Global Health History of Tobacco

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Key Points of the Presentation
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- The introduction of manufactured cigarettes has lead to the displacement of traditional forms of tobacco use and a rapid increase in consumption.
- The epidemic of smoking-related disease first evident in high-income countries
- Tobacco control policies used as part of a comprehensive strategy – WHO FCTC
- The role of socioeconomic inequalities to the smoking epidemic
- Lopez et al., 1994 model of the smoking epidemic
- How social gradients in cigarette smoking change as habit takes hold.
- Tobacco control policies as part of wider policies to promote equity - policies beyond tobacco control are needed to address the inequity of this global killer.
History of tobacco industry as a vector of social inequalities
Overview of tobacco industry in the present

- 6 trillion cigarettes/year; other tobacco products (smokeless, water-pipe, etc); global value of US$614 billion

- It is estimated that in 2008, US$20 billion were generated outside territories where companies are headquartered.

- Some domestic companies still exist.

- Top 5 brands overall (excluding CNTC brands): Marlboro, Winston, Mild Seven, LM and Kent
  - National and regional brands also prevalent
The tobacco industry

- **China National Tobacco Company** is the largest (by volume), followed by (by world market share):
  - **Phillip Morris International (PMI)**, based in Switzerland (Philip Morris USA, is based in the US)
    - Top-selling brands: Marlboro, LM
  - **British American Tobacco (BAT)**, based in the UK
    - Top selling brands: Pall Mall, Viceroy, Dunhill, Lucky Strike and Vogue
    - Strong presence in emerging markets
  - **Japan Tobacco and Japan Tobacco International (JTI)**, based in Japan and Switzerland
    - Top selling brands: Mild Seven, Winston, Camel (both outside of the U.S.), Sobranie, LD, Benson & Hedges, and More
  - **Imperial Tobacco**, based in the UK
    - Top selling brands: West, Davidoff, Embassy, R1, Gitanes, Lambert & Butler and Prima
Tobacco in the world

- Christopher Columbus brought samples back to Europe.
- 16th century a few Europeans started to use it – Jean Nicot (for whom nicotine is named) popularize the use.
- Introduced to France in 1556, Portugal in 1558, and Spain in 1559, and England in 1565.
- First commercial crop in Virginia, USA in 1612
- Within the decade, became colonial US largest export (as a cash crop, fueled demand for slave labor).
Tobacco in the world

- Mostly used as pipe, chewing and snuff
- Cigars became popular in the early 1800s
- Cigarettes became popular after US Civil War, and increased in popularity after introduction of white burley crop and invention of cigarette-making machine by James Buchanan Buck Duke, in the late 1880s.
- Health impact not known, and in fact, thought to be medicinal by some (except for King James edict in 1612)
Starting targeting women

- 1920s, women became targets of cigarette marketing campaigns.
- In 1930, researchers in Cologne, Germany, made a statistical correlation between cancer and smoking.
Menthol target

- Even then, it remained the only menthol cigarette on the market until the Brown & Williamson Tobacco Company created the Kool brand in 1933. Not coincidentally, this was one year after Spud became one of the top five best-selling cigarette brands.

- R.J. Reynolds Company launched the first menthol filter-tip cigarettes in 1950 under the Salem brand. Other brands include Newport (#1 menthol in the U.S.), Marlboro Menthol, American Spirits Menthol, Misty, Consulate, Pall Mall Menthol and Camel Menthol.

- In the UK there are a number of cigarette brands who have adopted to selling menthol variants, such as: Lambert & Butler, JPS, Sterling, Mayfair and Richmond.
Health concerns

- 1944, the American Cancer Society began to warn about possible ill effects of smoking.

- 1952, Readers Digest published Cancer by the Carton, detailing the dangers of smoking.

- 1954 “frank statement” the major U.S. tobacco companies formed the Tobacco Industry Research Council to counter the growing health concerns.
  - “We accept an interest in people's health as a basic responsibility, paramount to every other consideration in our business.”
  - Started the marketing filtered and “low tar” cigarettes (sales boomed) as healthier.
1960s and 1970s

- 1964 US Surgeon General report and other health authorities concluded that cigarette smoking is causally related to lung cancer in men (no data for women at the time, but trend in same direction).

- 1960s and 1970s tobacco companies target women through independence and aspiration campaigns, e.g. Virginia Slims.

- Industry expansion internationally maintaining the aspirations of “western life” ideals of wealth, power and independence as it entered LMIC.
  - Entry brands as access to international brands such as Marlboro.
Second-hand smoke

- 1980s: increasing evidence, and still growing, of harmful effects of exposure to second-hand tobacco smoke (SHS).

- Industry massive worldwide campaign to discredit health science and policies related to SHS.

