Capitalist Institutions and the Politicization of Public Health Issues

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Abstract

This paper links capitalist institutions to the politicization of public health issues. I argue that the configuration of political and economic institutions affects the scope of health professions' contribution to the politicization of public health problems, such as tobacco control. Specifically, I hold that the institutional configurations of Liberal Market Economies provide economic and political incentives for health professions to make public health issues a political priority, whereas this is not the case in Coordinated Market Economies. To illustrate this argument empirically, I use data from a Discourse Network Analysis of tobacco advertising restrictions and related public health measures in Australia, Germany, Switzerland, and the United States, and compare the political activity of health professions with governments, political parties, and other interest groups. The article contributes to the literature as it points out how differences in configurations of economic and political institutions affect the scope of health professions' political activity and the politicization of public health issues.

Keywords: Varieties of Capitalism, Health Professions, Interest Groups, Public Health, Tobacco Control, Australia, Germany, Switzerland, USA

JEL Codes: I10, I19, P5

Introduction

This paper analyzes the following two research questions: (1) how do configurations of capitalist and political institutions shape the political activity of health professions concerning public health matters, notably tobacco-advertising restrictions? (2) Why are there differences between countries? These two questions are relevant for the following reasons.

Public health problems pose an important challenge for policymakers. On the one hand, infectious diseases returned to the agenda of decisionmakers. On the other, lifestyle-related factors of health, especially smoking, are one of the leading causes of death – well ahead of infectious diseases such as malaria or HIV/AIDS (Yach & Bettcher, 1998; Hiilamo & Glantz, 2015). The existence of public health policies, especially those not related to deadly infections pose an essential puzzle for researchers because such policies are unlikely to come along with a sizeable electoral prize for politicians. Healthcare-related policies, for example, reducing hospital waiting lists and making health care affordable, promise a much better electoral reward than tobacco control policies (Trein, 2018, p. 23-26). Nevertheless, non-medical public health policies, such as tobacco control, exist and have become an important instrument in the repertoire of policymakers (McDaid et al., 2015; Joossens & Raw, 2016). For example, researchers have emphasized that a strong state capacity (Nathanson, 2007; Hiilamo & Glantz, 2015, p. 16), federalism and diffusion (Shipan & Volden, 2008; Studlar, 2010), EU membership (Duina & Kurzer, 2004), a favorable public opinion (Toshkov, 2013), or international advocacy coalitions (Princen, 2007; Wipfli, Fujimoto & Valente, 2010) facilitate the adoption of anti-smoking policies. To the contrary, corporatist institutions (Studlar, Christensen & Sistari, 2011, p. 738) impede the adoption of restrictive tobacco control policies, and especially the tobacco industry has demonstrated a strong capacity to oppose tobacco control policies (Yach & Bettcher, 2000; Grüning, Gilmore & McKee, 2006; Apollonio & Glantz, 2017). Although scholars have emphasized the role of tobacco advocacy coalitions at the

international level (Princen, 2007; Wipfli, Fujimoto & Valente, 2010), there is little empirical and comparative research on the politicization of public health issues, for example regarding pro-tobacco control advocates, from a cross-country perspective. This lack of such research is puzzling because to put into place successful public health policies needs not only technical skills and knowledge but also political will and support (Szreter & Wolcock, 2004, pp. 659-660). This problem is especially relevant once we consider that support from powerful interest groups is essential to make a policy agenda successful (Hacker & Pierson, 2014). A highly influential interest group that could support public health policies are health professionals, such as medical doctors, as they are not only experts in matters of public health but also influential political actors (Starr, 1982, 2009).

In this paper, I take public health problems as an example to offer a general argument about the politicization of professions, notably the scope of their political activity. I assess under which conditions professions make issues, which are important for the public good but not necessarily relate to their special interests, a political priority. I argue that configurations of economic and political institutions (e.g., Amable, 2003; Emmenegger, 2009; Bandelj and Sowers, 2010) create economic and political incentives for professions to politicize policy problems beyond their special interests, such as public health. I focus on one public health issue, in particular, tobacco control as anti-smoking policies respond to a significant public health problem (Hiilamo & Glantz, 2015, pp. 241-242). The article forges a link between politico-economic institutions and political activity of health professions broadly defined (medical doctors and other health-related professions such as public health academics and activists). Starting from the research on the sociology of professions (Macdonald, 1995; Rodwin, 2011), Varieties of Capitalism (Hall & Soskice, 2001; Jackson & Deeg, 2006), and institutions of interest intermediation (Siaroff, 1999; Lijphart, 2012), the paper analyzes how institutional configurations shape and incentivize the political activity of health

professions concerning public health issues, with a particular focus on tobacco control.

My argument has two parts. Firstly, I hold that if economic institutions provide incentives to invest in transferable skills (Hall & Soskice, 2001; Amable, 2003, pp. 160-161), health professions – especially doctors – have economic incentives to also invest in public health degrees and will make public health matters a political priority. Secondly, I argue that, in the context of a pluralist, e.g., competitive, system of interest aggregation (Lijphart, 2012), health professions have political incentives to make public health a political priority. In such a setting health professions use public health advocacy to increase their legitimacy clout, which they need to defend their special interests (Trein, 2018), for example their interests concerning the private provision of health care services (Cammet et al., 2015). Against this background, health professions, including the medical profession, will use their reputation as scientists (Ingold & Gschwend, 2014) to support public health issues through public advocacy and brokerage (Ingold & Varone, 2012). In case economic institutions provide incentives to invest in special skills and professions are included in corporatist structures of decision-making, they have fewer incentives to care about and to politicize public health matters.

To empirically illustrate this argument, I use data from a Discourse Network Analysis (Leifeld, 2013). This method links policy statements and policy events reported in newspaper articles with collective actors and their support for the policy mentioned. I examine "quality press" (Meyer, 2005) coverage of tobacco advertising restrictions and related public health measures to compare the political activity of health professions (e.g., medical profession, cancer council, public health doctors) with other actors in the political process (bureaucracy, parties, economy and interest groups, courts), in Australia, Germany, Switzerland, and the United States during the period 1993 – 2013. I focus on tobacco control because it is a significant public health issue, and on advertising restrictions especially because this policy is salient for economic interest groups. I also code

statements that relate to other tobacco policy instruments to account for the diversity of policy instruments in tobacco control and related public health issues, notably alcohol- and obesity-related policies. The four countries allow me to assess my argument as they differ on the central explanatory dimension of interest, namely the configuration of economic and political institutions. Australia and the United States are Liberal Market Economies with pluralistic institutions of interest aggregation. On the other hand, Germany and Switzerland are Coordinated Market Economies with corporatist institutions of interest aggregation.

