Original Article

The global tobacco control 'endgame': Change the policy environment to implement the FCTC

Paul Cairney[a,*] and Hadii Mamudu[b]

[a]Department of History and Politics, University of Stirling, Pathfoot, Stirling, FK94LU, UK.
E-mail: p.a.cairney@stir.ac.uk

[b]Department of Health Services Management and Policy, College of Public Health, East Tennessee State University, S. Dossett Drive, Lamb Hall, P.O. Box 70264, Johnson City, TN, 37614, USA.

*Corresponding author.

Abstract The World Health Organization (WHO) Framework Convention for Tobacco Control (FCTC) has prompted major change in tobacco control globally. However, policy implementation has been uneven, making 'smoke free' outcomes possible in some countries, but not others. We identify the factors that would improve implementation. We describe an *ideal type* of 'comprehensive tobacco control regimes', where policy environments are conducive to the implementation of tobacco control measures designed to eradicate tobacco use. The ideal type requires that a country have certain policy processes: the department of health takes the policy lead; tobacco is 'framed' as a public health problem; public health groups are consulted at the expense of tobacco interests; socioeconomic conditions are conducive to policy change; and, the scientific evidence is 'set in stone' within governments. No country will meet all these criteria in the short term, and the gap between the ideal type and the current state is wide in many countries. However, the WHO experience provides a model for progress.
Journal of Public Health Policy (2014) **35**, 506–517. doi:10.1057/jphp.2014.18; published online 15 May 2014

Keywords: policymaking; WHO FCTC; implementation; tobacco control; policy transfer

Introduction: Could the Framework Convention for Tobacco Control (FCTC) produce a tobacco control 'endgame'?

The tobacco 'endgame' represents a major shift in public health debates – from controlling the tobacco market and reducing smoking,

to eradicating both.[1,2] Two elements are needed: *proposal* of new policy instruments and *recognition* that politics is just as important as policy. Yet, the endgame discourse today does not fully recognise the importance of the political process to the fate of policy instruments. In practice, it is difficult to separate the effect of an endgame policy instrument from the effect of its implementation in different local environments.

Some authors writing about the endgame correctly point to the continued importance of the World Health Organization (WHO) FCTC, but make only vague reference to a lack of 'political will' to explain lack of progress.[3] This is a natural response from scholars seeking policy change, but unhelpful because it fails to recognise adequately the role of the environment in which policymakers operate. We construct a framework to understand the causal mechanisms of the global tobacco policy process.

We compare the real world with an ideal that represents conditions needed to permit full implementation of endgame policy instruments. This permits us to see just how far away countries are from that end. We can make recommendations to advance an endgame agenda for the particular context. The experience of countries that have lead the way, and of WHO, offer a model for long-term change.

We analysed the policy literature to create a synthesis – a comprehensive review of WHO and Parties documents evaluating FCTC progress. We also interviewed more than 300 *policy participants* in 39 countries.[4,5]

Background: The Uneven Implementation of the FCTC

The FCTC, developed in 2003 to address the global tobacco epidemic, has promoted comprehensive tobacco control regimes where countries combine measures to:

- reduce the demand for tobacco and the effects of smoking in the population:
  - high prices,
  - health education and warnings on packaging,
  - bans on tobacco advertising and sponsorship,
  - smoking cessation programmes,

  - smoking bans in enclosed public places to reduce second-hand smoke (SHS), and
  - reduce the supply of tobacco (including restrictions on the sale of tobacco to minors and the illicit trade of tobacco, and economic incentives to grow non-tobacco products)
- fund tobacco control advocacy and scientific research on tobacco-related harm,
- counter global tobacco industry influence, through
  - tobacco control,
  - litigation, and
  - international cooperation and agreements.

WHO reports on FCTC implementation[6–8] show a large increase in the worldwide adoption of tobacco control measures since the FCTC negotiations began in 2000. Implementation, however, has been uneven in several ways.

First, comprehensive measures seem likely in only a few countries. Legislation to control tobacco broadly – required ingredient disclosure, education, regulating tobacco advertising, and banning smoking in indoor public places – can be found in very few countries – Australia, Canada, Finland, Norway, Sweden, New Zealand, the United Kingdom and, to a lesser extent, the United States.[5,9]

Second, the FCTC reports suggest that implementation is generally least apparent in countries where the tobacco epidemic has yet to emerge and the idea of tobacco control is relatively new. Surveys of expert opinion also highlight a gap between a small number of countries undergoing 'substantial' policy change, and a large number where policy change and enforcement is 'non-existent', 'limited', or 'moderate'.[10]

Third, in almost all countries, some measures – economic incentives and litigation – are less likely to be introduced than others, including education, restrictions of sales to minors, and on packaging.

