FOREIGN POLICY CASE STUDIES

Tobacco Control

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The development of international tobacco control policy was a unique interaction of public health and foreign policy, played out on the global stage. Nevertheless, despite the overwhelming evidence base, the agreement was a challenge for public health due to the competing priorities of different government departments and non-governmental key players. The eventual achievement of an international multi-sectoral agreement may be a model for future public health interventions within federal Europe.

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Introduction

Recent developments in tobacco control policy in both domestic and international contexts make this an appropriate sphere within which to analyse changes in the relationship between foreign policy and public health. It admittedly offers a rather narrow lens, the implications for security that are so evident in the case studies of migration, bioterrorism and HIV/AIDS being both less apparent and lacking their severity and immediacy. That is not to say that such implications are entirely absent. Emerging evidence from tobacco industry documents has highlighted the significant involvement of armed forces, police and customs in the global trade in smuggled tobacco products (Collin *et al*, in press), while in sub-Saharan Africa broader concerns arise from the scale of reliance on tobacco as a cash crop, particularly in Malawi and Zimbabwe (Campaign for Tobacco Free Kids 2001). Notwithstanding this limitation, there are several compelling reasons for including tobacco control within this series, and these take on a particular resonance for the United Kingdom.

Firstly, there is the sheer scale of the challenge to global health posed by the pandemic of tobacco-related death and disease. Importantly, there now exists a clear evidence base demonstrating that key features of the global economy have facilitated the global expansion of transnational tobacco companies (TTCs) and increased tobacco consumption among developing countries. Secondly, the scale and power of economic interests associated with the tobacco industry means that health policies designed to reduce consumption have long been comparatively politicised. Furthermore, the release of millions of pages of industry documents following litigation in the United States provides a unique opportunity to explore the strategies employed by transnational corporations to exert political influence (Ciresi *et al* 1999; Lee *et al* 2004; Collin *et al* 2004). Thirdly, the corporate sector in the United Kingdom plays a particularly important role within the political economy of tobacco, reflecting the longstanding prominence of British American Tobacco (BAT) as a global actor and the rapid recent expansion of both Imperial Tobacco and Gallaher. Fourthly, the development of tobacco control policy in the UK has been significantly affected by Europeanization, with the gradual development of health policy at an EU level, and increasingly by devolution. Fifthly, the somewhat schizophrenic record of the Blair governments in handling tobacco issues since 1997 has repeatedly emphasised the tensions inherent in attempting to reconcile public health with conflicting policy objectives.

Finally, most significantly in the present context and cross-cutting each of the above factors, the global politics of tobacco control have recently been dominated by a striking innovation in health governance. By initiating negotiations for a Framework Convention on Tobacco Control (FCTC), the World Health Organisation undertook its first attempt at an international public health treaty. Importantly, the FCTC process clearly constituted an attempt to develop an appropriate response to globalisation, recognising the inability of traditional national and international governance to effectively counter the health impacts of TTCs. A core element of then Director-General Gro Harlem Brundtland's attempt to revitalise WHO, the FCTC negotiations were characterised by, *inter alia*:

- considerable success by WHO in co-ordinating support from other international organisations for its health-focused agenda, particularly that of the World Bank;
- extensive engagement by member states, requiring considerable inter-departmental consultation and collaboration;
- over-riding consensus on the value of a framework convention, but substantial conflict over its content and development reflecting tensions between health and competing objectives;
- efforts to situate tobacco control objectives more prominently on related policy agendas, including development, human rights and gender;
- a partial but significant opening of the policy process to participation by civil society;
- formal support from the UK government but inconsistent positions and an absence of positive leadership.

Following brief introductions to the global tobacco industry and pandemic and to the context of tobacco control policy in the UK, the primary focus of this case study will be on analysing the politics of the FCTC. The conclusion will then reflect on how the FCTC process illuminates the relationship between health and foreign policy communities, using the conceptual framework developed for this Nuffield Trust programme (McInnes and Lee 2004).

