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# Policy coherence, integration, and proportionality in tobacco control: Should tobacco sales be limited to government outlets?

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**ABSTRACT**

Multiple factors, including marijuana decriminalization/legalization, tobacco endgame discourse, and alcohol industry pressures suggest that the retail regulatory environment for psychoactive or addictive substances is a dynamic one in which new options may be considered. In most countries the regulation of tobacco, marijuana, and alcohol is neither coherent, integrated, nor proportional to the potential harms related to these substances. We review the possible consequences of restricting tobacco sales to outlets run by government-operated alcohol retail monopolies, as well as the likely obstacles to such a policy. Such a move would allow governments increased options for regulating tobacco sales, and increase policy coherence, integration, and proportionality for substance regulation. It also could serve as an incremental step toward an endgame goal of eventually eliminating sales of commercial combustible tobacco.

Keywords: Tobacco control; alcohol control; marijuana control; policy coherence

Introduction

Policymakers seeking to present a logically justifiable regulatory system for tobacco may want to consider policy coherence, integration, and proportionality. The concept of 'policy coherence' suggests that various policies related to an issue are mutually reinforcing.[1] The coherence can be across jurisdictions (e.g., the Framework Convention on Tobacco Control attempts to ensure that one country's policies do not undermine those of another),[1] across agencies or arenas[2] (e.g., health policies are not undermined by trade or taxation policies), or across the broader spectrum of substances (e.g., addictive or psychoactive substances are all treated similarly).[3] Maintaining consistency may involve 'policy integration', in which all substances (alcohol, tobacco, other drugs) are regulated by the same agencies (which may or may not result in coherence). 'Policy proportionality' ensures that substances are regulated in according to the harm or risk they present.

One way of approaching tobacco policy coherence, integration, and proportionality would be to regulate tobacco as part of a continuum of addictive or psychoactive substances that cause varying degrees of harm. Currently, in many countries some substances are criminalized (cocaine or heroin) and some are legal but controlled in multiple different ways (alcohol, tobacco and, more recently, marijuana), often by different agencies. Regarding coherence and integration, taxation of tobacco, for example, is often not administered by health agencies, and the rate is rarely at levels recommended from a health perspective.[4] Proportionality is also an issue. Tobacco is addictive, kills more than half its users, and impairs the health of others. Alcohol is addictive to some and can lead to abuse and both short term and long term health problems, as well as indirect harms (e.g.,

violence, parental neglect), but may also be used unproblematically. Marijuana may be addictive for some, but can also be used for medical purposes or recreation without harm. In the state of Virginia tobacco sellers are not licensed; spirits are sold only in state operated stores and beer and wine retailers must be licensed; and possession of marijuana is criminalized. This incongruence allows the most dangerous substances to be the most widely available.

A more coherent, integrated, and proportional policy approach to tobacco that has been raised – but not yet analyzed – is to limit tobacco sales to government-controlled outlets.[5-7] This approach could be used by any jurisdiction, but would be most practical for those that already have – or are considering instituting – such outlets for other substances, such as alcohol or marijuana. Internationally, some 15 countries alreadyhave government retail monopolies for alcohol,[8] and Hungary recently established such a system for tobacco, though it does not have one for alcohol.[9] Uruguay decriminalized marijuana with the intention of establishing government dispensaries; however, this part of the law remains to be implemented. In the U.S., Federal law permits state or local governments to regulate or prohibit the sale of tobacco products, and the 2014 U.S. Surgeon General's Report mentioned sales restrictions as a possible endgame strategy.[10] Several jurisdictions in the United States may be ideally situated to implement such a measure, as they have already established government retail monopolies for alcohol. Some are contemplating adding marijuana to the mandate of their alcohol control systems. Other states, currently without alcohol control systems, are considering such systems for marijuana.

