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Michael Eriksen
Georgia State University

Lawrence Green
University of California - San Francisco

Linda Bailey
North American Quitline Consortium

Terry Pechacek
Georgia State University

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New Tobacco Control Era Dawns

Global Tobacco Trends Spark Hope, Sound Alarm

by Michael Eriksen, ScD; Lawrence Green, DrPH; Linda Bailey, JD, MHS; Terry Pechacek, PhD, Office on Smoking and Health, Centers for Disease Control and Prevention, U.S. Department of Health and Human Services

Tobacco control is heralded as one of the 10 greatest public health achievements of the 20th century in the United States. This recognition reflects the dramatic reduction of smoking prevalence among U.S. adults from 42.4 percent in 1965 to 24.7 percent in 1997. But just as the United States, Canada, Australia, New Zealand and several European countries were dramatically reducing their tobacco consumption, the developing world faced a tobacco epidemic. What does experience tell us about effective tobacco control strategies for the future?

Industrialized Nations Show Hopeful Signs

Effective programs as well as supportive public policies are needed to curtail tobacco use. The positive trends in U.S. smoking prevalence have resulted not simply from scientific knowledge that tobacco use and environmental exposure to tobacco are hazardous to health, but from a combination of public education, advocacy for nonsmokers' rights, restrictions on cigarette advertising, improvements in treatment and prevention programs, and an improved understanding of the economic costs of tobacco. Public policy advances (see chart) have also contributed to the reductions; and legislation restricting smoking in public places, increased taxation and enforcement of minors' access laws have made a substantial impact. And now, the disclosure of tobacco industry documents provides opportunities for a new approach to tobacco control programs and policies—actions that address corporate intent to confuse, mislead, and obfuscate the public’s understanding of the harm caused by smoking.

BATA Battles BAT In Bangladesh

by Debra Efroymson, Regional Advisor, PATH Canada, Dhaka, Bangladesh

With a population of about 123 million, Bangladesh is one of the poorest and most densely populated countries in the world. Nearly half the population lives below the poverty line. And while life expectancy has increased over the past decade, it stands at 60.5 for women and 60.7 for men, with diarrhea, cardiovascular diseases and asthma the top three causes of death.

Tobacco vs. Food Consumption

Tobacco use has not been well-monitored in Bangladesh. The latest large survey appears to simply study smoking, ignoring the huge issue of smokeless tobacco use. Smoking rates are much higher in men (43.8%) than in women (4.6%), with men aged 35 to 49 having the highest rate—66.1 percent. And, the economic burden of tobacco in Bangladesh is substantial.

In 1996, average yearly expenditure on food for men and women, was just 2.4 times what they spent on tobacco in 1997. Men who smoke cigarettes (rather than cheaper forms of tobacco) spend nearly as much on cigarettes as on food. Since about half the population is malnourished and a large portion of spending goes to food, it is clear that reducing tobacco use could hugely benefit nutritional status.

John Player GOLD LEAF posters adorn a run-down shop-front in Comilla, Bangladesh

The Industry’s Agenda

Bangladesh is home to several local tobacco companies. In 1998, the Bangladesh Tobacco Company was bought out by British
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**Global Trends**

### Developing Country Trends Signal Alarm

As tobacco control programs and policies succeed—and sales plummet—in industrialized nations, the tobacco epidemic is aggressively spreading into developing countries. The World Health Organization (WHO) currently estimates that about 1.15 billion smokers in the world consume an average of 14 cigarettes each day. Of these, 82 percent live in low- and middle-income countries. Such patterns of tobacco consumption will have devastating effects on future global health: 10 million people will die annually—11,000 deaths per day—from tobacco-attributed diseases by the late 2020s. In short, tobacco will overtake the pandemics of the present and past as the leading cause of death in developing countries.

Many developing countries face critical barriers to tobacco control. First, tobacco consumption, in parallel with per capita income, is growing in developing countries. Second, the citizens of developing countries are less exposed to education on the health hazards of smoking and, therefore, are less inclined to treat tobacco as a significant threat. Third, many developing countries still suffer from a heavy burden of infectious diseases and malnutrition and accord a lower priority to tobacco-related health effects. Fourth, and perhaps foremost, many developing countries have yet to assemble the political will needed to enforce measures that treat tobacco commensurate with the harm that it causes. In many, the government is tempted by the “smoke ring” of tobacco—specifically employment, revenue and trade. Tobacco marketing is costly in the long run, experience tells us. In California, data show that for every dollar spent on tobacco control, the state realized a savings of $1.50 in direct medical services and $4 in the overall cost of tobacco-associated illnesses.

### Effective Strategies Spell Effective Control

World Bank economists recognize that the public health benefits of tobacco control far exceed the costs, and price increases are the most effective strategy for reducing demand for tobacco products both in industrialized and in low- and middle-income countries. Mostly implemented through excise taxes, price increases reduce smoking, especially among youth. World Bank studies show that temporary income loss among producers and distributors may be one consequence, but without a dramatic need for downsizing. Furthermore, the impact of price increases may be significantly enhanced by measures that ban or restrict tobacco advertising and promotion or increase public awareness of tobacco’s harm. For example, cigarette labels may contain prominent health warnings and list ingredients or levels of tars, nicotine and other harmful constituents. In Sweden, Iceland, Norway and Canada, pictures are used or proposed to increase the impact of such warnings.

Nicotine replacement therapy and other cessation interventions are also effective demand-reduction tools. In the United States, proposals are being considered to mandate Medicaid coverage of both prescription and non-prescription smoking cessation drugs, removing current exclusions in the law. Private insurers and managed care organizations are making similar commitments to helping smokers quit.

The recent World Bank report “Curbing the Epidemic” concludes that supply reduction is a less promising approach to tobacco control. Some attention to such policies, nevertheless, is warranted. For example, smuggling becomes a concern when neighboring areas experience cost differentials (i.e., in border areas and special jurisdictions such as military bases and tribal reservations). Measures such as more prominent tax stamps and aggressive enforcement and prosecution can be effective in preventing smuggling. Indeed, trade policies and tobacco control should be complementary. The U.S. Congress recently prohibited the expenditure of tax dollars to support the export and promotion of cigarettes, and U.S. diplomatic posts are now directed to assist tobacco control efforts in host countries.

At the global level, in 1996, WHO member states initiated a Framework Convention on Tobacco Control (FCTC), a legal instrument intended to address the global problem of tobacco use. Once adopted by WHO, the convention and related protocols will be subject to ratification by member states. (See WHO...p.7. Also, visit: WHO’s website, http://www.who.int/tobacco/fctcintro.htm; and the U.S. Government site, http://www.cdc.gov/tobacco/.)

Non-governmental organizations, research institutes and professional associations also play a critical role in the development of tobacco control programs and policies through their domestic and international activities. For the FCTC, these groups are essential. The U.S. Government will call on such partners to participate in the development and ratification of the FCTC and the implementation of subsequent bilateral and multilateral protocols. The success of these multiple intervention strategies will reshape the tobacco control landscape worldwide for the year 2003 and beyond. Michele Chang of CDC contributed to this article.