

Beyond Ratification

The Future for U.S. Engagement on International Tobacco Control

A Report of the CSIS Global Health Policy Center

AUTHOR
Thomas J. Bollyky

November 2010



Beyond Ratification

The Future for U.S. Engagement on International Tobacco Control

A Report of the CSIS Global Health Policy Center

AUTHOR

Thomas J. Bollyky

November 2010

About CSIS

In an era of ever-changing global opportunities and challenges, the Center for Strategic and International Studies (CSIS) provides strategic insights and practical policy solutions to decision-makers. CSIS conducts research and analysis and develops policy initiatives that look into the future and anticipate change.

Founded by David M. Abshire and Admiral Arleigh Burke at the height of the Cold War, CSIS was dedicated to the simple but urgent goal of finding ways for America to survive as a nation and prosper as a people. Since 1962, CSIS has grown to become one of the world's preeminent public policy institutions.

Today, CSIS is a bipartisan, nonprofit organization headquartered in Washington, D.C. More than 220 full-time staff and a large network of affiliated scholars focus their expertise on defense and security; on the world's regions and the unique challenges inherent to them; and on the issues that know no boundary in an increasingly connected world.

Former U.S. senator Sam Nunn became chairman of the CSIS Board of Trustees in 1999, and John J. Hamre has led CSIS as its president and chief executive officer since 2000.

CSIS does not take specific policy positions; accordingly, all views expressed in this publication should be understood to be solely those of the author.

© 2010 by the Center for Strategic and International Studies. All rights reserved.

ISBN 978-0-89206-610-0

Cover photo: Street boys in Pokhara, Nepal; photographer, Wen-Yan King; <http://www.flickr.com/photos/medapt/430271831/>.

Center for Strategic and International Studies
1800 K Street, N.W., Washington, D.C. 20006
Tel: (202) 775-3119
Fax: (202) 775-3199
Web: www.csis.org

BEYOND RATIFICATION

THE FUTURE FOR U.S. ENGAGEMENT ON INTERNATIONAL TOBACCO CONTROL

*Thomas J. Bollyky*¹

Overview

Tobacco use is arguably the greatest threat to global health. Tobacco use and secondhand smoke kill more people annually than HIV/AIDS, tuberculosis, and malaria combined. Unless action is taken, an expanding pandemic of tobacco-related diseases promises to disable and kill hundreds of millions more in coming decades, mostly in low- and middle-income countries. Beyond its effects on morbidity and mortality, tobacco use has dramatic social and economic consequences, consuming health care budgets, robbing families of their primary wage earners, and hindering economic development.

Tobacco use is also one of the most preventable threats to global health. Cost-effective, evidence-based tobacco control programs have succeeded in developed and developing countries alike. The Framework Convention on Tobacco Control (FCTC)—the first treaty developed and adopted pursuant to the authority of the World Health Organization (WHO)—provides a blueprint for these tobacco control programs and a platform for their monitoring and implementation. If adequately resourced and implemented, the strategies prescribed in the FCTC offer the opportunity to avert millions of premature deaths in a sustainable manner.

Despite its widespread adoption, FCTC implementation has largely stalled globally. This situation can be attributed in part to insufficient incentives, resources, and technical support for FCTC implementation in low- and middle-income countries. In the absence of effective collective action, individual governments pursue uncoordinated tobacco control efforts, which breed trade disputes and increase the potential for cigarette smuggling. Failure to implement the FCTC would imperil its future as the vehicle for advancing global tobacco control and damage the credibility of the WHO.

Many arguing for increased U.S. engagement on global tobacco control have focused on the need for the United States to ratify the FCTC.² Given the poor near-term prospects for ratification and the lack of momentum behind FCTC implementation, a new approach is warranted.

1. Thomas J. Bollyky is a visiting fellow at the Center for Global Development. He thanks those colleagues, particularly Samira Asma, Doug Bettcher, Paul Bollyky, Brooke Cashman, Larry Gostin, Kelly Henning, Kristen McCall, Steve Morrison, Phil Nieburg, Tim O'Leary, Vinayak Prasad, Cindy Prieto, and Bill Savedoff, who kindly provided input and commented on drafts of this paper.

2. See, for example, Benn McGrady, *U.S. Engagement in International Tobacco Control* (Washington, D.C.: CSIS, June 2009).

Although the United States should ratify the FCTC, it should not wait to do so before increasing its support for low- and middle-income countries' FCTC implementation. This approach would accomplish the same objective—to meaningfully demonstrate U.S. commitment and leadership—and do more to advance global tobacco control. To accomplish those goals, the United States should engage in a four-part strategy to help provide the resources, incentives, and technical support necessary for developing countries' implementation of the FCTC:

- *Make tobacco control a global health priority.* A necessary first step toward formulating a new approach to international tobacco control is acknowledging it as a U.S. global health priority. Global tobacco control is central to the success of the Global Health Initiative and should be the signature U.S. initiative on noncommunicable disease. There must be more coherence in U.S. trade and global health policies on tobacco. The United States should work with multilateral and bilateral development agencies and regional economic and health institutions to likewise prioritize international tobacco control.
- *Improve resources for global tobacco control.* Tobacco control is severely underfunded, particularly in developing countries. The United States should seek a commitment among partner countries of the Group of 20 (G-20) to institute a surtax on tobacco consumption to fund tobacco control programs in developing countries. Surtax revenues should go into a dedicated fund administered by the WHO, World Bank, or an independent international actor.
- *Create incentives for FCTC implementation.* The United States should build the necessary incentives for an outcome-driven, bottom-up approach to FCTC implementation in developing countries. One such incentive could be cash-on-delivery (COD) aid for tobacco control. Funding for such incentives should be derived from the surtaxes on tobacco consumption.
- *Increase technical assistance, surveillance, and support.* The remaining resources from the surtax should be used to support multilateral and regional technical assistance and build capacity for developing countries' FCTC implementation. The United States should support these efforts by increasing technical assistance in its areas of comparative advantage: tobacco surveillance, taxation, product regulation, and monitoring and evaluation.

Tobacco Use Is Arguably the Greatest Threat to Global Health

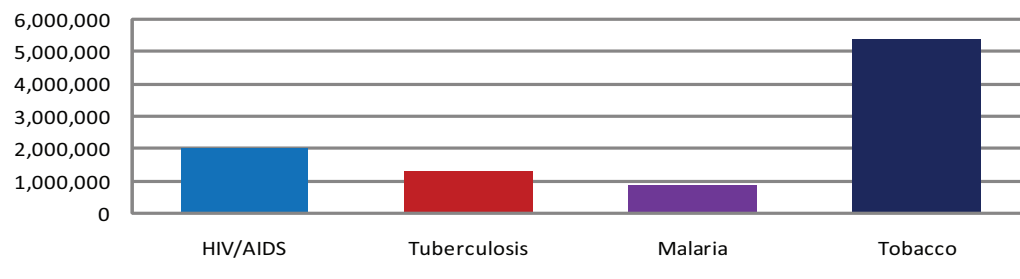
Tobacco use is the leading cause of disease and premature death worldwide (figure 1). There are 1.2 billion smokers worldwide, roughly one-third of the world's adult population.³ Seven hundred million children—approximately 40 percent of all children—are exposed to secondhand tobacco smoke at home.⁴ Tobacco use is generally higher among the poor and is increasing among girls.⁵ Tobacco use and secondhand smoke are directly linked to the onset of an astonishing number of diseases—cancers, cardiovascular disease, strokes, childhood illnesses, pregnancy complications, and respiratory disease. Smoking increases the risks of tuberculosis (TB) infection, drug resis-

3. Lawrence O. Gostin, *Public Health Law: Power, Duty, Restraint*, 2nd ed. (Berkeley: University of California Press, 2008), p. 255.

4. World Health Organization (WHO), *Report on the Global Tobacco Epidemic 2009: Implementing Smoke-Free Environments* (Geneva: WHO, 2009), p. 20.

5. Institute of Medicine, *Promoting Cardiovascular Health in the Developing World: A Critical Challenge to Achieve Global Health* (Washington, D.C.: National Academies Press, 2010), p. 73.

