

International Aspects of Tobacco Control

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A. Introduction: a few facts

— Professor Stephen Sugarman, Law School —
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1. Outside of China, which is the world's largest tobacco market, the manufacture and distribution of tobacco products, mainly cigarettes, is increasingly dominated by fewer than 10 large trans-national tobacco companies ("TTCs"), including the two U.S. giants, Philip Morris and RJR, and the Japanese giant, Japan Tobacco ("JT").
2. In the past 15-20 years, the TTCs have made large inroads into markets in Asia, Latin America, and the formerly communist nations of Eastern Europe.
3. As has been clearly evident in Japan, the American TTCs bring with them aggressive marketing and highly visible advertising campaigns. JT, which had a near monopoly on cigarette sales 12 years ago, has now lost nearly 25% of the market to foreign brands.
4. In many countries a common cigarette smoking pattern is observed. As a country gets richer, men first begin to smoke, and soon the gender gap is enormous. Then women begin to smoke in modest numbers. Later, the rate of smoking for men declines, while at the same time the rate for women goes up. In "mature" markets like the U.S., the gap may be entirely eliminated.

5. In Japan, the gap is still very large. Men now still smoke at a rate approaching 60% (the highest by far among the wealthy countries), although down from an astounding, if brief, high of more than 70% a while back. The prevalence of women smokers is now approaching 15%. But the rate for younger women is increasing rapidly, especially for urban women who work out of the home.

6. Because tobacco-related diseases have a long latency period, a big increase in the death rate only occurs after a significant share of the population has smoked for more than 30 years. The U.S. hit that point by the 1950s or 60s. Japan has just recently hit it, because heavy cigarette smoking in Japan was relatively uncommon until 1960. So, whereas in 1970 in Japan there were 10 times as many stomach cancer deaths as compared with lung cancer deaths, by now there are more lung cancer deaths than stomach cancer deaths, which have remained steady.

7. Based upon who is already smoking, if we project past experience with both cessation and disease rates, we can see into the future, and it is not pretty. Before long there will be, world wide, 10 million deaths a year from smoking, two thirds of them in what is now the so-called developing world.

B. WHO Efforts -- the Domestic Side

1. The World Health Organization ("WHO") has declared disease and death from tobacco products an international epidemic or pandemic, and for some time WHO has been urging individual nations to adopt a broad package of tobacco policies. These include, most importantly:

I) High tobacco excise tax rates that automatically increase faster than inflation. This policy is designed to discourage consumption, by getting people to quit, never to start, and not to relapse after quitting. All economists believe there is some price elasticity of demand for cigarettes, perhaps -.4, and many think that the demand by teens is even more elastic.

II) Bans or tight controls on the advertising and promotion of tobacco products

III) Anti-smoking information campaigns, including school and community programs, large and strong warnings on the packages, and anti-smoking commercials on TV and billboards.

IV) Tight controls on youth access to tobacco products, such as eliminating vending machines, forbidding self-service displays in stores, and having clerks check for proof of age when young people seek to purchase tobacco products.

V) Strong protection of non-smokers from second-hand smoke, by making workplaces and public places smoke-free, including stores, restaurants, and means of transportation.

2. At present, WHO is working on an international treaty.

I) The current thinking is that this would be a "convention" with "protocols." The idea is that the convention would be aspirational, containing few, if any, binding provisions. The hope is that most nations would quickly agree to and adopt such a convention.

II) The protocols would contain binding restrictions. It is hoped that most countries would, before long, adopt all of the protocols. But it is acknowledged that this could be an uneven process, and some key nations might hold out on key provisions.

III) As I see it, the protocols would be of two sorts. One type would be like those just mentioned -- important policies aimed at the domestic market. The others would be aimed at issues that have a special international aspect to them. I will address them in that order.

3. Impact of the domestic-oriented protocols, if adopted.

I) If the domestic-oriented policies that are supposed to be contained in the protocols were widely adopted, it is said that countries like Australia, Sweden and a few others would be little impacted because they already have these internal policies in place. Put differently, only a few nations have enacted all that WHO favors. Some other nations would be moderately impacted by the protocols, because they have a fair proportion of these domestic provisions already in place. Many nations, however, would be significantly impacted.