The results of the empirical analysis support my argument and show that medical and public health organizations in Australia and the United States were more politically active (released more public statements) in support of tobacco advertising restrictions and related public health issues than those in the other two countries. This information buttresses my argument that the configuration of economic and political institutions affects the scope of professional organizations' activity towards the politicization of public health issues. After discussing the results of the Discourse Network Analysis, I proceed with a discussion of the link between health professions' political activity and the adoption of tobacco advertising policies, to assess the political impact of the politicization of public health issues through health professions. I contend that the extent to which the (public) political activity of health professions and the degree to which a country restricts tobacco advertising needs to be interpreted carefully. Notably, the structure of veto points at the national and subnational levels of government moderates how policy ideas on tobacco advertising restrictions transfer into policy measures. Furthermore, there are other pathways to restrictive tobacco control policy; for example, the EU Directive on tobacco advertising restrictions resulted in the regulation of tobacco advertising in many countries.

Although the empirical part of the paper focuses on public health issues, I offer a broader contribution to the political economy literature, in demonstrating how institutional configurations

create economic and political incentives for professions to politicize policy issues beyond their special interests. I use public health problems as a starting point to theorize the politicization of professions in different configurations of economic and political institutions. Therefore, this paper serves as an origin for a broader assessment of the scope of professions' political activity in developed democracies. My argument is important for the political science literature in general, as it emphasizes the importance of professions for the politicization of policy issues that are important to the public interest.

The Theoretical Link between Professions' Political Activity and Configurations of Capitalist and Political Institutions

In this paper, I want to understand how professions politicize public health issues, in a comparison between countries and with other interest groups. Public health issues are policy problems that require a policy response that focuses on a population or group setting and have a preventative character, for example, tobacco control policy and HIV prevention (Trein, 2017a, p. 749). "Politicization in general terms means the demand for, or the act of, transporting an issue into the field of politics, making previously unpolitical matters political" (Zürn et al., 2012, p. 73). In other words, I am interested in how professional actors contribute to augmenting the political attention to particular policy issues, in this case public health issues. Therefore, I use the terms politicization and political activity interchangeably.

I argued before that public health policies – notably those that focus on non-communicable diseases – deal with important policy challenges but that they do not provide a significant political prize for policymakers (Trein, 2018). Therefore, influential professional actors, such as medical organizations, can make an important contribution to politicizing public health problems. According to sociological studies, professional roles are different from other occupations because

they are more than just breadwinning roles, for example, a day job in construction or a supermarket (Freidson, 1983; Larson, 1977; Macdonald, 1995; Saks, 1995). In addition to their economic function, professions have a social function, which means that they provide services that are essential to society, such as medical care (Rodwin, 2011), legal advice (Rueschemeyer, 1973), or auditing (Rueschemeyer, 1983; Armstrong, 1985). Due to their expertise, professional organizations have a reputational power that can be used not only to advocate their particular interests but can be used to put important policy challenges on the political agenda generally defined. In other words, professions could act as public interest groups (Berry, 1977, p. 4; Schuck 1977, p. 133) and remind government publicly of pressing policy challenges, for example public health regulations. Nevertheless, to act as public interest group requires that medical and public health researchers and practitioners consider their role not only professional-occupational, i.e., in the provision of medical and health services, but also political, i.e., in politicizing public health issues.

Economic incentives for professions to politicize public health issues

The first reason that explains why professions have incentives to politicize public health issues points to the structure of capitalist institutions. Comparative research on institutional configurations of capitalism primarily aims at explaining economic outcomes, for example, different production and innovation strategies (e.g., Amable, 2000, 2003; Jackson & Deeg, 2006), or strategies to achieve competitiveness (Hall & Soskice, 2001). Nevertheless, this research provides also important insights into the institutional configuration of economic and political institutions. This quality makes it useful for research that goes beyond economic performance of capitalist systems, such as the one in this paper.

I argue that, in countries, that are Liberal Market Economies according to the comparative political

economy literature (Hall & Soskice, 2001, pp. 1-68), professional actors have incentives to politicize public health issues. This argument is plausible because, in Liberal Market Economies, it is advantageous economically for individuals to invest in broadly usable general skills, for example, to be a lawyer, doctor, scientist or accountant. Due to the liberal employment and wage-bargaining system as well as the lack of an apprenticeship system (Hall & Soskice, 2001, pp. 1-68; Amable, 2003, pp. 160-161; Emmenegger, 2009), membership in a profession is more attractive for individuals as it improves economic security considerably (Freidson, 1983, pp. 23-26; Rueschemeyer, 1973, pp. 63-122). Furthermore, Liberal Market Economies come along with a higher freedom of professional education from state intervention because the state has less control over the education system, including universities, which are an essential element for the formation, training, and socialization the members in professions (Goedegebuure et al., 1993; Dobbins & Knill, 2014). Also, in countries that belong to the group of Liberal Market Economies, researchers (and professions) traditionally needed to give a high importance to practical implications of their research agenda to secure funding. For example, in the late 19th century, in the UK, research funding was much less generous in the UK than in the countries of Continental Europe (Braun, 1997, pp. 94-95). In the U.S., the importance of the utilitarian paradigm to secure research funding contributed to researchers developing a more practical approach (Braun, 1997, pp. 116-117).

Due to these elements, it makes sense to consider professions as Free Professions (Rodwin 2011, p. 321), in the institutional configuration of Liberal Market Economies. This logic implies for the health domain that professions will have a higher professional and political interest in non-medical, i.e., public health, issues and have cultivated a habit to be more active politically. Therefore, in Liberal Market Economies, I expect that the line blurs between professions' role as researchers and policy advocates. Consequently, health professions will advocate publicly for public health issues (Trein, 2018).

Contrariwise, in Coordinated Market Economies, it is possible to establish economic security and professional satisfaction even without membership in a profession and by investing in a specific skill set, due to the encompassing wage- bargaining, apprenticeship and social security system (Hall & Soskice, 2001, pp. 1-68; Amable, 2003, pp. 160-161; Emmenegger 2009). Professional identity is less critical to achieving economic well-being because access to relatively well-paid jobs is possible with a high school degree, occupational education, or a simple university degree. Therefore, health professions have less economic incentives to care about the non-medical aspects of their profession, such as those related to public health. Furthermore, in Coordinated Market Economies, following the ideal of the "Bildungsbürgertum," a general level of education is more important for personal development and the signaling of own status than belonging to a profession for economic reasons (Freidson, 1983, pp. 23-26; Rueschemeyer, 1973, pp. 63-122). Besides, in these group of countries, the state controls the education system and the universities more directly (Goedegebuure et al., 1993; Dobbins & Knill, 2014). This logic implies that – traditionally – professional and research organizations were under more state control and therefore less likely to publicly advocate on political problems. On the other, they also had access to jobs and research funding. For example, in the late 19th century, in Germany, state and bureaucracy controlled but did also fund science and education (Braun, 1997, pp. 99-102). This context contributed to shaping the political habitus of professional actors.

