



Submission of the

Tobacco Control Resource

Centre

to the Public Hearings on

the WHO Framework

Convention on Tobacco

Control

31 August 2000

The TCRC – An Alliance of European Medical Associations Against Tobacco

1. The Tobacco Control Resource Centre (TCRC) works in partnership with national medical associations across Europe, supporting them in their efforts to help patients, educate their members and inform public policy with respect to tobacco. The Centre was established in 1997 by the European Forum Medical Associations (EFMA). The TCRC is funded by the Europe Against Cancer Programme of the European Commission and the British Medical Association, and receives other support from national medical associations and from WHO.
2. The TCRC's main partners are 59 national medical associations across the 51 member states of the WHO European Region. These associations represent almost 2 million doctors across the Region - more than 60% of the European medical profession (see Appendix 1 for EFMA member associations).
3. Tobacco is the single greatest preventable cause of illness and death in Europe. The TCRC's evidence to these hearings is motivated by both European medical professionals' first-hand knowledge of the human misery and suffering caused by tobacco, and their ethical responsibility to act to protect their patients and improve the public health.

The burden of tobacco

4. More than 70,000 published scientific papers and reports document the major fatal diseases caused by tobacco – cancers, cardiovascular diseases and lung diseases – as well as the plethora of illnesses it induces [1].
5. Passive smoking is an established cause of heart disease [1] and lung cancer [2] in adults. In children, passive smoking causes lower respiratory illness, reduced lung growth and middle ear disease. Second-hand smoke can cause asthma, and increases the severity of the condition in children who are already affected [3].
6. Nicotine is highly addictive. Tobacco dependency is recognised as a behavioural disorder in the World Health Organisation International Classification of Diseases [4]. Habitual use of nicotine through smoking meets the key medical criteria for drug dependence, including psychoactive effects, compulsive use and self-reinforcing behaviour. Smokers experience a withdrawal syndrome when they abstain from tobacco [5].

The European tobacco epidemic

7. Tobacco is the single biggest killer in Europe. Every year in the WHO European region, tobacco is responsible for 1.2 million deaths each year – a staggering 137 people every hour. One in six of all deaths in Europe is caused by tobacco. Europe has the highest levels of tobacco consumption per head, the highest numbers of tobacco-related deaths, and the highest burden of disability caused by tobacco [6].
8. Unless urgent action is taken, it is estimated that tobacco products will kill 2 million Europeans annually by the year 2020, and account for one in five of all deaths in the region [7].
9. Patterns of tobacco use vary across the region. While around 35% of adult Europeans are daily smokers, usage is markedly higher (44%) in the eastern parts of the region than in the west (30%). While tobacco usage is stable or declining in most western countries, it is increasing elsewhere, predominantly in Central and Eastern Europe. In

[1] Law MR, Morris JK, Wald NJ. Environmental tobacco smoke and ischaemic heart disease: an evaluation of the evidence. *BMJ* 1997;315:973-79. <http://www.bmj.com/cgi/content/full/315/7114/973>

[2] Hackshaw AK, Law MR, Wald NJ. The accumulated evidence on lung cancer and environmental tobacco smoke. *BMJ* 1997;315:980-89. <http://www.bmj.com/cgi/content/full/315/7114/980>

[3] International Consultation on Environmental Tobacco Smoke and Child Health. Consultation Report. World Health Organization, 1999. WHO/NCD/TFI/99.10. <http://www.who.int/toh/consult.htm>

[4] International Classification of Disease, 10th revision (ICD-10). Geneva: World Health Organization, 1975.

[5] UK Department of Health. Report of the Scientific Committee on Tobacco and Health. London: Her Majesty's Stationery Office, 1998.

[6] WHO. Combating the Tobacco Epidemic. In: The World Health Report 1999. Geneva, World Health Organization, 1999. <http://www.who.int/toh/>

[7] Haglund M. Regional summary for the European Region. In: Corroa MA, Guindon GE, Sharma N, Shokoohi DF (eds) *Tobacco Control Country Profiles*. Atlanta, GA, American Cancer Society, 2000.

Central and Eastern European countries, smoking rates are high among men, and rapidly increasing among women, while in the countries in northwestern Europe, smoking rates are similar among both men and women [7].

