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## Tobacco Control 2



# Tobacco control in Asia

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For the purpose of this article, Asia refers to WHO's combined South-East Asia and Western Pacific regions and thus includes Australia and New Zealand. Asia has the highest number of tobacco users and is the prime target of transnational tobacco companies. The future of global tobacco control rests in this region and the challenges are clear. China, India, and Indonesia are key markets and Asia is a frontrunner in tobacco control measures, such as plain packaging of cigarettes. Some countries in Asia have a long history of tobacco control activities beginning in the 1970s, and WHO's Western Pacific Region is still the only region where all countries have ratified WHO's Framework Convention on Tobacco Control. We reviewed the history, research, epidemiology, tobacco control action, obstacles, and potential responses and solutions to the tobacco epidemic in this region. Levels of development, systems of government, and population size are very different between countries, with population size ranging from 1500 to 1.3 billion, but similarities exist in aspects of the tobacco epidemic, harms caused, obstacles faced, and tobacco control actions needed.

### Introduction

Asia, with its vast population distributed across many countries with varied political systems, faces the challenge of rising tobacco consumption. The tobacco industry regards Asia's economic and demographic growth as a business opportunity to expand its trade. Public health and development activists have mobilised social action to counter this threat and contain the health and economic costs of tobacco in the region. Although global efforts for tobacco control are now better aligned, with the highest number of tobacco users worldwide, Asia is at the frontline of the tobacco epidemic. Campaigns to curb the epidemic must succeed in this region if the world aspires to be free from tobacco in the 21st century.

### History

#### US trade sanctions

Asia pioneered tobacco control measures: Singapore banned tobacco advertising, and banned smoking in the auditoria of cinemas and theatres and on public buses in 1970 (3 years ahead of Norway), and, in 1991, Singapore was the first country to ban duty-free incoming cigarettes. In Hong Kong, the then-British colonial government benefited from the experience of tobacco control measures in the UK, and noted the measures introduced in Singapore. The Hong Kong Council on Smoking and Health (the first government-funded council in Asia) was established in 1987, the same year that Hong Kong banned manufacture, importation, and sale of smokeless tobacco, being only the second jurisdiction to do so.

Many other Asian countries started tobacco control measures in the 1970s and 1980s, most beginning with health education in schools or text-message health warnings on cigarette packs. Commensurate with the global experience of that time, most early laws were neither sufficiently specific nor comprehensive, or they

had loopholes. For example, many early bans on promotion only specified tobacco advertising, and not the full range of marketing, such as sponsorship; these laws had to be progressively revised and strengthened. Early educational messages were poorly funded (by comparison with the sophisticated advertisements of the tobacco industry), clumsy, technical, and difficult for the general public to understand. Asia has shown that tobacco control is not the prerogative of high-income countries, and that Asian nations—including low-income and middle-income countries—can grasp the political nettle of tobacco control, and can do so effectively.

Tobacco was politicised in the late 1980s, when the Office of the US Trade Representative threatened various Asian jurisdictions with trade sanctions under Section 301 (a) of the Trade Act of 1974.<sup>1</sup> With these threats of economic sanctions, Japan, the Republic of Korea, and Taiwan bowed to US pressure and accepted American cigarette imports. Only Thailand challenged the Trade Representative: full paper advertisements were taken out in US newspapers; congressional hearings were held in Washington DC in 1990, when several Asian public health officials (including JM) testified; and international opinion was mobilised. In adjudication of the case, the US General Agreements on Tariffs and Trade ruled that Thailand's importation ban was not justified, but nevertheless, Thailand could maintain its law banning advertising and promotion, and could introduce other tobacco control measures as long as they were applied to domestic and imported products equally.<sup>2</sup>

A 1996 study<sup>3</sup> from the National Bureau of Economic Research showed that US trade policies had encouraged tobacco use internationally. The market share of US cigarettes in the four affected jurisdictions in Asia increased substantially after the countries were compelled to import US tobacco products under trade agreements—cigarette consumption per head was almost 10% higher than it would have been if markets had stayed closed to

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This is the second in a Series of three papers about tobacco control

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American cigarettes. Although this finding was of extreme concern at the time, it galvanised Asia's tobacco control advocates and was the most instrumental factor toward an early understanding of the need to address political, economic, environmental, and trade components, and the need to tackle the tobacco industry and its supporters head-on. This political awareness was, and remains, crucial.

