GLOBALISATION & TRANSBORDER HEALTH RISK IN THE UK

CASE STUDIES IN TOBACCO CONTROL AND POPULATION MOBILITY

Jeff Collin and Kelley Lee, Centre on Global Change and Health, London School of Hygiene and Tropical Medicine

The Nuffield Trust
FOR RESEARCH AND POLICY
STUDIES IN HEALTH SERVICES

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Foreword by John Wyn Owen CB
Secretary, the Nuffield Trust

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This project was undertaken as part of a programme of research and teaching within the Centre on Global Change and Health at the London School of Hygiene & Tropical Medicine. The overall aim of the Centre is to increase understanding and awareness of how processes of global change are impacting on human health, and how policies could be developed and strengthened to respond to the emerging risks and opportunities. In carrying out this work, the authors are grateful to many current and former colleagues who have contributed ideas, material and information along the way. In particular, we wish to thank Angela Burnett, David Bradley, Richard Dodgson, Anna Gilmore, Andy Haines, Ros Stanwell-Smith, Tony McMichael and Paul Wilkinson.

FOREWORD

This report builds on the Nuffield Trust's interest in the implications of globalisation for health in the UK and partnership with the Centre on Global Change and Health at the London School of Hygiene and Tropical Medicine.

Since 1999, the Trust has worked to raise awareness and stimulate thinking around how global change affects health and how policy ought to respond to the emerging risks and opportunities. This report places these questions in historical context, confirms the close relationships between globalisation and UK public health, and identifies a number of pressing policy concerns.

In particular, the report highlights key issues for how we think about the role of the state. The conceptual model of the territorial nation-state cannot provide us with all the answers to the challenges that are faced. We need to think increasingly about public health policy and practice beyond the border, closer cross-sectoral and interagency collaboration, and enhanced global governance for public health. The key finding is that greater importance still needs to be given to the protection and promotion of public health in current debates about globalisation.

As globalisation continues to influence what were previously thought of as solely domestic UK concerns, it is also transforming the meaning of foreign policy. The report therefore also represents an important complementary contribution to the Trust's emerging programme on health and foreign policy. This is based on the proposition that health should be a means of engagement with the global community, a positive currency of globalisation, and an exemplar of modern foreign policy.

John Wyn Owen CB
Secretary, the Nuffield Trust

LIST OF ABBREVIATIONS

ASH	Action on Smoking and Health
ATC	American Tobacco Company
BAT	British American Tobacco
CAP	Common Agricultural Policy
CBI	Confederation of Business and Industry
CECCM	Confederation of European Community Cigarette Manufacturers
EC	European Community
ECJ	European Court of Justice
EEC	European Economic Community
ERT	European Roundtable of Industrialists
EU	European Union
FCA	Framework Convention Alliance
FCTC	Framework Convention on Tobacco Control
GATT	General Agreement on Tariffs and Trade
ICRC	International Committee of the Red Cross
IMO	International Migration Organisation
NHS	National Health Service
PM	Phillip Morris
QMV	Qualified Majority Voting
SNP	Scottish National Party
TTCs	Transnational Tobacco Companies
UK	United Kingdom
UNHCR	United Nations High Commissioner for Refugees
US	United States
USIBs	United States International Brands
VAT	Value Added Tax
WHO	World Health Organisation
WTO	World Trade Organisation
WTO	World Tourism Organisation

CHAPTER 1. **INTRODUCTION**

1.1 Background

The diverse challenges of globalisation for public health are being increasingly recognized around the world. Traditionally, the protection and promotion of public health has largely been a nationally-focused endeavour. While countries have long cooperated together, notably since the nineteenth century, to address health issues of an international nature, these efforts have been largely focused on the control of certain infectious diseases. Means of collaboration have been primarily through national governments in the form of regulatory controls at national borders, exchange of information, and agreement of common practices and nomenclature. The twentieth century brought an expansion of international health cooperation through bilateral aid programmes, activities of the World Health Organisation (WHO) and other UN organisations, and nongovernmental organisations (NGOs). Nonetheless, the main determinants of health were seen to derive from, and be confined within, national borders. It is in this context that the mandate of the UK Department of Health (DOH) remains focused on the health of people in the UK, and the raison d'être of the National Health System (NHS) continues to be the domestic sphere.

One of the major debates within the field of public health in recent times has centered on the determinants of health, what they are, what relative importance they should be given, and how they should be addressed. Globalisation poses a direct challenge to traditional concepts of the determinants of health. In brief, globalisation is defined here as a process of closer interaction of human activity within economic, political, cultural and other social spheres, and along spatial, temporal and cognitive dimensions (Lee 2001). There is growing evidence that globalisation is changing the nature of health risks, how they threaten human health, and the way in which health systems must respond to them. At the same time, globalisation poses opportunities for meeting these new challenges and even promoting health across national boundaries.

For national public health systems, processes of globalisation pose the following challenges:

- the intensification of crossborder flows of people, other life forms, goods and services, capital, information and communication that may affect human health;
- the expansion in illicit flows that may impact on human health; and
- the increase of transborder flows that ignore in whole or in part territorial boundaries.

A review of priority global health issues for the UK is provided in Lee (1999). It is in this context that this study seeks to review and assess public health measures in the UK. In some respects, this study was overtaken by a policy review undertaken by The Nuffield Trust entitled *Global Health, A Local Issue*[1], which led to the production of a number of background papers addressing selected aspects of global health. This was a welcome development as it provided the means of reviewing a broader range of issues than was possible within the limited scope of this study. Building on the broad scope of this complementary review, this study undertakes two detailed case studies that illustrate the nature of risks and opportunities posed by global change.

1.2 Purpose and objectives of the study

The purpose of the study is to review and assess selected public health measures and policies in the UK in relation to transborder health risks(THRs) and opportunities (THOs) arising as a consequence of globalisation.

The objectives of the study are:

- to review past and existing public health measures in the UK which seek to control THRs and optimise THOs;
- to review the links between UK measures and those at the European and international levels;
- to assess the extent to which they are sufficient and appropriate for controlling THRs posed by globalisation; and
- to put forth recommendations for strengthening public health measures in the UK.

The above objectives are addressed through two detailed case studies. First, the implications for the public health system of intensified **population mobility** will be addressed with reference to the dramatic increase in tourism and recent trends in migration, including refugees, asylum seekers and undocumented migrants. The case study questions whether traditional measures centered on communicable disease control at ports of entry can address the diverse health challenges posed.

THRs are not confined to infectious diseases, and their directions and modes of transmission are complex. This diversity is illustrated by the second case study, an analysis of the

1 Parsons L. and Lister G. eds. Global Health: a Local Issue (London: The Nuffield Trust, 2000). www.nuffieldtrust.org.uk

globalisation of the **tobacco industry**. The role of transnational tobacco companies in the shifting burden of tobacco-related morbidity and mortality is a dramatic example of the health impacts of intensified flows of goods and services, but also illustrates the significance of flows of capital and finance and of ideas, knowledge and cultures. Recent developments in tobacco control also illustrate that the multiple dimensions of globalisation offer significant opportunities for advancing public health objectives through improved governance.

1.3 Methods of the study

The study began by reviewing a substantial body of primary and secondary literature concerned with public health in the UK. A wide range of issues was then considered for potential case studies. Some were issue specific (e.g. bovine spongiform encephalopathy) while others concerned broad policy areas (e.g. food policy). In the end, it was decided to select case studies that captured the different dimensions of globalisation as defined by Lee (2001), as well as the two-way flow of health risks and opportunities into and out of the UK. Population mobility illustrates well the spatial and temporal dimension of global change as people move more intensely and extensively about the globe. Correspondingly, tobacco control demonstrates especially well the spatial and cognitive dimensions of global change.

The study then proceeded to focus its efforts on reviewing primary and secondary documents related to the two case studies. Of particular interest were legislation, policy statements, statistical data on relevant flow variables, company reports and internal tobacco industry documents. The latter, available on-site at the British American Tobacco Depository in Guildford and on-line using a number of websites, was an especially useful source for understanding the strategy and activities of the industry.

The study carried out semi-structured interviews with key informants from a wide range of UK, European and international organisations concerned with public health. A list of interviewees is provided in Appendix A.

1.4 Globalisation, transborder health risks and public health: A conceptual framework

A basic working definition of the term transborder health risk (THR) can be derived from a simple process of transliteration - “risks to human health that transcend national borders in their origin or impact” (Dodgson et al. 2002). Beyond this starting point, it is worth considering in greater depth the diversity of phenomena that could be regarded as representative of such risks, acknowledging the existence of competing conceptions of risk. It is then possible to develop criteria upon which a categorisation of THRs could be developed that has relevance to the UK context.

First, the term “border” can be applied to either a specific line of demarcation or to a zone within which such a boundary is situated (Anderson 1996), although its use in this context is confined to the former sense. The identification of an occurrence as “transborder” therefore indicates the crossing of the jurisdictional limits of an authority, and may be

regarded as implying a limited capacity to effectively regulate its access to or exit from a given territorial space. The reference here is primarily to inter-state rather than intra-state borders, so the focus of attention is on health risks that transcend the external limits of the UK.

Various nationalist claims notwithstanding, the identification of the territorial limits of the UK is relatively unproblematic in international terms. Potential future challenges to the defined borders of the UK are the possible accrual of key functions to the common external frontier of the European Union or their devolution to the governments of Scotland or Wales. Also, on occasion it may be appropriate to refer to risks that cross the administrative boundaries separating England, Northern Ireland, Scotland and Wales, but these cannot strictly be referred to as transborder.

Second, "health" is understood within the context of THRs in a broad sense akin to WHO's frequently cited definition as "a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity" (WHO 1946). This is reflected by Baggott (1998:1) who distinguishes between "the positive approach, where health is viewed as a capacity or asset to be possessed, and the negative approach, which emphasises the absence of specific illness, diseases or disorders".

In the existing literature on globalisation and health, primacy has so far been accorded to the negative approach and its emphasis upon morbidity and mortality. This preponderance has also been apparent in the ways in which THRs have generally been perceived, with popular attention focused on perceived threats to the UK posed by emerging and re-emerging infectious diseases. While these are clearly of substantial and arguably increasing importance, it is important to recognise that THRs are not confined to them. THRs also have relevance to the positive approach to health, for example influencing broad determinants of health such as social and physical environments (Durch et al. 1997: 47) and encompassing "mental as well as physical aspects of health, and social as well as individual well-being" (Baggott 1998:2).

It is also important to address the question of whose health is under consideration in this context. It should be stressed that the focus of this study on the UK should not be read as implying that attention is confined to risks posed to British citizens or risks experienced only within UK borders. This analysis of THRs is concerned with the export of risk from, as much as with the importation of risk into the UK. Similarly, there is no delimitation of focus with reference to citizenship. Undocumented migrants, for example, will be addressed in terms of both the health risks they are subject to rather than simplistically focusing on potential risks to the broader population that might sometimes be associated with illegal immigration.

The subject of "risk" has attracted substantial interest in recent years accompanied by an associated proliferation of frequently conflicting conceptusalisations. In attempting a classification of approaches to risk, Renn (1992) distinguishes between technical, economic, psychological, sociological, and cultural perspectives. The complexity of this schema is further indicated by the subdivision of technical analyses across the actuarial approach, the assessment of health and environmental risks, and probabilistic risk assessment. Unsurprisingly, the disciplinary diversity encompassed here is reflected in the absence of an agreed definition of risk.

The most basic, albeit rather crude, division that can be identified is between conceptions of risk that reflect a positivist perspective on objective risk and those that emphasise perceived risk, often expressed in terms of the social construction of risk (Heyman 1998). The former approach is epitomised by the definition of risk formulated by the Royal Society in 1983:

> The Study Group views 'risk' as the probability that a particular adverse event occurs during a stated period of time, or results from a particular challenge. As a probability in the sense of statistical theory, risk obeys all the laws of combining probabilities (as cited in Adams 1995:8).

This quantitative approach to risk has been increasingly criticised for its treatment of probability as "unproblematically given" (Heyman 1998: 6). It insists upon the objective status of risk as ascertainable by scientific calculation:

> Scientific judgment on risks and uncertainties are underpinned and framed by unavoidably subjective assumptions about the nature, magnitude and relative importance of these uncertainties. These 'framing assumptions' can have an overwhelming effect on the results obtained in risk assessments (ESRC 1999: 7).

These inherent problems become far more pronounced when attempts are made to assess risk in the context of limited scientific knowledge, as in the cases of genetically modified organisms, BSE/vCJD, nuclear power or the implications of global warming.

> Quantified risk assessments require that the probabilities associated with particular events be known or be capable of plausible estimation. When scientists cannot agree on the odds, or the underlying causal mechanisms, of illness, injury or environmental harm, people are liberated to argue from belief and conviction (Adams 1997).

These methodological limitations notwithstanding, the perception of risk as being objectively identifiable on the basis of sound scientific inquiry remains the dominant perspective when risk is incorporated within policy-making processes. A clear example is provided by the WTO Agreement on the Application of Sanitary and Phytosanitary Measures (SPS Agreement). The SPS Agreement was "drawn up to ensure that countries apply measures to protect human and animal health (sanitary measures) and plant health (phytosanitary measures) based on the assessment of risk, or in other words, based on science" (WHO 1997:1). Here risk assessment is primarily viewed as a task for statistical calculation[2]. The Agreement does allow for the provisional adoption of measures in the context of an insufficiency of scientific evidence (in paragraph 7 of Article 5), but a clear responsibility is placed on states to "obtain the additional information necessary for a more objective assessment of risk and review the sanitary or phytosanitary measures accordingly within a reasonable period of time" (WHO 1997: 13).

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2 Risk assessment is defined in the Annex to the SPS Agreement as "The evaluation of the likelihood of entry, establishment or spread of a pest or disease within the territory of an importing Member according to the sanitary or phytosanitary measures which might be applied, and of the associated potential biological and economic consequences; or the evaluation of the potential for adverse effects on human or animal health arising from the presence of additives, contaminants, toxins or disease-causing organisms in food, beverages or feedstuffs." (WHO 1997: 18)

This seems to combine recognition of the contemporary limitations of scientific calculation of risk, with a faith in the ability to transcend them in the near future. Its importance lies in an ongoing privileging of the "objective" determination of risk as the most appropriate basis for policy-making. This narrow conception of risk ignores the importance of social context, and views with dismay the frequent divergence between scientific estimates and public reactions (Bennett and Calman 1999). In seeking to manage risks, it is associated with placing the burden of proof on those who assert the existence of a significant threat to health rather than its absence. Given the unquantifiable nature of so many contemporary risks, "the demand for 'sound science' becomes the excuse for procrastination" (Tindale 1998).

In examining transborder health risks, risk needs to be operationalised in such a way as to permit consideration and assessment both of those capable of probabilistic calculation and of emergent risks that are beyond the effective limits of such traditional scientific inquiry. Although this involves an uncomfortable straddling of objectivist and constructivist perspectives, a potentially useful classification is offered by Adams (1997: 285) in identifying three categories of risk:

- directly perceptible risks e.g. traffic to and from landfill sites;
- risks perceptible with the help of science e.g. cholera and toxins in landfill sites; and
- virtual risks that scientists do not know/cannot agree on e.g. BSE/CJD and suspected carcinogens.

This approach can reasonably be simplified into a distinction between perceptible risks and virtual risks for application to analyses of THRs. While specific THRs will be located within either category, there is a clear expectation that contemporary socioeconomic processes are generating an increasing range of virtual risks that are ill-suited to assessment by traditional means.

In identifying THRs as an important subject for analysis, there is no assertion that they represent an intrinsically new phenomenon. Epidemiology has, for example, long established the transcendence of national borders by diseases such as plague, cholera and influenza. The emergence and historical development of national public health systems owes much to this recognition. This study does, however, suggest that the significance of such risks is increasing. This assertion is based on the identification of:

- the emergence of new forms of THRs;
- the intensification or re-emergence of long-established THRs; and
- increasing levels of interconnectedness between states and societies.

This renewed salience is attributed to the closely related processes of the emergence of risk society and globalisation. Primarily associated with a sociological approach to risk developed by Ulrich Beck and Anthony Giddens, the idea of risk society expresses the claim that recent transitions in the character of modernity have resulted in risk becoming more pervasive and more threatening. For Giddens (1998: 28), "there is a new riskiness to risk."

> (I)n the current period risk assumes a new and particular importance. Risk was supposed to be a way of regulating the future, of normalising it and bringing it under our dominion. Things haven't turned out that way. Our very attempts to control the future tend to rebound upon us, forcing us to look for different ways of relating to uncertainty (Giddens 1999: 2).

Influenced by ecological perspectives and a critical reappraisal of technology and science, the emergence of risk society is attributed to the production of "manufactured certainty" (Beck 1998: 12). This is seen as reflecting the transformation of nature through the ubiquity of human intervention (such that nature is now identified as threatened by rather than as a threat to humanity) and the expansion of choice associated with the declining significance of tradition.

> Now manufactured uncertainty means that risk has become an inescapable part of our lives and everybody is facing unknown and barely calculable risks. Risk becomes another word for 'nobody knows'. We no longer choose to take risks, we have them thrust upon us. We are living on a ledge – in a random risk society, from which nobody can escape. Our society has become riddled with random risks. Calculating and managing risks which nobody really knows has become one of our main preoccupations. That used to be a specialist job for actuaries, insurers and scientists. Now we all have to engage in it, with whatever rusty tools we can lay our hands on – sometimes the calculator, sometimes the astrology column (Beck 1998: 12).

Giddens distinguishes between two forms of risk, namely external risk and manufactured risk, and suggests that risk society is characterised by the rise to pre-eminence of the latter. External risk is "risk experienced as coming from the outside, from the fixities of tradition or nature" (Giddens 1999: 3), whereas the emergence of manufactured risk is a consequence of the ending of these two fixities.

> Manufactured risk is risk created by the very progression of human development, especially by the progression of science and technology. Manufactured risk refers to new risk environments for which history provides us with very little previous experience. We often don't really know what the risks are, let alone how to calculate them accurately in terms of probability tables. (Giddens 1998: 28)

The scale of such risks is often expressed in fairly apocalyptic terms, as in Tindale's description of governmental procrastination in addressing climate change as "the global gamble" (Tindale 1998: 67) or Adams' designation of nuclear power, ozone holes and the greenhouse effect as "mega-risks" (Adams 1995: 32). Giddens (1999: 2), however, expresses a less pessimistic view that incorporates recognition of the positive value that can be attached to risk. The pervasiveness of risk is associated with a radical expansion of choice (Giddens 1998: 30), while "a positive embrace of risk is the very source of that energy which creates wealth in a modern economy".

This also highlights the obvious but frequently neglected point that society is not organised in such a way that the eradication or minimisation of risk constitutes an overriding value. There are competing goals and objectives which can justify a less cautious approach to risk, while risk itself may for some people in some circumstances constitute a good to be pursued rather than harm to be avoided. Hence the designation of an activity as "risky" does not necessarily mean it is unattractive. This relative subordination of risk assessment is both familiar and significant in connection with THRs. Attempts to manage such risks occur within the context of competing priorities, as indicated by the tension between precautionary measures and the presumption in favour of liberal trading relations when assessing questions such as BSE/CJD or GM foods.

For both Beck and Giddens, the transition towards risk society is inextricably linked with the emergence of globalisation. In one sense, this reflects the fact that "very few new-style risks have anything to do with the borders of nations" (Giddens 1999: 5). To the extent that they transcend national borders and are resistant to effective regulation at the national level, many manufactured risks may be regarded as constituting indicators of the extent of contemporary globalisation. In another sense, the identification of risk society itself may be regarded as an expression of globalisation in reflecting "the emergence of interregional networks and systems of interaction and exchange" (Held et al. 1999:27). This reflects the impact of globalisation in the technological sphere (Lee 2000: 7), expressed by Giddens in the claim that:

> It is not just people like Nick Leeson, not just the new financial entrepreneurs, who live at the barbaric outer edge of modern technology. All of us now do … A risk society is a society where we increasingly live on a high technological frontier which absolutely no one completely understands and which generates a diversity of possible futures. (Giddens 1998: 25)

The universality of such a claim is clearly mediated by immense variations in the extent to which individual states are enmeshed within such interregional networks. But to the extent that all states are vulnerable to manufactured transborder risks, risk society is a global society.

This congruence should not, however, lead to the simple equation of transborder with global. This would represent a lack of precision in both inadequately defining globalisation (treating transnational as synonymous with global) and ignoring more geographically restricted processes, most notably Europeanisation. Globalising forces are not the only ones transcending the borders of the United Kingdom. Though clearly closely interlinked with globalisation, Europeanisation has its own particular attributes. Schmidt, for examples, identifies the existence of distinctive economic, institutional and ideational pressures operating at the European level (Schmidt 1999). This is unsurprising given the incremental transfer of authority to European institutions and the commitment to the free movement of trade, people, services and goods (enshrined in the Treaty of Rome and revitalised by the Single Market programme). The character and management of many transborder health risks imported into and exported from the UK are, therefore, likely to incorporate distinctive European dimensions.

1.5 Outline of the Report

This report begins with a brief history of public health in the UK from the perspective of transborder health risks. Of particular interest is how such risks have been defined and controlled from the mid-nineteenth century to the present. National regulations need to be considered alongside those entailed by the UK's membership of the European Union and international health organizations from the twentieth century. Chapter 3 presents the case study of population mobility as an illustration of some of the key challenges for public health posed by globalisation. This is followed by discussion of the case study of tobacco control in Chapter 4. The lessons and conclusions drawn from the two case studies, as well as more general analysis of the public health implications of globalisation, are provided in Chapter 5. This is accompanied by recommendations for research and policy.

CHAPTER 2. **TRANSBORDER HEALTH RISKS AND PUBLIC HEALTH IN THE UK: AN HISTORICAL OVERVIEW**

2.1 Introduction

An analysis of how globalization is relevant to public health in the UK in the early twenty-first century begins with an understanding of the historical roots of existing institutions and practices concerned with transborder health risks. This is a variably documented history that necessarily draws selectively from a multidisciplinary literature on "the history of collective action in relation to the health of populations" (Porter 2000). What is immediately apparent is the need to go beyond "nuts and bolts" descriptions of public health policy and practice. While the institutional structures and policies that define formal public health practice over time are the starting points for such analyses, it is the changing economic, sociocultural and political context in which the UK public health system evolves, along with prevailing scientific knowledge and the nature of health risks faced, that lie at the heart of what has been done and why.

This chapter briefly reviews the history of how transborder health risks have been addressed in the UK up to the 1960s. We begin rather farther back, in the sixteenth century, not because transborder health risks did not exist prior to this period, but because the age of European exploration marks an intensification of human mobility between Europe and the rest of the world. It is from this period that, according to Crosby (1986) and others, the expansion of European political and economic power led to unprecedented health consequences worldwide. From this starting point, we find gradual change over a number of centuries in the beliefs, ideas and practices defining public health. By the late nineteenth century, the foundations for present day institutions were laid, and then built upon incrementally during the twentieth century by improved scientific knowledge and medical practice.

2.2 The formation of the European states system and public health

Although the modern public health system was not established until the nineteenth century, the roots of thinking and practice on transborder health risks lie much farther back. The

earliest recorded official efforts to deal with human disease associated with mobile populations date from the introduction of leprosy in Europe circa 350 B.C. and its subsequent spread by the Romans to most of the continent. Without means of preventing or curing the disease, local officials isolated and limited the movement of infected individuals to control its spread. Other measures adopted were mandatory inspection of selected travellers arriving in Britain, known as *Lepraschau*, and a system of public health warning (Lazarus Bell) to others of an infected individual (Gushulak 1998).

Along with leprosy, other diseases were spread via Roman conquest throughout Europe. For example, it is believed that malaria was brought to England from Italy, initially by the Romans and reintroduced over subsequent centuries by returning soldiers and other travellers. The Middle Ages were highly malarious, and the disease remained endemic until the 1930s to 1940s (Desowitz 1997: 210-11). With the collapse of the Roman Empire, new opportunities for epidemic disease to spread were created by the collapse of central authority, political instability, and in many places the destruction of basic infrastructure (e.g. water and sanitation).

By the early fourteenth century, trade between Europe and other continents expanded substantially, bringing increased flows of people, animals and other life forms across vast distances. The growth of commerce and industry from the twelfth century was accompanied by the growth of towns and cities in Europe, leading to the rise of a middle class enriched by trade and mercantilism. It was during this period of growing economic activity and population mobility that the bubonic plague spread from central Asia to Europe, arriving in Italy in the 1340s. The resultant high levels of morbidity and mortality prompted the introduction of quarantine practices.[3] As with leprosy, despite the lack of scientific knowledge, vagaries of diagnosis and practical means of controlling the disease, there was an intuitive desire to separate the local community from external sources and victims of the health risk. Quarantine became regularly used over the next four centuries and became standard practice throughout the trading world whenever ships and their passengers were suspected of posing an infectious risk to local populations. Along with plague, other diseases (e.g. cholera) were gradually added to the list of quarantineable conditions.

