The Argument for Global Tobacco Control

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Introduction

The prevention and control of non-communicable diseases (NCD) have been largely neglected, although these conditions have become the primary cause of global mortality. In fact, NCDs accounted for approximately 63% of worldwide deaths in 2008.[2] Currently, NCD mortality exceeds the cumulative mortality attributed to communicable, maternal, perinatal and nutritional disorders in every region but Africa.[3] A leading risk factor for NCDs is tobacco usage. Tobacco consumption causes five to six million deaths annually.[3] Approximately 71% of lung cancer deaths, 42% of chronic respiratory disease cases and 10% of cardiovascular disease cases are attributed to smoking.[3] Projections of current trends predict that by 2030, this number will reach nearly 10 million and up to 70% of smoking-related deaths will occur in low and middle-income countries (LMICs).[4] By 2050, smoking will have caused an estimated total of 450 million deaths.[4] Although these statistics are certainly alarming, they have not garnered adequate attention from international donors. In fact, in 2007, only 3% of all development assistance for health targeted NCDs.[5]

This paper presents an ethical argument in favor of greater involvement of the international community, particularly the governments of high-income countries (HICs), in global tobacco control efforts. Section I provides the theoretical framework by which smoking may be defined as a market failure. Section II explores the applicability of John Stuart Mill's harm principle to the government's involvement in tobacco control efforts. Section III focuses on the social and economic institutions that have increased global tobacco consumption. Specifically, the policies pursued by HICs have dramatically increased cigarette usage and its associated afflictions among vulnerable populations in LMICs. This rise in tobacco usage in LMICs may be termed a negative externality of domestic and international policies. Therefore, according to the theoretical framework outlined in Section I, HICs and LMICs share an ethical responsibility to recognize the tobacco epidemic as a global health priority and to help reverse the increases in tobacco consumption worldwide. The final sections of this paper elaborate upon corresponding policy recommendations.

Section I: Theoretical Framework

Currently, the international community does not use consistent ethical guidelines for prioritizing specific health conditions on the global health agenda. Thomas Pogge, Director of the Global Justice Program at Yale University, attempts to provide such a framework. Pogge recognizes that governments and the international community have limited resources devoted to public services; therefore, he provides criteria whereby these governments may judge and rank their ethical responsibility to address particular public health concerns. Pogge posits that a government's moral responsibility to mitigate health disparities both within and among countries is based on the relationship between social institutions and health outcomes. He states that economic institutions, namely "the basic rules governing ownership, production, use, and exchange of natural resources, goods, and services," are the principal social institutions that affect global health.[6] A cursory understanding of Pogge's framework and its scenarios suggests that cigarette usage falls in "scenario 6", which states that social institutions "avoidably [leave] unmitigated the effects of a self-caused defect."[6] Pogge states that because social institutions do not directly cause the defect in this scenario, the government is less responsible for addressing the needs of the affected populations.[6] In other words, because tobacco consumption is perceived as an individual choice, the government does not have a moral responsibility to mitigate resulting health conditions such as tobacco addiction (which may itself be considered a disease) and NCDs such as cancer.

However, the conceptualization of the global tobacco epidemic as a market failure will show that "scenario 3" is a more appropriate characterization. In "scenario 3," "social institutions foreseeably and avoidably engender" a poor health outcome and thus ethically require international interference.[6] Unlike "scenario 6," "scenario 3" shifts the responsibility from the individual to the institutions. In "scenario 6," institutions do not mitigate self-caused defects; in "scenario 3," institutions, for which more optimal alternatives exist, actually *cause* the health outcome. In this context, the poor health outcomes are the scientifically demonstrated consequences of tobacco usage. Specifically, epidemiological studies have associated tobacco usage with increased risk of mortality associated with tuberculosis, lower respiratory infections, cardiovascular diseases and cancer, among other diseases.[7] The negative health effects of tobacco are well-established, therefore social institutions that facilitate the growth of the tobacco industry "foreseeably and avoidably engender" a poor health outcome. The "scenario 3" classification of the global tobacco epidemic serves as the basic ethical framework for this paper.

