacco industry



Context: Commercial determinants of health

The power of corporate actors, specifically of the alcohol and tobacco industries, has been analysed within the broader discourse of the commercial determinants of health.(50,54–56) Previous studies have focused on the negative impact of the political activities of the alcohol and tobacco industries on global public health.(57,58) Despite this focus, the WHO recently defined the commercial determinants of health as "the conditions, actions and omissions by corporate actors" that can have both "beneficial or detrimental impacts on health." (59) The recognition of the detrimental and vital role of commercial actors in society is also reflected in the scientific literature.(60,61) For instance, the Lancet series on the commercial determinants of health presented a broader consensus definition of the commercial determinants of health, defined as the "systems, practices, and pathways through which commercial actors drive health and equity." (62) While the literature on this topic has grown in the past decade, the majority of the research is still focused on high-income countries in Western Europe and North America, but more scholars call for research on the commercial determinants of health in LMICs, in the Asia Pacific, Latin America and Africa. More recently, the 2023 Lancet series on the commercial determinants of health identified mutually reinforcing and interrelated practices that

commercial entities utilize to accumulate structural, instrumental and discursive power: political, scientific, marketing, supply chain and waste, labour and employment, financial and reputational management practices. (62)

Context: Political determinants of health

The discourse on the political determinants of health is closely intertwined with the discourse on the commercial determinants of health. The literature on the political determinants of health has focused on the impact of welfare states, political traditions, democracies and globalization on global public health. (63–65) Scholars have also explored the analysis of power and politics in health systems, health policy, and transnational processes. (49,66–68)

Context: Legal determinants of health

Similarly, the discourse on the legal determinants of health relates to the discourse on the political determinants of health, such that the legal determinants of health are often subsumed under the political determinants of health. (69) Scholars utilizing the legal determinants of health as an analytical tool have focused on human rights, the right to health, and exploring the power of law to promote global health and achieve the Sustainable Development Goals. (70–73)

Systems thinking in alcohol and tobacco control

Systems thinking is an analytical approach based on the interrelationships between elements of a complex system. We used systems thinking to study the policy process for tobacco and alcohol control in the Philippines and Singapore. This approach assumes that systems comprise dynamic, interrelated, interacting and interlocking building blocks. (74) Systems thinking has been applied to global health research but mostly focused on high-income countries. Studies based on this approach used social network analysis as a method, and emphasised the interdependent and interconnected nature of a system, e.g. a health or political system. (75) A group of global health scholars recently published a collection of articles applying systems thinking for a variety of global health issues affecting LMICs, from the community health level to a planetary health level.(76)

In tobacco control research, systems thinking has been applied to the design of smoking cessation programs(77), to the development and evaluation of regulatory frameworks(78–80), to the assessment of the FCTC implementation(30,81), and the analysis of the tobacco industry as a commercial determinant of NCDs.(82)

In alcohol control research, systems thinking has been applied to the analysis of the alcohol industry as a commercial determinant of NCDs (82,83), to the development of frameworks for alcohol-free environments (84,85), to the evaluation of voluntary regulation by the alcohol industry (86), to the study of the alcohol industry's arguments in response to alcohol policies (83), to the analysis of the

relationship between alcohol advertising and public health (87), and to the development of an integrated NCD approach to alcohol and tobacco policy.(88)

Study setting

This section describes the two countries considered for this study: the Philippines and Singapore. The alcohol and tobacco control measures recently implemented by both countries supply the policy cases for this PhD project.

The Philippines

The Philippines (the country where I grew up and of which I am a citizen) is a lower middle-income economy in Southeast Asia, with a population of 110 million in 2021 and a unitary government in the form of a presidential republic. The UNDP ranks the Philippines as a country with medium human development. (89) In terms of health system development, the Philippines has a newly industrializing health system. (90)

Alcohol control in the Philippines is focused on non-health interventions such as anti-drunk driving laws for road safety, fiscal measures including a series of alcohol tax reforms (91–93), a law that prohibits the depiction of children below 18 years old in alcohol advertising(94), and administrative measures regarding the display of alcohol at point-of-sale in retail. (95)

The Philippines implemented an omnibus tobacco control law in 2003 (96), two years before the country ratified the Framework Convention on Tobacco Control. The Philippines has since implemented a law on graphic health warnings (97) , a series of tobacco tax reforms (93) (91)and most recently, a law regulating e-cigarettes.(98)

Singapore

The city-state of Singapore (where I worked as a policy researcher for several years) is a high-income economy in Southeast Asia with a population of 5.4 million people. The UNDP has categorized Singapore with a very high human development status. (99) In terms of health system development, Singapore has a developed health system. (90)

Singapore has implemented alcohol control policies centred around fiscal measures, particularly alcohol taxation, and public order measures which include liquor control zones, liquor licensing, and limiting alcohol accessibility for specific time periods.

Tobacco control in Singapore started in the 1970s when the first prohibitions for smoking in indoor places came into effect. Since then, the government has progressively added more public places where smoking is prohibited. Singapore has one of the highest tax rates on tobacco products in Southeast Asia. In the past decade, Singapore has banned virtually all forms of tobacco display, advertising,

promotion, and sponsorship (including at point-of-sale), banned e-cigarettes and heated tobacco products, gradually increased the minimum legal age for smoking from 18 to 21, and required plain packaging on tobacco products.

Background of the policy review

While there have been case studies of tobacco control in Singapore(100,101), we found no comprehensive and in-depth review of alcohol control policies in Singapore or the Philippines in the research literature. The most recent overview of alcohol control policies in the Philippines and Singapore are summarized in the grey literature as one-page country profile snapshots in the 2018 Global Progress Report on Alcohol and Health produced by the World Health Organization. (9) For this PhD project, I adapted the WHO health system building blocks to systematically assess the progress of alcohol and tobacco control policies in the Philippines and Singapore. I specifically expanded the scope of the governance and leadership building block to incorporate health and non-health sector interventions.

Background of the document review and analysis

Official government documents and public corporate documents provide valuable research data. Legislative proceedings, corporate actors' submissions to public consultations, and corporate documents (e.g., annual reports) provide insights into how both state and non-state actors frame their policy positions and political agendas. (102,103) I used these documents to gain insights into policy making and to assess the influence of corporate actors in both countries.

Background of the qualitative interviews

In-depth semi-structured interviews are a valuable tool for gathering nuanced and previously undocumented information about the political dynamics of alcohol and tobacco control policy processes. The 30 interviews that I conducted shed light on the actions of the alcohol and tobacco industries and their interactions with other policy actors in the Philippines and Singapore. They provide a deep understanding of the policy process that would not have been achievable through other research methods. The insights gained from these interviews can help formulate strategies to counter industry tactics to influence policy. Data privacy laws require that the in-depth interviews be anonymized before analysis. For all the interviews included in the PhD project, we only refer to the general affiliation of the interviewees, ensuring their privacy and confidentiality.

Research during COVID-19: A Reflexive Narrative

As a PhD student from the Philippines with a non-medical or non-health background (I was trained as a political scientist and worked as a policy researcher), I am privileged to have the opportunity to pursue a PhD in global health. As a self-funded PhD student, I had the freedom to design this PhD project independently. This PhD project started pre-pandemic, and the fieldwork spanned the whole

three-year period of the pandemic as declared by the WHO. I acquired ethics approval for the PhD project in the Philippines and Singapore before COVID-19 was declared a pandemic. I had planned to conduct field interviews in Singapore and the Philippines in 2020. The pandemic shifted the planned qualitative data collection approach from in-person interviews to virtual interviews over Zoom. However, Zoom interviews meant that most interviewees had 'Zoom fatigue' when I requested interviews during the pandemic. The pandemic restrictions meant that I had to deviate from the approved research protocol and changing the research protocol required that I justify both the delay in my research project and the deviations in the research protocol to the National Ethics Committee in the Philippines. I had to submit the changes and justification for the changes and seek further approval for the field work to continue. Given the lack of physical access to legislative hearings, I had to wait until legislative proceedings were cleared before I could collect and download the documents for data extraction and analysis. All this delayed my fieldwork by one year, but I was still fortunate to have access to publicly available documents that were available online and to have access to my interviewees over Zoom.

Objectives of the PhD project

This PhD project has three objectives:

(1) To provide a comparative analysis of current tobacco and alcohol control laws and policies in the Philippines and Singapore;
(2) To examine the power of the tobacco and alcohol industries in shaping tobacco and alcohol policies in two Southeast Asian countries, the Philippines and Singapore;
(3) To identify key lessons and challenges for alcohol and tobacco control in the Philippines and Singapore

Methodological Contributions of the PhD candidate

Qualitative Research

I am a self-funded PhD student, and I was not a part of any other research project at the University of Geneva. I conducted the research for this PhD thesis independently, in addition to my full-time job. Under the guidance of my supervisors, I was responsible for all aspects of the research: conceptualisation, study design, data collection, data extraction, conducting interviews, data analysis, drafting of the manuscript and publication of both articles. The original PhD proposal also included looking into illegal drugs, but the Doctoral Committee advised me to only focus on alcohol and tobacco, given the data availability and accessibility issues related to illegal drugs.

Article 1- Comparing tobacco and alcohol policies from a health systems perspective: The cases of the Philippines and Singapore

For the first article, I conceptualised and designed the study, and I conducted a scoping review of the policy literature on alcohol and tobacco control in the Philippines and Singapore. In addition, I used the WHO Framework Convention for Tobacco Control and the WHO Global Strategy to Reduce Harmful Use of Alcohol to develop a policy-scoring framework for tobacco and alcohol control. I constructed the policy-scoring framework based on a framework that I developed with Professor Tikki Pang (one of the members of the Doctoral Committee) in a previous study that we co-authored (30). To design the policy scoring framework, I assigned weighted scores for each specific article in the FCTC and for each recommendation in the Global Strategy. For the policy scoring framework, I also downloaded all relevant policy documents and extracted the policy data from secondary sources. I conducted the comparative analysis independently. I drafted the manuscript for publication. I revised the manuscript based on critical feedback from Professor Jean-Francois Etter. I submitted the manuscript for publication and applied to the Swiss School of Public Health for the reduction of article processing charges for the publication of the manuscript in the International Journal of Public Health. After receiving peer reviews, I revised and finalised the manuscript with Professor Jean-Francois Etter. The University of Geneva and I contributed equally to covering the article's publication fees once it was accepted for publication.

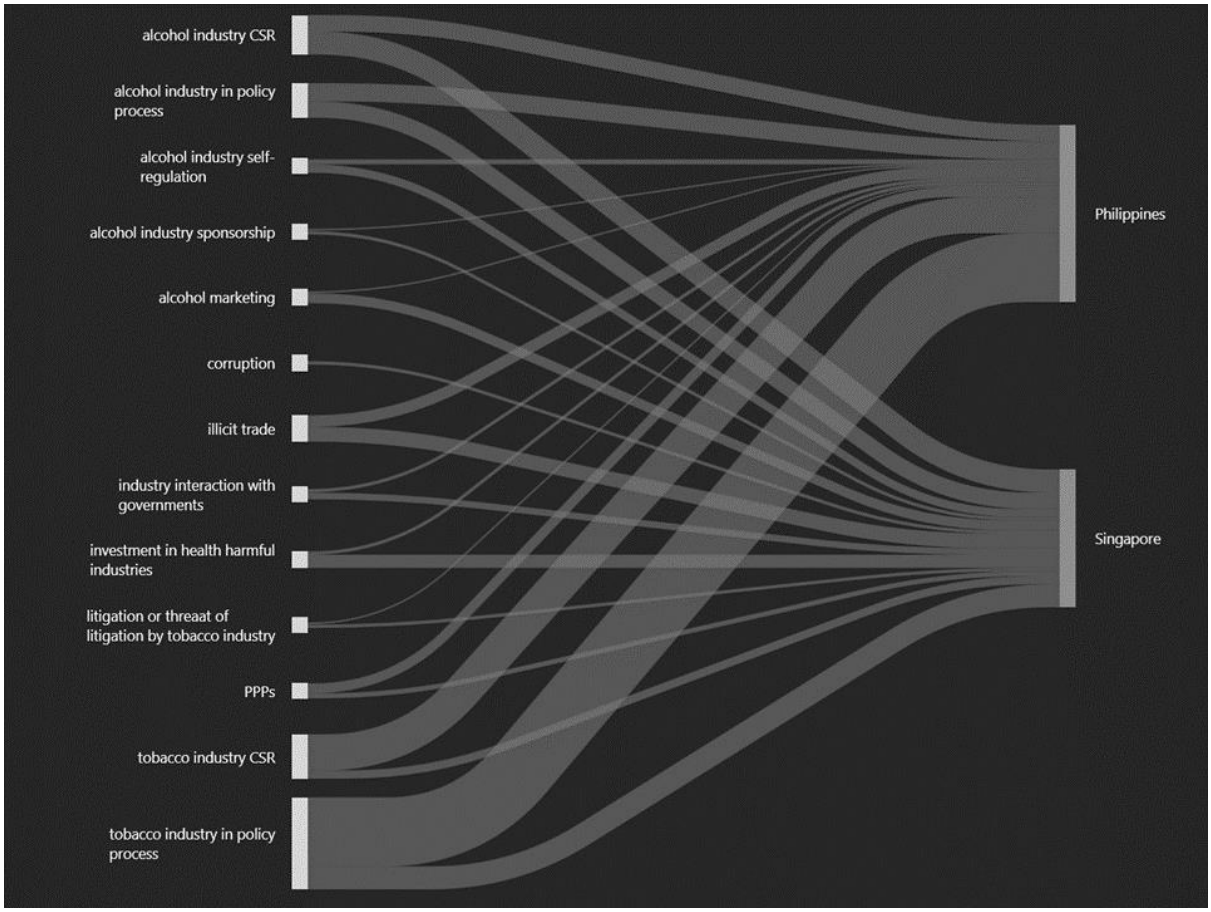
Article 2- Examining the power of the alcohol and tobacco industries in policymaking: lessons and challenges for the Philippines and Singapore

Literature Review. For the second article, I developed a conceptual framework from the political science literature and from the most recent literature on political, legal and commercial determinants of health.