### Research

In 1981 in Japan, the late Takeshi Hirayama published the first major global cohort study<sup>4</sup> of passive smoking in 91 000 non-smoking married Japanese women, showing that the wives of heavy smokers had a higher risk of developing lung cancer than did the wives of non-smokers. Governments, university departments, and other health organisations have increasingly undertaken high-quality research of tobacco prevalence; adverse health effects of active and passive smoking;<sup>5,6</sup> public opinion; effective tobacco control interventions, including cessation; the behaviour of tobacco companies; and the economic and trade aspects of tobacco.

Research of the economic costs of tobacco has provided compelling data: between 2003 and 2008, 3·2% of total health-care expenditures in China were used to treat tobacco-related illnesses.<sup>7</sup> Findings showed a link between tobacco and poverty.<sup>8</sup> More than 30 min of labour are required to purchase a packet of cigarettes in India, New Zealand, and Malaysia, and more than 1 h is required in Singapore.<sup>9</sup> For the cost of a packet of a leading cigarette brand, a person could buy 81 servings of rice in Cambodia, or more than 40 servings in China, Indonesia, Thailand, and Vietnam.<sup>9</sup> However, cigarettes have become more affordable in real terms (ie, with income growth) in Asia.<sup>9</sup> In China in 2000, nearly 14% of the average income per head was needed to buy 100 packets of the cheapest cigarettes; in 2010 this number dropped to less than 3%.<sup>9</sup>

Research of the effectiveness of tobacco tax has shown it to be an essential component of tobacco control. In 2012, the Asian Development Bank estimated that, in the absence of intervention, smoking will eventually kill

about 267 million current and future cigarette smokers who are presently alive in five Asian countries (China, India, Philippines, Thailand, and Vietnam), and increases in tax would reduce the number of smokers and the number of smoking-related deaths, and would generate substantial new revenues.<sup>10</sup> Importantly, the Development Bank noted that the poorest socioeconomic groups in each country would bear only a small part of the extra tax burdens, but would reap many of the health benefits of reduced smoking. Up to now, only seven countries in Asia apply high excise and other tax at more than 70% of cigarette price.<sup>11</sup>

Research has sometimes been supported technically and financially by international organisations—eg, WHO, the US Centers for Disease Control Global Tobacco Surveillance System,<sup>12</sup> the International Tobacco Control Project,<sup>13</sup> and the US National Institutes of Health. Respected academic institutions and researchers in many Asian countries have used their research for policy and have channelled international and local research to the decision makers, which has added great weight to political lobbying. Translation of research into policy is a particular challenge, and not only in Asia. Many governments do not instinctively source data when designing government policy, and few policy makers in Asia have the scientific background to interpret the validity of the evidence, especially in low-income and middle-income countries.

### Epidemiology and health effects

More than half the tobacco consumed in the world is consumed in Asia. 430 million smokers reside in WHO's Western Pacific region,<sup>14</sup> and about 250 million smokers and almost the same number of smokeless tobacco users in the South-East Asia region.<sup>15</sup> Tobacco control measures have led to a reduction in prevalence of tobacco use in men in most countries in the past few decades. Since 1980, rates of smoking in men have halved in Australia, Hong Kong, Japan, New Zealand, and Singapore. Smoking in women has not increased to the extent predicted in the 1980s. This finding is particularly surprising because Asian women have become more independent, have greater purchasing power, and are less likely to follow admonitions from authority, teachers, and parents than they have been previously. However, such changes should not give rise to complacency and increases in smoking in girls in Asia are a particular concern.<sup>16</sup>

Smoking prevalence is still high in some countries (table 1), especially in men (figures 1, 2). South Asia has the highest use of smokeless tobacco worldwide (figure 3). Most of the six million annual tobacco deaths worldwide are in Asia. In WHO's South-East Asia region, an estimated 1·3 million people die every year from tobacco-related disease,<sup>15</sup> whereas in the Western Pacific region<sup>14</sup> two people die every minute, placing a huge burden on health-care systems.