The period from the late fifteenth century was a particularly significant one for the development of transborder health risks because of the further intensification of human mobility across continents, and of the more formal delineation of state borders. Initially arising from European exploration of the Americas, Africa and other continents, intercontinental links steadily grew with colonisation, the slave trade and industrial revolution. Indeed, a number of writers cite the arrival of Christopher Columbus in the Americas in 1492 as critical to the history of human health and disease. While human migration across the continents predated this date, it is a convenient marker for the intensification of population mobility. As a result, it is from this period that new epidemiological patterns of infectious disease truly embrace all continents. Dubbed the "Columbian exchange" (Crosby 1972), the age of exploration brought an unprecedented intercontinental flow of microbes and hence the first properly global pandemics.

3 From the Italian word quarantina (period of forty days), quarantine is the period of detention or isolation of persons or animals to prevent the spread of disease, usually consisting of the maximum known incubation period of the suspected disease.

Other political and social changes during this period had direct relevance to the nature of transborder health risks. Widespread movement of troops as a result of ongoing warfare in Europe during the sixteenth and seventeenth centuries played a central role in the spread of disease. As Hays (1998:71) writes, soldiers were "unwashed, itinerant, and promiscuous, a powerful agent for the diffusion of disease". The disruption, and oftentimes destruction, of local infrastructures from warfare also undermined efforts to improve public health and sanitation. For example, a pool of Europeans infected with typhus was built up over time that brought sustained epidemics in Europe continuously until the First World War. Similarly, the Thirty Years War is described by Zinsser (1965) as "the most gigantic natural experiment in epidemiology to which mankind has ever been subjected" (Zinsser 1965).

As well as the import and movement of infectious agents within Europe, diseases were exported to other parts of the world, in the case of the New World, with devastating consequences. In most cases, the spread of diseases such as measles, typhoid and smallpox was the unintentional result of contact with populations with no immunity. Given a contemporary lack of understanding about the transmission and control of such diseases, few if any preventative measures were taken. The profound demographic consequences for the indigenous peoples of the Americas during this period is studied in detail by Crosby (1972).

The establishment of the modern states system is an important feature in the evolution of public health measures. The treaties signed by the Peace of Westphalia of 1648 ending the Thirty Years War (1618-48) established the concept of the territorial state and the "sovereign" power of heads of state in ruling the populations within them. This principle of state sovereignty, defining the state and rules of interaction among states, gradually spread from Europe to the rest of the world over the next four centuries. The emergence of the modern states system also marked the growth of central governments that were, in turn, made possible by the expanding economic activity of cities.

This growth of the state apparatus brought an impetus for more concerted development of public health institutions. Rosen (1993: 58) describes the Renaissance as "the dawn of a new period of history, the modern period, within which public health as we know it developed". With a basic political infrastructure in place, it was possible to mount more organised efforts to address public health threats. In Britain during the sixteenth and seventeenth centuries, the Privy Council adopted continental responses to outbreaks of disease, "ordering confinement of the stricken, destruction of vermin, disinfection of household goods". As Hamlin (1993:134) writes, "these steps were reactive rather than preventive, concerned with controlling the spread of plague rather than maintaining health".[4] Importantly, however, the balance between central and local government remained decidedly in favour of the latter. This weakness of the central state left counties, boroughs and parishes to deal with public health matters, each with its own "traditions, institutions and ineptitudes". For example, the *Weekly Bills of Mortality* were initiated in the late sixteenth century by parish clerks in London to warn or reassure the public about an epidemic.

4 See for example *The Cures of the Diseased in Remote Regions, Preventing Mortalitie, incident in Forraine Attempts of the English Nation* by Humphrey Lownes (1598).

2.3 The transborder health consequences of the industrial revolution

As the birthplace of the industrial revolution, Britain had early experience of the widespread socio-economic changes brought about by rapid industrialisation, including their associated public health impacts. The responses to these developments formed the foundations of the modern public health system we have today. Interestingly, the public health movement was born from a broader concern with social welfare and class relations that emerged during the Enlightenment, rather than from within the medical professions. This period saw the rise of humanitarianism focused on the betterment of people physically and spiritually. By the mid eighteenth century, a movement concerned with the needs of the poor arose, leading to the founding of hospitals, charities, and campaigns seeking social reform. Importantly, prevailing attitudes towards the causes of ill health also began to shift attention towards environmental conditions, and away from the perceived inherent characteristics or behaviour of the afflicted. Campaigns were initiated and carried forward into the nineteenth century, for example, to reform prisons, and improve the infrastructures of towns and cities (Hamlin 1993: 138).

The relatively weak role of the medical profession in influencing policy change during this time was largely due to the lack of scientific knowledge about the protection and promotion of public health. On the subject of infectious disease, for example, conflicting concepts and theories sharply divided the medical community. The pathologist Rudolf Virchow put forth a theory of epidemic disease in 1849 as a manifestation of social and cultural maladjustment. Others subscribed to the idea that epidemics arose from a specific constellation of weather conditions and local circumstances (i.e. miasma).

The importance of causes of ill health from beyond national borders has long been of concern to public authorities because of the simple geography of the British Isles. By the eighteenth century, the ascendance of the British Empire placed the country at the geographical centre of intensifying flows of people, goods and services, and ideas. Links with a growing number of colonised territories worldwide also brought increased exchanges through immigration, business and trade, and military conflicts. Significantly, there remained an absence of formal border controls and people were relatively free to move about, unhindered by the passport and customs controls found today. Coupled with a still nascent public health system, this meant that the country was particularly vulnerable to transborder health risks.

The importation of so-called tropical diseases to Britain during this period posed periodic yet serious threats to local communities. Desowitz (1997) describes an outbreak of yellow fever in 1865 as the consequence of a flourishing iron smelting industry bringing active maritime trade between Swansea and Santiago, Cuba. The outbreak occurred when the cargo ship Hecla arrived in Swansea with a number of sailors suffering from the disease. Despite denials from the ship's captain that the illnesses were "dropsy", the port physician recommended immediate quarantine under recently adopted British laws. However, influential shipping interests weakened the enforcement of these laws, and the ship was not ordered out of Swansea or to fly the yellow jack from its mast. Eventually, 29 local people contracted yellow fever over the next month resulting in sixteen deaths. As Desowitz (1997) writes, the incident "revealed how porous Britain was to invasion by foreign microbes".

Other tropical diseases imported during this time were plague, malaria and cholera. Among these, cholera was perhaps the most feared. For thousands of years, cholera was a disease largely confined to parts of South Asia, with occasional outbreaks elsewhere as a result of religious pilgrimages or trade links. From 1817 five pandemics occurred during the nineteenth century, spreading the disease from South Asia to the rest of Asia, Europe, Africa and the Americas. The apparent cause of this change in epidemiology was the colonisation of the region that led to widespread economic, political and social disruption. Combined with the displacement and migration of local people, movement of British troops throughout the region, impoverishment of rural communities by land reforms and taxation and, critically, construction of irrigation canals without sufficient drainage to raise cash crops, the conditions for cholera to assume pandemic status time and again were created (Watts 1997; Lee and Dodgson 2001).

Cholera first arrived in Britain in 1831 by ship at the port town of Sunderland. Almost immediately, the disease found conducive conditions among the urban poor whose numbers had rapidly swelled during the Industrial Revolution. Contemporary knowledge about the nature of the disease, whether it was contagious, predisposing causes and appropriate treatment was woefully inadequate. If infectious, quarantines and *cordon sanitaires* were clearly required. Once again, however, powerful economic interests conflicted with public health concerns. Hampered by the Continental Blockage imposed by Napoleon, British prosperity depended on its mercantile fleet and worldwide trade. The need to maintain free trade led the government to favour explanations of cholera as non-contagious. Officials accepted that it was a variant of an English fever, with individuals predisposed by immorality, poverty, neglect of family values and heavy drinking. The focus of efforts by local boards of health, therefore, was preventive measures and clean up campaigns among the working classes (Watts 1997). Even the famous removal of the Broad Street pump handle by John Snow in 1854 did not change prevailing attitudes and practices. It is estimated that 130,000 people in Britain died during the five cholera pandemics.

As well as being associated with the poor and disadvantaged in society, many diseases, notably those imported from abroad, were blamed on the personal habits of certain nationalities. This was a common practice in many countries. The “English sweats”, for example, was possibly influenza or a form of typhus, while typhus fever was known variably as Hungarian disease. A particular good example is syphilis. The disease appeared in epidemic form in Europe at the end of the fifteenth century, first in Naples and then spreading to the rest of the continent, reaching England and Scotland in 1497. The English and Italians referred to it as the French disease or pox, and the French called it the Neapolitan disease. As Rosen (1993: 73-74) writes, “Nonresidents who were suspected of having the disease were expelled from the community or prevented from entering it. Sick citizens had to go to special hospitals for treatment.” Indeed, ordinances were passed requiring citizens to seek treatment at special facilities, and physicians treating syphilitics were required by law to report cases to the authorities. By the eighteenth century, middle-class morality became dominant and the disease acquired a social stigma, thus going underground. The unpleasant physical symptoms “fed already-existing suspicion of indigent transients”.

The development of modern epidemiology from the 1840s as a distinct discipline, accompanied by advances in statistical data collection and analysis, contributed significantly to understanding and developing effective responses to changing patterns of infectious disease. The contributions, and perhaps overdomination, of bacteriology from around the 1870s, by Robert Koch, Patrick Manson, Ronald Ross and others, provided further critical evidence of the role of disease vectors and microbes in many diseases (Beaglehole and Bonita 1997). As understanding improved of the causes and patterns of specific diseases, speculation and prejudice among the medical professions were gradually undermined.

The slow application of these advances, to protect and promote public health in Britain, was in large part due to the complex bureaucratic structures of the time. One of the features of early public health efforts was the continued fragmentation of authority and action. Public health remained largely a local responsibility despite the growth of central government during the eighteenth century. In London alone, which was uniquely omitted from the provisions of the 1848 Public Health Act, 48 sanitary districts were created, each with a Medical Officer of Health. The result was a "large network of different authorities with responsibility for administering metropolitan public health. At least three government departments, six metropolitan-wide authorities and dozens of different types of purely local bodies, including Paving and Burial Boards, were entrusted with different aspects of metropolitan public health administration." (Tanner 2000:38). The Corporation of the City of London was, and remains, a separate entity. It ran the Port of London Health Authority that played a key role in preventing the entry of diseases such as rabies, cholera and plague into the country (Tanner 2000:40). Similarly, the task of inspecting common lodging houses was the responsibility of the Metropolitan Police until 1894 despite concern about infectious diseases among "vagrants". As new legislation was passed, additional layers of government were added to existing ones, a decentralised and disaggregated system that remained until the creation of the Ministry of Health in 1919.

2.4 The creation of a national system of public health

The devastating human toll of epidemics during the nineteenth century brought home to public officials the weaknesses of current institutions, infrastructure and policies. Attitudes gradually, but steadily, shifted from attributing the causes of disease to particular population groups, to redefining public health in broader terms requiring coherent policies and administration (Hamlin 1993: 139). Building on the work of William Farr, who as one of the leaders of the public health movement was firmly committed to environmental and social reform, the Public Health Act of 1875 laid the foundations for a modern public health system in England.[5] The Act consolidated previous legislation, providing a complete statement of the powers and responsibilities of local sanitary authorities (Holland and Stewart 1997).

Importantly, the focus of public policy shifted from a preoccupation with infectious diseases to noncommunicable disease epidemiology, and thus to improving the basic living and working conditions of the general population. The Report of the Royal Commission on the

5 The Public Health (Scotland) Act was adopted in 1897 with similar provisions.

Housing of the Working Classes (1885), for example, pointed to the appalling housing conditions of the poor from overcrowding and lack of sanitation. Similarly, the Report of the Royal Commission on the Sanitary State of Large Towns and Populous Districts drew attention to the link between inadequate housing and unemployment. Housing legislation followed, accompanied by reforms in town planning, diet and nutrition, and education. Alongside government efforts came a number of initiatives by enlightened industrialists, such as George Cadbury and Robert Owen, who began to construct housing for their workers and to develop model industrial communities (Holland and Stewart 1997).

As basic living conditions improved in Britain, the burden from infectious diseases (the major cause of death in the nineteenth century) declined. Significantly, however, lessons learned about the broader determinants of health domestically did not translate to the international context. Indeed attention to the risks from infectious diseases from outside of Britain intensified rather than abated. As domestic conditions improved for preventing and controlling disease, the focus shifted to conditions abroad that could be imported or impact on the health of British people. This led to the formalisation of measures to control external risks in legislation and institutional structures. The most important of these was the linking of public health with immigration policy and practices. In 1903 a Royal Commission on Immigration was established, in response to political refugees and Jewish immigration from Eastern Europe, which commented on the health status of immigrants in terms of deficiencies in cleanliness and hygiene, and risks of infectious diseases. Although the latter was refuted by the Medical Officer of Health for the Port of London, it was the Aliens Act adopted in 1905 that formalised and legitimised the use of medical professionals, knowledge and technologies to control immigration into Britain. This was achieved by requiring inspections by an Immigration Officer and Medical Inspector prior to being granted entry into the country. The role of the Medical Inspector was to refuse entry to certain categories of people including those likely to be "a detriment to the public by reason of infirmity or disease" (Foot 1965).

The substantial increase in immigration to Britain after the Second World War, largely from former Commonwealth territories, brought to the fore such attitudes regarding the public health needs of immigrant populations. As Sevak (forthcoming) writes, immigrant health was primarily seen in the context of the risk of infectious diseases being brought into the country. This association between immigrants and infectious diseases was not helped by the higher prevalence among certain populations of such diseases as tuberculosis, linking the prevalence to ethnicity rather than other factors such as socioeconomic status, housing and other living conditions. Attitudes and policies towards immigration during this period extended to practices within the public health system to the extent that, according to Sevak (forthcoming), medical officers and the health system have been used to enforce legislation on immigration (Immigration Act of 1965). To the present day, people arriving from South Asia and other designated parts of the world may be required to have a formal medical examination and x-ray from a British consulate-approved doctor before an application for leave to enter is processed.

The practice of using health professionals and services, as well as other social welfare agencies (e.g. education, unemployment benefit offices), to enforce immigration policies continues to the

current day. In the context of public health, NHS hospitals, for example, are requested to check the eligibility of individuals to access health services. However, because of the difficulty of distinguishing eligibility and the administrative burden of doing so systematically, checks are generally carried out on the basis of skin colour or fluency in English. As well as raising issues of racial bias, this practice raises a range of issues concerning the efficacy of this ad hoc system and the actual impact on public health on the basis of economic right rather than public health exigency. Detailed discussion of the public health issues surrounding migration and other population mobility issues is provided in Chapter Three.

The creation of the National Health Service (NHS) after the Second World War was an important further consolidation of the piecemeal system that had evolved from the nineteenth century. As Hamlin (1993) writes, the health system was an "ill-unified amalgam of programmes and institutions, central and local, influenced by all manner of political, cultural and professional concerns, not all of them apparent" (Hamlin 1993:154). Undoubtedly, the NHS has contributed to major improvements in health over the past fifty years. Life expectancy between 1948-96 increased for men from 66.1 years to 74.4, and for women from 70.5 to 79.6 years largely influenced by improvements in nutrition, housing, occupational hazards, lifestyle and medical care. There has been a shift in causes of death away from communicable diseases and genitourinary diseases, and increased deaths from respiratory diseases and cancers; substantial decrease in the number of deaths from infectious diseases, from 30 142 in 1948 to 3 636 in 1996 largely due to the introduction of antibiotics; mortality rates declined until 1983 since when they have been rising again; morbidity also declined for infectious diseases such as measles, mumps and rubella with introduction of mass vaccinations (Kelly et al. 1998).

In relation to transborder health risks, public health institutions remained focused on ports of entry and the importation of infectious diseases from abroad. The traditional screening of people, animals and other potential health risks at seaports continued to expand as trade links grew during the twentieth century. The advent of commercial airlines increased number of people travelling by airplane to and from British airports. The rapid expansion of Heathrow and Gatwick as international airports was followed by the growth of a number of regional airports (e.g. Birmingham, Manchester, Luton). Finally, the opening of the Channel Tunnel in 1998 created a port of entry to the UK by rail. For all of these ports of entry, by sea, land and air, systems of screening for potential risks to public health were established. The underlying rationale for such practices was the isolation (quarantine) and, if necessary, exclusion (*cordon sanitaire)* of health risks from British territory.

The perceived effectiveness of this strategy seemed to be supported by advances in the prevention, control and treatment of infectious disease. With improved living conditions and modern medical science, epidemics on a scale encountered only a generation ago seemed poised for relegation to the dustbins of history. With Britain now armed with vaccines, antibiotics and other treatments, the key challenge for public health officials was seen to be the protection of Britain from risks arising among people without access to such interventions. This "fortress" approach to transborder health risks was hardly unique to the UK. All industrialised countries introduced policies and procedures focused on ports of entry in an effort to exclude risks from entering the country.

2.5 Summary and conclusions

The social, economic and political history of Britain makes it an especially useful illustration of how transborder health risks have been addressed over the centuries. The migration of people to and from the British Isles, the extensive and intensive trade links worldwide, the Industrial Revolution, the participation in war and conflict, and the geography of the country as an island state, have placed Britain at the crossroads of many transborder flows.

The historical development of public health measures to address transborder health risks has been incremental and somewhat ad hoc, to a large extent following the development of public health systems for domestic populations. These efforts were further hampered by a lack of scientific knowledge and prevailing social attitudes. As such, there has been an early and persistent focus on infectious disease, and a preoccupation with risks flowing into the country. Outgoing threats or the role that Britain played in contributing to the origins of transborder health risk (e.g. colonisation, slave trade, socioeconomic inequalities) were not readily recognised.

Like public health institutions as a whole, those concerned with transborder health risks remained complex, fragmented and highly decentralised both organizationally and operationally until the end of the Second World War. The creation of the NHS brought a more centralised and coordinated structure to deal with "border health" issues. There were continued tensions, however, between responsibilities for protecting and promoting public health, and other policy goals notably immigration control. The ill-fit between the two policy agendas has become increasingly stark amid more recent trends in globalisation since the second half of the twentieth century. The UK of the twenty-first century, within a world of increasing globalisation, illustrates the need to review the appropriateness of institutions and policies focused on controlling ports of entry. Given the further intensification of flows of people, other life forms, goods and services, information, and financial capital, territorial boundaries have become highly eroded and arguably reduced to marginal relevance. Britain's membership in the EU, with its progress towards the free movement of people, is a clear example of this. It is in this context that this study reviews and assesses the appropriateness of existing public health measures.

CHAPTER 3. **UK PUBLIC HEALTH AND THE GLOBAL CHALLENGE OF POPULATION MOBILITY**

Population mobility is a phrase coined to encompass the entire spectrum of people on the move: who moved, when they moved, how they moved, where they moved to, and why they moved. Including individuals or identifiable groups; voluntary, assisted or forced movements; and movements within or beyond established political, socio-cultural, ethnic or environmental boundaries.

MacPherson (2001)

3.1 Introduction: Population mobility as a transborder health risk and opportunity

There is, of course, no novelty in the observation of a link between transcontinental movements of people and associated impacts on the health of both travellers and local populations in destination and return countries. Although such impacts were doubtless experienced from the migration of *Homo erectus* from Africa around 1 million BC, a landmark event in this context is what has been termed the "Columbian exchange" following 1492. The subsequent introduction into the New World of diseases such as smallpox, malaria, yellow fever, cholera and bubonic plague (Crosby 1972) heralded the emergence of true pandemics. Embryonic attempts to protect resident populations from health risks associated with international travel actually pre-date this, with the concept of quarantine emerging as standard maritime practice in parts of Europe from the fourteenth century (Gushulak 1998). The relationship between the movements of people and of pathogens was neatly captured in the mid-nineteenth century by Jon Snow's observation that "Epidemics of cholera follow major routes of commerce. The disease always appears first at seaports when extending into islands or continents" (Snow 1849).

While acknowledging the long established historical connection between human travel and health, there are features of the current scale of population mobility that have particular implications for human health. The enormous growth in population mobility across a number of categories in recent decades suggests that there is something both quantitatively and qualitatively different from previous eras, and that transborder health risks assume a new salience.

The relationships between globalisation, population mobility, and transborder health risk in the UK are discussed here with reference to two broad flows, namely overseas tourism and inward migration. In this context, following the definitional categories used in UK national

statistics, the divide between tourism and migration lies in the duration of travel. Hence, tourism is used here in a comparatively inclusive sense, encompassing travel for business as well as leisure, to cover "visits abroad… for a period of less than twelve months by people permanently resident in the UK (who may be of foreign nationality)" (UK Office for National Statistics 2001). Similarly migration is used with reference to "someone who intends to stay for at least a year either in the UK (for inflows) or in the destination country (for outflows)" (Glover et al. 2001).

These categories of overseas tourism and inward migration do not, of course, constitute comprehensive coverage of the range of transborder population movements, notably excluding emigration and tourists visiting the UK. Nor should they be thought of as discrete processes or groups. There is, in practice, no simple behavioural distinction between the tourist and the migrant. It is particularly important to note that migrants who have become settled in the UK can be subject to comparatively high levels of risk during subsequent visits to/from friends and relatives residing abroad. The selection of tourism and migration does, however, allow for the effective illustration of trends in the scale and diversity of travel-related THRs, and particular themes highlighted within them facilitate an assessment of the appropriateness of current UK public health provisions in the context of globalisation.

Traditionally, travel medicine has primarily focused on restricting transmission of infectious diseases across national borders, with an emphasis on epidemiological studies and protecting health through immunisation and chemoprophylaxis (Clift and Page 1996). Such concerns not only remain highly relevant to the protection of public health, but their significance increases as the greater frequency and distance of international travel encourages the global spread of newly emerging and re-emerging infectious diseases. This dimension of health risk is addressed below under tourism by assessing the relationships between tourism and the epidemiology of malaria, tuberculosis and HIV/AIDS in the UK.

THRs related to population mobility are not, however, confined to communicable disease. Their diversity in terms of character, duration and range of people affected can be addressed via a framework for examining migration and health issues developed by the International Organization for Migration (IOM):

> (T)hrough a functional approach, migration health can be described in terms of three discrete but interdependent undertakings: the predeparture phase, the migratory journey itself, and the arrival at destination… Some of the health-related consequences may not be realized or appreciated until the individual is much further along the 'migration' process… It is also possible that some of the migration-associated health effects and outcomes will manifest themselves in the locally born offspring of migrants. (Gushulak and MacPherson 2000; 68-9)

This approach highlights the potential presence of health risks at each stage of international travel. Health risks associated with the pre-departure phase might be particularly acute for refugees, whose flight is often triggered by conflict or disaster situations, but might also encompass the failure of tourists to take adequate precautions against tropical diseases prior to travel. The recent increase in attention to occurrences of deep vein thrombosis (DVT) during long-haul flights, so-called 'economy class syndrome' (House of Lords Select

Committee on Science and Technology 2000), illustrates the relevance of THRs during a journey itself. Such risks reach their utmost severity in tragedies associated with illicit smuggling of undocumented migrants, as in the deaths of 58 Chinese migrants in the sealed container of a lorry at Dover in June 2000 (Kelso 2001). Attention to the post-arrival phase highlights the fact that population mobility may have long-term, and even cross-generational relevance to the health status of migrants. The persistence of such health risks may reflect the lengthy incubation period of a disease such as tuberculosis, experiences of poverty and social exclusion, or hazards associated with subsequent return visits to friends and relatives. The even longer-term health impacts of genetic admixture are also increasingly being explored in relation to population mobility.

This framework also highlights the broader public health relevance of THRs associated with population mobility, since risks may be assumed by communities at points of origin and destination as well as by travellers themselves. This has primarily been viewed in the existing literature and currently policy in terms of the potential for communicable disease transmission, but can encompass a broader range of risks. For example, expansion of tourism can have adverse impacts on certain resident populations, such as the indigenous people of the Amazon basin via social disintegration and abandoned subsistence activities. Similarly, the medical treatment of visitors in low-income countries may diminish availability of scarce health care resources for local populations (Frechtling 1997). Alternatively, the migration of health professionals may have deleterious impacts on the capacity of countries of origin. The associated costs and benefits are unlikely to be simplistically zero-sum, with the loss of expensively trained personnel being potentially offset by diverse gains such as skills acquisition, remittance transfers and the development of international networks. Prevailing recruitment patterns and the comparative fragility of public health systems in low-income countries suggest, however, that the "brain drain" associated with the migration of health professionals constitutes a THR for some countries. Such issues are generally under researched.