Moving tobacco sales to government-operated stores could facilitate better congruence between the potential harm of substances and their regulatory status and (as

part of that congruence) movement toward a tobacco endgame.[11] This paper analyzes potential advantages, challenges, and disadvantages of such an approach to tobacco control, focusing primarily on the US although in most respects the analysis could be applied in any jurisdiction.

**The Establishment of Cannabis, Tobacco, and Alcohol Regulation**

Although currently alcohol, tobacco, and marijuana are all considered psychoactive substances with varying potentials for harm, addiction, and abuse, historically they were regarded as very different from one another. Thus in the US (and most other countries) lawmakers placed them in different regulatory systems. Early in the 20th century, concerned primarily about unregulated use of opiates and cocaine, the U.S. Congress and the states established anti-narcotics laws.[12] Marijuana was gradually included in these laws due to a confluence of factors, including its association with poor and working class Mexicans (who were characterized as ‘foreign’ and ‘undesirable’). Regulators and the popular press claimed marijuana was highly addictive, caused users to commit violent crimes, and ultimately resulted in insanity and death.[12] By the late 1930s, nearly all states prohibited marijuana sales and use; this was followed by Federal legislation.[12] However, in the 21st century, numerous states (and some countries) have loosened regulations to allow for medical or recreational use of marijuana.

Tobacco, specifically cigarettes, was a target of social reformers in the U.S.,. Numerous states passed (and sometimes repealed) laws prohibiting cigarette sales in the years before World War I.[13] The war transformed cigarettes from a symbol of moral weakness and dissipation to one of soldierly manliness. By the end of the 1920s cigarettes

were legal for adults in all states.[13] The Food and Drug Administration's enabling legislation excluded tobacco from oversight and tobacco products remained unregulated at the federal level until enactment of the Family Smoking Prevention and Tobacco Control Act in 2009.[14] Internationally, the situation is similar to that in the U.S., with different jurisdictions having varying restrictions on use (e.g., clean indoor air laws), licensing for sale and age of purchase, and packaging, but little regulation of the product which is almost universally legal for adult use.

As with marijuana, an unfortunate association arose between immigrants and problematic use of alcohol. After many years of temperance advocacy with some success in the states, the US ratified the Eighteenth Amendment to the Constitution in 1919. It prohibited manufacture, sale, and transportation of alcohol and came to be known as 'Prohibition'. Its repeal in 1933 returned alcohol policy to the states. Those that chose to regulate it ('alcohol control states') then established state monopolies for alcohol sales at the wholesale or retail level; most other states developed license systems. Twelve states (and some municipalities) continue to have governmentally-operated retail outlets. Some states have reduced the types of alcohol controlled by their monopolies (e.g., privatizing wine sales). [15] Others have abandoned the control-store approach in favor of licensing (e.g., Ohio and Washington).[16] The alcohol industry advocates privatization and has used referenda, legislation, and litigation to achieve it.[16]

In the twelve alcohol control retail states, however, the state stores model limits the number of liquor outlets. As Table 1 shows, where measured, tobacco outlets per 100,000 population far outnumber alcohol outlets in such states. In terms of regulatory policy

coherence, integration, and proportionality, there is no public health justification for maintaining the vastly higher density of tobacco outlets.

Adoption of a government tobacco monopoly could contribute to a broader 'endgame' strategy – one specifically designed to change or eliminate permanently the structural, political, and social dynamics that sustain the tobacco epidemic– to end it in a specific jurisdiction within a specific time.[11] Achieving an endgame is now a national goal in Finland[17] and New Zealand,[18] for example, although they do not have specific, concrete plans for achieving this goal.

The 2014 US Surgeon General's report on tobacco use suggested consideration of bans on tobacco sales at the city or state level as one option for achieving a tobacco endgame. [10] A recent sales ban in Massachusetts was, however, quickly rescinded after public protests.[19] Thus, it may not be feasible to move directly from allowing cigarettes to be sold virtually everywhere to prohibiting sales altogether. Instead, an endgame, like other tobacco control policy innovations, will likely involve a variety of incremental approaches in multiple jurisdictions. A state tobacco monopoly could be one such approach.