	Total	Male	Female
Indonesia	34·8%	67·0%	2·7%
China	28·1%	52·9%	2·4%
Democratic People's Republic of Korea	27·7%	47·7%	7·3%
Japan	23·4%	38·2%	10·9%
Thailand	20·2%	39·1%	2·2%
Vietnam	15·6%	31·0%	1·0%
India	14·0%	24·3%	2·9%
Singapore	13·0%	22·8%	3·6%
Hong Kong	11·1%	19·9%	3·0%

Table 1: Daily cigarette use in selected Asian countries, according to 2011 or most recent data<sup>17,18</sup>

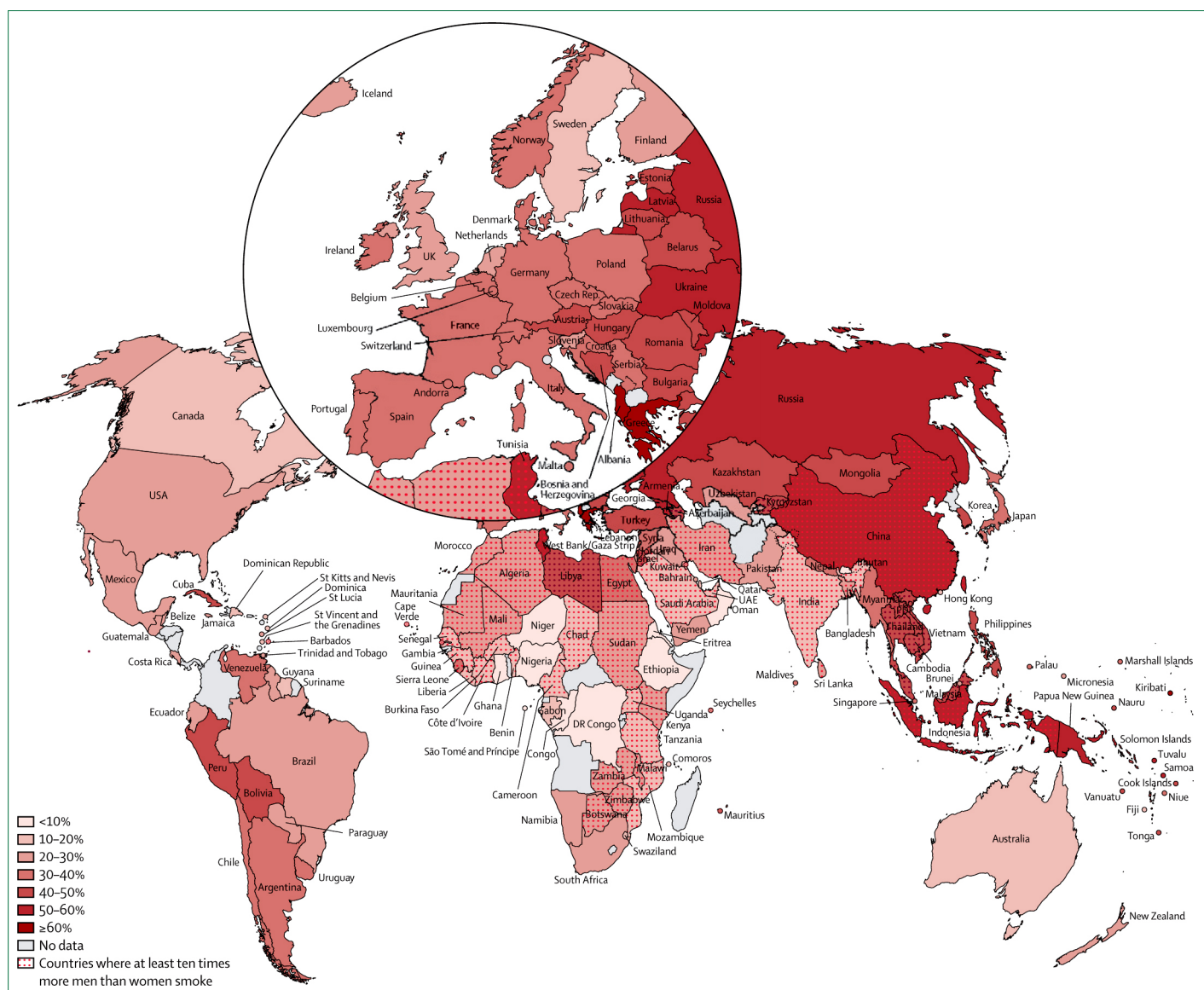


Figure 1: Global comparisons of prevalence of cigarette smoking in men, by country, in 2010 or later<sup>9</sup>