Fourth, some countries – Brazil, Singapore, Thailand, and Uruguay are examples – have invented specific tobacco control instruments. Overall, the country-by-country picture is mixed. Simple distinctions such as 'developed/developing' fail to give us a reliable indicator or predictor of progress.

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

The FCTC experience confirms a general conclusion in public policy writings: implementation involves much more than generating evidence-based objectives and policy instruments. To use an international agreement to achieve domestic outcomes, we must also consider the motives, opportunities, and abilities of policymakers. What sets some countries apart depends on policy environments. Are they more or less conducive to the introduction of a 'comprehensive' set of tobacco control instruments?

On the basis of the experiences of the most advanced tobacco control regimes, ones that developed gradually over the last 30–50 years, we constructed an ideal-type policy environment. We set out five conditions that would have to be met to allow the full implementation of the FCTC, plus additional endgame policy instruments. No country has met all these conditions. Discussions that compare the ideal type with reality may explain lack of policy progress. They may let us recommend how to reduce implementation gaps. We may lose sight of this long-term vision, when focusing primarily on current debates and specific policy instruments.

First, a country's department of health, usually sympathetic to the FCTC's aims, must take the policy lead. It must have the capacity, and status within government, to pursue comprehensive tobacco control. It must be able to stand up to trade and treasury departments that highlight the economic value of the tobacco trade. Health departments pay more attention to evidence about ill health and understand tobacco as a pressing public health problem. Moreover, they are also more likely to consult with medical and public health groups and to reject the interests of tobacco companies.

Few countries can meet this aim in the short term, but in some countries, we see hopeful trends since World War II. Within their health departments, the focus is unequivocally on tobacco control compared with the 1950s/1960s, when many focused on industrial air pollution and other problems. In the 1970s, health departments tried tobacco policymaking in negotiation with the industry. Since the 1980s, we detect a marked change in approach. In countries such as the United Kingdom, the Treasury has now become highly supportive of the Department of Health's central role and objectives.[5]

Second, in government, tobacco must be 'framed' as a public health problem: an epidemic to be eradicated aggressively (based on public

health 'endgame'[1,2] or 'winnable battle' strategies[11]). Even in leading countries, those that have made the most progress, tobacco was once viewed primarily as a product with economic value, and tobacco growing and manufacturing was often subsidised or encouraged. Tobacco was to be traded freely and profited from. It was seen to provide jobs, exports, and tax revenue. This economic frame, combined with an appeal to the freedom to sell and smoke a legal product, dominated the political agenda. More recently tobacco has been framed as a public health problem, and there is new attention to the role of SHS. Many governments feel able to move tobacco control up the list of priorities. They promote control as a response to a health crisis; one that trumps economic concerns and challenges tobacco's reputation as an economic good.

Third, medical and anti-smoking public health groups must be consulted, while ignoring tobacco interests. Giving primary responsibility to the health department has helped this process. Health departments are much more likely than a treasury or trade department to make use of anti-smoking health groups as the key source of information and advice.

In countries such as the United States and United Kingdom, we have been able to trace post-war shifts in departmental responsibility and consultation. The tobacco industry was a strong ally of many governments for decades before and after World War II. Tobacco companies were the most often consulted when Finance and other departments coordinated policy. Health departments were weak, and public health groups struggled to be included in tobacco policy networks. The older relationships, although not completely replaced, have yielded to a trend towards dominance of health departments and anti-smoking health groups.

Fourth, social and economic conditions must be conducive to policy change. Prevalence of smoking influences the economic benefit (including tax revenues) of tobacco, and public opinion on tobacco control.[12] In the ideal, the economic benefit of tobacco production and consumption is deemed to be zero or negative, and the public supports tobacco control. In practice, leading countries, those with advanced tobacco control regimes, see declining value of tobacco tax revenues, and finance departments, once protective of the industry, are open to greater use of taxation to discourage consumption and/or to pay for health services for smokers.

But variation exists. The UK government claims to have set taxes at an optimal rate to bring in revenue without encouraging smuggling and counterfeiting. The US tax system, combined with the Master Settlement Agreement that was negotiated between government and the tobacco

industry to settle tobacco litigation, does not yet bring in revenue at the international norm. However, we do see declining numbers of smokers and declining opposition to tobacco control. These changes allow governments to 'get ahead' of public opinion when introducing tobacco control.