This chapter's primary emphasis on health risks associated with heightened population mobility should not detract attention from the opportunities that are also offered by these flows. Such opportunities are being explored within the UK, if in a somewhat fragmented and sporadic fashion, although the benefits offered by such opportunities are often not without controversy. The health sector provides a particularly pronounced example of how employers have increasingly used migration as a means of addressing skills shortages within the UK:

> 31 per cent of doctors and 13 per cent of nurses are non-UK born; in London 23 per cent and 47 per cent respectively. Half the expansion of the NHS over the last decade – that is, 8,000 of the additional 16,000 staff – had qualified abroad. A Royal College of Nursing survey reported 78 per cent of hospitals with medium to high recruitment difficulties. (Glover et al. 2001: 38)

There is also an increasing awareness of the potential resource represented by doctors among the UK's refugee population, among whom there are seemingly disproportionate numbers (Cheeroth and Goraya 2000), and for whom re-training programs can offer clear benefits to both individual refugees and the health service (Adams and Borman 2000). Opportunities

for British doctors to work overseas are similarly regarded as enhancing professional development, and consequently as beneficial to individuals and the NHS (Banatvala and Macklow-Smith 1997). More controversially in January 2002, nine individuals from Kent were reported as being the first patients to undergo operations in France in order to reduce NHS waiting times (BBC News 2002a).

Viewed at a more abstract level, from the perspective of macroeconomics, the public health system could be regarded as benefiting from the positive net contribution made by migrants. A recent report for the Home Office calculated that in the UK "the foreign-born population contributes around 10 per cent more to Government revenues than they receive in Government expenditure, equivalent to perhaps £2.6 billion in 1998/99" (Glover et al. 2001: 44). Such estimates are rather provisional, but they are in line with recent findings in the US and serve as a counter to unsubstantiated claims that migrants represent a "drain" on public resources including health services.

Importantly, the above opportunities for health benefits serve as an antidote to the popular tendency to view migrants as "vectors of disease". To the extent that the interrelationships between globalisation, population mobility and health have been explored, it has been primarily in terms of a heightened sense of vulnerability within high-income states to newly emerging and re-emerging infectious disease (Garrett 1996; Institute of Medicine 1997). THRs have been largely and simplistically conceived in this context as threats posed to high-income countries by poorer nations, as symbolised by media scare stories surrounding reported outbreaks of plague in India and Ebola in the Congo. The approach taken in this report seeks to understand population mobility and health from a broader perspective, acknowledging the wide range of risks and opportunities posed.

3.2 Population mobility, globalisation and the UK

From a public health perspective, globalisation can be understood in terms of a set of processes that are intensifying human interaction across spatial, temporal and cognitive boundaries (Lee 2001). The essential globality of such changes lies in the heightened interconnectedness across diverse population groups worldwide. On this basis, the rapid increases in the scale and reach of the movement of people across international borders from the middle of the twentieth century provides perhaps the archetypal manifestation of globalisation. Yet it is one that is frequently overlooked, as noted in a recent report by the Research Development and Statistics Directorate of the Home Office: "(w)hile migration is an integral part of globalisation, many discussions of globalisation focus exclusively on trade, investment and capital flows, and ignore the movement of people" (Glover et al. 2001).

There is an integral link between globalisation and population mobility. Weiner (1995) suggests, for example, that "worldwide migration is to a large extent the result of the globalization of world trade, communications, and transportation". Weiner attributes a massive global increase in migration to inter alia increased awareness of opportunities in other countries, reduced barriers to movement via cheap and available transport, and greater knowledge of differentials in income and population growth. Particular categories of migrant flows have also been strengthened by the end of the Cold War, and subsequent political and

economic changes in central and eastern Europe, by heightened instability and conflict, and by environmental changes such as deforestation. Analysis of the social and economic features of migration in the UK attributes recent increases to the strength of the UK economy, the existence of established immigrant populations, and the English language skills of migrants.

Increased population mobility is associated with multiple impacts across the temporal, spatial and cognitive dimensions of globalisation. The ability to travel faster and further, transnational telecommunications, more extensive contacts with individuals abroad, and the increasingly cosmopolitan nature of many major cities are central to popular experience and perception of globalisation. This sense of the world as approximating towards a "global village" is well-captured by the Small World Phenomenon. This is the idea that anyone in the world can be reached by a short chain of acquaintances, following a famous experiment conducted by psychologist Stanley Milgram in 1967, giving rise to the phrase 'Six Degrees of Separation' (Small World Research Project 2002). The notion that one is just six handshakes from anyone else in the world, however questionable its methodology, powerfully encapsulates the perception of travel and migration as effective vectors of disease.

According to the World Tourism Organization, the global total of international arrivals worldwide reached 699 million in 2000, representing an annual increase of 7.9%. The average annual gain in tourist arrivals over the ten years up to 2000 was 4.3%, and it has been estimated that this total will surpass 1.56 billion by 2020 (World Tourism Organization 2001; World Tourism Organization 2002). While people are clearly undertaking more international travel, increasingly they have also been travelling further afield. More people are making transcontinental journeys, and the number of long haul travellers is expected to reach 377 million by 2020 (World Tourism Organization 2001). The impact of the events of 11 September 2001 does, however, illustrate that there is nothing inexorable about such growth. The last quarter of 2001 witnessed an 11% drop in arrivals worldwide (World Tourism Organization 2002).

Trends in migration in recent decades are also indicative of the rapid overall growth in population mobility, although reliable figures are notoriously difficult to generate for particular categories of migration. The International Labour Organization (ILO) estimates that 130 million people worldwide are working as migrants, up from 75 million in 1965. It also reports that this figure is supplemented by 10-15 million people working as undocumented migrants (ILO 2000).

A dramatic expansion in the number of refugees is also evident over the last forty years. The United Nations High Commissioner for Refugees (UNHCR) estimates that the total number of refugees and others of concern to UNHCR (a category including asylum seekers, refugees returning home and internally displaced persons) had reached 21.8 million in 2000. This figure is down from a peak in 1995 of 27.4 million, reflecting how such flows fluctuate in response to conflicts and humanitarian disasters. Nonetheless, there has been sustained growth from only 1.4 million in 1961 (UNHCR 2001; French 2000).

Methodological problems are particularly severe in trying to estimate flows of smuggled migrants and victims of trafficking. There is consensus, however, that there is a global increase in the scale and significance of such activities. The often desperate conditions under

which these activities occur, moreover, means that they are liable to entail particularly severe THRs. Among the more frequently cited estimates of such flows are:

- Around 4 million people are thought to be victims of trafficking each year (USAID 1999);
- Profits from the traffic in human beings now amount to US$7 billion annually (UN 1998b);
- Trafficking in human beings and illegal immigration is now equivalent in financial terms to drug trafficking (UN 1998b); and
- 500,000 women were trafficked into the EU in 1995 (IOM 1996; Kelly and Regan 2000).

The UK, in particular, has been heavily involved in this rapid worldwide growth in population mobility, with trends in the UK providing an acute example of the intensification of flows in tourism and migration. The number of overseas residents arriving in the UK in 2000 was 25.2 million, double the figure for 1980. Residents of the UK made 56.8 million visits abroad in 2000, a rise from 42.1 million in 1996 (UK Office for National Statistics 2001). Such activity means that the UK had the third highest international tourism expenditure in the world in 2000, at US$36.6 billion or 7.7% of the world total. The UK was also sixth in the world in international tourist arrivals, with 25.2 million or 3.6% of the world total (World Tourism Organization 2001).

Despite the restrictive nature of UK immigration policy, there has also been an expansion in inward migration to the UK in recent years. The total figure reached 330,000 in 1998, up from around 150,000 in 1981 (Glover et al. 2001). The UK's total refugee population was estimated by UNHCR as just under 150,000 at the end of 2,000, up 20,000 on the previous year. One feature of this trend that has attracted particular controversy has been the expansion in the number of people claiming asylum. Over 75,000 people claimed asylum in 2000, representing substantial and sustained growth from 4,000 in 1988. This placed the UK third behind Germany and the US among industrialised countries in terms of number of asylum applications lodged (UNHCR 2001b). When viewed in terms of applications per head of population, however, this ranking drops to ninth among European states and twelfth among industrialised countries (Council of Europe 1999; UNHCR 2001b). It is also worth noting that, of the 80 million people who entered the UK in 1998, only 0.5% did so as migrants (Glover et al. 2001).

The scale of the UK's involvement in international tourism and migration has led some to argue that associated THRs might especially be keenly felt in the UK. Habib and Behrens (1999) for example argue that, as a result of its "unique ethnic diversity, large tourist influx, and long established links to developing countries, the United Kingdom is particularly susceptible to imported infections". It is argued in this report, however, that the mobility of tourists and migrants does not automatically imply disease transmission. A cautionary example in this respect is provided by the hysteria that surrounded reports of an outbreak of plague in Surat, India in 1994. As Grabowski and Chatterjee (1997) note, "it is important to remember that nobody returning from a holiday in India to any country in the world had contracted the disease, despite the fact that in the last quarter of 1994 alone 71,455 UK travellers went there".

3.4 Population mobility, transborder health risks and London

It is important to recognise the extraordinary extent to which the UK-experience of population mobility is dominated by London. Indeed, in some categories, the UK and London can almost be treated as synonymous. In terms of visits made to the UK by overseas residents, London is much the most popular region to stay in with 13 million overnight visits. The five most frequent ports of entry are all located in the South East, accounting for three-quarters of international arrivals, and Heathrow alone accounts for 39% (UK Office for National Statistics 2001). Although under researched, it would appear that this preponderance is reflected in particularly disproportionate health impacts. London has, for example, the highest annual notification rate for malaria at 7.3 per 100,000 in contrast with an average of 1.9 per 100,000 for England and Wales (PHLS 2000a).

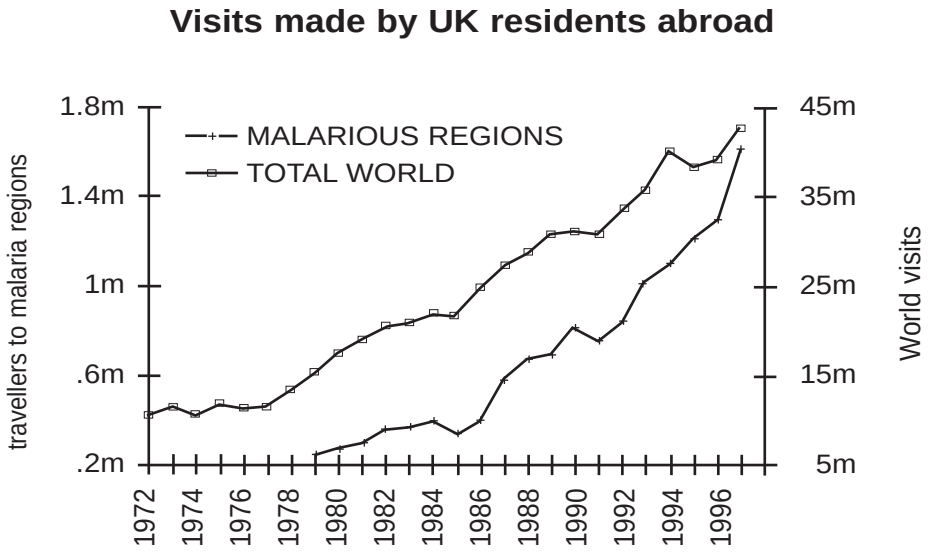
London is particularly important in the context of migration to the UK, with the trend towards an increasing concentration of migrant populations in the capital. Over half of all migrants live in London and the South East, while more than two-thirds of new migrants now settle in the area (Glover et al. 2001). This focus on the capital is even more pronounced in the case of asylum seekers, with some 85% estimated to live in London (Lowdell and Daniell 1999), a proportion that provided the impetus to the government's controversial policy of near-compulsory dispersal (see below). There is also a marked divergence in the distribution of refugees and asylum seekers across London boroughs, ranging from 2 per 1,000 population in Havering, to 86 per 1,000 population in Hackney (Audit Commission 2000). The broader category of migrants is disproportionately concentrated in areas of both relative prosperity and relative deprivation (Glover et al. 2001).

The remarkable extent to which different categories of migrants have chosen to settle in and around London might be regarded as imposing difficulties in some boroughs. This might be stated in terms of added pressure on social housing, increased demands on social services, or an overburdening of time-consuming consultations for some GPs (Audit Commission 2000). Yet it must also be recognised that London, as a global city, benefits greatly from the presence of migrants, not least economically, and is in many respects best placed to address their needs. The health needs of refugees and asylum seekers, for example, may be well-served by the presence of established communities able to provide social support, concentration of relevant community organisations, and of specialist health care organisations such as the Medical Foundation for the Care of Victims of Torture.

3.4.1 Malaria

The increased THRs associated with the expansion of international travel is well-illustrated by malaria. The increased scale and geographic range of contemporary travel patterns of British citizens means that travellers are increasingly exposed to a broader range of potentially infectious agents. Figure 3.1 illustrates that visits made by UK residents to malarious regions have increased proportionately with the overall expansion of international travel.

Figure 3.1: Trends in visits made by UK residents abroad



Source: Habib and Behrens (1999)

As might be predicted from the UK's distinctive over representation among international travellers, there is a concomitant vulnerability to such imported infections. Of the 10,000 cases of malaria reported in the EU in 1996, for example, one quarter of cases were reported in the UK (Habib and Behrens 1999).

THRs are not, however, a mere function of geography. The epidemiology of malaria in the UK also exemplifies the manner in which comparative levels of risk reflect behavioural and socioeconomic characteristics of overseas visitors, as well as their destinations. The dramatic contrast in circumstances between staying in well-equipped modern city hotels and adventure holidays in the outback, for example, is associated with varying potential for infection.

> Some travellers to malarious regions are at much greater risk of contracting malaria than others. The business traveller or urban tourist who stays in an air-conditioned hotel in the capital will be at low risk, except in some African cities which retain breeding sites for *Anopheles gambie*, and in those south Asian cities with the urban tank-breeding *Anopheles stephensi*… The package tourist to an African coast resort might be at high malaria risk (though one to an equivalent resort in Thailand might have *no* risk). The highest levels of risk are encountered by overland travellers who may go off the beaten track and spend several months in rural areas with high malaria endemicity - far from good medical advice. (Bradley 1995)[6]

Particular professional groups may also be considered subject to comparatively high levels of risk. Members of the armed forces, for example, may contract infectious diseases during the

6 More recently, attention has been drawn to particular risks encountered by business travellers during brief forays away from the comparative safety of the air-conditioned city hotel. The most recent guidelines for malaria prevention in the UK emphasise that surveys identify business travellers as having "a substantially higher incidence of malaria than tourists, and often lower stated compliance with prophylaxis" (Bradley and Bannister 2001).

course of overseas postings. Between 1995-2000 47 service personnel contracted malaria, although this was apparently within the range of anticipated cases. However, fifteen soldiers recently sued the Ministry of Defence after contracting malaria in Sierra Leone, with at least 200 soldiers having arrived in West Africa without anti-malarial medicines (Evans 2001).

The epidemiology of malaria in the UK also illustrates the way in which gradual changes in the composition of British society are, in turn, shaping the nature of health risks experienced within it. The largest category among cases of imported malaria in the UK is represented by migrants travelling to visit friends and relatives in their country of origin. Between 1987-92, 79% of cases of imported malaria concerned travellers from ethnic minority groups, while UK residents travelling to visit friends and relatives constituted 49% (Behrens 1997). This encompasses two main subgroups: a south Asian population from India and Pakistan, and west Africans visiting Nigeria, Ghana and Sierra Leone (Bradley 1995).

Cases of malaria in the UK also illustrate the importance of awareness of, and preparedness for, health risks associated with international travel, as well as the potential difficulties in providing appropriate treatment for imported infections. Among the 3,551 cases of malaria reported in the UK between 1992-94, there were 14 deaths. Twelve cases had involved taking inadequate preventive measures and eight had taken no prophylaxis whatsoever (Clift et al. 1997). There is also the important problem of under-reporting to the Malaria Reference Laboratory, estimated as high as 40%, with diagnosis complicated by the difficulty of distinguishing malaria from other causes of fever more common in the UK. Delayed diagnosis and treatment can have potentially fatal consequences (Habib and Behrens 1999).

Some of the more curious cases of imported malaria exemplify the manner in which international travel undertaken by individuals can have broader implications for the health of the community. The phenomenon of airport malaria was first documented in 1977 since when 75 cases have been observed in western Europe. Diagnosis and treatment is complicated by the patient's non-travel to an endemic region, but with transmission occurring in the vicinity of international airports via imported mosquitoes. Airport malaria primarily occurs during hot summers, which facilitates the survival of anopheles mosquitoes (Eurosurveillance 2000; Lusina *et al*. 2000). In 1999, Nottingham City Hospital reported three cases of hospital-acquired malaria which resulted in one death (PHLS 1999).

3.4.2 HIV/AIDS, sexually transmitted diseases and population mobility

Despite the long association between international travel and the transmission of sexually transmitted diseases (STDs) along sea routes, around ports and via military campaigns, there remains controversy about whether travel itself constitutes an independent risk factor for STDs. Matteelli and Carosi (2001) have been among those who have argued that travel "interferes with human sexual practice by splitting fixed sexual partnerships and removing social taboos that may inhibit sexual freedom", whereas Black (1997) cautions against an automatic presumption that travel necessarily contributes to increased risk-taking.

Research into the sexual behaviour of young British adults provides some reinforcement for such caution, emphasising that the group that reported a new relationship abroad were also the most likely to identify a relatively large number of partners at home. One proviso to this

observation, however, is the distinction between the sexual behaviour of men and women. Whereas the behaviour of men abroad is generally in line with that at home, the behaviour of women abroad is shaped by that of their partners (Bloom et al. 1998). While the transmission of STDs is clearly a function of behaviour rather than geography, the variable epidemiological distribution of STDs is relevant to the scale of risk encountered. For example, estimated worldwide distribution of curable STDs for 1995 was estimated at 150 million in southeast Asia, 65 million in sub-Saharan Africa, 16 million in Europe and 14 million in North America (Mulhall 1996).

The relationship between travel and STDs has new salience with HIV/AIDS. The arrival of HIV/AIDS in the UK can be attributed to travel, and the movement of tourists and migrants continues to shape the epidemiology of the HIV virus. This is particularly true with respect to heterosexual sex as a means of transmission. This is now the route of infection for over one-quarter of diagnosed infections, and the great majority of these have been acquired abroad, primarily in sub-Saharan Africa (PHLS 2000a). It should also be noted that travel is relevant to the spread of HIV/AIDS via injected drug use. The first intravenous drug user (IDU) known to seroconvert in Edinburgh reported a journey to Southern Europe and subsequent needle sharing with other IDUs in Edinburgh, while drug-using behaviour has been identified as a push factor in Italian IDUs travelling to London (Broring 1997).

A lack of research means that far less is known about the relationship between population mobility and other STDs. One London study demonstrates that, although only 8% of cases of gonorrhoea were acquired abroad, there is a strong link between overseas infection and antibiotic resistance. Another study identifies a similar incidence of STDs among travellers and non-travellers alike (cited in Matteelli and Carosi 2001). Importantly, there is a clear link between commercial sex workers and population mobility that is likely to be relevant to STD transmission. This is usually because of the overrepresentation of migrants among commercial sex workers. Between one-half and three-quarters of those working as prostitutes in London's Soho area are estimated to be from overseas. Of 32 commercial sex workers arrested in one raid in February 2001, 22 were from Kosovo and the remainder were Albanian, Moldovan, Iraqi, Thai, Russian and Belarussian (Taylor 2001). The proportion of trafficked and other undocumented migrants among such women, furthermore, impedes access to health care and is likely to be associated with unsafe practices (see below). Population mobility is also relevant to the behaviour of clients, most obviously via the highly publicised cases of "sex tourism" to countries such as Thailand (Mulhall 1996). It has been argued that lower prices and/or more relaxed inhibitions can make travellers more likely to visit commercial sex workers when abroad (Broring 1997).

3.4.3 Tuberculosis

A particularly striking example of how changes in the ethnic composition of British society have shaped the distribution of health risks is provided by trends in the epidemiology of tuberculosis (TB). The long-term nature of THRs associated with migration becomes evident from the manner in which TB in the UK has become increasingly a disease afflicting certain ethnic minorities. In a national survey in 1998, 56% of cases in England and Wales occurred in people born abroad (PHLS 2000a).

Table 3.1: Rate of all cases of tuberculosis (per 100,000 population) in England and Wales by ethnic group, 1988-98

	Rates of tuberculosis/100,000 population		
Ethnicity	**1988**	**1993**	**1998**
Black African	65	151	210
Indian subcontinent	132	128	121
Black Caribbean	29	22	26
White	5.4	4.8	4.4
Other	21	34	46
Overall	9.4	10.1	10.9

Source: 1998 National Tuberculosis Survey in England and Wales

Disputes about the reasons for this pattern emphasise the relevance of both prevailing circumstances in the country of origin, and socioeconomic conditions encountered by migrants during the post-arrival phase. Conditions in the country of origin can continue to influence the health of immigrants to the UK, not only during the course of their lifetimes, but also among succeeding generations. This may partly reflect the incubation period for the disease or the need for ongoing attention to treat health problems acquired prior to residence in the UK. In cross-generational terms, however, this reflects the likelihood that migration does not constitute a once and for all break with the country of origin. THRs associated with visits to friends and relations place tourist activities of particular ethnic groups among those factors most likely to contribute to travel-related disease, with some evidence suggesting that British-born children of immigrants are particularly vulnerable.

In seeking to account for the higher rates of tuberculosis among ethnic minorities, Parsons and Atkinson (1999) offer three potential explanations:

- infection acquired abroad only becomes clinically manifest in the UK because of long incubation periods for the disease (lead times);
- people coming to the UK arrive healthy but become infected or re-infected in the UK because of bad housing, overcrowding or poor working conditions; and
- a few people come to the UK seeking treatment although these numbers do not contribute statistically significantly to the increased numbers seen.

The relative significance of migration and poverty in explaining the high levels of TB in some of the UK's larger cities remains contested. Research into the standards of living of migrants in the UK emphasises the polarised nature of outcomes. While migrants are disproportionately evident among high-income earners, they are also over represented among the poor (Glover et al. 2001). This experience of poverty can place many migrants and their children in the sort of living and working conditions that are conducive to TB infection. The high levels of infection among migrants cannot, therefore, be simplistically attributed to imported infection from the country of origin. A recent study to quantify variation in relative risks of TB at hospital ward level in Manchester, Liverpool, Birmingham and Cardiff did, however, identify country of birth as the most influential explanatory variable (Bennett et al.

2001). Population mobility was here accorded a clear primacy, with poverty indicators being of secondary importance.

Finally, although a very minor feature in the overall epidemiology of the disease, TB illustrates the potentially direct infectious consequences of travel. A contact tracing exercise conducted after the death from TB of a woman who had flown in 1994 from Honolulu to Chicago, then to Baltimore and back, established that transmission to five other passengers had occurred during the flight, with transmission associated with seating proximity and flight duration (Cossar 1997).

3.5 Transborder health risks: Refugees and asylum seekers

As outlined above, there has been a significant increase in recent years in the numbers of people lodging applications for asylum within the UK, an increase that has led to a remarkably high political salience being attached to issues surrounding refugees and asylum seekers. The prevailing hostility of media comment, particularly within the tabloid press, has encouraged a governmental response characterised by a clear concern to be perceived as firm, with discourse conducted overwhelmingly in terms of immigration control rather than human rights and the Geneva Convention. Both the rising numbers of refugees and asylum seekers, and the strident nature of media and policy responses, brings increased attention to the diverse health problems often encountered by individuals within these categories and the particular difficulties experienced in addressing them.

Such problems can clearly be understood in terms of THRs associated with population mobility, and can be considered in terms of two broad categories. First, there are health issues that are intrinsically associated with the refugee experience, and are overwhelmingly shaped by circumstances and experiences in the country of origin and of the subsequent journey and exile. Second, there are health issues that arise as a consequence of the particular ways in which the receiving country administers refugees and asylum seekers. In terms of the functional approach to migration health outlined by Gushulak and MacPherson (2001), the former encompasses the pre-departure and journey phases, and the latter addresses health issues following arrival in the destination country. Given the focus of this study, following a brief discussion of the general health problems confronting many refugees and asylum seekers internationally, attention will primarily focus on problems experienced as a result of UK-specific factors.