## The role and activities of governmental, intergovernmental, and non-governmental organisations

### WHO

WHO has assisted Asian nations with targeted advice and guidelines; 5-yearly action plans on tobacco or health for the Western Pacific region, starting from 1990; and the resolution passed by the South-East Asia Regional Committee in 2008 became the operational way to guide Member States in their efforts to implement WHO's Framework Convention on Tobacco Control. World No Tobacco Day has been celebrated in Asia every year since 1988.<sup>19</sup> The Framework Convention on Tobacco Control—WHO's first health treaty—came into force in 2005 (table 2). Of the 176 countries that are now parties to this

treaty (representing about 90% of the world's population), the Western Pacific region remains the only WHO region where all countries have ratified the Convention.<sup>20</sup> The only important exception is Indonesia. The Framework Convention on Tobacco Control has led to increased resources in low-income and middle-income countries, for example, from Bloomberg Philanthropies<sup>21</sup> and the Bill & Melinda Gates Foundation.<sup>22</sup> In January 2013, the signing ceremony for the Illicit Trade Protocol was opened, with three of the first 12 signatories being from Asia: China, Burma, and the Republic of Korea.

In 2008, WHO developed the MPOWER policy framework (Monitor tobacco use and prevention policies, Protect people from tobacco smoke, Offer help to quit tobacco use, Warn about the dangers of tobacco, Enforce