The concept of market failure adds another helpful dimension to this ethical framework. A market failure is a scenario in which the allocation of goods and services is inefficient. In this paper, the specific type of inefficiency considered is allocative inefficiency, in which inputs or outputs are not used in a way that no further gains in output or welfare are possible. Market failures may be caused by negative externalities (costs borne by a third party) arising from an economic transaction between consumer and producer, imperfect competition and information asymmetry. The application of each of these economic concepts to the global tobacco market is further clarified in Section III. Market failures are generally used as the justification for governmental regulation of the failed sector; hence, a global market failure may likewise justify intergovernmental regulation. This economic concept may be synthesized with Pogge's guidelines through the following framework: if international economic institutions elicit allocative inefficiency in a particular sector, then those actors who constructed or perpetuated those institutions have an ethical responsibility to intervene in the market.

The global tobacco market meets the criteria defined in the synthesized framework for increasing the prioritization of tobacco-related mortality on the global health agenda. The absence of strong international regulation of the tobacco industry allows the societal harm of tobacco addiction and associated diseases to remain unchanged. This suboptimal outcome of poor public health constitutes allocative inefficiency and thus market failure. International economic institutions largely constructed by HICs facilitated the proliferation of the tobacco market in LMICs and as a result HICs have a moral responsibility to respond to the resulting

health crises abroad.

Section II: A Reconceptualization of the Smoker

The most common arguments regarding tobacco control mechanisms derive from John Stuart Mill's harm principle. Mill asserts that the individual is sovereign "over himself, over his own body and mind," and that everyone should be allowed to engage in their own self-destructive habits.[8] By this logic, the government may not interfere with cigarette smoking, despite the destructive effects of first hand smoke (FHS).

The aptness of the argument regarding the right of the individual is contingent on several assumptions. For example, according to Mill, an individual's rights may only be protected insofar as his actions do not cause harm to others.[8] Yet biological and epidemiological studies have suggested that the toxins found in cigarette smoke are harmful to persons other than the smoker.[9] According to the CDC, since 2000, second hand smoke (SHS) has caused well over 3,000 cancer-related deaths in nonsmokers within the United States per year.[9] Several scientific studies have shown that SHS contains roughly 70 carcinogens.[9] Thus, the probability of developing cancer increases with increasing exposure duration.[9] According to this interpretation of Mill's harm principle, the secondary effects of smoking warrant governmental intervention.

Both of the arguments outlined above are flawed, as they place the entire responsibility of smoking and its negative effects on the smoker himself. Only those who inhale SHS are victims, while smokers are the perpetrators who engage in wrongful practices. As Brandt posits, "in the last years of the twentieth-century, the American smoker has become a pariah in a powerful moral tale of risk and responsibility—the object of scorn and hostility."[10] This one-dimensional perception of the smoker does not place any responsibility on the government because it does not take into consideration the socioeconomic factors that increase the prevalence of smoking among particular communities. As argued below, while outsiders may view the smoker as a pariah and render cigarette smoking entirely a consequence of individual choice, smokers within particular socioeconomic communities may not face such stigma from their peers and may not experience any pressure to *not* smoke. These smokers may be exposed to a slew of stressors that actually encourage the habit. Due to the addictive nature of cigarette smoking, the effects of these determinants are grave.

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These trends may be attributed to the social environments of impoverished populations. As posited by Harwood, Salsberry and Ferketich, socioeconomically disadvantaged populations tend to experience high levels of stress derived from income insecurity, minimal control in the work environment and deprivation of material goods.[11] Cigarettes may serve as a coping mechanism against such depressive factors.[11, 12] Furthermore, as suggested by Peretti-Watel *et al.*, exposure to smokers in the social environment is linked to persistent smoking.[12] If those in a person's social group are perpetual smokers, a person may accept smoking as a norm. These social factors suggest that smoking cigarettes is not entirely an individual's choice, but is, in part, determined by an individual's socioeconomic circumstances. The risk factors among the economically disadvantaged for life-long smoking are exacerbated by their relative inability to battle tobacco addiction. Phelan and Link posit that "the capacity to control disease and death creates disparities; […] when we make gains in our ability to control disease, people with more knowledge, money, power, prestige, and beneficial social connections are better able to harness the benefits of the control we have developed."[13] In the context of tobacco consumption, the more privileged are able to afford smoking cessation treatments due to the relative flexibility of their resources. On the other hand, the economically disadvantaged may be unable or less willing to allocate money to nicotine patches or other treatments due to more immediate expenses. Despite the cumulative costs of cigarettes and the potential economic burden that smoking may pose, addiction may prevent an impoverished individual from pursuing the "rational financial decision" to seek help to stop smoking.[14]