Finally, the scientific evidence on the harmful effects of smoking and SHS must be 'set in stone' within governments. Policy is most likely to move forward when policymakers accept fully the scientific evidence that links smoking and SHS to ill health. This has happened in the countries that are now ahead, but only after a lag between key scientific reports and positive government responses.

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

We describe an ideal type because no country meets these criteria fully. Further, even in countries with advanced tobacco control regimes, the time span between the initial identification of smoking (and then SHS) as related to ill health and the initiation of a major policy response was *20–30 years*, usually followed by gradual policy change over a similar period.[5] It took considerable time to create a policy environment conducive to comprehensive tobacco control policy. Collective experience of leading countries provides a model for change, and is reflected in developments within the WHO, a United Nations (UN) organisation where countries are represented by their ministries of health.

The WHO is a model for most countries

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

Bank supporting tobacco as an economic product. Over time, global tobacco control policy became 'institutionalised' in the WHO Tobacco Free Initiative. Since 1999, tobacco control at the UN has been largely the preserve of WHO.

Second, tobacco control climbed onto the agenda and was reframed as primarily a health problem. When tobacco was the sole responsibility of countries, it was often low on the agenda. Many treated tobacco as a source of revenue and economic development and WHO's involvement was limited, with tobacco competing for attention with issues such as infectious diseases. As the scientific evidence accumulated about tobacco-caused death and disease, the role of the WHO increased. Energetic WHO Directors General advanced their organisation's role.

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

Fourth, attitudes towards the socioeconomic context have shifted. Tobacco companies still try to influence policy with the argument that tobacco provides jobs, plus tax, and export revenue.[16] This is now challenged by highlighting the economic ill-effects caused by tobacco use. From 1992, the World Bank has invested in research to make the economic case for tobacco control[20] and worked with the WHO to further the FCTC.[16] Moreover, public opinion has followed, with surveys demonstrating a majority support the FCTC.[5]

Finally, the main driver for WHO involvement has been the accumulation of the evidence linking tobacco to ill health, assembled by expert committees.[13] WHO has disseminated *best practices* in tobacco control.[20] It has worked with its International Agency on Research on Cancer to generate and disseminate scientific information on tobacco use and control.

Many parties to the FCTC struggle to implement it

FCTC implementation remains less straightforward than it might be because a supportive policy environment is not found in many countries. Many health departments are not heard. Other departments – agriculture, finance, and trade – drown out the voice of health.[5,21] Tobacco policy rarely appears on the policy agenda and the public health frame

must still compete with economic arguments.[5] Tobacco companies spend their generous resources to influence legislators[22] and challenge tobacco control in the courts.[23] Thus tobacco companies remain powerful within policy discussions and the capacity of anti-tobacco groups to influence policy is low.[21,24–26] Tobacco growing and manufacturing remains an important source of jobs, exports, and revenue. Moreover, smoking prevalence is still rising in many countries. Medical–scientific knowledge has not had its full impact. Domestic anti-tobacco groups still lack resources.[5,24]

Consider China and India that account for half of all tobacco users in the world. China has one third of the world's smokers and 38 per cent of tobacco production.[23,27] Although China supported the FCTC, its environment is not conducive to implementation.[28] China maintains a state monopoly over tobacco production that provides 8–11 per cent of total government revenue. Tobacco control is low on their agenda and the image of health damage must still compete with a perception that China's tobacco industry contributes to economic growth.[27] Tobacco policy has been placed under the economic development agency that consults regularly with the tobacco industry. The health ministry is 'sidelined'.[27] Public health groups have few resources and are not engaged, partly because of the tense, if improving, relationship between government and non-governmental organisations (NGOs)[27,29]. Medical knowledge is poor, as fewer than half of physicians surveyed[30,31] had a comprehensive knowledge of the links between smoking and illness; more than one-third of doctors smoke in front of their patients. Smoking rates are also high among the police forces responsible for enforcing bans on smoking in public places.[32–34] Scientific research capacity is low.[35]

India has demonstrated a commitment to the FCTC and is a world leader in regulating tobacco use in media and films.[36] Yet India's tobacco policy profile is similar to that of China.[37] India continues 'to pass legislation that is poorly enforced, and challenged in the courts'.[37] India enacted a smoking ban in 2008, but the fine for non-compliance is low and surveillance to ensure compliance 'inadequate'.[37] India lacks health education capacity and smoking cessation clinics, resulting in patchy public knowledge of the risks of smoking.[37] Most of the public 'may not have ever engaged in discussion on the merits of tobacco control' and may still be relatively likely to view tobacco production in positive terms (a perspective common in many countries[38]).