Thus, I argue that Coordinated Market Economies come along with "Professions of Office" (Rodwin, 2011, p. 321). In this institutional configuration, professional organizations are less politicized than in Liberal Market Economies. This configuration implies for health professions that they have less economic interests to focus on broader health-related skills that go beyond the medical core discipline. Furthermore, due to the traditionally strong link between the state and scientific organizations, they have less organizational traditions to place new scientific insights on

the political agenda to demonstrate the utilitarian dimension of their work. In this context, there is a strict line between professions' role research and advocacy work (Trein, 2018).

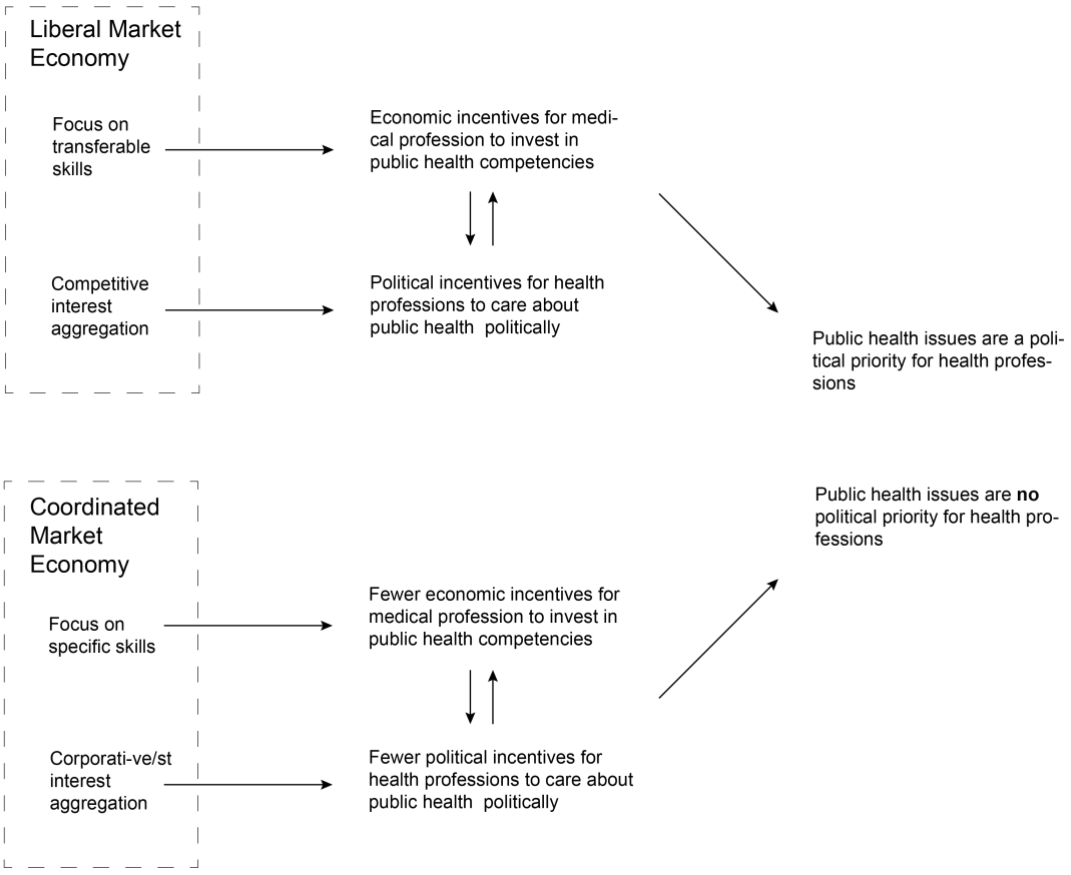
Political incentives for professions to politicize public health issues

The second element that explains why health professions display stronger public support for public health issues, in Liberal Market Economies compared to Coordinated Market Economies, is linked to the democratic institutions that come along with these two different capitalist institutional configurations. Precisely, it is related to the difference in interest group inclusion between the two forms of political economies. Notably, Liberal Market Economies tend to have a pluralist system of interest intermediation, in which all interest groups compete for policymakers' attention (Siaroff, 1999, Hall & Soskice, 2001). In such a setting, professions have a high incentive to be politically active and to politicize essential policy challenges that concern their professional field, but not their special interests, because it will increase their legitimacy clout prospectively, once they have to lobby for their special interests. For example, in a pluralist system of interest intermediation, the medical profession, public health doctors, and health foundations have an incentive to politicize tobacco control policies (for example by actively demanding policy action as a consequence of research results) as this will increase their reputation and thus their legitimacy clout. Therefore, they can contrast their negative image once they lobby for their special interests, such as retaining private elements in health care provision, which is notoriously unpopular amongst the population as it increases out-of-pocket health care cost (Cammet et. al., 2015).

To the contrary, Coordinated Market Economies come along with a corporatist system of interest group inclusion (Siaroff, 1999, Hall & Soskice, 2001). The term corporatism refers to an institutional arrangement, in which the state "... grant[s] a deliberate representational monopoly ..." (Schmitter, 1974, p. 94) to interest groups. According to Lehmbruch, this form of interest

intermediation has developed into an "... institutionalized pattern of policy-formulation in which large interest organizations cooperate with each other and with public authorities ..." (Lehmbruch, 1977, p. 94). In corporatist countries, governments tend to consult all main interest groups during the policymaking process (Lijphart, 2012). Important interest groups, such as health professions, have often secured an institutionally recognized position to advocate their special interests (Böhm et al., 2013; Trein, 2017a). Therefore, they do not need to increase their legitimacy clout by broaching issues publicly that do not correspond with their special interests, such as tobacco control policies.

Figure 1: Summary of the argument



In summary, this argument implies for the analysis of the politicization of public health policies and tobacco control measures in particular that, in Liberal Market Economies, health professions

will make tobacco control a political priority, in the sense that they support regulation publicly. To the contrary, in Coordinated Market Economies health professions have less economic and political incentives to support tobacco control policies politically, and therefore, they will not make these measures a political priority in public (Figure 1).

Data and method

To substantiate the above-made theoretical claims empirically, I examine public statements by health professions and related political actors in support of public health policies. Precisely, I analyze collective actors' (e.g., medical association, cancer council, political parties, or government) statements in support of, or opposition to, tobacco advertising restrictions as well as related tobacco control and public health policy such as smoking bans, alcohol advertising, or obesity-related policies. A more detailed description of the different actor categories is in the supplementary materials to the paper. I focus primarily on tobacco advertising restrictions because this policy instrument is salient for economic interest groups and it keeps the analysis feasible. To widen the policy scope of the analysis, I also coded statements concerning the other policy instruments mentioned, if they appeared in the newspaper articles that returned statements relating to tobacco advertising restrictions.