As the negative health effects associated with smoking have become apparent, Western governments have shifted away from blatant support of the tobacco industry towards an emphasis on public health interests. All fifty states within the U.S. have passed cigarette taxes, ranging from $0.07 to $3.46 per pack.[15] In 1999, California declared all public and work places smoke-free and since then, Massachusetts, Nevada and New York have enacted similar legislations.[16] As a result of these types of measures, the smoking rate in adults 18 years or older dropped from 42% in 1965 to 20.5% in 2008.[15] While the implementation of these policies has clearly not eliminated smoking in the U.S. and other Western countries, governmental regulations of the tobacco industry appear to have contributed to the dramatic decline in smoking rates and demand for cigarettes within these countries.

Section III: Cigarette Smoking as a Global Market Failure

Despite the significant decrease in the prevalence of smoking within the U.S., American tobacco companies have remained lucrative, in part due to a substantial increase in global trade. Although cigarette consumption fell by 20% in the U.S. from 1975 to 1994, cigarette production rose by more than 11% overall during this same period as companies expanded their markets to other countries.[17] Companies targeted newly developed or rapidly developing countries, particularly in East and South Asia. The rapid increase of cigarette sales in these regions incited competition among large multinational corporations (MNCs), such as Philip Morris (PM), which aimed to dominate these new markets.[18] As a result, the U.S. witnessed an increase of 18% in cigarette exports in 1988 alone and secured its position as the largest cigarette exporter in the world.[18]

The increase in cigarette exports from Western HICs to LMICs continued throughout the subsequent decade. In 2005, for example, the British American Tobacco (BAT) company reported that it sold 40 billion cigarettes in Equatorial and West Africa.[19] Smokers in Sub-Saharan Africa contributed an estimated $340 million to BAT's net earnings.[19] By 2008, BAT reported that approximately 75% of its sales are concentrated in developing countries.[19] According to Glynn et al., "The data are very clear in indicating that the tobacco epidemic has now expanded to, and become more focused on, the world's low- and middle-income countries (LMIC)."[20]

The power and influence of tobacco companies in these markets are often understated. Stebbins accurately describes the general international attitude toward cigarette smoking in developing countries. He writes:

> A temptation exists to blame governments when health-threatening products are allowed within their borders. However, this view ignores the extent to which extra-national forces influence domestic policies and conditions. Also a temptation exists to blame cigarette smokers themselves for their lethal habit even though billion-dollar promotional schemes draw people into the smoking habit while distracting them from the consequences of consuming a drug whose addictive properties make it difficult to quit.[21]

In other words, LMICs (the third party) bear the uncompensated and direct consequences, or negative externalities, of HICs' economic policies toward the tobacco industry and the international economic institutions that allow tobacco companies to aggressively promote their products. The negative externalities of increased prevalence of smoking and disease burden reduce the welfare of popula-

tions in LMICs and thus constitute allocative inefficiency. Therefore, the global smoking epidemic may be characterized as an international market failure. This conceptualization of global tobacco consumption affirms Stebbin's claim that smokers in LMICs cannot bear the full responsibility for their actions; they simply bear the consequences of a foreseeable and avoidable market failure.[21] The factors that have contributed to the market failure are further explicated below.

The Tobacco Industry as an Oligopoly

Over the past twenty years, the global tobacco industry has come to be dominated by large multinational corporations (MNCs) that are garnering increasing political influence. Privatizations, mergers and acquisitions have concentrated market power in the hands of four main tobacco companies – British American Tobacco (BAT), Philip Morris (PM), Japan Tobacco International (JTI) and the Imperial Tobacco Group (Imperial).[22, 19] In 2008 alone, these four companies accumulated approximately $220 billion in total profits and controlled over half of the world's cigarette market.[19] This consolidation has rendered the tobacco industry an oligopoly rather than a competitive market.