- Second-hand tobacco smoke kills 600,000 people each year.
TFI ongoing monitoring of industry activities

- Monitoring the industry and sharing information about industry’s strategies to derail tobacco control is a WHO mandate.

- Resolution 54.18 of the 54th World Health Assembly (May 2001)

- TFI main activities on industry monitoring: tracking information for database, awareness raising, background information, technical assistance to member states and sister UN agencies
Article 5.3 GUIDING PRINCIPLES

Guidelines on the protection of public health policies with respect to tobacco control from commercial and other vested interests

- Principle 1: There is a fundamental and irreconcilable conflict between the tobacco industry’s interests and public health policy interests.

- Principle 2: Parties, when dealing with the tobacco industry or those working to further its interests, should be accountable and transparent.

- Principle 3: Parties should require the tobacco industry and those working to further its interests to operate and act in a manner that is accountable and transparent.

- Principle 4: Because their products are lethal, the tobacco industry should not be granted incentives to establish or run their businesses.
Social determinants of tobacco use
Equity, social determinants and public health programmes

Edited by Erik Roes and Anand Swaminathan Rup
The Commission on Macroeconomics and Health

- Established in 2000 by the Director-General of WHO to assess the place of health in global economic development, the Commission highlighted the importance of investing in health to promote economic development and poverty reduction, in particular in low-income countries.

- The Commission recognized the double burden of disease — communicable diseases and non-communicable diseases are of great significance for all developing countries — and recognized tobacco as a major risk factor.

- The Commission released a report in 2001 and commissioned a number of papers, including a study of the impacts of trade liberalization of tobacco consumption.
Social determinants of tobacco use

Tobacco use is a marker of social inequity.

- Tobacco use is unequally distributed in the population. Patterns of inequity of distribution of tobacco use has been seen across income, age, ethnic groups and by gender.

- Evidence also shows differential health consequences of tobacco use across different groups of population.

- Progress in tobacco control is also disproportionately distributed, with the richest and most socially advantaged enjoying the most efficacious implementation of tobacco control interventions.
Differential health outcome due to smoking

The risk of dying from smoking is higher in the lowest social strata than in the highest strata.

NOTE: Social inequalities in male mortality in 1996 from smoking. Values are percentages of 35-year-old men dying at ages 35–69 years from smoking if the population death rates of 1996 were to remain unchanged. Source: Jha et al., 2006b
It's not just about poverty

Note: The values in the X axis represent deciles broken down from a deprivation index constructed for the study. The higher the numbers, the higher the deprivation is. Source: Ministry of Health, New Zealand, 2001
Provision of cessation services

- Pro-poor measures can significantly improve access to prevention and cessation services at all stages of care-seeking.

- Channelling tobacco tax revenues to subsidize cessation services for the poor and disadvantaged is an example of interrelationship between structural and service interventions.

- There is need for innovative and broad thinking when designing interventions to reduce health disparities due to tobacco use.
Strengthening implementation of the WHO FCTC with a social determinants approach

- While overall prevalence of tobacco use has reduced significantly in much of the developed world, this is not evidenced across all population subgroups (young people and lower socioeconomic groups).

- Few countries, even in the developed world, have fully implemented the range of tobacco control measures outlined in the Convention, including mechanisms to enforce compliance.

- In many developing countries tobacco use is increasing.
Recommended actions for the health sector

- Elevate tobacco control on the development agenda at the global and national levels

- Rally political support for key strategies, such as raising tobacco taxes and channelling these tax revenues to fund tobacco prevention and cessation for disadvantaged groups

- Support partnerships with civic and community organizations

- Institute measures that minimize barriers and increase access to tobacco prevention and cessation services for disadvantaged population sub-groups
Tobacco control and SDH

- Existing tobacco control programmes, in particular the WHO FCTC – if implemented in a comprehensive manner – lay the ground for strong structural measures that help address the upstream social determinants of health.

- Tobacco control interventions will be better implemented if developed in collaboration with other programmes.
  - Synthesis of the work of the different nodes shows that 7 of the 13 conditions covered have tobacco use, alcohol and substance abuse on their pathways adding to the differential vulnerability.
Tobacco control and SDH

But tobacco control programmes may not reach specific populations that fall outside usual regulatory mechanisms or operate on the margins of society, thus failing to reduce differential vulnerability impacts of tobacco use.
- Actions to minimize barriers to tobacco prevention and cessation services for disadvantaged groups

Efforts to prevent and control tobacco consumption among disadvantaged groups are not likely to succeed outside of an integrated approach that seeks to reduce the underlying social inequities that:
- Predispose these groups to tobacco use, and
- Confer on them a relative disadvantage in accessing cessation services.
Tobacco Free Initiative

... for a tobacco free world

Knowing is not enough; we must apply.
Willing is not enough; we must do.

Johann Wolfgang von Goethe