Figure 1. Causes of Global Mortality, 2008



Sources: UNAIDS, “AIDS Epidemic Update – December 2009”; WHO, “Tuberculosis Fact Sheet”; Kaiser Family Foundation, “Estimated Malaria Deaths 2006–2008”; WHO, “Report on Global Tobacco Epidemic 2009.”

tance, poor treatment outcomes, and mortality.⁶ According to the WHO, tobacco-related diseases kill more than five million people annually—more than HIV/AIDS, malaria, and TB combined.⁷ The WHO attributes an additional 600,000 premature deaths per year to secondhand smoke.⁸ If current trends persist, the WHO predicts that tobacco-related deaths will claim more than eight million people per year by 2030 and one billion lives by the end of this century.⁹ More than 80 percent of these deaths will occur in developing countries.¹⁰

Beyond the loss of life, tobacco use has dramatic social and economic consequences. Tobacco-related illness is the top health expenditure in many countries.¹¹ These costs consume scarce health care resources in developing countries and undermine the capacity of health systems in those countries to respond to infectious and nutritional diseases and other health threats. Tobacco use also consumes household budgets, robs families of their primary wage earners, and hinders economic development.¹² The American Cancer Society estimates that tobacco use imposes \$500 billion in costs annually on the world economy, which is approximately three times more than the tax revenues that governments generate from tobacco use each year.¹³

6. Ibid., pp. 103–104.

7. WHO, *Report on the Global Tobacco Epidemic 2009*, pp. 13–14.

8. Ibid., p. 20.

9. Ibid., p. 14.

10. Omar Shafey et al., *The Tobacco Atlas*, 3rd ed. (Atlanta, Ga.: American Cancer Society, 2009), p. 38.

11. Lawrence O. Gostin, “Global Regulatory Strategies for Tobacco Control,” *JAMA* 298, no. 17 (2007): 2057.

12. See Institute of Medicine, *Promoting Cardiovascular Health in the Developing World*, pp. 136–142, which describes the impact of cardiovascular disease globally, including from tobacco use in particular, in terms of direct costs (health care expenditures, lost productivity, and earnings) and indirect costs (lower savings, less investment and education), as experienced on both macroeconomic and microeconomic levels; see also Ying Xin et al., “The Impact of Smoking and Quitting on Household Expenditure Patterns and Medical Care Costs in China,” *Tobacco Control* (January 21, 2009), <http://tobaccocontrol.bmj.com/content/early/2009/01/21/tc.2008.026955>, which reports survey results in rural China revealing that smoking reduced expenditures on basic needs such as food, utilities, durable goods, and education; and Roy M. John, “Crowding Out Effect of Tobacco Expenditure and Its Implications on Household Resource Allocation in India,” *Social Science and Medicine* 66 (2008): 1356, which reports that households in India that consumed tobacco had lower nutritional intake and education and less clean fuel consumption than tobacco-free households.

13. Shafey et al., *Tobacco Atlas*, p. 42; WHO, *Report on the Global Tobacco Epidemic 2009*, pp. 10, 60, which reports that governments collect \$167 billion in tobacco taxes. See also Roy M. John et al., “Economic

Tobacco Use Is One of the Most Preventable Threats to Global Health

Tobacco control works. The strategies of global tobacco control are evidence based and cost-effective, and offer the opportunity to avert millions of premature deaths in a sustainable manner. Excise taxes, bans on smoking in public settings, and marketing restrictions have cut smoking rates in developed and developing countries alike. Between 2002 and 2007, the New York City tobacco control program reduced adult-smoking prevalence from 21.5 percent to 17.5 percent, which is expected to result in 80,000 fewer smoking-related premature deaths.¹⁴ Low- and middle-income countries like Bhutan, Poland, South Africa, and Thailand have likewise implemented successful tobacco control programs.¹⁵ Extensive independent analysis has confirmed that comprehensive tobacco control programs are cost-effective.¹⁶ According to a recent analysis, a 20 percent global decline in adult smoking by 2020 would prevent 100 million premature tobacco-related deaths.¹⁷

The FCTC provides a blueprint for comprehensive tobacco control and a platform for policy coordination and development. The WHO developed the FCTC to address the challenges of implementing and maintaining tobacco control programs in the face of globalizing tobacco trade, industry influence, and marketing.¹⁸ The FCTC entered into force on February 27, 2005, and quickly became one of the world's most widely subscribed treaties with 170 states that are parties to the FCTC, representing 86 percent of the world's population.¹⁹

FCTC represents a top-down approach to global tobacco control. States that are parties to the FCTC are required to implement specific domestic tobacco control strategies to reduce the supply and demand for tobacco products.²⁰ FCTC demand reduction strategies include price and tax measures as well as nonprice measures such as smoke-free legislation; tobacco product

Cost of Tobacco Use in India," *Tobacco Control* 18 (2009): 138, which estimates that the total economic cost of tobacco use in India in 2004 was \$1.7 billion, which is more than the \$1.46 billion that India collected that year in tobacco excise taxes and much more than the \$551,876 that India spent on tobacco control activities.

14. "Implementation of Tobacco Control Policies Proves Hard to Do," *Lancet* 369, no. 9580 (2007): 2133.

15. See WHO, *Report on the Global Tobacco Epidemic 2009*, pp. 61, E238–41, E258–261, E284–85; Molly Kinder, "Case 14: Curbing Tobacco Use in Poland," in *Millions Saved: Proven Successes in Global Health*, ed. Ruth Levine (Washington, D.C.: Center for Global Development, 2004); Sonam Ugen, "Bhutan: The World's Most Advanced Tobacco Control Nation?" *Tobacco Control* 12 (2003): 431; Mia Malan and Rosemary Leaver, "Political Change in South Africa: New Tobacco Control and Public Health Policies" in *Tobacco Control Policy: Strategies, Successes, and Setbacks*, ed. Joy de Beyer and Linda Waverley (Washington, D.C.: RITC and World Bank, 2003), p. 121; Prakrit Vateesatokit, "Tailoring Tobacco Control Efforts to the Country: The Example of Thailand," in *Tobacco Control Policy*, ed. de Beyer and Waverley.

16. See Institute of Medicine, *Promoting Cardiovascular Health in the Developing World*, pp. 320, 338–347, which summarizes the substantial literature that supports the cost-effectiveness of anti-tobacco regulatory interventions such as taxation, smoke-free public places, restrictions on marketing, and youth cessation.

17. Thomas R. Frieden and Michael Bloomberg, "How to Prevent 100 Million Deaths from Tobacco," *Lancet* 369 (2007): 1758.

18. Gro Harlem Brundtland, "Achieving Worldwide Tobacco Control," *JAMA* 284 (2000): 750.

19. There are currently 171 parties to the FCTC, but one is the European Community, which is not a state. See "Parties to the WHO Framework Convention on Tobacco Control," WHO, FCTC, 2010, www.who.int/fctc/signatories_parties/en/index.html.

20. FCTC, arts. 4–5.

advertising, packaging, and labeling regulation; and cessation support programs.²¹ FCTC supply reduction strategies include controlling illicit trade in tobacco products, sales to minors, and crop substitution.²² The FCTC, however, does not contain specific standards for national tobacco control strategies or mechanisms for monitoring or enforcing their implementation.²³ Instead, the Conference of Parties (COP) supplements FCTC obligations over time through the development of more detailed guidelines and protocols. To date, the COP has developed nonbinding guidelines on smoke-free legislation and tobacco product packaging, advertising, promotion, and sponsorship, and it is in the midst of developing a binding protocol on cigarette smuggling for completion in 2012.²⁴ In 2008, the WHO, with the support of the Bloomberg Initiative to Reduce Tobacco Use, also developed MPOWER, a package of evidence-based, actionable, and measurable strategies to support FCTC implementation at the country level.²⁵

Implementation of the WHO FCTC Is Lagging

Despite its widespread adoption, FCTC implementation and tobacco control efforts in developing countries are largely stalled. The WHO's 2009 report on the global tobacco epidemic revealed that:

- Less than 10 percent of the world's population is covered by any of the WHO-recommended measures to reduce demand for tobacco;
- 90 percent of the world's population is without protection from tobacco industry marketing;
- 95 percent of the world's population lives in countries where taxes represent less than 75 percent of the retail cigarette price; and
- Only 9 percent of FCTC member states mandate smoke-free bars and restaurants, and 65 member states report no implementation of any smoke-free policies on a national level.²⁶

Some of the reasons why FCTC implementation is stalled can be attributed to the industry and countries involved. As tobacco use has declined in rich countries, transnational tobacco companies have aggressively sought to expand markets for their products in low- and middle-income countries.²⁷ Many countries lack the governance, resources, and capacity to implement effective

21. FCTC, arts. 6–14.

22. FCTC, arts. 15–17.

23. See Gostin, *Public Health Law*, p. 255, which notes that the FCTC is vulnerable to the critique that its provisions are hortatory and nonobligatory, soft rather than hard law.

24. WHO, *Guidelines for implementation of the WHO Framework Convention on Tobacco Control* (Geneva: WHO, 2009), www.who.int/fctc/guidelines/en/. See Rebecca L. Haffajee and M. Gregg Bloche, "The FCTC and the Psychology of Tobacco Control," *Asian Journal of WTO and International Health Law and Policy* 5 (2010): 87, 92–97, which concludes that FCTC guidelines are not legally binding.

25. The acronym MPOWER stands for Monitor tobacco use and policies; Protect people from second-hand smoke; Offer help to quit; Warn about the dangers of tobacco; Enforce bans on advertising, promotion, and tobacco company sponsorship; and Raise taxes on tobacco products. See WHO, *Report on the Global Tobacco Epidemic, 2008: The MPOWER Package* (Geneva: WHO, 2008), www.who.int/tobacco/mpower/2008/en/index.html.