To analyze newspaper statements, I conducted a Discourse Network Analysis (Leifeld, 2013). Researchers used this method in other policy fields to understand the composition of actor coalitions, for example regarding climate (Fisher, Leifeld & Iwaki, 2013) or pension policy (Leifeld, 2013). Usually, discourse network data is used to conduct network analyses; however, it is also possible to extract time series data on the political activity of various actors, such as health professions, and the statements regarding an individual policy overall. For the argument of this paper, it is sufficient to focus on descriptive data of public statements made by various actor groups

(health professions, economy related interest groups, political parties, and governments) regarding tobacco advertising restrictions and associated tobacco control and public health issues. Analyzing the networks as such is not necessary for the research in this paper (cf. supplementary materials for details).

Like other examples of discourse network analyzes (Leifeld, 2013), this paper focuses on one newspaper per country as a text corpus. Two different newspapers were analyzed for Australia to cover the period since 1991, as the national ban on tobacco advertising passed parliament during this period. The newspapers are The Australian (1995-2011) and The Age (1991-1995) for Australia, the Frankfurter Allgemeine Zeitung (1993-2013) for Germany, the Neue Zürcher Zeitung (1993-2013) for Switzerland, and The Washington Post (1993-2012) for the United States. For each country, I conducted a Discourse Network Analysis using the software tool Discourse Network Analyzer developed by Philip Leifeld (Leifeld, 2013).

The paper uses the findings of the Discourse Network Analysis to operationalize the dependent variable, i.e., the political activity (politicization) of public health issues by health professions and other political actors. If a collective actor made a high number of statements about tobacco advertising and related matters, it implies that the collective actor is more politically active. This empirical strategy is plausible given the importance of media activity for interest groups (Binderkrantz, 2012).

Results

In the following, I will discuss the results of the analysis of the political activity of health professions and interest groups. In a nutshell, the results show that health professions and public interest groups have been more politically active concerning public health issues, in Australia and the United States than in Germany and Switzerland. In the latter two countries, economy-related

interest groups have dominated the political debate. These findings remain stable over time and do not seem to be impacted by policy adoption. In Germany and Switzerland, health professions and interest groups have not become more politically active in this matter after other countries adopted tobacco control policies.

Political activity of health professions and interest groups

Table 2 presents the distribution of actors in the different categories revealed by the newspaper analysis, per country. The overall number of collective actors coded is the highest in the United States, followed by Switzerland, Germany, and Australia. There are apparent differences between Australia and the United States on the one hand, and Germany and Switzerland on the other, regarding some of the actor categories we analyzed for this paper. Notably, Australian and American health professions made up much larger shares of the interest groups that participated in the political debate concerning tobacco advertising prohibitions and related public health issues. The picture is similar for the category of other interest groups, which entails, for example, sports-related actors. To the contrary, economy-related interest groups participate more in the public debate on tobacco control policy in Germany and Switzerland than in the other two countries, even though the differences are much smaller between health- and economy-related actors in Australia and the United States than in Germany and Switzerland.

Regarding government-related actors, the results show higher figures for Australia and the United States. Nevertheless, Switzerland follows closely, whereas this number is tiny in Germany. The results also indicate that national political parties are most active regarding tobacco control policy in Switzerland, followed by Australia and the United States. Eventually, international actors – foreign governments and EU-related actors – are considerably more present in the debate in Germany and Switzerland than in the two Anglo-Saxon countries.

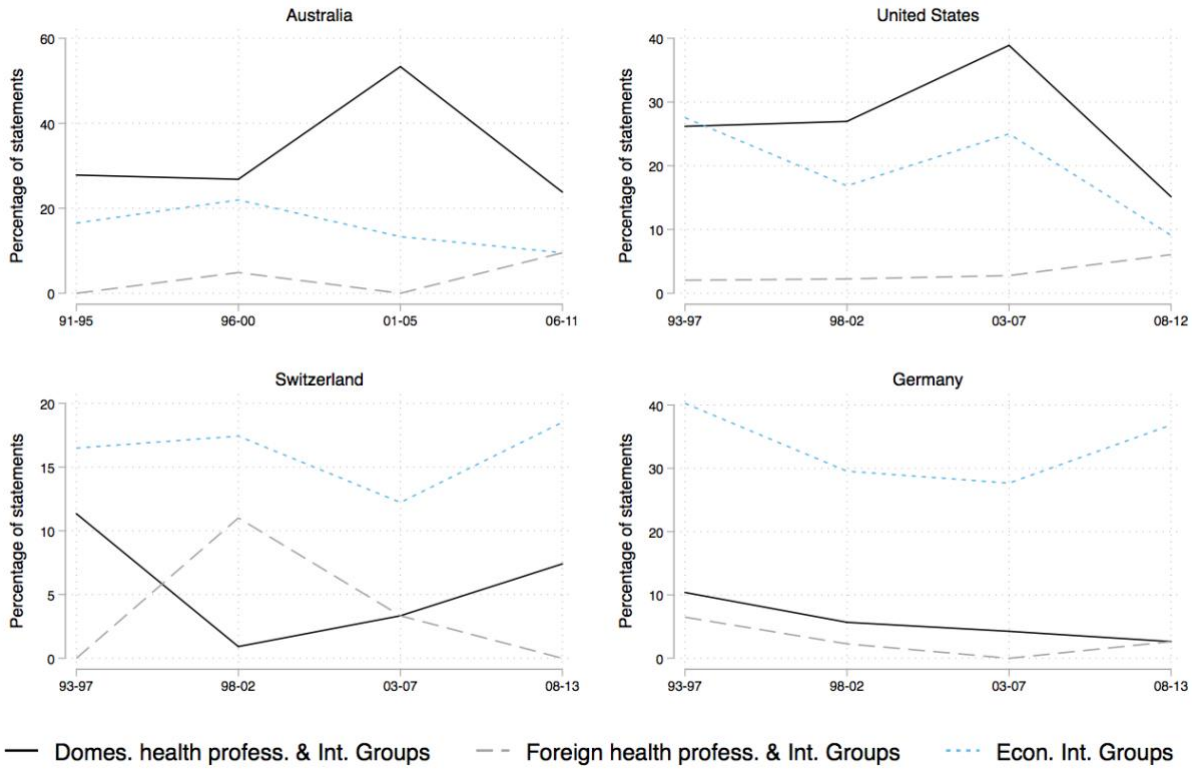
Table 1: Distribution of actors over the coded statements (% of all actors)

	Australia	Germany	Switzer-land	United States
Domestic health professions / interest groups	27.4	8.6	8.3	23.4
Foreign health professions / interest groups	1.6	5.7	2.1	2.8
Legal-profession-related organizations	0	3.8	0.7	6.1
Economy-related interest groups	14.5	31.4	22.4	19.4
Other interest groups (mostly sports related)	22.6	5.7	7.7	19.4
National / subnational government-related organizations	21	7.6	18.9	21.1
EU-related organizations	1.6	8.6	3.5	0
Foreign governments	1.6	17.1	11.2	2.2
Courts	0	2.9	3.5	3.9
National political parties	9.7	4.8	16.8	1.7
International political parties	0	3.8	4.9	0
Sum of all statements	*62*	*105*	*141*	*180*