Content Analysis of Government Documents, Corporate Documents and News Articles. For the second article, I conceptualised and designed the study. I downloaded all the government documents, corporate documents, and news articles for the data collection. I extracted all the relevant data from the documents and news articles and conducted the data analysis independently. For analysis, I used the READ approach for health policy research: (a) ready materials, (b) extract data, (c) analyse data and (d) distil findings. (104)

Thematic Analysis of Qualitative Interviews. I designed the interview protocol and drafted the participant information sheet, an interview guide and consent form with Professor Jean-François Etter's technical review and approval. I was responsible for submitting and getting the research protocol approved in the Philippines and Singapore with the respective ethics committees or institutional ethics boards. As an advocate engaged in alcohol and tobacco control research, I am familiar with the alcohol and tobacco control community in both the Philippines and Singapore. I compiled the initial list of interviewees from my advocacy and professional network. Professor Tikki Pang recommended potential interviewees in Singapore. I recruited the interviewees through purposive and snowball sampling, and I conducted the interviews independently. I recorded and transcribed the interviews for those who consented to audio recording. For those who did not consent to the audio recording but consented to the interview, I took notes during the interview to produce interview memos. I conducted most of the interviews in Singapore in-person before COVID-19 pandemic restrictions and conducted the rest of the interviews in Singapore when COVID-19 pandemic lockdowns were in place. I conducted all interviews in the Philippines virtually on Zoom. I stored the audio recordings of the interviews in an encrypted folder on an external hard drive and on a secure cloud storage account. I transcribed the interviews and sent the interview transcripts to the interviewees for validation. I conducted the thematic analysis of the interviews independently based on an initial set of themes from a previous study where I analysed submissions to a public consultation on standardised packaging in Singapore.(38) See Figure 8 for the thematic analysis. I drafted the manuscript for journal publication. I revised an earlier version of the manuscript based on initial feedback from Professor Pascal Bovet and Professor Jean-François Etter. I finalised the manuscript based on critical feedback from Professor Jean-François Etter. I submitted an abstract of the manuscript for consideration in a special issue of a journal. I submitted the manuscript after the journal's editors provisionally approved the abstract. After peer review, I revised and finalised the manuscript with Professor Jean-François Etter. The University of Geneva's Publication Fund contributed to covering the minimum of the publication fees once the manuscript was accepted for publication. The journal waived a portion of the publication fees in consideration of my status as PhD student.

Figure 8. Thematic analysis



Results

Publication 1

Comparing Tobacco and Alcohol Policies from a Health Systems Perspective: The Cases of the Philippines and Singapore, *International Journal of Public Health*

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Comparing Tobacco and Alcohol Policies From a Health Systems Perspective: The Cases of the Philippines and Singapore

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Objective: To provide a comparative analysis of current tobacco and alcohol control laws and policies in the Philippines and Singapore

Methods: We used a public health law framework that incorporates a systems approach using a scorecard to assess the progress of the Philippines and Singapore in tobacco and alcohol control according to SDG indicators, the WHO Framework Convention on Tobacco Control and the WHO Global Strategy to Reduce Harmful Use of Alcohol. We collected data from the scientific literature and government documents.

Results: Despite health system differences, both the Philippines (73.5) and Singapore (86.5) scored high for tobacco control, but both countries received weak and moderate scores for alcohol control: the Philippines (34) and Singapore (52.5). Both countries have policy avenues to reinforce restrictions on marketing and corporate social responsibility programs, protect policies from the influence of the industry, and reinforce tobacco cessation and preventive measures against alcohol harms.

Conclusion: Using a health system-based scorecard for policy surveillance in alcohol and tobacco control helped set policy benchmarks, showed the gaps and opportunities in these two countries, and identified avenues for strengthening current policies.

Keywords: tobacco control, health systems, alcohol control, Philippines, Singapore, health policy, public health law, policy surveillance

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INTRODUCTION

The burden of noncommunicable diseases (NCDs) is now pervasive in both high-income and low- and middle-income economies. In a high-income country like Singapore, NCDs account for an estimated 84% of the burden of disease and about 83% of deaths, and even in a lower-middle-income country like the Philippines, NCDs already account for more than 64% of the burden of disease and 70% of deaths [1]. According to the Global Burden of Disease study, tobacco and alcohol use remained the top risk factors for disease and death burden in the Philippines and Singapore since 1990, for both males and females [2]. When disaggregated by gender, males bear a higher tobacco-attributable and alcohol-attributable burden of disease than females in both the Philippines and Singapore [2].

From a global health perspective, the World Health Organization (WHO) Framework Convention on Tobacco Control (FCTC) has been a powerful legal framework and a foundation for the development and implementation of tobacco control policies in countries at various economic development levels [3, 4]. While tobacco control implementation has been assessed using the World Bank's Tobacco Control Scale, the WHO FCTC and health systems frameworks, alcohol control policies vis-à-vis the WHO Global Strategy to Reduce Harmful Use of Alcohol (Global Alcohol Strategy hereafter) have yet to be assessed using a systems perspective [5–9].

The methods of public health law, including policy surveillance, have also been used to assess tobacco and alcohol measures, and have been invariably adopted by the WHO in monitoring international health law, including the FCTC [10, 11]. Despite the growth in comparative mechanisms, alcohol policy surveillance has yet to be institutionally adapted for the rigorous evaluation of legislation for alcohol control in any of the member states of the Association of Southeast Asian Nations (ASEAN).

The Philippines and Singapore offer case studies of two different health systems in ASEAN with recent reforms in their tobacco and alcohol control policies. While both countries face the increasing burden of NCDs and the expansion of the alcohol and tobacco industry [12], both countries offer policy lessons on alcohol and tobacco control towards the development of a regional framework for alcohol control [13].

This study aims to provide a comparative analysis of tobacco and alcohol policies in the Philippines and Singapore from a public health law and systems approach. This study offers a comparative policy surveillance framework that acknowledges the complexity of both alcohol and tobacco control and assesses countries on their progress in tobacco and alcohol control beyond demand and supply-reduction measures, by looking into the WHO health system building blocks—with particular focus on leadership and governance, financing, human resources, information, service delivery and access to essential medicines [8].

METHODS

We used a systems approach to develop a scorecard measuring the progress of the Philippines and Singapore in tobacco and alcohol control, based on the WHO's health system's six building blocks (leadership and governance, financing, human resources, information, service delivery and medical products and technologies) vis-à-vis Sustainable Development Goal 3 (Health and Well-Being) outcome indicators, the FCTC, and the Global Alcohol Strategy [14–17].

We drew on methodology from transdisciplinary public health law, particularly policy surveillance, which involves the empirical tracking of law and policies of disease, and global health law which focuses on international law and health [11, 18].

For the policy surveillance, we conducted an online document search to include official English versions of policy documents (legislation, implementing rules and subsidiary regulations and related guidelines specific to tobacco and alcohol) and reports from the websites of the WHO, websites of various Philippine and Singapore government agencies and online policy databases. Both the Philippines and Singapore use English as one of their official languages. These were cross-checked with official English versions in the Singapore Statutes Online and in the Philippines' Official Gazette available online. We supplemented this with reports in English from non-governmental organisations, corporate documents and news articles.

Additionally, we supplemented this with a review of the peer-reviewed literature in English on PubMed published from January 2009 to December 2020. Please see **Supplementary Figure S1** for the search strategy. We included articles that specifically refer to alcohol and tobacco policies in the Philippines and Singapore. We excluded epidemiological, clinical, and behavioural studies with no reference to alcohol or tobacco policies in the Philippines and Singapore.

Scorecard

We adapted the tobacco control scorecard and the indicators developed by Amul and Pang [8]. They assessed the implementation of tobacco control using the health system building blocks by assigning scores for each article in the WHO FCTC, with the highest scores (10 points) allotted for MPOWER measures which include monitoring tobacco use, protecting people from tobacco smoke, offering help to quit tobacco, warning about the dangers of tobacco, enforcing tobacco advertising, promotion and sponsorship (TAPS) bans, and raising taxes on tobacco (See **Table 1**). The scorecard incorporated indicators from the FCTC Implementation Database and the WHO Global Health Observatory.

Existing alcohol policy assessment tools focused only on five domains—physical availability, drinking context, alcohol prices, alcohol advertising and drivers of motor vehicles [19–21]. A detailed AAPS policy scorecard for Southeast Asia is also incorporated into the scorecard for alcohol control policies [12]. For the alcohol control scorecard, we incorporated indicators and also compiled policy data (where available) from the WHO Global Information System for Alcohol and Health, and the country profiles in the most recent WHO Global Status Report on Alcohol and Health [22, 23]. We assigned scores for each policy recommendation in the Global Alcohol Strategy, with the highest scores (10 points) allotted for measures in the WHO SAFER Initiative (SAFER) [24]. These policies included restrictions on alcohol availability, drink-driving countermeasures, access to screening, brief interventions and treatment, restrictions on alcohol advertising, promotion and sponsorship (AAPS), and raising alcohol prices through excise taxes and other pricing policies [24] (See **Table 2**).

To incorporate policies that go beyond the health system for implementation and enforcement including taxation, illicit trade, marketing restrictions, community action, smoke-free environments, and drunk-driving countermeasures, we adapted the concept of health system governance as a process that involves "ensuring strategic policy frameworks exist and are

TABLE 1 | Scoring framework for the tobacco control scorecard based on the World Health Organization Framework Convention on Tobacco Control according to the health system building blocks (Singapore and the Philippines, 2022)[a].

Health system building block	Framework convention on tobacco control article	Indicator	Score
Leadership and governance (65)	Article 5.1. Development, implementation, updating and review of multisectoral national tobacco control strategies	Multisectoral national tobacco control strategy	2.5
	Article 5.2. Establishing, reinforcing, financing a national coordinating mechanism or focal points for tobacco control	National coordinating mechanism or focal point for tobacco control	2.5
	Article 5.3. Protecting public health policies from the commercial and vested interests of the tobacco industry	Whole-of-government code of conduct/non-interference policy	5
	Article 6. Price and tax measures to reduce demand for tobacco	At least 75% excise tax share on final price	10
	Article 8. Protection from tobacco smoke	Compliance with regulations on smoke-free environments	10
	Article 11. Packaging and labelling of tobacco products	At least 50% of package consists of large graphic health warnings	10
	Article 12. Education, communication, training and public awareness	Anti-tobacco mass media campaigns	5
	Article 13. Tobacco advertising, promotion and sponsorship	Complete ban on direct tobacco advertising	5
		Complete ban on tobacco promotion and sponsorship	5
	Article 15. Illicit trade in tobacco products	Tracking regime to further secure the distribution system	5
	Article 16. Sales to and by minors	Sales to minors prohibited	2.5
	Article 17. Tobacco growing and support for economically viable alternatives	Viable alternatives provided to tobacco growers	2.5
Financing (10)	Article 26. Financial resources	At least USD 0.11 government expenditure on tobacco control per capita	5
		National health insurance covers cost of smoking cessation support	2.5
		National health insurance covers cost of NRT	2.5
Service delivery (10)	Article 14. Demand-reduction measures concerning tobacco dependence and cessation	Toll-free quitline/helpline	5
		Availability of smoking cessation support in any facility (primary care, hospitals, health clinics, community)	5
Information (5)	Article 20. Research, surveillance and exchange of information	Recent, representative and periodic (at intervals of five years or less) data for both adults and youth	3
	Article 21. Reporting and exchange of information	Periodic reports to the FCTC Secretariat (every two years)	2
Human resources (5)	Article 12d. Training or sensitization and awareness programmes on tobacco control for health workers, community workers, social workers, media professionals, educators, decision makers, administrators and other concerned persons	Full-time staff for tobacco control	2
		Training on tobacco control for health workers, community workers, social workers, media professionals, educators, decision makers, administrators and others	3
Medical products, vaccines and technologies (5)	Article 14.2d. Facilitating accessibility and affordability of pharmaceutical products for the treatment of tobacco dependence	Nicotine replacement therapy is in the country's essential drug list or publicly available	2
		Nicotine replacement therapy free or reimbursable	3
		Maximum score	100

[a]*This scoring framework is adapted from Amul and Pang [8] which is a modified version of the European Tobacco Control Scale and the Southeast Asia Tobacco Control Alliance Framework Convention Tobacco Control Scorecard and included indicators from the World Health Organization Report on the Global Tobacco Epidemic, the World Health Organization Global Health Observatory [8].*

combined with effective oversight, coalition-building, regulation, attention to system design and accountability" and is determined by the interaction of the State, health service providers, and citizens [25]. Additionally, we also adapted the principle of health in all policies which recognize "the policy practice of including, integrating or internalizing health in other policies that shape or influence the social determinants of health [26]".

GGA devised the scoring system based on an existing tobacco control scorecard which used the WHO health system building blocks as a framework [8]. GGA compiled the policy data from the document search and allotted the scores for each country. Based on the results of the document search for policy data, GGA generated the scores for each policy in each country based on the extracted policy data. Each indicator has allotted points and when there are policy data that meets the indicator's full scope, a full score is tabulated for that indicator. When the policy only covers a partial scope of the indicator, the tally of points scored for each partial scope is tabulated. When there is no policy for that indicator, no points are tabulated for that indicator. Total scores for both the tobacco and alcohol control scorecard range from 0 to 100. An overall score between 1 and 25 is categorized as poor, between 26 and 50 is weak, between 51 and 75 is moderate, and between 76 and 100 is strong.

Tables 1, **2** show the breakdown of the indicators and the scoring system used in this study. There were fewer data

TABLE 2 | Scoring framework for the alcohol control scorecard based on the World Health Organization Global Strategy to Reduce Harmful Use of Alcohol according to the health systems building blocks (Singapore and the Philippines, 2022)[a].

Health systems building block	World Health Organization Global Strategy to Reduce the Harmful Use of Alcohol	Indicators	Score
Leadership and Governance (73)	Alcohol control measures must be guided and formulated by public health interests and protected from industry interference and commercial interests	Whole-of-government written code of conduct or non-interference policy (*proxy indicator*)	5
	Area 1. Leadership, awareness, and commitment (15)	National, subnational strategies, plans of action and activities • Written national policy • National action plan	5
		Establishment of implementing institution or agency	0.5
		Coordination with other relevant sectors	5
		Access to information, effective education, and public awareness of alcohol-related harms	2
		Raising awareness of harm to others • Presence of awareness-raising activities	2.5
	Area 3. Community Action	Community mobilization to prevent under-age drinking and develop alcohol-free environments • National support for community action	1
	Area 4. Drink-driving policies and countermeasures	National minimum legal blood alcohol concentration when driving a vehicle	1
		sobriety checkpoints and random breath testing	1
		administrative suspension of driving licences	1
		graduated licensing for novice drivers	1
		ignition interlocks	1
		mandatory driver education, counselling, and treatment	2
		availability of alternative transportation in drinking places	1
		public awareness and information campaigns	1
		targeted mass media campaigns (youth events, holidays)	1
	Area 5. Availability of alcohol	Legislation to prevent illegal alcohol production • National control of production, import, sale, distribution and export (through government monopoly or through licensing)	3
		Legislation to prevent illegal alcohol sale	3
		Appropriate minimum age for purchase and consumption of alcohol • National legal minimum age for on-/off-premise sales of alcoholic beverages	2
		Prevent sales to intoxicated persons and those below legal age • Restrictions for on–/–off premise sales of alcoholic beverages	2
	Area 6. Marketing of alcoholic beverages (10)[a]	Regulatory frameworks based on legislation for alcohol marketing • Legally binding regulations on alcohol advertising (beer, wine, spirits) • Legally binding regulations on product placement (beer, wine, spirits) • Legally binding regulations on alcohol sponsorship (beer, wine, spirits) • Legally binding regulations on sales promotion (beer, wine, spirits)	6
		Development of public agencies for systems of surveillance of alcohol marketing	2
		Administrative and deterrence systems for infringement on marketing restrictions	2
	Area 7. Pricing policies (10)	Domestic taxation • Excise tax on beer, wine, spirits	3
		Regular price review • Inflation adjustment on alcohol taxes	3
		Price measures other than taxation • Banning of price promotions, discounts, sales below costs, flat rates for unlimited drinking and other volume sales (1) • Minimum alcohol pricing (1) • Price incentives for non-alcoholic beverages (1) • Reducing subsidies to economic operators in alcohol (1)	4
	Area 8. Reducing the negative consequences of drinking and alcohol intoxication) (7)	Regulating drinking context to minimize violence	1
		Laws against serving to intoxication and legal liabilities	1
		Management policies on server training • Systematic alcohol server training	0.5
		Reducing alcoholic strength	0.5

(Continued on following page)

TABLE 2 | (*Continued*) Scoring framework for the alcohol control scorecard based on the World Health Organization Global Strategy to Reduce Harmful Use of Alcohol according to the health systems building blocks (Singapore and the Philippines, 2022)[a].