One manner in which these companies have increased their clout is through collusion. Although tobacco firms compete for similar markets, they attempted to cooperate for mutual benefit. As early as 1977, seven tobacco companies formed the International Committee on Smoking Issues (ICOSI), which was eventually replaced by the Tobacco Documentation Center (TDC) and Hallmark Marketing Services (HMS).[23] Through these two partner organizations, tobacco companies have employed tactics to undermine national and international attempts to regulate the industry.[23] For example, the member firms agreed to exclude any mention of the health effects of cigarette smoking in their marketing campaigns and to object to the legislated application of cigarette warning labels.[23] While the membership and standing of the TDC and HMS have dramatically declined since the withdrawal of BAT and PM in the 1990s, these organizations established significant precedence for collusion in the industry. Several smaller associations of tobacco companies were subsequently established to enable similar communication and cooperation among MNCs, as well as national companies and subsidiaries.[23]

As a result of this collusion and consolidation, the few firms that dominate the market hold immense economic and political power. Particularly, tobacco companies wield sufficient influence to threaten and undermine the international community's attempts to regulate the industry, such as through the World Health Organization's (WHO) Framework Convention on Tobacco Control (FCTC).[22] Tobacco companies' success in penetrating new markets abroad may be attributed to aggressive lobbying efforts within the U.S to persuade the U.S. government to support their attempts to enter Asian markets in the late 1980s.[24] Due to the imbalance of power between the U.S. and these countries, the U.S. was able to effectively coerce countries such as Japan, Taiwan and South Korea to abolish tariffs on imported cigarettes through threats such as the use of sanctions.[24] Tobacco corporations thus used their influence with their own governments to establish a foothold worldwide.

Evidently, the political influence associated with the tobacco oligopoly contributed to the current market failure. As a cohesive group with a united agenda, the tobacco companies were able to influence their policy makers and manipulate international economic institutions to favor the opening of tobacco markets abroad. Collusion within the tobacco industry harmed social welfare in LMICs causing a market failure. However, the culpability of international actors and their resultant ethical responsibility to devote resources to tobacco control rests on the question of whether the negative externalities of social institutions either passively allowed or avoidably and foreseeably facilitated the industry's gain of power and influence.

The Externalities of the Legal Framework

The rapid shift in target markets from HICs to LMICs may in part be attributed to HICs' relationship with the tobacco industry. These countries enacted national policies and programs to reduce tobacco consumption within their own borders. Although the negative externalities of these legal actions were grave, they may have potentially been unintended and unforeseen. If the U.S. government, for example, was aware of these externalities when constructing anti-tobacco policies, it could have overlooked the ramifications in LMICs. Yet these same governments directly facilitated the tobacco industry's expansion into developing markets through social institutions, such as international and national trade policies.

Tobacco companies used stipulations of the General Agreement on Tariffs and Trade (GATT) to infiltrate global markets. The GATT, established in 1948, is the primary document governing international trade, and specifies that every country must engage in "non-discrimination between a country's domestically produced goods and foreign goods, and also among all foreign goods."[25] Consistent with this international regime, Section 301 of the 1974 Trade Act in the U.S. grants the President the authority to retaliate or authorize sanctions against countries that engage in discriminatory practices against American goods.[26] The law effectively barred foreign governments from establishing any restrictions against tobacco companies. Even if such restrictions were intended as public health measures, the tobacco companies would portray such actions as favoritism of domestic tobacco companies over foreign MNCs. As a result, the tobacco industry was able to penetrate markets in Japan, South Korea and Taiwan by convincing the U.S. government to threaten sanctions against these countries.[27] The application of the GATT provisions in this manner reveals the U.S. government's intimate relationship with the tobacco industry.

At the same time, the GATT includes provisions that serve social welfare. Namely, the GATT explicitly states that all "measures necessary to protect human, animal, or plant life or health," such as national laws or regulations, are excluded from its trade policies.[25] Restrictions on tobacco, therefore, can potentially be interpreted as a public health measure rather than a discriminatory practice. Yet the World Trade Organization (WTO) and other international actors have far narrowly interpreted this provision for public health.[25] The national government implementing restrictions against tobacco imports must prove that its policies qualify for the GATT public health exception by a) showing that "no less trade restrictive measures that achieve the same public health purpose were available," and b) showing that the "proposed public health measure does not constitute a 'disguised restriction on international trade.'"[25] Unfortunately, for the majority of cases, trade tribunals have ruled against national governments that have allegedly violated trade agreements for goods that harm public health.[25]

Hence, while the GATT technically offers some flexibility by excluding goods that harm health from its trade policies, namely those that mandate non-discrimination, such prioritization of health over trade has not been practically achieved. The cooperation between the U.S. government and tobacco companies is further demonstrated by the government's exportation of more than one billion dollars of tobacco to developing countries from the 1970s to 1980s as part of the Department of Agriculture's Food for Peace Program.[17] This close relationship between the government and tobacco industry was not unique to the U.S. during the 1980s and 1990s and was replicated in many other developed countries, including the United Kingdom.[26] These governments' actions suggest a causal link between the social institutions that govern global health and trade and the market failure of global tobacco consumption—the governments of several developed Western countries allowed tobacco companies to accrue power and affect global tobacco consumption patterns.