In Figure 2, I compare the activity and participation of health professions and public interest groups in the political debate to other interest groups, especially economy-related interest groups over time. I report aggregated figures for five-year periods because there are not enough statements for yearly data points. The periods vary slightly between countries, depending on when the newspapers were available. The results point in a similar direction to the figures in Table 1. Domestic health professions and public interest groups produced a considerably larger share of the public statements in support of tobacco advertising restrictions and related public health issues in Australia and the United States than in Germany and Switzerland. In these two countries, economy-related interest groups dominated the debate concerning tobacco advertising and related public health issues. In the United States, economy-related interest groups conducted a similar political activity to

domestic health professions and interest groups until the mid-1990s, but then the number of statements they gave dropped. The numbers decline notably after the passage of the Master Settlement Agreement (MSA), in which tobacco companies accepted advertising restrictions, in exchange the States dropping a lawsuit that demanded compensation for the medical costs related to smoking. In Switzerland, foreign health-related organizations played a significant role around the turn of the century, whereas the political activity of domestic health professions and related public interest groups declined after the popular initiative regarding tobacco advertising restrictions failed, in 1993.

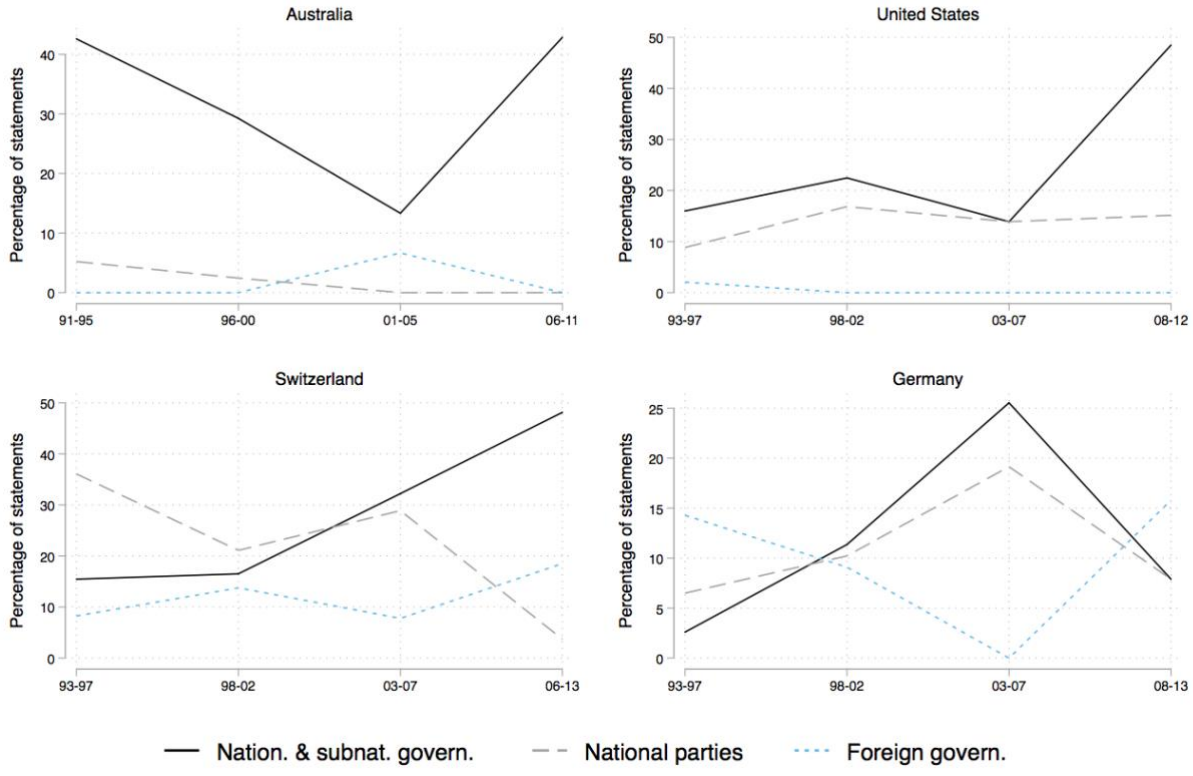
Figure 2: Statements over time (Health- and economy-related actors)



Turning to the presence of government-related actors in the public debate, Figure 3 shows how national and subnational governments, national political parties, and foreign governments appear in the news reports regarding tobacco advertising restrictions and related issues. The results

indicate for all the countries that, compared to national political parties and foreign governments, the federal government, subnational governments, government-related organizations as well as parliaments were most politically active, or produced the most reported actions in this regard, such as the adoption of advertising restrictions by the Swiss cantons. Statements by political parties played a considerably less critical role in the political process, notably in Australia, but also in the United States. In Switzerland, parties were very active in the debate during the early 1990s before a national referendum regarding tobacco advertising restrictions. Germany shows a similar pattern. Overall, statements and actions by foreign governments are more present in the debate in Switzerland and Germany than in Australia and the United States.

Figure 3: Statements over time (Government-related actors and political parties)



These results empirically buttress the argument, as mentioned earlier. Overall, the findings underline my reasoning that in countries with Free Professions (Rodwin, 2011, p. 321),

professional actors are more politically active regarding public health issues. These findings substantiate the contention that in Liberal Market Economy types countries (Hall & Soskice, 2001, pp. 1-68;), there is a higher number of domestic health professions, which are more politically active regarding public health issues. I hold that institutional configurations provide economic and political incentives (Siaroff, 1999, pp. 178-179; Amable, 2003, pp. 160-161; Emmenegger, 2009; Lijphart, 2012) for such behavior. On the other hand, in Coordinated Market Economies, the economic and political incentives for professions to politicize public health issues are absent. Therefore, economy-related interest groups dominate the debate compared to health professions and health interest groups, which makes it easier for tobacco companies to discredit public health research (Grüning, Gilmore & McKee, 2006).

Nevertheless, the results also demonstrate that economy-related interest groups are also important in the U.S. and are only less active politically than health-related interest groups. Furthermore, political parties are more visible concerning the politicization of public health issues in Coordinated Market Economies than other interest groups – whether health-related or not – as Figure 3 and Table 1 show. This finding is related to the multiparty character of the political system and shows that issue politicization happens through the channels of political parties rather than pressure groups. This finding suggests that in neo-corporatist systems of interest intermediation, health professions and interest groups are less inclined to mobilize their professional power for public health issues because existing institutions of interest intermediation assure their inclusion in the political process in any case. Nevertheless, economy-related interest groups are active in the public debate on the politicization of public health issues.

The link to policy adoption

Although the main focus of this paper is on the politicization of public health issues, I will now

turn to the adoption of tobacco advertising restrictions and discuss their adoption, in the light of the findings regarding the political activity of health professions. The goal of this discussion is to consider how we can link the political activity of health professions to the adoption of tobacco advertising restrictions and warning labels. I add warning labels to the analysis to give a broader impression of tobacco control policy in the countries.