26. WHO, *Report on the Global Tobacco Epidemic 2009*, pp. 7–10, 36, 60.

27. Jesse Bump et al., *Towards a Political Economy of Tobacco Control in Low- and Middle-Income Countries* (Washington, D.C.: International Bank for Reconstruction and Development/World Bank, 2009), pp. 1, 17–19.

and sustainable tobacco control programs.²⁸ New tobacco control initiatives face fierce political opposition from foreign and local producers—some of which may be fully or partly owned by the government.²⁹ Governments fear that increased tobacco taxes will harm local economic interests and incite political unrest among low-income smokers. Globally, governments collect 173 times more in annual tobacco tax revenues—\$167 billion—than they spend each year—\$965 million—on tobacco control.³⁰ Consumers and policymakers in many developing countries are not fully aware of the health consequences of tobacco use.³¹ Governments lack accountability to their constituents for the consumption of a legal product for which the health consequences are not apparent for years. Patient groups are nonexistent or a minor presence in most developing countries. Civil litigation, which played a critical role in improving tobacco control and education in the United States, is far less common and successful in developing countries.³²

Part of the lagging implementation is, however, attributable to the design of the FCTC itself. The FCTC prioritizes tobacco control inputs—specific supply and demand reduction measures and policies—over outcomes—reduced tobacco use.³³ It also does not provide resources, technical support, or incentives for developing-country implementation. Perhaps accordingly, most FCTC parties have adopted those FCTC-prescribed measures that encounter little industry resistance—educational programs, prohibitions of sales to minors, and warnings on tobacco packaging—rather than the strategies—increased excise taxes, advertising bans, and smoke-free legislation—that have proven to be the most effective at cutting tobacco use prevalence.³⁴

The absence of effective collective action to address the tobacco epidemic has had harmful effects. Countries seeking to address the negative health impact of tobacco products have undertaken uncoordinated tobacco control regulation and taxation. Differences in their approaches have sparked trade disputes and increased the potential for cigarette smuggling.

There is nothing inherently inconsistent between tobacco control and international trade law. Generally speaking, tobacco control measures—such as excise taxes, bans on tobacco advertisement, and labeling requirements—are consistent with international trade law so long as they do not discriminate between domestic and imported versions of the product (national treatment) or different exporting countries (most-favored-nation treatment), are based on scientific evidence,

28. *Ibid.*, p. 60; Frieden and Bloomberg, “How to Prevent 100 Million Deaths from Tobacco,” p. 1758; Brundtland, “Achieving Worldwide Tobacco Control,” p. 751.

29. See, for example, Bump et al., *Towards a Political Economy of Tobacco Control*, pp. 18–19; Sebastián Albuja and Richard A. Daynard, “The Framework Convention on Tobacco Control (FCTC) and the Adoption of Domestic Tobacco Control Policies: The Ecuadorian Experience,” *Tobacco Control* 18 (2009): 18, which describes international and local tobacco companies’ efforts to undermine FCTC implementation in Ecuador; and K. Alechnowicz and Scott Chapman, “The Philippine Tobacco Industry: The Strongest Tobacco Lobby in Asia,” *Tobacco Control* 13 (2004): 71, which outlines successful tobacco industry efforts to thwart tobacco marketing, advertising, and packaging restrictions in the Philippines.

30. WHO, *Report on the Global Tobacco Epidemic 2009*, pp. 10, 60.

31. Prabhat Jha et al., “Tobacco Addiction,” in *Disease Control Priorities in Developing Countries*, 2nd ed., ed. Dean T. Jamison et al. (New York: Oxford University Press; Washington, D.C.: World Bank, 2006).

32. Lawrence O. Gostin, “The ‘Tobacco Wars’—Global Litigation Strategies,” *JAMA* 298 (2007): 2537.

33. See Haffajee and Bloche, “The FCTC and the Psychology of Tobacco Control,” which criticizes the command-and-control approach of the FCTC and its guidelines for failing to address the psychological and cultural reasons why people engage in risky behavior.

34. WHO, *Report on the Global Tobacco Epidemic 2009*, pp. 7–10, 36, 60.

and are no more restrictive than scientifically necessary.³⁵ In practice, however, national tobacco control regulations are an increasing source of World Trade Organization (WTO) dispute settlement, with two actions already in 2010 and a third on the way.³⁶ These suits include a WTO action brought by Indonesia over the recent U.S. ban on clove cigarettes. In March 2010, an international tobacco company filed the first-known bilateral investment treaty (BIT) claim against a domestic tobacco regulation.³⁷

The illicit trade in cigarettes is likewise in part a product of the failure of collective action on tobacco control. International cigarette smuggling is estimated to account for 10.7 percent of sales or 600 billion cigarettes annually.³⁸ Cigarettes are often smuggled because taxes represent a large share of their price, making illicit trade profitable. The problem is particularly acute where there are significant variations in cigarette tax rates among neighboring states and in countries where informal markets and widespread corruption facilitate contraband sales.³⁹ Cigarette smuggling undermines taxation as an element of tobacco control and deprives governments of billions of dollars in revenue. Smuggled cigarettes evade health regulations on youth access, additives, and labeling requirements.⁴⁰

Current U.S. Engagement on Tobacco Control

The United States has a long history of leadership on domestic tobacco control. The 1964 advisory report to the U.S. surgeon general was among the earliest evidence of the negative health effects of tobacco consumption and led to increased worldwide awareness of these risks.⁴¹ The United States

35. General Agreement on Tariffs and Trade 1994 (GATT), arts. I, III, XX(b), (d). See “Thailand—Restrictions on Importation of and Internal Taxes on Cigarettes,” report of the panel adopted on November 7, 1990, DS10/R, 37S/200, ¶ 73, www.sice.oas.org/dispute/gatt/90CIGAR2.asp, which ruled that smoking constitutes a serious risk to human health and held that Thailand’s taxes, advertising bans, labeling, and price restrictions qualified under the health exception in GATT Article XX(b), but its ban on cigarette imports did not.

36. See “DS411, Armenia—Measures Affecting the Importation and Internal Sale of Cigarettes and Alcoholic Beverages (Complainant: Ukraine), July 20, 2010”; “DS406, United States of America—Measures Affecting the Production and Sale of Clove Cigarettes (Complainant: Indonesia), April 7, 2010.” More than 20 WTO members have raised concerns at WTO meetings about Canada’s Cracking Down on Tobacco Marketing Aimed at Youth Act, which bans the manufacture and sale of cigarettes containing a range of additives and may effectively prohibit traditional blended cigarettes containing burley tobacco. See “Tobacco and Alcohol Again Among Members’ Trade Concerns,” *WTO News*, June 23–24, 2010.

37. See “Tobacco Company Files Claim against Uruguay over Labelling Laws,” *Bridges Weekly Trade News Digest*, March 10, 2010, which reports that Philip Morris International filed a complaint against Uruguay for labeling requirements that allegedly harm the company’s trademarks and market share.

38. Framework Convention Alliance, “How Big Was the Global Illicit Tobacco Trade Problem in 2006?” (paper prepared for the second session of the Conference of the Parties to the WHO FCTC, Bangkok, June 30–July 6, 2007, p. 5).

39. Dan Merriman et al., “How Big Is the Worldwide Cigarette-Smuggling Problem?” in *Tobacco Control in Developing Countries*, ed. Prabhat Jha and Frank J. Chaloupka, pp. 365–367 (New York: Oxford University Press, 2000); Prabhat Jha and Frank J. Chaloupka, eds., *Curbing the Epidemic: Governments and the Economics of Tobacco Control* (Washington, D.C.: World Bank, 1999), pp. 64–65.

40. Tsai-yu Lin, “Exploring a Modest Balance for Trade in Tobacco, Anti-Tobacco Smuggling, and Health Concerns in Light of the Dominican Republic-Cigarettes Case,” *Asian Journal of WTO and International Health Law and Policy* 3 (2008): 311.

41. *Smoking and Health: Report of the Advisory Committee to the Surgeon General* (Washington, D.C.: U.S. Department of Health, Education, and Welfare, 1964).

was an early mover on warning labels on cigarette packages (1965), banning cigarette advertising on television and radio (1971), forbidding smoking on commercial flights (1987), and identifying the addictive properties of nicotine (1988).⁴² U.S. criminal and civil tobacco litigation uncovered tobacco product risks, punished tobacco company malfeasance, compensated victims, and deterred future harmful behavior.⁴³ In 2004, Congress ended the U.S. tobacco price support program that had operated since the late 1930s and subsidized tobacco growers with \$1.57 billion between fiscal years 1985 and 2005.⁴⁴

U.S. cities and states, New York City and California in particular, have led the way with groundbreaking and effective tobacco control programs. On June 22, 2009, President Barack Obama signed the historic Family Smoking Prevention and Tobacco Control Act (FSPTCA), empowering the U.S. Food and Drug Administration (FDA) to regulate the domestic manufacture, labeling, advertising, and sale of tobacco products.⁴⁵ The Congressional Budget Office estimates that the FSPTCA will reduce U.S. youth smoking by 11 percent over the next decade.⁴⁶ Although more remains to be done domestically, the percentage of U.S. adults who smoke dropped from 42 percent to 19 percent between 1965 and 2008.⁴⁷

In contrast, U.S. engagement on global tobacco control has been limited. On January 18, 2001, President Bill Clinton issued an executive order instructing U.S. executive branch agencies to take “strong action to address the potential global epidemic of diseases caused by tobacco use.”⁴⁸ That order, which remains in effect, requires U.S. agencies to support bilateral and multilateral efforts on global tobacco prevention and control, work to deter youth smoking globally, better coordinate U.S. trade and public health policies on tobacco, conduct an international tobacco control needs assessment pilot, and develop a research and training program that links U.S. and foreign institutions on global tobacco control. Nearly 10 years later, however, the United States is among a small minority of states that have signed but not ratified the FCTC. In 2009, U.S. funding for global health was \$8.38 billion; the annual U.S. budget dedicated to international tobacco control was approximately \$7 million.⁴⁹ Most of that support comes through programs at the U.S. Centers for Disease Control and Prevention (CDC) and National Institutes of Health (NIH).