Section IV: The Challenges of Smoking Cessation in Developing Countries

These early trade arrangements enabled transnational tobacco companies to infiltrate markets all over the world. Companies including BAT and PM have established a foothold in regions such as Sub-Saharan Africa, North Africa, Western and Eastern Europe, South Asia and East Asia.[3] For the sake of simplifying the discussion of the tobacco industry's actions in developing markets, this section focuses on cigarette smoking in several Asian territories for which information is most readily available. However, the analyses are applicable to the transnational tobacco companies' (TTC) actions elsewhere, such as Sub-Saharan Africa.

One of the primary causes of market failure is information asymmetry. In the case of the tobacco industry, such asymmetry takes the

form of the consumer's inability to access full information on the health effects of cigarettes. Tobacco companies initially entered new markets in developing countries due to the promise of reaching previously untapped and vulnerable populations, including socioeconomically disadvantaged individuals. The relatively weak legal restrictions on the operation of tobacco companies in these countries allowed these firms to gain access to their target markets. For example, although warning labels were required in the U.S., TTCs were able to export cigarettes without such labels to countries with less stringent regulations.[18] Moreover, in the U.S., knowledge regarding the health risks posed by tobacco consumption has been disseminated through comprehensive education programs infused in primary school curricula, public service announcements and the mandatory placement of warning labels on cigarette packages. However, such proactive and consistent education campaigns have not been as consistently or effectively implemented in developing countries.

TTCs were able to further capitalize on the education systems abroad through aggressive advertising campaigns. These companies directed the majority of their advertisements in Asia toward youth. In its corporate documents, PM openly and repeatedly affirmed its prioritization of attracting young smokers.[28] The Taiwan branch of PM was particularly interested in gaining access to the youth market; this cohort constituted two-thirds of all new smokers in the state.[28] The firm introduced scented and sweetened cigarettes in Singapore in order to increase the attractiveness of their products among young consumers.[29] As a result, in the ten years following their entrance in the market, the percentage of youth smokers preferring foreign over domestic cigarette brands increased from less than 5% to 75%.[28] Smoking prevalence among young adults increased by over 16%, most likely because foreign cigarette brands increased the popularity of smoking among youth.[28] Foreign companies introduced aggressive advertising techniques adopted in the west to these new markets.[24] Similar shifts were noticed in many other Asian tobacco markets, such as Taiwan and Thailand.[24]

The tobacco industry's emphasis on the youth market aligns with its prioritization of profits. Companies recognize that this strategy rapidly expands their markets, as non-smoking youth can be easily influenced and will remain long-term consumers due to the addictive nature of nicotine.[24] These individuals often do not recognize the risks of addiction until they are unable to combat it.[30]

Indonesia serves as a prime example of TTCs' manipulation of youth and the information gap. Of all of the countries in the world, Indonesia ranks five in annual cigarette consumption per person.[31] According to the Global Tobacco Youth Survey (GTYS), approximately 12.6% of Indonesian students between 13-15 years of age smoke cigarettes.[31] More than 90% of all students in 2006 stated that they had seen some form of tobacco advertisements.[31] Particularly alarming is the finding that over 60% of the students acknowledged the high usage of cigarettes at home.[31] This exposure not only puts youth at risk of second hand smoke (SHS) related illnesses, but also increases the likelihood that they will begin smoking themselves. As discussed in Section II, the prevalence or level of social acceptability of cigarette usage in an individual's environment may encourage or pressure him to engage in the behavior. The high exposure of students to TTCs reveals the extent to which tobacco companies have managed to pervade daily life in Indonesia.[31] As a result, smokers' habits particularly in such countries as Indonesia cannot be reduced to Mill's conceptualization of an independent, individual choice.