TABLE 1 about here

**Potential Advantages of Moving Tobacco Sales to Existing Government-Operated Alcohol Outlets**

Policy change is more feasible if it incrementally builds on existing policies, coordinates problem definition with political and policy initiatives, and serves to advance multiple governmental objectives.[20, 21] Personnel at government alcohol stores already enforce age of purchase rules. If jurisdictions established the same age limit for alcohol and tobacco purchases (age 21 is increasingly common in the US) such verification systems

would be simple to implement.  If marijuana is legalized, the existing system of alcohol stores could sell those products as well. A transition of tobacco sales to government stores could promote more coherent policy for regulation of legal substances whose use causes social harms.

Because the government would retain all profits from sales, moving tobacco sales to government-operated alcohol outlets should be economically feasible. Costs would consist primarily of creating display and storage space, training personnel, and purchasing products. Governments could negotiate wholesale terms and set retail prices high enough to discourage use while covering costs.

To mitigate objections from tobacco retailers, governments could create a 'transition fund' from tobacco revenue– to provide retailers a one-time or multi-year payment based on their usual tobacco profits. These funds would enable retailers to reduce reliance on tobacco sales. As tobacco consumption continues to drop, they would need to do this anyway. Government stores could facilitate information gathering about profits from tobacco sales. This could assist other governments attempting novel retail policies.

Reduction in outlets would allow funds currently used for surveillance and enforcement of age of purchase laws to be redeployed for public education about and enforcement of the ban on sales by private retailers. Compliance checks for a smaller number of government stores would be easier to conduct regularly.

Nearly ubiquitous availability of tobacco (particularly in disadvantaged neighborhoods)[22] contributes to misperceptions that tobacco is a normal consumer product and undermines public health messages. Moving sales to existing government-operated alcohol outlets would signal that tobacco products are dangerous and require special

measures. It would also give governments maximal control over multiple policy instruments. Governments could limit or eliminate point of sale advertising or display, limit the range of brands or products for sale, refuse to sell flavored or menthol products, sell only one variety per brand family, or set purchase limits to reduce secondary illegal sales to minors. These measures could be undertaken incrementally to allow time for consumer education. Selling tobacco in government stores only would also limit the hours of sale and the density and location of tobacco outlets.

A government tobacco monopoly would enable better use of tax and pricing policy. Currently, when governments raise tobacco taxes, the industry either temporarily lowers prices to minimize the quit attempts that a sharp price increase can inspire,[23] or increases prices[23, 24] to maximize profits while suggesting to consumers that the price increase is due to the tax. A government tobacco monopoly would neutralize both responses. Any increase in price redounds to the good of the government. Pricing policies might be constrained by tobacco prices in neighboring states or countries, particularly in border areas.

Establishing a government tobacco monopoly could reduce relapse and smoking initiation by making products less available and visible. Tobacco outlet density has been positively correlated with smoking status,[25] youth and young adult initiation;[26, 27] exposure to cigarette retail displays undermines quit attempts.[28] By contrast, alcohol monopolies reduce consumption and alcohol-related problems;[29] in the U.S., alcohol control states consistently have lower alcohol consumption per capita than non-control states.[30] Fewer high school students in monopoly states than those in non-monopoly states report drinking alcohol in the past 30 days or binge drinking in the past 30 days.[31]

Selling tobacco in government stores would also likely reduce sales to underage youth. As government store employees, clerks would be accustomed to performing age checks for all purchases (in many U.S. alcohol control states underage persons are not allowed entry). Increased compliance checks would make risking illegal sales less appealing. As government store employees, clerks would not be motivated by the potential profits to be made by underage sales, as owners or operators of small stores might be.