Table 3: Key reforms of tobacco advertising and warning labels after 1990

	Key reforms/events of tobacco advertising restrictions after 1990
Australia	1992: Nationwide ban of all printed tobacco advertising 1997: Actions to ban point-of-sale (POS) advertising 2006: First health warnings on tobacco packages 2000: Decision to phase out tobacco sponsoring of sports events by 2006 2012: Plain packaging introduced
Germany	1998: First EU directive to ban tobacco advertising → The ECJ declared it to be unconstitutional 2003: EU passes revised directive to ban tobacco advertising (2003/33/EC); Germany implements warning labels 2006: Germany implements limited tobacco advertising restrictions according to the revised EU directive since 2016: about further restrictions of tobacco advertising (ban of outdoor advertising not in the 2018 coalition agreement)
Switzerland	1992: Failed popular initiative aiming to ban tobacco and alcohol advertising 2000: The first canton, Geneva, restricted tobacco advertising by 2010: 15 cantons restricted tobacco advertising

	2010: Introduction of warning labels (2012/14 second round of warning labels) 2016: Tobacco product law in preparation (encompassing advertising restrictions watered down at proposal stage)
United States	1998: Master Settlement Agreement bans most printed tobacco advertising in 46 states 2009: Family Smoking Prevention and Tobacco Control Act; entails restricting tobacco marketing even further, such as in video and audio marketing 2011: Stricter health warnings passed by the U.S. Food and Drug Administration (FDA)

Source: (Cornuz et al., 1996; Duina and Kurzer, 2004; Studlar, 2006; Scollo & Winstanley, 2008; Mitchell and Studdert, 2012; Hammond, 2013)

Overall, the data suggest that we need to be careful to link health professions' political activity directly to tobacco advertising restrictions. Table 2 shows the main reforms of tobacco advertising restrictions and warning labels after 1990, in the four countries. Australia is a forerunner concerning encompassing tobacco advertising restrictions. As early as 1992, the national government banned tobacco advertising altogether. In 2000, it decided to phase out tobacco sponsorship by 2006 (Scollo & Winstanley, 2008). In 2012, Australia was the first country to introduce plain packaging legislation (Mitchell and Studdert, 2012). Germany restricted print tobacco ads following EU regulations, but outdoor advertising remained mostly legal (Duina & Kurzer, 2004; Studlar, 2006, p. 387) (last country in the EU). A proposition to change this did not make it into the coalition agreement of the current government (Jacob, 2018; Ullrich, 2018). In the

countries in the sample that are not EU members, tobacco advertising legislation evolved differently. In Switzerland, tobacco advertising bans were voted on in popular initiatives. In 1979 and 1993, voters refused popular initiatives proposing to ban alcohol and tobacco (Cornuz et al., 1996). In the following years, some of the subnational governments (cantons) restricted tobacco advertising. Geneva was the first canton to do so. By 2010, 15 cantons had limited tobacco advertising at least partially (Trein, 2017b). In Switzerland, so far, there is no national restriction of tobacco advertising beyond the ban on advertising on TV and radio. The federal government is planning a new national law to regulate tobacco products, yet, parliament opposed significant restrictions of tobacco advertising and sponsoring in the law (FoPH, 2018). In the United States, the States banned tobacco advertising after the MSA in 1998. The MSA is a legal agreement between the four largest tobacco corporations in the United States and the attorney generals of 46 American states. The tobacco companies agreed to reduce their marketing practices and compensate the States either for medical care or Medicaid costs (Schroeder 2004). In 2009, the Family Smoking Prevention and Tobacco Control Act restricted tobacco advertising practices even further, such as video and audio marketing (Gostin, 2009).

Against the background of this data, the direct link between tobacco advertising restrictions and the political activity of health professions and public interest groups is, however, less clear. Although health professions were more active politically in Australia and the U.S., Germany, and Australia have more restrictive tobacco advertising and sponsoring laws than Switzerland and the U.S. according to the WHO (WHO, 2017). One explanation for this points to international factors. Switzerland and the U.S. signed but did not ratify the 2003 FCTC (Framework Convention on Tobacco Control) by the WHO, whereas Germany and Australia ratified the treaty (WHO, 2017). Ratifying the treaty implies banning tobacco advertising comprehensively, which could explain differences in policy output.

Furthermore, German legislative and policy action to restrict tobacco advertising are linked to the implementation of EU Directives (Duina and Kurzer, 2004). A second explanation relates to the configuration of political institutions (Studlar, 2007, p. 179). Both, the U.S., and Switzerland combine a high level of policy competencies for subnational units (Cantons or States) with separation of powers at the national level (1. two parliamentary chambers; 2. the presidency in the US / a collegial government in Switzerland). These institutional arrangements make it difficult to achieve encompassing national tobacco advertising regulations, no matter of health professions' political activity. Opponents of tobacco advertising restrictions have many institutional venues to bring forward arguments against the regulation of tobacco control and exploit the veto structure of national politics and separated competencies between levels of government to oppose encompassing regulations (Gostin, 2009; Trein, 2017b). Such institutional complexity impedes a direct influence of health professions' political activity on the regulation of tobacco advertising. In the U.S. case, the tobacco market leader Altria negotiated a regulation of tobacco products with Congress, rather than health professions winning a substantial victory in persuading legislators to disregard arguments of the tobacco industry (Gostin, 2009).

Discussion

The empirical analysis of this paper suggests that institutional configurations of capitalism and interest group intermediation facilitate the political activity of health professions concerning tobacco advertising restrictions and related public health measures. The data I presented points out that if health professions broach publicly about regulating tobacco advertising, they participate in putting the topic on the political agenda, for example by promoting scientific evidence. Whether the political activity of health professions leads to actual policy change depends, however, on the context of the specific national political system. For example, if the government possesses a clear

majority in parliament, such as in Australia, it is easier to transfer the demands and ideas by health professions into policy. On the other hand, if there are multiple veto points, such as in the U.S., the direct impact of health professions' political activity on policy change is limited. Thus, the cases in this article point out that the structure of veto points at the national level limits or enables the potential for health professions' political activity to translate into policy outcome. For example, in Canada, which should have a level of health professions' political advocacy in favor tobacco advertising restrictions similar to Australia, has restricted tobacco advertising and promotion to the same extent as Australia and much more than the US, although Canada is more decentralized than Australia. The institutional configuration – Westminster style parliamentarian system and executive federalism with formal coordination between the federal and subnational level – makes it more likely that the government succeeds in restricting tobacco advertising (Studlar, 2007).