Health systems building block	World Health Organization Global Strategy to Reduce the Harmful Use of Alcohol	Indicators	Score
		Care or shelter for severely intoxicated people	0.5
		Providing consumer information and labelling alcoholic beverages on alcohol-related harms • Legally required health warning labels on alcohol advertisements and/or on alcohol containers • Requirement to display consumer information about calories, additives, vitamins and micro-elements on the labels of alcohol containers • Number of standard alcoholic drinks displayed on containers • Alcohol content displayed on containers	3.5
	Area 9. Reducing the public health impact of illicit alcohol and informally produced alcohol (5)	Licensing regimes on production and distribution of alcoholic beverages • Legislation to prevent the illegal production of alcohol (beer, wine, spirits) • Legislation to prevent the illegal sale of alcohol (beer, wine, spirits)	2.5
		Regulation on sales of informally produced alcohol	0.5
		Control and enforcement system (tax stamps)	0.5
		Tracking and tracing systems for illicit alcohol	0.5
		Cooperation in combating illicit alcohol	0.5
		Public warnings about contaminants and health threats from informal or illicit alcohol	0.5
Health Service Delivery (10)	Area 2. Health services' response (9)	Increasing capacity for health and social welfare systems for prevention, treatment and care for alcohol use disorders	2
		Supporting initiatives for screening and brief interventions for hazardous and harmful drinking at primary health care settings & early identification and management of harmful drinking among pregnant women	2
		Improving capacity for prevention, identification and interventions for families and individuals living with foetal alcohol syndrome	1
		Coordination of integrated prevention, treatment and care strategies and services for alcohol use disorders and comorbid conditions	1
		System of registration and monitoring of alcohol-attributable mortality and morbidity with regular reporting	1
		Culturally sensitive health and social services	1
		Securing and enhancing availability, accessibility, and affordability of treatment services for groups of low socioeconomic status	1
	Area 3. Community Action	Providing community care and support for affected individuals and their families	1
Information (5)	Area 10. Monitoring and Surveillance (5)	Framework and systems for monitoring alcohol consumption, and alcohol-related harm • National monitoring system for alcohol consumption • National monitoring system for health consequences of alcohol • National monitoring system for social consequences of alcohol • National monitoring system for alcohol policy responses	2
		National entity for monitoring alcohol	0.5
		Common set of indicators for tracking harmful use of alcohol and policy responses • National surveys where alcohol is specifically addressed or part of a larger international survey	0.5
		Data repository based on internationally agreed indicators	1
		Policy evaluation mechanisms	1
Human Resources (5)	Area 3. Community Action (5)	Rapid assessment of gaps and priority areas for intervention	0.5
		Facilitating recognition of alcohol-related harms at the local level and promoting responses to local determinants	1
		Strengthening the capacity of local authorities	1
			1

(Continued on following page)

TABLE 2 | (*Continued*) Scoring framework for the alcohol control scorecard based on the World Health Organization Global Strategy to Reduce Harmful Use of Alcohol according to the health systems building blocks (Singapore and the Philippines, 2022)[a].

Health systems building block	World Health Organization Global Strategy to Reduce the Harmful Use of Alcohol	Indicators	Score
		Providing information on effective community-based interventions and building capacities at the community level Developing community programs	1.5
Financing (4)	Mobilizing resources/funding for prevention, treatment, and rehabilitation (*proxy indicators*)	Mobilizing resources/funding for prevention Mobilizing resources/funding for treatment Mobilizing resources/funding for rehabilitation	2 1 1
Access to Essential Medicines (3)	Availability of essential medicines for alcohol use disorders and alcohol dependence (*proxy indicators*)	Availability of naltrexone in the national Essential Medicines List Availability of acamprosate in the national Essential Medicines List Availability of disulfiram in the national Essential Medicines List	1 1 1
		Maximum score	100

[a]*This scoring framework used relevant indicators from the World Health Organization Global Information System for Alcohol and Health which is a component of the World Health Organization Global Health Observatory, and the World Health Organization Global Status Report on Alcohol and Health.*

TABLE 3 | Tobacco control score card for the Philippines and Singapore, based on the World Health Organization Framework Convention on Tobacco Control with the health systems building blocks as a framework (Philippines and Singapore, 2020).

Health systems building blocks	World Health Organization Framework Convention on Tobacco Control (corresponding points)	Philippines[a]	Singapore[b]
Leadership and Governance	Leadership and governance sub-total	**53**	**55.5**
	Article 5.1. Development, implementation, updating and review of multisectoral national tobacco control strategies (2.5)	2.5	2.5
	Article 5.2. Establishing, reinforcing, financing a national coordinating mechanism or focal points for tobacco control (2.5)	2.5	2.5
	Article 5.3. Protecting public health policies from the commercial and vested interests of the tobacco industry (5)	5	5
	Article 6. Price and tax measures to reduce demand for tobacco (10)	7	8
	Article 8. Protection from tobacco smoke (10)	10	5
	Article 11. Packaging and labelling of tobacco products (10)	10	10
	Article 12. Education, communication, training, and public awareness (5)	5	5
	Article 13. Tobacco advertising, promotion, and sponsorship (10)	6	10
	Article 15. Illicit trade in tobacco products (5)	5	0
	Article 16. Sales to and by minors (2.5)	2.5	2.5
	Article 17. Tobacco growing and support for economically viable alternatives (2.5)	2.5	NA
Financing	Article 26. Financial resources (10)	**3.5**	**9**
Health Service Delivery	Article 14. Demand-reduction measures concerning tobacco dependence and cessation (10)	**7**	**8**
Information	Information sub-total	**5**	**5**
	Article 20. Research, surveillance, and exchange of information (3)	3	3
	Article 21. Reporting and exchange of information (2)	2	2
Human Resources	Article 12(d). Training or sensitization and awareness programs on tobacco control for health workers, social workers, media professionals, educators, decision-makers, administrators, and other concerned persons (5)	**3.5**	**5**
Access to Essential Medicines	Article 14.2d. Facilitating accessibility and affordability of pharmaceutical products for the treatment of tobacco dependence (5)	**1.5**	**4**
Total Score[c] (100)		**73.5**	**86.5**

[a]*Scores are based on policy data from the World Health Organization Framework Convention on Tobacco Control Philippines Report 2018 and 2020 and cross-checked with reported legislation [8, 32, 33].*
[b]*Scores are based on policy data from the World Health Organization Framework Convention on Tobacco Control Singapore Report 2018 and 2020 and cross-checked with reported legislation [8, 30, 31].*
[c]*An overall score between 1 and 25 is categorized as poor, between 26 and 50 is weak, between 51 and 75 is moderate, and between 76 and 100 is strong.*
Specific subtotals and the total values are highlighted in bold.

TABLE 4 | Alcohol control score card for the Philippines and Singapore, based on the World Health Organization Global strategy to reduce the harmful use of alcohol with the health systems building blocks as a framework (Philippines and Singapore, 2020).

Health systems building blocks	WHO Global Strategy to Reduce the Harmful Use of Alcohol (corresponding points)	Philippines[a]	Singapore[a]
Leadership and governance	Leadership and governance sub-total	**26**	**34.5**
	Alcohol control measures must be guided and formulated by public health interests and protected from industry interference and commercial interests (5)	0	0
	Area 1. Leadership, awareness, and commitment (15)	5	8.5
	Area 3. Community Action (1)	0.5	0.5
	• Community mobilization to prevent under-age drinking and develop alcohol-free environments		
	Area 4. Drink-driving policies and countermeasures (10)	4	4.5
	Area 5. Availability of alcohol (10)	8	10
	Area 6. Marketing of alcoholic beverages (10) [b]	0.5	1
	Area 7. Pricing policies (10)	3	4
	Area 8. Reducing the negative consequences of drinking and alcohol intoxication) (7)	1	1.5
	Area 9. Reducing the public health impact of illicit alcohol and informally produced alcohol (5)	4	4.5
Health Service Delivery	Health service delivery sub-total	**3**	**6**
	Area 2. Health services' response (9)	3	5
	Area 3. Community Action	0	1
	• Providing community care and support for affected individuals and their families (1)		
Information	Area 10. Monitoring and Surveillance (5)	**2**	**2.5**
Human Resources	Area 3. Community Action (5)	**1**	**3.5**
	• Rapid assessment of gaps and priority areas for intervention (0.5); facilitating recognition of alcohol-related harms at the local level and promoting responses to local determinants (1); strengthening the capacity of local authorities (1); providing information on effective community-based interventions and building capacities at the community level (1); developing community programs (1.5)		
Financing	*Proxy indicator:* Mobilizing resources/funding for prevention (2), treatment (1) and rehabilitation (1)	**1**	**3**
Access to Essential Medicines	*Proxy indicator:* Availability of essential medicines for alcohol use disorders and alcohol dependence (3)	**1**	**3**
Total Score (100)[c]		**34**	**52.5**

[a]*Scores are based on policy data from the World Health Organization Global Information System on Alcohol and Health 2016 and cross-checked with relevant legislation [63].*
[b]*Index score based on Alcohol Advertising, Promotion and Sponsorship (AAPS) Policy Scorecard by Amul [12].*
[c]*An overall score between 1 and 25 is categorized as poor, between 26 and 50 is weak, between 51 and 75 is moderate, and between 76 and 100 is strong.*
Specific subtotals and the total values are highlighted in bold.

sources for alcohol control than for tobacco control, and where data is not available, we used proxy indicators for financing and access to essential medicines.

RESULTS

In the peer-reviewed literature, we found 93 articles on tobacco control and 94 articles on alcohol control in the Philippines, and 200 articles on tobacco control and 139 articles on alcohol control in Singapore. We used Endnote to compile all search results for various combinations of the search terms and removed duplicates using the 'find duplicates' function; after screening the remaining 211 titles and abstracts for articles using the specified inclusion and exclusion criteria, we retained 24 articles on Singapore and 17 articles on the Philippines for inclusion in the qualitative synthesis.

Combining results from the literature and policy data from the document search, the next section offers a snapshot of the policy framework for alcohol and tobacco control in each country, followed by a narrative synthesis based on each country's strengths and gaps in the health system building blocks, and a discussion on avenues of intervention for both countries.

Policy Framework

The Philippines and Singapore are both parties to the FCTC and both have selectively implemented some policy recommendations from the Global Alcohol Strategy [15, 16, 27]. However, both countries have yet to ratify the FCTC Protocol to Eliminate Illicit Trade in Tobacco Products (hereafter "Protocol on illicit trade"), which came into force in 2018, and they have not yet announced any plans to do so [28]. **Table 3** and the following sections show that both countries have implemented most of the WHO FCTC measures [29–32]. **Table 4** shows that both countries have implemented only a selection of recommendations from the Global Alcohol Strategy, with a particular focus on alcohol taxation and drunk-driving prevention measures [22]. Both countries implement surveillance on tobacco use; both

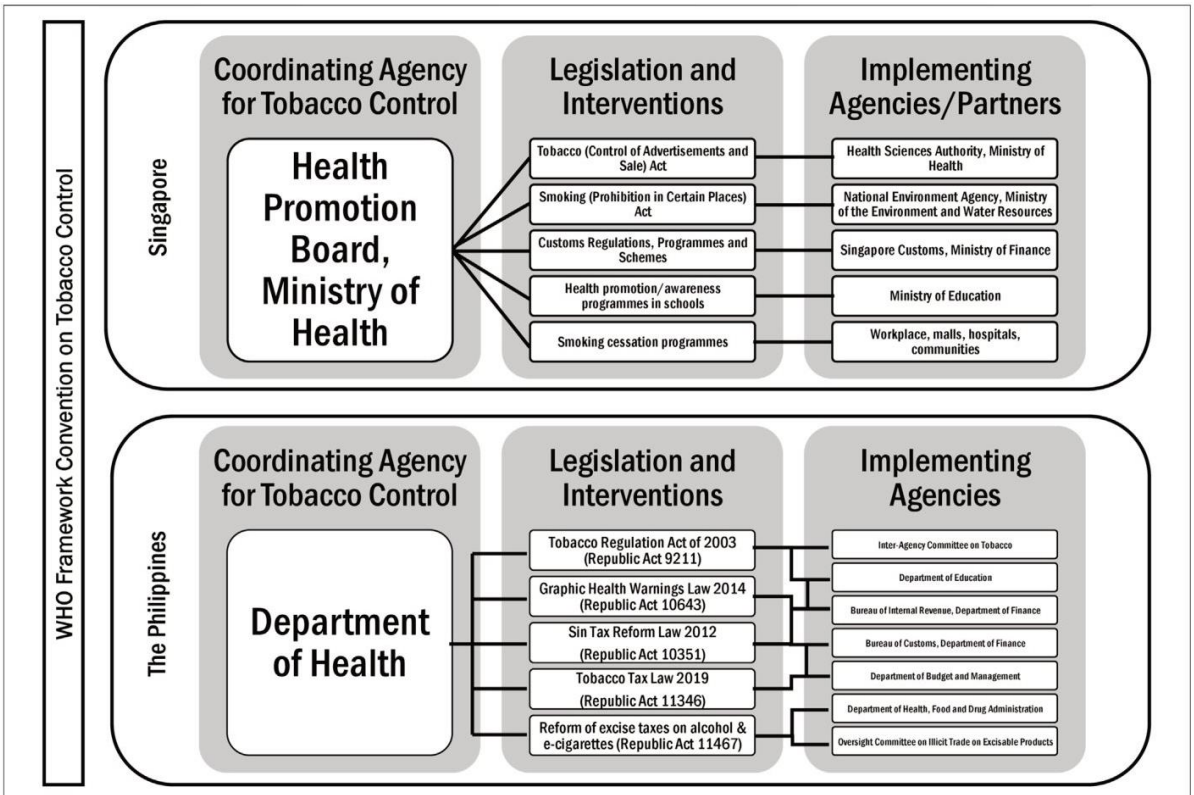

FIGURE 1 | Tobacco control in Singapore and the Philippines (Singapore and the Philippines, 2020).

participate in the Global Tobacco Surveillance System [33]. Both countries also report to the WHO for the Global Status Report on Alcohol and Health, albeit these reports show limited surveillance in both prevalence and policy [22]. **Tables 3**, **4** also show that the Philippines has strong tobacco control, but weak alcohol control. Singapore scored strongly on all health system building blocks for tobacco control but obtained moderate scores for alcohol control.