Globalisation and Tobacco

Recent trends highlight the increasingly inequitable distribution of global tobacco consumption and in its related health impacts. A broad decline in prevalence across most high-income countries over recent decades has coincided substantial increases among low and middle-income countries (LMICs), the latter already accounting for 82% of the world's smokers (Gajalakshmi *et al* 2000). Around 4.9 million deaths were attributable to tobacco use in 2000, an increase of 45% since 1990, with rapid escalation in developing countries that now account for 50% of these deaths (WHO 2002). It is predicted that, without significant intervention, by 2030 the global total will reach 10 million deaths pa (equivalent to around one in six adult deaths), 70% of which will occur in developing countries (Gajalakshmi *et al* 2000).

This shift has been facilitated by broader social and economic changes associated with globalization and, in particular by trade liberalization. The opening of emerging markets in LMICs has enabled the rapid expansion of operations by TTCs, focused particularly on Asia, underpinning their status as the primary vectors of the tobacco pandemic. While trade liberalization has led to increased tobacco consumption, the distribution of this rise has been uneven. There has been no substantive effect on consumption in higher-income countries, but trade liberalization 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). The entry of TTCs into new markets has also been shown to have a significant impact in raising consumption. This is demonstrated by the effects of the so-called Section 301 agreements, by which access to the markets of Japan, South Korea, Taiwan and Thailand was obtained following the threat of trade sanctions by the US (and, in the Thai case, adjudication by GATT). It is estimated that the opening of these markets increased per capita cigarette consumption by an average of 10% by 1991 (Chaloupka and Laixuthai 1996).

As such figures suggest, global political and economic change has transformed the prospects of the tobacco industry. 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). Such new opportunities triggered a major shift in corporate strategy across the TTCs, shifting from the extensive diversification characteristic of the 1980s to renewed reliance on and reinvestment in tobacco (Warburg 1995). Expansion into new markets offset concerns about gradual decline in traditional markets in North America and Western Europe, fundamentally changing the character and focus of TTCs. In 1989 Philip Morris' tobacco operations in the US provided profits of US$3.1 billion compared with just US$0.8 billion internationally, but by 1998 the balance was almost reversed, with domestic profits of US$1.5 billion dwarfed by US$5 billion of international profits (Joossens and Ritthiphakdee 2000).

Such expansion has progressed alongside substantial consolidation within the industry. Dramatic changes such as BAT's 1999 merger with Rothmans and Japan Tobacco's purchase

of RJ Reynolds' international tobacco business were part of over 140 mergers and acquisitions by TTCs between 1990 and 2001 (Physicians for a Smoke-Free Canada 2001). By the end of the 1990s, three-quarters of the world cigarette market was controlled by just four companies: Philip Morris (PM), British American Tobacco (BAT), Japan Tobacco International (JTI) and the China National Tobacco Corporation (Crescenti 1999). While the latter's share is almost entirely attributable to its dominance of the enormous Chinese market, PM, BAT and JTI have assiduously pursued growth through worldwide expansion and in 2002 had combined tobacco sales of over $121 billion (World Bank 2003). Even greater consolidation has occurred in leaf purchasing, where the global market is now set to be dominated by just two companies (Dow Jones Newswires 2004).

In summary, the transformation of the tobacco industry enabled by globalisation has resulted in its dominance by a small group of extremely powerful global actors, based in the US, UK and Japan but with diverse interests that are increasingly focused on developing countries. Given the scale of tobacco's impact on global health and with internal documents revealing extensive political influence exerted by the TTCs, this context broadly illustrates both the need for an effective FCTC and outlines the formidable interests opposed to its realisation (Collin, Lee and Bissell 2004).

The United Kingdom and the Politics of Tobacco Control

An initial examination of the record of the Labour governments since 1997 suggests an impressive commitment to curbing tobacco consumption both within the UK and internationally. Health professionals and advocates had invested hopes in the incoming Blair administration attaching greater significance to tobacco control than its Conservative predecessors, and in many respects such hopes have been realised.

The publication in 1998 of the white paper 'Smoking Kills' established the objective of reduced tobacco consumption as central to the new government's public health agenda, particularly in combating health inequity. Smoking was recognised as the leading avoidable cause of death in the UK, responsible for some 120 000 deaths per year. Additionally, the white paper highlighted the critical role of tobacco control measures in tackling health inequalities, with smoking contributing more than any other identifiable factor to the gap in healthy life expectancy between those most in need and those most advantaged (HMSO 1998).