On the other hand, this article shows how the corporatist arrangements of Coordinated Market Economies limit the public appearance of health professions and empower business interests regarding tobacco advertising and related public health measures. Nevertheless, there are Coordinated Market Economies that have significant tobacco advertising restrictions, such as Finland, Norway, and Sweden (Joosens and Raw, 2016). In these countries, governments succeed in implementing encompassing tobacco advertising restrictions, despite politico-economic institutions that emphasize the acquisition of specific skill, produce Professions of Office, and have corporatist interest intermediation structures. Other Coordinated Market Economies, such as Austria and Denmark have, however, less encompassing tobacco control regimes (Joosens and Raw, 2017). According to these examples, the institutional venues moderate how health professions' political ideas turn into policy action (Crouch, 1993; Neuman, Bitton and Glantz, 2002; Nathanson, 2007).

Conclusion

This paper started from the research question how economic and political institutions shape the political activity of health professions in contributing to the politicization of public health issues with a particular focus on tobacco control policy. The presence of political activity demanding non-medical public health policies, such as tobacco control, by health professions is puzzling because it is not in their interest, especially not in the interest of medical interest groups. In harkening back to the literature on the sociology of professions (Rodwin, 2011), institutional configurations of capitalism (Hall & Soskice, 2001; Amable, 2003; Jackson & Deeg, 2006; Emmenegger, 2009), corporatism in general (Siaroff, 1999; Lijphart, 2012), and in health care especially (Böhm et al., 2013; Trein, 2017a), I argue why in some countries health professions and interest groups do advocate public health issues, whereas in others they do not. I hold that Liberal Market Economies provide economic and political incentives for health professions to care about non-medical health issues as transferable skills are essential and competitive, and pluralist interest intermediation are present. Consequently, health professions and health interest groups care about investing in non-medical competencies of health to improve their economic chances and gain additional legitimacy clout when they advocate policy problems beyond their special interests, such as tobacco advertising restrictions. Contrariwise, Coordinated Market Economies come along with depoliticized Professions of Office because institutional configurations provide economic and political incentives for health professions to not make non-medical aspects of health policy, such as tobacco control policy, a political priority. Individuals have fewer incentives to include broad skills about health in their formation. Health professions are involved in policymaking through corporatist institutions and do not need to gain the additional legitimacy clout by advocating policy problems beyond their special interests, such as tobacco advertising restrictions.

To substantiate the argument empirically, I conducted a systematic comparative analysis of health

professions' political activity regarding tobacco advertising and related public health policies in Australia, Germany, Switzerland, and the United States, in a Discourse Network Analysis. The findings support the argument that health professions are more politically active in countries with Free Professions than in states that have Professions of Office. The analysis shows that in Australia and the United States, organizations related to health professions support the restriction of tobacco advertising at a high frequency in public. Contrariwise, in Germany and Switzerland, this is less the case. Whereas politically active professions help in putting the topic on the agenda politically, it depends on the political clout of international organizations/institutions, the configuration of political venues at the national level, and the policy discretion of subnational governments how these ideas turn into tobacco advertising restrictions and related measures.

The findings of this paper are attractive to scholars of political economy, health policy, and public health because they explain how economic and political institutions shape the political activity of professions and interest groups regarding tobacco advertising restrictions and other public health policies. Furthermore, the paper contributes theoretically to the political economy literature (e.g., Amable, 2000, 2003; Jackson & Deeg, 2006) as it examines the institutional conditions under which health professions take the role of public interest groups and use their reputational power as scientists and doctors (Ingold & Gschwend, 2014) to advocate for policies that are beyond their particular interests. Such a political activity might be particularly important in a context, such as tobacco control because powerful interest groups (tobacco industry) have an interest and the means to delegitimize and discredit public health-related research (Grüning, Gilmore & McKee, 2006). Further research could expand this analysis and examine whether professions attempt to exercise political influence through other channels than newspapers such as meetings with influential decision-makers. In addition, scholars should assess the politicization of public health issues in a wider array of sources, for example in including additional newspaper sources, which I could not

do in this article for reasons of feasibility. Eventually, future scholarship should consider the politicization of other professions, such as lawyers, in different contexts of capitalist institutions and concerning other pressing policy challenges.

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Supplementary material to the paper entitled:

Capitalist Institutions and the Politicization of Public Health Issues

1. Sources and analytical procedure

Like other examples of discourse network analyzes (Leifeld, 2013), this paper focuses on one newspaper per country as a text corpus. Two different newspapers were analyzed for Australia to cover the period since 1991, as the national ban on tobacco advertising passed parliament during this period. The newspapers are The Australian (1995-2011) and The Age (1991-1995) for Australia, the Frankfurter Allgemeine Zeitung (1993-2013) for Germany, the Neue Zürcher Zeitung (1993-2013) for Switzerland, and The Washington Post (1993-2012) for the United States. Since I use only one newspaper per country, it was important to select each newspaper carefully to avoid biased results. Precisely, I used the following criteria to choose the newspapers. First, they had to be quality newspapers. Quality newspapers are part of the "quality press" (for a similar use of the term cf. Meyer, 2005). Traditionally, these newspapers are broadsheet newspapers that aim at maintaining a high degree of seriousness in their reporting practices. Secondly, the paper should not lean too far to the left or the right. To decide whether a paper does not lean too much to the left or the right, I rely on my reading of the papers' commentary sections. Thirdly, they had to be national newspapers. I performed a keyword search in the database LexisNexis to extract the relevant articles. The keywords for the search were "tobacco advertising" and "tobacco advertisement" in the English-speaking newspapers and "Tabakwerbung" in the German- speaking newspapers. I read and write English and German; thus, language was no problem. The Washington

Post was only available until 2012 in the LexisNexis database account of my University.

For each country, I conducted a Discourse Network Analysis using the software tool Discourse Network Analyzer developed by Philip Leifeld (Leifeld, 2013). The analytical procedure with this entails the following steps:

1. Definition of statements and events (a passage in the text that reports that an actor voiced support or opposition to tobacco advertising restrictions or related public health measures; alternatively, I coded events, for example once the Council of the European Union (EU member state governments) decided to create a European Directive to ban advertising and sponsoring and this was reported in one of the national newspapers, I coded this as support action for national tobacco advertising bans) (cf. supplementary material for example statements).
2. Definition of the collective actor that made the statement (for example, Australian Medical Association, Philip Morris).
3. Coding whether the collective actor supports or opposes tobacco advertising restrictions and related public health measures.
4. Export of network data and transformation into time series data by actor categories.

Only statements/events that referred to actual news were coded. If a newspaper article repeated a statement/event from three years ago in support or opposition of tobacco control, the analysis did not measure it, as such a statement would bias the results. What is more, I accounted only for statements that could be attributed to an individual and an organization, or an organization only, as this reflected the above discussed theoretical expectations. Sometimes, several articles in a newspaper repeated certain statements. To avoid repetition, statements were not coded if they had previously appeared in another article. For example, if a newspaper repeated a statement that had

already been reported the day before, it was not included in the coding.