II) At present, the latter group includes both the US and Japan because, at the national level at least, both countries now have very weak tobacco-control policies. National tobacco taxes and prices are very low in both the US and Japan -- as compared to nearly all other rich nations. Neither country seriously restricts advertising and promotion. Both have weak anti-smoking education programs. Neither country has a national law requiring smoke-free workplaces and public places, apart from a US law about air travel. Japan makes almost no real effort to keep youths from obtaining cigarettes, even though the official age when one can buy tobacco products is 20, the highest among all wealthy countries. Yet, Japanese retailers are almost never prosecuted for selling to minors, and studies show that almost all retailers will readily sell cigarettes to young boys and girls wearing school uniforms that make it obvious that they are underage. Also there are said to be 500,000 cigarette vending machines in Japan that are readily accessible to children and are the source of cigarettes for most high school pupils who smoke. In the US, national legislation now provides states with financial incentives to discourage tobacco sales to minors, and some states are slowly beginning to work on the problem. Finally, while the required warning on cigarette packages is moderately strong in the US, it is very weak in Japan.

III) On the other hand, despite weak national policies, some individual US states and many local communities in the US have adopted laws that control where people can smoke, impose considerably higher taxes on cigarettes, restrict where tobacco ads may be placed (although these are under strong legal attack right now), and in California one sees anti-smoking TV ads and billboards that are aimed at youths and smokers. Moreover, recent legal settlements between state Attorney Generals and the tobacco companies have also resulted in state controls on tobacco advertising and promotion that now promise to extend throughout the US. These settlements are also expected to lead to a price increase of about 50 cents a pack of cigarettes, which is around a 20-25% increase in many states.

IV) In Japan, policies follow the conventional Japanese methods of "guidance" and voluntary consensus. Hence, the railroad companies themselves now restrict smoking on trains and in stations, and a small but growing number of large enterprises have smoking

controls in place. But, nonetheless, smoking is much more all around you in Japan than in the US, especially in restaurants where the contrast with California, for example, is dramatic.

V) How likely is it that the US would adopt the WHO domestic-oriented policies without formal action by WHO? In fact, the US would already have much stronger policies in place (than it now has) had the proposed, so-called "global settlement" with the tobacco companies been adopted in 1997. Ironically, that deal fell through, at least in part, because of the opposition of tobacco-control advocates who pushed for even tougher regulation and who fought against the limitations on lawsuits that the settlement would have included. The US would also have fairly strong national policies in place if the regulations of tobacco proposed by the Food and Drug Administration ("FDA") in 1996 been upheld and if President Clinton's calls for a large national tax increase on tobacco products been turned into law. But the FDA regulations have so far been held by the courts to be illegal, and Congress has been caught up with other issues. Hence, I believe that there are rather uncertain prospects for the US adopting the WHO policies without international action.

VI) In Japan, anti-smoking advocates tend to believe that so long as the government continues to own more than two-thirds of the stock of JT, strong anti-smoking policies will never be put in place.

VII) In both countries, it is not just the political power of the tobacco companies that blocks reforms. There are also many other interests who seem to depend upon on the popularity of smoking: they include tobacco farmers, retailers, advertising companies, restaurant owners (though US data suggests that their fears are misplaced), and so on. In the US, many cultural organizations and popular magazines also seem to depend on support or advertising from tobacco companies, and hence they are slow to support tobacco control policies.

4. If the WHO convention and protocols are put forward, is this likely to make the US and Japan more likely to adopt domestic policies they haven't already adopted? More precisely, will these two countries support and sign the convention and protocols and enact what is then required? The theory behind the WHO strategy is that an international treaty process will bring world-wide political pressure on all nations to deal more seriously with the health problems caused by tobacco products. Moreover, WHO claims that a treaty would strengthen the political position of domestic anti-tobacco forces who would be able to invoke international norms on their side.

I) Yet, I am skeptical about whether the fact that other countries and WHO are behind an anti-tobacco convention and protocols would have much impact in the US. After all, the US has not yet even adopted either the "land mine" treaty or the "rights of the child" treaty. Moreover, prospects for the US adopting any international treaty that affects US business are poor unless the US business interests themselves favor the treaty, as has happened in some cases. To be sure, the tobacco companies in the US are now weakened and perhaps politically vulnerable, but since the US anti-smoking forces have been unable to persuade the US Congress to act these past two years when they seemed to be in a very strong political position, one must be concerned that the WHO documents would be ignored in the US.

