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Title

The Global Tobacco Control 'Endgame': change the policy environment to implement the FCTC

ABSTRACT

The WHO Framework Convention for Tobacco Control has prompted major change in global tobacco control. However, policy implementation has been uneven, producing the possibility of 'smoke free' outcomes in some countries but not others. We identify the factors that would improve implementation. We produce an ideal-type of 'comprehensive tobacco control regimes', in which countries have policy environments conducive to the implementation of tobacco control measures designed to eradicate tobacco use. It requires these policy processes in each country: their department of health takes the policy lead; tobacco is 'framed' as a public health problem; public health groups are consulted at the expense of tobacco interests; socioeconomic conditions are conducive to policy change; and, the scientific evidence is 'set in stone' within governments. No country will meet these criteria in the short term, and the gap between the ideal-type and reality is wide in many countries. However, the WHO experience provides a model for progress.

Keywords: policymaking, WHO Framework Convention on Tobacco Control, implementation, tobacco control, policy transfer

Introduction: Could the FCTC produce a tobacco control 'endgame'?

The tobacco 'endgame' represents a major shift in public health debates, from controlling the tobacco market and reducing smoking, to eradicating both.[1,2] It has two elements: the proposal of new policy instruments, and a recognition that politics is just as important as policy. Yet, the endgame discourse does not yet recognise just how important the political process is to the fate of policy instruments, and how difficult it is in practice to separate the effect of an endgame policy instrument from the effect of its implementation in different local environments.

Some endgame articles correctly point to the continued importance of the World Health Organization (WHO) Framework Convention for Tobacco Control (FCTC), but only make vague reference to a lack of 'political will' to explain its lack of progress.[3] This is a natural response for scholars seeking policy change, but it is unhelpful because it does not recognise adequately the role of the environment in which policymakers operate. In its place we construct a framework to understand the causal mechanisms of the global tobacco policy process.

We compare the real world with an ideal-type which represents the conditions that would have to be met to allow the full implementation of endgame policy instruments. This allows us to identify just how far away countries are from securing that end, and to make recommendations to further an endgame agenda in that context. The post-war experience of some leading countries, and the WHO, provide a model for long term change.

Our analysis is based on a synthesis of the policy literature, a comprehensive review of WHO and Parties documents evaluating the progress of the FCTC, and over 300 interviews with policy participants in 39 countries.[4,5]

Background: the uneven implementation of the FCTC

The FCTC was developed in 2003 to address the global tobacco epidemic by promoting comprehensive tobacco control regimes. In a comprehensive regime, countries combine a wide range of measures to:

- reduce the demand for tobacco and the effects of smoking in the population (including high prices, health education and warnings on packaging, bans on tobacco advertising and sponsorship, smoking bans in enclosed public places to reduce secondhand smoke (SHS), and smoking cessation services)
- reduce the supply of tobacco (including restrictions on the sale of tobacco to minors and the illicit trade of tobacco, and economic incentives to grow non-tobacco products)
- fund tobacco control advocacy and scientific research on tobacco-related harm
- counter global tobacco industry influence, through tobacco control, litigation, and international cooperation and agreements.

WHO reports on FCTC implementation[6,7,7,8] show a large increase in the worldwide adoption of tobacco control measures since the FCTC negotiations began in 2000. However, implementation has been uneven in several ways. First, the possibility of comprehensive measures currently seems likely only in a handful of countries. The use of legislation to control tobacco extensively, in areas such as the regulation of ingredients disclosure, education, tobacco advertising and smoking in indoor public places, is only visible in very small number (including Australia, Canada, Finland, Norway, Sweden, New Zealand, the UK and, to a lesser extent, the US).[5,9]

Second, the FCTC reports suggest that implementation is generally least apparent in countries where the tobacco epidemic is yet to emerge and the idea of tobacco control is relatively new. Surveys of expert opinion also highlight a gap between a small number of countries undergoing ‘substantial’ policy change, and a large number where policy change

and enforcement is 'non-existent', 'limited' or 'moderate'.[10] Third, in almost all countries, some measures (such as economic incentives and litigation) are less likely to be introduced than others (including education, sales to minors, and packaging). Fourth, some countries (such as Brazil, Singapore, Thailand and Uruguay) are innovators in specific tobacco control instruments. Overall, the country-by-country picture is mixed and simple distinctions such as 'developed/ developing' do not give us a reliable indicator or predictor of progress.

How should we address these uneven policy outcomes? Focus on the policy environment

The FCTC experience confirms a general conclusion in the public policy literature: implementation is about much more than the generation of evidence-based objectives and policy instruments. We must also consider the varying motives, opportunities and abilities of policymakers to turn an international agreement into domestic outcomes. In particular, what sets some countries apart is the extent to which their policy environments are relatively (but not completely) conducive to the introduction of a 'comprehensive' set of tobacco control instruments.

Based on the experiences of the most advanced tobacco control regimes (which developed gradually over the last 30-50 years), we construct an ideal-type policy environment which sets out five conditions that would have to be met to allow the full implementation of the FCTC and additional endgame policy instruments. In practice, no country meets these conditions. Rather, the discussion allows us to compare the ideal-type to reality, to explain a lack of policy progress and recommend how to reduce the implementation gap. This is a long term vision, of which we may lose sight when focusing primarily on current debates and specific policy instruments.

