

Interagency Committee on Smoking and Health
Capital Hilton, Washington, DC
January 29, 2013
9:00 AM – 4:30 PM

A review of global tobacco control efforts and best practices by the U.S. and global partners, to inform U.S. domestic efforts as well as our efforts as a global partner in tobacco control.

Agenda:

Welcome and introductions

Simon McNabb, (credentials), Designated Federal Official for the Interagency Committee on Smoking and Health, Senior Policy Advisor, Office on Smoking and Health, CDC, welcomed participants and introduced the U.S. Surgeon General, Vice Admiral Regina Benjamin. The Surgeon General added her welcome and asked ICSH Committee Members to introduce themselves.

ICSH members and representatives:

Indian Health Service - Susan Karol, MD, Chief Medical Officer

Agency for Healthcare Research and Quality - Not present

U.S. Department of Veteran's Affairs - Victoria Davey, PhD, MPH, RN, (title)

National Cancer Institute - Harold Varmus, MD, Director

National Institute of Child Health and Human Development - Alan Guttmacher, MD, Director

Environmental Protection Agency - Alison (last name, credentials, title unknown)

U.S. Food and Drug Administration – Corinne Husten, MD, MSPH, Senior Medical Advisor, Center for Tobacco Products

U.S. Department of Education – (first name unknown) Costa, (credentials, title unknown)

Health Resources Services Administration - Mary Wakefield, PhD, RN, (title unknown)

U.S. Department of Defense - Jack Smith, MD, Director, Clinical and Program Policy Integration, Office of the Assistant Secretary of Defense for Health Affairs

Centers for Disease Control and Prevention - Tim McAfee, MD, MPH, Director, Office on Smoking and Health

National Institutes of Health - Barry Portnoy, PhD, Senior Advisor for Disease Prevention

National Heart, Lung, and Blood Institute - Susan Shurin, MD, Acting Director

U.S. Federal Trade Commission - Rosemary Rogers (need credentials & title)

Substance Abuse and Mental Health Services Administration - Doug (last name, credentials & titles unknown)

National Institute on Drug Abuse - Nora Volkow, MD, Director

Public Members:

Teh-Wei Hu, PhD, Professor Emeritus of Health Economics, University of California, Berkeley,

Luke Douglas, PhD, Professor of Social Work, George Warren School of Social Work, Washington University of St. Louis

Sandra Mullin, (credentials) Senior Vice President, World Lung Association

Susan Kansagra, MD, MBA, Assistant Commissioner, Bureau of Chronic Disease Prevention and Tobacco Control, NY City Department of Health and Mental Hygiene

A quorum being present, the meeting began as scheduled.

Call to Order and Charge to the Committee, VADM Regina Benjamin, MD, MBA, U.S. Surgeon General, Committee Chair

The following is a summary of Dr. Benjamin's call to order and welcoming remarks:

Welcome to the January 2013 meeting of the Committee. The purpose of this meeting is to hear from leaders in the field of tobacco control; review what is known and what more needs to be understood; and identify what is needed in terms of research and best practices to make further progress to improve the public health by reducing the prevalence of tobacco use.

The focus of this meeting is the global tobacco epidemic and improvements in addressing this issue around the world. We are especially grateful to all the international visitors for sharing their experiences and efforts with us. Tobacco use is not only a public health issue, but is a personal issue both for me and for millions of families around the globe who have suffered tremendous loss because of tobacco. I lost both my mother and my uncle to smoking-related disease and I know firsthand the devastation to families this epidemic causes.

Last spring the Office of the Surgeon General released *Reducing Tobacco Use Among Youth and Young Adults: A Report of the Surgeon General*. Tobacco remains the leading cause of death and every day 1,200 people in this country, the vast majority of whom started smoking before they were 18 years old, die from smoking. The tobacco industry spends over a million dollars an hour in the U.S. alone to market tobacco. Virtually no one starts smoking after age 25. If we can stop this segment of the population from starting to smoke before they reach age 26, we can make the next generation tobacco free.

In 2013 prevention is the foundation of public health. I am proud to be working for an administration that embraces the concept that all Americans should become healthier, live longer, and thrive, and I am privileged to chair this Committee. Many agency representatives who comprise this committee work hard to help reduce the prevalence of tobacco use and the health and financial burdens it causes. Today there are a total of 17 Federal agencies working on this issue, which is a historic number.

One of the U.S.'s primary public health goals is to increase the number of Americans who quit smoking at all stages of life. One of the seven strategic goals of the Department of Health and Human Services (HHS) is tobacco-free living. The Federal government's tobacco action plan moves us forward to become tobacco free, a difficult challenge that we are determined to meet. For example, the U.S. Department of Housing and Urban Development (HUD) is involved in efforts to make multi-family living units smoke free. The Veteran's Administration is working to help reduce tobacco use among American veterans, and there is a Department of Defense comprehensive tobacco control program for all military personnel.

Last year for the first time ever, the Federal government funded a national ad campaign to encourage smokers to quit. The successful *TIPS* mass media campaign resulted in 200,000 additional Americans calling quit lines and accessing fFederal cessation websites. We have created a new website, www.betobaccofree.gov, which is intended to be a one-stop site for tobacco control and prevention-related information and support. At that site visitors can find the Surgeon General's public service announcements (PSAs) and winners of the youth PSA challenge, as well as a large selection of other informational and support material. These steps, and many others, are proof that health care and disease prevention do not just occur in a physician's office, they occur all around us, where we live, work, learn, worship, and socialize.

The year 2014 marks the 50th anniversary of the of the first Surgeon General's Report (SGR) on Smoking and Health. When Luther L. Terry, M.D., Surgeon General of the U.S. Public Health Service, released the first report of the Surgeon General's Advisory Committee on Smoking and Health in January 1964, he chose Sunday for the release to minimize effects on the stock market and to maximize news coverage. It was the lead news story in the Sunday papers the next day and it is just as important a story today as it was 50 years ago. In 2014 I will release another SGR that will take a historical look at how far we've come, the epidemiology of tobacco use, and the policies that will make our nation tobacco free.

This is one of the goals of this international meeting. The conversation we have here today will help us become tobacco free. After 50 years of mounting evidence on the dangers of tobacco use, it is still the leading cause of death globally, killing 6 million people each year. The ICSH meeting brings participants important information about great public health models. I look forward to using this day to review best practices and make recommendations to help us achieve freedom from the death and disease brought about by tobacco use.

The following is a summary of the international greeting by Holly Wong, (credentials), Deputy Director, Office of Global Affairs (OGA), U.S. Department of Health and Human Services:

Thank you for joining this important meeting. I'm pleased to represent the Department of Health and Human Services, and Dr. Daulaire, who cannot be here today. The entire Department understands how important it is to focus on global tobacco control. There is a strong and growing recognition that the health of Americans cannot be achieved without thinking about global health. It was this concept that led to the establishment of the Office of Global Health Strategy for HHS.