Although the Indonesian government has enacted several legal restrictions on the operations of the tobacco industry, the implementation and effectiveness of these laws remain weak. While the government mandates the printing of warning labels on cigarette packages, the public's comprehension of the health risks remains poor. As shown in a 2008 study conducted by Barber, et. al., "boys 13 to 17 years old could repeat the health warnings on cigarette packs but also claimed that smoking one to two packs per day was not harmful to health."[32] This misconception stems from the deceptive marketing strategies of tobacco companies. For example, the government requires that companies print tar and nicotine levels on cigarette packages, but such labeling has been manipulated to sell these products as "healthy" options. Although these "healthy" options often contain marginally lower percentages of toxins than other cigarettes, the reductions are not substantial enough to change the health outcome.[32] These techniques have effectively undermined the government's relatively passive attempts to educate the consumer of the health risks associated with smoking, particularly as these strategies are geared toward easily influenced youth.

The consumer's lack of knowledge regarding the detriments of cigarette smoking violates Mill's harm principle. Mill states that even in cases where the usage of a drug does not directly impact others, "such a precaution, for example, as that of labeling the drug with some word expressive of its dangerous character, may be enforced without violation of liberty."[33] He continues, explaining "the buyer cannot wish not to know that the thing he possesses has poisonous qualities."[33] In other words, Mill supports the individual's right to make an informed decision. Without the mandatory placement of effective warning labels on tobacco products, the consumers remain unaware of the potential consequences of their choice to begin smoking. As a result, consumers make uninformed decisions, which have long term consequences.

Therefore, TTCs' operations in LMICs appear to be driven primarily by technical efficiency rather than allocative efficiency, as no regulator forces TTCs to consider social welfare. As a result, the externalities of their product promotion are perhaps even more severe in these developing countries than they were in their original markets. In the U.S., tobacco companies competed for the seemingly safest product, and thus lowered the tar and nicotine contents of their cigarettes.[18] However, in less developed countries, these same companies faced no such marketing pressure and thus were able to minimize production costs by selling cigarettes with significantly higher toxin concentrations.[18]

Although the full effects of the rise in tobacco consumption on population health may only be apparent after a significant delay, upward trends in the associated NCDs have already been observed. Specifically, in India, approximately 32% and 6% of cancer deaths in men and women respective (ages 30-69 years) were linked to smoking.[4] Similarly, China had similar rates of approximately 28% and 6% in men and women, respectively in 2000.[4] The high prevalence of smoking-related deaths will only increase as tobacco consumption rises worldwide.

The onset of chronic diseases poses unique challenges in developing countries. One primary challenge is the weakness of the health system infrastructure in many of these nations. As Pisani affirms, health interventions cannot be successful and sustainable if the health system is incapable of reaching the entire population.[34] Chronic diseases, such as cancer and cardiovascular disease, require constant treatment. If the patient does not have consistent access to care, chances of survival dramatically decline. Yet many of these affected nations do not possess or train the personnel required to monitor and combat the tobacco epidemic and the NCDs associated with it. [16, 34] Current trends suggest that governments are "[unwilling] to assign the resources required to prevent further tobacco-related death and disease among their own populations, let alone to help subsidize measures to control tobacco use in other countries."[16] Thus, the underfunding of tobacco control efforts, coupled with weak health systems, suggest that a smoker in a developing country has a reduced chance of fighting any diseases that may result from his habits.

Finally, cigarette smoking may exacerbate other public health challenges specific to LMICs. For example, smoking may increase susceptibility to tuberculosis and the risk of death due to the disease. According to Jha, almost 40% of tuberculosis deaths among middle-aged men may be attributed to smoking, as this behavior may facilitate the pathogen's transition from an inactive to active form[4]. The dual burden of communicable and non-communicable diseases influenced by smoking, therefore, may further cripple health systems and patients, as they must continually finance treatment for both categories of health defects. Given the limited resources available in LMICs, HICs should assist in defraying this immense financial burden.

Section V: International Policy Options

As previously discussed, the governments that preside over the new tobacco markets are partially responsible for addressing tobacco consumption within their borders. However, their attempts to fight the influential TTCs through national regulations have proven insuf-

ficient possibly due to the limited power and resources of LMICs to fully commit to such initiatives.