The paper does not measure statements mentioning policy implementation issues, for instance if a newspaper reported that a company broke a ban on tobacco advertisement. To compare the political activity of health professions to other actors in the political system, I empirically subsume organizations under different categories that reflect the theoretical debate. For example, significant groups included health professions and related interest groups, which should be in favor of tobacco control policy, and economy-related groups that tend to oppose tobacco advertising bans. Other categories entail national and international governments, as well as domestic or international parties. A full description of each group type can be seen in the supporting material to the paper (cf. supplementary material).

2. Actor categories used in the discourse network analysis

This appendix explains the strategy that the author applied to group actors in different categories that are relevant to the argument put forward in the paper.

1. Domestic health-related interest groups and professions. This group comprises of actors such as the medical association, cancer councils, the lung league, but also the Surgeon General, in the U.S., which has a distinctly professional mandate.
2. Foreign health related professions and interest groups. This category entails actors that refer to health interest groups and profession in other countries or at the international level. For example, the WHO entered this category, because its advocates tobacco control policies, although it has a different legal statute than interest groups that operate on a global scale.
3. Legal profession related organizations, for example, state attorneys or departments of law at universities. Originally, the goal of this category was to depict the activity of legal

professions in the media. Nevertheless, during the coding process, it has evolved into a somewhat hybrid class between public – state related – and professional actors.

4. Economy related interest groups and profit-oriented corporations in the larger sense, such as the tobacco companies or newspaper publishers. In some occasions, newspapers reported that the tobacco industry made a statement about something, yet without specifying further from which company the statement came. In this case, "tobacco industry" was coded as an organization because the newspaper article does not refer clearly to a tobacco company.
5. Other interest groups. These interest groups are neither related to economic interests nor economy related organizations. Mostly, they are sports related, such as Baseball teams, in the U.S.
6. National / subnational government related organizations. This group entails national and subnational governments and organizations that are related to them, such as public health departments, but also national and subnational parliaments. In the case of double affiliations, e.g. politicians that belong to a party and are members of government at the same time, I coded party affiliation. Exceptions are head of governments, whom I coded as government representatives. Nevertheless, if an article only mentioned that there is a statement by the federal government, I coded the statement for the federal government. Parliamentary chambers only occur if they passed or rejected a policy proposal.
7. EU related organizations. These are organizations that are related to the European Union, such as the European Commission.
8. Foreign governments. This category entails statements or acts by governments of other countries.
9. Courts. This category entails decisions by courts, such as the U.S. Supreme Court.

10. National political parties. These are statements by party members at the national and the subnational level.
11. International political parties This category contains statements from political parties in other countries.

3. Example statements from Discourse Network Analysis

In the following, I present one example for a statement from each country. Underneath the coded statement, I mention the collective actor and the support for or opposition against the statement that I put in the text. I select statements that support the main finding of the paper and illustrate the importance of health professions for Australia and the U.S. and industry and economy related interest groups for Germany and Switzerland. More examples including those that illustrate the opposite are available on request.

Australia

"The president of the Australian Medical Association, Dr Brendan Nelson, said Philip Morris's objections to the act showed that the legislation was effective. What has the tobacco industry got to comment upon apart from the product it produces? The director of the Australian Council on Smoking and Health, Ms Noni Walker, said Philip Morris had shown a blatant disregard for the health of Australians in its last-ditch attempt to continue advertising cigarettes." The Age, June 7, 1994

Coding:

- Collective actor: Australian Medical Association
- Support for tobacco advertising bans: yes

Germany

„Die Gewerkschaft Nahrung,- Genuß,- Gaststätten (NGG) hat das Europäische Parlament aufgefordert, das geplante Verbot der Tabakwerbung abzulehnen. Der Gewerkschaftsvorsitzende Franz-Josef Möllenberg bezeichnete am Samstag im Saarländischen Rundfunk den Beschluß der EU-Gesundheitsminister als Schizophrenie und sehr unehrlich. In Deutschland seien bis zu 400000 Menschen und ihre Familien von einem Werbeverbot negativ betroffen. Es seien nicht nur 15000 Arbeitsplätze unmittelbar in der Tabakwirtschaft gefährdet. Es gehe auch um 250000 Mitarbeiter des Groß- und Außenhandels und viele Beschäftigte, die für Druckmedien arbeiten." [Author's translation: The Union for the German Restaurant and Bar Workers (NGG) demands the European Parliament to oppose the planned ban of tobacco advertising. The head of the union, Franz-Josef Möllenberg held that decision by the EU health ministers [to ban tobacco advertising] are schizophrenic and not honest. In Germany, the planned advertising ban will affect up to 400 000 individuals and their families. In addition to 15 000 endangered jobs in the tobacco industry, the planned ban affects also 250000 jobs in the trade sector and many workers of print media.] Frankfurter Allgemeine Zeitung, December 8, 1997.

Coding:

- Collective actor: *Union for the German Restaurant and Bar Workers (NGG)*
- Support for tobacco advertising bans: no

Switzerland

„An der Versammlung in Bern stellte Kündig vor allem die Sorgen der Werbewirtschaft im Zusammenhang mit - im Nachgang zur EU - befürchteten staatlichen Massnahmen gegen die

Tabakwerbung vor. Er kritisierte den Fundamentalismus, der auch nach der klaren Ablehnung der Zwillingsinitiativen unverdrossen alle möglichen Bevormundungsmassnahmen gegen den Tabakkonsum einführen wolle. Das sei zudem inkonsequent und ein Vorbote ähnlicher Aktionen gegen Alkohol, Zucker, Autos und so weiter: Solange die Handels- und Gewerbefreiheit ein Produkt auf dem Markt belässt, muss es auch beworben werden können. Nur so können ja auch Produktverbesserungen bekanntgemacht werden. Dem Widerstand gegen Werbeverbote für Tabak komme deshalb auch die symbolische Bedeutung des Wehrens gegen Anfänge zu, meinte Kündig." *[Author's translation: During the reunion in Bern [capital of Switzerland] Kündig [Head of the Swiss Advertising Industry Association] spoke about the concerns of the advertising industry against the context of the regulative measures against tobacco advertising proposed by the EU. He criticized the fundamentalism in all proposals to restrict tobacco consumption, although the voters rejected a ban on tobacco and advertising restrictions, in 1993. Such legislative action is inconsistent and a precursor of similar regulation regarding alcohol, sugar, and cars. As long as a product can be traded freely, it should also be legal to advertise it because this is the only way to announce product improvements. Thus, opposing tobacco advertising restrictions has a symbolic meaning to avoid fend off restrictions for advertising in general.] Neue Zürcher Zeitung, April 3, 1998.*

Coding:

- Collective actor: *Swiss Advertising Industry Association*
- Support for tobacco advertising bans: no

U.S.

"The American Academy of Pediatrics says that smoking should be prohibited in public places

where children go. The organization also supports a complete ban on tobacco advertising. They want to see manufacturers put stronger warning labels on cigarette packages. And they think the government should charge higher taxes on cigarettes." Washington Post, October 7, 2010.

Coding:

- Collective actor: *American Academy of Pediatrics*
- Support for tobacco advertising bans: yes

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