Box 3.1: Definitions

Refugee: A refugee is a person who has fled his or her home country and is unable or unwilling to return because of a well-founded fear of being persecuted for reasons of race, religion, nationality, political opinion or membership of a particular social group.

Refugee status: A person is officially recognised as a refugee when the government of the receiving country decides that they meet the definition of a refugee under the 1951 UN Convention Relating to the Status of Refugees. A person with refugee status is given indefinite leave to remain in the UK.

Asylum seeker: An asylum seeker is a person who flees his or her home country and seeks refugee status in another country, possibly because of war or human rights abuses. Under Part VI of the UK Immigration and Asylum Act 1999, the term asylum seeker includes people who claim that their removal from the UK will breach Article 3 of the European Convention on Human Rights that prohibits torture, inhuman or degrading treatment or punishment.

Exceptional leave to remain or exceptional leave to enter: These entitlements are granted to an asylum seeker who, despite failing to meet the strict definition of a refugee, is allowed to stay in the UK for a definitive period for other reasons, for example, because it would be dangerous for them to return to their home country. Those granted either status may apply for settlement after four years.

Source: RefAid (2002)

3.5.1 Common health issues among refugees and asylum seekers

It is important to recognise that the majority of individual refugees and asylum seekers do not have specific health needs. Such individuals are largely young and comparatively fit, and even for those that do experience problems, health may well be a comparatively low priority in comparison with the challenges of finding accommodation, food and work (Burnett and Peel 2001). In a similar vein, refugees and asylum seekers should not be regarded as an undifferentiated group. Any limited homogeneity is liable to attach solely to the particular ways in which receiving countries address individuals of hugely differing origins, cultures and experiences.

These important provisos notwithstanding, it is scarcely surprising that the dramatic circumstances that instigate or accompany the process of pursuing refugee status are frequently associated with significant health impacts. Research into the health of refugees upon arrival in Australia highlights the frequently damaging impacts associated with the refugee experience.

> Refugees entering Australia have a higher rate of long-term medical and psychological conditions than other migrants, tend to report a poorer state of well-being and visit health care providers more frequently… Humanitarian entrants will almost certainly have been exposed to traumatic events such as prolonged periods of deprivation, the loss of loved

> ones or a perilous escape from their homelands. In addition, a significant proportion has been subject to severe physical and/or psychological torture. There is now a large body of evidence that this exposure may have long-term physical and psychological sequelae. (Victoria Foundation n/d: 15)

While mental health issues may be particularly prominent, there is a great diversity in the health concerns experienced by refugees (Table 3.2).

Table 3.2: Specific Health Concerns of Refugee Patients

Antenatal care and refugee women	Immunisation
Dental disease	Infectious and parasitic diseases
Depression and anxiety	Nutrition and diet
Eating difficulties	Post-traumatic stress disorder
Failure to thrive (children < 2 years)	Psychosomatic disorders
Family violence	Sexual assault
Female genital mutiliation	Tuberculosis
Hepatitis B	

Source: Adapted from Victoria Foundation (n/d: 75).

A comparable diversity in health issues has been identified among refugees and asylum seekers in the UK. Health problems that have been identified as specific to and characteristic of individuals within such groups include:

- physical after-effects of war, torture, displacement and fleeing from country of origin;
- problems linked to country of origin or prevailing socio-economic circumstances, including HIV/AIDS, poor nutrition, or communicable diseases (among which TB is most significant from a public health perspective); and
- mental health problems following trauma and more widespread social and psychological problems associated with loss of status, coping with a new culture etc. (Lowdell and Daniell 1999; Audit Commission 2000).

As regards prevalence of such problems among refugees and asylum seekers, studies indicate that one in six refugees has a physical health problem severe enough to affect their life, whereas two-thirds have experienced anxiety and depression (cited in Burnett and Peel 2001b). A recent health needs assessment of asylum seekers in Sunderland and North Tyneside highlighted an overall low rate of immunisation as well as low levels of screening for cervical cancer and tuberculosis (Blackwell et al. 2002).

3.5.2 Health of refugees and asylum seekers: Problems encountered in the UK

The above might be largely regarded as relatively universal examples of the THRs to which a significant proportion of refugees and asylum seekers are liable to be subject within receiving

countries. It has become increasingly clear, however, that health problems encountered by such individuals within the UK are not confined to these intrinsic difficulties. There are a number of features of the experiences of refugees and asylum seekers following their arrival in the UK that can exacerbate their health. It is worth noting that some reports indicate that the health of such entrants actually deteriorates during the two to three years following arrival in the UK (Jacobsen 1999; Cowen 2001). In part such deterioration is likely to reflect poverty and social exclusion experienced by other marginalised social groups. But policies ostensibly designed to support new immigrants are increasingly recognised as actually harmful, reflecting the manner in which asylum policy has been shaped by an emphasis on demonstrating a restrictive approach to immigration.

Inadequacies of initial health assessments and screening

From the perspective of both the health of refugees and asylum seekers, and of broader public health in the UK, this report finds that the current system of initially appraising health status raises concern. A report by the Audit Commission (2000) highlights the absence of a systematic approach to assessing the health needs of new arrivals. The closest approximation to such a system occurs at the major receiving airports, Heathrow and Gatwick, where claimants arriving from countries classified by WHO as 'high risk' may be referred to the Port Health Control Unit (PHCU). Even here, however, there are fundamental problems in operation and administration:

> These units see some 25 per cent of new asylum seekers each year and have medical officers present 24 hours a day. The process usually involves screening for TB, but medical examinations are often cursory. Follow-up procedures are also poor – there are often practical problems in making further contact with such a highly mobile group, and there is no consistent tracking of those who are screened on arrival. For example, Liverpool Health Authority reported that it receives no information on asylum seekers from Port Health Control, and TB screening has to be repeated (Audit Commission 2000).

The British Medical Association (BMA), in contrast, recommends that all refugees and asylum seekers receive thorough medical examinations upon arrival, acknowledging the limited effectiveness of those undertaken by under-resourced port medical officers. A particular concern lies in poor recognition of indicators of torture and maltreatment in countries of origin, which can have serious implications for the outcome of the asylum application, as well as for the health of the individual (BMA 2001).

Difficulties are far more pronounced elsewhere, and no health screening of asylum seekers is carried out at the channel ports or cargo ports (Burnett and Peel 2001b). The absence of any health assessment may also characterise the experience of those that apply for asylum in-country, rather than at port of entry, and to applicants from countries not accorded high risk status by WHO. Such gaps in coverage place a premium upon health checks undertaken when asylum seekers later seek access to primary health care. A survey of GPs in London highlighted the haphazard and sporadic nature of practice at this level, with the majority not checking vaccination status. Only 3 of 58 GPs checked for mental health problems, while 28% did not offer health screening to asylum seekers (Hargreaves et al. 1999).

Obtaining access to primary health care

A significant factor in the limited success in addressing the health needs of refugees and asylum seekers lies in the problems in obtaining satisfactory access to primary health care. The most extreme example of such problems is the reported refusal of some GPs to register asylum seekers. Young, single and homeless people have often found it impossible to register with GPs (Burnett and Peel 2001a), while a recent report by a refugee health access project in Barnet noted that clients were sometimes misleadingly informed that a surgery's list was full (Cowen 2001). More commonly, the practice of only giving temporary registration to refugees and asylum seekers leads to absent medical records, poor continuity of care and non-receipt of health check, screening and immunisation (Audit Commission 2000).

These problems of access may reflect a lack of awareness among health workers and professionals of the entitlement of refugees and asylum seekers to free basic health care. All asylum seekers are unambiguously entitled to full registration, and there is no obligation for doctors to check immigration status or passports. The general unfamiliarity of practitioners with issues confronting refugees has also been identified as problematic, with lack of experience reflected in uncertainty in addressing issues such as torture and associated problems (BMA 2001). This lack of expertise is indicative of the extent to which asylum seekers and refugees can often be perceived as problematic patients, and some GPs have reported that consultations can take three or four times longer than for other patients (Audit Commission 2000).

The lack of familiarity by asylum seekers with the health system in the UK constitutes a predictable obstacle to effective access. This is exacerbated by a lack of accessible information. For example, upon being granted temporary permission to stay, applicants are sent a standard letter by local health authorities (BMA 2001). Understandable suspicion of public officials is often a barrier to effective health care, and the perception of confidentiality can be impaired by the shortage of appropriately trained interpreters. Linguistic and cultural differences clearly impact on the success with which health care is accessed, and can pose particular problems for the provision of specialist services such as mental health services for victims of torture. The inadequacy of provision to the wider community can also exacerbate the problems confronting refugees; it has been reported that "severe cases of post-traumatic stress disorder and depression are neglected because of long waiting lists for mainstream mental health services – the latter are often running at capacity for the whole population and can take on only high-risk cases" (Audit Commission 2000).

Inequity in provision of financial support

The restricted level and particular nature of support for asylum seekers since the UK Immigration and Asylum Act 1999 has led to concerns regarding the implications for health. Under the Act, previous entitlement to social security benefits was replaced by the introduction of a restrictive system of vouchers. The concept of the voucher system was severely criticised from the outset as stigmatising, likely to exacerbate social exclusion and punitive in intention, and its subsequent operation has been accompanied by reports of worrying health impacts.

The low level of benefits accorded to asylum seekers is intrinsically problematic. Vouchers do not provide equivalence with levels of support given to other recipients of social security payments. Under the voucher system, asylum seekers are restricted to just 70% of the income support received by UK citizens, while particular categories of asylum seekers are also denied benefits that other recipients with similar needs can expect to receive. Thus elderly asylum seekers need to cope on less than half the level UK pensioners are entitled to under the Minimum Income Guarantee, disability benefits are excluded, children do not receive milk tokens, and maternity benefits are restricted (Woodhead 2000; Refugee Council et al. 2000).

The utility of benefits to asylum seekers is further undermined by the idiosyncratic way in which the voucher system has operated. Most notorious among these has been the condition preventing shopkeepers from giving change when vouchers are used, placing an onus on asylum seekers to ensure that shopping bills reach an exact figure. Such a burden on new arrivals can be time consuming at store checkouts, heightening the visibility of such exchanges, and adding to the potential for stigma. The limited range of outlets at which vouchers can be used limits the range of shops asylum seekers can shop, often having to travel to supermarkets rather than use shops at which staple foods of their country of origin are available more cheaply and easily.

The cumulative impact of such problems in the operation of the voucher system is reflected in findings of ill-health made by groups working with asylum seekers. In one national survey of 50 such support organisations:

- 92% reported that asylum seekers were not coping well with the voucher scheme;
- 82% said that they were unable to buy sufficient food;
- 70% had seen cases of asylum seekers experiencing hunger; and
- only 2% felt that it was possible for asylum seekers to maintain good health under the voucher system (Refugee Council et al. 2000).

In response to a questionnaire conducted by a refugee health access project in Barnet, 41% of people attributed physical health problems and 41% anxiety or depression to the low level of support received through vouchers, while almost one in three reported that they lacked food (Cowen 2000).

The policy of dispersal

A policy of dispersal of asylum seekers has operated in tandem with the system of social support via vouchers. In line with other forms of migration (Glover et al. 2001), the vast majority of refugees and asylum seekers have chosen to settle in London and the southeast, with 85% estimated to live in London (Lowdell and Daniell 1999). Following complaints of an overwhelming burden on social services for some local authorities, as well as high profile tensions among communities in towns such as Dover and Folkestone, a policy of dispersing individuals to other parts of the country was adopted under the UK Immigration and Asylum Act 1999. Continued receipt of social welfare support is contingent upon accepting allocated accommodation, regardless of the location of this offer. The policy also signalled a reduction in the autonomy of asylum seekers.

Whereas the stated intention of the dispersal system is the creation of clusters of support services for specific communities, any burden of which should be shared out by local authorities throughout the country, in practice the process has been driven by the availability of social housing. This has often resulted in asylum seekers receiving poor quality or unpopular housing for which local authorities have had difficulty in finding occupants. In addition to the heightened sense of alienation accompanying seemingly random enforced movements at short notice, asylum seekers in new areas have often had to cope with racism, harassment and violence (Woodhead 2000).

While the desire to ease pressure on social services in parts of London and the southeast is understandable, given the disproportionate number of asylum seekers in the region, in practice the policy of dispersal removes often vulnerable individuals with complex needs from obvious sources of support and expertise. The ethnic diversity of London is reflected in the concentration of refugee support organisations in the capital, and it is the presence of social networks and established communities that best explains why asylum seekers are attracted to it (UNHCR 2000).

The BMA has expressed disquiet about the implications of dispersal for access to appropriate health services by asylum seekers, since the new areas to which they are moved do not have the accumulated expertise developed by familiarity with such new arrivals. The haphazard nature of the dispersal programme is epitomised by the initial failure to inform relevant Health Authorities of the imminent arrival of comparatively large numbers of asylum seekers. This absence of a systematic approach is reflected in broader public health concerns arising from a "risk of premature dispersal since screening systems for infectious diseases were already in place in areas which traditionally received large numbers of asylum seekers and immigrants but were absent or less developed elsewhere" (BMA 2001).

Underlying such reservations about the principle and operation of dispersal is the concern that it is likely to induce asylum seekers to abandon the social support system. Given that the refusal to accept allocated accommodation leads to a removal of benefits, in combination with the clear attraction of community support networks available in London, there are clear incentives to disengage from the asylum process. This may, in turn, lead to an increased reluctance or inability to access health care, as well as increased problems of destitution and social exclusion (Burnett and Peel 2001a).

Detention and delay

The detention of asylum seekers is likely to become an increasingly salient issue given the intention of the UK White Paper entitled *Secure Borders, Safe Haven* (2002) to expand places to 4,000 by spring 2003. This would represent a more than twofold increase on the number of detentions under the Immigration Act 1971 for May 2001, and a quadrupling from March 1999 (Refugee Council 2002). The frequency with which asylum seekers are currently detained in the UK has led to concerns about health impacts, particularly with regard to mental health. Often neither the decision to detain nor its duration is adequately explained to asylum seekers, who may undergo "multiple traumatic experiences" (Pourgourides et al. 1996). Detained asylum seekers are held for an average of eight months, but many are held

for a period of years (Izycki 2001). In addition to disquiet about the principle and frequency of detention, the conditions under which the policy is implemented have raised concerns. The BMA has cited the variation in standards of practice across detention centres, with criticisms about the provision of health care sometimes including a lack of 24-hour medical cover, inadequate screening for mental health problems, and high levels of medication (BMA 2001). In broader terms, the major fire at the Yarl's Wood immigration centre in February 2002 highlights the potentially serious consequences of the frustration asylum seekers feel when compelled to live in prison-like conditions, in this case in conditions of inadequate safety given the absence of a sprinkler system (Morris 2002; Foot 2002).

Overall, a persistent theme in the experience of asylum seekers in the UK is the extent to which the functioning of systems of support actually serve to inflict significant levels of stress and anxiety. The process of arrival and application for asylum is perhaps intrinsically fraught and unsettling, but the manner in which the UK attempts to provide for the needs of such arrivals exacerbates such difficulties. This is particularly evident in the ongoing difficulties in ensuring a fair and rapid determination of the application. This decision is clearly of fundamental importance to asylum seekers, and the uncertainty experienced during this period makes adaptation to new circumstances and planning for the future necessarily provisional. While speeding up the application process was a core objective of the UK White Paper entitled *Fairer, Faster and Firmer* (1998), the average processing time of 19 months remains vastly in excess of the stated goal of two months and an additional four months for an appeal (Amnesty International 2001).

3.6 Transborder health risks: Undocumented migration and trafficking

It is important to recognise that the impact of globalisation on public health is not confined to legal forms of population mobility. The significant THRs associated with illicit flows across national borders are perhaps most familiar in the case of narcotics, but there are also distinctive hazards associated with various forms of the illegal movement of people across borders and undocumented periods of residence. As a generic term, undocumented migration is generally preferred to illegal migration since it better captures the frequent tendency of migrants to drift in and out of legal status by such means as extending residency beyond the designated period of a visa (Salt and Stein 1997).

This is an area inevitably fraught with methodological problems given the practical impossibility of generating reliable data. It is, however, clear that there has been an increase in undocumented migration at the global level alongside trends in documented migration. Despite successive attempts to tighten border security, the UK is not excluded from such trends. The best available indicator of the scale of undocumented migration to the UK is the annual Control of Immigration Statistics, although such data is likely to significantly under represent the number of undocumented migrants particularly among the employed (Dobson et al. 2001). During 2000, some 47,300 illegal entrants ("persons who entered the country clandestinely or by deception') were served papers as part of enforcement proceedings. This represented more than double the 1999 figure, an increase of around 26,000, with the increase being primarily the result of more asylum decisions leading to the notice of illegal entry being served (Dudley and Harvey 2001). It appears that undocumented migration to

the UK has risen in recent years alongside trends in other categories, and especially those relating to economic incentives, part of larger European trends reflecting increased irregular migration from eastern Europe (Glover et al 2001).

From the perspective of THRs, it is important to note that the legal status of an individual migrant can have real implications for the nature and severity of risks encountered. Covert, undocumented entry is likely to be associated with the assumption of more significant health risks than arrival via officially recognised channels.

Table 3.3: Health risks, regular migrants and clandestine migrants

	Regular migrants	Clandestine migrants
Socio-economic conditions	Depending on level of integration	Poor
Environmental health risks	Variable	High
Legal rights to health system	Present	Absent
Access to health system	Difficult	Very difficult
Type of health services	Public health system	Voluntary organizations
Coverage of health services	High	Low and scattered

Source: Matteelli and El-Hamad (1996: 181).

In terms of the functional approach to migrant health outlined above, it is clear that illicit migration is strongly associated with significantly higher levels of risk across each stage of the migration process. With reference to the smuggling of migrants Gushulak and MacPherson (2000) note that:

> Due to the conditions associated with the clandestine movement of people, the adverse health effects of migration are likely to be of greater magnitude in the smuggled migrant population. These conditions include the factors contributing to the selection of the individual for smuggling, the process of smuggling, and the post-arrival consequences of being an illegal alien.

THRs associated with illicit migration are likely to be particularly pronounced in the journey and post-arrival phases, as is evident from a consideration of smuggling and trafficking respectively. Although closely linked, and often confused, it is possible to distinguish between these terms. Under the Protocol to Prevent Suppress and Punish Trafficking in Persons signed by 101 countries, an elaboration of the UN Convention against Transnational Organized Crime, trafficking is used to designate transnational migration entailing coercion:

> 'Trafficking in persons' is intended to include a range of cases where human beings are exploited by organized crime groups, where there is an element of duress involved and a transnational aspect, such as the movement of people across borders or their exploitation within a country by a transnational organized crime group. Trafficking is the

> '…recruitment, transportation, transfer, harbouring or receipt of persons…' by improper means, such as force, abduction, fraud, or coercion, for an improper purpose, such as forced or coerced labour, servitude, slavery or sexual exploitation (UNDCP 2002).

In contrast to post-entry coercion and exploitation usually associated with trafficking, migrant smuggling occurs where "an individual requests assistance to cross into another nation state where (s)he has no right of residence and the smuggler's involvement goes no further than the crossing of the border" (IOM 2000).

3.6.1 Migrant smuggling

The recurring high-profile deaths of undocumented migrants attempting to covertly cross national borders dramatically illustrate the particular severity of THRs associated with illegal migration. In December 2001, 13 refugees entered a shipping container in Zeebrugge expecting to be transported to the UK, but only five survived the suffocating conditions by the time the sealed unit was re-opened five days later in the Irish port of Wexford (Kelso 2001). Most infamously, 58 people from Fujian province in eastern China were found dead at Dover in June 2000. The migrants suffocated in the sealed container of a lorry with only two survivors (Kelso 2000). The Channel Tunnel has repeatedly been the target of regular and increasingly desperate attempts to enter the UK, with two pregnant women among nine Romanians discovered in a small compartment underneath a train in March 2001 (Allison 2001). Elsewhere in Europe similar incidents have yielded tragedies and narrow escapes. In 1997 hundreds of illegal immigrants were killed in a shipping incident off the coast of Sicily (Salt 1997), while up to 1,000 Iraqi and Turkish Kurds were rescued from a grounded vessel off the French coast in February 2001 (Beaumont, Henley and Barnes 2001).

The attempts by migrants to illegally enter the UK inevitably entail heightened risks by comparison with more regulated forms of transit. As in the cases above, such risks may be largely attributable to the unsuitable nature of vehicles deployed in an attempt to pass borders unnoticed, but they may also reflect the broader criminal milieu in which such migrants must move. Migrant smuggling, for example, may occur alongside that of narcotics or contraband tobacco:

> the very nature of smuggling entails other risks and may be associated with other illegal activities that would put the health of the migrant at risk. Co-smuggling of people and contraband goods such as drugs and other valuables (cash, gold, gems, art, and artefacts) may actually place the health and life of the migrant at greater risk during search, seizure, or flight from the authorities (Gushulak and MacPherson 2000: 72).

While such incidents are perhaps likely to occur wherever border controls operate, it is clear that the nature of immigration policy in the UK and the EU has increasingly served to compel refugees, asylum seekers and undocumented migrants to seek out the services of smugglers. Among the elements underpinning this imperative are the impossibility of arriving legally as an asylum seeker in the UK, the particularly restrictive nature of British immigration policy, and the increasing trend towards a policy of "Fortress Europe."

The expansion of visa requirements, acting in combination with the above mentioned

restrictiveness of legislation, shifts some of the burden of border control onto transport providers. This makes it practically impossible for refugees to travel to the UK without resort to smugglers. The Immigration (Carriers Liability) Act introduced this process by providing for fines of airlines of £2,000 per passenger that they bring to the UK without the correct visa, which almost by definition covers refugees. The extension of such provisions to cover lorries and the Channel Tunnel via the Immigration and Asylum Act 1999 removed the remaining legal means of reaching the UK safely (Asylum Aid 2002). This is indicative of the tightening of immigration policy from the 1962 Commonwealth Immigration Act onwards (Graham 2000).

Such restrictions are in line with a broader trend among western European countries, and particularly within EU members, largely in response to an increase in asylum applications, an approach that has given rise to the label "Fortress Europe" (Graham 2000). This is epitomised by the development of the "safe third country" rule among EU states under the Dublin Convention of 1997. This means of limiting obligations to asylum seekers is designed to shift the burden of dealing with asylum applications on to the first "safe" country entered rather than on the final country of destination (Human Rights Watch 1999).

These legislative trends are, of course, far removed from the traditional parameters of health policy but they do have significant implications for exacerbating THRs. The absence of legal means of arrival in the UK, and the restrictive nature of UK immigration policy, pushes refugees and economic migrants alike into the hands of smugglers and traffickers. As one immigration adviser to the Chinese community explained to the Select Committee on Home Affairs in the aftermath of the Dover tragedy:

> There is a severe shortage of labour in the UK Chinese food industry. Earnings in China are 1/20th of those in the UK. Chinese immigration trafficking is the result of the Government's refusal to admit a controlled flow of legal immigration. Economic migrants are forced to become asylum-seekers …. The current cost in coming to the UK is in excess of 200,000 RMB (£16,500), equivalent to at least 30 years' savings in China for an average migrant. Those who cannot raise the money from relatives and friends have to borrow from loan sharks or Snakeheads, in which case a guarantor is involved. Interest is currently 2-2.5% per month compound. Punishment for non-repayment is severe. Beatings and maiming are common (Select Committee on Home Affairs 2001).

3.6.2 Trafficking

The vulnerability of some illegal entrants in the post-arrival phase is most dramatically illustrated by the case of trafficked migrants. This is again an area in which the generation of reliable data is impossible. At least 71 women are known to have been trafficked into commercial sex work in the UK in 1998, although it is likely that the real figure is several times greater. A recent report for the Home Office produced an annual estimate of between 142 and 1420 women trafficked into the UK (Kelly and Regan 2000). The contemporary phenomenon of trafficking became evident a decade ago in brothels controlled by Triads, and police and immigration officers have subsequently become aware of trafficking to the UK from South America, Thailand, and central and eastern Europe.

Table 3.4: Sending countries and trafficking routes to the UK

Region of origin	Sending countries	Routes
South America	Brazil	via Lisbon
South East Asia	Thailand, Philippines, Malaysia, Hong Kong, Singapore	Air direct into Heathrow or via mainland Europe, and rail via Eurostar
Central/Eastern Europe	Lithuania, Hungary, Ukraine, Belarus	Various trans-Europe routes by air, sea and rail (Eurostar) eg through Greece and Italy, then to the UK
East and West Africa	Nigeria, Ghana, Kenya, Uganda	Air direct or via mainland Europe

Source: Kelly and Regan (2000).