Through various means, the tobacco industry has been able to successfully evade national regulations. For example, many tobacco companies have supplemented their advertisements with manipulative marketing methods. Specifically, firms such as PM and Mild Seven (a Japanese multinational tobacco company) have engaged in *brand stretching*. This practice involves the usage of cigarette brand names and logos on non-tobacco products.[28] In Taiwan, for example, the government limited cigarette advertising to magazines and points of sales. In order to get around this legislation, Mild Seven began to sell watches and other consumer goods in 2000. Partially as a result of these efforts, Mild Seven has become the predominant cigarette brand of choice among youth.[28] Similarly, in Singapore, PM marketed a wine cooler called Alpine in order to gain a consumer base for its new cigarette brand by the same name.[29] Therefore, the tobacco industry was able to subvert national regulations through marketing methods.

Furthermore, in the absence of coordinated efforts among national governments, powerful tobacco companies have been able to successfully discourage the government from enacting strict anti-tobacco policies through financial and political pressure.[35] This is evidenced by the government's revision of the Regulation on Tobacco Control (PP No. 81/1999) from a prohibition on all electronic advertisements to a weak limitation on the times during which tobacco companies could access such advertising venues.[35] Such relaxations on restrictions regularly occur across many LMICs due to the tobacco companies' lobbying efforts. In fact, the heavy influence of tobacco companies over the government prevented Indonesia from signing and implementing the World Health Organization's Framework Convention on Tobacco Control, discussed in the subsequent section.[35]

Unfortunately, even when governments are able to resist the external pressure posed by TTCs, companies may still externally influence national markets resulting in insufficient national legislation to limit duplicitous marketing schemes. For example, the tobacco industry was able to subvert national authorities to gain entrance to the Singaporean market by taking advantage of globalization. Singapore has one of the most comprehensive and strongest anti-tobacco regulations and national programs in the world, in part due to the government's strong authority as a nation-state. The government banned smoking in public places as early as 1970, and further banned tobacco advertisements in 1971. The state supplemented these legislations by prohibiting brand stretching.[29] In an attempt to bypass these regulations, PM increased its advertisements for the Marlboro brand on Malaysian television. This strategy was devised to target the many Singaporeans who receive and watch Malaysian channels.[29] This incident suggests that while national policies are certainly necessary and useful in the control of cigarette smoking, they may be rendered inefficacious. Such subversion of national legislation is particularly a concern in the increasingly globalized world, where advertisements displayed in one country may easily be transmitted to others via the Internet. Therefore, developing countries cannot cope with the challenges of the tobacco epidemic through distinct national efforts but rather through international cooperation.

Developing countries cannot cope with the challenges of the tobacco epidemic through distinct national efforts but rather only through international cooperation.

In an attempt to control the profit-seeking tobacco industry, the World Health Organization (WHO) drafted the Framework Convention on Tobacco Control (FCTC) in 2003. The explicit purpose is to reduce the "demand and supply of tobacco and tobacco products."[36] The document first and foremost recognizes the undeniable health detriments of cigarette smoking. The convention then aims to "protect present and future generations from the devastating health, social, environmental and economic consequences of tobacco consumption and exposure to smoke."[37] Among its broad policy recommendations, the FCTC recommends the implementation of cessation and education programs, in order to reduce the demand for the products and facilitate the process of quitting.[37] Additionally, the FCTC calls for an increase in funding for global tobacco control.[37]

The language of the FCTC suggests a shift in the international community's relationship with the tobacco industry. The document blatantly places blame on tobacco companies, and asks member governments to protect their public health programs from the "commercial and vested interests of the tobacco industry."[37] The FCTC requests that each member nation enact regulations against these firms, such as the prohibition of marketing and advertising, requirement of clear labeling of tobacco products and implementation of cigarette taxes.[37] Hence, this document appears to reprimand tobacco companies and, finally, shifts the paradigm of trade-over-health to health-over-trade. In this manner, the FCTC appears to address the basic social institutions that enabled the spread of the tobacco epidemic.