The Office of Global Health Strategy coordinates the international work of all HHS agencies, including the CDC, NIH, and many others. The OGA coordinates and is liaison with ministries of health and public health agencies, and multilateral agencies, around the world. Over the last few years the priority has been non-communicable diseases (NCDs) and tobacco, and coordination with the World Health Organization (WHO) partners from public and private sectors. The OGA is also working with other entities in the U.S. Government on trade policy which could mean a move toward ratification of the Framework Convention on Tobacco Control (FCTC). I was privileged to lead the U.S. delegation to the FCTC's Conference of Parties (COP) and this was the first time HHS had attended the meeting (as an observer).

Global cooperation is critical both to public health in our individual countries and to global health overall. We are very grateful to those presenting at this conference for giving us the opportunity to hear best practices on the global tobacco experience.

The State of Tobacco Control, Michael P. Eriksen, ScD, Dean, Georgia State University Institute of Public Health

The following is a summary of the presentation by Dr. Eriksen, who was the director of CDC's Office on Smoking and Health when the ICSH first convened 30 years ago:

I'm pleased to be here and to provide the second printing of the fourth edition of the *Tobacco Atlas*, first published in 2002, to ICSH meeting participants. This important reference assembles international data on tobacco, and includes the following important global findings:

- Currently 6 million deaths per year due to tobacco,
- 16 percent of male and 17 percent of female deaths result from tobacco use,
- Most deaths occur in low- and middle-income countries, so the burden is borne by countries least able to cope with premature death and low life expectancy,
- If the current trend continues there will be 1 billion tobacco-related deaths in the 21st century.

These deaths are not just related to lung cancer and emphysema, because tobacco use affects every organ system in the body. We have the opportunity to act now and to do what we know will work to save lives. That is inspiring and motivating.

The challenges are significant for tobacco control in this country but they are much greater globally. For example in Poland, smoking related cancer causes more deaths in middle aged men than all other cancers combined. This cannot be tolerated. There is now overdue emphasis globally on non-communicable diseases (NCDs) and tobacco is the only risk factor that affects all NCDs.

Consumption varies widely around the world. Global consumption was 50 billion in 1900; this increased over 100 fold over the 20th century because of marketing of a product that is deadly and addicting. China and the Western Pacific consume the vast majority of cigarettes. Five countries--China, Russia, the U.S., Indonesia, and Japan--smoke more than half the cigarettes in the world. China smokes nearly 40 percent. Indonesia is not part of the FCTC, a vehicle for change, and the only global health treaty to turn around this epidemic. It is heartening that it is on the radar screen for the current administration in the U.S.

Among adults, Asian and Middle Eastern men are ten times as likely to smoke as women now. Tradition and custom contribute to lower rates in women. However, that is likely to change in future. We already know in some countries there is parity between men and women.

Forced smoking from secondhand smoke (SHS) exposure causes 600,000 deaths per year globally, particularly in the Western Pacific region. Innocent children are exposed by their parents. In China more women die from SHS than from smoking.

In Eastern Asia and Eastern European countries smoking is still prevalent. But we have made major progress in many parts of world. Daily smoking rates in Hong Kong are 11 percent, and 15 percent in the U.S., and we are approaching single digits. That should be an aspiration for the rest of the world.

Dr. Benjamin wants to make the next generation tobacco free. But many, many marketing campaigns, such as one from 2011 called “Kiss,” are geared to adolescent girls and boys. Globally, boys and girls smoke at similar rates. In some countries, girls smoke more than boys.

Tobacco production is also a factor in the epidemic. Most countries grow tobacco. Almost half the world’s tobacco is grown in China, a recent phenomenon. And the tobacco industry propagates the myth that tobacco control will cause economic damage to farmers.

Tobacco is big business and it is often difficult to change official policy on tobacco use because it is a major economic force. For example tobacco companies make \$35 billion a year. If we do some creative epidemiology, then \$35 billion profit divided by six million

deaths means the tobacco companies make 6 thousand dollars for ever death caused by tobacco.

There is good news and there are solutions. They've been outlined by the FCTC and captured in the Surgeon General's Reports, particularly the year 2000 report. We know what works. Pricing, indoor clean air laws, denormalizing use, banning advertising, graphic warning labels – all these strategies work. We need to continue to tell the truth. This is unlike any other public health issue, because we know what to do. We've been saying this for decades but we still have work to do. People are dying every day. Millions die every year. Together we can make a difference.

Questions:

Question: Is there a correlation between percent of money countries collect from tax and unwillingness to work on tobacco control?

Dr. Eriksen: I think that is one factor. In Georgia, my home state, the inertia around tobacco control does not concern revenue. The politicians want government to be small. Countries are concerned about farmers, convenience stores, manufacturers, and small business. It's not so much about tax.

Comment: Dr. Hu: In China the tobacco industry is part of government, so government has a vested interest in revenue and industry, and tobacco farming. In the case of China, Indonesia and India, the economic concern is equal to the health concern.

Question: Dr. Benjamin: In the photo of a Chinese school, we saw a tobacco ad featured very prominently. Did the government put that there?

Dr. Hu: No the industry put that there, but in China, the industry is government. Industry pushes the government on tobacco issues.

The Global Tobacco Surveillance System, Samira Asma, DDS, MPH, Chief, Global Tobacco Control Branch, CDC's Office on Smoking and Health

The following is a summary of Dr. Asma's presentation:

The Global Tobacco Surveillance System (GTSS) is a set of standardized surveys that is an initiative of the World Health Organization (WHO), CDC, and participating countries. The main intent is to help countries create and enhance tobacco control policies by measuring the scope of the problem and the progress of their programs and policies. Article 20 of FCTC mentions the GTSS because surveillance should be an integral part of tobacco control. Data should be comparable across countries. The GTSS lets countries fulfill this obligation.

The Global Youth Tobacco Survey (GYTS) is the largest of the GTSS surveys. GYTS is school based, self-administered and has already been repeated three to four times in several countries, generating trend data. Current results show that one in 10 students

currently smoke, one in four try tobacco before age 10, and two in three youth smokers want to quit.

The Global Adult Tobacco Survey (GATS) is funded by the Bloomberg Initiative. It has been implemented in 31 countries since 2008. The most recent highlights from 17 countries show that a total of 865 million adults currently use tobacco and 369 million are exposed to SHS at work, while three in 10 think about quitting. This survey produces tobacco use prevalence data by gender and includes data on smokeless tobacco use.

In terms of exposure to SHS at work, Uruguay is the best protector of workers. Uruguay and Brazil have the highest percentage of quitters. Brazil has one of the most effective health warning labels. Only a few countries implement point of sale (POS) bans. In these countries there are low levels of exposure to marketing in stores. There are exciting results from these bans in Turkey.