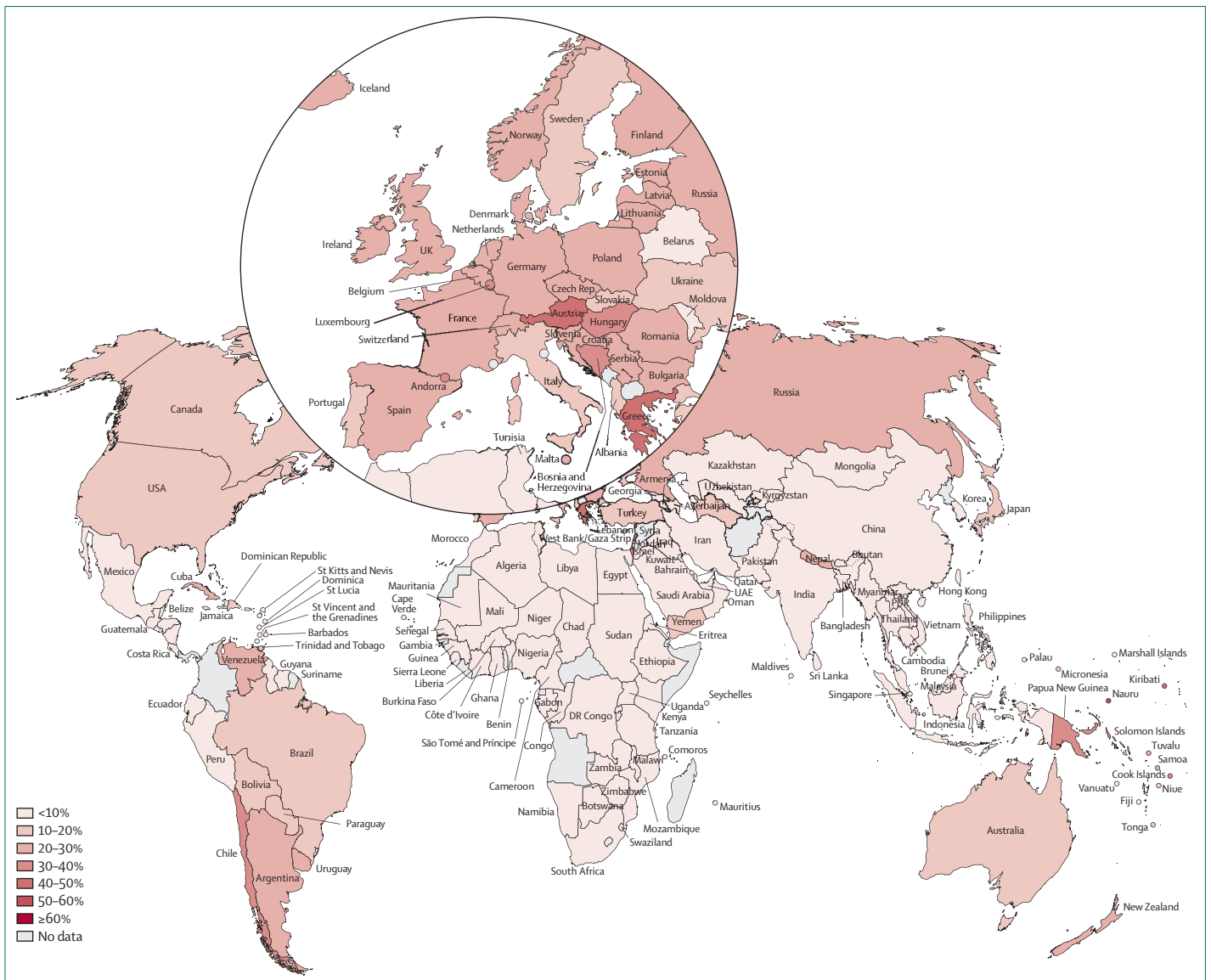


Figure 2: Global comparisons of prevalence of cigarette smoking in women, by country, in 2010 or later<sup>8</sup>

bans on tobacco advertising, promotion and sponsorship, and Raise taxes on tobacco) to provide a detailed roadmap for effective solutions, to complement the Framework Convention on Tobacco Control (table 2). A Report on the Global Tobacco Epidemic is now published every 2 years. Asia, Australia, New Zealand, Singapore, and Thailand were among the highest 20 overall scorers in the most recent assessment of countries in 2011.<sup>17</sup>

### Government

The role of governments is crucial worldwide, but especially so in Asian countries where governance has a more top-down approach. Only governments can mandate public health legislation such as smoke-free areas, health warnings, and bans on all promotion; remove

business operation licences for non-compliance; implement taxation policy; and ratify UN treaties, such as WHO's Framework Convention; however, all these techniques work best when supported by civil society. Therefore, political lobbying has had to be high on the agenda of anyone hoping to influence public health policy in Asia.

### Non-governmental organisations

International non-governmental organisations, such as the Union for International Cancer Control, the International Organisation of Consumer Unions, and local health organisations ran tobacco control meetings and workshops throughout the 1980s in China, Hong Kong, Japan, Macau, Malaysia, Philippines, Singapore, and