First, a country's department of health must take the policy lead. It must have the capacity, and status within government, to pursue comprehensive tobacco control,

unencumbered by trade and treasury departments which have more incentive to highlight the economic value of the tobacco trade. Health departments are relatively sympathetic to the FCTC's aims. They pay more attention to the evidence on ill health and understand tobacco as a pressing public health problem. They are more likely to consult with medical and public health groups and reject the role of tobacco companies.

This is an aim that few countries can meet in the short term, but we can identify long term post-war trends in some countries. The focus within their health departments has now shifted towards unequivocal tobacco control when, in the 1950s/60s, many focused on other problems such as industrial air pollution and, in the 1970s the focus was on tobacco policymaking in negotiation with the industry. We detect a marked shift in approach, and status, since the 1980s. Further, in countries such as the UK, the Treasury has now become highly supportive of the Department of Health's central role and objectives.[5]

Second, tobacco must be 'framed' in government as a public health problem: an epidemic to be eradicated aggressively (based on public health 'endgame'[1,2] or 'winnable battle' strategies[11]). Even in leading countries, tobacco was once viewed primarily as a product with economic value, and tobacco growing and manufacturing was often subsidised or encouraged. It was described as a product to be traded freely and profited from, and seen as a necessary source of jobs, exports and tax revenue. This ensured that an economic frame, combined with an appeal to the freedom to sell and smoke a legal product, dominated the political agenda. A more recent reframing of tobacco as a public health problem, aided by attention to the role of secondhand smoke, has allowed many governments to raise tobacco control up its list of priorities and promote control as a response to a health crisis which trumps economic concerns (and challenge tobacco's reputation as an economic good).

Third, medical and anti-smoking public health groups must be consulted at the expense of tobacco interests. This is aided by giving primary responsibility to a health

department, which is much more likely than treasury and trade departments to favour anti-smoking health groups as its key source of information and advice.

In countries such as the US and UK, we can identify important post-war shifts in departmental responsibility and consultation. The tobacco industry was a strong ally of many governments for decades before and after World War II. Tobacco companies were the most consulted when policy was coordinated by finance and other departments, while health departments were often low status and public health groups struggled for inclusion in tobacco policy networks. This relationship has not reversed completely, but we can identify significant long term trends in that direction.

Fourth, social and economic conditions must be conducive to policy change. This includes the prevalence of smoking in a population, which influences the economic benefit (including tax revenue) of smoking, and public opinion on tobacco control.[12] In the ideal-type, the economic benefit of tobacco production and consumption is deemed to be zero or negative, and the public supports tobacco control. In practice, in leading countries, we can identify the declining value of tax revenue to finance departments once protective of the industry, and a greater use of taxation to discourage consumption and/ or pay for health services for smokers - albeit with great variation (from the UK Government's claim to have set tax at an optimal rate, given the threat of smuggling and counterfeit, to the US' tax system which, even when combined with the effect of the Master Settlement Agreement, does not yet raise it to the international norm). We can also identify a drop in the number of smokers and declining opposition to tobacco control, which allows governments to 'get ahead' of public opinion when introducing tobacco control.

Finally, the scientific evidence on the harmful effects of smoking and secondhand smoking must be 'set in stone' within governments. Policy is most likely to change when policymakers accept fully the scientific evidence on the links between smoking, secondhand

smoke and ill health. This happened in leading countries, but only after a lag between key reports and government responses.

Change in these five factors is mutually reinforcing. For example, increased acceptance of the scientific evidence helps shift the way that governments understand the tobacco problem.[13-15] The framing of tobacco as a health problem allows health departments to take responsibility. A decrease in smoking rates reduces the barriers to tobacco control and more tobacco control means fewer smokers. Consequently, when the FCTC is adopted, it is by a supportive health department which 'sets in stone' the scientific evidence, prioritises the public health frame, and consults routinely with public health groups at the expense of tobacco interests.

We describe an ideal-type because no country meets these criteria fully. Further, even in countries with advanced tobacco control regimes, the gap between the initial identification of smoking (and then second hand smoke) related ill health and the initiation of a major policy response was *20 to 30 years*, followed by gradual policy change over a similar period.[5] It took considerable time to create a policy environment conducive to comprehensive tobacco control policy. Their collective experience provides a model for change, and is reflected in developments within the WHO.

The WHO is a model for most countries

The FCTC *eventually* took place in an environment conducive to major policy change and the WHO's policy environment is closer to the ideal-type than most countries. First, the responsibility for tobacco control shifted (despite resistance from leaf-growing countries such as Malawi, aided by tobacco companies[16,17]). Tobacco control was once the preserve of individual countries, with organisations within the UN and World Bank supporting tobacco as an economic product. Over time, global tobacco control policy became 'institutionalised'

in the WHO Tobacco Free Initiative. Tobacco control in the UN has largely been the preserve of the WHO since 1999.