II) By contrast, I believe that Japan is more likely to want to go along with what the international community says is the right thing to do. It would probably quickly adopt the convention. But it might be much slower to embrace all of the protocols. Perhaps it would quickly endorse the controls on advertising and promotion since that might help JT hold onto its share of the market. Japan might also officially embrace controls on youth smoking -- but then do little to enforce them. Similarly, it might agree to anti-smoking education -- but then not invest much in strong campaigns. Strong controls on where people can smoke are also probably going to be much slower in coming. The tax side is very complicated. In fact, a big tax hike would net the government a lot more money, far more than any reduced profits to JT. But there is currently a sense that the taxes on tobacco and alcohol are somehow in balance, and it may be difficult to get the government to agree sharply to increase one without the other. Disconnecting the two taxes might occur if anti-smoking advocates were effective in convincing the government that the two are very different sorts of dangers. Finally, a WHO convention might force the Japanese government finally to change its current warning on cigarettes. Many believe that the current warning is misleading because it suggests that moderate smoking is probably not dangerous, which is certainly a very bad message to give to people. Indeed, the government might, on its own, quickly require a stronger warning if it understood that this might reduce JT's vulnerability to personal injury lawsuits that are just now beginning in Japan. I believe that is so, but I don't think the government is yet paying any attention to my analysis.

5. Is it likely that the ongoing WHO process will yield an international treaty that is adopted by a large number of nations? This is now difficult to predict. The new head of WHO, the former Prime Minister of Norway, has made tobacco control one of her two top priorities. Yet is it too early to tell whether this personal commitment will matter. Japan

could play a key role in promoting the convention, but it is unlikely to do so, since the Ministry of Finance people involved still seem to identify strongly with JT.

6. Would adoption of the WHO domestic-oriented policies really make much of a difference in terms of public health outcomes?

I) Many smoking-control advocates put their greatest hopes in a high tax bringing down the smoking rate. Note, however, that some smokers will contend with price increase by a) smoking more carefully, e.g. down to the end, b) inhaling more deeply, c) reducing somewhat their daily quantity, or d) in places like the US, switching to much cheaper brands (which are not yet much in evidence in Japan). None of these behavioral impacts really helps promote public health, even though the quantity of cigarettes smoked may decline.

II) Note that the US and Japan now have similar prices and yet Japan has a much higher smoking rate. Taxes and prices are much higher in France, Australia and the UK than they are in the US, but the smoking rate in the US is a bit lower. So, surely we cannot anticipate that a high tax itself will reduce smoking rates to, say, 10-15% of adults.

III) Moreover, those who bear the burden of high taxes are adult smokers (who smoke more than 95% of the cigarettes), and these are people who the anti-smoking community usually says are addicted. This seems rather unfair, and unless the government also generously funds smoking cessation programs, I think that one should be at least cautious about too quickly supporting large tobacco tax increases even if they have a desirable impact on youth smoking rates.

IV) What about advertising bans? The effectiveness of these controls is much disputed. For example, is it the recent growth in glamorous tobacco ads or the changing role of women in general that has yielded the big increase in young women's smoking in Japan of late? It would be very surprising, in any event, if a shift from, say, Japan's current situation to a complete and enforced ban could have more than a 10% impact on the smoking rate (although even this is, of course, a lot of saved lives).

V) In the US, there is little evidence that school or community education campaigns make much of a difference. In Japan, one study found that teen smoking is actually greater in schools where smoking controls on teachers are in place. Yet this discouraging result may simply reflect a reverse causal connection -- that is, only schools with smoking problems are prompted to adopt rules that forbid teachers from smoking in the presence of students. Internationally, there is little evidence that stronger warnings on cigarette packages make much difference, but Japan could be an exception to the rule. In the US, nearly all smokers say they know that smoking causes death to half of those who are long term smokers, and most smokers say they want to quit and have already tried to quit at least once. But in Japan, not nearly as many smokers seem to acknowledge the dangers, and surprisingly few say they want to, or plan to, quit. Indeed, a surprisingly high share of doctors in Japan still smoke (perhaps a third of all doctors). Some say that Japanese doctors and the public at large have put their faith in health screening strategies -- strategies of the sort that Japan has implemented to deal with its high rate of stomach cancer. But annual chest X-rays and the like just won't do to protect victims of smoking. For this reason, a change in the warning on tobacco products could possibly make a difference in Japan. Even more promising would be to run clever anti-smoking ads on TV. Evidence from California suggests that these do seem to have an impact. Some Japanese anti-smoking advocates say that they just have to wait until the smoking rate for men dips below 50%, at which time an ad campaign can be launched saying that "most Japanese men don't smoke." Their theory is that Japanese are so conformist that this information alone will change a great deal of behavior. I am skeptical about this argument; after all, most young unmarried women who work in shops don't smoke, but somehow the percent that do so has recently leaped up to a reported 40%.