Protection from tobacco – what works

10. Medical professionals have both the ability and the responsibility to act protect the public from the harms of tobacco. In a series of statements and declarations, EFMA has recognised the importance of individual action by doctors in informing the public and in helping their patients to stop smoking. However, tackling tobacco also requires effective action on a larger scale. EFMA has therefore also emphasised the need for effective action by governments and by regional and national organisations to curb the tobacco epidemic [8].
11. Experience from Europe shows that strong, comprehensive tobacco control programmes backed by national legislation are effective in reducing the burden of tobacco-induced illness and death. At the core of such programmes are measures that: increase public knowledge of the nature and scale of the damage inflicted by tobacco use; increase tobacco prices through taxation; and regulate both the nature of tobacco products and the activities of the tobacco industry. Effective national tobacco control programmes are backed by strong legislation that is carefully monitored and strictly enforced [9].
12. EFMA has therefore called for the enactment of strict legislation to prohibit both indirect and direct advertising of tobacco, to heavily tax tobacco products, to exclude tobacco from national price indices, to ensure effective health warnings on all tobacco products, and to ensure the right to smoke-free public places [8]. International authorities, including the World Health Organisation and the World Bank, agree that these measures are at the core of an integrated strategy to address the tobacco pandemic [10].

The response of the tobacco industry to the health effects of tobacco

13. The tobacco epidemic is fundamentally shaped by the activities of a large and very powerful transnational industry whose interests are directly opposed to those of the medical profession and the public health. For while increased tobacco sales inevitably make for more illness, suffering and death, they also mean increased industry profits.
14. Given the weight of the scientific evidence and the scale of the suffering caused by tobacco, a responsible industry would be expected to do all in its power to protect the health of its consumers. Instead, it has sought to protect its commercial interests, and to avoid effective regulation by governments and international authorities, by a number of strategies. As noted by the recent UK Health Select Committee inquiry into the tobacco industry, the net result is that current regulation is 'entirely inadequate' [11].

Denial of the health impact of smoking

15. *Active smoking.* While publicly denying the harmful effects of its product, the tobacco industry has been well aware of its hazards, and has conspired to keep this information from the public [12]. Only recently has the tobacco industry admitted the fact that active smoking harms health. However, these admissions fail to address the true nature and magnitude of the health effects of smoking.
16. *Passive smoking.* The tobacco industry has yet to admit that passive smoking causes illness. Privately, the industry has accepted the validity of independent studies on the harmful effects of passive smoking [13]. Publicly, it continues to deny that tobacco harms non-smokers.

[8] EFMA declarations and statements on tobacco, 1987-2000. <http://www.tobacco-control.org/>

[9] Simpson D. Doctors and Tobacco: Medicine's Big Challenge. London, Tobacco Control Resource Centre, 2000. <http://www.tobacco-control.org/>

[10] The World Bank. Curbing the Epidemic: Governments and the Economics of Tobacco Control. Development in Practise. Washington, DC: The World Bank, 1999. <http://www.who.int/toh/>

[11] UK House of Commons Health Select Committee. The Tobacco Industry and the Health Risks of Smoking. London, Stationary Office Ltd, 2000. <http://www.parliament.uk/commons/hsecom/>

[12] Francey N, Chapman S. Operation Berkshire: the international tobacco companies' conspiracy. BMJ 2000: 321;371-4. <http://www.bmj.com/cgi/content/full/321/7257/371>

[13] Environmental Tobacco Smoke and the Nonsmokers' Rights Movement. In: Glantz SA et al. The Cigarette Papers. Berkeley, CA: University of California Press, 1996. <http://www.library.ucsf.edu/tobacco/cigpapers/book/chapter10/6.html>

17. *Nicotine addiction*. Disregarding the compelling evidence that the effects of nicotine on the brain are similar to those of drugs such as heroin and cocaine [14], the industry trivializes the central physiological role of nicotine addiction in motivating smoking by comparing smoking to habits such as eating chocolate. Contrary to expert medical opinion, the industry maintains that nicotine is not addictive and that smoking is entirely a matter of 'free choice'.