But in actuality, the reforms elicited through the FCTC are minimal and weak. One aspect that is noticeably missing from the document is the regulation of foreign direct investment (FDI). The rapid growth of these multinational tobacco companies was in part facilitated through FDI. For example, tobacco companies invested in domestic cigarette production and distribution branches in Asian countries in order to increase their proximity to their new target markets.[36] TTCs further used FDI to buy domestic tobacco production plants in their new target markets. As a result, these companies were able to decrease the costs of production and increase their output.[36] While the FCTC mentions the role of FDI in the proliferation of cigarette smoking, it provides no policy recommendations on this topic. This one loophole may undermine the remaining FCTC suggestions, as it allows tobacco companies to use FDI to subvert tariffs and encourage increased consumption.[36]

Furthermore, the FCTC has not yet effected significant tangible changes in global tobacco control. The general weakness of the FCTC is derived from the power imbalance between the tobacco industry and the international actors involved in its drafting. Specifically, several countries and TTCs opposed the inclusion of a clear statement defining health as a priority over trade. These actors feared that such a provision would allow "disguised protectionism."[27] According to this argument, the formal prioritization of health may undermine the GATT and allow many countries to arbitrarily impose tariffs and other trade restrictions on foreign goods. The compromise between those who wished to emphasize health and those who wished to preserve the current trade system resulted in the deliberate omission of the topic's mention in the FCTC.[27] These actors justified their decision by stating that the combination of the FCTC and the WTO's health allowances were sufficient to suggest that health is a priority over trade. They argued that explicit language was unnecessary.[27] This defense is baseless and seems to indicate that the international community has not yet recognized the need for a dramatic shift in priorities. Therefore, the FCTC is an inadequate means to rectify the negative externalities of the social institutions that enabled developed countries to export the tobacco epidemic across the world.

Section V: Conclusion

Tobacco control has long incited debate in the international community. Many global health policy makers ignore this subject due to the perception that cigarette smoking is an individual choice. In accordance with Mill's harm principle, these policy makers believe that they do not have a responsibility to address the health conditions associated with tobacco consumption. This paper aimed to disprove this notion by invoking the theoretical frameworks created by Pogge and conceptualizing the current state of the tobacco epidemic

as a market failure. An individual's socioeconomic status and social environment is strongly linked to his likelihood of engaging in persistent cigarette smoking. This central finding transfers the blame placed on the smoker to the social institutions that permit and exacerbate such disparities. These effects of the social institutions may be defined as negative externalities that facilitated the market failure. According to Pogge's framework, the analysis of smoking in this manner thus warrants governmental intervention. Indeed, governments of HICs in which cigarette smoking first posed a significant public health problem established regulations that reduced, but did not eliminate, the disease burden linked to these negative externalities.

Unfortunately, the western government's regulations engendered far more significant negative externalities than they mitigated within their borders. By restricting the activity of tobacco companies, these states pushed the industry to seek markets in developing countries, particularly in Asia and Africa. Moreover, international social institutions have enabled tobacco companies to become increasingly powerful economic and political actors. Through coercive practices, these transnational companies have been able to pressure governments, enter foreign markets and manipulate consumers to begin and remain addicted to smoking. The LMIC governments may be responsible for the national social institutions that increased the vulnerability of the consumers, such as inadequate access to education; however, the tobacco industry and the institutions that enabled TTCs to amass such power and influence are also at fault. Inadequate regulation and the international commitment to trade over health thus caused the market failure. Consistent with "scenario 3" in Pogge's framework, these social institutions and the HICs that perpetuated them "avoidably and foreseeably" produced negative health outcomes, and thus warrant international attention and intervention.

The discussion of the inadequacy of national policies suggests that international cooperation to fight the tobacco epidemic is necessary. While the FCTC is certainly a step in the right direction, verbal commitment must be accompanied by action. Specifically, although the U.S. signed the FCTC, it has not yet ratified the treaty. The explicit support and commitment of the U.S. to the treaty may cause a reduction in the political influence of tobacco companies. Furthermore, the signatories of the FCTC should implement international policies regarding the control of the industry through such strategies such as limitations or prohibition of these companies' engagement in FDI and taxation of their international financial transactions and operations. The funds collected through these means may then be allocated to tobacco control efforts within vulnerable countries. The international community should further supplement this money through a dramatic increase in funding provided by such HICs as the U.S., which exported the tobacco epidemic across the world.

These brief and cursory suggestions are not intended to serve as comprehensive policy recommendations. Rather, the main conclusion of this work is that developed Western countries such as the U.S. bear a moral responsibility to devote funds and expertise to global tobacco control, as they themselves facilitated the global increase in tobacco consumption. Without establishing such commitment, any global policy recommendations may be politically infeasible.

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