Second, tobacco control rose on the agenda and was reframed as primarily a health problem. When tobacco was the sole responsibility of countries, it was often low on the agenda and many treated tobacco as a source of revenue and economic development. The involvement of the WHO was limited, with tobacco competing for attention with issues such as infectious diseases. This changed as the scientific evidence accumulated, the role of the WHO increased, and it was headed by energetic directors-general.

Third, the WHO provided a new venue for public health influence. It sought to exclude pro-tobacco groups from the formal decision-making process (see Article 5.3 of the FCTC and its guidelines[18]) and encouraged the international tobacco control network of policy advocates and scientific experts.[13,19]

Fourth, attitudes to the socioeconomic context have shifted. Tobacco companies influence policy with the argument that tobacco provides jobs, tax and export revenue.[16] This benefit is now challenged by reports highlighting the economic ill-effects caused by tobacco use. For example, from 1992, the World Bank invested in research to make the economic case for tobacco control[20] and worked with the WHO to further the FCTC. [16] Such analysis has contributed to movements in public opinion, with surveys demonstrating majority support for the FCTC.[5]

Finally, the main driver for WHO involvement has been the accumulation of the evidence linking tobacco to ill health (based on the work of expert committees[21]). The WHO has become a key source in the dissemination of best practice in tobacco control.[20] It worked with the International Agency on Research on Cancer to generate and disseminate scientific information on tobacco use and control.

Many Parties to the FCTC struggle to implement it

However, FCTC implementation is currently less straightforward because this type of policy environment is not found in many countries. In many, health departments lack capacity and their voices are often drowned out by other departments, such as agriculture, finance and trade.[5,22] Tobacco policy arises on the agenda rarely and the public health frame competes with economic arguments.[5] Tobacco companies are powerful within networks and the capacity of anti-tobacco groups is low.[22-25] Tobacco companies have the resources to influence legislators[26] and challenge tobacco control in the courts.[27] Tobacco growing and manufacturing is an important source of jobs, exports and revenue and smoking prevalence is rising. The medical-scientific knowledge has had less of an effect. Domestic anti-tobacco groups lack resources. [5,23]

Consider, for example, China and India which account for half of all tobacco users in the world. China has one third of the world's smokers and 38% of tobacco production. [27,28] Although China supported the FCTC, its environment is not conducive to implementation.[29] China maintains a state monopoly over tobacco production which provides 8-11% of government revenue. Tobacco control is low on the agenda and the health image competes with the importance of its tobacco industry and economic growth to the Chinese government.[28] Tobacco policy is led by an economic development agency which consults regularly with the tobacco industry, and the health ministry is 'sidelined'.[28] Public health groups are neither well-resourced nor engaged - partly because the Chinese government has a tense relationship with NGOs (although note recent developments[28,30]). Public and medical knowledge is low: less than half of physicians surveyed[31,32] had a comprehensive knowledge of the links between smoking and illness; more than one-third smoke in front of their patients. Smoking rates are high among the police forces responsible for the implementation of bans on smoking in public places.[33-35] Scientific research capacity is low.[36]

India has demonstrated a commitment to the FCTC and is a world leader in the regulation of tobacco use in media and films.[37] However, it has similar issues to China.[38] It continues 'to pass legislation that is poorly enforced and challenged in the courts'.[38] India passed legislation to introduce a smoking ban in 2008, but the fine for non-compliance is low and there is 'inadequate surveillance' to ensure compliance.[38] India lacks capacity in health education (public knowledge of the risks of smoking is patchy) and smoking cessation clinics.[38] Most of the public 'may not have ever engaged in discussion on the merits of tobacco control' and may still be relatively likely to view tobacco production in positive terms (a point that applies to many countries[39]).

Conclusion

The FCTC experience provides a clear lesson: the policy environment is as important as the policy instruments designed to eradicate tobacco use. Our ideal-type identifies the mutually reinforcing changes in policy processes necessary to secure an environment conducive to the tobacco control endgame: departments of health become central to tobacco policy; they frame tobacco as a public health problem to be solved; they support and consult with public health groups and marginalise tobacco interests; they are strengthened by (and help accelerate) a reduction in smoking and therefore a drop in the economic value of tobacco and opposition to tobacco control; and, they institutionalise the evidence on smoking and passive smoking.

In many countries, there is a wide gap between the ideal-type and the reality. Most have signed the FCTC agreement, but its implementation is left to under-resourced health ministries (competing with powerful finance and trade ministries), with tobacco control low on the agenda and minimally resourced or enforced. A country focused on tobacco as an economic product, with a finance ministry at the core of policy, maintaining strong links to

the industry, with low attention to the links between smoking (and secondhand smoke) and ill health, and a growing smoking population, will not implement the FCTC as well.

The FCTC's role is to set the agenda for tobacco control in countries that have not yet addressed the tobacco 'epidemic'. The experience to date suggests that this outcome is possible but far from inevitable. Country representatives form part of a supportive coalition during international negotiations, only to find a series of obstacles when they return to less favourable domestic environments. In that context, the WHO's policy environment, as a model for individual countries, is as important as the policy instruments it supports.

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