Manipulation of tobacco products

18. The industry has produced 'light' cigarettes, described as low in tar and nicotine. These products were developed in an effort to alleviate smokers' health concerns and marketed accordingly. However, yields of tar and nicotine stated on the packet bear little resemblance to those absorbed by the smoker [15]. The industry was well aware both that these cigarettes offered no real health benefits, and that marketing of 'light' cigarettes would 'actually retain some potential quitters in the cigarette market' [16].
19. While the technology is available to reduce the nicotine content of cigarettes, an analysis by the USA FDA found that the levels of nicotine in cigarettes has increased rather than decreased. This has been made possible through the introduction of additives that increase the effective dose of nicotine delivered to the smoker, while having no effect on testing systems used by most regulatory authorities to ascertain the levels of tar and nicotine displayed on cigarette packs [17].

Non-disclosure of the content of their product

20. Cigarette smoke contains more than 4000 components, including many toxins, mutagens and carcinogens. In addition, more than 600 substances are authorized for use in tobacco products [18]. Additives can be used to modify cigarette smoke to make it more palatable and to increase the dose of nicotine that the smoker receives. The tobacco industry has failed to disclose the additives used in particular products, as well as information on their toxicity and biological effects.

Failure to compensate for damage caused to consumer

21. During the past 50 years, some 100 million people have been killed by smoking [19]. While failing to fully inform the consumer of the true nature and risks of smoking, the tobacco industry has also failed to compensate those who suffer from smoking-induced illnesses as the result of using its product as intended.

Resistance to regulation

22. The legitimate role of government in protecting the consumer and the public health includes effective regulation. The tobacco industry has consistently resisted and campaigned against the implementation of effective measures, while focusing on interventions that are likely to have little or no effect on tobacco consumption. Regulation of the tobacco industry has often been attempted through voluntary agreements with the industry. Experience shows that the effectiveness of this mechanism is extremely limited [11].

The need for international regulation of tobacco

23. Regulation of the transnational tobacco trade is essential both to the success of effective national tobacco control policies and as a measure to address transborder factors that influence the global burden of tobacco-induced disease and death.
24. Internal tobacco industry documents detail how the tobacco industry 'plans, develops and operates its markets on a global scale', focusing on the concept of 'global brands' and the 'global smoker' [20]. Four transnational companies now dominate the world market, accounting for more than 70% of the world's trade [21].

[14] Pich EM et al. Common neural substrates for the addictive properties of nicotine and cocaine. *Science* 1997;275:83-86

[15] Bates C, Jarvis M. Low Tar: why low tar cigarettes don't work and how the tobacco industry fooled the smoking public. London: ASH, 1999. <http://www.ash.org.uk/papers/big-one.html>

[16] Imperial Tobacco Ltd, 1978. Response of the market and of Imperial Tobacco to the smoking and health environment. Exhibit AG-41, RJR-Macdonald Inc. v Canada (Attorney General). Cited in: Cunningham R. *Smoke and Mirrors*. (p. 164) Ottawa, ON: International Development Research Centre, 1996.

[17] Kessler DA. The control and manipulation of nicotine in cigarettes. *Tob Control* 1994;3:362-69

[18] Bates C, et al. *Tobacco Additives*. London: Action on Smoking and Health/The Imperial Cancer Research Fund, 1999.

[19] Peto R et al. *Mortality from Smoking in Developed Countries 1950-2000*. Oxford: Oxford University Press, 1994.

25. Market liberalization and international trade agreements have also provided opportunities for the industry to exploit new markets. As the UK-based transnational BAT reports: 'The 1990s have seen new opportunities ... especially in central and eastern Europe and in the Far east, with the opening up of markets previously closed to Western tobacco manufacturers' [22]. Recent rapid growths in tobacco consumption among women and young people in Europe and elsewhere have been linked to increased targeting of promotional activities to these populations [7].
26. Where effective national measures to curb tobacco consumption have been introduced, transborder influences can undermine their success [22]. For example:
 - International trade agreements have been used to open up new markets to transnational tobacco companies, and to influence changes in national tobacco control policies.
 - Tobacco smuggling undermines effective taxation policies. Contraband world sales grew more than 100% between 1990 and 1997, with the eastern European region accounting for a substantial proportion of this volume. In the UK, it is estimated that around 18% of all cigarettes sold are contraband.
 - Promotional activities that use the global broadcast media transcend national boundaries. During the African Nations Cup earlier this year, pitch-side advertising for tobacco at soccer matches was beamed into homes across Europe by satellite television.
27. In addition, the continuing failure of tobacco industry to act responsibly in relation to the proven dangers of tobacco to human health, its coordinated international efforts to confuse the public regarding the health effects of tobacco [12], and its attempts to influence public policies for the protection of both smokers [22] and non-smokers [23] reinforce the need for supranational regulation.