Although evidence seems to point towards increasing numbers of trafficked migrants, their significance to public health is primarily qualitative rather than quantitative. It is the severity of THRs encountered by such groups that commands attention, risks created and perpetuated by the coercive circumstances in which trafficked migrants find themselves.

Trafficking is most frequently associated with commercial sex work, with deception, threats and violence exercised in the control exerted by brothel owners and pimps over women indebted by the costs of transit to the UK. According to one researcher working on trafficking, "(t)hese women are some of the most disenfranchised you're ever likely to meet. The occupational hazards of their job are rape, murder and HIV, and with no documents, they're not likely to walk into a police station and report any problems" (Taylor 2001). There are also suggestions that this vulnerability compels trafficked women from Eastern Europe to work in the sex industry without protection, heightening the risk of HIV and other STDs (Burrell 2002).

There is also increasing concern about the extent of the involvement of children in trafficking. Attention has particularly focused on the fate of young asylum seekers who have gone missing, with 66 having disappeared in West Sussex since 1995. Children are used in benefit fraud, and may be forced to work in sweatshops or commercial sex work, while debt bondage and threats to family command compliance (*The Guardian* 2002).

3.6.3 Undocumented migration and public health in the UK

While the THRs associated with illegal or undocumented migration are undoubtedly confronted most seriously by the migrants themselves, the connotations of such illegal movements imply that local populations in receiving countries may also be at risk. There is a tendency to treat such broader public health risks in rather dramatic terms, as epitomised by the recent statement of a senior police officer that the increasing number of trafficked commercial sex workers in the UK represented a "time bomb" for HIV/AIDS and other serious

health problems (Burrell 2002). While such risks are inevitably beyond accurate quantification, at the very least public health is not well-served by restrictions in access to basic health care regardless of legal entitlement. In the case of trafficking, for example,

> The irregular or illegal immigration status experienced by most migrants who complete a trafficked journey can … limit both the desire to seek and the ability to receive adequate health care. In many cases migrants may avoid seeking treatment for fear of immigration-related repercussions. Less than adequate health care can result in sub-optimal disease prevention and control in the community where the trafficked migrant resides, leading to increased local prevalence of both communicable and non-communicable diseases. (Gushulak and MacPherson 2000)

Research in the Netherlands, after the passage of a 1998 law excluding illegal immigrants from national health insurance cover, indicated that their health was endangered. Reliant on a small network of doctors who do not object to their illegal status, pregnant women delayed seeking help until late in pregnancy, while referrals often failed through lack of funding or fear of expulsion (Sheldon 2001). Reflecting similar concerns, the BMA highlights the "humanitarian and public health arguments for providing basic health care for any illegal immigrants in a host country" (BMA 2001).

3.7 Conclusions: Shifting the frontier of transborder health risks

This chapter concludes that historical methods of regulating THRs, focused on the assertion of control over national boundaries, are ill-suited to coping with the challenges posed by the scale and speed of population mobility characteristic of recent trends in globalisation. This is most easily illustrated by attempts to curtail the transmission of infectious diseases across borders. As MacPherson (2001) observes:

> There is almost no place on Earth that cannot be reached by a migrant or a product, within 1-2 days of travel. The impact of this phenomenon is that the frontier, the historical barrier to the movement of contagion, has shifted from the quarantine station to clinical presentation at the local hospital or community centre or domestic residence. With this shift, the traditional public health barriers to transmissible virulent diseases, by exclusion and detention, have been effectively bypassed. (MacPherson 2001)

This reduction of the utility of traditional modes of public health protection, centred on points of entry, is the inevitable consequence of twentieth-century technological developments and socioeconomic trends by which long-distance journey times decisively outstripped incubation periods and the numbers of people crossing national borders increased exponentially.

In the UK context, such observations raise questions about the role of Port Health Control Units. The BMA has attributed the frequently cursory nature of examinations given to asylum seekers at PHCUs to a lack of funding and insufficient staff (BMA 2001). There are, however, more fundamental issues surrounding the capacity of PHCUs to cope given the vast numbers of people entering the UK on a daily basis. Only around one-quarter of asylum seekers entering the UK each year are seen by Port Health Control, and the volume of

passenger traffic means that the screening process is perhaps inevitably rather haphazard. As the director of the TB Research Unit in Liverpool, Peter Davies, put it: "All they can do is spot people who are coughing and screen them - the rest are randomly selected" (Carlowe 2001).

While there may be ways of improving the performance of PHCUs, it is clear that the physical border of the state is no longer the appropriate focus for seeking to manage the transnational spread of disease. The rapidity, reach and scale of contemporary travel patterns make the effective performance of such a function at ports of entry impossible. As David Heymann, Executive Director for Communicable Diseases at WHO recently stated to the US Senate Committee on Foreign Relations:

> The phenomenal recent increase in global travel and trade has given microbes multiple opportunities to spread around the globe in novel ways and with unprecedented speed. Microbes can incubate in apparently healthy travellers, hide in food, animals, or cargo, or be carried by insects stowed away in the cabin and luggage holds of jets or in the pots of exotic plants… In just the past two years, unexpected outbreaks of relatively new or previously rare diseases have taken populations on every continent by surprise… In the face of such highly mobile, microscopic and easily disguised threats, national borders are porous. An outbreak anywhere in the world must now be considered a threat everywhere else. (Heymann 2001)

The challenges of such rapid movement of pathogens therefore require complex communications systems for early alert and real-time outbreak detection, as envisaged in WHO's development of an integrated approach to communicable disease surveillance (WHO 2000).

A clear corollary of this declining ability of port-centred enforcement to effectively regulate THRs is, therefore, a necessary shift in emphasis towards ensuring effective access to health care services in-country. The basic question in the transnational dimensions of disease control shifts from "How can we exclude or detain acutely infected travellers?" to "How can the awareness of health risks and access to health services be maximized for migrants and tourists?"

Such a shift from frontline borders would also be better suited to the task of addressing the diversity of THRs associated with population mobility. The primacy historically accorded to preventing the geographical spread of a handful of acute infectious diseases needs to be challenged. This reflects the diversity of emerging and re-emerging infectious disease, the economic and social significance to destination countries of chronic infection among migrants, and, significantly, the importance of recognising that THRs are not confined to communicable diseases. As MacPherson (2001) has recently noted, additional "health characteristics of mobile populations and their outcomes, such as cancer, cardiovascular disease and stroke, fertility and fecundity as well as ageing, are emerging as having significance with respect to mobile populations and global health". Such characteristics need to be considered in combination with the wide-ranging health risks associated with pre-departure, *en route*, and post-arrival phases, and with the distinctive problems associated with specific groups of migrants and tourists.

CHAPTER 4. **UK PUBLIC HEALTH AND THE GLOBAL CHALLENGE OF TOBACCO CONTROL**

4.1 Introduction

The complex intertwining of transborder health risks and opportunities associated with globalisation, as discussed in Chapter 1, is well-illustrated by recent developments with regard to tobacco control. Analysis of these developments assists understanding of the complex issues surrounding the tobacco industry and tobacco control efforts, as well as the varied health impacts of globalisation. More specifically, there are several compelling reasons for selecting tobacco control as a case study in the context of this study:

- scale of the burden of disease from tobacco use worldwide and in the UK;
- recent and predicted trends in the nature of the pandemic;
- trends in the structure and activities of the tobacco industry;
- global significance of UK tobacco companies;
- emergent tensions between trade and public health policies;
- illustration of the multiple spheres and dimensions of globalisation;
- encompassing of illicit forms that globalisation can take;
- exposing challenges to primacy of the state and to national health governance; and
- the unique analytical value of tobacco industry documents to informing public health policy and practice.

These themes are addressed in this chapter in two main ways. First, the chapter begins by reviewing the trends in the global burden of disease from tobacco-related disease, followed by a discussion of the changing structure of the tobacco industry. This complements the assessment of the public health implications of increasing population mobility addressed in Chapter Three. Tobacco manufacture, consumption and control are discussed in relation

to the intensification of flows of goods and services, capital and finance, and ideas, knowledge and cultures. Second, the global dimensions of tobacco control are examined in relation to health governance in the UK. This includes a discussion of UK public health efforts, and the implications of devolution, membership of the European Union and World Health Organisation. The chapter concludes with a brief assessment of the significant opportunities that globalisation offers for combating the pandemic of tobacco-related death and disease.

4.2 Globalisation and tobacco

4.2.1 The global pandemic of tobacco-related death and disease

The starting point for any discussion of tobacco in the context of globalisation is a recognition of the magnitude of the global health impacts of tobacco. World cigarette consumption increased by around 50% between 1975-96 (Chaloupka and Corbett 1998), and a total of 5.3 trillion cigarettes were consumed in 1997 (Knight et al 1998). The public health impact of this rise in consumption is significant. It is estimated that some four million deaths per year are attributable to tobacco, representing around one in ten adult deaths. By 2030 the total number of deaths attributable to tobacco are expected to rise dramatically to some 10 million deaths. Such figures suggest that around 500 million people that are alive today will eventually be killed by tobacco. This expansion in the burden of disease from tobacco is also characterised by increasing inequity in its distribution. Smoking-related deaths were once confined largely to men in high-income countries, a reflection of smoking patterns over the last three to four decades. There is now a marked shift in smoking patterns, with a clear shift from high to middle and low-income countries. This will be followed in due course by rapidly rising trends in tobacco-related diseases in coming decades. By 2030 70% of deaths from tobacco will occur in the developing world, up from around 50% at present (WHO 1999a; Jha and Chaloupka 1999).

Tobacco consumption also constitutes the single greatest cause of preventable illness and premature death in the UK. According to the 1998 White Paper 'Smoking Kills':

- smoking kills over 120,000 people each year in the UK;
- for every 1,000 20-year-old smokers, it is estimated that one will be murdered, six will die in motor accidents, 250 will die in middle age from smoking, and 250 will die in older age from smoking;
- smoking causes 84% of deaths from lung cancer and 83% of deaths from chronic obstructive lung disease;
- smoking causes 1 out of every 7 deaths from heart disease totalling 40,300 deaths a year in the UK from all circulatory diseases; and
- smoking, more than any other identifiable factor, contributes to the gap in health life expectancy between those most in need and those most advantaged (HMSO 1998a).

4.2.2 The changing structure of the tobacco industry

These trends in mortality and morbidity reflect the shifts in the tobacco industry and, in particular, the changing strategies and priorities of transnational tobacco companies (TTCs). The globalisation of the tobacco industry is reflected by the fact that 75% of the world cigarette market is now controlled by just four companies: Philip Morris (PM), British American Tobacco (BAT), Japan Tobacco/RJ Reynolds and the China National Tobacco Corporation (Crescenti 1999). The latter's share can be solely attributed to its dominance of the enormous Chinese market, but the remainder have been assiduous in their pursuit of growth through worldwide expansion. Each company now owns or leases plants in at least fifty countries throughout the world (Hammond 1998). Philip Morris (PM) saw its global revenues increase by 226 percent to US$27.4 billion between 1989-99 (WCTOH 2000), during which there was a transformation in the comparative profitability of its domestic and international tobacco operations. Whereas in 1989 PM's tobacco operations in the US provided profits of US$3.1 billion compared with US$0.8 billion internationally, the relative balance almost reversed by 1998, with domestic profits of US$1.5 billion dwarfed by US$5 billion of international profits (Joosens and Ritthiphakdee 2000).

The shift towards dominance by a handful of actors is also characteristic of the growing trade in tobacco. Recent years have seen the number of major companies involved in the purchasing, processing and shipment of raw tobacco fall from eight to three. Universal Corporation, Dimon Incorporated and Standard Commercial Corporation now dominate the global trade in tobacco leaf with combined revenues of US$7.9 billion in 1997 (Hammond 1998). These broad trends in the tobacco industry mirror the rapid growth in trade figures in recent years. The period from 1994-97 witnessed a 12.5% increase in unmanufactured tobacco exports globally, following a decade of negligible growth. Cigarette exports were relatively stable between 1975 and 1985, began to steadily rise thereafter, and grew by 42% between 1993-96 (Taylor et al. 2000). The disparity in consumption and production trends in the United States during this period is striking.

> [O]verall tobacco consumption declined by about 20 per cent during 1975-95, from 607.2 billion cigarettes in 1975 to 487.0 billion in 1995, while total production rose by almost 15 per cent during the same period. A 370 per cent surge in cigarette exports accounts for the difference. (Chaloupka and Corbett 1998)

This pattern is of particular significance given the position of the US in world tobacco trade, but it is not unrepresentative of broader trends across many high-income countries.

This dramatic expansion in the scale of trade in tobacco and tobacco products has been greatly assisted by developments in trade liberalisation. The Uruguay Round concluded in 1994 brought an expansion of the GATT trading regime to cover agricultural products, including tobacco, an inclusion that is emblematic of a broad dismantling of barriers to tobacco trade through numerous international, regional and bilateral trade agreements (Chaloupka and Corbett 1998). Regime change in central and Eastern Europe has reinforced this trend. BAT's then chairman Sir Patrick Sheehy noted in 1993 that "the tobacco markets open to our products have actually tripled in size in recent years, under the twin impact of market liberalisations across the northern hemisphere and the crumbling of monolithic communism east of the river Elbe" (Sheehy 1993).

The opening of cigarette markets in Asia to competition from western-based TTCs has been particularly significant, both to the development of the global industry, and in exacerbating the tobacco epidemic. This is illustrated by research into the effects of the so-called Section 301 agreements by which access to the markets of Japan, South Korea, Taiwan and Thailand was gained following the threat of trade sanctions by the US and, in the Thai case, adjudication by GATT. It has been estimated that the opening of these markets increased per capita cigarette consumption by an average of 10% by 1991 (Chaloupka and Laixuthai 1996).

From the perspective of global public health policy, it is important to note that trade liberalisation seems to have had a variable effect on tobacco consumption across different countries. Trade liberalisation has led to increased consumption of tobacco overall but, while it has no substantive effect on higher-income countries, it has had a large and significant impact on smoking in low-income countries and a significant, if smaller, impact on middle-income countries (Taylor et al. 2000).

It is also important to recognise the significance of the illicit aspects of this recent expansion in the global trade in tobacco products, with smuggled cigarettes having been estimated to account for around one-third of total exports worldwide (Joossens 1998). This has important implications for public health policy, since the lower prices of cigarettes that have avoided duty undermine the effectiveness of taxation in curtailing consumption (Joossens et al 2000).

In common with tobacco companies based in other countries, the UK tobacco industry has had to solve the dilemma of how to maintain profitability in a context of long-term decline in consumption in its traditional markets. This has been achieved through the aggressive pursuit of worldwide expansion, notably targeted at emerging markets in low and middle-income countries. Domestically, the UK's cigarette market is dominated by Gallaher and Imperial which together account for around 81% of total sales (BBC News 2001). These companies have been primarily based on domestic sales, but are spectacularly reinventing themselves as international tobacco companies. Gallaher's international operations generated operating profits of £87.9 million in 2000, an increase of 20.4% on the preceding year, and accounted for 64.7% of total cigarette unit sales. This included sales of 23.1 billion cigarettes within the Commonwealth of Independent States (CIS), representing 56% of total international volume, while a further 4.9 billion cigarettes (11.8%) were sold in the group's "new emerging markets, principally in Africa and the Middle East" (Gallaher 2000). During 2001, Gallaher acquired a controlling interest in a cigarette manufacturing factory in the Ukraine (Gallaher 2001b), and made rapid progress in Asia Pacific, lifting in-market sales by over 50% in the first quarter (Gallaher 2001a).

Imperial Tobacco Group Plc is also transforming itself into a significant international company with extraordinary rapidity, as Table 4.1 illustrates. Imperial began its overseas expansion in the mid 1990s, and international sales have subsequently grown to represent over 45% of group operating profit (Imperial tobacco 2001a).[7]

7 It should be noted that reports into the involvement of Imperial Tobacco in smuggling cigarettes have cast doubt on the authenticity of this international growth. It is alleged that over half of its exports return to the UK as contraband (ASH 2001e).

Table 4.1: Imperial Tobacco Group Plc Operating Profits (£ millions)

	United Kingdom	International	Total
1997	312	79	391
1998	319	117	436
1999	330	188	518
2000	329	231	560
2001*	325	279	604

* Preliminary results for year ended 29 September 2001-12-04

Source: Imperial Tobacco 2001a, 2001b.

This shift in operations is indicative of Imperial's attempt to implement the "strategic evolution of the Group from its UK roots into a multi-national group with worldwide tobacco interests", and represents a clear decision to become "less reliant on the profitable but declining UK market" (Imperial Tobacco 2000). The company's chairman, Gareth Davies, envisages overseas business eventually accounting for around 75% of operating profit, with the Asia Pacific region and the former Soviet bloc cited as key target markets (Slingsby 2001). In April 2001, Imperial bought a controlling stake in Tobaccor, the second largest cigarette manufacturer and distributor in Sub-Saharan Africa with substantial interests in Vietnam. Tobaccor has a market leading position in eight African countries, a region that has been targeted for substantial future growth. As Imperial (2001b) states, "we see Tobaccor as a cornerstone for the further development of a sustainable growth business in Africa".

In global terms, the significance of Gallaher and Imperial is dwarfed by British American Tobacco (BAT) which identifies itself as the world's most international tobacco group. This claim is supported by the following statistics:

- BAT now sells 900 billion cigarettes per year in 180 countries (Maguire 2000).
- 70% of BAT's cigarettes are sold in Africa, Asia, Latin America and Eastern Europe (Saloojee and Dagli 2000)
- BAT has an active market presence in 180 markets, employing almost 90,000 people worldwide (BAT 2001a)
- In 2000, BAT made an operating profit of £1800 million[8] (BAT 2001b)
- Following its merger with Rothmans, BAT now has a global market share of 16%, just behind Philip Morris with 17% (ASH 2001c).

It is not being too fanciful to suggest that the globalisation of the tobacco industry constitutes the historical *raison d'être* of BAT. BAT came into existence as a joint venture to resolve a trade dispute between the then dominant tobacco companies of the UK and the US, Imperial and

8 Distributed by region, this represented profits from operations in America-Pacific (£878m), Europe (£541m), Latin America (£425m), Amesca or Africa, the Middle East and South and Central Asia (£370m) and Asia-Pacific (£361m).

the American Tobacco Company (ATC). As part of the settlement reached in 1902, each agreed to withdraw from the other's respective domestic markets, while the BAT subsidiary was granted the trademarks, export capacity and foreign assets for all other markets. The founder of ATC James B. Duke rhetorically asked the press, at the announcement of the new venture, "Is it not a grand thing in every way that England and America should join hands in a vast enterprise rather than be in competition? Come along with me and together we will conquer the rest of the world" (Cox 2000).

Such cohesion did not last and, amid later disputes and conflicts, BAT became a predominantly British company. The settlement did, however, grant BAT an effective monopoly position in the international cigarette industry that lasted until the end of the First World War (Cox 2000). It also established BAT as a tobacco company uniquely international in its interests and operations, with strategy inevitably outward looking given the denial of access to the UK and US domestic markets. The conditions of its creation continue to influence the character of the company, and this legacy does much to explain the geographic scope of its current trading and manufacturing activities.

BAT's performance and prospects have been revitalised in recent years by political and economic developments associated with globalisation. BAT Managing Director Ulrich Herter has noted the transformation in opportunities for the TTCs:

Remember that during the 1980s, international cigarette companies were confined to competing in less than half of the world's markets, where there was little organic growth. These were economically liberalised, but largely mature markets. Since then, with the decline of communism and restrictive state monopolies, the potential competitive field for international cigarette companies has effectively doubled (Herter 2000).

Particular importance is attached to Asia Pacific, the region that accounts for 41% of the global market. Its potential is indicated by BAT's current status as the largest of the TTCs despite having only around 5% of the region's markets (Herter 2000). BAT has made major investments in Malaysia, Korea, Vietnam and Thailand in recent years, and saw profits in the region increase by US$189 million (35%) between 1999-2000 (BAT 2001a). With one-third of the world's smokers, the largely untapped Chinese market constitutes a clear priority for BAT, particularly given China's new membership in the World Trade Organisation (WTO). In March 2001, BAT announced the agreement of the Chinese government to land acquisition that will allow BAT to build a new cigarette factory in Sichuan Province.

The scale of the UK's involvement in the global trade in raw tobacco and tobacco products is shown in Table 4.2. The UK is the fourth leading importer of unmanufactured tobacco and third largest exporter of cigarettes. The principal countries of origin for the UK industry's supplies of tobacco leaf are Brazil, Zimbabwe and the US, with 33%, 16% and 11% of imports respectively. While the UK's manufactured tobacco products (overwhelmingly cigarettes) are exported to multiple and highly dispersed destinations, the Far East is the primary regional destination (41% of exports) followed by the EU (21%) and the Middle East (14%) (DTZ

9 It should be noted that the DTZ Pieda Consulting Report, *The Economic Significance of the UK Tobacco Industry in 1999*, was prepared for the Tobacco Manufacturers' Association.

Pieda Consulting 1999[9]). Trading activity on this scale is clearly significant to the national economy. The trade in manufactured tobacco products generates a notable trade surplus, estimated at £894 million in 1998, with the value of cigarette exports (£899.4 million) almost ten times the value of cigarette imports (£95.2 million). When leaf imports are taken into account, the overall trade balance in tobacco products amounted to £588 million (DTZ Pieda Consulting 1999).

Table 4.2: The involvement of the UK in the global trade in tobacco

Leading importers of unmanufactured tobacco (1999, metric tonnes dry weight)		**Leading exporters, cigarettes** (1997, million pieces)	
Russian Federation	264 670	United States	243 190
Germany	260 510	Netherlands	113 000
United States	241 065	United Kingdom	108 031
United Kingdom	137 183	Brazil	86 000
Japan	98 920	Germany	82 000
Netherlands	84 813	Singapore	70 124
World Total	2,003 068	World Total	1,073 115

Source: Chaloupka F and Nair R (2000), "International issues in the supply of tobacco: recent changes and implications for alcohol," Addiction*, 95 (Supp 4): S477-S489.*

What might be termed the economic case for tobacco may appear to be strengthened by the scale of revenues derived by the Exchequer from taxation. In 1999 the government earned around £7625 million from the tobacco industry, comprising £5830 million in tobacco duty and £1795 million in VAT (ASH 2001c). The industry's value to the Exchequer is, of course, significantly undermined by the current scale of smuggling as described above. HM Customs and Excise estimated total lost tax revenue from smuggled tobacco products at £2.5 billion in 1999 (HM Customs and Excise 2000a, 2000b). This important caveat notwithstanding, however, tobacco products represent the second most lucrative category of consumer goods, after petrol, in terms of revenue generation. While only 9,620 people were directly employed in tobacco manufacturing in 1998, those sympathetic to the industry's economic contribution emphasise the estimated 62,855 full-time equivalent jobs directly and indirectly supported by it (DTZ Pieda Consulting 1999).

The enormity of economic and financial activity generated by the tobacco industry has historically been a major impediment to tobacco control efforts at the national level. In part, this reflects a sense that the TTCs are equipped with the resources to prevent the adoption of measures that would threaten their future profitability. The increasing evidence of their pervasive influence on public policy is discussed below. More fundamentally, however, it reflects an assessment that the tobacco industry is simply too important to national

economies to jeopardise via comprehensive tobacco control and, in particular, "excessive" taxation.

Fortunately there is growing evidence of the erroneous nature of these arguments, in large part, generated by the increasing interest of the World Bank in tobacco control. A landmark in this regard has been the publication by the World Bank of the report *Curbing the Epidemic* (Jha and Chaloupka 1999), the dissemination of which has contributed greatly to recognition of the national economic benefits associated with effective tobacco control. This politically critical message has been reinforced by the more detailed exploration of economic issues surrounding tobacco use in developing countries (Jha and Chaloupka 2000). It has been estimated, for example, that an increase of cigarette taxes of 10% globally would raise cigarette tax revenues by nearly 7%, while causing nearly 42 million smokers to quit. This would, in turn, prevent a minimum of 10 million tobacco-related deaths (Sunley et al. 2000; Ranson et al. 2000). The World Bank reports that comprehensive tobacco control measures are cost-effective:

> Policies that reduce the demand for tobacco, such as a decision to increase tobacco taxes, would not cause long term job losses in the vast majority of countries. Nor would higher tobacco taxes reduce tax revenues; rather, revenues would climb in the medium term. Such policies could, in sum, bring unprecedented health benefits without harming economies (Jha and Chaloupka 1999).