Challenges and Potential Concerns

A major challenge to implementing such a policy change will be the tobacco industry's political influence and ability to mobilize opponents.[32] The tobacco industry would be likely to mobilize political actors such as convenience store associations and 'citizen' front groups[33] to oppose the measure. Tobacco sellers ('buralistes') in France have been strong opponents of tobacco control measures they perceive to affect their profits.[34,35] Some objections from retailers might be assuaged by the transitional payments discussed above, but we must acknowledge that stores will be unable to sell a profitable item that brings in customers who may make other purchases. Developing retailer and public education programs with effective messaging would be essential, and this could require additional expenditures.

There might also be opposition to the initial costs (shelving, staff training, transitional payments). Implementing the policy first in jurisdictions where tobacco consumption is dropping and the public supports tobacco control measures could increase the likelihood of success. Some government alcohol stores already sell tobacco products; this would reduce costs and complexities of implementation.

Alcohol control systems have encountered opposition in recent years, and some control jurisdictions have relaxed their policies (e.g., privatizing wine sales while maintaining government stores for spirits).[36] In the US, no states have established control systems since the immediate post-Prohibition period; thus, expanding such systems might meet opposition from those who would like to eliminate them, including the alcohol industry.[16] In other countries (for example,  Finland and the Scandinavian countries), government retail monopolies may be better accepted[37] and expansion into tobacco products better received. The addition of marijuana sales to government stores and framing expansions of the system as a means to rationalizing substance regulation could also increase public acceptance.

Such expansion might create new public health challenges.  With emphasis on free trade and free markets, business managers pressure alcohol monopolies to open new outlets and increase profits.[38] Adding tobacco products as a new profit center could contradict public health goals unless endgame targets (e.g. achieving sales reductions over time) are built into changes in the monopoly system.

Alcohol control bureaucracies might be unwilling to be purveyors of an addictive and deadly product, or regard moving tobacco into their system as suggesting that alcohol and tobacco are equivalent dangers. Again, built-in endgame goals might mitigate these objections.

The most obvious adverse effect of availability restrictions is an increase in informal market activities (e.g., illegal imports and internet purchases). The tobacco industry's standard argument against all effective tobacco control measures is an alleged increase in illicit trade.[39] However, a government tobacco monopoly would keep a legal supply available

and informal market activities could be limited by effective enforcement. As with 'plain packaging' (devoid of promotional wording or images), ingredients disclosure, and product labeling, the tobacco industry might use international law and treaties to oppose government tobacco monopolies.[40] International law and trade agreements constrain domestic regulations, but allow government measures to protect human and environmental health. Restricting the supply and marketing of alcohol and tobacco have been defended successfully against challenge as both necessary and proportionate to achieving government health goals.[29, 41]

Tobacco control advocates might disagree about which products should be restricted to government stores. Some would argue that such a policy should apply equally across product types. Others would argue for a 'harm reduction' approach in which only the most dangerous products (combustibles) would be transitioned to government stores, leaving smokeless tobacco, e-cigarettes and various nicotine products thought to be less harmful still available at private retail stores. Some tobacco companies claim to support regulation based on the relative harm of tobacco products and could seize the opportunity to capture a larger market for 'less harmful' products. The latter approach might also reduce political resistance and encourage users to transition to noncombustibles. It would parallel decisions by some alcohol control regimes about product categories (e.g., restricting only higher alcohol content beverages to government stores).

Disadvantages

Predicting the disadvantages of a government tobacco monopoly is complicated by the absence of creation of control state regimes in the last 70+ years and by the differences between alcohol and tobacco products. One objection might be that limited store locations

present ‘equity’ issues – some communities might have less access to tobacco products than others. Disadvantaged communities, however, regard the current situation as inequitable because tobacco products are more available and heavily promoted to them than to others, and more available than other, healthy products.[42] Ensuring that community representatives are involved in planning and allocating resources for the transition would be critical.

Making tobacco less convenient might also spur interest in online sales. In the US, online sales are regulated through the PACT Act (2010) that is intended to ensure state taxes are collected and proper identification is required. Internet vendors continue to promote tax free cigarette sales and the Act is ineffectively enforced.[43] A high level of credit card fraud associated with online tobacco purchase attempts may limit such sales.[43]

Health harms of tobacco are aggravated by simultaneous alcohol use.[44] If both substances are sold at the same locations, dual use could increase.