The WHO Framework Convention on Tobacco Control

28. EFMA has long recognised the importance of both international scientific and technical cooperation and of action by governments and international bodies in effectively tackling the tobacco epidemic. Noting the urgent need for international action in curbing the tobacco epidemic, the TCRC urges all concerned to work with the World Health Organisation to ensure that at the core of the Framework Convention are comprehensive, proven measures to protect the public from the suffering and premature death caused by tobacco [8].
29. In March 2000, representatives from national medical associations from across Europe present at the annual plenary of EFMA recommended support for the World Health Organization Framework Convention on Tobacco Control (FCTC), and requested the TCRC to coordinate support for the FCTC by medical associations that are members of EFMA [24].
30. The TCRC notes with concern that the transnational tobacco industry continues to deny the true magnitude of the epidemic, to reject expert opinion regarding the addictiveness of tobacco, to aggressively market a deadly product, and to mislead its consumers. While seeking to convince the public that it has changed, the tobacco industry continues to attempt to resist, frustrate and challenge all efforts to regulate its activities.
31. We are convinced that the negotiating process towards the Framework Convention must have as its focus effective public health measures that are proven to save human lives, rather than economic considerations. We urge our colleagues in the health professions throughout the world, as well as civil society and governments everywhere, to lend their full support to a convention, and to facilitate and expedite its ratification in as many countries as possible.

[20] Taylor AL, Bettcher DW. WHO Framework Convention on Tobacco Control: a global good for public health. *Bull Wrlld Hlth Org* 2000;78:920-9. <http://www.who.int/bulletin>

[21] Joosens L. From public health to international law. *Bull Wrlld Hlth Org* 2000;78:930-7. <http://www.who.int/bulletin>

[22] Salojee Y, Dagli E. Tobacco industry tactics for resisting public policy on health. *Bull Wrlld Hlth Org* 2000;78:911-912. <http://www.who.int/bulletin>

[23] Ong EK, Glantz SA. Tobacco industry efforts subverting International Agency for Research on Cancer's second-hand smoke study. *Lancet* 2000; 355: 1253-59 <http://www.thelancet.com/newlancet/reg/issues/vol355no9211/publichealth1253.html>

[24] Report and recommendations of the TCRC workshop to the European Forum of Medical Associations. Warsaw, Poland, 16 March 2000. <http://www.tobacco-control.org/>

Appendix 1. Members of the European Forum of Medical Associations

Albanian Medical Association	Israel Medical Association
Andorra Medical Association	Italian Federation of Doctors and Dentists
Armenian Medical Association	Kazakhstan Association of Physicians and Pharmacists
Austrian Medical Association	Kyrgyzstan Medical Association
Azerbaijan Medical Association	Latvian Medical Association
Byelorussian Association of Physicians	Lithuanian Medical Association
Belgian Association of Medical Unions	Association of Doctors and Dentists of the Grand Duchy of Luxembourg
Conseil National de l'Ordre des Médecins Belges	Macedonian Medical Association
Bosnian Medical Association	Medical Association of Malta
British Medical Association	Medical Association of Montenegro
Bulgarian Medical Association	Royal Dutch Medical Association
Croatian Medical Association	Norwegian Medical Association
Croatian Medical Chamber	Federation of Polish Medical Societies
Czech Medical Association	Polish Chamber of Physicians and Dentists
Danish Medical Association	Polish Medical Association
Estonian Medical Association	Portuguese Medical Association
Finnish Medical Association	Romanian Medical Association
Confédération des Syndicats Médicaux Français	Association of Physicians of Russia
Conseil National de l'Ordre des Médecins Français	The Russian Medical Society
Georgian Medical Association	Slovak Medical Association
German Medical Association	Slovak Medical Chamber
German Hartmannbund	Slovenian Medical Association
German Marburger Bund	Medical Chamber of Slovenia
Association of German Physicians in Private Practice	Medical Council of Spanish Medical Colleges
Panhellenic Medical Association	Swedish Medical Association
Hungarian Medical Association	Swedish Society of Medicine
Federation of Hungarian Medical Societies	Swiss Medical Association
Icelandic Medical Association	Turkish Medical Association
Irish Medical Organisation	Association of Ukrainian Doctors
	Physicians Association of Uzbekistan