The third GTSS survey is Tobacco Questions for Surveys (TQS) that allows countries to add a particular set of questions on tobacco use and tobacco control to other surveys they are conducting. Turkey has used both GATS and TQS, in 2008 and 2010, and the data by gender for the two surveys are comparable. This shows us that TQS is a reliable measure.

CDC has an interactive website on GTSS that allows research into individual country details, data by regions, and data produced by various surveys.

International Collaboration Representatives:

Bob Chapman, (credentials), Director, U.S. Government and Multicultural Global Health Advocacy, ACS Cancer Action Network (ACSCAN); Gregg Haifley, (credentials), Associate Director, Federal Relations, American Cancer Society, Cancer Action Network, Inc.; and Patricia Sosa, (credentials), Director of Latin American Programs for the Campaign for Tobacco Free Kids

The following is a summary of Patricia Sosa's presentation on the global Bloomberg tobacco initiative:

In 2007 Bloomberg launched a major initiative to combat tobacco use in low- and middle-income countries. The initiative includes five policy objectives in 15 countries and five collaborators in addition to CTFK: CDC, the Johns Hopkins Bloomberg School for Public Health, WHO, the World Lung Foundation, and the International Union against Tuberculosis and Lung Disease (THE UNION).

There are positive tobacco control developments on every continent, and many in Latin America. In India where the highest prevalence of tobacco use is smokeless, there have been successful efforts combatting gutka use. In Russia there is commitment to tobacco control at high levels of government. There are 67 countries and jurisdictions that have passed warning label laws, 33 countries have 100% smoke-free/SHS laws, and 35

countries have passed or strengthened bans on advertising, marketing and sponsorship. Indonesia has not yet ratified the FCTC, and the battle in Indonesia and many other countries is difficult because the tobacco industry is a fierce opponent.

Over the years, the tobacco industry has gotten more aggressive. This is illustrated in the work in China and the many challenges there. Still, there is deep commitment from local officials and media and public health officials, and there has been progress. Tobacco control is becoming a serious issue and part of the conversation at the highest levels of China's government. There is a growing understanding of the link between tobacco consumption and disease, which led to the smoke-free Olympics and China's smoke-free work initiative.

In the Ukraine there is passion and commitment by local advocates in a very difficult environment with high smoking prevalence. There are increased tobacco taxes, smoke-free laws, and an advertising ban.

There have been surprising events in Vietnam. The government owns the tobacco industry and there are high smoking rates yet even in this environment they've banned smoking indoors, passed warning labels laws, and increased tax rates.

In Mexico the congress has been successful at imposing a tobacco tax increase. Mexico City has tobacco prevention murals all over the city and they are using social media and direct lobbying to encourage smokers to quit.

Uruguay is a pioneer in stemming the epidemic. The nation was sued by Philip Morris over its tobacco control efforts. The government and international community are working together to fight Philip Morris and the litigation.

The following is a summary of Gregg Haifley's presentation on the American Cancer Society's Cancer Action Network:

The Cancer Action Network is an advocacy affiliate that makes cancer a top national and international priority. On cusp of the 50th anniversary of the first SGR on tobacco, we have learned in this country about tobacco control and we know what works. As a result we've cut smoking rates in half in recent decades. We continue to make progress.

The Tobacco Atlas distributed by Dr. Eriksen demonstrates the successes other countries are having around the world. One new and emerging issue is plain packaging. Unfortunately, whenever we are successful the tobacco industry tries to thwart our progress. They use free trade agreement and initiate trade disputes. These disputes are costly to the nations enacting tobacco control policies and serve to frighten other countries that are considering adopting similar regulations. As an organization and as a group of nations we must adopt legitimate trade policies regarding tobacco. The U.S. is drafting a policy in the Transpacific Partnership Trade Agreement. We want to work within this trade agreement to ensure it contains good tobacco language. The time has

come for trade policy that reflects the science and protects nations that are trying to protect their citizens.

Our organization is concerned about the global health crisis caused by tobacco use. In this century one billion people will die from tobacco-related causes and the crisis is growing in developing countries. This interferes with efforts to combat poverty and burdens health care systems and economic development opportunities of those countries. At the same time that crisis is occurring, the tobacco industry profits handsomely. This group has consensus on what works and that is the guidelines in the FCTC. It's the quickest and most widely-embraced treaty in the world. The U.S. has not ratified it yet but has started implementing some of the policies via the FDA. Hopefully the U.S. will join the other countries and will ratify the FCTC.

The following is a summary of Bob Chapman's presentation on tobacco control on the Africa continent:

The African region is a good-news story mixed with some bad news. The region has the lowest tobacco usage rates in the world but those rates are increasing alarmingly. Overall smoking rates are projected to increase because of aggressive targeted marketing to secure that untapped customer base. The next generation of African women is more likely to smoke. A major void in public policy and lack of regulation of the industry is contributing to the problem. We have the opportunity to prevent a major health crisis from taking root. The tobacco consumption (cigarettes) is currently low but projected to increase by 2030 to 30 percent if left unchecked. This would constitute almost a total reversal in low smoking rates to date. This is why the Gates Foundation decided to fund tobacco control efforts in the region.

The Africa Tobacco Control Consortium Project comprises 12 countries (Nigeria and South Africa have a role in knowledge and best practice sharing). The American Cancer Society's Cancer Action Network focuses on working with non-governmental organizations (NGOs) on the ground, and the goal of this effort is to promote evidence-based tobacco control policy to encourage smokers to quit. These NGOs are culturally sensitive and familiar with the population. Initiatives to generate research and knowledge go into supporting the entire continent's efforts.

Some public policies not yet widely adopted in Africa include increasing prices of tobacco, graphic health warnings, smoke-free air laws, and bans on advertising, sponsorship, and promotion. There are 63 countries worldwide requiring health warnings; only four are in Africa. There has been success in terms of excise tax increases in Togo, Senegal and Benin. Taxation of tobacco is a promising strategy in Africa and a win-win solution for governments and consumers. The nations look to the WHO for guidance in this area. The ACSCAN provides advocacy and economic expertise in Africa. Unfortunately, policymakers in the region are still not emphasizing NCDs in their public health initiatives.

Questions:

Question: Dr. Cavalcante: Tobacco production is a key for the tobacco industry. Controlling production gives companies the power to control the cost of tobacco. Brazil is the world's second largest tobacco leaf producer and also the world's major exporter of tobacco leaves. Like tobacco consumption, production is shifting to developing countries. Big tobacco can find vulnerable farmers to seduce and make them believe growing tobacco will give them wealth. My question is why in developing nations is there no plan to provide alternatives to tobacco growers, especially where the farmers depend on alternatives. Many municipalities depend on tobacco production. We must have alternative crops. The farmers are as much as a victim as smokers. Alternative crops are not enough of a priority. We understand in Brazil that if we do not take this on board we will not succeed.