42. *Trade and Health Issues: Dichotomy between U.S. Tobacco Export Policy and Antismoking Initiatives*, Report no. GAO/NSIAD-90-190 (Washington, D.C.: U.S. General Accounting Office, 1990), p. 35.

43. Gostin, “The ‘Tobacco Wars.’”

44. Jasper Womach, “Tobacco-Related Programs and Activities of the U.S. Department of Agriculture: Operation and Cost,” Report no. 97-417 (Washington, D.C.: Congressional Research Service, September 27, 2006).

45. *Family Smoking Prevention and Tobacco Control Act*, Public Law 111-31, codified at U.S. Code 21 (2009), § 321.

46. “Congressional Budget Office, Cost Estimate: H.R. 1256, Family Smoking Prevention and Tobacco Control Act,” March 16, 2009, www.cbo.gov/ftpdocs/100xx/doc10025/hr1256.pdf.

47. “Trends in Current Cigarette Smoking among High School Students and Adults, United States, 1965–2007,” Centers for Disease Control and Prevention, 2009, www.cdc.gov/tobacco/data_statistics/tables/trends/cig_smoking/index.htm; but see Lawrence Deyton, Joshua Sharfstein, and Margaret Hamburg, “Tobacco Product Regulation—A Public Health Approach,” *New England Journal of Medicine* 362 (2010): 1753, which reports that in 2008 tobacco use still caused more than 400,000 U.S. deaths and led more than 8.5 million Americans to have chronic illnesses.

48. Executive Order no. 13,193: “Federal Leadership on Global Tobacco Control and Prevention,” January 18, 2001, *Federal Register* 66: 7387.

49. Jen Kates, “The U.S. Global Health Initiative: Overview & Budget Analysis,” Policy Brief, Kaiser Family Foundation, Menlo Park, Calif., December 2009.

The CDC conducts and supports tobacco surveillance in low- and middle-income countries. In 1998, the CDC, WHO, and the Canadian Public Health Association initiated the Global Tobacco Surveillance System (GTSS) to assist countries in establishing tobacco control surveillance and monitoring programs.⁵⁰ GTSS consists of three school-based surveys of youth, school personnel, and students in the health professions as well as a household survey of adults. The CDC provides financial and technical support, fieldwork training, and data management for GTSS. The youth survey has been conducted for more than ten years in 167 WHO member states and other territories.⁵¹ By all accounts, the CDC's contributions have greatly improved the reliability of GTSS survey data and the validity of its statistical analyses.⁵² These efforts also cost the CDC less than \$3 million in 2009, which represented less than 3 percent of its overall tobacco control budget.⁵³

In 2001, pursuant to President Clinton's executive order, NIH's Fogarty International Center launched a grant program, the International Tobacco and Health Research and Capacity Building Program for tobacco control research and training.⁵⁴ This program supports transdisciplinary research and capacity building in low- and middle-income countries and has provided \$37 million for 25 grants to be conducted through FY 2012.⁵⁵

Global tobacco control also benefits from U.S. financial support for the WHO generally and NIH-funded scientific research on tobacco addiction and cessation. U.S. federal employees provide ad hoc and informal technical assistance on tobacco taxation and other related matters. The U.S. Agency for International Development (USAID) has a formal tobacco policy, reissued in August 2009, which indicates that USAID will not undertake tobacco control programs for staffing and budget reasons, but will seek to support such efforts through its participation in international policy forums and via other relevant performance goals.⁵⁶ Otherwise, U.S. development agencies have, to date, implemented almost no programs on international tobacco control. The FDA likewise has few, if any, programs on international tobacco control. FSPTCA specifically excludes

50. "Global Tobacco Surveillance System (GTSS)," Centers for Disease Control and Prevention, www.cdc.gov/tobacco/global/gtss/index.htm.

51. Charles W. Warren et al., "Evolution of the Global Tobacco Surveillance System (GTSS) 1998–2008," *Global Health Promotion*, supp. 2 (2009).

52. See, for example, Institute of Medicine, *Promoting Cardiovascular Health in the Developing World*, pp. 167, 403. It is unclear whether the CDC produced or released the pilot tobacco control needs assessment required under the 2001 executive order, but CDC support for GTSS has a similar function and is most likely more effective.

53. The FY 2009 budget for the Global Tobacco Control Branch of the CDC Office of Smoking and Health is \$2.6 million and the FY 2010–2012 budget for the field epidemiology training program is \$600,000. The CDC's overall FY 2009 budget for its tobacco programs was \$106,164,000. *Department of Health and Human Services, Fiscal Year 2010: Centers for Disease Control Justifications of Estimates for Appropriations Committees*, 2010, p. 162. The Bloomberg Initiative contributes an additional \$13 million via the CDC Foundation to support CDC's efforts on the GATS implementation in developing countries.

54. "International Tobacco and Health Research and Capacity Building Program," Fogarty International Center, U.S. National Institutes of Health, 2009, www.fic.nih.gov/programs/research_grants/tobacco/.

55. "NIH Awards Nearly \$17 Million for Projects Focused on Reducing Tobacco-Related Deaths in Developing Nations," Fogarty International Center, U.S. National Institutes of Health, November–December 2007, www.fic.nih.gov/news/publications/global_health_matters/GHM_tobacco_12-07.htm; "Fogarty International Center Announces First Awards for International Tobacco and Health Research and Capacity Building Program," NIH News Release, September 25, 2002, www.nih.gov/news/pr/sep2002/fic-25.htm.

56. "ADS, Chapter 210: Tobacco Policy," USAID, August 7, 2009, www.usaid.gov/policy/ads/200/210.pdf.

manufacturers and distributors that do not manufacture, package, or import cigarettes for U.S. sale or distribution from the act's restrictions on cigarette marketing and labeling.⁵⁷

Finally, the United States has somewhat restricted its support for tobacco trade and promotion. In the past, the United States had used bilateral trade measures to pressure emerging Asian economies into opening their markets to imported cigarettes.⁵⁸ The entry of multinational tobacco companies sharply increased consumption in these countries, which were unprepared for intensive tobacco marketing, particularly to women and youth.⁵⁹ In 1998, Representative Lloyd Doggett (D-TX) attached to an appropriations bill an amendment barring U.S. agencies from promoting “the sale or export of tobacco or tobacco products” or seeking the “reduction or removal by any foreign country of restrictions on the marketing of tobacco or tobacco products” unless those restrictions “are not applied equally to all tobacco or tobacco products of the same type.”⁶⁰ President Clinton's 2001 executive order reaffirmed the Doggett Amendment, but it included an expanded exception allowing U.S. agencies to take all necessary actions under U.S. trade laws and international agreements to ensure nondiscriminatory treatment of U.S. tobacco products.⁶¹

The impact of these restrictions has been mixed at best. On one hand, the Doggett Amendment has enabled the Office of the U.S. Trade Representative to resist congressional pressure to challenge other countries' tobacco control regulations in WTO dispute resolution.⁶² The U.S. Department of Health and Human Services also now participates in interagency discussions of U.S. trade policy and negotiations related to tobacco products.⁶³ On the other hand, U.S. trade actions continue to liberalize tobacco trade. The United States compelled China, as a condition of its 2001 WTO accession, to agree to reduce its tariffs on imported cigarettes and eliminate nontariff barriers to foreign cigarette sales.⁶⁴ Nearly all active and pending U.S. free trade agreements (FTAs) negotiated since the Doggett Amendment reduce or eliminate trading partners' tariffs on tobacco

57. *Family Smoking Prevention and Tobacco Control Act*, § 201.

58. See *Trade and Health Issues*, pp. 22–23, which describes the U.S. government actions pursuant to Section 301 of the U.S. Trade Act during the 1980s against six Asian countries.

59. See Allyn Taylor et al., “The Impact of Trade Liberalization on Tobacco Consumption,” in *Tobacco Control Policies in Developing Countries*, ed. Jha and Chaloupka, pp. 343–364; Frank Chaloupka et al., “U.S. Trade Policy and Cigarette Smoking” (working paper no. 5543, Asia National Bureau of Economic Research, 1996); and *Trade and Health Issues*, which notes that during the first year after the introduction of multinational cigarette companies into South Korea, smoking among teenagers rose from 18.4 percent to 29.8 percent and smoking among female teens quintupled, from 1.6 percent to 8.7 percent.