In the UK, the apparently impressive economic figures cited above therefore need to be set against the enormous costs incurred as a result of tobacco consumption. Treating illness and disease caused by smoking has been estimated to cost the NHS up to £1.7 billion each year in GP visits, prescriptions, treatment and operations (Buck et al. 1997). In 1997-98, 364,200 people were admitted to NHS hospitals for smoking-related diseases, averaging 9,500 hospital beds each day. An estimated 34 million working days are lost to British industry by sick leave related to smoking (ASH 2001c).

4.2.3 Globalisation and tobacco: The cognitive dimension

Accounts of the globalisation of the tobacco epidemic understandably focus primarily on economic aspects such as the impact of trade liberalisation, the scale of smuggling, and the significance of the industry to national economies. The effects of global change are, however, much more diverse than can be addressed by a narrowly economic conception of globalisation. Trends in the development of the tobacco epidemic are indicative of the significance of what Lee (2000) terms the cognitive dimension of globalisation:

> The cognitive dimension of globalisation concerns changes to the creation and exchange of knowledge, ideas, norms, beliefs, values, cultural identities and other thought processes. How we think about ourselves and the world around us is being changed by globalisation. The causes of this are varied including the mass media, educational institutions, think tanks, scientists, consultancy firms and 'spin doctors'.

This dimension highlights the importance of efforts by TTCs to shape 'our mental frameworks' (Gill 1995) as an integral part of their strategy to secure rapid expansion in new

markets. Though these are addressed more thoroughly elsewhere (Collin 2002 forthcoming), it is important here to note the significance of attempts to establish global image and awareness of key international brands, efforts to create a 'global smoker', and the global basis of the industry's conflict with tobacco control advocates.

Developing global brands

Premium international brands constitute the fastest growing portion of the world cigarette market with annual sales growing at about five percent during the 1990s (Herter 2000). They are of key strategic significance to TTCs since they offer higher prices, production volumes, economies of scale and, crucially, opportunities to coherently build perceptions of a brand on a cross-national basis. For BAT:

> International brands are defined as those brands that are available in a number of markets and currently sell, or have the potential to sell, significant volumes in the future. They are generally priced at a higher or premium level, have consistent pack designs and communications to the smoker with a clear target consumer in mind … The fact that a "foreign" brand is sold on another market is not sufficient to justify its description as an International Brand, because the latter involves a mix of global availability, plus perception of internationality to the consumer. (BATCO Marketing Intelligence Department 1994)

The template for this strategy was set by Philip Morris' success in transforming Marlboro from a stagnant American brand in the early 1960s, to a truly transnational business phenomenon and 'one of the quintessential global brands' (Klein 2000). Marlboro continues to dwarf its competitors accounting for 8.4 percent of global cigarette consumption (Hammond 1998). Marlboro is particularly interesting case in the context of cognitive globalization because of the methods by which this dominance was achieved:

> (I)t seems safe to say that one reason why Marlboro, valued at US$31 billion, towers over competing tobacco brands is that Philip Morris has underwritten the brand with much bigger advertising expenditures (US$118 million). In contrast RJR spent US$18.7 million on Winston and US$69 million on Camel. (Ourusoff 1992)

The global rise of Marlboro is inseparable from the brilliance of its advertising and marketing. The Marlboro Man was declared by Advertising Age to be the number one advertising icon of the twentieth century (Yach and Bettcher 2000), and the campaign transformed the fortunes of the brand. It established a strong image that has been applied consistently if not uniformly across markets. In Hong Kong, for example, a local distaste for cowboys led to the Marlboro Man being depicted as driving a Jeep (Kluger 1996).

Towards the global smoker

Consumers of traditional forms of tobacco such as bidis, kreteks and chewing tobacco represent an enormous potential market for expansion by the TTCs, and attempting their conversion to white stick cigarettes represents a key means of promoting what has been referred to as the 'global smoker' (Yach and Bettcher 1999). One tobacco trade publication

has described the continuing predominance of traditional products within key markets for expansion, such as India and Indonesia, as illustrating the limits of globalization, but it is made clear that these barriers are being aggressively targeted:

> For how long will these markets resist the attraction of global trends? In one or two generations, the sons and grandsons of today's Indians may not want to smoke bidis or chew pan masala. Cigarette manufacturers seem not to be asking if, but how fast these markets will change. Global brands are one way to accelerate this process. (Crescenti 1999)

For BAT the 1130 billion bidis consumed per annum in India represent 'a potentially lucrative source of business if they can be converted to cigarettes' (Burgess 1994).

The transnational qualities conferred upon western-style white stick cigarettes by TTCs have been deployed as a key resource for increasing market share. The rise of cigarette sales has been presented as an indicator of modernity and symbol of economic progress within low-income countries. A letter from the ITC to the Minister of Health similarly emphasised that 'any Government initiative must first encourage a conversion to cigarettes, which is the internationally accepted form of tobacco use' (Chugh 1992). Such promotion has been accompanied by inferences of personal prestige and veiled health claims. In Indonesia, a BAT study of smokers of global brands found that one of the perceived advantages of white cigarettes was that 'it is less dangerous to health' (BAT Indonesia n/d). The attempt to associate cigarettes with western and, particularly, American images of freedom and prosperity is widespread. Such efforts have been particularly stark in Eastern Europe and the former Soviet Union. In the Czech Republic, for example, an ad for L&M cigarettes features a picture of the pack alongside the Statue of Liberty with a slogan translating as 'This is what America tastes like! New Arrival!' (Cunningham 1996).

The global contest with tobacco control

For the TTCs, the primary competition is not among themselves, nor even with smaller national manufacturers, but with advocates of tobacco control. Their shared stake in resisting the further spread of comprehensive regulation is more central to continued industry success than the relative fortunes of key brands. The companies view this as a genuinely globalized conflict, with the passage of effective tobacco control measures in any one country potentially 'raising the bar' in other parts of the world. TTCs have therefore engaged in highly coordinated and expensive attempts to control the multiple debates surrounding tobacco issues.

This is evident in attempts to manage the very terms on which such debates are conducted. The concern with language has been longstanding, covering diverse aspects of how the TTCs operate and are perceived. It is clear in the contemporary mantra of corporate responsibility propounded by tobacco companies. Hence Brown & Williamson proclaims that it is 'a responsible company in a controversial industry' (Brown and Williamson 2001) while adverts for Gallaher carry the tagline 'AN INTERNATIONAL TOBACCO COMPANY BEHAVING RESPONSIBLY' (Gallaher 2001). Such posturing aims to remould the way in which they are

perceived by the public and decision makers, with a subtext of having rectified errors in previous behaviour. This logic informs current industry positions on addiction. Apparent admissions on the part of TTCs that nicotine is addictive have received much media attention (BBC News 1999), but such admissions merely represent attempts to defuse the issue via its trivialization. Hence Japan Tobacco International accepts that smoking is addictive 'as the term addiction is used today', but insists that 'equating the use of cigarettes to hard drugs like heroin and cocaine, as many do, flies in the face of common sense' (Japan Tobacco International 2001). Similarly, according to the Chairman of BAT Martin Broughton (1999),

> On the matter of addiction, there are several definitions in use: under some, smoking, as well as coffee drinking and also chocolate eating, is addictive. While stopping smoking can be difficult for some, we do not consider that there is anything in cigarette smoking that removes the ability of someone to quit, as evidenced by the millions who have.

Smuggling provides a clear example of how TTCs have sought to shape the discourse within which specific policy issues are contested. Despite mounting evidence of the extent of their complicity in smuggled cigarettes, estimated to account for around one-third of total exports worldwide (Joossens 1998), they have frequently convinced policy makers that smuggling is a product of 'excessive' taxation of tobacco products. JTI insists that the "root causes of contraband are high taxes, the unforeseen consequences of trade and regulatory controls, and inadequate law enforcement" (JTI 2001), Brown & Williamson (2001) claim that 'High taxes and import restrictions or bans cause smuggling', while Gallaher (2001) asserts that the 'high taxes imposed in some countries create a situation where cigarettes and other tobacco products are increasingly being smuggled into these countries'. This claimed link is of immense significance to the tobacco companies since increased taxation is such an effective means of reducing consumption (Sunley et al. 2000; Ranson et al. 2000). Industry arguments, backed by strong media pressure, have provided the basis for changes in taxation policy in countries such as Canada and Sweden, and most recently in the UK (Cunningham 1996; Joossens et al. 2000; Bennett and Blackwell 2001).

4.3 The challenge of global tobacco control to health governance

Within the scholarly globalisation literature, much interest has been given to the apparent challenge to the preeminence of the state as the most appropriate organisational basis for politics and governance. Some authors identify a clear decline in the capacity of the modern state to exercise authoritative control within its borders. Others suggest that the effects of globalisation are more complex and differentiated, leading to simultaneous strengthening and undermining of state capacity in different spheres and with variation in such impacts across states. There is, however, broad agreement that the intensification of transborder flows characteristic of globalisation require, and are encouraging, shifting balances in the responsibilities of subnational, national, regional and international levels of governance.

For tobacco control, the increasingly global nature of this public health challenge has clear implications for health governance at all of these levels. A review of existing public health measures for tobacco control highlight the need to reassess current institutions and policies to take account of increasingly transborder issues.

4.3.1 Tobacco control in the UK

> The United Kingdom can best be classified as having modest advertising controls and modest education programs (Gray 1998).

A review of tobacco control regulation at the national level makes it difficult to challenge this rather dismissive assessment. In the continued absence of government legislation signaled in successive Labour Party manifestos, regulation of advertising and sports sponsorship remain on the basis of voluntary agreements with the industry. This is despite increasing recognition of the inadequacies and abuses of self-regulation by the tobacco industry (Hastings and MacFadyen 2000; Health Select Committee 2000). The Committee for Monitoring Agreements on Tobacco Advertising and Sponsorship oversees both the Voluntary Agreement on tobacco products' advertising and promotion and the Voluntary Agreement on Sponsorship of Sport by Tobacco Companies in the UK, the latter being subject to the notable omission of not applying to international sponsorship such as Formula One (ASH 2002).[10] Provision for restriction on smoking in public places is also largely reliant on voluntarism, via the Public Places Charter established in 1988 between the government and the hospitality industry (HMSO 1998a).

Though the UK's record with regard to taxation of tobacco products has generally been impressive in international comparative terms, the recent abandonment of the policy of annual increases threatens to undermine this. The one area in which the UK can be legitimately regarded as at the forefront of tobacco control is with respect to cessation, following last year's announcement of the availability of nicotine replacement therapies available on prescription on National No Smoking Day (ASH 2002).

The international dimensions of the tobacco epidemic have received some regulatory attention. The government's support for the development of a Framework Convention on Tobacco Control by WHO is committed by both the Department of Health's 1998 White Paper Smoking Kills (HMSO 1998a) and the Department for International Development's 2000 White Paper 'Eliminating World Poverty: Making Globalisation Work for the Poor' (HMSO 2000). In 1999 new guidelines were issued by the Foreign Office to British embasssies stating that they should not "be associated in any way with the promotion of the tobacco industry" (BBC News 1999).

An examination of tobacco control regulation at the national level, however, is inadequate either to understanding the range of control measures applicable within the UK or to addressing the future challenges of controlling the tobacco epidemic. The historic primacy of the nation state as the level at which public policy is essentially determined is increasingly questioned, and developments in tobacco control illustrate the increasing significance of sub-national and supranational governance to public health.

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10 Legislation regarding advertising appears likely to be significantly strengthened in the near future, albeit as a result of rather extraordinary parliamentary circumstances. Following the enforced abandonment of the Tobacco Advertising and Promotion Bill due to shortage of parliamentary time prior to the 2001 general election, and its surprise omission from the Queen's Speech thereafter, the Liberal Democrat peer Lord Clement-Jones introduced an almost identical bill in the House of Lords. This has now been adopted as a Government Bill, completing its committee stage in May 2002 (House of Commons Library 2002).

4.3.2 The implications of devolution on tobacco control in the UK

The potential impact of devolution in changing the contours of health policy in the UK is well-illustrated by the response in Scotland to the re-elected Labour government's decision not to include a bill to ban tobacco advertising in the Queen's Speech of September 2001. One of the commitments of the election manifesto of the Labour Party's first term in office was to support the passage of a European Union directive (98/43/EC) by preparing regulations for its implementation in the UK. Following the annulment of the Directive by the European Court of Justice (ECJ) in October 2000, the government published 'The Tobacco Advertising and Promotion Bill' on 14 December 2000. Successful passage of the bill, however, was prevented by the timing of the general election in June 2001. Failure to include it in the new legislative programme provoked widespread dismay (Day 2001).

Having previously desisted from exercising its prerogatives in favour of the more comprehensive and effective measures possible under UK-wide legislation, the Scottish Executive came under increasing pressure to enact its own legislation. The substantial intra-party political sensitivities involved in such a step initially led to the apparent preclusion of this option (Ritchie 2001). The tobacco epidemic is particularly acute in Scotland, since smoking annually accounts for over 13,000 deaths, or one in five of all deaths, while the NHS in Scotland spends some £140 million on treating smoking-related diseases (Scottish Office 1999). The intervention of the Scottish National Party's shadow health minister Nicola Sturgeon in publishing a draft bill renewed pressure on the Scottish Executive as the bill attracted the support of prominent public health groups (SNP 2001a). It also could be expected to command substantial cross-party support.

Party political calculations were further complicated by the longstanding commitment of the Labour Party in Scotland to ban tobacco advertising, a commitment contained in the White Paper *Towards a Healthier Scotland* (Scottish Office 1999). This was reiterated by the late First Minister Donald Dewar in response to the ECJ ruling against the EU advertising directive (Scottish Executive 2000a). In this context, the inaction of the Scottish Executive led to accusations that devolution was being undermined by the reliance on so-called Sewel motions by which Holyrood defers to Westminster (Nelson 2001). Scottish Minister of Health Susan Deacon has intimated that she will pursue a ban within Scotland unless there are clear indications of progress towards a UK-wide ban (Macdonell 2001). This has met with predictable annoyance at Westminster, with Robin Cook, the leader of the House of Commons, reportedly urging Scottish ministers not to support the private members bill introduced by the SNP (Cozens 2001).

The advance in institutional pluralism represented by devolution can here be seen to constitute a significant new point of entry into the policy-making process for public health. By comparison with traditional Whitehall dominance of the policy agenda, devolution more clearly allows action to address specific regional health problems. Health policy is allocated by the Scotland Act 1998 (HMSO 1998b) as a devolved issue within which the Scottish Parliament and Executive can exercise competence.

From a UK-wide perspective, the reforms can be seen as introducing powerful new means of exerting pressure on the policy process. The prospect of a move towards a prohibition on

advertising in Scotland would constitute a marked rebuke to the Labour government for its omission of a bill from the Queen's Speech. This can be seen in conjunction with similar pressure being exerted within the reformed House of Lords. Lord Clement Jones has introduced a Private Members Bill that is exactly the same as the government's proposed legislation that expired for lack of parliamentary time (Cozens 2001)

The potential tensions in the new arrangements are apparent, however, in both the reluctance of the Scottish Executive to act, and in the limited measures open to Scottish legislation. Regardless of the formal devolution of health policy to Scotland, it is clear that the breadth of issues involved in tobacco control thoroughly transcend the divide between devolved matters (on which the Scottish Parliament is competent to act) and reserved matters (that remain the prerogative of Westminster). Despite the bill being described as one which "pushes the powers of the Scottish Parliament to the limit" (SNP 2001b), there are significant legal and practical limitations to its scope. This is evident in the inability to ban advertising in magazines and newspapers that are sold in England as well as Scotland, and in the limited provisions for curtailing sports sponsorship (HMSO 2001).

The above illustrates the scope for incoherent and ineffective policy-making on public health issues, a problem that is particularly significant in the context of advertising. The transborder nature of modern advertising and marketing activities is liable to undermine the effectiveness of both national and subnational regulation, placing a premium on effective policy coordination across different levels of government. Advertising bans have been demonstrated to only be effective when initiated as part of comprehensive tobacco control programmes (Saffer and Chaloupka 2000; Joosens 1997). The above omissions would be likely to seriously undermine the effectiveness of Scottish legislation.

4.3.3 Tobacco control, the UK and the European Union

More established and far-reaching implications for public health in the UK stem from accession to the European Community, and from the development of European integration during the thirty years of British membership (Mossialos et al. 1998). Accession to the then EEC in 1973 entailed a dramatic amendment to the twin doctrines of parliamentary and national sovereignty via the principle of the primacy of European law over the domestic law of member states. The implications for governance of this act have progressively heightened as the supranational features of the Community's institutions have been strengthened and their policy competence widened through a succession of treaties, most notably the Single European Act (1986), the Treaty on European Union (1991) and the Treaty of Amsterdam (1997).

The institutions of the European Union (EU) are now central to the context in which tobacco control policy is conducted for its member states. The diversity of the EU's impacts on policy-making was acknowledged by the White Paper *Smoking Kills* (HMSO 1998a). The White Paper included, for example, a desire for member states to increase minimum levels of duty on tobacco products, recognition that product regulation and labelling issues should be tackled on a European-wide basis, and identification of the tensions between support for tobacco production under the Common Agricultural Policy (CAP) and public health objectives. This is in addition to the stated need to implement the EU Directive banning

tobacco advertising and sponsorship, described as "the core of the steps we will be taking to tackle smoking in Britain" (HMSO 1998a).

The gradual expansion of policy competence to encompass some provision for public health (Mossialos and McKee 1998) has been accompanied by the development of tobacco control measures at the Community level. This is perhaps an unsurprising area for policy intervention given the scale of the tobacco epidemic within the EU, estimated at 500,000 tobacco-related deaths per year (Peto et al. 1992). The development of tobacco control policy by the EU has been characterised by a dual approach, with the adoption of both preventative and legislative measures (Ryan 2001). The impact of the Community via direct interventions in tobacco control is, however, arguably less noteworthy than that stemming from the broader development of the Community. In particular, it is worth highlighting the perverse effects of support for tobacco producers under the CAP, and the opportunities provided to cigarette manufacturers by the attempt to create a single internal market encapsulated in the 1992 project. The limited nature of tobacco control at the European level cannot be understood without recognising the hostile political and institutional context within which public health advocates have had to operate. In conjunction with a number of key member states,that have been notably sympathetic to industry attempts to frustrate the development of tobacco control policies, TTCs have been remarkably successful in influencing the policy process within the European Community.

Tobacco control in Europe: prevention activities

The Europe Against Cancer Programme has been the core of EC efforts with respect to smoking prevention. Established in 1987, initial activities supported were generally small initiatives operating at the national level, but the pattern of projects supported has shifted towards larger projects operating across several member states. These are operated via two networks: European Network for Smoking Prevention and European Network for Young People and Tobacco. Additional funding for information projects came with the creation of the Community Fund for Research and Information on Tobacco in 1992. This was funded by the imposition of a levy on CAP support given to the production of raw tobacco, initially at 1% but raised to 2% in 1998. Half of this levy is available for smoking prevention programmes, while the other half is intended for research into developing new varieties of tobacco. An additional communication campaign targeting adolescents is currently being developed.

Although there has therefore been a steady growth in the EU's smoking prevention activities, it is important to emphasise the modest nature of these efforts. The total annual budget allocated to them is around Euro13 million. John Ryan, Deputy Head of Unit within the Health and Consumer Protection Directorate General of the European Commission (more commonly known as DG 24), has noted that the "the limited budgetary and staffing resources available to prevention efforts cast doubt on their ability to make a significant and lasting dent in tobacco consumption" (Ryan 2001).

Tobacco control in Europe: legislation

More significance can be attributed to legislative measures adopted by the institutions of the Community, although it remains fair to say that those measures actually adopted have been

far more modest in impact than would have been the case for proposals that have been thwarted. If the EU was to be viewed as an independent entity, looking primarily at Community-wide measures and ignoring varying national provisions, then the existing tobacco control regime is comparatively weak. The principal elements of current regulation are summarised in Box 4.1.

Perhaps the most striking features of the legislation that has been adopted at the European level are the manner in which the pursuit of public health objectives has been reliant on an internal market justification. Hence, labelling requirements were formally adopted to enable the sale of tobacco products throughout the Community, while the 'Television without Frontiers' Directive banned tobacco advertising to facilitate transmission of television signals between member states. Regardless of other objectives, they could be presented as legitimate moves towards the development of the single European market (Fennelly 2001). The timing of these measures, incidentally, is far from coincidental, since they form a tiny part of the vast legislative programme by which the Community aimed to complete the single market by 1992.

This pattern reflects the subordination of public health to unhindered trade within the framework established by the Treaties. The primary legal basis for tobacco control measures is provided by Article 95 (3) of the Treaty of Amsterdam stating that Commission proposals should take as their basis "a high level of protection in terms of health, safety, environmental protection and consumer protection" (European Union 2001). Although initially heralded as providing a new scope for public health interventions at the European level, the limitations imposed by the Treaty are becoming increasingly apparent.

> Using Article 95 as a legal basis…restricts the type of initiative which may be taken to those cases where a genuine and substantive Internal Market justification is established. Similarly, the principles of subsidiarity and proportionality entail strict examination of the necessity for EU action on a particular issue and its scope (Ryan 2001).

Article 95 is therefore subject to severe limitations in its ability to provide the basis for the development of effective public health regulation. This has led some to advocate treaty revision in order to provide the EU with a more explicit competence to promote public health (Godfrey 2001).

The impact of these legal limitations is evident in the fate of the EU's most significant attempt to date to tackle the problems of the tobacco epidemic. The adoption of a Directive on advertising and sponsorship by the European Parliament and the Council of Ministers in1998 (98/43/EC) represented the apparent culmination of a ten-year campaign to implement a comprehensive advertising ban at the European level. While the tortuous progress of this proposal is best explained by the political obstacles considered below, the eventual annulment of the Directive is attributable to the inadequacies of the EU's legal framework for the protection of public health.

Box 4.1: Legislative measures adopted by the EC for tobacco control

Television Without Frontiers Directive, 1989 (89/552/EEC)
- ❍ bans all forms of TV advertising for tobacco products
- ❍ prohibits sponsorship of programmes by those whose principal activity is manufacture or sale of tobacco products

Labelling Directives, 1989 and 1992 (89/622/EEC; 92/41/EEC)
- ❍ tar and nicotine yields printed on side of packet
- ❍ health warning on front to cover at least 4% of packet
- ❍ additional specific warnings for products other than cigarettes
- ❍ prohibition on placing oral tobacco products on the EC market (later subject to exception for Sweden on accession to EU)

Tar Yield Directive, 1990 (90/239/EEC)
- ❍ establishes ceiling on tar content of cigarettes
- ❍ maximum tar yield to be 15mg per cigarette by end 1992 and 12mg by end 1997

Tax Directives, 1992 (92/78/EEC; 92/79/EEC; 92/80/EEC)
- ❍ provide for a Commission report every 3 years on rates, overall minimum excise duty and structure of such duties

Resolution on Smoking in Public Places, 1989 (OJ C 189 of 26.7.89, p.1)
- ❍ a non-binding Council Resolution
- ❍ invites member states to adopt measures banning smoking in public places and on public transport

Directives Protecting Workers from ETS (89/654/EEC; 92/85/EEC)
- ❍ minimum health and safety requirements for workplace, requiring employers to protect workers from passive smoking in rest areas
- ❍ measures to encourage improvements for pregnant workers and new mothers

Source: Adapted from Ryan 2001; Gilmore and McKee forthcoming; and European Commission 1997.

The central elements of the advertising and sponsorship Directive (Article 3) included prohibitions on:

- ❍ all forms of advertising and sponsorship in the Community;
- ❍ the use of tobacco brand names, trademarks and emblems on other products and services (subject to the proviso that this would not be applied retrospectively on existing products); and
- ❍ any free distribution with the purpose or effect of promoting tobacco products.

There were some limited exceptions such as advertising in trade journals and publications not primarily intended for sale within the Community. But the Directive did constitute an

attempt to develop a comprehensive approach to the impact of advertising and marketing of tobacco products. It incorporated a clear recognition of the importance of tackling indirect, as well as direct, forms of advertising including trademark diversification and sports sponsorship, notwithstanding the controversial extension granted to tobacco sponsorship for Formula One racing (Bremner et al. 1997). This broad approach is consistent with empirical evidence that such a comprehensive set of prohibitions can reduce tobacco consumption while limited bans are of negligible effect (Saffer 2000). It has been estimated that the Directive could have saved 38,000 lives per year (Joossens 2001).