Singapore is historically a strong authoritarian state, and this translates to strong political will and leadership in terms of tobacco control, which began in the 1970s, while alcohol control has mainly been focused on price measures, including taxes and tariffs (**Supplementary Table S1**), and recently on reducing accessibility, with licensing (**Supplementary Table S3**), no-liquor zones and sale restrictions, and increasing penalties for drunk driving [34–36]. **Figure 1** presents the laws and implementing agencies that govern tobacco control policies in the Philippines and Singapore [37]. Only in the past decade did the Philippine government (particularly the Presidency) show leadership in terms of both tobacco and alcohol control, with consecutive reforms on alcohol taxation and anti-drunk driving laws (**Supplementary Tables S2, S4**) [38]. **Figure 2** shows the legislation and responsible agencies that implement the policies for alcohol control in the Philippines and Singapore [39].

Strengths in Tobacco Control

Table 3 shows that both countries score relatively high on the tobacco control scorecard, but that Singapore (86.5) scored higher than the Philippines (76.5). Singapore's strengths lie in the strict enforcement of its tobacco control policies including tobacco taxation policies, financing of health promotion, smoke-free policies, a comprehensive ban on tobacco advertising, promotion, and sponsorship (TAPS hereafter), packaging and labelling measures (standardised packaging), and access to essential medicines and therapies for tobacco cessation [37, 40] (**Table 3**). Singapore adjusts its tax rates according to inflation, and it increased its tobacco tax rate to 67.5% in 2018, while it increased alcohol tax rates to SGD88 per litre in 2014 [41]. Singapore has comprehensively banned advertising, promotion, and sponsorship of tobacco products (including e-cigarettes) [42]. Singapore has also progressively raised the minimum legal age for smoking to 21 years [43] and banned the import, distribution, sale or offer for sale of cigarette packs that contain less than

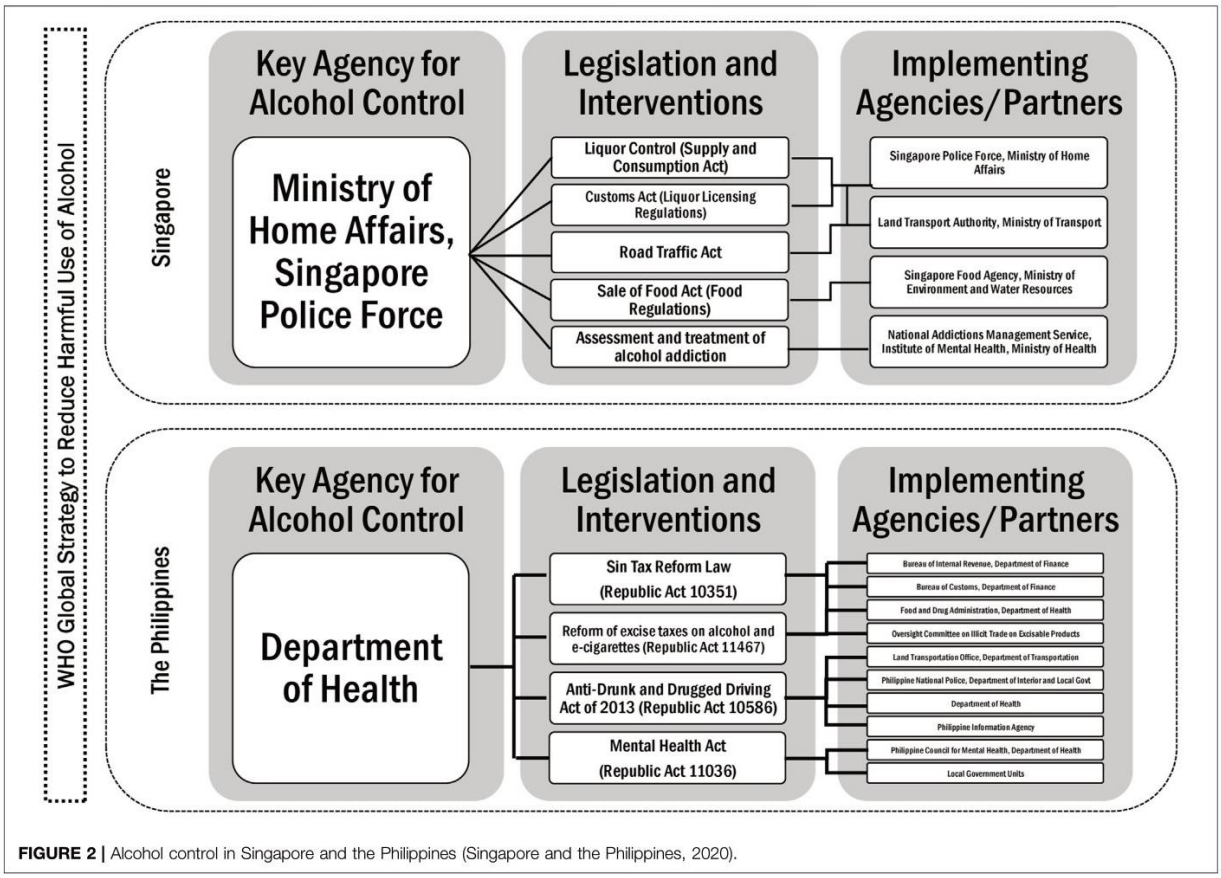

FIGURE 2 | Alcohol control in Singapore and the Philippines (Singapore and the Philippines, 2020).

20 sticks, and it does not have any duty-free concessions or goods and services tax relief for cigarettes [37, 44].

Both countries have implemented several measures in compliance with the FCTC article on illicit trade, including the Singapore Duty-Paid Cigarette (SDPC) markings and the Philippines' tax stamps under the Internal Revenue Stamps Integrated System (IRSIS) to be affixed on all unit packets of cigarettes and alcohol products in 2018 [8, 37].

Singapore also scores high in terms of access to essential medicines, and nicotine replacement therapy, bupropion and varenicline (medications to treat tobacco dependence) are part of Singapore's essential medicines list (EML), while only varenicline is part of the Philippines' EML [45, 46]. Nicotine replacement therapy is free or reimbursable through the public health sector in Singapore but not in the Philippines [8, 40]. Singapore's Health Promotion Board implements public education campaigns that complement multi-sectoral and community-based national smoking cessation programmes [47].

The Philippines' strengths in tobacco control lie in its tobacco taxation policies (**Supplementary Table S1**) and its explicit policy of protecting the public administration from tobacco industry interference [48, 49] (**Table 3**). The Philippines' recent tax reforms have set tax rates that increase every year from 2020 to 2024, after which tax rates are set to increase annually by 5% for tobacco products and 6% for alcohol products [38].

Gaps in Tobacco Control

Singapore's weakness in tobacco control lies in the lack of explicit, publicly available guidelines to protect public policies from industry interference, despite the city-state's otherwise strong anti-corruption measures. Singapore implements a "government-wide code of conduct and internal guidelines for relevant agencies' governing interaction with the tobacco industry," but there is no publicly available written policy about these guidelines [30]. Additionally, Singapore's *Prevention of Corruption Act* covers such interactions in both the public and private sectors [50].

The Philippines' key weakness in tobacco control lies in the inclusion of the tobacco industry in the Philippines' Inter-Agency Committee on Tobacco because this creates a conflict of interest. The Philippines became a party to the FCTC only after legislation established this tobacco control policy-making committee that includes the tobacco industry, which is an infringement of Article 5.3 of the FCTC that obligates the Philippines as a party to the

FCTC to protect tobacco control policies from commercial interests of the tobacco industry [51].

Additionally, both countries have weaknesses in terms of illicit tobacco trade control, and both have yet to ratify the FCTC Protocol on illicit trade. The Philippines has less comprehensive tobacco marketing restrictions, and there are still loopholes for the protection against advertising and promotion, especially at the point of sale, which the tobacco industry exploits [52]. Moreover, the Philippines still tolerates sales of single-stick cigarettes, although the law requires that cigarettes be sold in 20-cigarette packs [53]. Furthermore, the Philippines still allows duty-free concessions on tobacco products [8].

The two countries vary in their approach to electronic nicotine delivery devices (ENDS), with Singapore being comprehensively restrictive—banning emerging and alternative nicotine products, while the Philippines preferred regulation through taxation [32].

Strengths in Alcohol Control

Singapore (52.5) scored higher than the Philippines (34) on the alcohol control scorecard (**Table 4**). As shown in **Table 4**, despite a marked difference in financing capacities, the strengths of Singapore's alcohol control measures lie in an array of tax measures, licensing regime, restrictions in availability (minimum legal age, zoning, and time of sale), access to essential medicines, and drunk driving prevention measures. Singapore scores high on access to essential medicines for alcohol use disorders. The most common medications for alcohol use disorders and alcohol dependence—naltrexone, acamprosate and disulfiram are available on prescription in Singapore, but not subsidised [54, 55]. Moreover, Singapore's National Addictions Management Service offers a helpline for those seeking help with their alcohol addiction and runs an inpatient facility and treatment services for adolescents with substance abuse issues [56, 57].

As with tobacco control, the strength of the Philippines' alcohol control measures particularly lies in its alcohol taxation policy [48]. For tracking and tracing the products (a measure against illicit trade), the Philippines also requires import permits and tax stamps on imported alcoholic beverages. In 2019, to protect children, the government issued guidelines on the commercial display at point-of-sale, and on the sale, promotion, and advertising of alcoholic beverages [58]. In terms of licensing, both Singapore and the Philippines have retail licensing regimes for alcohol, but only Singapore has retail licensing regimes for both tobacco and alcohol.

Gaps in Alcohol Control

Despite the socio-economic differences between them, both countries share weaknesses in alcohol policies. First, both lack comprehensive and legally binding regulations on alcohol advertising, promotion, and sponsorship; both Singapore and the Philippines have voluntary industry measures that are known to be ineffective and thus both countries have poor scores in policies to regulate alcohol marketing [12] (**Table 4**).

Second, Singapore and the Philippines also score low on alcohol pricing policies with the lack of minimum pricing, lower pricing of non-alcoholic beverages, below-cost and volume discounts ban, or added levy on specific products. Both countries still have duty-free concessions on alcohol at 2 L per person per trip.

Third, both do not have specific and written guidelines on interaction with the alcohol industry to protect policies from commercial interests, a key element of SAFER [24]. Moreover, despite the conflict of interest, both countries' governments still engage in public-private partnerships (PPPs) with the alcohol industry and promote the alcohol industry's corporate social responsibility (CSR) programmes [12].

Fourth, **Table 4** also shows that both countries still lack measures that help inform the public about alcohol harms on alcohol product packaging and labelling. The Philippines even lacks harmonization of its alcohol labelling regulations to apply for both local and imported alcoholic beverages [12].

Fifth, the Philippines' lower scores on alcohol control can be attributed in part to the low access to essential medicines for the treatment of alcohol use disorders, as only naltrexone is listed in its EML [46].

Sixth, both countries have similarly low scores on information because of the lack of a national system for monitoring and surveillance of alcohol harms, despite having national surveys on youth and adult alcohol consumption. Singapore has a national system of epidemiological data collection for alcohol use and health service delivery, but the Philippines does not have any of the two; both do not report data from health services on alcohol use and alcohol use disorders.

Seventh, the Philippines scores low (3) in health service response to harmful alcohol use because of the slow implementation of policies which mandate prevention, treatment, and rehabilitation for alcohol use disorders at the community level [53]. There is room to enhance health service delivery for alcohol use disorders, especially with the predominant public-private referral system for treatment and rehabilitation services for alcohol addiction. In a country of about 100 million, there are only 13 private rehabilitation facilities and one government-run rehabilitation centre for alcohol dependence and alcohol addiction [59].

Finally, as a high-income economy with a developed health system, Singapore does not earmark taxes on tobacco and alcohol for prevention and control measures of these products. However, it has invested in health promotion with an average annual budget of SGD186 million (USD133 million) from 2009 to 2019 [37, 60]. On the other hand, as a lower-middle-income economy, the Philippines, with the 2019 tax reforms (**Supplementary Table S4**), has earmarked revenue from taxes on alcohol, tobacco, heated tobacco and vapour products, and sweetened alcoholic beverages to fulfil its universal health coverage goals (60%), health infrastructure development (20%), and the SDGs (20%) [48].

Earmarking tax revenue for healthcare from 2004 led to a substantive increase in the Department of Health's budget, explained by an 87.5% increase in excise tax revenue from

alcohol and tobacco from 2015 to 2019 [48, 61]. However, the Philippines still has a low score in financing tobacco and alcohol control because the taxes are not earmarked for this purpose.

DISCUSSION

In this study, we described the strengths and weaknesses of tobacco and alcohol control policies in Singapore and the Philippines, using the WHO's health system building blocks as a framework for analysis. Singapore has always considered tobacco control a critical concern for public health, but alcohol control remains primarily an issue of public order and road safety rather than a public health issue. As shown in the policy framework for alcohol control in Singapore in **Figure 2**, the key agency for alcohol control is the Singapore Police Force, not the Ministry of Health. In the Philippines, while both alcohol and tobacco control are on the public health agenda, alcohol control policies are reliant on alcohol taxes aimed at revenue generation for universal health coverage. The scorecard shows that when assessed by health system building blocks, most of the alcohol control policies in the Philippines are weak, except when recent tax reforms led to an increase in alcohol taxes earmarked for healthcare.

Various tobacco control scorecards have been used to track the implementation of the FCTC, but assessments of alcohol control policies are less comprehensive [9, 62, 63]. This study's originality lies in its use of health systems as a framework to assess alcohol control policies in two diverse countries [64].

Avenues for Intervention

The results of the health system scorecard analysis for alcohol and tobacco control suggest various avenues for intervention. First, leadership and governance are critical in tobacco and alcohol control, as the effective implementation of the FCTC and the Global Alcohol Strategy relies on concrete, legally binding and enforceable policy measures [65]. This calls for stronger engagement of various actors—intergovernmental organizations, global health networks, non-government organizations, community organizations, and the academe—to work with governments to pursue, promote and support the implementation of stronger alcohol and tobacco control policies.