60. *Tobacco Exports: USDA's Foreign Agricultural Service Lacks Specific Guidance for Congressional Restrictions on Promoting Tobacco*, Report no. GAO-03-618 (Washington, D.C.: U.S. General Accounting Office, 2003), p. 23.

61. Executive Order no. 13,193: “Federal Leadership on Global Tobacco Control and Prevention.”

62. See “Opposition to Canada Tobacco Law Mounts, But U.S. Unlikely to Fight,” *Inside U.S. Trade*, April 9, 2010.

63. See, for example, House Committee on Ways and Means, *President's Fiscal Year 2004 Budget for the U.S. Department of Health and Human Services*, 108th Cong., 1st sess., February 6, 2003, which includes a statement from the secretary of the Department of Health and Human Services Tommy Thompson that indicated that his department participated in the deliberations of the Trade Policy Staff Committee and Trade Policy Review Group on extending eligibility under the Generalized System of Preferences to tobacco products from Indonesia and U.S. negotiations of tobacco tariff reductions in Chile, Australia, Costa Rica, El Salvador, Guatemala, Honduras, Nicaragua, and the Dominican Republic.

64. Fei Zhong and Eiji Yano, “British American Tobacco's Tactics during China's Accession to the World Trade Organization,” *Tobacco Control* 16 (2007): 133.

products.⁶⁵ All U.S. BITs cover tobacco-related investment.⁶⁶ BITs have facilitated the establishment of multinational cigarette company production facilities in low- and middle-income countries and helped companies evade tariffs, lower production costs, and exercise increased influence on local policies.⁶⁷

The Case for Increased U.S. Engagement on Global Tobacco Control

The modest current U.S. engagement on global tobacco control does not accord with U.S. policy, as mandated under the 2001 executive order, to take strong action to prevent a global epidemic of tobacco-related disease. That said, global tobacco control has several disadvantages in competing for scarce U.S. global health resources. With the significant exception of TB, tobacco-related diseases are noncommunicable; the health of U.S. citizens does not depend on health of other states' citizens with respect to tobacco use. While cigarette consumption increases in developing countries, its adverse health effects will not be apparent for years. Tobacco control requires sustained and coordinated interventions, which are difficult to marshal.⁶⁸ The global tobacco epidemic is at its worst in emerging economies—China, Russia, India, Brazil, and Indonesia—which have resources to counteract this rise.⁶⁹ Finally, many perceive tobacco use to be a consumer choice involving a legal product despite study after study that demonstrates the devastating health effects of secondhand smoke and that most smokers start in their impressionable teens and underestimate the risk of addiction and its economic and health consequences.⁷⁰

This analysis, however, does not adequately reflect the global tobacco disease burden or U.S. interests in the FCTC as a cornerstone of global health governance and global tobacco control.

65. See “United States–Singapore Free Trade Agreement,” entry into force on January 1, 2004, at annex 2C; “United States–Australia Free Trade Agreement,” entry into force on January 1, 2005, at chapter 2; “United States–Morocco Free Trade Agreement,” entry into force January 1, 2006, at annex IV; “United States–Peru Trade Promotion Agreement,” entry into force February 1, 2009, at annex 2.3; “Agreement between the Government of the United States of America and the Government of the Sultanate of Oman on the Establishment of a Free Trade Area,” entry into force on January 1, 2009, at annex 2-B; “United States–Colombia Trade Promotion Agreement,” signed November 22, 2006, at annex 2.3; “U.S.–Panama Free Trade Agreement,” signed June 28, 2007, at Panama Agricultural Tariff Schedule; “Free Trade Agreement between the United States and the Republic of Korea,” signed June 30, 2007, at annex 2-B. The only exception is the U.S. FTA with Jordan, which does not address tobacco product tariffs, perhaps for religious reasons.

66. For a list of bilateral investment treaties, including electronic links, see U.S. Trade Compliance Center, U.S. International Trade Administration, http://tcc.export.gov/Trade_Agreements/Bilateral_Investment_Treaties/index.asp.

67. See Chang-fa Lo, “FCTC Guidelines on Tobacco Industry Foreign Investment Would Strengthen Controls on Tobacco Supply and Close Loopholes in the Tobacco Treaty,” *Tobacco Control* 19 (2010): 306.

68. See David P. Fidler, “The Challenges of Global Health Governance” (working paper, Council on Foreign Relations, New York, May 2010), p. 8, which notes that states tend to pursue global health problems that directly threaten their interests, require collective action, and involve limited, feasible interventions.

69. Two-thirds of the world’s smokers live in 10 countries: China (which has 30 percent), India, Indonesia, the Russian Federation, the United States, Japan, Brazil, Bangladesh, Germany, and Turkey. Tracy Hampton, “Global Report Highlights Tobacco Use, Offers Countermeasures for Nations,” *JAMA* 299 (2010): 1531.

70. See, for example, *The Health Consequences of Involuntary Exposure to Tobacco Smoke: A Report of the Surgeon General* (Washington, D.C.: U.S. Department of Health and Human Services, Public Health Service, 2006); Prabhat Jha et al., “The Economic Rationale for Intervention in the Tobacco Market,” in *Tobacco Control in Developing Countries*, ed. Jha and Chaloupka, pp. 877–881.

Tobacco use is the greatest threat to global health. U.S. leadership in global health is a rare area of political consensus in increasingly partisan times. U.S. investments in global health are visible, concrete, and highly valued; they save lives and enhance U.S. credibility around the world.⁷¹ In a recent speech before the UN, President Obama cited global health and development as not only moral imperatives, but U.S. strategic and economic imperatives.⁷² In a recent speech, Secretary of State Hillary Rodham Clinton cited humanitarian interest and economic and social development in less-developed countries as key drivers of U.S. global health investments.⁷³ Few global health threats can compare with the human and economic toll of tobacco-related diseases in developing countries. Improved global tobacco control is central to the realization of U.S. global health and development goals on disease prevention, TB control, maternal and child health, and health system strengthening.

Tobacco control works. The consultation document for the Global Health Initiative—the Obama administration’s new comprehensive U.S. global health strategy—indicates that future U.S. global health investments will target what has worked in the past, the potential to build on and expand existing platforms, and the possibility for strong collaboration with partners.⁷⁴ Few global health issues meet these standards as well as global tobacco control. Tobacco control programs are cost-effective and have succeeded in developed and developing countries alike. The WHO FCTC is among the most widely adopted international treaties and provides a platform for future efforts. The MPOWER package outlines evidence-based, actionable, and measurable strategies for FCTC implementation at the country level. The WHO, the Bill & Melinda Gates Foundation, the Bloomberg Initiative, and other well-established nongovernmental organizations (NGOs) all work on global tobacco and would be capable potential U.S. partners.

Increased U.S. engagement would make a difference. The United States can help prevent critical expansions in the tobacco epidemic. Without effective global tobacco control, the demographic shift in tobacco consumption from industrialized countries to developing countries continues, spurred by rising incomes, trade liberalization, and intensive global marketing, particularly to women and youth. While that shift is already well established in Asia, Eastern Europe, and Latin America, it has yet to take hold in Africa. Tobacco use rates in Africa are relatively low (20 percent for men), but many expect African countries to be the next major potential market for tobacco products.⁷⁵ Many African governments lack the capacity to implement effective national tobacco control programs or the health care resources to cope with a pandemic of tobacco-related diseases. Likewise, women have historically smoked at a significantly lower rate than men in most parts of the developing world, but the Global Youth Tobacco Survey has found that girls now smoke at the

71. “The U.S. Commitment to Global Health: Recommendations for the New Administration” (Washington, D.C.: Institute of Medicine of the National Academies, 2008), p. 1.

72. Barack Obama (remarks of the president at the Millennium Development Goals Summit, United Nations Headquarters, September 22, 2010), www.whitehouse.gov/photos-and-video/video/2010/09/22/president-obama-millennium-development-goals-conference.

73. Hillary Rodham Clinton, U.S. secretary of state (remarks on “Global Health Initiative: The Next Phase of American Leadership in Health around the World,” School of Advanced International Studies, Washington, D.C., August 16, 2010), www.state.gov/secretary/rm/2010/08/146002.htm.

74. “Implementation of the Global Health Initiative: Consultation Document,” U.S. Department of State, 2009, pp. 12–13.

75. “Teaming Up for Tobacco Control,” *Lancet* 372 (2008): 345.

same rate as boys in more than 60 percent of the countries surveyed.⁷⁶ If that trend continues and more women begin smoking at the rates that men do today, associated tobacco-related death rates will sharply increase.

Urgent action can prevent this spread of the tobacco epidemic before it takes hold.⁷⁷ The Gates Foundation, WHO, and NGOs are working to establish prevention programs and legal frameworks for tobacco control in African countries before the epidemic starts. Tobacco control should be incorporated into the growing number of bilateral and multilateral health programs being established to address the needs of women and girls. Increased U.S. leadership and support can help ensure the success of these efforts.