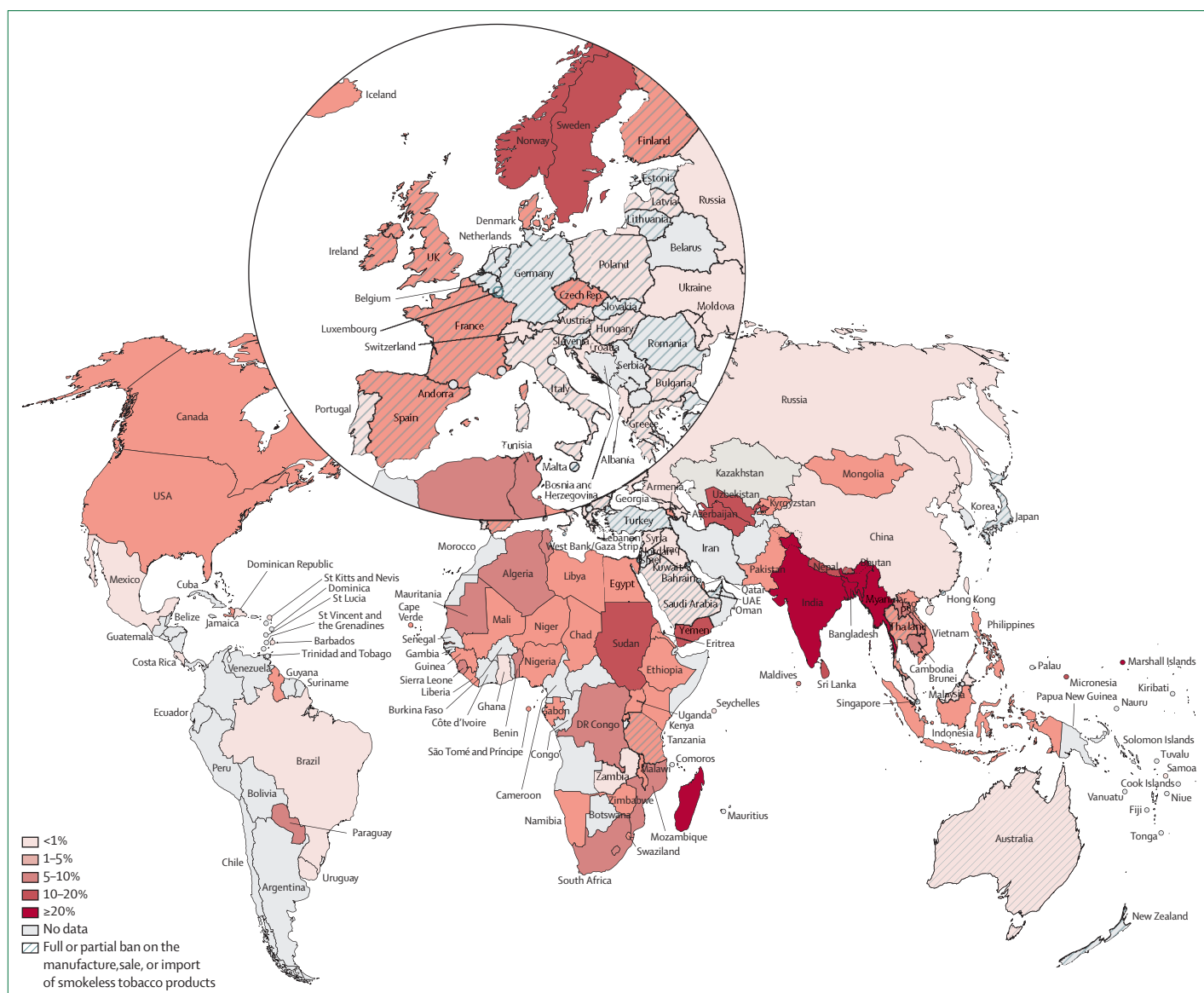


Figure 3: Global comparisons of prevalence of smokeless tobacco use in adults, by country, in 2010 or later<sup>a</sup>

Taiwan. Several advocates of tobacco control from the Americas, Europe, Australia, and New Zealand gave unstinting support to the fledgling tobacco control efforts in many countries. Presently, most major international cardiovascular disease, cancer, lung and other organisations such as the Framework Convention Alliance and the Non-Communicable Diseases Alliance are active in Asia. Furthermore, several effective national non-governmental organisations are in place in, for example, Australia, India, Thailand.

Three major regional NGOs exist. First, the Asia Pacific Association for the Control of Tobacco (APACT). When the storm clouds of the trade threats were gathering over Asia, David Yen in Taipei decided that a regional organisation and a pan-Asian strategy were needed. In

1989, he founded and funded APACT at a time when Asian countries were rarely in contact with one another. APACT, in coordination with WHO, organises major regional tobacco control conferences in Asia every 2–3 years: Taiwan (1989), Republic of Korea (1991), Japan (1993), Thailand (1995), the Philippines (1998), Hong Kong (2001), Republic of Korea (2004), Taipei (2007), Australia (2010), and Japan (2013), with participants from countries as diverse as Australia, New Zealand, Mongolia, and Laos. Second, JM founded the Asian Consultancy on Tobacco Control (ACTC) in 1990, as a coordinating organisation to help with the sharing of information, experience, and expertise about tobacco control among countries in the Asia-Pacific region. Third, BR established the Southeast Asia Tobacco Control Association (SEATCA) in

	Criteria	Countries
Monitoring of tobacco use	Recent (data for 2005 or later) representative (survey sample representative of the national population) and periodic (for at least every 5 years) data for adults (aged ≥15 years) and adolescents (aged 13–15 years)	Australia, Burma, India, Indonesia, Japan, Mongolia, New Zealand, Philippines, Republic of Korea, Sri Lanka, Thailand, Vietnam
Protection from tobacco use	All public places completely smoke free or at least 90% of the population covered by complete subnational smoke-free legislation	Australia, Bhutan, Maldives, Marshall Islands, Republic of Korea, Singapore, Thailand
Offers to help to quit	National quit telephone line, with nicotine replacement therapy and some cessation services cost-covered; smoking cessation support available in health clinics or other primary care facilities, hospitals, office of health professionals, or the community	Australia, New Zealand, Republic of Korea, Singapore
Warning about dangers	For individual packages, and any outside packet and labelling used in retail, >50% (average of the front and back of the cigarette pack) of the cigarette packet has pictures or pictograms and appropriate characteristics such as specific health warnings that describe specific harmful effects of tobacco use on health; warnings are large, clear, visible, legible, rotate, and are written in all main languages of the country	Australia, Brunei, Malaysia, New Zealand, Singapore, Thailand
Enforced bans	Ban on all forms of direct and indirect forms of tobacco advertising	Burma, Thailand
Raised taxes	>75% of retail price is tax	Cook Islands