Conclusion

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

In many countries, a wide gap exists between the ideal type and the current situation. Most have signed the FCTC agreement, but its implementation is left to under-resourced health ministries (competing with more powerful finance and trade ministries). Tobacco control remains low on the agenda, with few resources to enforce policies. A country focused on tobacco as an economic product, with a finance ministry at the core of policy, maintaining strong links to the industry, with little attention to the association between smoking (and SHS) and ill health, plus a growing smoking population, will not implement the FCTC effectively.

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

About the Authors

Paul Cairney, PhD, is Professor of Politics and Public Policy, University of Stirling, UK. He wrote *Understanding Public Policy: Theories and Issues* (Palgrave Macmillan) and co-authored (with Professors Donley Studlar and Hadii Mamudu) *Global Tobacco Control: Power, Policy, Governance and Transfer* (Palgrave Macmillan).

Hadii M. Mamudu, PhD, MPA is Assistant Professor of Public Health at East Tennessee State University, US, where he studies tobacco control. He wrote *The Politics of the Evolution of Global Tobacco Control: The Formation and Functioning of the Framework Convention on Tobacco Control* (E-mail: mamudu@etsu.edu).

References

1. Malone, R.E. (2013) Tobacco endgames: What they are and are not, issues for tobacco control strategic planning and a possible US scenario. *Tobacco Control* 22(Suppl 1): i42–i44.
2. Thomson, G., Edwards, R., Wilson, N. and Blakely, T. (2012) What are the elements of the tobacco endgame? *Tobacco Control* 21(2): 293–295.
3. Myers, M.L. (2013) The FCTC's evidence-based policies remain a key to ending the tobacco epidemic. *Tobacco Control* 22(Suppl 1): i45–i46.
4. Cairney, P. (2012) *Understanding Public Policy: Theories and Issues*. Basingstoke, UK: Palgrave Macmillan.
5. Cairney, P., Studlar, D. and Mamudu, H.M. (2012) *Global Tobacco Control: Power, Policy, Governance and Transfer*. Basingstoke, UK: Palgrave Macmillan.
6. WHO. (2012) 2012 Global progress report on implementation of the WHO framework convention on tobacco control. Geneva, Switzerland: WHO, http://www.who.int/fctc/reporting/2012_global_progress_report_en.pdf, accessed 3 April 2013.
7. WHO. (2010) 2010 Global progress report on the implementation of the WHO framework convention on tobacco control. Geneva, Switzerland: WHO, http://www.who.int/fctc/reporting/progress_report_final.pdf, accessed 15 March 2013.
8. WHO. (2009) 2009 Summary report of the global progress in the implementation of the WHO framework convention on tobacco control. Geneva, Switzerland: WHO, http://www.who.int/fctc/FCTC-2009-1-en.pdf, accessed 15 March 2013.
9. Sanders-Jackson, A.N., Song, A.V., Hiilamo, H. and Glantz, S.A. (2013) Effect of the framework convention on tobacco control and voluntary industry health warning labels on passage of mandated cigarette warning labels from 1965 to 2012: Transition probability and event history analyses. *American Journal of Public Health* 103(11): 2041–2047.
10. Warner, K.E. and Tam, J. (2012) The impact of tobacco control research on policy: 20 years of progress. *Tobacco Control* 21(2): 103–109.
11. Centers for Disease Control and Prevention. (2013) Winnable battles. Atlanta, GA: CDC, http://www.cdc.gov/winnablebattles/, accessed 15 December 2013.
12. Pacheco, J. (2012) The social contagion model: Exploring the role of public opinion in the diffusion of anti-smoking legislation across the American states. *The Journal of Politics* 74(1): 187–202.
13. Mamudu, H.M., Gonzalez, M. and Glantz, S.A. (2011) The nature, scope, and development of the global tobacco control epistemic community. *American Journal of Public Health* 101(11): 2044–2054.
14. Warner, K.E. (2005) The role of research in international tobacco control. *American Journal of Public Health* 95(6): 976–984.
15. Widome, R. *et al* (2010) Science, prudence, and politics: The case of smoke-free indoor spaces. *Annals of Epidemiology* 20(6): 428–435.
16. Mamudu, H.M., Hammond, R. and Glantz, S. (2008) Tobacco industry attempts to counter the World Bank report curbing the epidemic and obstruct the WHO framework convention on tobacco control. *Social Science & Medicine* 67(11): 1690–1699.