Bob Chapman: I am not an expert on crops but I am a former resident of Brazil, and Brazil is very far ahead of many of us in tobacco control when you look at the statistics. Other experts know more about this crop issue, and how to wean farmers off of tobacco production. The World Bank is looking at this in Asia, but congratulations to Brazil because you show that tobacco control can be successful. You are at the age range in the pyramid where the usage can explode. The farmers are being exploited in Brazil. We have to make sure we are being just as effective at giving them alternatives.

Patricia Sosa, CTFK: We are looking at the issue not only in countries highly impacted by tobacco production but also in the international context. This meeting is the place to put the issue on the table. The U.S. has the experience of weaning off of tobacco production but much tobacco growing went to Brazil. Brazil has policy at the federal and local level and the U.S. wants to learn from Brazil on this issue. This kind of exchange is very necessary. We need to be careful about the crop issue, though. The tobacco industry makes it an economic issue even when it is not one. They threaten farmers, for example in Indonesia and Kenya, that if they stop growing tobacco they will starve.

Dr. Hu: I want to echo on the topic of farming. In African countries there are many tobacco farms and the farmers are women. This is not just a crop issue, it's a women's health issue. The U.S. should offer training and technology transfer. In addition to talking about consumption we should talk about supply side. Empower the African continent not to be exploited.

Dr. Benjamin: Let's take a short break and also thank the CDC Foundation for providing the coffee and tea stations.

International Efforts in Global Tobacco Control and Prevention

Laurent Huber, (credentials), Director, Framework Convention Alliance

Luk Joossens, (credentials), Framework Convention Alliance, Belgium

The following is a summary of the presentation on the Framework Convention on Tobacco Control (FCTC) by Laurent Huber who, in addition to serving as Director of the Framework Convention Alliance, is the founder of Action on Smoking and Health (ASH) and a recipient of the C. Everett Koop and Luther Terry awards:

Tobacco use is a global problem and challenge. Those working on the framework on climate change have had a problem developing a tool but in tobacco control we have a tool in the Framework Convention on Tobacco Control (FCTC) and it's one every country should take advantage of.

The FCTC is an evidence-based treaty to save lives. It's an international treaty initiated by sovereign governments. It was not a group of 'health freaks' who put this together. The FCTC contains a range of strategies to protect lives through tobacco control. One of the most rapidly embraced treaties in the world, it was adopted in 2003 and entered into force in 2005. It has been ratified by 40 countries, and today has been joined by 176 parties; it covers 88 percent of the world population. The absent countries include the U.S., Indonesia, Argentina, and Switzerland. We have the treaty and the guidelines that assist with the implementation. We want our populations to get the best protection possible. We should use the guidelines to measure governments' advocacy.

Some articles of the FCTC include protection of tobacco control policies from commercial and other vested interests of the industry; protection of individuals from SHS; packaging and labeling; advertising, communication and public awareness; dependence and cessation; and access to treatment. There are articles with guidelines, or recommendations still in development, that include price and tax measures, regulation and disclosure of contents of tobacco products, research on economically sustainable alternatives to tobacco growing, and liability.

The Protocol on Illicit Trade in Tobacco Products was adopted in Seoul in November and is now open for ratification by FCTC parties. Article 5.3 of the FCTC addresses tobacco industry interference and stresses that public health interests are irreconcilable with the interests of the tobacco industry. When governments must interact with the industry, it must be through official hearings, there must be more than one government representative and a formal record of the meeting must be created, government officials cannot receive any gifts or services from members of the tobacco industry, and the government cannot use research funded by the industry. Government representatives can only participate in tobacco-industry sponsored events if participation is in the institutional interest of the agency.

Price and tax measures are covered by Article 6 of the FCTC. Because this issue is included in the treaty, prices in many signatory nations have increased. Today, smokers in Ireland pay over \$11 U.S. for a pack of cigarettes and 79% of that is due to excise tax. In Australia the price is nearly \$11 U.S., of which 64% is tax, and the government is considering another tax increase that will bring prices to \$20 U.S. a pack.

Secondhand smoke is addressed in Article 8. Ireland became one of the first countries to go smoke free, and Brazil's new law bans smoking in all enclosed collective-use spaces, both public and private. In New Zealand the 100% smoke-free law passed in 1990 was amended in 2003, and includes all bars, restaurants, cafes, sports clubs, and casinos. In the 1990s it seemed impossible that many countries in the world would go smoke-free. France is smoke-free today.

There have also been notable packaging and labeling successes. Australia has totally plain packaging and in Uruguay graphic labels cover 80% of the front and back of cigarette packs. There are advertising, promotion and sponsorship movements in Ukraine, France, and South Africa. As we strengthen our policies there will be increased demand for cessation services. In Brazil there is movement increase access to treatment.

Even though the FCTC has resulted in great improvements in tobacco control globally, there are many challenges. Implementation and enforcement are inadequate in many countries. In many countries the whole of government is not engaged in tobacco control. Often finance ministries and public health ministries may not see eye to eye. Sometimes tobacco control is not even on the agenda for public health.

Development agencies do not include tobacco in the portfolio of things they fund. How can the health ministry of a small country counter the efforts of the tobacco industry? Just getting funds from Bloomberg and Gates is not enough and not sustainable. For example, Philip Morris stock continues to rise. Governments have a right and obligation to protect their citizens but they are under attack from the industry. The tobacco industry has moved the fight to the courtroom, and this is even more costly for countries trying to enact tobacco control measures.

This trend was addressed by Dr. Margaret Chan, Director General of WHO, who also made tobacco control a priority at the United Nations High-Level Meeting on Non-Communicable Diseases in New York. In the political declaration from the meeting, there was unprecedented attention on the FCTC and its potential to reduce NCDs, specific commitment to accelerated implementation of the FCTC, a link between development and tobacco control, references to tobacco taxation as an important strategy, and agreement on the importance of exclusion of the tobacco industry from the table because their interests and the public health interests are irreconcilable.

Other mechanisms that can affect global tobacco control include the Conference of the Parties, which make important decisions on financial resources, mechanisms of assistance, and international cooperation for strengthening sustainable implementation of the FCTC, and the MDG Review, which works at the country level.

Trade agreements are another area of opportunity. The Transpacific Partnership will create one of the largest trading blocks in the world. It is seen as model FTA for the 21st century. It gives unprecedented rights to corporations, including the right to sue governments. It is critical that we establish tobacco as a unique product that must be treated and regulated differently under the provisions of this treaty, or the impact on global tobacco control could be devastating.

Tobacco control cannot occur in a vacuum. It must use other global governing tools. It must work at the country level. It cannot be sustained through philanthropic funding. Development agencies will have to be ready if and when Gates and other charities are no longer available.