Second, given the pervasiveness of self-regulation for the alcohol industry in the Philippines and Singapore and the lack of marketing restrictions, the political influence of the alcohol industry merits a better response from policymakers. This is possible and has been done in Europe and the Americas [12, 66]. This calls for policy approaches that capture the commercial determinants of health [67].

Third, a look into the global policy environment is necessary. While the FCTC requires parties to allot funding for tobacco control, there is no similar financing recommendation for the implementation of the WHO Global Alcohol Strategy. This creates a funding gap for implementing alcohol control policies, in both the Philippines and Singapore.

The two countries diverge in their approach to ENDS with prohibition in Singapore and regulation in the Philippines. While there is initially strong regulation on the minimum legal age of use of ENDS in the Philippines at 21, recent legislation lowered this age to 18, the same minimum legal age for cigarette use in the country. This stands in contrast to the minimum legal age in Singapore where the minimum legal age for the purchase, use, possession, sale, and supply of cigarettes was raised to 21 [43].

The Global Alcohol Strategy is not legally binding, but its policy recommendations are cost-effective and are included in the WHO's Best Buys for NCDs which includes alcohol and tobacco control measures [68]. These evidence-based and cost-effective measures are encapsulated in the WHO's SAFER initiative, through which the country cases were assessed in this study but have yet to be adopted and implemented globally [24].

However, governance and leadership are hindered by policymakers' lack of recognition of emerging but preventable public health issues. For example, while recent studies have pointed out the problem of binge drinking in Singapore, there have been no attempts to assess the potential of legally binding policies that can help prevent, if not minimize, the harmful effects of binge drinking, not only to the consumer but also to others around them, beyond increasing penalties for violating drunk driving regulations [69, 70]. Both countries are still hindered by a disease-based model for policymaking for NCDs instead of a risk-based public health model that is focused on disease prevention and health promotion [71].

The SDGs, the FCTC and the Global Alcohol Strategy provide a distinct policy window for further integration of disease prevention and health promotion not only in tobacco control but also in alcohol control. The relevant literature from low- and middle-income economies points out how interventions focused more on the detection and treatment of alcohol dependence rather than on harmful alcohol use, which is responsible for more alcohol-related harm, lead to delayed identification and care for harmful and hazardous drinkers [72]. Treatment gaps for alcohol use disorders even in a high-income economy like Singapore are due to delayed identification of the cases, often exacerbated by stigma [73].

An opportunity that both countries should consider is on implementing legally binding restrictions and regulations on AAPS, CSR and PPPs. There is pending legislation in the Philippines promoting and financially incentivizing CSR with no restrictions to health harmful industries, which has drawn opposition from public health advocates [74]. However, there is no robust evidence that the alcohol industry's CSR initiatives aimed at reducing harmful drinking contribute to such goals and further complicated by a conflict of interest [74–76]. Such policy blind spots increase the alcohol industry's power and influence, which are still evident even in institutions of global health governance [77].

Limitations

This study has limitations that should be considered in the interpretation of its findings. It does not attempt to comparatively assess policy outcomes, stringency or effectiveness. Moreover, this study cannot provide a basis to generalize tobacco and alcohol control policies across middle- and high-income countries because of the small number of countries that were included for comparison.

Conclusion

This study shows that using a health system-based scorecard for policy surveillance in alcohol and tobacco control can help set policy benchmarks, show the gaps and opportunities, and contribute to strengthening current policies. By using a public health law framework to assess tobacco and alcohol policies, we also identified neglected and new avenues for interventions. These opportunities include additional restrictions and regulations on alcohol marketing, financing of prevention (not just treatment) of tobacco and alcohol harms, and measures to protect policies from industry interference.

This in-depth comparative case study of two countries can be a useful framework to assess tobacco and alcohol control in other countries at various stages of economic and health system development. This study also provides opportunities for policymakers to assess a country's progress over time vis-à-vis its national health agenda and global voluntary targets.

AUTHOR CONTRIBUTIONS

GGA conceptualized and designed the study, collected, and analysed the data, and wrote the first draft of the manuscript. J-FE contributed to the critical revision of the manuscript. GGA and J-FE provided approval for the version of the manuscript submitted for publication. GGA and J-FE agree to be accountable for all aspects of the work in ensuring that questions related to the accuracy or integrity of any part of the work are appropriately investigated and resolved.

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CONFLICT OF INTEREST

The authors declare that the research was conducted in the absence of any commercial or financial relationships that could be construed as a potential conflict of interest.

SUPPLEMENTARY MATERIAL

The Supplementary Material for this article can be found online at: https://www.ssph-journal.org/articles/10.3389/ijph.2022.1605050/full#supplementary-material

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Examining the power of the alcohol and tobacco industries in policymaking: Lessons and challenges for the Philippines and Singapore

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Abstract

Aims: Transnational alcohol and tobacco corporations are expanding operations in Southeast Asia. This study has two objectives: to examine the power of the tobacco and alcohol industries in shaping tobacco and alcohol policies in the Philippines and Singapore, and to identify key lessons and challenges for alcohol and tobacco control.

Methods: We developed a conceptual framework from the literature on power and political, commercial, and legal determinants of health. We conducted a literature review and content analysis of official government documents, corporate documents, and news articles on the tactics of the alcohol and tobacco industries. To triangulate findings, we also conducted a thematic analysis of 30 interviews that we conducted in the Philippines and Singapore.

Findings: Transnational and national alcohol and tobacco corporations used various tactics to influence the policy process for alcohol and tobacco control in the Philippines and Singapore. These industries utilised lobbying, litigation or threat of litigation, revolving doors, and marketing to exercise their instrumental power. They exercised their structural power by exploiting their market dominance and promoting public-private partnerships and alcohol marketing self-regulation. In the Philippines, the tobacco industry benefitted from regulatory capture. Both industries tapped framing tactics, corporate social responsibility, and public-private partnerships to exert their discursive power.

Conclusions: Our study detailed how the alcohol and tobacco industries have exercised their instrumental, structural, and discursive power to influence and interfere in alcohol and tobacco control policies in the Philippines and Singapore. Less regulated, the alcohol industry retains an advantage over the tobacco industry in both countries.

Introduction

Scholars have used power as an analytical concept that overlies the legal, political, and commercial determinants of health to generate various conceptual and methodological frameworks for public health research (Gómez, 2022; Wood et al., 2022). Recent discourse on the legal determinants of health (LdoH) has revolved around human rights and the right to health, and the power of the law, in the framework of the UN Sustainable Development Goals on health (Gostin et al., 2019; Montel et al., 2022; Zeegers Paget & Patterson, 2020; Zweig et al., 2021). The literature on the political determinants of health (PdoH) has examined power in health systems, health policy, transnational processes and discussions of welfare states, political traditions, democracies, and globalisation (Barlow & Stuckler, 2021; Barnish et al., 2018, 2021; Gore & Parker, 2019). The discourse on the commercial determinants of health (CdoH) has focused mainly on the negative impact of corporate activities on global public health, and highlighted the need for more research from low- and middle-income economies in Asia Pacific, Latin America, and Africa (de Lacy-Vawdon & Livingstone, 2020; Gilmore et al., 2023; Maani et al., 2023; McCambridge et al., 2020; Room et al., 2022).

In Southeast Asia, there is emerging research on the legal and political determinants of health and a growing literature on the commercial determinants of health, focusing mainly on the tobacco, alcohol, food, sugar-sweetened beverages, and formula milk industries (Amul et al., 2021; Amul &

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Keywords: power, alcohol policy, tobacco policy, alcohol industry, tobacco industry

Pang, 2018b; Amul, 2022; Baker et al., 2021; Hoe et al., 2021; Huse et al., 2022; Jaichuen et al., 2018; Sohn, 2012). As transnational alcohol and tobacco industries continue to expand operations in Southeast Asia, the region offers an opportunity to examine their power in health policymaking (Amul, 2020; Amul & Pang, 2018b).

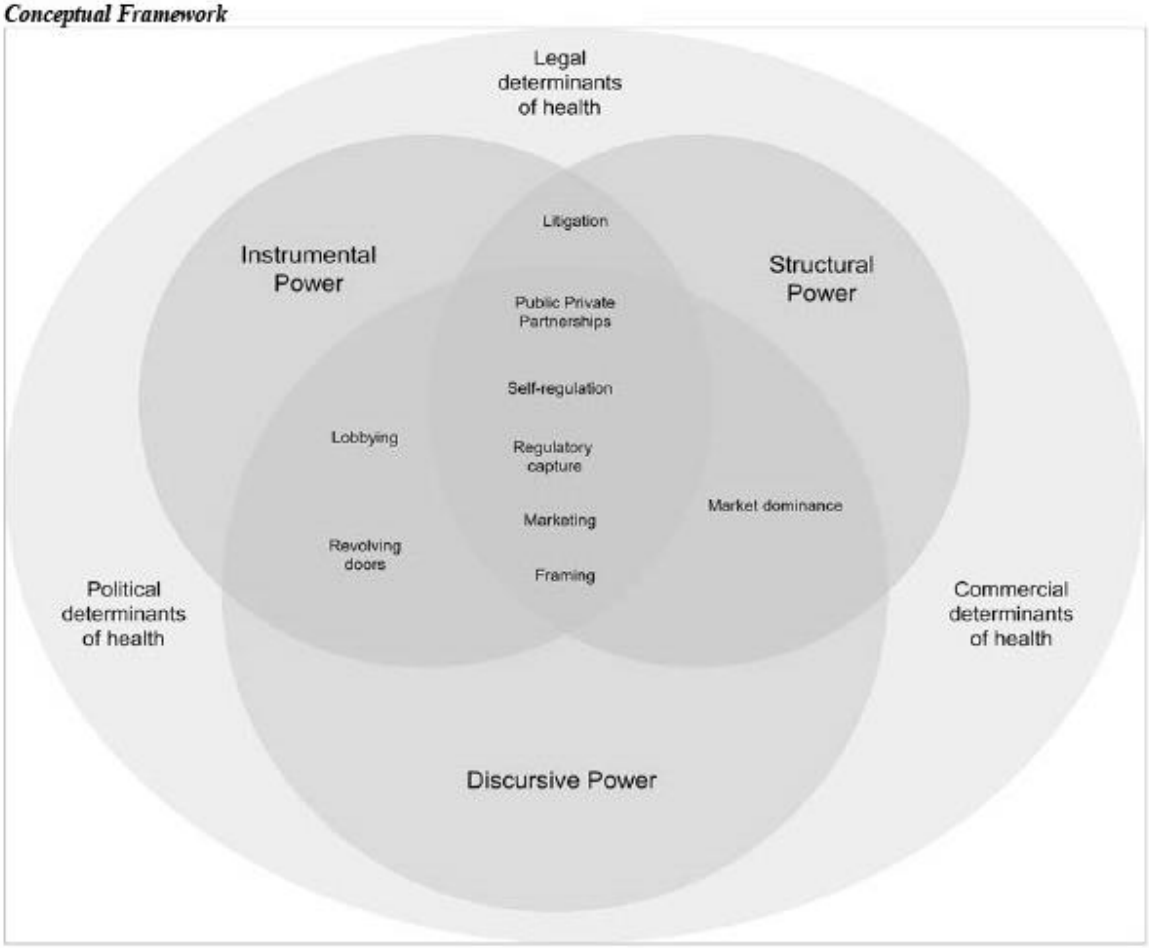
Conceptual Framework

We developed a conceptual framework derived from the political science literature and the literature on the political, legal, and commercial determinants of health (Freudenberg, 2014; Fuchs, 2007; Hay, 2002; Lee & Hawkins, 2017; Lukes, 2005; Mikler, 2018; Wilks, 2013). We used Lukes' three-dimensional view of power: decision-making (instrumental power), agenda-setting (structural power), and preference shaping (discursive power; Fuchs, 2007; Lukes, 2005; Mikler, 2018).

This framework, shown in Figure 1, highlights the types of power that the alcohol and tobacco industries have utilised to influence the policy process and the various strategies and tactics they have employed in high- and low-and-middle-income countries. In this study, we adopted the definitions in Table 1.

Figure 1

Conceptual Framework



Considering all the above, this study aims to examine the power of the tobacco and alcohol industries in shaping tobacco and alcohol policies in two Southeast Asian countries, the Philippines and Singapore. We used case studies of the actors, institutions and legislative processes shaping these policies (Gilson, 2012). We selected Singapore and the Philippines because they have recently implemented alcohol and tobacco control legislation to provide an analysis of alcohol and tobacco control in these two different countries in Southeast Asia, a high-income country and a lower middle-income country, with different histories, political and health care systems, and distinct levels of human and economic development (Amul & Etter, 2022; Koh, 2020; Severino & Salazar, 2007). Additionally, one of the authors (GGA) is a citizen of the Philippines, was a health policy researcher in Singapore, and had access to the tobacco and alcohol control community in these countries (See Reflexivity Statement in the Appendix).

Using policy cases in the Philippines and Singapore, we sought to answer two research questions. First, what kinds of power and tactics do corporate actors exercise in the policy process for alcohol and tobacco control in the Philippines and Singapore? Second, what are the key lessons and challenges for alcohol and tobacco control in the Philippines and Singapore? These policy cases offer an in-depth examination of policymaking where the alcohol and tobacco industries exercise their influence as policy actors through various tactics in different policy environments.

Table 1

Conceptual Framework

Concept	Definition
Power	The ability of actors to successfully pursue a desired political objective
Instrumental power	Coercive power that corporate actors use to achieve trade and investment liberalisation and expand global markets through direct lobbying, public relations, and revolving doors (Fuchs, 2007; Mikler, 2018)
Structural power	Agenda-setting power used by corporate actors to maintain an underlying control of processes and resources through size and market dominance and domination of trade and investment relations (Fuchs, 2007; Mikler, 2018)
Discursive power	Co-opting or 'hegemonic' power in pursuit of legitimacy achieved through non-market strategies, including corporate social responsibility programmes and promotion of self-regulation that creates a system of values and norms (Eastmure et al., 2020; Fuchs, 2007; Mikler, 2018; Wilks, 2013)
Commercial determinants of health	"the social, political, and economic structures, norms, rules, and practices by which business activities designed to generate profits and increase market share influence patterns of health, disease, injury, disability, and death within and across populations" (Freudenberg et al., 2021). The World Health Organization defined CDoH as the "conditions, actions and omissions by corporate actors" that can have "beneficial or detrimental impacts on health" (World Health Organization, 2021).
Legal determinants of health	Legal instruments such as statutes, treaties, and regulations that express public policy, as well as the public institutions (e.g., courts, legislatures, and agencies) responsible for creating, implementing, and interpreting the law – the rules and frameworks that shape all the social determinants of health; refers to the power of law to address the underlying social and economic causes of injury and disease and how the law can substantially influence health and equity (Gostin et al., 2019)
Political determinants of health	The transnational norms, policies and practices arising from political interaction across all sectors affect health outcomes (Ottersen et al., 2014). It involves analysing different power constellations, institutions, processes, interests, and ideological positions that impact health across different political systems, cultures and levels of governance (Kickbusch, 2015).