The validity of the Directive was tested in the European Court of Justice (EJC) in litigation brought by Germany, following a High Court challenge brought in the UK by a group of British tobacco companies led by Imperial Tobacco (Anderson 2001). The ECJ gave its verdict on the two cases on 5 October 2000, annulling the Directive (C-396/98; C-74/99). In essence, it was the comprehensive nature of the proposals that led to the repudiation of the legal basis of the Directive. The ECJ explicitly recognised that it was perfectly legitimate to prohibit advertising in periodicals, magazines and newspapers in order to ensure the free movement of such products within the EU, an action analagous to the earlier ban on television advertising. The Directive could not, however, be generally seen as eliminating obstacles to the free movement of advertising media and services. The ECJ stated that prohibitions on advertising on posters and ashtrays or on advertising in cinemas could not in any way be viewed as facilitating trade in such products. Reflecting on the Directive, the then Advocate General Fennelly noted:

> The inevitable conclusion is that the Directive was not, so far as liberalisation of trade in goods and services were concerned, validly adopted on the basis of the internal market Articles. *The broader implication of the Court's approach is that Article 95 may only be used to expand the boundaries of free trade. The corollary of this is that any restrictions found to be necessary should be subsidiary to that objective.* (Fennelly 2001, italics added).

Given that Article 95 constitutes the basis of the limited public health competence of the EU, it is therefore clear that public health legislation is subordinate to the primary internal market objective of free trade.

The Commission has responded to the delineation of the scope for legitimate action provided by the ECJ in this case by developing a new directive on tobacco advertising. This focuses very much on those areas identified by the ECJ as within the competence of the EU, such as international sponsorship and advertising in publications traded across member states (ASH 2001a). While this clearly constitutes an understandable response by the Commission in the aftermath of the annulment, the omissions in the new Directive have inevitable attracted criticism from public health groups.

The Commission has also moved to strengthen existing control measures with respect to content and labelling. In May 2001 the Council of Ministers and the European Parliament agreed to a new directive on the sale, marketing and manufacture of tobacco products (European Commission 2001). Among the key measures of this proposed legislation are:

- new maximum yields per cigarette of 10 mg for tar, 1 mg for nicotine, and 10mg for carbon monoxide;

- tobacco products to carry a general health warning covering 30% of package surface and an additional specific health warning covering not less than 40% of the surface;
- rules for the use of colour photographs or illustrations to depict health consequences to be adopted by end 2002;
- tobacco products to be marked by batch number or equivalent to ensure product identification and traceability;
- manufacturers and importers of tobacco products to submit ingredients and their quantities by brand name and type, as well as toxological data; and
- misleading product descriptions (ie 'mild', 'light') that imply a particular product is less harmful are to be forbidden from September 2003.

This last proviso is central to the wide-ranging legal challenge that this Directive will have to overcome if it is to be successfully implemented, one that will again expose tensions between trade liberalisation and public health objectives. The government of Japan, for example, has a large stake in Japan Tobacco International, whose strategically key 'Mild 7' international brand is jeopardised by the Directive's product labelling provisions. Japan therefore introduced a complaint to the WTO Technical Barriers to Trade Committee even before the formal adoption of the Directive (Ryan 2001). The new Directive is likely to be tested within the European legal system in much the same manner as the advertising directive. The German government, for example, issued reservations about the new directive and is apparently considering bringing a case before the ECJ. BAT and Gallaher have already announced that they will be bringing litigation to seek the annulment of the directive.

Particularly interesting from the perspective of a broader interest in transborder health risks is the directive's attempt to impose standards on cigarettes exported from the EU. The rules on maximum tar, nicotine and carbon monoxide yields are intended to apply to products manufactured for export beyond the member states from January 2007. This represents an attempt to counter the allegations of double standards made against tobacco companies. TTCs based in countries with comparatively stringent content requirements have produced cigarettes that would be illegal in their home markets, exporting them to countries with limited or non-existent controls over such yields. Consequently, this provision can be viewed as an attempt to introduce some degree of quality control over the EU's contribution to the global cigarette market. From a trade-oriented perspective, however, it might be seen as a naïve intervention that will serve only to hand over hard won market share in those countries where cigarettes are typically of higher tar and nicotine yields to American competitors (Howells 2001). It remains to be seen whether the ECJ will view the matter more starkly, as acting beyond Community competence or as an inappropriate restraint of trade. The Commission apparently views the provisions on exports as commensurate with GATT Article XX(b) with regard to measures necessary to protect human health (Ryan 2001).

Tobacco and European integration

This attempt to apply the same standards to exports from the EU as to products traded within it may be interpreted as an attempt to deflect criticism from the more noted external impacts

of the EU's tobacco regime. The scale of financial support conferred under the CAP to tobacco growers within member states has attracted substantial criticism within the EU and internationally. In marked contrast to the limited funds accorded to the EU's smoking prevention programmes, EU subsidies for tobacco growing amounted to Euros 984.5 million in the year to October 2000 (ASH 2001b).

This disparity has drawn increasing criticism, alongside a more basic critique of the inappropriateness of offering large-scale financial support to such a harmful product. The UK House of Commons Select Committee on Health, for example, expressed the belief that "European policy is already hugely compromised by the CAP subsidy, and that unless appropriate resources go into tobacco control European action in this sphere will lack credibility" (UK Health Select Committee 2000). Such arguments are given further weight by the poor quality of the tobacco crop produced within the EU, with Tony Blair complaining in a speech to the World Bank that the "crop conflicts with EU health policies, and is rarely of sufficient quality for the world tobacco market. Most is either stored or simply destroyed" (Blair 2001).

The quality limitations of the EU's tobacco crop have still more damaging implications from the perspective of global public health. It is generally inadequate for the needs of the premium brands produced within the EU, and is largely exported to low- and middle-income countries. Only around 23% of EU tobacco production is used internally, while the main export markets include central and eastern Europe and North Africa. Given the scale of financial support given to the crop, this practice amounts to dumping EU tobacco on the global markets, arguably suppressing the prices obtained by tobacco growers in developing countries. Given the above, the Court of Auditors of the EC produced a damning critique of the tobacco regime of the CAP in 1993:

> Subsidies are paid for producing tobacco that has practically no market in the Community. Almost all this tobacco is exported to Central and Eastern Europe and North Africa where there are insufficient controls of tar content and where the countries can hardly afford to cope with additional bought-in mortality and high health costs… (This) is not only an economic issue, but also a question of whether the recruitment of developing countries to replace the shrinking Community market is compatible with the cooperation policy of the Community and morally justifiable considering the accompanying economic and health problems imposed on these countries (Court of Auditors 1993).

The Court of Auditors concluded that such financing of tobacco production constituted a misuse of public funds. This view now seems to be attracting broader support within the institutions of the EU, and the current president of the European Commission, Romano Prodi, has called for a phasing out of tobacco subsidies (Prodi 2001). This ambition was incorporated in the Commission's recent proposals for sustainable development in the European Union (European Commission 2001).

The renewed commitment to establishing a single market among member states from the mid 1980s inevitably altered the trading environment within which cigarette manufacturers operate, and so has implications for tobacco control. Regardless of broader debates about the impact of trade liberalisation on public health, there is a basic and

undeniable tension with respect to tobacco control. Economic theory would predict that the removal of barriers to trade in tobacco products would bring increased competition and consequently exert downward pressure on prices. On the basis that there is a well-established inverse relationship between price and consumption, cigarette smoking would therefore be expected to increase (Taylor et al. 2000). As discussed above, there is growing evidence of the impact of trade liberalisation in promoting the globalisation of the tobacco industry and in increasing tobacco consumption. While there is a need for greater research to explore the specific impacts of the single internal market on smoking within the EU, it is instructive to briefly consider the attitude of the tobacco companies to its development.

One key feature of the single European market for the TTCs was the opportunity it provided to increase market share in member states where there had been significant levels of protectionism. This was usually a reflection of the stake of governments such as those of Spain, France and Italy in state tobacco monopolies. In a speech to the World Tobacco Symposium in September 1993 Ulrich Herter, BAT's Managing Director for tobacco, noted that "(a)s barriers to free trade fall between the 12 member states, government tobacco monopolies are slowly beginning to crumble and opportunities are emerging" (Herter 1993). A secret internal report on the implications of the 1992 project emphasised the changes and opportunities within the cigarette markets of the member states:

> BATCo. market strategy is to defend and develop its position in existing Operating Company markets, whilst aggressively taking up the opportunities created in the markets of Southern Europe. These priority opportunity markets will be Italy, Spain, France and Greece where there is growth potential for our strategic international brands. (Bingham 1989)

As with many other companies, the move to a single market was viewed as offering major opportunities for economies of scale. In this respect, European integration was viewed as congruent with key trends in the global cigarette industry. Of particular importance here was the increasing strategic emphasis placed upon promoting premium international brands, especially those of American origin (or USIBs). These global and regional developments were viewed by BAT as providing the basis for restructuring their operations in Europe. A 1989 document entitled 'Project Streamline' highlighted these opportunities:

> The present approach to the European tobacco business is fragmented is (sic) that each company is considered as a separate business/profit centre with its own performance guidelines. Already, the growth of international brands in European domestic markets (particularly USIB's) has already gone some way towards unifying Europe as although each market exhibits national differences this swing has created a common trend to the detriment of national brands. This trend will be accelerated by any formal formation of a single market is (sic) the EC at the end of 1992. Accordingly, it is essential to organise our European companies onto a European basis recognising that a European focus on marketing should be backed by a similar perspective for production. This latter reorganisation is also urgently needed as considerable surplus production capacity exists in our European companies. European marketing can also enable the exploitation of any niches in markets where such opportunities are identified. (BAT 1989)

Among the proposals for redressing this excess production capacity was the closure of factories including those in Liverpool and Amsterdam. The enthusiasm with which this opportunity was identified is in stark contrast to the current protestations of the Tobacco Manufacturer's Association that the export standards envisaged in the new directive will lead to job losses in UK manufacturing industry (Clark 2001).

Tobacco industry influence within the European policy process

The limited progress of tobacco control in the European Community particularly on advertising, following the initial wave of Directives between 1989 and 1992, cannot be understood in isolation from political pressures exerted at the European level by the tobacco industry. Internal tobacco industry documents, released as a result of litigation in the US (Ciresi et al. 1999), illustrate the scale of activities undertaken by TTCs as they became aware of the potential impact of EC regulation. Certainly the legislative stalemate between 1992-98 owes much to organised opposition of the industry (Neuman et al. 2002), while the initial legislative progress has been attributed to the earlier inadequacies of industry oversight and intervention in the EC policy process (Gilmore and McKee forthcoming).

The cornerstone of the tobacco industry's success in curtailing progress for much of the 1990s was the strength of its political links within key member states. Particularly important is the role of Germany, which remains a dependable ally in resisting tobacco control efforts. Industry documents clarify the importance attached to Germany as a primary means by which TTC positions could be powerfully expressed within EC policy-making. The tobacco companies demonstrate a clear understanding of the veto points that remained within EC policy making, despite reforms introduced following the Single European Act to address perceived institutional sclerosis (Taylor 1989). While the erosion of unanimity as the basis of decision-making increased the potential for introducing tobacco control measures in the face of opposition from recalcitrant states, tobacco companies displayed a clear reading of the changing dynamics of European integration. They, in turn, adjusted to the introduction of qualified majority voting (QMV) by focusing on maintaining a reliable blocking minority of states as a bulwark against progress on tobacco control.

Industry attempts during the 1990s to defeat the emergence of a European Directive prohibiting advertising, for example, combined a clear reading of the requirements of the QMV system with the active support of key actors and countries. A Philip Morris document assessing the blocking minority within the Council of Ministers, by which the defeat of such a Directive could be attained, urges the use of "all possible German influence to prevent a weakening of the blocking minority. Work with Chancellor Kohl to put ad ban on Commission subsidiarity list" and of the "successful revision of Dutch code (sic) and contacts with the economics ministry to keep the Health Minister from undermining the Dutch position" (Philip Morris n/d, a).

The above emphasis on working with Chancellor Kohl illustrates the extent to which the industry pervades the highest levels of the political system in some member states. It appears that Philip Morris was indeed successful in securing German opposition to the advertising directive on the basis of subsidiarity, a principle rather vaguely introduced into the European

treaties but which has had more political significance as a rhetorical device employed in defence of the sovereignty of member states. Significantly, a 1993 memo from David Greenberg, a Corporate Affairs Executive for Philip Morris notes that "the German Government has included the EC ad ban in its list of directives to be dropped out under the subsidiarity principle" (Girod and Greenberg 1993).

It is also worth noting the role played by the Conservative government in the UK as a key part of the blocking minority on the advertising ban, cultivated by the tobacco companies around this time. A BAT document notes that:

> (O)pposition to a total ban has already been expressed in the Council of Ministers by the UK, Germany, Denmark and Holland. If maintained this constitutes a blocking minority which would make it impossible for the directive to be approved…. We would prefer the issue to be addressed before a general election takes place in the UK, as a Labour government would in all probability support a total ban (BAT n/d).

In 1990 then Prime Minister Margaret Thatcher denounced the proposals as "meddling" in the domestic affairs of member states. Following her departure from office, Mrs. Thatcher was hired as a "geopolitical consultant" by Philip Morris for a fee of US$250,000 per annum, along with a similar contribution to the Margaret Thatcher Foundation (Neuman et al. 2002). The British position remained largely unchanged under the following Major administration. A July 1991 letter to the Chairman of the Tobacco Advisory Council, from the then Secretary of State for Health William Waldegrave, clarifies the government's stance. The longstanding advocacy of voluntary agreements negotiated with the industry is emphasised, along with a belief that it "would be preferable if it were left to individual Member States to consider what type of regulation of tobacco advertising was necessary for the pursuit of their own health policies" (Waldegrave 1991). The ongoing commitment to blocking a comprehensive EC ban on advertising is reiterated, one which was expected to hold for so long as the UK was not isolated by other member states:

> The UK therefore remains opposed to the proposed Directive on various grounds. I expect this to remain the case in relation to the current draft of the Directive as long as there is a blocking minority. If the action of other Member States means that there was no longer a blocking minority, we should, as I explained, need to consider our position. At that point continued and isolated opposition might simply prevent us from arguing for drafting changes which would at least ameliorate what could be (sic) totally blocked. But at present that position does not arise and we will seek to maintain the blocking minority by making our position clear to the Commission and to other Member States concerned. (Waldegrave 1991)

It was not until the election of a Labour government in 1997 that the blocking minority crumbled, with the advertising Directive being approved in 1998. At that point the industry became reliant on litigation to achieve its objectives, although the latter was also conducted in conjunction with political actors given the role of Germany in bringing the Directive before the ECJ (Joosens 2001).

In addition to powerful support within member states, the tobacco companies were able to obtain high levels of access to key actors within EC institutions. Research conducted at the

University of California, San Francisco identifies Martin Bangemann, a German appointment to the European Commission with responsibility for industrial affairs, as a key ally of Philip Morris (Neuman et al. 2002). In 1993, the company's three-year regional plan for the EEC describes Bangemann's role as advancing counter proposals to a comprehensive ban. The plan describes a "minimum harmonization proposal (Bangemann's proposal)" as "an alternative (to be) approved or at least proposed during 1993-1994", proposing to "secure Bangemann's availability to present 'his' proposal; establish a timetable with his staff" (Philip Morris-EEC 1993).

The above represents a specific example of coordinated organisation of the political efforts of the tobacco companies within the EEC under the aegis of the Confederation of European Community Cigarette Manufacturers (CECCM) (BAT n/d). Among the stated means by which industry pressure was to be exerted on the Commission were:

- letters to individual Commissioners who are likely to be receptive to our viewpoint viz:
  - by tobacco company Chairmen
  - by our allies in the advertising and media world
  - by general business organisations
- Co-ordination of Commissioner's Cabinet Members with the focal points being the Brittan and Bangemann Cabinets to ensure that those opposing a ban work together and hence effectively (BAT n/d, b).

An additional document details progress made in contacting individual commissioners. For example, Commission President Jacques Delors was contacted by Initiative Media International; Agriculture Commissioner Ray MacSharry by the Irish Tobacco Association and Gallaher; Commissioner for Competition Policy Leon Brittan by BAT, Gallaher and the CBI among others; and Bangemann by the German Advertising Association, Reemtsma and Philip Morris (BAT 1991b).

It is important to note that industry efforts at managing the European policy process were not confined to the comparatively high politics of the advertising directive, but extended across the Commission's emergent tobacco control agenda. An overview of Commission proposals under the Europe Against Cancer programme in 1989 notes that "BATCo. policy on these issues is to oppose them at every level of influence within the Community both to achieve their withdrawal wherever possible and to modify them where withdrawal is unrealistic" (Bingham 1989). The lobbying activities undertaken in pursuit of such objectives were to be focused "upon key European MP's, appropriate UK government staff in Brussels, and Commission officials, both in the cabinets of Commissioners and in the Commission itself" (Bingham 1989).

The growth of policy competence of the EC required persistent monitoring of developments in such related areas as food legislation, patent activities, biotechnology, genetically modified products and environmental considerations. BAT's Research and Development section seemingly found it easier to keep track of, and indeed influence, changes at the European level than nationally, noting that "(if) you are considering just EC changes, by and large we have in relative terms quite a degree of notice and opportunity to monitor and even influence

change" (Read n/d). The tobacco companies were also seeking to maintain advantageous conditions by anticipating likely developments at the Community level. Hence the expectation that, at some point, the EC would seek harmonisation of tobacco additives led to the suggestion that "making a proposal on this subject could be useful in pre-empting the unilateral development of some other rules by the Commission, and would also allow a negotiating position to be developed in which early warning of potential impact on Company products could be obtained" (Mitchell 1990).

As in other parts of the world, the tobacco industry has made assiduous use of diverse pressure groups and controlled front groups to generate a sense of broader and more respectable civil society support for industry-defined objectives (Saloojee and Dagli 2000). The covert use made by the industry of pressure groups is well illustrated by their campaign to retain duty free sales on intra-EC journeys. A document dealing with BAT's planning for the consequences of the planned single internal market emphasises the extent to which such campaign activities were coordinated by tobacco companies. In addition to encouraging national associations, the document notes that:

> upon the initiative of BATCo., an international duty free confederation has been established recently in order to raise the profile of lobbying to a European scale. Its activities which are largely orchestrated by the tobacco companies, are concentrated upon co-ordination of the policies and activities of the national associations, providing them with information with which to lobby effectively, and to undertake all necessary lobbying on a European scale. It is important that this lobby is not seen to be a tobacco lobby but the significance of duty free to BATCo. and the other tobacco companies explains why they and BATCo. have concentrated so much effort and resources to it. (Bingham 1991)

In the context of resisting an advertising directive, BAT sought to make use of the European Round Table of Industrialists (ERT). ERT has a particularly important standing in the context of European integration, being widely credited with a significant catalytic role in encouraging the adoption of the 1992 single market agenda (Cowles 1995). BAT sought to persuade ERT to take up the defence of advertising freedom with the European Commission (BAT 1991c), suggesting that discussion should be initiated by either Unilever or Nestlé since it "would be expedient for this to be neither a 'tobacco' man nor an alcohol man" (Dreyer 1991).

A letter subsequently sent to Jacques Delors, on behalf of the ERT, states that "(f)ree commercial speech should be considered an integral part of the principles of the free market economy" (Dekker and Maucher 1991). An earlier draft letter followed this statement with a recognition that it "may happen that this freedom is in conflict with other values. It should then be judged on the basis of the principle of proportionality, whether this freedom should be curtailed" (BAT 1991d). Patrick Sheehy, then Chairman of BAT, dismissed the draft's acknowledgement of counterveiling values as a concession to "paternalistic arguments that deny that most people are sufficiently mature to make relevant choices based on unrestricted access to relevant information" (Sheehy 1991). Sheehy's suggested removal of this qualification to the defence of commercial freedom appears to have been accepted, constituting the only substantive divergence from the earlier draft.

4.3.3 The Framework Convention on Tobacco Control

The UK's membership in the EU is also relevant to understanding the terms and character of the UK's contribution to negotiations towards a Framework Convention on Tobacco Control (FCTC) being carried out under the auspices of the World Health Organisation (WHO). The World Health Assembly unanimously adopted Resolution 52.18 (WHA 1999) to initiate a two-step process leading to negotiating the FCTC, and a record 50 states took the floor to commit political and economic support (WHO 2000a). This process envisaged Working Groups to establish the technical foundation of the proposed convention, followed by the establishment of an Intergovernmental Negotiating Body (INB). The FCTC is anticipated to take the form of a broad convention outlining legal parameters, structures and general obligations for all signatories, in combination with a number of protocols detailing more specific commitments to which states can choose to accede on a case by case basis (WHO 1999z). Semi-annual negotiating sessions of the INB have been held in Geneva since November 2000, and the objective is for a negotiated convention to be ready for presentation to the WHA in May 2003.

The European Commission has a central role to play in the negotiations given its mandate from the Council of Ministers to conduct negotiations in those fields for which the EU has policy competence. In practice this has meant that EU member states have overwhelmingly adhered to a common position within the FCTC, especially as national positions on areas outside this competence have been coordinated by the Presidency[11]. It is also relevant to note that various applicant countries for membership of the EU have also aligned themselves behind this common position. The justification for such coordination lies in the view that it collectively empowers member states, putting the EU as a whole in a stronger negotiating position (European Commission 2001rr).

This essentially procedural development does, however, have substantive policy implications. From a tobacco control perspective, it has been widely perceived as constraining those EU member states that might wish to advocate a less modest conception of the FCTC, and one which has attracted condemnation from a number of health groups (ASH 2001d; PR Newswire 2001). This can be partially explained by the pressures for a lowest common denominator position that are often seen as inherent in the development of a consensus position. This tendency is reinforced by the fact that the most consistently obstructive state in relation to tobacco control is Germany, the largest, wealthiest and increasingly the most powerful member state of the EU.

A full understanding of the position adopted by the European Commission and the EU's member states also requires recognition of the constraints imposed by *acquis communautaire*, the name given to the body of existing European legislation within the framework established by the treaties. The decision to act on the basis of a common position makes it difficult to envisage the EU being willing to negotiate a Framework Convention that challenges the *acquis*, with the consequence that FCTC is largely envisaged by EU negotiators as the EU's own relatively weak control measures writ large.

11 The Presidency of the European Union is an organisational role, overseeing and advancing legislative and political processes within the EU. It rotates between member states on a six-monthly basis, being held by Spain and then Denmark during 2002.

This is most obviously relevant with respect to advertising, where the ECJ's annulment of the comprehensive 1998 directive has led to the adoption of a notably weak position in comparative terms. The EU position focuses primarily on transborder advertising and fails to address indirect forms of advertising. This restricted scope is very much in line with the parameters established by the ECJ's decision, but is widely viewed as incompatible with the requirements of global public health. There has been some internal pressure for the EU to move beyond the limits of the *acquis*, notably from the European Parliament. It has urged the EU delegation to "be open to considering and supporting proposals for tobacco control measures going beyond existing EU legislation" (Hayes 2001). The most recent round of INB negotiations was notable for Ireland's intervention in discussions on advertising, departing from the modest common position in making a case for a comprehensive ban covering both direct and indirect advertising (Framework Convention Alliance 2001a)

4.4 Conclusions

There remain a number of measures that could be adopted at local, sub-national and national levels to significantly reduce tobacco consumption and advance public health. On issues such as taxation, advertising and smoking in public places the UK lags behind international standards of best practice. It is increasingly clear, however, that action at the national level is insufficient to ensure public health objectives. In part this reflects the gradual transfer of policy competence to the European Union, but it can also be attributed to the impact of the globalisation of the tobacco industry that has the capacity to undermine national control measures. The effectiveness of national prohibitions on tobacco advertising, for example, is jeopardised by the industry's successful use of sports sponsorship and marketing, particularly via Formula 1 motor racing. Even action at a regional level may be insufficient in scope, with rumours that Formula 1 will restructure its programme of races towards Asia to evade a forthcoming EU prohibition on tobacco industry involvement in the sport (Williams 2002). The UK therefore has a clear stake in supporting tobacco control efforts at the global level to advance national objectives for public health.

Such efforts are also necessary to advance the UK's commitments to global health and development, exemplified by the commitment to advancing international tobacco control in the Department of Health's 1998 White Paper 'Smoking Kills' and DfID's 2000 White Paper 'Eliminating World Poverty: Making Globalisation Work for the Poor'. Given the core role of the UK's tobacco industry in promulgating the tobacco epidemic, and the extent to which its government's have at various points been culpable in advancing international industry objectives, there is also a moral obligation on the UK to promote global tobacco control.