This commitment to tackling tobacco control has subsequently in the passage of comparatively substantial legislation. Among achievements to be highlighted in this context are:

- The Tobacco Advertising and Promotion Act 2002, banning press, billboard and most internet advertising of tobacco products
- Point of Sale regulations imposing stringent restrictions on advertising where tobacco products are sold, such as shop display counters.
- Brand sharing regulations prohibiting the promotion of tobacco products via another product sharing its trademark
- An end to tobacco sponsorship by 31 July 2005 (DoH 2004a)
- The Tobacco Products (Manufacture, Presentation and Sale) (Safety) Regulations 2002, providing for enlarged health warnings, maximum yields of tar nicotine and carbon monoxide, and the prohibition of 'misleading descriptors' on tobacco products (e.g. light or mild) (DoH 2004b)

Additionally, the government can legitimately claim to have established itself as a global leader in the area of cessation, particularly via efforts to improve access to nicotine replacement therapies.

At the European level, the election of the Blair government broke the persistent blocking minority that had long maintained a legislative stalemate on tobacco regulation within the European Community (Neuman *et al* 2002). The UK has since been broadly supportive of tobacco control measures at the regional level, and recent domestic legislation has primarily been the transposition of directives agreed among the EU member states.

Internationally, both the departments of Health and International Development have highlighted the important potential contribution of tobacco control in advancing their respective agendas (DoH 1998, DfID 2000). Within the context of general pressure for reform of the Common Agricultural Policy, the government has repeatedly highlighted the perverse and inequitable effects of the high levels of support given to the production of low quality tobacco within the EU (**ref**). Measures have also been taken limit the involvement of government officials and agencies in promoting tobacco sales abroad.[1] Guidelines were issued by the Foreign Office in 1999 stating that British embassies should not "be associated in any way with the promotion of the tobacco industry" (BBC News 1999), while both unmanufactured and manufactured tobacco are classified by DFID as ineligible for aid funding (DFID nd). The recent focus of international work by UK government departments has, of course, been the FCTC, and the nature of their contribution to the process is discussed below.

Despite this comparatively extensive chronicle of engagement and achievement in tobacco control, analysis of the domestic and international record of the Labour government also reveals a substantial level of disquiet and ambiguity. There have been a perhaps surprising number of instances where government policy and conduct has diverged significantly from the consensus on best practice among health professionals (WHO 2004).

The first high profile instance of actions that seemingly contradicted the commitment of the 'Smoking Kills' white paper was the government's active support for allowing motor sports an extended exemption from both national measures and from a proposed European ban on sports sponsorship. While publicly justified with reference to the economic significance of technologically advanced Formula One racing teams based in the UK, it was subsequently revealed that the Labour Party had received a £1 million donation from Bernie Ecclestone, the dominant figure within the sport (Rawnsley 2001). Given both Formula One's reliance on tobacco sponsorship and the sport's significance the global ambitions of the tobacco industry (Carlisle *et al* 2004), this embarrassing saga also raised questions about the government's commitment to tackling the marketing of tobacco products. These were exacerbated by the surprising failure to include an advertising ban in the Queen's speech following success in the 2001 general election (Collin and Lee 2002).

Further concern has been raised by the government's response to extensive corporate documentation indicating the complicity of BAT in cigarette smuggling (Collin *et al*, in press). In response to evidence presented to the House of Commons Select Committee on Health in 2000, an inquiry was launched by the Department of Trade and Industry. This eventually resulted some four years later in a quiet announcement that no further action would be taken, while the inquiry's findings would not be published. Disquiet was heightened by the recent disclosure of corporate and government documents indicating that the then Trade minister Stephen Byers was subjected to pressure to downgrade the original scope of the inquiry, pressure apparently arising from BAT's access to the Prime Minister (Evans, Leigh and Maguire 2004). The implication that the DTI subsequently served to protect the interests of "one of Britain's 'world class' companies" raises particular concerns from an international

1. This contrasts, for example, with the role of the UK ambassador to Thailand in promoting market opening and undermining control legislation (McKenzie *et al*, in press).

perspective, given the significance of smuggling as a health issue (Joossens *et al* 2000) and its relevance both to developing countries and to the FCTC (Collin *et al*, in press).