The United States has interests in international tobacco control and global health governance. The United States has interests in the success of the FCTC, even if the United States does not ultimately ratify it. The Obama administration has recognized that multilateral platforms and international partnerships are critical to the sustainable achievement of global health objectives.⁷⁸ The FCTC is the first treaty that the WHO developed and adopted pursuant to its treaty-making authority.⁷⁹ As such, it represents an important step forward for the WHO as an institution and for global health governance generally. The FCTC created and embodies the global anti-tobacco movement.⁸⁰ Failure to implement the FCTC would undermine the FCTC's credibility as an instrument for advancing global tobacco control and would damage the ability of the WHO to lead on other global health challenges.⁸¹

Ineffective collective action on tobacco control has negative consequences for the United States. In the absence of effective collective action to address the tobacco epidemic, countries seeking to address the negative health impact of tobacco products have undertaken uncoordinated efforts on tobacco control regulation and taxation. The absence of coordination has created trade tensions, bred trade disputes, and increased the potential for cigarette smuggling.

So long as tobacco products remain legal, it is not politically feasible to seek their removal from trade agreements or demand a special exclusion from WTO or BIT dispute resolution. Excluding tobacco products or investments from future trade and investment agreements would likewise not accomplish much for the vast majority of states that are already signatories to other

76. Shafey et al., *The Tobacco Atlas*, p. 68; and WHO, "WHO Calls for Protection of Women and Girls from Tobacco" (press release, May 24, 2010), which reports that tobacco advertising increasingly targets girls.

77. See, for example, Ellis Owusu-Dabo et al., "Smoking in Ghana: A Review of Tobacco Industry Activity," *Tobacco Control* 18 (2009): 206, which concludes that an early advertising ban contributed to sustained low levels of tobacco consumption in Ghana, particularly relative to neighboring countries.

78. Jennifer Kates and Rebecca Katz, "U.S. Participation in International Health Treaties, Commitments, Partnerships, and other Agreements" (Menlo Park, Calif.: Kaiser Family Foundation, September 2010), pp. 1-2.

79. "About the WHO Framework Convention on Tobacco Control," WHO, 2010, www.who.int/fctc/about/en.

80. See Institute of Medicine, *Promoting Cardiovascular Health in the Developing World*, p. 394, which notes that WHO efforts to develop the FCTC led the Food and Agriculture Organization (FAO) and World Bank to change their programs supporting tobacco farmers and convinced UNICEF to address aspects of tobacco control that affect children.

81. Fidler, "The Challenges of Global Health Governance," p. 23.

such agreements that cover tobacco.⁸² A more coordinated, international approach to tobacco regulation and control measures through the FCTC is the most sustainable option for reducing the likelihood of trade disputes, including with respect to the new FDA tobacco regulations.⁸³

The United States likewise has interests in preventing international cigarette smuggling. Cigarette smuggling undermines tobacco control and deprives governments of billions of dollars in revenue. It provides opportunities for corruption, undermines the rule of law, and is a potential source of funding for terrorist organizations and organized crime.⁸⁴ Effectively addressing the illicit trade in cigarettes requires a coordinated, multifaceted approach among the law enforcement, finance, and health ministries of affected states.

A Comprehensive, Cost-Effective U.S. Strategy on Global Tobacco Control

Increased U.S. engagement in global tobacco control should begin with ratification of the FCTC. Ratification would be the clearest demonstration of U.S. commitment to global tobacco control and support for the WHO's exercise of its treaty-making power to address global health challenges. Ratification would enable the United States to drive and shape FCTC implementation and guidelines in its areas of interest such as product regulation, taxation, and the illicit tobacco trade.⁸⁵

The United States is, however, unlikely to ratify the FCTC, at least in the near term. Although President Obama is on record supporting FCTC ratification, the administration has not yet submitted the FCTC to the Senate.⁸⁶ This likely reflects the sour U.S. political climate, the preoccupation of the administration and Congress with health care and financial reform, and an increased wariness of treaties rather than a lack of interest in the FCTC. At the time of writing, the administration had submitted only four treaties for ratification to the Senate; the Senate, in turn, had ratified only one of the treaties (a tax agreement with France) during the 112th Congress—the fewest treaties ratified in any Congress in U.S. history.⁸⁷ U.S. congressional elections loom, and there is little reason to expect an outcome that increases cooperation between the administration and Senate on treaty ratification or the FCTC in particular.

82. See Benn McGrady, Trade Liberalization and Tobacco Control: Moving from a Policy of Exclusion towards a More Comprehensive Policy,” *Tobacco Control* 16 (2007): 280.

83. Article 2.4 of the WTO Agreement on Technical Barriers to Trade requires WTO members to use international standards unless they are ineffective or inappropriate for the regulatory purpose sought.

84. Merriman et al., “How Big Is the Worldwide Cigarette-Smuggling Problem?” p. 365; *Terrorist Financing: U.S. Agencies Should Systemically Assess Terrorists’ Use of Alternate Financing Mechanisms*, Report no. GAO-04-163 (Washington, D.C.: U.S. General Accounting Office, November 2003).

85. Under article 29.2 of “Rules of Procedure of the Conference of the Parties to the WHO Framework Convention on Tobacco Control,” the United States is currently restricted to participating in the FCTC COP as an observer, does not have the right to vote, and is limited to speaking after states that are parties to the FCTC.

86. On July 19, 2005, the then senator Obama coauthored a letter (with 10 other senators) describing the FCTC as “crucially important” for domestic and global health and asking President George W. Bush to send the FCTC to the Senate for immediate consideration.

87. John B. Bellinger III, “Without White House Muscle, Treaties Left in Limbo,” *Washington Post*, June 11, 2010, sec. A; Julian Ku, “The Transnationalist Obama Administration, Except on Treaties,” *Opinio Juris Blog*, June 6, 2010, <http://opiniojuris.org/2010/06/11/the-transnationalist-obama-administration-except-on-treaties/>.

The United States need not wait to ratify FCTC before working with the WHO, partner governments, and nonstate actors to realize the treaty’s potential. Increased U.S. technical support and resources for FCTC implementation would accomplish many of the same objectives as ratification—demonstrating U.S. commitment and leadership—and do more to advance global tobacco control. To accomplish these goals, the United States should engage in a four-part strategy that helps provide the resources, incentives, and technical support necessary for developing countries’ implementation of the FCTC.

Make Tobacco Control a Global Health Priority

A necessary first step toward formulating a new U.S. government approach to international tobacco control is acknowledging it as a U.S. global health priority. If global health and disease prevention are strategic U.S. priorities, then international tobacco control must be as well. Moreover, U.S.-based firms, with the support of U.S. trade policy, have stimulated and benefited from tobacco consumption among youth outside our borders; the U.S. government cannot be seen as complacent or indifferent to the consequences.⁸⁸ The Obama administration should recognize global tobacco control as a central component of the achievement of its Global Health Initiative objectives and its signature initiative on noncommunicable disease. This position is consistent with U.S. law and interests in improving global health governance.

Part of this effort should include improving the coherence of U.S. global health and trade policies on tobacco. It is not politically feasible or practical for the United States to remove tobacco from its existing trade agreements or demand a special exclusion from WTO or BIT dispute resolution. Future trade negotiations can also reduce tobacco product subsidies and improve international coordination on tobacco product regulation in ways that further global tobacco control goals. The United States should, however, make it a matter of official U.S. trade policy to refrain from seeking or granting tariff reductions for tobacco products, and it should exclude tobacco-related investments from future FTAs and BITs with developing countries.⁸⁹ Tariff reductions reduce the price of tobacco products, undermining tobacco control in countries without adequate domestic tobacco taxation systems to compensate. U.S.-based multinational tobacco companies have used investments in low- and middle-income countries to evade tariffs, lower production costs, and exercise increased influence on local policies. The impact has been significant in those countries without well-established tobacco control programs or sufficiently powerful civil societies and health ministries to help policymakers resist industry pressure. It should not be U.S. trade policy to facilitate multinational tobacco companies’ efforts by improving the protection for their investments.

88. See John Pekkanen, “Thank You for Smoking,” *Washingtonian*, December 1, 2007, which describes the long history of U.S. government support for tobacco exports in Democratic and Republican administrations alike.

89. The United States and its trading partners have excluded agricultural commodities from past FTAs due to political sensitivities; see Remy Jurenas, *Agriculture in U.S. Free Trade Agreements: Trade with Current and Prospective Partners, Impact, and Issues*, Report no. RL34134 (Washington, D.C.: Congressional Research Service, 2008), which notes that U.S. FTAs with Australia, Jordan, and South Korea exclude sugar, tobacco, and rice, respectively. Investment chapters of U.S. FTAs and BITs routinely operate with negative or positive lists that exclude or include sectors, respectively, from their provisions.

U.S. global health dollars and expertise influence other donor governments and international organizations.⁹⁰ The United States should work with relevant foundations and international and national NGOs to convince multilateral and bilateral development agencies and regional economic and health institutions to likewise prioritize tobacco control in their technical assistance, capacity building, trade, and funding activities. The 2011 G-20 meetings in France and the United Nations Summit on Non-Communicable Diseases provide excellent opportunities for U.S. leadership on global tobacco control.

