



Tobacco Control



at a glance

Why is reducing use of tobacco a priority?

Tobacco is becoming **one of the single biggest causes of death worldwide**. By 2030 it is expected to kill 10 million people per year; half aged 35-69. The epidemic is **increasingly affecting developing countries**, where most of the world's smokers (82% or 950 million) live. Close to half of all men in low-income countries smoke daily and this has been increasing. For example, smoking prevalence among Chinese men increased from 40% in the 1950s to 63% in 1996 (Chinese Academy of Preventive Medicine 1996). Women's smoking rates are also increasing fast. By 2030, developing countries will account for 70% of all tobacco deaths. **Many deaths and much disease could be prevented by reducing smoking prevalence.**

Smoking and poverty. Episodes of ill health, the costs of health care, and premature death are frequently cited by poor people as their gravest concerns, and as the precipitating cause that pushes families into poverty. Smoking prevalence tends to be higher among men with less education and lower incomes, so they bear a greater health risk. Also, the opportunity cost of money spent on cigarettes is obviously higher for people living on low incomes – money spent on tobacco products could help feed families. Tobacco is often a significant part of family expenditure: low income households with at least one smoker in Bulgaria spent 10.4% of their total income on tobacco products in 1995; urban households in Tibet spent 5.5% of their monthly disposable income on tobacco products in 1992; and in China, smokers in 2,716 households in Minhang district spent 17% of household income on cigarettes (Gong et al, JAMA 1995, 274:1232-4).

The **harm from second-hand smoke** to others, especially unborn and young children, further justifies intervening to reduce tobacco use. 710 million children live in households where someone smokes (Lopez, WHO, 1999). Many **smokers do not know their risks**, begin smoking at very young ages and most later regret ever starting and would like to quit.

For example, 61% of Vietnamese smokers surveyed in 1995 said they wanted to quit, and 44% had tried to quit (Jenkins et al, 1997). In China and in other developing countries, the average age at which people begin to smoke is falling from early 20s to teens. Nicotine is highly addictive, so it is important to **discourage smoking initiation**, especially among young people. Because many of the expected deaths from tobacco use will be among the 1.1 billion people who now smoke, persuading and **helping people to quit** is key to reducing disease and death from tobacco use.

The Framework Convention on Tobacco Control (FCTC)

The FCTC was adopted by WHO member countries in May 2003. It will commit all countries that ratify it to: eliminate all tobacco advertising, promotion and sponsorship within 5 years (with a narrow exception for those nations whose constitutions prohibit a complete ban); require warning labels occupying at least 30% of the area of cigarette packs (and suggests 50% or more); prohibit misleading tobacco product descriptors such as "light" and "mild"; and protect nonsmokers from tobacco smoke in public places. The FCTC also urges strict regulation of tobacco product contents; higher tobacco taxes, global coordination to fight tobacco smuggling, and promotion of tobacco prevention, cessation and research programs.

National tobacco control efforts are usually led by the Ministry of Health, associations of physicians and other health groups, or dedicated anti-smoking groups. NGOs, women's groups, youth groups, lawyers, economists and environmentalists play key roles in some countries. Ministries of Finance, Economic Planning and Taxation are important, because higher tobacco taxes are the single most effective way to reduce use. Other stakeholders include: Ministries of Agriculture and farmers, Ministries of Labor and Industry, employee groups, Ministries of Education, media, retailers, and sports groups (sponsorship).

Cost Effective Interventions to reduce death and disease caused by tobacco use

Measures to reduce demand for tobacco products are highly cost effective – very high on the list of public health

“best buys”

Objective: Reduce tobacco use, to reduce death and disease caused by tobacco use.