Methods

To triangulate our findings, increase the validity of our results and reduce bias, we combined various qualitative data collection strategies that have been used to study corporations and health policy, including a literature review, document analysis, and in-depth interviews (Lee & Hawkins, 2017; Dalglish et al., 2021).

Literature Review, Document Collection, Data Extraction and Analysis

We searched Google Scholar and PubMed for review articles and recent systematic reviews (from 2017 to 2022) on power and the legal, political, and commercial determinants of health. We also downloaded relevant documents from government, corporate and media websites to analyse the roles of policy actors in tobacco and alcohol policies in the Philippines and Singapore (Lee & Hawkins, 2017). Table 2 shows the search terms used, the types of documents, the types of extracted data, and the period the search covers. All documents collected were in English (an official language in both countries). For analysis, we used the READ approach for health policy research: (a) ready materials; (b) extract data; (c) analyse data; and (d) distil findings (Dalglish et al., 2021).

Qualitative In-depth Interviews and Thematic Analysis

To explore the kinds of power exercised by the alcohol and tobacco industries, GGA conducted qualitative in-depth interviews with 30 participants recruited through a purposive and snowball sample of policy actors working on alcohol and tobacco control in Singapore and the Philippines from October 2019 to August 2022 (Lee & Hawkins, 2017). See Table 3 and Supplementary Material for more details. We developed a study protocol, which included an interview guide and an informed consent form. The interview guide was broad, and the specific questions asked depended on the official role or affiliation of the interviewee. Points of

inquiry included but were not limited to (a) their perception of progress in alcohol or tobacco control policies in the country; (b) their insights on the role of the alcohol or the tobacco industry in the policy process; and (c) their experience with the policy process for tobacco or alcohol control.

Table 2

Literature Search, Document Collection, Data Extraction and Search Terms used

Type of document	Data extracted	Search terms	Period covered
Research literature: Screening: included articles that mention political, legal, or commercial determinants of health in their main text; excluded articles that do not mention the tobacco industry or the alcohol industry, or the Philippines or Singapore	• Type of power exercised by the tobacco and alcohol industry (if identified) • Strategies and tactics of the tobacco and alcohol industry (including examples from the Philippines or Singapore)	"power" AND "tobacco industry" OR "alcohol industry" AND "determinants of health" AND "Singapore" OR "Philippines	2017 to 2022 To ensure that we did not exclude key research literature, we conducted a citation search to include systematic reviews cited in the articles. We also included CDoH literature published in 2023.
Corporate: Annual reports from tobacco and alcohol companies with at least a 5% market share based on Euromonitor data (Amul, 2020; Amul & Pang, 2018b).	• Annual profits • Mergers and acquisitions • Marketing expenses • Any reference to alcohol or tobacco policies • Press releases about alcohol or tobacco policies	• Regulat* • Sin tax • Tobacco tax • Alcohol tax • Liquor tax • E-cigarette tax • Liquor control • Plain packaging • Standardised packaging	2017 to 2021
Corporate: Corporate Social Responsibility or Sustainability reports	• Types of corporate social responsibility activities • Objectives of corporate social responsibility activities • Target beneficiaries of corporate social responsibility activities	• SDG • Health	2017 to 2021
Government documents	• Legislative proceedings o Congressional Records and Senate Journals in the Philippines o Official Reports from the Parliamentary Debates in Singapore • Court decisions specific to tobacco litigation from the CTFK Tobacco Control Laws website for each country (Campaign for Tobacco-Free Kids, 2022) • Speeches, government reports or webpages and press releases that refer to specific tobacco and alcohol policies included in each country case study	• Tobacco • Cigarettes • Alcohol • Liquor • Sin tax	• 22 July 2019 to 1 June 2022 (Philippines 18th Congress) • 10 October 2011 to 25 August 2015 (Singapore 12th Parliament)) • 15 January 2016 to 23 June 2020 (Singapore 13th Parliament)
Media: News articles	• Industry statements on policies • Coverage of corporate social responsibility activities	• Sin tax • Tobacco tax • Alcohol tax • Liquor tax • Liquor control	• 2015 to 2022 (Singapore) • 2019 to 2022 (Philippines)

GGA conducted 10 in-person interviews from October to December 2019 in Singapore, seven virtual (Zoom) interviews with respondents from Singapore, and 13 virtual interviews with respondents from the Philippines from January 2020 to August 2022. GGA transcribed and thematically coded all recorded interviews and interview memos using *Atlas.ti*. GGA anonymised all interview transcripts to only refer to interviewees by their general affiliations. GGA sent each interviewee a transcript for their review and validation. See the Supplementary Material for details.

GGA processed the interviews using a reflexive approach to thematic analysis: (a) data familiarisation; (b) systematic coding and re-coding; (c) generating initial themes; (d) developing and reviewing themes; (e) refining, defining, and naming themes; and (f) writing the analysis (Braun & Clarke, 2022). GGA coded the interviews using induction

(data-driven) and deduction (theory or framework-driven) at both semantic and latent levels (Braun & Clarke, 2022). GGA generated initial or candidate themes from the final set of codes and developed and reviewed themes using coded extracts from the interviews (Braun & Clarke, 2022). We integrated the thematic analysis into a narrative synthesis.

Ethics

The National University of Singapore Institutional Review Board (IRB) approved the study protocol on 27 September 2019 (IRB Reference Number S-19-279) for the interviews conducted in Singapore. The National Ethics Committee (NEC) in the Philippines approved the study protocol on 11 November 2019 (NEC Code 019-016-Amul-EXIIT) for the interviews conducted in the Philippines.

Results

Research Literature, Government and Corporate Documents

The literature search produced 14 review articles in PubMed and 27 review articles in Google Scholar. After screening their titles, reading their abstracts, and deleting irrelevant studies and duplicates, we reduced the list to 12 articles. The citation search enabled us to add nine review articles and two Lancet-commissioned articles. We also added one book on CDoH and a series of articles published in 2023 by the Lancet Commission on CDoH. We integrated the literature search results on the kinds of power, strategies and tactics exercised by corporate actors into the narrative synthesis (Supplementary Table 1).

In addition, we downloaded a total of 249 documents: including 117 relevant documents from government websites in the Philippines and Singapore and 132 corporate documents (Supplementary Table 3). Supplementary Table 3 also indicates the type of documents downloaded and the search terms used. For the initial stage of the thematic analysis, we adopted the list of themes from a previous analysis of public consultation submissions from corporate actors (Amul, 2022).

Interviews

GGA conducted 29 interviews with 30 people, 13 from the Philippines and 17 from Singapore. To ensure the confidentiality and privacy of the interviews, we anonymised all interview transcripts and memos. Table 3 provides the anonymised interviewee profiles. Figure 2 shows a theme map from the thematic analysis. Relevant extracts from the interviews are incorporated in Supplementary Tables 4-6.

Kinds of Power, Strategies and Tactics

The following section offers a narrative synthesis of the types of power exercised by the alcohol and tobacco industries and the political activities that the alcohol and tobacco industries used to exercise power in the Philippines and Singapore, based on an analysis of the documents we collected and of the interviews we conducted.

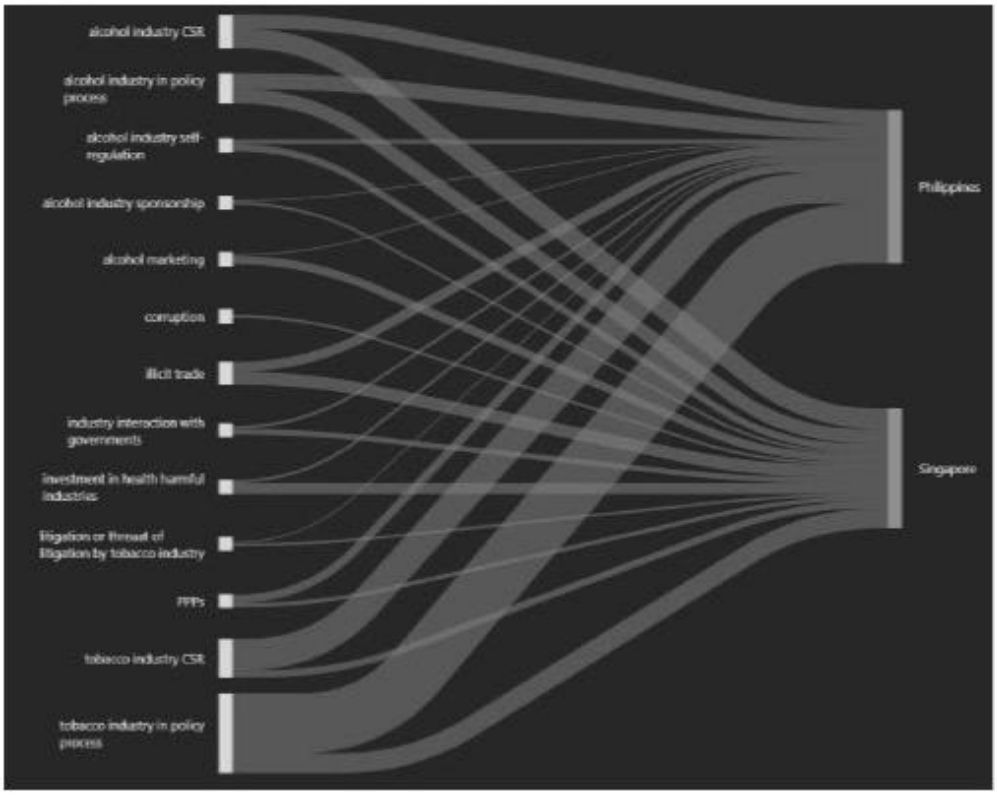
Table 3

Profile of Anonymised Interviewees

Country	Anonymised profile[a] of interviewees[b]	Number of interviewees[c]
Philippines	Government officials	3
	Representative of a non-governmental organisation	4
	Representative of a patient advocacy organisation	1
	A leader of a community organisation	1
	Representative of an intergovernmental organisation	1
	Public health practitioner	1
	Health policy advocate	1
	Researcher	1
	Subtotal	**13**
Singapore	Government officials	3
	Tobacco control advocate	2
	Harm reduction advocate	1
	Mental healthcare professional	1
	Healthcare professional and tobacco-free generation advocate	1
	Local non-governmental organisation	1
	Representative of a business association	1
	Academic	6
	Public health researcher	1
	Subtotal	**17**
	Total	**30**

Figure 2

Theme Map based on Thematic Analysis of Interviews



Instrumental Power

In CDoH discourse, instrumental power refers to political mobilisation through corporate political activities such as lobbying, litigation, revolving doors, marketing, and participation in the legislative process (Fuchs, 2007; McCambridge et al., 2020; Mialon et al., 2020; Ulucanlar et al., 2016). See Supplementary Table 4 for examples.

Lobbying. Lobbying has long been a critical tobacco industry tactic to block, delay or weaken tobacco control policies in the Philippines, particularly tobacco taxes and graphic health warnings on cigarette packs (Amul et al., 2021). While less documented in the research literature, the alcohol industry has also used lobbying to influence alcohol policy in the Philippines. See Supplementary Table 4 for tobacco and alcohol lobbying activities. Public hearings in the Philippine Congress and public consultations on proposed policies in Singapore have provided the tobacco and alcohol industries with lobbying opportunities to exercise their instrumental power, promote their interests and weaken, delay, or stop policies from being implemented. Lobbying by the tobacco industry and its allies was evident in the public consultation process for plain cigarette packaging in Singapore (Amul, 2022).

Litigation or threat of litigation. The Philippine Tobacco Institute (PTI) is the private entity representing the tobacco industry in the Inter-Agency Committee – Tobacco (IACT). Since 2003, this Institute has had a history of litigation against government entities, particularly the Philippines' Department of Health, which is also a member of the IACT (Campaign for Tobacco-Free Kids, 2022). Supplementary Table 4 shows details of these legal challenges. In most cases, the local courts ruled in favour of the tobacco industry (Campaign for Tobacco-Free Kids, 2022). In the Philippines, the alcohol industry also has a history of using litigation to stop the implementation of higher alcohol taxes and to claim excise tax refunds on erroneous tax assessments (See Supplementary Table 4). In Singapore, the introduction of plain packaging in 2020 has not been met with litigation, even though the tobacco industry and its allies had threatened to do so during the public consultation process (Amul, 2022).

Revolving doors. The revolving door between governments and corporations is also an essential strategy for alcohol and tobacco companies to influence policy. The recruitment of former and, in some cases, current government officials on the boards of tobacco and alcohol companies and their corporate social responsibility (CSR) arms in the Philippines and Singapore ensures that their instrumental power can reach back into these officials' networks within the government. See Supplementary Table 2.

Marketing. The lack of marketing regulations allows the alcohol industry in the Philippines and Singapore to invest heavily in aggressive marketing practices. Even during the COVID-19 pandemic lockdowns, the alcohol industry spent billions of pesos on alcohol advertising, promotion, and sponsorship in the Philippines. See Supplementary Figure 1 for marketing expenses by alcohol companies in the Philippines. While Singapore has comprehensively banned tobacco advertising, promotion, and sponsorship (TAPS), the Philippines still allows point-of-sale marketing of tobacco products (Amul & Pang, 2018b). The tobacco industry in the Philippines has been documented to use policy loopholes to circumvent TAPS regulations (Amul et al., 2021).

Structural Power

Structural power manifests in these industries' ability to acquire private authority and private governance through market dominance, self-regulation, public-private partnerships (PPPs), and regulatory capture (Fuchs, 2007; Mikler, 2018). See Supplementary Table 5 for examples.

Market dominance. The alcohol and tobacco industries' structural power is tied to their resources, particularly the economic power of the transnational tobacco and alcohol corporations that have expanded operations through joint ventures, mergers and acquisitions in the Philippines and Singapore (Amul, 2020). The alcohol and tobacco industries supported and benefitted from the Philippines' corporate income tax reforms that have reduced corporate income tax rates since 2021. See Supplementary Table 5 for details. In Singapore, Heineken's Asia Pacific Breweries, the only large-scale brewery in the city-state, has used its market dominance with its outlet-exclusivity practices (Competition Commission of Singapore, 2015).

Public-private partnerships (PPPs). PPPs are "reputational management practices" by the tobacco and alcohol industries through initiatives that enhance their corporate image, legitimacy, and credibility (Gilmore et al., 2023). Although Article 5.3 of WHO's Framework Convention for Tobacco Control mandates that health policies should be protected from the tobacco industry's influence, the tobacco industry engages in PPPs in the Philippines and Singapore. For instance, the industry cooperates with public agencies to tackle the illicit tobacco trade. The industry also participates in joint monitoring programs with agencies under the Philippines' Department of Finance and reports illicit trade intelligence to Singapore Customs (Lucio Tan Group, 2020, 2021).