To such incidents can be added the abandonment of the policy of year-on-year tax increases in the face of industry claims that it smuggling was the result of excessive taxation (Collin and Lee 2002), and the seemingly bizarre nature of the government's position on restricting smoking in public places. The reluctance to embrace a comprehensive ban along the lines pioneered by Ireland reportedly reflects concerns by Health minister John Reid that such measures would be economically or electorally damaging.

Such episodes undoubtedly lend themselves to lurid accounts in which the Labour governments or Blair himself are depicted as the obedient creatures of tobacco companies (Cohen 2000). While such caricatures may be reasonably dismissed, these disputes do demonstrate that the development of tobacco policy continues to be characterised by competition between conflicting priorities. A public health agenda is clearly established as the primary lens through which tobacco issues are addressed, but equally clearly it is not entirely dominant in circumstances where health objectives are perceived as compromising disparate employment, trade or electoral concerns. A pattern emerges of a significant and broad commitment to tobacco control, primarily shaped by public health concerns, but nonetheless qualified by and sometimes subordinate to competing priorities. This pattern can also be seen as characterising the UK's contributions to the development of the FCTC.

Negotiating the Framework Convention on Tobacco Control

A text laboriously developed following two preliminary meetings of a working group and across six sessions of an Intergovernmental Negotiating Body (INB) received the unanimous endorsement of the 56th World Health Assembly in May 2003. This signalled the successful conclusion of four years of negotiations for a Framework Convention on Tobacco Control (FCTC), representing the first attempt by WHO to exercise its constitutional authority to develop a global public health treaty (Shibuya *et al* 2003). Among the key features of the final text are provisions encouraging countries to:

- Enact comprehensive bans on tobacco advertising, promotion and sponsorship
- Require large rotating health warnings on packaging, to cover at least 30% of principal display areas, and with provision for pictorial warnings
- Prohibit the use of misleading descriptors such as 'light' or 'mild'
- Increase taxation of tobacco products
- Provide greater protection from involuntary exposure to tobacco smoke
- Develop measures to combat smuggling (Hammond and Assunta 2003).

The FCTC text is lacking in binding obligations, which may be developed further by a number of issue-specific protocols (Joossens 2000), and failed to include language that would clarify its status in relationship to existing trade agreements ('health vs. trade' being the single most divisive issue during negotiations) (Collin 2004). Such caveats notwithstanding, however, the final text was both broadly welcomed by health groups and a remarkable advance on the heavily criticised preceding draft (Kapp 2003).

The principal value and interest of the FCTC, however, resides in the process of its development rather than in the content of the actual text (Taylor 2000; Collin, Lee and Bissell 2004; Collin 2004). The remainder of this section highlights specific characteristics of this process considered to be of particular relevance to the relationship between foreign policy and public health.

Support of UN organisations and the World Bank

A key task for WHO in enabling the development of the FCTC was to secure the support, or at least the acquiescence, of other international agencies with an interest in tobacco issues. An important initial step was the establishment in 1999 of the Ad Hoc Inter-Agency Task Force on Tobacco Control to improve coordination and cooperation. Significantly, WHO was awarded leadership of the task force, signalling a shift by UN agencies towards primarily viewing tobacco issues from a health perspective. It replaced a UN focal point that had been situated within the UN Conference on Trade and Development (UNCTAD). An inquiry into

tobacco industry influence within WHO highlighted the extent to which the UNCTAD-based focal point had "opened the door to tobacco industry influence throughout the UN", influence that was also strongly in evidence within the Food and Agriculture Organization (FAO) (Zeltner *et al* 2000).

The work of the Task Force engaged the participation of fifteen UN organisations as well as the World Bank, the International Monetary Fund and the WTO (Wiplfli *et al* 2001). Its technical work in support of the negotiation process included projects on environmental tobacco smoke, deforestation, employment and the Rights of the Child (Taylor and Bettcher 2001; WHO and UNICEF 2001). Such projects effectively illustrate both the multisectoral impacts of tobacco policy and a strategic decision to attempt to situate tobacco control more prominently within other policy agendas, including development and human rights.

The increasing engagement of the World Bank was of critical importance in enabling the FCTC process, and particularly in building support for it among developing countries. A landmark in this regard was the publication by the World Bank of the 1999 report, *Curbing the Epidemic*, depicting comprehensive tobacco control measures as providing a virtuous circle of cost-effectiveness and impacts on health:

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).