Interventions	Beneficiaries/Target Groups	Process Indicators
Higher taxes on cigarettes and other tobacco products	smokers potential smokers (especially youth)	✓ price of cigarettes/bidis etc (adjust for inflation) ✓ tax as % of final sales price
Non-price measures		
Bans/restrictions on smoking in public and work places: schools, health facilities, public transport, restaurants, cinemas etc.	non-smokers protected from second-hand smoke	✓ smoke-free public spaces and places
Comprehensive bans on advertising and promotion of all tobacco products, logos and brand names ¹	smokers and potential smokers (especially youth) societal attitudes to smoking	✓ laws, regulations, extent to which respected/enforced
Better consumer information: counter-advertising, media coverage, research findings	smokers and potential smokers societal attitudes to smoking	✓ knowledge of health risks, attitudes to smoking
Large, direct warning labels on cigarette boxes and other tobacco products	smokers	✓ % of box surface covered by label, message, color/font specifications
Help for smokers who wish to quit, including increased access to Nicotine Replacement (NRT) and other cessation therapies	smokers	✓ number of ex-smokers
Impact / surveillance Indicators for tobacco use (from survey data):		
<p>adult smoking prevalence: % of people 15 and older who use any tobacco product at least once a day (daily/regular smoker) or occasionally, % who have ever smoked</p> <p>intensity: average number of cigarettes (and other tobacco products) smoked/used daily</p> <p>quit behavior: % who used to smoke, but currently do not smoke at all</p> <p>youth use: % of young people who currently use any tobacco product (defined as having used a tobacco product on one or more days during the past 30 days),</p> <p>initiation age: age at which current and ex-smokers first started to smoke at least one cigarette a day</p> <p>Note: A Global Youth Tobacco Survey is being implemented in many countries with support from WHO and CDC. See: http://tobacco.int/en/youth/gyts/html (on the WHO website) or http://www.cdc.gov/tobacco/research_data/youth/gytsfact-sheets.pdf (CDC website)</p>		

¹ If full bans are impossible, strong restrictions, and significant counter-advertising should be pursued.

The evidence shows: (useful information)

- The **best results are achieved when a comprehensive set of measures to reduce the use of tobacco are implemented** together. Many countries have succeeded in reducing smoking prevalence dramatically, and consequently reduced cancers, heart disease and other circulatory diseases, respiratory diseases, and low birth weight incidence.
- **Price increases** are the most effective and cost-effective deterrent – especially for young people and others with low incomes, who must, of necessity, be highly price responsive. A price rise of 10% decreases consumption by about 8% in low- and middle-income countries. Higher taxes will generate additional government revenue.
- In almost all countries, as people switch expenditures from tobacco to other goods, **there will not be net job losses**. As demand for tobacco products falls, jobs lost in tobacco farming, manufacturing and distribution, are offset by new jobs created in other sectors in response to changed expenditure patterns. Some countries (Malawi and Zimbabwe) and areas within other countries whose economies depend heavily on tobacco, may need help in adjusting to new consumption patterns.
- Erosion in global demand for tobacco will probably be slow and gradual, in the face of growing population numbers, rising incomes, social norms, addiction, and advertising and promotion of tobacco use.
- **Most measures to reduce supply are ineffective** (prohibition, youth access restrictions, crop substitution efforts and trade restrictions). **Control of smuggling** is the exception, and **is the key supply-side measure to pursue**.
- Will poor smokers be hurt by tobacco product price increases? Those who decide to quit or cut back their use of tobacco products will gain health and income. People who do not reduce or quit smoking in the face of price increases will pay more. If this is an important issue, compensating tax/price cuts in other products (eg basic foods) might be considered, and/or targeted cessation programs.
- **Many smokers want to quit**, and could use help. Most people who quit do so without help, but nicotine addiction makes quitting very hard. Quit rates can be substantially increased through advice from health care providers, telephone “quit-lines”, formal and informal support-groups, and cessation therapies including nicotine-replacement (NRT). Over-the-counter (non-prescription) sales improve access to NRT. There are many potential opportunities for cessation advice and support: e.g. as part of TB treatment.
- **What works for youth?** The most effective tool to reduce/deter use of tobacco products by young people: **price increases**. Bans on tobacco product sales to young people are difficult and costly to enforce. Policies should be tailored to affect the usual sources from which young people get their cigarettes or other tobacco products. For example, some countries have reduced youth access to tobacco products (especially cigarettes) by banning sales through vending machines. **Free distribution of tobacco products and promotional products (T-shirts, school note books etc) should be strictly banned**.
- **Health warnings** on cigarette packages should be large (cover at least 30% of the surface area and preferably 50% or more), clear (e.g., black on white), in local languages, and have a set of specific required messages that change periodically. Information on the adverse health impact of tobacco use and the benefits of quitting should be widely disseminated.
- The tobacco industry argues that **advertising and promotion** affects market share and not overall prevalence levels, but countries that have implemented comprehensive bans on all advertising and promotion have reduced tobacco use much more quickly and to lower levels than other countries. Partial bans are not effective – if only a partial ban is politically feasible, then there is a very strong case for mandating counter-advertising (e.g the Fairness Doctrine in the USA, and in South Africa where the state radio corporation gave free air time every day for anti-smoking messages, while continuing to benefit

