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Global health, equity and the WHO Framework Convention on Tobacco Control

Jeff Collin¹

Abstract: The report of the WHO Commission on Social Determinants of Health demonstrates the renewed salience of health inequalities within the international health policy agenda. The tobacco pandemic is characterized by an escalating burden of death and disease that is increasingly being borne by developing countries. Efforts to promote global health equity must therefore prioritize reductions in tobacco consumption. The WHO Framework Convention on Tobacco Control (FCTC) offers a remarkable opportunity to address the health inequalities associated with tobacco use, and represents an important innovation within global governance. But the FCTC's failure to adequately address the health impacts of trade liberalization highlights the difficulties of ensuring policy coherence across international health, development and economic policies. Recognition of such limitations is important both to inform the further development of the FCTC and to ensure that appropriate lessons are drawn for future initiatives. (*Global Health Promotion*, 2010; Suppl (1): pp. 73–75)

Key words: equity, Framework Convention on Tobacco Control, global health, health, tobacco control

The recent WHO Commission on Social Determinants of Health (CSDH) concluded that 'social injustice is killing people on a grand scale' (1) and this is nowhere more true than in the context of tobacco. This partly reflects the sheer scale of mortality attributable to tobacco, with total deaths expected to rise from 5.4 million in 2005 to 6.4 million in 2015 and 8.3 million in 2030 (2). But the strong relationships between tobacco use, health and inequalities mean efforts to tackle the social determinants of health must attach critical importance to reducing tobacco consumption. The adoption of an equity perspective is key to the development of effective tobacco control policies. This is clear at a national level whether one looks at the relationship between smoking and socio-economic status, the shifting gender profile of tobacco use, or industry targeting of disadvantaged social groups, while debates concerning the potentially inequitable impacts of some tobacco control policies suggest at least that equity concerns should be given greater

weight in future initiatives (3–7). Such issues become paramount when considering health inequalities between countries. The global health impacts of tobacco use are increasingly inequitable; whereas by 2030 attributable deaths are projected to decline in high income countries by 9%, they are expected to double from 3.4 million to 6.8 million across low- and middle-income countries (2).

The need to combat this shift provides the rationale for the WHO Framework Convention on Tobacco Control (FCTC), the first public health treaty initiated by the World Health Organization. Negotiated from 1999 to 2003 and taking effect in 2005, the FCTC has now been ratified by 168 countries, making it among the most widely and rapidly accepted of UN treaties. It was hailed by the CSDH as

an excellent (if rare) example of coherent, global action to restrain market availability of a lethal commodity

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and a global governance mechanism depicted as a model for other health-damaging commodities like alcohol and processed food (1). Few in public health would contest the virtues of the FCTC, the realization and ongoing development of which constitute a remarkable achievement, given the scale of opposition to it from a politically and economically powerful industry (8). Yet while the value and significance of the FCTC are beyond dispute, it is also necessary to acknowledge its limitations so as to inform the ongoing negotiation of protocols to the Convention and to draw appropriate lessons for other public health issues. The FCTC is excellent, such excellence is rare, but the extent to which it represents coherent, global action is questionable and it does little to restrain the market availability of this lethal commodity.

In line with most tobacco control initiatives, and with the principal exception of its strong focus on countering the illicit trade in cigarettes, the FCTC focuses overwhelmingly on seeking to reduce demand for tobacco products rather than curtail their supply. Given the established efficacy of interventions such as increased taxation or comprehensive marketing bans, this is in many respects perfectly understandable and appropriate. But it also ignores compelling evidence regarding the impact of trade liberalization in increasing tobacco consumption and exacerbating global inequalities. An average per capita cigarette consumption of 10% across four countries (Japan, South Korea, Taiwan and Thailand) has been attributed to the impact of market entry by transnational tobacco companies (9) while a broader analysis by the World Bank concluded that trade liberalization

has a large and significant impact on smoking in low-income countries, and a smaller, but still important effect on smoking in middle-income countries, while having no effect on higher income countries (10).

The FCTC represents an attempt to respond to the challenges posed by core features of contemporary globalization, and its preamble acknowledges that the:

spread of the tobacco epidemic is facilitated through a variety of complex factors with cross-border effects, including trade liberalization and direct foreign investment (11).

Furthermore, the relationship between tobacco control and trade agreements, particularly those of the World Trade Organization (WTO), constituted perhaps the dominant issue during FCTC negotiations, and a clear majority of countries favoured the inclusion within the Convention of language that would give precedence to health over trade (8). Yet the text of the FCTC fails to clarify this relationship, and this raises questions about the extent of the FCTC's coherence in both strategic and political terms. Strategically, it means that the FCTC policy agenda fails to address a major driver of the globalization of the tobacco pandemic. Politically, this highlights the limited extent of policy coherence in the tobacco control positions adopted by high-income states and international organizations; health objectives have ultimately been subordinated to core principles of foreign and economic policy (8).

While the rapid advances in tobacco control legislation at national level demonstrate the broad contemporary primacy of health objectives domestically, in an international context this pattern is much less clear, notably among those countries that host tobacco transnationals. There have been attempts to curb the extent to which such governments have actively promoted the interests of tobacco companies overseas. In the United States, the 1997 Doggett Amendment aimed to prevent governmental involvement in the promotion of tobacco products overseas but its provisions were repeatedly undermined under the Bush administrations (12). This may be unsurprising of a country which has not yet ratified the FCTC, and whose approach to negotiations actively incorporated the preferences of the world's leading cigarette manufacturer (13). The UK, by contrast, can in many respects be seen as comparatively progressive on tobacco issues from a global health perspective. Yet its record is inconsistent in ways that can be attributed to three of the world's leading cigarette manufacturers being UK-based, creating ongoing tensions between trade and health concerns. This is illustrated by the UK government's insistence on the retention of duty-free sales during FCTC negotiations and the abandonment of a government inquiry following evidence of British American Tobacco's (BAT) complicity in smuggling.

Above all, the eventual silence of the FCTC on its relationship with trade agreements reflects the overwhelming primacy afforded to trade liberalization by the USA, the UK and other high-income

countries. The commitment to expansion across developing regions means that tobacco companies have a very clear stake in retaining this commitment, exemplified by BAT's recognition that 'Free and open international trade is crucial for the long-term health of our company' (14). In this critical respect, therefore, the FCTC can be seen as having preserved prospects for the future growth of transnational tobacco companies.

The FCTC is clearly informed by a strong political commitment to equity, evident in its commitment to 'the participation of indigenous individuals and communities' and to measures that 'address gender-specific risks' (11). Its achievements are substantial and growing, and it is distinctive within a broader international health context for its commitment to address non-communicable diseases exacerbated by globalization. The FCTC cannot fairly be understood as reflecting the *interests of the wealthy* in the way that infectious disease priorities and the Millennium Development Goals may be critiqued (15). But it is important to acknowledge the limits to the political consensus that underpins it. The FCTC thereby exemplifies the major challenges involved in attaining coherence across the health and development agendas of states and international organizations, and the ongoing need for greater public health engagement in trade and economic debates.

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