Improve Resources for Global Tobacco Control

Recent commitments by the Bloomberg Initiative and the Gates Foundation notwithstanding, tobacco control is severely underfunded, particularly in developing countries and relative to other global health programs. Ninety-nine percent of government spending on tobacco control occurs in just 17 developed countries.⁹¹ There is almost no capital investment in tobacco control in developing countries outside of the 15 Bloomberg Initiative focus countries and 5 Gates Foundation focus countries. Per capita spending on tobacco control ranges from one-tenth of one cent per capita per year in low-income countries, to a half cent per capita annually in middle-income countries, and to roughly \$1.80 per capita per year in high-income countries.⁹² A recent analysis indicated that the health development assistance spent per death from HIV/AIDS (\$782), malaria (\$1,189), and tuberculosis (\$1,127) far exceeds the amount spent on tobacco-caused diseases (\$35).⁹³ Nearly four billion people live in low- and middle-income countries that spend less than \$20 million per year combined on tobacco control.⁹⁴ Tobacco industry investments and promotion dwarf these amounts spent on global tobacco control.⁹⁵ The current global economic crisis is likely to further reduce governments' spending on tobacco control.

Successful tobacco control programs require adequate and predictable resources. The United States should seek a commitment among G-20 partner countries to institute a surtax on tobacco consumption to fund global tobacco control programs, particularly in developing countries. Even a relatively small tobacco surtax could generate significant funds. A recent WHO working paper estimated that a voluntary solidarity levy of five cents on packs of cigarettes in high-income countries would generate \$4.6 billion.⁹⁶ That amount would more than quadruple the funding for tobacco control globally.

90. Ruth Levine, "Healthy Foreign Policy: Bringing Coherence to the Global Health Agenda," in *The White House and the World: A Global Development Agenda for the Next U.S. President*, ed. Nancy Birdsall (Washington, D.C.: Center for Global Development, 2008).

91. WHO, *Report on the Global Tobacco Epidemic 2009*, p. 62.

92. Ibid.

93. Cynthia Callard, "Follow the Money: How the Billions of Dollars That Flow from Smokers in Poor Nations to Companies in Rich Nations Greatly Exceed Funding for Global Tobacco Control and What Might Be Done about It," *Tobacco Control* 19 (2010): 285, 288.

94. Ibid.

95. See, for example, Shafey et al., *The Tobacco Atlas*, 68, which states that the tobacco industry spends \$13 billion per year on marketing in the United States alone; Kirill Danishevski et al., "Public Attitudes towards Smoking and Tobacco Control Policy in Russia," *Tobacco Control* 17 (2008): 276, which estimates transnational tobacco industry investments in Russia between its political transition in 1991 and 2000 to be \$1.7 billion.

96. WHO NCDnet International Advisory Council, "Discussion Paper III: Using Tobacco Taxes and an Additional Solidarity Tobacco Levy for International Health" (September 2010), p. 5. A recent task force on

A surtax on tobacco consumption in G-20 countries would have both instrumental and consequential benefits. Increased excise taxes have instrumental benefits because they encourage reduced tobacco consumption, irrespective of how the funding is ultimately spent. This surtax would also have consequential benefits because it would generate much-needed funding for global tobacco control efforts in developing countries.

These surtax revenues should go into a dedicated fund administered by the WHO, World Bank, or an independent international actor. Both the surtax and fund should be transitional in nature, providing time-limited support that begins to decrease gradually after a defined number of years. The duration of that support and the initiation of the phaseout should vary with the level of economic development of the recipient country. Low- and middle-income countries have the potential to levy increased tobacco taxes and must do so in order to reduce domestic consumption. The purpose of the surtax should be to jump-start FCTC implementation, provide start-up investment in tobacco control expertise and capacity, and establish adequate domestic tobacco taxation to fund sustainable MPOWER and other tobacco control programs.

Excise taxes have been used to support other global health programs like UNITAID, but such taxes have required high-level commitment to marshal partner government support and to implement.⁹⁷ The Obama administration would need to demonstrate similar leadership and commitment here. It will not be easy. Many countries, including the United States, have had difficulty earmarking tobacco tax revenues for domestic tobacco control.⁹⁸ The surtax should be modest on a per product basis and temporary. The United States should leverage the need for action in advance of the 2011 UN Summit on Non-Communicable Diseases and in order to make progress on the UN Millennium Development Goals on maternal and child health by their 2015 deadline. Because most G-20 countries other than the United States, Argentina, and Indonesia are parties to the FCTC, the tax would be consistent with their obligations under the FCTC to pursue multilateral mechanisms for ensuring sufficient resources for its implementation.⁹⁹

After G-20 leaders pledge to pursue the surtax for global tobacco control, the parties should convene an expert panel to design that tax (national cigarette excise regimes vary considerably) and determine the appropriate level of taxation.¹⁰⁰ The work of that panel should conclude in time for G-20 governments to announce the surtax and the other strategies described in this paper at the 2011 UN Summit on Non-Communicable Diseases.

innovative financing for health systems, chaired by the then U.K. prime minister Gordon Brown and World Bank president Robert Zoellick, likewise included a recommendation to explore the viability of a global solidarity tobacco levy; see “More Money for Health and More Health for the Money,” Taskforce on Innovative Financing for Health Systems (2009), pp. 11–13.

97. A tax on airline tickets sold in seven countries provides 72 percent of UNITAID’s funding for malaria, HIV/AIDS, and TB programs; see “How Innovative Financing Works,” UNITAID, 2007, www.unitaid.eu/en/How-innovative-financing-works.html.

98. See, for example, Duff Wilson, “Tobacco Funds Dwindle as Obesity Fight Intensifies,” *New York Times*, July 28, 2010, reporting that U.S. state governments use tobacco tax revenues to balance budgets and address other health priorities.

99. FCTC, art. 5.6. Like the United States, Argentina has signed but not yet ratified the FCTC. See “Parties to the WHO Framework Convention on Tobacco Control.”

100. Emil M. Sunley, “Taxation of Cigarettes in Bloomberg Initiative Countries: Overview of Policy Issues and Proposals for Reform” (paper prepared for the Bloomberg Initiative to Reduce Tobacco Use, December 2009), which describes a high degree of variation in national tobacco tax schemes.

Create Incentives for Implementation

Effective tobacco control necessitates sufficient political will for governments to overcome industry opposition, local cultural and environmental factors regarding smoking behavior, competing health and development priorities, and resource scarcities. To help address those challenges, the United States should build incentives for an outcome-driven, bottom-up approach to FCTC implementation in developing countries to complement the top-down, policy prescriptive approach of the FCTC. Funding for such incentives should be derived from the surtax described in the preceding section.

One such approach would be the cash-on-delivery (COD) Aid concept, developed by Nancy Birdsall, William D. Savedoff, and others at the Center for Global Development.¹⁰¹ The basic COD Aid concept is that a funder and recipient enter into a contract in which these parties agree to a mutually desired outcome and fix a payment for each unit of confirmed progress. The funder pays a fixed sum for incremental progress toward an outcome—in this case, some indicator of reduced tobacco use prevalence—rather than specific policy inputs or outputs. The recipient is free to achieve the outcome according to local circumstances. An independent third party collects data and verifies progress on the outcome in order to ensure both the funder and recipient have confidence in the result. Once progress is verified, the funder pays for the improved outcomes. The arrangement is transparent and public. The recipient is free to spend the payment according to its own needs.¹⁰²

In this proposal, the funder would be the independent international entity that administers the tobacco control surtax fund. The recipient would be a national or local government or regional entity. The outcome would be a defined measure of reduced tobacco use. That outcome should be quantifiable and linked to an indicator in the various global tobacco surveillance surveys that the CDC, WHO, and their partners already conduct.

The COD Aid approach would have manifold benefits for global tobacco control. Funders would be more accountable to their citizens and constituents by linking increased assistance to reduced tobacco consumption rather than tobacco control policies. Conversely, the COD Aid approach would introduce accountability for recipient governments on tobacco consumption because the arrangement and its objectives are public and transparent. It would encourage institution building and local solutions to best achieve reductions in tobacco use. By providing unrestricted rewards, the COD Aid approach would align the incentives of local leaders with tobacco control objectives. Finally, this approach would complement the MPOWER approach spearheaded by WHO and the Bloomberg Initiative and the surveillance efforts of CDC and its partners. It would increase developing-country demand for technical assistance on effective tobacco control strategies as well as provide incentives for maximizing the effectiveness of those resources. It would leverage existing tobacco surveillance efforts and create incentives for improved surveillance.

The COD approach would also present challenges. COD Aid payments need not necessarily exceed the costs of improving tobacco control but would have to be sufficient to attract policymakers' attention. Accordingly, COD Aid for tobacco control would be most effective in low-income countries where the rewards provided would be compelling. COD Aid is less likely to be

101. Nancy Birdsall and William D. Savedoff, *Cash on Delivery: A New Approach to Foreign Aid*, with Ayah Mahgoub and Katherine Vyborny (Washington, D.C.: Center for Global Development, 2010).