Regulatory capture. The Department of Health in the Philippines continuously grapples with the tobacco industry's structural power, particularly because this industry has representation in the Inter-Agency Committee on Tobacco (IACT). This committee is supposed to be a tobacco control body, but the participation of the industry undermines its actions (Lencucha et al., 2015). Regulatory capture with tobacco industry representation in a policymaking body has historically complicated the policy process for tobacco control in the Philippines (Lencucha et al., 2015). The structural power of the tobacco industry, coupled with the complicated history of laws to regulate e-cigarettes and heated tobacco products in the Philippines, has resulted in the Department of Health and the Department of Trade and Industry competing over the regulation of these products, which caused delays in implementation (Solidum et al., 2022).

Self-regulation. The current absence of alcohol marketing regulations in Singapore and the Philippines, and the lack of civil society monitoring, also translates into a more powerful industry unimpeded by marketing regulations (Amul, 2020). Self-regulation of the alcohol industry's advertising in the Philippines and Singapore provides good cases of co-option, where the private sector, including the alcohol industry and advertising agencies, media associations, and recently e-commerce platforms, set the terms of their self-regulation. Alcohol companies promote voluntary codes of conduct for alcohol marketing in the Philippines and Singapore to avoid statutory regulation (Amul, 2020; Supplementary Table 5). In addition to voluntary codes of conduct, alcohol companies have also utilised voluntary pledges to prevent minors from accessing alcohol products online and to promote responsible drinking in virtual drinking sessions through a social media campaign to avoid regulation during COVID-19 lockdowns (Malasig, 2021). Promoting self-regulation has been a tactic of the alcohol industry to delay regulation (Yoon & Lam, 2013).

Discursive Power

The exercise of discursive power by the alcohol and tobacco industries in the Philippines and Singapore is evident in their policy substitution practices, public relations campaigns for their corporate social responsibility initiatives, and public-private partnerships (Amul et al., 2021). These industries exploit traditional and social media's reach to develop policies and promote societal norms and ideas that legitimise their role as political actors (Fuchs, 2007). See Supplementary Table 6 for examples.

Framing. The tobacco and alcohol industries' corporate political activities (e.g., participation in public consultations and invitations to public hearings) have legitimised their role as political actors (Savell et al., 2016; Wilks, 2013). There was almost universal consensus among interviewees about the tobacco industry's political activities in the Philippines and Singapore. However, there was a divergence among academics and public health researchers about the alcohol industry's activities. Such discursive power enables the alcohol industry to be viewed positively compared to the tobacco industry. See details and excerpts from interviews in Supplementary Table 6. It is a common strategy for the alcohol industry to collaborate and create interest groups to lobby for their interests locally, regionally, and globally. Through these interest groups (e.g., business associations and public relations organisations), the alcohol industry lobbies and promotes voluntary measures and the image of a "responsible" industry that does not require regulation (Amul, 2020; Savell et al., 2016).

Corporate social responsibility initiatives. The tobacco and alcohol industries also exercise discursive power by strategically marketing their corporate social responsibility (CSR) initiatives (Amul, 2020; Amul et al., 2021; Marten et al., 2020). These initiatives aimed to provide a framework for promoting the tobacco and alcohol industry's "good corporate citizenship" in the Philippines before and during the COVID-19 pandemic. Before COVID-19, tobacco and alcohol companies in the Philippines invoked the Sustainable Development Goals in their CSR initiatives through their corporate foundations. These CSR activities involved interactions with government agencies, government officials, civil society organisations, and the private sector. (See Supplementary Table 2 for pre-COVID-19 CSR activities). The alcohol and tobacco industries' CSR activities during the pandemic allowed them to promote themselves as altruistic and socially responsible corporations in traditional mass media and social media (Bueno, 2021; Reyes, 2020).

Public-private partnerships. The discursive power of the alcohol industry is also evident in the public-private partnerships for "home-grown" branding in the Philippines for San Miguel Beer and Singapore for Tiger Beer in national and global marketing campaigns (CNN Philippines Life Staff, 2017; Heineken, 2023). These companies' histories and brands are deeply embedded in each country's colonial history, culture, and society (Amul, 2020).

Discussion

Lessons and Challenges for Alcohol and Tobacco Control in the Philippines and Singapore

We derived three lessons and challenges for alcohol and tobacco control in the Philippines and Singapore from the thematic analysis of the interviews and documents (See Supplementary Table 7). First, it is necessary to understand the political determinants of health in each context. These determinants include the political system, the political dynamics, the external and internal drivers for policy reform, the presence of policy champions, policy windows, and advocacy coalitions. Second, it is essential to harness the legal determinants of health by using global, regional, national, and intersectoral norms and laws for health governance. Third, it is necessary to tackle the commercial determinants of health through counter-marketing tactics and active monitoring of the political activities and tactics of the industry.

Singapore is consistently ranked as the least corrupt country in the region, while the Philippines is one of the most corrupt countries worldwide (Transparency International, 2023). The Philippines and Singapore operate on different political systems and are at different stages of health system development (Amul & Etter, 2022). In terms of power asymmetry, however, the Philippines and Singapore show similarities regarding the government's prioritisation of economic goals over public health goals and the value of industries, including the tobacco and alcohol industries.

For a long time, strong presidents have dominated Philippine politics (Abinales & Amoroso, 2017; Thompson, 2014). Patronage politics and an institutionally weak and corrupt state define government interactions with strategic interest groups. These groups heavily influence political dynamics among policy actors – and in this study, the private sector particularly, and the alcohol and tobacco industries specifically (Abinales & Amoroso, 2017; Thompson, 2014). The alcohol and tobacco industries continuously exercise their instrumental and structural power to define and set the political agenda. Various policy actors project their discursive power to advocate and develop policies that contribute to achieving public finance and health objectives. In the Philippines, multisectoral action by various policy actors was critical for the alcohol and tobacco tax reforms. First, the joint efforts of the Department of Health and the Department of Finance promoted universal healthcare coverage through earmarked alcohol and tobacco taxes. Second, the Sin Tax Coalition, an alliance of organisations and health advocates, campaigned and supported advocacy for health tax reforms (Philippine Health Insurance Corporation, 2019). Third, legislative champions for the health tax reforms in both houses of Congress were willing to oppose pro-industry legislators. The President's statement of urgency for the bill to be passed by Congress into law ultimately provided the policy window for the health tax reforms (National Economic and Development Authority, 2022; See Supplementary Note on the legislative process in the Philippines). Financing universal healthcare complements the Philippines' commitments to the Sustainable Development Goals – a common ambition supported by all policy actors. The reforms of the excise taxes on tobacco, alcohol and e-cigarettes led to the implementation of earmarked tax revenues for universal health care financing (Amul & Etter, 2022). Lobbying and bargaining dominated the policy process – a common strategy in Philippine politics to reach a policy consensus (Caoili, 2006).

In contrast, Singapore's distinct parliamentary system benefits from a high level of legitimacy, with a prime minister as head of government and an elected president as head of State, and with a dominant political party that has driven exceptional economic growth (Tan, 2018). Proposed tobacco and alcohol policies, while debated in the Singapore Parliament, are often unimpeded because of a depoliticised civil society (Tan, 2018; Woo, 2015). Tobacco control advocacy in Singapore rests mainly on the government, and no civil society organisation is active in alcohol control (Amul & Etter, 2022). Singapore's meritocratic system is part of the dominant party's ideology, shaped by its version of democratic politics and paternalistic authority (Woo, 2015). For example, compared with other democratic states, statutory (or regulatory) boards and government-linked companies (GLCs) in Singapore are more engaged in the policy process, from formulation to implementation (Woo, 2015). Singapore's varied but consistent approach to tobacco and alcohol control, and the framing by different policy actors, can influence the policy agenda and move it away from the public health agenda.

Alcohol and tobacco policy reviews in Singapore and the Philippines show how stringent or lax these countries can be regarding alcohol and tobacco control (Amul & Pang, 2018b; Amul, 2020). The legal environment in the

Philippines still allows the alcohol industry to exercise its instrumental, structural, and discursive power, which promotes regulatory or legislative capture (Brown, 2019; Liberman, 2014). For example, the Philippines and Singapore do not regulate alcohol advertising, promotion, and sponsorship through regulatory laws (i.e., laws passed by the executive or judiciary) nor through statutory law (i.e., laws passed by the legislature; Amul, 2020).

However, the legal environment is less enabling for the tobacco industry. Before introducing plain packaging for cigarettes, Singapore had already comprehensively banned tobacco advertising, promotion and sponsorship, and the display of tobacco products at point-of-sale (Amul & Pang, 2018a). An analysis of the process leading to the adoption of Singapore's plain packaging policy exemplifies the global city-state status of Singapore – with contributions from local, regional, and international actors highlighting how the perceived power of the Singapore model shapes the city-state's role in regional and global health governance (Amul, 2022). In the Philippines, the Tobacco Regulation Act, which established the IACT in 2003, was implemented before the Philippines ratified the WHO Framework Convention on Tobacco Control (FCTC) in 2005. This precedence complicated the political dynamics of FCTC implementation (Lencucha et al., 2015).

Governments incur legal costs when the industry legally challenges governmental agencies because of bureaucratic errors. In the Philippines, the alcohol industry's history of litigation on erroneous tax assessments highlights the bureaucratic inefficiencies of the tax increases. There is a risk that the alcohol industry will use such inefficiencies to oppose future tax reforms. The government similarly incurs costs when it takes legal action against the industry for violating its laws, even when it is a legal action to enforce compliance (Campaign for Tobacco-Free Kids, 2014).

Implications

We compared how the alcohol and tobacco industries exercise their instrumental, structural, and discursive power to shape the alcohol and tobacco policies in the Philippines and Singapore. The study supports the validity and analytical utility of our theoretical framework based on power to study transnational alcohol and tobacco corporations and alcohol and tobacco policies in high-income and low-and middle-income countries (Butler et al., 2017; Elliot et al., 2022; Fuchs, 2007; Hawkins, 2017; Hird et al., 2022; Holden & Lee, 2009; Maani et al., 2023; Mikler, 2018; Wilks, 2013). Our findings are congruent with previous research on the tobacco industry's efforts to frame itself as a vital economic actor, reinforcing its market dominance and political power in the Philippines (Fitzpatrick et al., 2022).

The alcohol industry demonstrably impacted the alcohol control policy processes in both countries using its instrumental, structural, and discursive power. The industry exercised its power strategically through the various tactics documented in this study. Researchers have also observed over the past decade that these power dynamics have influenced how the Philippine government has addressed non-communicable diseases through fiscal reforms aimed at "balancing" health and commercial interests (Kaiser et al., 2016; Lencucha et al., 2015; Chavez et al., 2014). Previous research has also shown that the pluralistic nature of politics in the Philippines influences the political dynamics of health tax reforms. In the case of the tobacco, alcohol and e-cigarette tax reforms, previous research showed how multisectoral collective action shaped policy development (Chavez et al., 2014; Elliot et al., 2022; Hoe et al., 2022a; Rasanathan et al., 2017).

Our results on the experiences of the Philippines and Singapore in formulating and implementing tobacco and alcohol control policies are consistent with previous research on CDoH in at least three ways. First, other researchers also found that the focus on health can be a unifying factor in the cases of earmarked taxes for universal health care in the Philippines and the plain packaging of tobacco products in Singapore (Elliott et al., 2020; Hoe et al., 2021; Kaiser et al., 2016). Second, the influence of global tobacco and alcohol governance laws and norms on national and local public health policy is well documented in the literature (Barlow & Stuckler, 2021; Gostin et al., 2019; Lee & Hawkins, 2017). Third, researchers have also documented how a political and economic agenda can strengthen or weaken the public health agenda, depending on the context (Chavez et al., 2014).

We found that while the Philippines have strong tobacco and alcohol industries, its level of industry interference differs from that of Singapore, with direct industry interference in the Philippines but a less implicit history of interference in tobacco and alcohol control in Singapore (Amul et al., 2021; van der Eijk & Tan, 2023). This finding is consistent with previous research on the alcohol industry's "privileged" participation in policymaking and implementation (Hoe et al., 2022b).

We identified two related policy challenges: the lack of regulation of alcohol marketing in traditional and social media, and the dearth of civil society organisations working on alcohol control in both countries, and this result is congruent with what other studies found (Amul, 2020; Amul & Etter, 2022). Our results show that self-regulation and public- and private-private partnerships are critical for the alcohol and tobacco industry. However, previous research found no evidence for the effectiveness or safety of industry self-regulation, public-private partnerships, or private-private partnerships (Moodie et al., 2013).

While other authors showed that there is a potential for intersectoral governance in tackling CDoH without treaties (Allen et al., 2021; McHardy, 2021), this study's insights from the Philippines demonstrate that international legal frameworks and legal support are indispensable for low- and middle-income countries. The WHO FCTC, for example, provides a guide for intersectoral governance and a policy window for national policymakers and advocacy coalitions. However, the Philippines has also been limited by pre-FCTC legislation, which enables the tobacco industry to be involved in a tobacco control policy body.

Finally, we found relatively few relevant published papers focusing on low-and middle-income countries in the Asia Pacific, and this is in line with recent calls from the global

policy and research community for increased funding for alcohol control and alcohol policy research in low- and middle-income countries (Griswold et al., 2018; McCambridge et al., 2020; Parry & Amul, 2022; Room et al., 2022; World Health Organization, 2022).

Strengths and Limitations

As of writing, this is the first study to systematically examine and compare the power of the alcohol and tobacco industries in two countries in Southeast Asia that can be useful not only for policymakers but also for civil society advocacy. Originality, timeliness, and usefulness are strengths of this study. However, caution must be taken in considering the generalisability of the findings of this qualitative study. The document analysis was limited to publicly available data. We tried to maximise the validity by triangulating publicly available data from official and corporate documents with insights from interviews with policy actors and results from previous research on the alcohol and tobacco industries. We conducted a limited number of interviews with officials outside the public health sector and representatives from the private sector in the Philippines. We tried to address this limitation by triangulating insights from interviews on corporate activities from other policy actors, news coverage and legislative proceedings.

Conclusion

Our study detailed how the alcohol and tobacco industries have exercised their instrumental, structural, and discursive power to influence and interfere in alcohol and tobacco control policies in the Philippines and Singapore. Less regulated, the alcohol industry retains an advantage over the tobacco industry in both countries. Despite political, economic and health system development differences, both countries share similar challenges in alcohol and tobacco control. To counter the industries' power over health policy, (1) researchers and civil society organisations should support the development of mechanisms that help policymakers to prioritize health over commercial interests and manage conflicts of interest that emanate from power asymmetries within countries and between governments and corporations; and (2) governments, intergovernmental organisations, and civil society organisations should collaborate to monitor the alcohol and tobacco industries' tactics and to raise public awareness about their political strategies.