The following is a summary of the presentation on Combatting Illicit Tobacco Trade Globally by Luk Joossens who, in addition to serving with the Framework Convention Alliance in Belgium, is also a Luther Terry Award winner:

I first want to emphasize to Dr. Benjamin that the international community holds the Surgeon General's Reports on tobacco use in high regard. This is very important work that has been done and we urge you to share this critical research as widely as possible.

Illicit tobacco trade results in less revenue for government, cheaper prices, increased consumption, and increased disease prevalence. The most effective way to reduce consumption is to increase prices. Illicit cigarettes are always cheaper than the legal cigarettes. If we did not have illicit trade, consumption would be reduced by two percent, and we'd save 160,000 lives globally per year.

How big is the illicit trade? Today 11.6% of the global cigarette market is illicit, mainly in low- and middle-income countries. In some countries the illicit trade is up to 80% of the cigarette market. It must be combatted at the global level because illicit trade is done via containers, is cheap relative to transportation of tobacco products, involves customs officials, and currently is untraceable. It has to be made traceable and payments must be made traceable. How is it possible the containers disappear? In free zones there are no customs control and no examination of the containers. They simply disappear under cover of another load.

The free zones are booming throughout the world and many illicit tobacco products go through Dubai, which is a very large free zone. For example, cigarettes produced in Greece are marketed in Tunisia. But they don't go directly to Tunisia, they go to Dubai, around Africa and then to market in Libya and Tunisia. Street selling of cigarettes is common. And smuggling is also carried out through cars, trucks, and bicycles.

There is a wide variety of smuggling levels around Europe. One of the highest rates is Latvia. And much of illicit trade is not linked to prices, but driven by the supply side. Ukraine, Russia, Moldova and Belarus also have high rates of smuggling.

Levels of smuggling depend on:

- Ease and cost of smuggling tobacco into a country,
- Presence of organized crime networks,
- Likelihood of getting caught,
- Severity of the punishment for smuggling,
- Informal distribution networks,
- Complicity by the industry, and
- The level of corruption in a country.

Smuggling surged in the U.K. from four percent to over 20% but has now decreased to nine percent after the government took measures. The U.K. launched an action plan and controlled the borders in addition to the industry. When they added control of the industry with supply chain legislation, including fines up to five million pounds, they had success. They increased sanctions and intelligence and spent on strategy. This has worked.

The cause of smuggling is demand and supply, regardless of the amount of tax on cigarettes. Supply is more important than demand. This is an illicit trade protocol that needs a global solution. To solve illicit trade, we need tougher supply chain control which entails licensing, due diligence, tracking, recordkeeping, financial traceability, and protocols for free zones. A protocol was adopted in November 2012 and first signed by South Africa, China, France, and Panama. Thirteen nations in all have signed as of today.

The most important component in a successful program to address illicit trade is a unique and secure unremovable identification on each pack of cigarettes that is linked to a database. This detailed information might assist investigations. Turkey and Brazil have led the way with sophisticated tax stamp systems and codes. This is known as a data matrix and uses the same technology as bar codes on boarding passes. The marking should provide information on where, when, and how the tobacco product was manufactured; the name, order number, and payment records of the first customer; the intended market; warehousing and shipping information; and any known subsequent purchaser. Brazil has been using data matrix codes on exported cigarettes since 2011.

Illicit tobacco products represent a loss of revenue for governments and a public health problem. Illicit trade is a global problem and combatting it might be helped by using the FCTC.

Questions:

Dr. Eriksen: Is the industry cooperating given that they have self interest in counterfeiting control?

Luk Joossens: The attitude of the industry has changed. Fifteen years ago the industry was involved in illicit trade. Now they have changed their strategy to say to government that they want to be part of solving illicit trade, but they will try to control the agenda. The governance of the industry is very important. There are very detailed accusations against companies and they are awaiting the outcome of the investigation.

Laurent Huber: Regarding industry involvement in protocol, governments wanted to kick everyone out of the room so there would be no observers. Now the organizations with observer status in a treaty can observe.

Dr. Kansagra: In New York City we have the highest pack price in nation. The Department of Finance had the tobacco industry involved in curbing illicit trade, but they turned the other way or have been complicit. Don't rely on the tobacco industry to police itself.

Question: What is the advantage of the U.S. ratifying the FCTC?

Laurent Huber: The U.S. is excluded from policy and attendance and development of guidelines because it has not ratified the FCTC. The U.S. is a global tobacco control leader and needs to be a full player. This treaty is very successful, unlike many other treaties. When a country is implementing a tobacco control policy they go to the FCTC. Many tobacco control initiatives would be made easier if the U.S. ratified the treaty. Even without ratification, why doesn't the U.S. mention this entity in its own tobacco control efforts? Even though it is not ratified, why not advocate the elements and articles of the treaty? All of them are part of the U.S. tobacco control agenda, and if people are made aware that there is a treaty that addresses tobacco issues in many of the same ways they are addressed in the U.S., perhaps there would be less resistance. Another advantage is that the U.S. could contribute resources to help address issues on a global level that also affect the U.S., such as illicit trade.

Question: Simon McNabb: Someone mentioned the FCTC is on the radar in the U.S. What's the likelihood it will be ratified?

Laurent Huber: The U.S. ratification process is complicated. Since there is a fair amount of illicit trade in U.S. and Canada it would be helpful to have the U.S. involved in writing the protocol.

Dr. Benjamin: I am playing devil's advocate. Tobacco is legal and there is a loss of revenue because of illicit trade. Is it a loss of revenue to the tobacco industry or the nations?

Luk Joossens: The tobacco industry always claims it is a victim.

Break for lunch

Australian Tobacco Control Efforts

Angela Pratt, PhD., Tobacco Free Initiative, World Health Organization.

The following is a summary of Dr. Pratt's presentation on tobacco control efforts in Australia and on tobacco control in China:

In April 2010 Australia introduced a policy on plain packaging as part of a comprehensive tobacco control program that included quit lines and a tax increase on tobacco products. Australia was the first country to introduce plain packaging laws. There was pushback and interference against this from the tobacco industry, but the good news is the government overcame industry interference.

The largest four tobacco companies launched a challenge against the plain packaging initiative. Industry tactics included bogus front groups such as the Alliance of Australian Retailers. In reality that “Alliance” was funded wholly by the industry to oppose tobacco control laws. Then the tobacco industry publicized “economic research” stating that the bans would cost the retail industry millions. It emerged that this supposedly comprehensive research was based on six businesses in total. Other tactics included an ad campaign saying that the bans were turning Australia into a nanny state and a general argument that the plain packaging went too far.

During the 2010 Australian federal election the industry spent second only to the two major political parties. The tobacco industry traditionally makes donations primarily to the Conservative party. In 2010, 97% of *worldwide* tobacco lobby donations went to political parties in Australia. After the 2010 election no party had a majority but that did not derail the tobacco control initiatives. When the legislation was before the Australian Parliament in 2011, the industry spent \$14 million on a radio and TV campaign. That’s equivalent to \$170 million U.S. As they poured millions into the ad campaign, they also lobbied political opponents.