VI) How about youth access controls? Of course, children now obtain cigarettes from many sources beyond retailers and vending machines -- including older siblings and friends, parents, and in the black market. But tight controls on children's ability to purchase cigarettes directly do seem to reduce youth smoking somewhat and help to make smoking seem less normal (although for some youths this just increases its attraction).

VII) Workplace controls on smoking appear to be a very good idea for two reasons. First, they protect non-smokers, although the dangers to non-smokers of second-hand smoke have probably been exaggerated, which is not to say there are none. Second, studies suggest that these policies also appear to cause some smokers to quit (or not relapse).

VIII) In sum, strong tobacco-control policies can make a difference. But before smoking rates can be reduced to 10% or less (a common policy goal), I believe there will have to be a cultural shift in taste. How might that shift occur? Some apparently believe that the dramatic imposition of a group of strong tobacco control policies all at once -- like the full range of those favored by WHO -- could help usher in that cultural shift. But one should not be overconfident. Consider Australia, for example, where, despite the introduction of very strong controls, nearly 30% of adults still smoke, including approximately that share of people in their 20s and 30s.

C. WHO Efforts - the International Side

1. Special international problems

I) Smuggling. Smuggling is something of a true international problem, although not quite the problem the tobacco industry typically warns against when opposing higher taxes. The two main examples of serious smuggling do not come from illicit traffic between low tax and high tax places -- as the industry usually envisions. Rather the main problem involves the import and storage of tobacco in Belgium on a tax free basis, its purported shipment to eastern Europe or Africa, but its real shipment to countries where criminal activity of this sort thrives, especially Italy and Spain. The second most important example involves smuggling of Canadian cigarettes out of, and then back into, Canada, primarily via Indian Reservations that sit on the US-Canada border. In both cases, the products come into the market basically without tax.

II) A second claimed international problem is that banned tobacco ads leak into nations from the outside, say in magazines, on the Internet, or via TV.

III) A third arguably international problem is that tobacco companies don't put warnings that are required domestically on the products they export (at least when the domestic warning is stronger). Although Philip Morris has now apparently agreed, as a minimum, to put the required US warning on its Marlboro cigarettes worldwide, this is seemingly quite the exception. In a similar vein, some anti-smoking groups in Japan have complained that JT fails to warn strongly in the domestic market even though it puts the stronger US warning on the very same cigarettes it sells, say, in Hawaii.

2. The WHO convention and protocols might well attack these problems. These are indeed problems whose solution requires some international cooperation. Yet, one must realize that the elimination of all of these problems, by itself, would probably only limit smoking prevalence a small amount.

3. Instead of WHO imposing the international controls, a different idea is for "home" countries to impose extra-territorial controls on their TTCs. In fact, there are some efforts now going on in the US Congress to move in this direction. But US domestic controls must be stronger for this to matter a great deal. (Still, at least the US Trade Representative could stop pushing the export of US tobacco products, and, in fact, a recent US law now points in that direction.) One understandable fear about this strategy is that the imposition of strong extra-territorial policies could cause the TTCs to relocate their "home" offices.

4. Finally, one might think about international litigation as an international tobacco-control strategy. For example, Panamanian and Guatemalan victims of tobacco products have now tried to sue the US tobacco companies in US courts. Whether these cases will be successful is quite another matter of course.

D. Conclusion

Although cigarette smoking (and other tobacco use) is undoubtedly a world-wide problem, combating that problem is primarily a matter of local action. But this does not mean that nations do not learn from each other or gain confidence from each other's actions. Nor does it mean that international bodies and international law have no place. In some countries at least, the prestige of WHO and the international treaty it plans to endorse (especially if strategically linked with other forces) could indeed play important roles in reducing the staggering level of disease and death that tobacco products now cause.