17. Otanez, M., Mamudu, H. and Glantz, S. (2007) Global leaf companies control the tobacco market in Malawi. *Tobacco Control* 16(4): 261–269.
18. WHO. (2011) WHO framework convention on tobacco control: Guidelines for implementation. Geneva, Switzerland: WHO, http://whqlibdoc.who.int/publications/2011/9789241501316_eng.pdf, accessed 8 April 2013.
19. Mamudu, H.M. and Glantz, S. (2009) Civil society and the negotiation of the framework convention on tobacco control. *Global Public Health* 4(2): 150–168.
20. Shibuya, K., Ciedierski, C., Guindon, E., Bettcher, D.W., Evans, D.B. and Murray, C.J.L. (2003) WHO framework convention on tobacco control: Development of an evidence-based global public health treaty. *British Medical Journal* 327(7407): 154–157.
21. Tumwine, J. (2011) Implementation of the framework convention on tobacco control in Africa: Current status of legislation. *International Journal of Environmental Research and Public Health* 8(11): 4312–4331.
22. Patel, P., Collin, J. and Gilmore, A.B. (2007) The law was actually drafted by us but the government is to be congratulated on its wise actions: British American tobacco and public policy in Kenya. *Tobacco Control* 16(1): e1.
23. Eriksen, M., Mackay, J. and Ross, H. (2012) *The Tobacco Atlas*. Atlanta, GA: American Cancer Society and World Lung Foundation.
24. McCool, J., McKenzie, J., Lyman, A. and Allen, M. (2013) Supporting Pacific Island countries to strengthen their resistance to tobacco industry interference in tobacco control: A case study of Papua new Guinea and Solomon islands. *International Journal of Environmental Research and Public Health* 10(8): 3424–3434.
25. Albuja, S. and Daynard, R.A. (2009) The framework convention on tobacco control (FCTC) and the adoption of domestic tobacco control policies: The Ecuadorian experience. *Tobacco Control* 1818–1821.
26. Tam, J. and van Walbeek, C. (2013) Tobacco control in Namibia: The importance of government capacity, media coverage and industry interference. *Tobacco Control*, doi:10.1136/tobaccocontrol-2012-050725.
27. Jin, J. (2012) FCTC and China's politics of tobacco control. New Haven, CT: Princeton University, http://www.princeton.edu/~pcglobal/conferences/GLF/jin.pdf, accessed 15 September 2013.
28. Lv, J. *et al* (2011) Implementation of the WHO framework convention on tobacco control in mainland China. *Tobacco Control* 20(4): 309–314.
29. Redmon, P., Chen, L.C., Wood, J.L., Li, S. and Koplan, J.P. (2013) Challenges for philanthropy and tobacco control in China (1986–2012). *Tobacco Control* 22(Suppl 2): ii4–ii8.
30. Wu, T. (ed.) (2008) *Tobacco Control Policy Analysis in China: Economics and Health*. London: Word Scientific.
31. Cairney, P. (2009) Tobacco control policy analysis in China: Economics and health (review). *China Quarterly* 200: 1106–1107.
32. Branigan, T. (2011) China Bans Smoking in Indoor Spaces – But Won't Penalise Puffers. London: *The Guardian*, http://www.theguardian.com/world/2011/may/01/china-bans-smoking-without-penalty, accessed 7 December 2013.
33. Huang, C. *et al* (2013) Smoking behaviours and cessation services among male physicians in China: Evidence from a structural equation model. *Tobacco Control* 22(Suppl 2): ii27–ii33.
34. Wan, X. *et al* (2013) Development of policy performance indicators to assess the implementation of protection from exposure to secondhand smoke in China. *Tobacco Control* 22(Suppl 2): ii9–ii15.
35. Koplan, J.P., Eriksen, M., Chen, L. and Yang, G. (2013) The value of research as a component of successful tobacco control in China. *Tobacco Control* 22(Suppl 2): ii1–ii3.

36. WHO. (2009) *Smoke-Free Movies: From Evidence to Action*. Geneva, Switzerland: WHO.
37. Schwartz, R.L., Wipfli, H.L. and Samet, J.M. (2011) World no tobacco day 2011: India's progress in implementing the framework convention on tobacco control. *Indian Journal of Medical Research* 133(5): 455–457.
38. Mehl, G., Wipfli, H. and Winch, P. (2005) Controlling tobacco: The vital role of local communities. *Harvard International Review* 27(1): 54–58.