The industry also used a range of legal tactics to try to defeat plain packaging. They threatened with libel action as a way to scare off Parliament. They made freedom of information requests as an interference tactic. The good news is that the high court upheld the laws with a 6-1 majority. The government’s success was a monumental defeat to the tobacco industry. However, trade disputes are ongoing in the courts. Australia is seeking likeminded country support in the WTO arena to turn back legal challenges from the industry on trade issues.

The Australian government has always been forward thinking in terms of tobacco control and packaging laws. Tobacco Plain Packaging (TPP) was the next logical step for Australia. FCTC was integral to the success of this policy development and enforcement. Australia drew on the international body of evidence in defending TPP laws and they pointed to FCTC guidelines. It was an instrument in overcoming interference from the tobacco industry.

Government announcements galvanized the Australian tobacco control groups. The government was vocal in its support and that support was strategic and coordinated. The government followed an exhaustive process that led up to the passage. This encouraged wide public support for the legislation. The legislative process was an important part of dismantling the industry arguments.

Australia also had a very strong public champion in Health Minister Roxon. However, the entire government was committed to this policy and could not have withstood the tobacco industry campaign had it just been the health ministry. In the end the tobacco industry's tactics came across as shallow and self-serving. The public saw that the industry was trying to bully the government and the industry misjudged the public support. A May 2011 opinion poll found very strong support for the legislation, even among smokers. The industry's criticism was not credible and their plan backfired.

Since the TPP debate in Australia, Tasmania's lower house of Parliament is considering phasing out cigarette sales altogether. Another debate was started by Simon Chapman to license cigarette sales and use a smart card as a way to limit sales. Australia is proud to lead the way in tobacco control. The evidence is emerging that a smoke-free generation is within their grasp.

Part II: Tobacco Control in China

I recently began working with WHO doing policy work in China. There is a great deal of expertise on China in this meeting room and several people who have worked in China. China is the biggest producer and consumer of tobacco in the world with over 300 million smokers (52.9 percent in males, 2.4 percent females). There are 1 million tobacco deaths per year and about 100,000 deaths from SHS. One-third of the smokers will die prematurely from tobacco-related illness.

As bad as problem in China is now, it will get worse. WHO reports that the global epidemic will not be stopped if it's not stopped in China.

Challenges in China include lack of awareness of smoking-related harm, the tobacco industry's status as a government-owned entity and monopoly, and conflicting government priorities. The tobacco industry in China is overseen by the same ministry that implements the FCTC.

There are also opportunities in China. China's National Tobacco Control Plan was released in December 2012. It received mixed reviews from the tobacco control community because it's weak in key areas. The opportunity is that it does include some targets. The country is implementing laws to create smoke-free public places. This would address the issue of SHS in China. It would also help to denormalize tobacco use.

There may be a new leadership and a new approach there as China is in the midst of a once-in-ten-year leadership transition. The new government may be prepared to take a stronger approach. Social and economic consequences of tobacco use will have to be addressed if tobacco control is to make needed strides in the country.

Turkey Tobacco Control Efforts

Toker Erguder, MD, PhD, WHO National Professional Officer on Tobacco Control

The following is a summary of the presentation on tobacco control efforts in Turkey by Dr. Erguder:

More than 100,000 people die of smoking each year in Turkey and one-third of Turks smoke. Smokers spend four times the annual budget of the Turkish Ministry of Health on cigarettes and other tobacco products.

Turkey is also a large tobacco-producing country. In 1996 it enacted its first tobacco control law which was a ban on advertisements. Turkey ratified the WHO FCTC in 2004. In July 2009 the 100% smoke-free laws were introduced, followed by health warnings in 2010. There was a large tobacco tax increase in 2011 and in July 2012 there was a total ban on advertisements and an increase in pictorial health warnings.

Turkey adopted the FCTC articles into its national tobacco program. These include media campaigns, cessation assistance, monitoring and surveillance. (GYTS, GATS, GHPTS, and GHPSS.)

Today 3,000 inspection teams and officers enforce smoke-free Turkey. They check taxi cabs, restaurants and other public places. As a result, Turkey has one of the highest implementation scores for all of WHOs' MPOWER scores.

Since these regulations went into effect and following increased enforcement, prevalence of tobacco use decreased drastically. The nation has seen a drastic decrease in tobacco use in the last 3.5 years.

Key factors in the public support of these efforts include backing by the Prime Minister, being part of an international coalition to support one another, and transfer of technology and knowledge.

Awards are motivating high-level politicians to support tobacco control. The country has received three major WHO World No-Tobacco Day awards, a WHO Health Minister's Special Award, and WHO recognition for best practices and highest implementation scores for all of the MPOWER measures. The Minister of Finance is tobacco controls' best friend. He is pleased that tobacco control results in revenue increases. There is more active support for tobacco control efforts from the Finance Minister than the Health Minister. If the Prime Minister of Turkey sees people smoking in public he takes their cigarettes away. The Turkish National Health Survey shows that NGOs are also supporting these activities. This illustrates the level of tobacco control commitment in Turkey.

Turkey is working in collaboration with CDC and WHO to help other tobacco control programs have success. Turkey hosted site visits from many other countries so they could

learn more through shared best practices. They are working with Parliaments of other countries and sharing their story with other governments and NGOs.

Challenges remain, such as high youth prevalence, especially among girls. Enforcement of smoke-free legislation in restaurants that serve alcohol, as well as plain packaging, are also challenges.

Brazilian Tobacco Control Efforts

Tania Cavalcante, MD National Cancer Institute of Brazil

The following is a summary of Dr. Cavalcante's presentation on tobacco control efforts in Brazil:

Brazil is a middle-income mega-country, with a population of 200 million. It is the second largest tobacco producer and largest tobacco leaf exporter in the world. There are 24.5 million smokers and 26 million former smokers.

Prevalence of smoking among people over age 15 is declining. Brazil conducts a phone survey each year on tobacco use as part of GATS. The most recent survey showed that among people over age 18, there was decreased smoking prevalence but no decrease among women. The challenge is how to reduce tobacco consumption among women. In 2009 among students, surveys indicate that 24.5% ever smoked and six percent are current cigarette smokers.

The good news is that in 2011 Brazil's rate of NCDs was reduced by 20% and tobacco control was the main reason for this decrease. Also there is a decline in lung cancer in the general population, but rates are increasing among women. Brazil has denounced "low-tar" and "low-nicotine" labeling.