Other potential disadvantages might arise from strengthening government involvement in tobacco sales. Jurisdictions that have eliminated government monopolies on alcohol have lost alcohol revenues;[45] thus, placing tobacco under a control regime might increase tobacco revenues (unless or until policy reduces use). This could create increased dependency on tobacco revenues, reducing policymakers’ appetite to implement those changes.[46] Earmarking tobacco revenues for tobacco control efforts, including research, prevention, and policy development and implementation, could help resolve these problems. Need for tobacco revenues beyond baseline levels would decrease as use decreased. Establishing an endgame goal of eliminating tobacco sales by a predetermined date from the outset could mitigate such dependence.

Integration of tobacco and alcohol control bureaucracies could be problematic. Alcohol control systems were not designed to be and have never been part of a strategy to end alcohol use. Without specific policies designed to reduce sales, a similar philosophy could permeate tobacco control systems, resulting in an institutionalization of government tobacco sales, rather than an endgame.

A final concern would be placing the imprimatur of government on tobacco sales. Tobacco control advocates believe that the widespread availability of tobacco products signals that they are ‘normal’ and thus less dangerous than they really are. Moving products to a government store places them in a ‘special’ category. The intended message is that they are too dangerous to be widely available. It might instead signal that they are ‘officially approved’. Tobacco users might reasonably assume that the government would not sell products known to kill their users. It could also create the perception that the government was in partnership with tobacco companies, a direct conflict with its public health objectives.

## Conclusion

The incongruity of warning the public about the dangers of tobacco products, while continuing to allow their ubiquitous sale, could be addressed with a transition of sales to existing government operated stores. Tobacco in government stores would improve policy coherence, integration, and proportionality, thus reducing current regulatory disparities among harmful (and potentially harmful) substances. Such a move would allow continued sales of tobacco products, but allow governments increased options for regulating them. It could also serve as a step toward an endgame goal of eliminating sales of commercial tobacco. While transitioning tobacco sales to government-run alcohol stores may run

counter to trends in privatization of public services, the policy dynamics around health care costs, marijuana legalization, and dropping smoking rates suggest that it may be timely to examine this option.

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Table 1. Population, alcohol and tobacco outlets, and tobacco use prevalence in alcohol control states

| State | Population | Alcohol outlets (N) | Alcohol outlets per 100K population | Tobacco outlets (N) | Tobacco outlets per 100K population | Adult tobacco use prevalence (%) |
|---|---|---|---|---|---|---|
| Alabama | 4,780,127 | 175 | 3.7 | 7811 | 163.4 | 21.1 |
| Idaho | 1,567,652 | 171 | 10.9 | 1565 | 99.8 | 15.9 |
| Maine | 1,328,361 | 503 | 37.9 | 1860 | 140.0 | 19.3 |
| Montana | 989,417 | 97 | 9.8 | 1760 | 177.9 | 19.9 |
| New Hampshire | 1,316,466 | 78 | 5.9 | 189 | 14.3 | 17.5 |
| North Carolina | 9,535,692 | 423 | 4.4 | NA | NA | 19.1 |
| Oregon | 3,831,073 | 248 | 6.5 | NA | NA | 17.0 |
| Pennsylvania | 12,702,887 | 604 | 4.7 | 14,028 | 110.4 | 19.9 |
| Utah | 2,763,888 | 144 | 5.2 | 454 | 16.4 | 9.7 |
| Vermont | 625,745 | 80 | 12.8 | 992 | 158.5 | 16.4 |
| Virginia | 8,001,045 | 351 | 4.4 | NA | NA | 19.5 |
| West Virginia | 1,853,011 | 178 | 9.6 | 4481 | 241.8 | 26.7 |

NA: Data not available; no sales license is required.