102. *Ibid.*, pp. 17–20. In the health context, this approach has some similarities with the Global Alliance for Vaccines and Immunization, which in the past had rewarded countries for each child immunized.

a solution for most of the large emerging countries, such as China, India, and Russia, in which tobacco consumption is the greatest, although it may work there on the sub-national level. The low-income countries in which such a COD Aid approach would mostly likely succeed are also those with the least tobacco surveillance and monitoring.¹⁰³ Because COD Aid would reward results, it could introduce distortions in existing tobacco control efforts and bias tobacco surveillance and analysis, which would require careful selection of outcomes and auditing to address. Finally, there are limits to the frequency in which tobacco surveys may be conducted and still yield reliable results; accordingly, there would be a multiyear interval between payments for incremental reductions in tobacco use prevalence. This may reduce the efficacy of the incentive for recipients.

One way forward would be to develop a COD Aid tobacco control pilot and test its feasibility and desirability. On the basis of the above analysis, one promising pilot could be reductions in youth tobacco use in one or more African countries. Considerations of the specific design of such a pilot—including the most appropriate indicator of youth tobacco control; payment size, structure, and schedule; and target countries—are beyond the scope of this policy paper, but they would need to be explored in depth before moving forward.¹⁰⁴ Other incentive mechanisms for low- and middle-income countries' implementation of tobacco control programs may also be appropriate and should be explored further as well.¹⁰⁵

Increase Technical Assistance, Surveillance, and Support for Implementation

FCTC implementation requires a mix of expertise and inputs—trade, taxation, surveillance, program monitoring and evaluation—that have not historically resided at the WHO, regional public health entities, or national health ministries. Much progress has been made in building up that expertise at the WHO Tobacco Free Initiative since the FCTC's entry into force, but the United States should work with G-20 partners and NGOs to further scale up and improve the technical resources of intergovernmental actors. Resources from the surtax should also be used to support tobacco control technical assistance and capacity-building efforts at regional organizations like the African Union, Asia-Pacific Economic Cooperation, and Association of Southeast Asian Nations. These regional and intergovernmental actors can best support FCTC implementation in emerging

103. WHO, *Report on the Global Tobacco Epidemic 2009*, p. 36, which reports that more than 20 percent of low-income countries and 15 percent of middle-income countries have no or inadequate national smoking prevalence data for adults or youth.

104. See, for example, William D. Savedoff et al., “Cash on Delivery Aid for Health” (working paper, Center for Global Development, Washington, D.C., 2010), which assesses potential indicators for COD Aid for reducing child mortality, improving maternal health, and combating HIV/AIDS and malaria.

105. Another possible approach would be a prize fund for international tobacco control programs similar to the Race to the Top fund currently operated by the U.S. Department of Education for state-level education reform. See United States Department of Education, Race to the Top Fund, at <http://www2.ed.gov/programs/racetothetop/index.html>. More research would be needed to determine whether such an approach would be effective on an issue as multisectoral as tobacco control (requiring the cooperation of health, finance, law enforcement, and other ministries) and on national governments (as opposed to an intracountry program targeting subnational or municipal governments). Assessments of the U.S. Millennium Challenge Corporation (MCC), which links U.S. aid to national governments' performance on governance and other indicators, might provide more guidance here. See, for example, Doug Johnson and Tristan Zajonc, “Can Foreign Aid Create an Incentive for Good Governance? Evidence from the Millennium Challenge Corporation” (working paper no. 11, Center for International Development at Harvard University, 2006).

economies with high tobacco consumption that may not be susceptible to new incentives like COD Aid. The United States should support these platforms with increased technical assistance in its areas of comparative advantage: surveillance, taxation, product regulation, and monitoring and evaluation.

Surveillance and monitoring are the bedrock upon which evidence-based, effective tobacco control programs are developed and implemented. Surveillance and monitoring are necessary for understanding consumption trends, local conditions, and the efficacy of existing tobacco control programs. The resulting evidence and analysis can bolster the case for more support and targeted policies. CDC's contributions and technical expertise are already invaluable in this regard. CDC's resources and mandate should be expanded to provide more support for low- and middle-income countries where tobacco use is rising fastest and surveillance data are least reliable. More support is also needed to integrate tobacco modules into broader public health surveys, as single-disease surveys are not sustainable over the long term.

Taxation is arguably the most effective means to reduce tobacco consumption. Implementing effective tobacco taxation is complicated by factors that vary among countries and cultures. These include prevalence; price elasticity; the availability of counterfeit, smuggled, and low-cost tobacco products; and the need for earmarking to improve the popularity and sustainability of taxation schemes.¹⁰⁶ Some developing countries also lack the capacity and technical expertise to administer and collect tobacco excise taxes. The U.S. Department of the Treasury should expand the resources and mandate of its Alcohol and Tobacco Tax and Trade Bureau to share its extensive technical expertise to improve the tobacco taxation and suppression of the illicit trade in cigarettes in developing countries.

Product labeling and the regulation of nicotine, tar content, and tobacco additives are important components of limiting the public health impact of cigarettes. However, most developing countries do not have the regulatory acumen to oversee this aspect of tobacco control. During the past year, FDA has begun to implement its much-expanded mandate for tobacco product regulation and is now one of only a handful of sophisticated regulatory agencies with expertise in this area.¹⁰⁷ FDA should assist developing countries that will soon be seeking to implement tobacco product regulations pursuant to FCTC requirements.

Tobacco use is closely linked to the realization of important U.S. global health priorities. Tobacco use undermines maternal and child health, household nutritional intake, and the capacity of developing-country health systems to respond to infectious and other health threats. Tobacco use increases risks of TB infection, drug resistance, poor treatment outcomes, and mortality. USAID and the State Department should incorporate FCTC implementation and global tobacco control into their implementation of the Global Health Initiative. The United States should integrate tobacco control and cessation into its international TB control and prevention programs as the WHO and the Global Fund to Fight AIDS, Tuberculosis and Malaria have begun to do.¹⁰⁸ The United States should coordinate its efforts with these and other international actors like the new

106. Mohammed K. Ali and Jeffrey P. Koplan, "Promoting Health through Tobacco Taxation," *JAMA* 303 (2010): 357; and Frieden and Bloomberg, "How to Prevent 100 Million Deaths from Tobacco."

107. McGrady, *U.S. Engagement in International Tobacco Control*, p. 10, which cites EU, Norway, and Canada as the other sophisticated tobacco regulators.

108. See *A WHO / The Union Monograph on TB and Tobacco Control: Joining Efforts to Control Two Related Global Epidemics* (Geneva: WHO, 2010), which proposes the integration of tobacco cessation, smoke-free environments, and tobacco control education into TB clinical interventions. The latest of the Global

UN Women program. This approach would be consonant with the FCTC, which encourages its states parties to integrate tobacco control into their overall health systems development and consider youth and gender issues in its implementation.¹⁰⁹

The United States should leverage and support international anti-tobacco activities at foundations and NGOs. The Bloomberg Initiative was instrumental in the development of the MPOWER package and has programs in China, India, Indonesia, Russia, and Bangladesh—countries that collectively account for approximately half of the world’s smokers. The Gates Foundation is a growing presence on tobacco control in Africa. The Johns Hopkins Bloomberg School of Public Health, World Lung Foundation, Campaign for Tobacco-Free Kids, and Framework Convention Alliance are all critical players and potential U.S. government partners on international tobacco control.



Now is an important moment in international tobacco control. The scientific evidence that tobacco use and secondhand smoke cause a myriad of terminal and disabling diseases is undeniable. Tobacco programs have succeeded in developed and developing countries alike. More than 170 parties have ratified the FCTC, which provides a blueprint for global tobacco control programs and a platform for their monitoring and implementation. A \$500 million, multiyear commitment from the Bloomberg Initiative and the Bill & Melinda Gates Foundation has injected sorely needed resources into global tobacco control. With the support of the Bloomberg Initiative, the WHO developed its MPOWER strategy, which provides evidence-based, actionable, and measurable strategies to support FCTC implementation at the country level.

Increased U.S. engagement on global tobacco control can transform this momentum into sustainable progress. The United States is the world’s largest economy and preeminent force in global health. Integration of tobacco control objectives into its Global Health Initiative and TB programs and U.S. trade policy would do much to help stem the expansion of tobacco use and its related diseases worldwide. Tangible U.S. leadership would help motivate multilateral and bilateral development agencies and regional economic and health institutions to likewise prioritize tobacco control in their efforts. While that leadership should begin with ratification of the FCTC, the United States should not wait to do so before increasing its support for FCTC implementation. The United States should work with G-20 partners, regional and intergovernmental institutions, foundations, and NGOs to provide the resources, incentives, and technical support that low- and middle-income countries lack for FCTC implementation and sustainable progress against an otherwise expanding global tobacco epidemic.

Fund’s funding proposals integrate tobacco control into national TB control and prevention programs for high-risk groups.

109. FCTC, arts. 4, 14, 16.

1800 K Street, NW | Washington, DC 20006
Tel: (202) 887-0200 | Fax: (202) 775-3199
E-mail: books@csis.org | Web: www.csis.org