At the end of the 1980s and in the 1990s the Brazil National Cancer Institute created a national coalition to decentralize management of tobacco control. The goal was to build a positive national environment across agencies regarding tobacco control legislation. In 2000, negotiations on the FCTC enhanced international tobacco control. Media reports of the negotiations motivated the government in Brazil to support tobacco control. Tobacco control in Brazil also has the support of the media. International NGOs like CTFK, The Union, and several partners work together and with the government to make a brotherhood of tobacco control.

Tobacco control cross cuts through the health agenda of the Intrasectorial Partnership National Committee of FCTC Implementation. There are 18 sectors of government sharing tobacco control responsibility. This was a result of the process of the negotiation of the FCTC.

The National Commission for FCTC implementation was created by the President of Brazil in 2003. Its main role is to implement a national agenda and prepare the Brazilian delegation for COPs. There are working groups linked to the commission. Legal

processes are handled by the Attorney General and economic alternatives to tobacco growing are coordinated by the Ministry of Agrarian Development.

Previously the tobacco industry used miscommunication to interfere with tobacco control. The exchange of information among all members of the National Commission is a key strategy to avoid interference from the tobacco industry.

Brazil recently enacted a total ban on advertising. This was huge because until the ban, point-of-sale advertising was allowed. Since 2002 there have been health warnings with photos on tobacco packs. In the GATS survey of 2008 65% of smokers said these warnings motivated them to want to quit smoking. Now Brazil is implementing Article 13 of the FCTC. Health warnings with photos will cover 100% of one side of the packages and by 2016, 30 percent of other side of the pack will be covered.

The tobacco industry is bringing a lawsuit to block the warning label regulations. One of their arguments is that there is no evidence that these warnings work. However, surveys showed strong support from the public, even among smokers, who want stronger health warnings. Some of the photos are not even strong enough. Brazil has learned through this process that people actually wanted more shocking photos and images. The second and more graphic round of health warnings was more impactful. A total of 48% of smokers said these warning increased their will to quit smoking and 91% of smokers said they regret smoking. A 2007 study measured the impact of health warnings, determining that they work if they are unpleasant but emotionally arousing. Smoking cues should be avoided. In a lawsuit, the tobacco industry claimed that the health warnings are not effective and hurt human dignity. The judge replied that it was worse for human dignity to think of people dying silently in their hospital beds.

Smoking is completely banned in enclosed places but now there is discussion as to the definition of an enclosed place. Strong debates are ongoing regarding the guidelines of Article 8. Brazil is trying to approve national tobacco control laws while some local areas are making their own laws. There are lawsuits questioning the constitutionality of smoking bans. Brazil also achieved the prohibition of use of the terms “light” and “mild,” as well as additives and flavors including menthol. The 2012 GATS showed that additives added to the likelihood that boys and girls would try cigarettes, mainly menthol. Taste was the most important reason for the choice. The tobacco industry sued to try to stop this measure. This has now reached the Brazilian Supreme Court level.

Another achievement is the Implementation of cessation assistance treatment for smokers in the public health system.

It is key that the Minister of Finance has been dedicated to enhancing national tax policy to accomplish Article 6 of the FCTC. Brazil had important changes in tax structure and minimum price policy.

The National Program for Diversification in Tobacco Growing Areas is helping child laborers and families who were seduced to become tobacco farmers and who now have

green tobacco leaf disease. The Program is also dealing with the environmental impact of tobacco agriculture. Currently 85% of tobacco grown in Brazil is exported. As long as other countries continue to use tobacco products, tobacco will impact the Brazilian economy.

Challenges remain:

- Smoking is more concentrated in low income populations and rural areas.
- Smoking prevalence is not declining significantly among women.
- Smoking cessation services need to increase.
- Strong opposition from the tobacco industry continues to affect tobacco control.

There is a huge economic burden from tobacco in Brazil with 131,000 deaths last year related to tobacco and 10 billion dollars spent on treatment of 15 kinds of tobacco-related disease. Brazil is thankful to the CDC for help with organizing the surveillance system and to the CDC Foundation who has helped collect the data for this presentation.

Questions:

Simon McNabb: One theme of all these presentations is that all sectors of government work together. Did you encounter parts of government who opposed or did not support tobacco control?

Dr. Erguder: For Turkey we had a problem with the Economic Minister in the beginning but now we have full support.

Dr. Cavalcante: In Brazil the Minister of Finance is our strongest ally and a key player in the FCTC compliance. The Minister of Trade is not on board because of Brazil's status as a major tobacco exporter. The Minister of Agrarian Development deals with family farming and crop diversification. The Minister of Agriculture deals with big agribusiness. The Minister of Agrarian Development and Minister of Agriculture disagree regarding crop diversification. We have a chance to try to convince them and it's a process. The Minister of Development and Foreign Trade wants to increase production of tobacco.

Dr. Pratt: In Australia we were lucky in that the whole of the government was generally supportive. There was a sense of pride that we were leading the world. We expected the Trade Minister to be resistant but now he is one of the best advocates nationally and internationally. We had to amass all the evidence to convince him.

Question: Do any of you have experience with school programs that teach students to respond critically to advertising? This is an essential skill and an important part of tobacco control.

Dr. Pratt: In Australia I don't think there are any school programs that critique impact of advertisement because there are no advertisements anymore. Tobacco products cannot be displayed in shops, and have to be behind a closed door that has a quit line number in

front of it. We have updated laws regarding internet advertising. There is no longer an education program in schools about withstanding the tobacco industry's message.

Dr. Erguder: In Turkey we outlawed tobacco company sponsorship and point-of-sale displays. Like in Australia, cigarettes are kept in a closed cabinet at point of sale. There is a prison sentence associated with selling cigarettes to youth. We are trying to create a smoke-free environment for children. Smoking is forbidden in the school setting and teachers cannot smoke. Turkey does not have school-based programs.

Dr. Cavalcante: Brazil initiated school-based programs in the 1990s to train teachers to discuss tobacco advertising, how it manipulates behavior, and how to become part of the process of sensitization about tobacco. We now have materials in the schools that must be used as part of many curricula including science, math, and Portuguese.

Dr. Kansagra: In New York City, tobacco control ads that were meant for adults also get to youth. Many strategies influence youth.

Dr. McAfee: It's very impressive to hear all three descriptions of how your governments work together. Here in the U.S., we are getting lots of heat from the tobacco industry and others regarding harm reduction, particularly from industry trade publications. There is a fair amount of genuine excitement around opportunities for the next generation who will use e-cigarettes or other products to possibly avoid some of the harm caused by cigarettes. Is this happening in your country? Is the tobacco industry introducing these products? Are you moving so fast you don't have time to worry about it? And regarding regulation of tobacco products, are there more aggressive regulations on the horizon?

Dr. Cavalcante: In Brazil it is complicated and it's like we are in quicksand. We have a history of making a mistake on "lights" and "milds" that came from the U.S. and we are very afraid to embark on the idea that we can have less harmful products. We must be very careful. We cannot repeat history of people endorsing the idea of low-risk products. We cannot run away from the discussion, either. Even from the point of view of public health, if you have a magic tobacco product, how can you describe that this would not hurt public health in general? It could convince people to keep smoking. It could make people start smoking. We will not have answers until into the future.