from substantial cigarette advertising revenues.

- Efforts to reduce smoking face formidable obstacles: nicotine addiction; social pressures; aggressive cigarette marketing and promotion; other pressing health problems; overestimates of the economic importance of tobacco; and the vested interests of those who live and profit by

cigarette sales. But there are many good success stories that could be replicated with political will, and broad support. **Modest action could save millions of lives and avert much disease, including among poor people, without long-term harm to economies.**

Resources

People in the World Bank and IMF

- HDNHE's tobacco team: Joy de Beyer, Ayda Yurekli, Sabrina Huffman. Maureen Law is the HNP Sector Board member responsible for tobacco. Email: jdebeyer@worldbank.org, ayurekli@worldbank.org
- IMF fiscal department (Peter Heller and Emil Sunley, for help in assessing the potential for tobacco tax increases and discussion with Ministry of Finance and other tax authorities.

Documents and data

- "Curbing the Epidemic: Governments and the Economics of Tobacco Control", World Bank, 1999. Development in Practice Series. On line at: <http://worldbank.org/tobacco>, or hard copy from the Infoshop, or HDNHE's tobacco team. Short, readable and clear. Analyzes and summarizes the research and key economic and social issues relating to tobacco control. Also available in 18 other languages, and a "key messages" summary brochure, and powerpoint slides are available.
- "Tobacco Control in Developing Countries", Jha and Chaloupka, OUP for the World Bank and WHO, 2000. Detailed background papers for "Curbing the Epidemic". Available online at www.worldbank.org/tobacco

- <http://worldbank.org/tobacco> for economics of tobacco notes on selected countries, country-specific data, slide presentations, useful websites (see especially WHO/TFI and CDC)
- Details of tobacco control activities in health projects funded by World Bank from Sabrina Huffman, HDNHE, World Bank. Email: shuffman@worldbank.org
- A good data base of tobacco prevalence studies and other country-specific data is being developed by WHO/CDC/World Bank/American Cancer Society – available in July 2001 at <http://worldbank.org/tobacco> also at CDC and WHO/TFI websites
- At a glance fact sheets on strong reasons to make smoke-free workplaces and how to go about doing it, and on tobacco pack information are available online at www.worldbank.org/phataglance and www.worldbank.org/tobacco

"How to" toolkit for analysis of economic issues

Explains in detail how to analyze tobacco price/consumption relationship, tax rates and revenues, options for setting and administering tobacco taxes, smuggling, employment, and impact on the poor. Describes data needs and sources, analytic model specification, and interpretation of estimation results. Available (in draft) from World Bank tobacco team, and at [www://worldbank.org/tobacco](http://www.worldbank.org/tobacco)

Expanded versions of the "at a glance" series, with e-linkages to resources and more information, are available on the World Bank Health-Nutrition-Population web site: www.worldbank.org/hnp