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General Conclusions and Perspectives

This chapter begins with a summary of the key findings from each study, followed by an interpretation of the results and the implications of the study, along with an overview of the limitations and strengths of the PhD project. It concludes with recommendations for policy and research.

Summary of key findings

First, developing the policy scorecards helped systematically compare alcohol and tobacco control policies in the Philippines and Singapore. Using the scorecards helped identify the strengths and gaps in alcohol and tobacco control in the Philippines and Singapore. The tobacco control scorecard showed that in terms of adhering to the WHO Framework Convention on Tobacco Control, both countries have progressed in tobacco control to various degrees despite differences in their economic development, and health and political systems. Our policy review based on an analysis of the alcohol control scorecards was the first published comprehensive overview of alcohol policies in both countries. The alcohol control scorecard showed that in terms of integrating the recommendations of the WHO Global Strategy to Reducing Harmful Use of Alcohol, the Philippines has made less progress than Singapore. However, both countries have room for improvement. Our analysis clearly shows the value of a legally binding international instrument for tobacco control (i.e., the WHO FCTC), but also raises the question of the value of the current normative approach to alcohol control, not only for low- and middle-income countries but also for high-income countries in Asia. Despite economic and political differences, both countries have yet to move away from a disease-based model for NCD policies to a risk-based public health model focused on disease prevention and health promotion. Comparing current tobacco and alcohol control laws and policies in the Philippines and Singapore provided the context for examining the power of the alcohol and tobacco industries in the policy process.

Second, with data from official legislative proceedings, corporate reports, news articles and interviews, we showed how these industries utilized a wide range of strategic tactics to exercise their instrumental, structural, and discursive power to influence the policy process in the Philippines and Singapore. In particular, we documented how industries employed direct and indirect lobbying tactics, which included litigation or threat of litigation and using revolving doors between the public and private sectors. Using its instrumental power, the alcohol industry also intensified its advertising, promotion and sponsorship in the Philippines and Singapore. The tobacco industry exploited litigation tactics to harass local governments and national government agencies in the Philippines. The favourable legal and political environments in the Philippines and Singapore have a multiplier effect on how the alcohol industry exploited legal channels and lobbying platforms to participate in political activities. Both

industries exercised their structural power by exploiting their market dominance and promoting public-private partnerships. In Singapore and the Philippines, the alcohol industry has succeeded in being less regulated by promoting self-regulation. In the Philippines, the tobacco industry benefitted from regulatory capture, watering down and delaying the implementation of tobacco control policies. Their structural power is deeply embedded in the globalised political economy, allowing the alcohol and tobacco industries to expand their operations to new markets through mergers and acquisitions. These industries have exploited their discursive power by framing themselves as responsible corporate actors and as partners of the government in their corporate social responsibility programs. These industries' discursive power is the most potent and deceptive, reinforcing their structural and instrumental power. Their 'corporate social marketing' (105) and their promotion of public-private partnerships fuel their structural and instrumental powers (54).

Lastly, the lag in alcohol control and the stagnation of tobacco control point to the multiplier effect of the power of the alcohol and tobacco industries on efforts to avoid, delay or weaken regulation in the Philippines and Singapore. The thematic analysis of the interviews highlights the fact that the political, legal and commercial activities of the alcohol and tobacco industries, which interfere with the policy process, will remain an obstacle to effective alcohol and tobacco control in both countries(106), but particularly in the Philippines. Additionally, being the less regulated industry in both countries, the alcohol industry has an advantage over the tobacco industry in terms of its power to interfere in the policy process. In the absence of a legally binding international instrument and of local statutory mechanisms, progress in alcohol control will remain dismal. A key lesson from implementing the WHO FCTC in both countries is to minimize policy loopholes in both the health and non-health sectors that the alcohol industry can exploit. Given the political dynamics of alcohol and tobacco control in the Philippines and Singapore, it will also be a challenge to use civil society mechanisms to ensure government accountability and to counter the political activities of these industries.

Interpretation of results

A systems framework for policy surveillance and the legal determinants of health

Setting policy benchmarks shows where the gaps and the opportunities are for interventions, and helps strengthen current effective policies. Standardised monitoring frameworks, including policy scorecards, are critical to hold governments accountable for achieving SDG targets on alcohol and tobacco control. (107) Such frameworks, even if normative, should also be contextualised for policy surveillance to take into account the qualitative elements of policy implementation and evaluation. (108) Methodologically, our study also confirms the contribution of comparative case studies to the literature on evidence-based health policymaking in LMICs.(109)

While alcohol and tobacco taxes have been earmarked to finance healthcare in the Philippines, other domestic laws can undermine soft legal instruments and binding international laws. (72) The inclusion of the tobacco industry in the inter-agency committee tasked with implementing tobacco control brings the Philippines into conflict with Article 5.3 of the WHO FCTC, which requires Parties to protect tobacco control policies from interference by the tobacco industry. (22) Non-health laws, including trade, investment and corporate laws, are also legal determinants of health that can adversely affect public health objectives. (72) Corporate income tax reforms in the Philippines effectively reduced corporate income tax rates and benefitted alcohol and tobacco corporations. Similarly, Singapore's goal to be the largest global transhipment hub in the region has also made it difficult for Singapore to ratify the WHO FCTC Protocol to Eliminate the Illicit Trade in Tobacco Products, which requires prohibiting tobacco products from being intermingled with non-tobacco products in free zones, international transit and transhipment. (110) This PhD project demonstrated the need to nuance how legal and policy frameworks can both constrain and facilitate the achievement of better health outcomes.

Advancing power as an analytical framework

As political determinants of health, the alcohol and tobacco industries collectively lobby governments to influence policy directly and indirectly. This PhD project corroborates previous research on their indirect instrumental power, which shows how alcohol and tobacco industries participate in the policy process through sectoral associations, and through their front groups and their corporate social responsibility entities. (38,43,58,111) Previous research has found that most of these activities are driven by corporate interests to avoid marketing regulations by promoting ineffective voluntary marketing codes. (106,112–114) While research on the alcohol industry's corporate social responsibility initiatives has found them ineffective in reducing alcohol consumption (105), such initiatives have provided the alcohol industry with a wide range of marketing opportunities behind the façade of the SDGs, especially in LMICs. (115,116) Framing 'responsible drinking' campaigns that view alcohol consumption as a matter of individual responsibility is one of the alcohol industry's most powerful and successful discursive tactics. (112,117,118)

The present study aligns with and reinforces the findings from previous research on transnational tobacco and alcohol corporations' power *outside* the global health regime, specifically within the neoliberal international trade and investment regime (119), and shows how these industries use their power to oppose policies, force government inaction, or push for policy non-decisions (38,120–122) A recent geopolitical analysis revealed that governments failed to take action on comprehensive and cost-effective alcohol policies globally. (123) In neoliberal regimes in low-and middle-income countries, free trade and investment agreements and international financial institutions were used as tools of structural power to prevent the introduction of effective public health policies through

institutionalising the industries' role in the agenda-setting process. (37,38,122,124) These industries effectively exercised discursive power by framing trade as more imperative than health. (38,122)

The alcohol industry's instrumental power is also visible at the global governance level, for example, in developing the United Nations Political Declaration of the Third High-Level Meeting on the Prevention and Control of Noncommunicable Diseases in 2018. (125) An analysis of the consultation documents for the political declaration showed how opposition from the private sector (alcohol, food and beverage industries) and from high-income countries led to ambiguous language about the policy in the declaration, or worse, excluded the opposed policy position from the declaration. (125) Recent research showed that the alcohol industry used framing strategies in the public consultation process for the Global Alcohol Action Plan (15,16) to shape specific recommendations that legitimise their role as "economic actors" and "stakeholders" in global alcohol governance. (15,16,57,126)

Industry rhetoric can lead to policies that are inconsistent with public health objectives. As shown in this study, the regulation of e-cigarettes in the Philippines through taxation became a policy window for the tobacco industry to lobby for a regressive policy that lowered the minimum age for the use and sale of e-cigarettes in the Philippines from 21 to 18 (127), and transferred authority to regulate e-cigarettes from the Department of Health to the Department of Trade and Industry. (128) Additionally, by shaping the discourse on alcohol consumption through marketing, the alcohol industry, which is not subject to extensive marketing regulations, gains instrumental and structural power. (129)

Discursive power and tactics reinforce instrumental and structural power. Despite the known harms of tobacco, the tobacco industry is framing its 'smoke-free transformation' to continue profiting from addiction. (130–132) At the same time, the alcohol industry has exploited 'tobacco exceptionalism,' which has complicated initiatives to reach global health policy coherence for other risk factors associated with noncommunicable diseases, including alcohol. (124,125,133–137)

The Expanded Corporate Playbook in Low- and Middle-Income Countries

Most of the alcohol and tobacco industries' tactics have been documented in the literature, but mostly in high-income countries in Western Europe and North America. (61,106,111,112) Our original contribution was to produce data on corporate tactics in a high-income country and a lower-middle-income country in Southeast Asia and to analyse them using the three types of power. Our research offers an expanded overview and analysis of the tactics of both industries in these two countries. Also, the tactics documented in this PhD are in agreement with previous research on how the alcohol and tobacco industries used an expanded "corporate playbook" with similar tactics and political strategies to broaden their power. (43,45,61,106,111,124,138–144) Previous research has also shown that the alcohol and tobacco industries were often allies (145) in attempts to undermine the policy process,

promote ineffective interventions across countries where they operate (106) and use corporate social responsibility initiatives as a public relations tool. (46,52,146)

Implications of the study

This PhD project has implications for policy, research, and advocacy for both alcohol and tobacco control:

First, awareness of the tactics used by the alcohol and tobacco industries to influence policy can help to better choose priorities, guide actions and inform strategies that shield alcohol and tobacco control policies from industry influence. Our results can also be used to inform the public about these tactics. The Truth Initiative is an example of how effective anti-industry campaigns can be, if they aim to educate young people about how the industry manipulates them. (147). Industries' attempts at interference should be considered inevitable, but (a) policymakers need to be aware that creating favorable legal and political environments for the alcohol and tobacco industries can amplify health harms from alcohol consumption and tobacco use (62), and (b) both policymakers and prevention specialists must be legally proficient and politically adept at avoiding or responding to interference with the necessary reforms and interventions.

Second, more interdisciplinary research led by local researchers is needed to investigate the role of the alcohol and tobacco industries in the policy process for alcohol and tobacco control in LMICs. Interdisciplinary researchers from fields outside public health, including political science, international political economy, sociology, history, anthropology, public policy, and media analysis can all help inform effective alcohol and tobacco control. Governments must provide a supportive legal environment for health policy researchers, to enable them to conduct health impact assessments of trade and investment policies that seek either to expand the alcohol and tobacco industries' market, or to reverse existing alcohol and tobacco control policies.

Third, civil society organisations involved in alcohol and tobacco control advocacy at the global, regional and national levels should be more involved in monitoring and publicly reporting the activities of the alcohol and tobacco industries, especially in countries or regions where they are based. Civil society organisations with a public health objective should also be aware of the conflict of interest of corporate social responsibility initiatives by the alcohol and tobacco industries. Managing conflicts of interest is also applicable to journalists and media outlets that serve as the public source of information but often become tools of corporate social marketing, misinformation and disinformation by the alcohol and tobacco industries. (144)

Limitations and strengths of the PhD project

Data collection

One limitation of the first study of this PhD project is the unavailability of some of the data for the policy scorecards. The lack of data is particularly concerning for the alcohol control scorecard, and this concern highlights the need for a comprehensive monitoring and surveillance system for alcohol control policies in all countries, regardless of their income groups or development levels. To overcome this limitation, I relied on proxy indicators for the system building blocks that closely align with the policy recommendations in the Global Strategy. Due to the limitations of being an independent researcher, we have assessed progress in implementing the Global Strategy using the alcohol scorecard in two countries only. While the tobacco control scorecard was used to compare ASEAN states in a previous study (30), the viability of the alcohol control scorecard could be tested in more countries in the region.

Moreover, the scorecard does not attempt to assess and compare the outcomes, stringency, or effectiveness of policies. Such assessments are available in the literature, although most available studies had a limited sample size and focused on high-income countries. (107,148) Future research can utilise the alcohol control scorecard to integrate the monitoring indicators recommended to member states in the Global Alcohol Action Plan.

Despite these limitations, the value of this study lies in its originality, using interdisciplinary approaches to study alcohol and tobacco control, the use of a systems framework to develop policy scorecards to assess alcohol control policies in two countries that differ in their political systems, as well as in their economic and human development.

Study design

Our second article focused on recent policies to examine the power of the alcohol and tobacco industries, and the scope of this study was limited to two countries. Thus, the study could not cover a variety of tactics documented in the literature, including industry tactics to influence scientific research related to alcohol consumption, tobacco use and e-cigarette use. (62,149) In addition, we did not interview representatives of the alcohol and tobacco industries, because most of them declined to participate and declared a conflict of interest. The convenience sample of interviewees and the lack of representation from non-health-related government agencies limited our ability to generalize our findings. Successive COVID-19 lockdowns required changing the research protocol in the middle of the PhD project from in-person to online interviews and relying on publicly available data accessible online.

To address this limitation, we included industry press releases and media coverage of alcohol industry statements to policies in the countries included in the study. Using these data sources also conforms

with recommendations from the alcohol and tobacco control research communities to avoid unnecessary interaction with the alcohol and tobacco industries for research. (144) The decision not to pursue potential participants from the alcohol and tobacco industries after a single follow-up reminder was thus a deliberate decision.

Despite these limitations, we hope our work is a useful and timely response to the sustained calls for more analysis of the power of transnational and local corporate actors in LMICs and to decolonise global health research and policy. (150) We also hope it is a useful contribution to the global health literature on the political, commercial, and legal determinants of health in Asia.

Conclusions and Recommendations for future research

Given the significance of alcohol and tobacco control in addressing noncommunicable diseases, this PhD project sought to assess alcohol and tobacco control policies and examine the power exercised by the alcohol and tobacco industries in the Philippines and Singapore. It contributes to the growing evidence base on how corporate power in low-and middle-income countries and across health-harmful industries undermine the design and implementation of evidence-based alcohol and tobacco control policies.

Future case studies in other LMICs in Asia that investigate the power of the alcohol and tobacco industries can examine the industries' discursive power in-depth through survey research of:

(a) the public's awareness of the alcohol and tobacco industries' corporate social responsibility initiatives across low-and middle-income countries,
(b) the public's understanding of the health and societal harms of alcohol and tobacco use, and
(c) the public trust in these industries.

More studies that use freedom of information policies in LMICs could expand research on the tactics used by the alcohol and tobacco industries. There is room for research into how national and global policies can increase transparency in interactions between government agencies, particularly government officials and the alcohol and tobacco industries, as well as between civil society organizations, the research community, and the media. Any proposed international legally binding instrument that aims to reduce harm to global public health should also be able to protect health policies from commercial interests and should consider all possible avenues of influence and power by the alcohol and tobacco industries.

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