Dr. Erguder: In Turkey the industry started introducing other products and there is the use of shisha and water pipes/hookahs. Some were claiming that was not really tobacco. We had a problem with electronic cigarettes so we changed the legislation. Turkey has a tobacco authority that is currently working on all the other tobacco products.

Dr. Pratt: Is product differentiation a strategy being pursued in Australia? The government took action to ban flavored cigarettes that are prevalent among youth. It is important to remain ever-vigilant. The industry will always look for new ways to market their wares. There is no sense of complacency. They lost the war but they are trying to circumvent the policy. They sold stickers to cover up the graphic images. In terms of the future regarding tobacco products, the short answer is I don't know and I must stress I no

longer speak on behalf of Australian government, but I don't think more aggressive regulations will be introduced in the near future. There will probably be some regulations that restrict supply. I favor that over a complete ban. Tobacco is a unique product. It kills half of its users. But prohibition doesn't historically work. All-out bans don't work. People are addicted and that thwarts the bans, but hopefully there will be an increasingly small minority of people who are nicotine addicted.

Dr. Benjamin: I want to thank everyone for participating. What are the take-home things that get us excited and how can we help you? How can we help the global movement? Is there anything else you want to discuss?

Dr. Hu: Tobacco control is not a health or economic issue, it is a political issue. We need a leader with vision who can carry the issue of the pros and cons and convince the legislature to be a champion. We need evidence from research. Thanks to the NIH we have that research. We need to take what we learned today and ratify the FCTC. We need to measure ourselves. There are lots of experts here. My own bias is taxation. That is a very important topic. We see it work in Brazil, Turkey, and Australia. Tax increases have an immediate impact on cessation. In the U.S. we have a bootlegging problem that is an avoidance tactic to circumvent the high taxes in certain states. I propose to take the Brazilian idea and set a minimum tax across all the states. Let's invite the Treasury Department to be our partner. We need (the tax) money for health care anyway. That will reduce the gap. That will reduce the bootlegging problems. The idea is to enact laws creating minimum taxation rates or raise taxes up to three dollars.

Dr. Benjamin: Congress sets the Federal tax on cigarettes but if it was up to me, I would raise the tax to protect the public health.

Comment: There is a Senate bill to raise the Federal tax on cigarettes right now.

Dr. McAfee: If we raise the tax by three dollars at the Federal level, the government gets \$60 billion in revenue. That's still relatively small compared to the entire budget. But then the continuation of smoking might be pivotal to government funding of things like the Child Health Insurance Program, which is funded with tobacco excise tax revenue. How do we do it without creating perverse incentives? We are reaping money from consumption.

Dr. Hu: One part of the Affordable Care Act is Medicaid. If you raise tax on tobacco and give it back to states that need it for Medicaid operation that's attractive.

Dr. McAfee: But then it's hard to make states funds available for media campaigns for cessation.

Dr. Hu: It depends on how you design the earmark tax. The question is the negotiation among Congress members. They'll be asking you (us) for our input.

Comment: I realize warning labels are tied up in litigation, but other countries are so far ahead of us in pack warnings. Here we are tied up in the court systems. We can learn so much from the other countries. I'm surprised that there is not more of an international voice. We are so allergic to getting advice from others. We need warnings on packs here, or plain packaging here.

Dr. Pratt: At the time we were doing plain packing in 2010, the same day we announced a 25% increase in excise tax on cigarettes and significant additional investment in social marketing. We announced the tax increase as part of a comprehensive program. They could not argue it was a revenue-raising scheme since we were also introducing plain packaging to reduce consumption. As the excise increased it decreased consumption overnight. The evidence showed that it did lead to an increase in revenue, but also that consumption decreased rapidly. One argument put forward by the tobacco industry was that that government has a conflict of interest because it is addicted to tax revenue. We say the annual revenue from excise tax is dwarfed by what we save in health care for tobacco-related illness.

Dr. McAfee: We have had mixed experience here. We have had so much trouble with funding for tobacco control programs over the past 5-10 years. In fact we have seen states raise taxes and at the same time, make horrible cuts in tobacco control. They are using revenue from tobacco excise taxes for other programs, not tobacco control – and not even health care necessarily. We have to keep our eyes open to the fact that something is disturbing about our own governmental taxation issues.

Comment: I was at a meeting last week of tobacco modelers. Instead of thinking of what happens in the near term if you pass a bill, if you use some much more sophisticated production models, you create a longer term plan. If prices go up, consumption down, cessation goes up, disease and medical costs go down, so you have a twenty-year plan for that cost shifting. Have a plan that says this is what we think will happen and this is how we will adjust, and that will help sell the concept to the public.

Comment: In the long term there are still health care costs. A smoker starts with cardio problems in his 40s or 50s. In his 60s, he has a massive heart attack. If he survives that, he gets emphysema and he dies of COPD in his 70s. He spends so much money in health care during those 30 years. He dies after much chronic care and acute care, so there are health care dollars spent all along. We can have a big change of costs savings in terms of lives saved and health care costs, but that big change is not immediate. It's 30 or more years out.

Dr. Eriksen: The obvious issue is the FCTC and why we don't ratify it. Some other countries have done more and quicker. Look at Turkey and Australia and Canada and you have to admit we have been surpassed. How can we be a global leader if we don't ratify the FCTC? It starts with the FCTC and being more aggressive.

Simon McNabb: I am impressed that having to sign the FCTC is what starts the conversation.

Dr. Benjamin: This is another example of strategies. Nobody wants to hear that the U.S. is not the best. We have to figure out a way to make people want to be the best, or at least the best at fighting tobacco.

Comment: Let's take some credit that other countries have learned from our mistakes and our best practices. I say don't do what we did, do it differently. It allows countries to jump ahead of us. In 2013 we should use this, as well as the 50th anniversary of the SGR, as a platform. Let's change the debate. Everyone knows smoking is bad. But do they know how it damages their health care costs and productivity? Let's talk about all the diseases. If the industry will hit with the cost of tobacco control, let's hit them back with the cost of doing nothing. At the end of the day it's about money. The return on investment on tobacco control is 20 to 25 years from now. Reframe that debate. It is an economic issue.

Dr. Hu: To speak to that point it reminds me of the pandemic in Asia, complicated by the fact that farmers had their chickens in the communities with them so it was an economic issue. How do we compensate that farmer? We know there are significant health care costs down the road. What is the price tag, the cost today if we write a big check, versus the benefit 25 years from now when there is no need to be in the tobacco control business because the check today solves the health issues for the future?

Conclusion

Dr. Benjamin thanked everyone for attending and for their contributions.