Though this chapter has inevitably focused on health risks associated with globalisation, it is clear that globalisation also offers a number of opportunities that can be harnessed to advance public health. Tobacco industry documents provide very clear evidence of the positive externalities attached to effective tobacco control measures adopted at national and regional levels. Industry awareness of the diffusion of such benefits is central to their efforts to influence policy, since the pervasive impact of successful tobacco control constitutes a fundamental threat to the continued profitability of the industry. The logic of such actions is evident in BAT's response to the proposal of an EEC-wide advertising ban:

We believe it is essential for BAT to take urgent and positive action to try and persuade the Commission not to issue any new directive for the following reasons:

- Protection of existing freedoms in the whole of Europe (east and west) is essential for the progress of international brands.
- Advertising in eastern Europe is already threatened; an EEC ban would have an immediate impact.
- The global 'domino effect' - an EEC ad ban will speed up the introduction of bans elsewhere. (BAT 1991a)

Industry recognition of the global scale on which the contest with tobacco control is conducted is testimony to the opportunities provided by globalisation to public health. This is particularly evident with respect to the cognitive dimension of globalisation; the intensified flows of information and knowledge across societies are being effectively exploited by the TTCs, but such trends are also being exploited to advance tobacco control.

Prominent among examples of such diffusion are a number of clear cases of policy learning, in which innovative tobacco control measures in one state have been subsequently mimicked by others. This has also been described as 'leap-frogging' - i.e. a process in which various countries have pioneered effective measures, which have then been progressively adopted elsewhere" (Framework Convention Alliance 2001). A particularly stark example of policy transfer is provided by Thailand's passage of comprehensive control measures in 1992, acts that very clearly used Canadian legislation as their prototype (Vateesatokit 1997). Similarly, advertising bans spread widely following their initial adoption in Scandinavia in the 1970s, the establishment of a health promotion fund based on a portion of tobacco taxation in Victoria, Australia has subsequently been taken up in Thailand, and the EU is now considering the use of shocking photographic health warnings piloted in Canada.

The possibilities for broader policy learning are significantly enhanced by the strengthening of transnational links among civil society actors. While talk of a global civil society may well be premature, it is clear that the tobacco companies have long operated on the assumption that it exists in the case of tobacco control groups. A 1987 industry guide to dealing with pressure groups demonstrates high levels of concern at the crossborder mobility of ideas and personnel. In planning to counter NGO activities, the guide emphasise that national manufacturers' associations should be aware of the "global implications of one country's regulations cascading through others - effects on marketing freedoms, intellectual property and volume" (INFOTAB 1987).

Technological development has had a number of positive impacts in encouraging effective links among activists. Central to such efforts has been the development of GLOBALink under the aegis of the International Union Against Cancer (UICC). A screened web-based network of individuals and organizations active in tobacco control, membership has grown from 80 in 1994 to nearly 2500 members from 106 countries in mid 2001. In addition to discussion groups, national and regional newsletters, and web publishing and hosting, GLOBALink also offers special services such as *TobaccoPedia*, an on-line tobacco encyclopedia, and is developing *TobaccoAcademy*, an international distance-learning project funded by the

Rockefeller Foundation (Israel 2001). More broadly, rapid developments in information technology have facilitated expanded access to millions of tobacco industry documents, thus greatly expanding awareness of how the industry operates (Shatenstein 2001), and has facilitated regional capacity building projects such as the Czech Republic's Internet-Based Tobacco Control Program funded by the World Bank (Savinova 2001).

Negotiations for a FCTC have also provided a major impetus to improving links among NGOs active in tobacco control and to encouraging groups, particularly from low-income countries, to engage in international issues. While NGO participation in early meetings was almost exclusively from high-income country NGOs and international health-based NGOs, such groups have subsequently given financial assistance to enable the participation of NGO representatives from the developing world. The coherence of NGO activities and the scope for impact by developing country activists, however, have been significantly increased as a result of the formation of the Framework Convention Alliance. This grouping of over 60 NGOs was created to improve communication between those groups already engaged in the FCTC process and to address the need for a systematic outreach to smaller NGOs in developing countries (Wipfli et al. 2001).

This is indicative of the process benefits that are already being derived from the FCTC. Additional gains can be seen in the ways in which the conduct of negotiations has required states to engage in tobacco issues on a co-ordinated, cross-departmental basis, often for the first time, and the increased involvement of other UN agencies and international organisations. WHO's success in engaging the World Bank in propounding the economic case for tobacco control has been of particular significance (Collin et al. 2002).

It is, however, critically important to the success of efforts to check the currently relentless progress of the global tobacco pandemic that the negotiations produce a powerful and effective Convention. As discussed above, the role of the European Union has to date been rather disappointing, and there is clearly a need for increased assertiveness among more progressive member states as a counterweight to attempts to enfeeble the convention. Recognition of the constraints imposed on the EU's position in the aftermath of the annulment of the advertising directive by the ECJ highlights the need to give the protection of public health a much firmer basis than EU treaties currently allow. The newly inaugurated Convention on the Future of Europe provides an important opportunity to advance this case, and it is to be hoped both that the UK government will support such steps and that public health advocates seek to engage fully with this process.

CHAPTER 5. **CONCLUSIONS AND RECOMMENDATIONS LESSONS FOR PUBLIC HEALTH IN THE UK**

5.1 Introduction

The aim of this study has been to review and assess public health measures in the UK in relation to globalisation and, in particular, the challenge of transborder health risks. The case studies of population mobility and tobacco control conducted for this study illustrate the diverse challenges for public health in the UK posed by the complex changes associated with globalisation. The intensification of flows of people and tobacco products are generating transborder health risks (THRs) that are qualitatively and quantitatively different from those of preceding eras, risks that require novel approaches to health governance if they are to be effectively addressed. This is not to imply the impending plague-ridden doomsday scenarios depicted in more excitable accounts of the links between globalisation and health. Rather, it is to acknowledge the greater importance that needs to be given to the protection and promotion of public health in current debates about globalisation, requiring informed and innovative thinking about the challenges before us.

As is inevitably the case with a relatively small project of this scope, there are clear limits to what can be inferred on the basis of examining two issue areas. Undoubtedly, many of the problems highlighted are essentially issue or group specific, and those working more directly in these areas are likely to be better placed to identify solutions to them. The observations from this study are also specific to the UK, a country that might be expected to be especially integrated across diverse global flows for historical, geographical and political economic reasons. Similar studies reviewing the particular public health measures of other countries, in relation to globalisation, are thus strongly encouraged. Despite these caveats, the study as a whole, and the specific case studies of tobacco control and population mobility serve a number of useful purposes, as well as identifying key challenges for health governance. Some of these have been raised in the previous chapters, and indeed partially addressed by policy makers in recent years, while others remain unacknowledged. These are reviewed and summarised in this chapter.

5.2 The usefulness of transborder health risk/opportunity as a public health concept

It is clear from the case studies that processes of global change are changing the character of risks to public health in the UK. While there are numerous methodological problems involved in the effective quantification and assessment of such risks, notably in identifying and measuring the impacts of global change at the national level, the concepts of transborder health risk and opportunity allow us to highlight the positive and negative externalities associated with particular flow variables such as people, goods and services, and information and communications.

Importantly, the study supports a broad understanding of the health risks and opportunities arising from global change. As described in Chapter Two, THRs have historically been understood primarily in terms of controlling the spread of infectious disease from abroad, and early forms of public health institutions and practices (e.g. quarantine, cordon sanitaire) focused on this task. The case study on population mobility highlights the continuing, and arguably renewed, relevance of this perspective as illustrated by current discussions of imported cases of malaria, HIV/AIDS and tuberculosis. High-level policy concern, particularly since 11 September 2001 with the threat of biological weapons, and the spectre of terrorism spreading anthrax, smallpox and other infectious diseases, is an extension of this historical focus.

The case studies, however, make clear that THRs are not confined to infectious disease. In Chapter Three, the diverse health risks encountered by some refugees, asylum seekers, undocumented migrants and victims of trafficking provide support for a broader approach. In the case of population mobility, THRs can arise at any stage of travel or migration, and evidence of cross-generational health impacts (e.g. genetic admixture) illustrates their potential duration over time. Similarly, while not usually thought of in such terms, the persistent scale of the epidemic of tobacco-related disease and death in the UK is testimony to the magnitude of THRs and their direct implications for public health. In global terms, the challenge of tobacco control for public health communities at the national level is complicated by the transborder nature of the strategies and activities of transnational tobacco companies in expanding their markets worldwide. These activities illustrate the spatial, temporal and cognitive dimensions of globalisation, and the particular difficulties faced by health governance limited to the national level.

The case studies also provide evidence of the ways in which globalisation is providing important opportunities for health. The multiple flows associated with global change are unlikely to be unidirectional in impact, and features of both the population mobility and tobacco control case studies illustrate the potential to improve health status and outcomes. We can cite here the potential for policy learning across national and regional contexts in developing effective tobacco control legislation and policies, the positive contributions of information technology for improving transnational linkages among tobacco control advocates, and, above all, the prospect of an effective Framework Convention on Tobacco Control. Intensified population mobility also offers significant benefits to health at the national level. These are illustrated by the contribution of overseas-born health

professionals to addressing acute skills shortages within the NHS, the potential role for refugee doctors following re-training programmes, and the net economic gains overall from inward migration that, in turn, provides additional revenues for public expenditure on the social sectors.

This report recommends the adoption of a broader conceptualisation of the impacts of globalisation on human health than presently prevails in the popular and scientific literature. Such an approach would recognise the diversity of transborder health risks and opportunities being created by globalisation for different individuals and population groups.

5.3 The particular vulnerability of the UK to THRs

While it is important to acknowledge that this study of public health measures in the UK is context specific, and there is a need for caution in making generalisations to other national contexts, the UK serves as an especially useful starting point for assessing the experience of THRs and THOs at the national level. The UK should be recognised as comparatively vulnerable to certain categories of transborder health risk, and particularly well-placed to take advantage of associated opportunities. This is due to the extent to which UK citizens engage in overseas travel, the correspondingly large number of visitors to the UK, the strength of historical and cultural links to many low-income countries, membership in the European Union, the country's scale of economic reliance on trade relations worldwide, the expansion of the English language globally, and geographical location as a hub for international transportation and communication networks.

In this context, it is equally clear that the UK is likely to function as a disproportionate exporter of transborder health risks and opportunities. In contrast to popular understanding of globalisation as primarily posing risks from low-income countries to high-income countries, the broader approach advocated above recognises the many directions in which risks and opportunities can flow. Hence, the integration of the UK's tobacco industry within the global tobacco trade is indicative of this capacity to spread risk transnationally. The particularly prominent role of the UK with respect to BSE and vCJD (Lee and Patel 2002) is a further example of the global dissemination of health risk. Correspondingly, the need for the UK to grapple with policy issues surrounding population mobility, global telecommunications regulation, and economic and trade policy can be highly informative for other countries. The export by the UK of health research, training, skills and expertise (e.g. Human Genome Project) of worldwide significance also demonstrates the contribution that the country makes to global health.

This report recommends that similar analyses of national public health systems be supported of countries that are believed to be especially relevant to understanding THRs and THOs. Criteria such as geographical location, trade as a proportion of GDP, links to global communication and transportation networks, cultural and historical factors, and demographic composition may be used. A range of countries may be selected to explore different geographical regions and levels of economic development. With additional national studies, comparative analysis of public health measures across countries may then be undertaken.

5.4 The need for public health policy and practice beyond the border

One of the key findings of this study is that globalisation poses a direct challenge to public health systems that focus efforts at the physical borders of states. Historically, infectious disease control has been given primary emphasis in international health cooperation based on the assumption that the integrity of national borders can be upheld. The protection of the health of populations living within a given geographical location (i.e. state), therefore, was dependent on the prevention and/or control of infectious agents crossing the physical boundaries of states. The development of quarantine policies epitomised this approach.

In practice, this was never a foolproof method for protecting public health as witnessed by the pandemics of smallpox, plague, cholera and other diseases over the past six centuries or so. Nonetheless, with improvements in basic living conditions in industrialised countries, accompanied by the development by national governments of health care systems, the focus on state borders was reinforced.

It is in this context that the public health system in the UK evolved to deal with risks arising from abroad. Ports of entry became natural focal points for such efforts based on the belief that monitoring and controlling the flow of people across British borders would reduce the risk of transborder infections. Policies and practices based on the "patrolling" of territorial borders have endured to the present day in the form of Port Health Control Units. The capacity of PHCUs, however, to effectively screen the ever growing flows of people, other life forms and goods across British borders is clearly limited. Moreover, the rationality of concentrating efforts at screening flows across borders is questionable given the nature of many THRs. The current practice of screening tourists and migrants for TB, for example, is often found to be subjective, random and clinically ineffectual.

This study recommends the need for a paradigm shift from a "fortress" approach to protecting public health in the UK to one that recognizes the need for policy action both beyond and within national borders. Given the increasingly porous nature of the territorial borders of all states to an expanding range of health determinants, there is a need to address these to see the causes of ill-health on a global rather than local scale. This has important implications regarding the rationale for international health cooperation and aid programmes.

5.5 The need for closer cross-sectoral and interagency collaboration

This study has found shortfalls in how transborder health risks are addressed because of problems of coordination among different sectors and agencies. Cross-sectoral collaboration has not been something in which government agencies have traditionally excelled, while the devolution of responsibilities to Scotland, Wales and Northern Ireland places a further onus on the proclaimed shift towards "joined-up government". The two case studies highlight the scale of such problems. On population mobility, there are clear anomalies. Successive reports on the health needs of asylum seekers by a variety of organisations, including the Audit Commission, Health of Londoners Programme and Medact, have emphasised the incoherence and fragmentation of responses across agencies. For example, follow-up procedures on initial health screening undertaken by Port Health Control Units has been extremely poor.

Liverpool Health Authority reported that it receives no information on asylum seekers from Port Health Control, meaning that TB screening has to be repeated (Audit Commission 2000).

Importantly, the objective of protecting public health amidst population mobility has historically taken second place to policies of immigration control. If there is screening of arrivals at ports of entry, a practice with dubious practical effect, initial selection is frequently carried out by passport control officials rather than by medical personnel. Within the current political climate, in particular, there is a desire by the government to be seen as taking a tough stand on immigration control. Policies aimed at discouraging and dispersing asylum seekers have direct public health implications.

The cross-sectoral impacts of tobacco also constitute a challenge to effective policy and governance, and divided responsibility characterises the modesty of tobacco control regulation in the UK. Issues surrounding tobacco control from a global perspective cross the competences of multiple departments and agencies including HM Customs and Excise, the Treasury, Department of Trade and Industry, and the Department for International Development as well as the Department of Health. The House of Commons Health Select Committee (2000) recommended the establishment of a Tobacco Regulatory Authority (TRA) with a broad remit for overseeing control policies. The Committee's report envisaged "a TRA with responsibility for all aspects of tobacco regulation consistent with the limitations imposed by European law", including areas such as product regulation and marketing. Alongside the absence of an advertising bill in the post-election Queen's Speech, the failure to initiate such a single regulatory body represents a disappointing response to the challenge of ensuring more effective regulation of the tobacco industry in the UK.

Related to the requirement for improved coordination is a clear need to rethink the historic basis of the regulation of transborder health risks, namely control at the border. As noted by the International Organization for Migration, the speed and volume of air travel combine to "functionally eliminate the international frontier in terms of infectious disease control" (Gushulak and MacPherson 2000). Clearly this challenges the state at a very sensitive point, and governments are unlikely to acknowledge their inability to effectively control their national borders, but there does need to be a fundamental questioning of the current role of Port Health Control Units. As the comparatively small proportion of asylum seekers seen by PHCUs illustrates, the scale of contemporary international travel makes systematic coverage of arrivals practically impossible. The speed of air travel means that health controls at the border can no longer be as effective as in the days when incubation periods outstripped journey times. Different approaches are now needed, and integrated electronic surveillance networks are a far more promising means of achieving the management of transborder infections.

This study recommends that the public health community engage more directly with other sectors, and with a broader range of relevant governmental and nongovernmental agencies in order to develop cross-sectoral approaches to transborder health risks. This requires going beyond the traditional focus on health determinants to understand how trade, taxation, telecommunications, immigration and transport policies, for example, have significant influence over public health outcomes.

5.6 The need to support more effective regional and global health governance

The challenges of strengthening health governance at the national level are multiplied at the regional and global level where there are an even greater number of institutional actors involved. At the regional level, the case studies highlight the diverse yet direct impact of UK membership in the EU on the capacity to protect and promote public health from THRs. The regulation of both population mobility and tobacco control is increasingly conducted at the European level. The concept of Fortress Europe connotes the extent to which asylum policy, for example, is heavily influenced by developments at the regional level such as the Dublin Convention.

The transfer of policy competence to the regional level has significant implications for public health, not least because of the low level of support that the EU's legal framework provides for measures to protect public health. When the EU has taken significant steps to intervene in health issues, most notably on the issue of BSE/vCJD, action was guided strongly by the priority of managing potential implications for trade. This reflects the clearly subordinate status of health in the EU's hierarchy of objectives. The annulment of the tobacco advertising directive in 2001 by the European Court of Justice again illustrates the primacy given to trade concerns over public health exigencies by the legal and policy framework of the EU. The ECJ's judgement has clarified the formal subordination of public health to single market harmonisation. In addition to having adverse effects on efforts to promote and protect public health within the EU, the constraints of trade policy strongly influences the EU's position in international forums notably the FCTC negotiations. The EU's stance so far has been weak, by public health standards, to the extent that it may threaten to undermine the protective potential of the FCTC globally. There is therefore a clear need for greater scope for public health protection at the European level than that currently allowed by EU treaties. The imminent Convention on the Future of Europe provides an opportunity for public health advocates to engage with European integration to advance such a case.

At the global level, the inadequacies of statecentric modes of health governance (Dodgson et al. 2002) are exposed by the findings of this study. The negotiations for a FCTC and the ongoing revision of the International Health Regulations (IHR) constitute explicit recognition of the inadequacy of existing provisions for regulating THRs. An exclusive reliance on intergovernmental cooperation is recognized as an inaccurate reflection of reality, and is neither practical nor desirable. Nongovernmental organizations have long played an important role in international health, both domestically and abroad.

The challenge for global health governance is the need for possible further expansion of this role, beyond filling gaps where state action is absent or implementing policies taken by governments. Within WHO, there is a growing emphasis on greater involvement by civil society groups, albeit subject to the constraints of working within an intergovernmental organisation answerable to its member states. In revising the IHR, for example, the effectiveness of WHO's responses to outbreaks has in the past been curtailed by the need to operate only on the basis of official sources of information supplied by member states. The new emphasis on surveillance in developing global health security enables WHO to offer

quicker assistance in the event of disease outbreaks. States will retain a major role in verifying such episodes, but the vast majority of information gathering is now being performed by nonstate sources. Similarly, the negotiations towards the FCTC have been characterised by a shift in the traditional relations between WHO and civil society groups. The Byzantine process by which such groups can enter into official relations with WHO has been somewhat accelerated and streamlined, chairs of sessions have been encouraged to allow active NGO participation, and NGOs have been able to play important roles in mobilising, motivating and monitoring member states (Collin et al. 2002).

This study recommends that the UK support the development of new forms of health governance at the national, regional and global levels that more effectively address THRs. Such forms of governance require closer cross-sectoral collaboration, that greater importance be given to public health priorities in relation to other policy areas, and a greater role for nongovernmental organizations or civil society.

5.7 The need for a strong public health voice in globalisation debates

The study finds that, although high-level policy makers recognize the critical importance of globalisation on the UK, public health concerns have generally taken a back seat to other policy areas. As discussed above in relation to regional and global health governance, other policy areas have so far been given a higher priority on policy agendas. The two case studies illustrate the tensions between public health needs, on the one hand, and trade and immigration policies on the other. A striking example is the omission of any reference to health in the 1998 White Paper entitled *Fairer, Faster and Firmer* that forms the basis of the Immigration and Asylum Act 1999. Similarly, a report for the Home Office aimed at developing a strategy for the integration of refugees into the UK (National Asylum Support Service 2000) recognizes the importance of access to health care and current difficulties. However, these concerns comprised only one section of the report and were not accompanied by any measures to address access problems in its action plan. The announcement in 2002 of the imminent overhaul of asylum and immigration policy includes provision for screening and health checks at induction centres and the establishment of health facilities at accommodation centres. This may herald a new awareness of the public health implications of population mobility, but may equally constitute liberal window dressing for an essentially authoritarian response to the asylum issue. Plans for the provision of health care at accommodation centres have not yet been finalised but have already attracted considerable controversy. Reports that private health firms may be contracted to treat asylum seekers provoked angry allegations of preferential treatment (BBC News 2002b). More sympathetic voices have highlighted the dangers of segregation and alienation implicit in such provision, particularly given similar features in related proposals such as educating asylum seeking children outside of usual state schools (Brown and Dillon 2002).

Meanwhile, the significance of public health considerations in shaping tobacco policy in the UK seems to have been undermined since the heady days of the White Paper *Smoking Kills*. This has been most publicly evident in connection with advertising, from the Ecclestone affair and the exemption of tobacco sponsorship for Formula One motor racing, to the absence of an advertising bill in the Queen's Speech of 2001. Arguably more important was

the decision to abandon the tax escalator of year-on-year tax increases in the face of tobacco industry pressure built around the smuggling issues. None of these policies can be defensibly presented from the perspective of public health where there is overwhelming evidence to support stronger controls.

The case studies illustrate that, even where clear empirical evidence strongly favours particular policy decisions to protect and promote public health, in itself this is insufficient for influencing the political process. In large part, this is because the public health community in the UK, as in other countries, wields less influence over policy making as part of the social sector. However, the study also finds that UK public health institutions have not yet engaged with the full implications of globalisation. The Department of Health remains heavily focused on "domestic" health and health determinants within UK borders.

The concerns over terrorism and, in particular, biological and chemical warfare since September 2001 have attracted the attention of the Department of Defence and the Foreign Office to THRs as a national security issue. While there is a danger of such issues overly narrowing the policy focus, as observed in the US since the mid 1990s (Institutes of Medicine 1997), this can also been seen as an opportunity for the public health community to open a fuller policy debate about the increasingly transborder nature of health determinants and outcomes.

This study recommends that the UK government develop a national strategy on global health that recognizes the broad and diverse challenges of globalisation for public health in the UK. Such a strategy requires high-level leadership to ensure involvement by all relevant parts of government, and engagement with the diverse range of individuals and institutions outside of government. The strategy would seek to achieve coordination of activities across institutions, and to ensure preparedness for THRs of immediate and longer-term concern.

APPENDIX. **LIST OF KEY INFORMANTS AND DISCUSSANTS**

Mr Clive Bates, Director, Action on Smoking for Health UK

Dr Douglas Bettcher, Coordinator, Framework Convention on Tobacco Control, Tobacco Free Initiative, WHO

Dr Angela Burnett, Medical Foundation for the Care of Victims of Torture

Mr William (Sandy) Cocksedge, International Health Regulations, Communicable Diseases, WHO

Dr Nick Drager, Project Leader, Globalisation, Human Rights and Cross Sectoral Issues, Department of Health and Development, WHO

Ms Fatimah El-Awa, Regional Adviser, Regional Office for the Eastern Mediterranean, WHO

Professor Stanton Glantz, University of California at San Francisco, USA

Dr Danielle Grodin, Director, Migration Health Services, International Organization for Migration, Geneva

Mr Ross Hammond, Campaign for Tobacco Free Kids

Ms Belinda Hughes, Framework Convention Alliance

Ms Caroline Hyde-Pryce, Royal College of Nursing

Dr Richard Kornicki, Tobacco Control Programme, UK Department of Health

Dr Daniel Koch, Chief Medical Unit, International Committee of the Red Cross, Geneva

Professor Ron Labonte, University of Saskatchewan, Canada

Professor Tim Lang, Thames Valley University, London

Dr Lindsay Martinez, International Travel and Health, WHO

Mr William Onzivu, Legal Officer, Framework Convention on Tobacco Control, Tobacco Free Initiative, WHO

Dr Peter Poore, Independent Adviser and core member, Global Alliance for Vaccines and Immunisation Financing Task Force

Dr Guenael Rodier, Director, Department of Communicable Disease Surveillance and Response, WHO

Dr Cathy Roth, Medical Officer, Epidemic Disease Control, Department of Communicable Disease Surveillance and Response, WHO

Dr Mike Ryan, Department of Communicable Disease Surveillance and Response, WHO

Dr Maria Santamaria, Department of Communicable Disease Surveillance and Response, WHO

Dr Rosalind Stanwell-Smith, Consultant in Public Health

Ms Judith Watt, SmokeFree London

Ms Jacqueline Weekers, Migration Health Services, International Organization for Migration, Geneva

Professor Julius Weinberg, City University

Derek Yach, Executive Director, Noncommunicable Diseases and Mental Health, WHO

Ms Cathy Zimmerman, Health Policy Unit, London School of Hygiene & Tropical Medicine

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