THE CONVERSATION

Five reasons why some countries are so lax at regulating smoking

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Despite all we know about tobacco harm, many countries still look the other way. Ehab Edward

Tobacco policy is a global issue. Smoking is the number one preventable cause of death and disease in the world. There are well over one billion smokers in the world, smoking rates are still rising in many countries, and it contributes to one in ten deaths worldwide (more than 6m a year and rising).

Public health groups treat smoking as an epidemic, arguing that we addressed it too late in many countries but can prevent it in others. They warn against the power of global tobacco companies who, when faced by high controls, move to countries with lower regulation and larger potential markets.

International rescue?

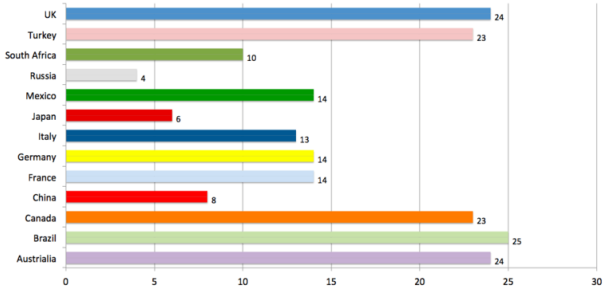
Tobacco is addressed increasingly by international agencies, including the World Health

Organisation, which recently oversaw the development of the Framework Convention on Tobacco Control (FCTC). The framework contains a commitment to raise tobacco taxes, ban tobacco promotion, ban smoking in public places, regulate tobacco ingredients, put health warnings on packs, provide health education, restrict sales and trade, and challenge tobacco companies in the courts. It has been signed by the vast majority of countries and has the potential to be a major source of global tobacco control. It is a symbol of a shift towards meaningful global public policy.

If only it were so simple in practice. What we now take for granted in countries like the UK took decades to produce. We identified the harmful effects of smoking from the 1950s and 1960s but only produced (what would now be seen as) a proportionate response in the 1980s. We identified the risks of passive smoking in the 1980s, but a smoking ban did not come until the mid-2000s.

The UK is part of only a very small group of countries, including Australia, Canada, Finland, Norway, Sweden and New Zealand, who have what is sometimes called “comprehensive” tobacco controls. In other words, they combine a large number of mutually reinforcing policy instruments designed to reduce smoking in the population.

Smoking controls among G20 countries



Based on scores for implementing WHO convention (South Korea, US, Argentina, Indonesia and India are not signatories).

Others have done less to address the problem. The US is something of a special case – it has played a large part in the international effort but has introduced more limited controls than the comprehensive tobacco controllers. On the other hand, Germany and Japan are often described as laggard developed countries, while most developing countries have relatively limited controls (exceptions include Brazil, Thailand and Uruguay).

The five factors

The gap between the evidence of a major problem and a proportionate response could be filled by a global tobacco control agreement like the one from the WHO. But even then, there are good reasons to believe that it would take many countries decades to implement what was agreed. With my colleagues Donley Studlar and Hadii Mamudu, I have researched why it takes so long for policy to move on tobacco in spite of global agreement on the risks. We concluded that comprehensive change in “leading” countries depended on five key developments to alter the policy environment that took decades to occur.

Institutional change. Government departments and other organisations focused on health policy took the main responsibility for tobacco control, largely replacing departments focused on finance, agriculture, trade, industry and employment.

Framing the problem differently. Tobacco was once viewed primarily as a product with economic value, and tobacco-growing and manufacturing was often subsidised or encouraged. Now the leading countries largely view it as a public health problem that needs to be tackled.

A shift in the balance of power. The tobacco industry was an ally of government for decades before and after World War Two. When policy was coordinated by finance and other departments, tobacco companies were the most consulted. Now, public health or anti-tobacco groups are more likely to be consulted and tobacco companies are often deliberately excluded.

The socioeconomic context. The number of smokers and opposition to tobacco control has declined.

The role of beliefs and knowledge. The scientific evidence linking smoking (and now passive smoking) to ill health has been accepted within most government circles.

The changes in these factors have also been mutually reinforcing. For example, increased acceptance of the scientific evidence has helped shift the way that governments understand the tobacco problem. The framing of tobacco as a health problem has allowed health departments to take the policy lead. Decreasing smoking rates reduces the barriers to tobacco control, while more tobacco control also means fewer smokers.

And if these are the factors that have facilitated comprehensive tobacco controls, the reverse is true in other countries. You tend to find that health departments are drowned out by other departments such as agriculture, finance and trade, for example. Or you find that smoking prevalence is rising; or anti-tobacco groups are poorly resourced; or tobacco growing and manufacturing is an important source of jobs, exports and revenue.

Dragon smoke

Our work also highlights a key irony of the WHO's framework: the countries that need the treaty are the least likely to deliver its aims, since their policy environments are the least conducive. Consider China for example, the world's largest tobacco-using and producing population (one-third of the world's smokers and 38% of tobacco production).

China maintains a state monopoly over tobacco production, which provides 7% of government revenue. Tobacco control is low on the domestic-policy agenda and the health image competes with an unusually strong economic image based on the importance of its tobacco industry and economic growth to the legitimacy of the Chinese government. Tobacco policy (and the implementation of the WHO framework) is led by an economic development agency which consults regularly with the tobacco industry. Public health groups are neither well resourced nor engaged.

Lighting up time in Pengzhou in central China. Lee Snider Photo Images

Public and physician knowledge of tobacco harm is low and smoking rates are high among the police force responsible for the implementation of bans on smoking in public places. If we combine these factors, it is hardly surprising that China is well behind comprehensive tobacco control countries.

Living in the UK it is easy to take tight tobacco control for granted. We may even come to accept new measures such as bans on smoking among foster parents and/or in cars. But if we travel elsewhere and smell smoke indoors, we should be quickly reminded that tobacco control varies markedly across the globe, and is likely to vary for decades to come.

International organisations might set the global policy agenda, but individual states still retain the right to modify and implement policy in their own way. Until the conditions for tighter controls are right at that level, there is a limit to what the international community can achieve.

Tobacco
Smoking
WHO
Tobacco control