Table 2: Asian countries that had implemented demand reduction measures in December, 2010<sup>27</sup>

2001. Building on common goals to curb the tobacco epidemic in the Association of Southeast Asian Nations (ASEAN), SEATCA progressively forged partnerships and collaborations with governmental and non-governmental organisations, research institutions, and WHO in most ASEAN countries—namely, Cambodia, Indonesia, Lao PDR, Malaysia, Philippines, Thailand and Vietnam. SEATCA organises strategic programmes, including capacity building, research, and policy advocacy aiming to foster tobacco control policy and strengthen implementation of WHO's Framework Convention.<sup>23</sup>

### Obstacles

Obstacles to tobacco control in Asia are similar to those in most other parts of the world. They include a focus on curative, not preventive, measures; reports of tobacco tax revenue but not the debit; misperceived concerns about economic losses if tobacco control measures are implemented; and governments' preoccupation with other events or diseases that cause far fewer deaths than tobacco, such as severe acute respiratory syndrome, Avian influenza, or financial crises. Both national monopolies and commercial transnational tobacco companies operate in Asia, often side by side. These groups have ignored the clinical evidence; promoted smoking; established pro-tobacco institutes; challenged tobacco control legislation; attacked individuals, organisations and WHO; mounted legal challenges against governments; and even secretly employed scientists in the infamous Asian Whitecoat Project to work undercover and slant the scientific data for second-hand smoke.<sup>24–26</sup>

Litigation and legal challenges have been used to obstruct and delay tobacco control. In India, the industry delayed implementation of The Cigarettes and Other Tobacco Products Act by almost a decade, with use of legal challenges.<sup>27</sup> In Indonesia, an unsuccessful but delaying challenge to a tobacco control law has taken place in the constitutional court, with the claim that tobacco was not harmful, did not cause lung cancer,

and could even be beneficial to health.<sup>28</sup> In the Philippines, the Department of Health's Administrative Order on pictorial health warnings on cigarette packs is being challenged by the tobacco industry in three district courts; the outcome is pending.<sup>29</sup> The tobacco industry launched a triad of legal challenges to block the Australian law on plain packaging, invoking internal, bilateral investment treaties and World Trade Organisation challenges.

### Potential responses and solutions

Tobacco control is being restructured in Asia. It has moved from being isolated, individualistic, and ad hoc, to a mainstream public health approach.<sup>30</sup> One new challenge is the integration of tobacco control in the framework of prevention of non-communicable diseases;<sup>31</sup> an even newer challenge is the framing of tobacco within national development plans, UN Development Assistance Frameworks, the poverty agenda, and inclusion in the next set of Millennium Development Goals. A new framework is needed to address the health epidemics of the 21st century, moving from a purely medical perspective to a perspective that incorporates political, economic, and financial considerations. Challenges remain, including the association and conflict of interest between governments and national monopolies in countries such as China, the scarce amounts of funding, the continuing legal challenges launched against governments undertaking tobacco control, and meeting of WHO's global monitoring target of reduced prevalence by 2025 and of obligations within WHO's Framework Convention on Tobacco Control and the Protocol on Illicit Trade.

Positive signs have emerged. Governments in general are more willing to tackle issues of tobacco use. Furthermore, funding from Bloomberg Initiative to Reduce Tobacco Use and the Bill & Melinda Gates Foundation is making a difference in low-income and middle-income countries. Some governments and health organisations in Asia (eg, in New Zealand and Hong Kong) have set

so-called end-game targets of less than 5% smoking prevalence. Tobacco use is completely preventable through political will and proven techniques could reduce this epidemic. The epidemic will not only be solved in the corridors of clinics and hospitals, but also in the corridors of power.

#### Contributors

JM conceived the report. JM, BR, and KSR contributed to writing and revisions of the report.

#### Conflicts of interest

We declare that we have no conflicts of interest.

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