The dissemination of this report has been critical in undermining the widespread belief in the existence of net economic benefits from tobacco production and consumption, the pervasiveness of which has historically constituted the single greatest political obstacle to the progress of effective regulation. The impact of the report was consolidated by subsequent more detailed exploration of economic issues surrounding tobacco use in developing countries (Jha and Chaloupka eds 2000). It is also worth noting the tobacco industry's internal recognition of the significance of Brundtland's ability to attract active support from the World Bank to the FCTC's prospects of success (BAT, nd).

Extensive participation by WHO member states

While concerned to make the FCTC process broadly inclusive, the primary focus of an international organisation such as WHO was inevitably on engaging the support of its member states. In this respect the level of involvement throughout a protracted process was impressive, albeit characterised by predictable inequalities across national delegations in terms of their scale and breadth of expertise. Resolution 52.18 was unanimously adopted by the World Health Assembly in 1999, when a record 50 states took the floor to commit political and economic support (WHO 2000). The first INB in October 2000 was attended by 148 countries, while the final round of negotiations in February 2003 involved delegations from 171 countries. Importantly, the demands of attendance and participation have required an expanded role for multisectoral collaboration on tobacco issues at the national level. For example, formal and informal committees have been established and regular inter-ministerial

consultations have been held, often for the first time, in countries as diverse as Zimbabwe, China, Brazil, Thailand and the US (Woelk *et al* 2000; Wipfli *et al* 2001).

The persistent leadership exercised by developing countries in pressing for a strong FCTC was rapidly established as a distinguishing feature of the FCTC negotiations, and this does much to explain the strength of the eventual text (Hammond and Assunta 2003). This leadership role reflects political decisions made both to shape the agenda and to cope with the onerous demands of the protracted sessions of the Intergovernmental Negotiating Body (INB) in Geneva. Excluding the specific case of the European Union, delegates from WHO's African region were the first to participate as a regional bloc. Anticipated divisions between tobacco producing and non-producing countries were avoided by developing common positions at preparatory meetings prior to each INB. Such positions were widely viewed as heightening the impact of African countries on the negotiations (Bates 2001) and the practice was subsequently adopted by other regions. In turn, this facilitated the development of cross-regional alliances, most significantly that between the African and South East Asian regions.

By contrast, a minimalist FCTC incorporating aspirations rather than obligations was consistently advocated by a small number of countries where transnational tobacco companies were particularly influential. These included Japan and Germany, but the United States emerged as their most prominent proponent, particularly (thought not exclusively) following the election of the Bush administration. Democrat Rep. Henry Waxman published articles and letters highlighting the administration's efforts to undermine FCTC negotiations. These included claims that, following a meeting with representatives of Philip Morris, US negotiators pursued 10 of 11 requested deletions from proposed text (Waxman 2002). Additionally, a leaked memo from the US Embassy in Riyadh urged Saudi Arabian assistance in backing US efforts to manage the debate around the relationship between trade and health, encouraging the attendance of delegates from economic ministries to ensure that the perspective of the health department was not unchallenged (Waxman 2003).

Corporate documents from BAT also indicate the scale of industry efforts to influence the negotiation process. An internal document from British American Tobacco (BAT) described the FCTC as "an unprecedented challenge to the tobacco industry's freedom to continue doing business", accepted that an agreement was likely and established a strategy for minimising its potential impact (Centre for Public Integrity 2003). Seeking to build support among potentially sympathetic states, health and finance ministers were to be targeted as "our priority stakeholders", while growers, unions and trade organisations were also identified as potentially useful. The document claimed "some success at governmental level" in stimulating favourable contributions to the drafting process by Brazil, China, Germany, Argentina and Zimbabwe (BAT n/d). Additionally, tobacco companies were sporadically successful in ensuring that their representatives formed part of negotiating delegations (Collin, Lee and Bissell 2004; Lee, Gilmore and Collin in press).

The FCTC and Civil Society

The FCTC process was also characterised by efforts to include civil society more fully within a fundamentally essentially state-centric policy process, efforts that were necessarily partial and a predictable source of tension. WHO generally allows heavily circumscribed

participation in its proceedings to NGOs that have entered into 'official relations' with it, a status achieved through a multi-year process by international health-related NGOs (usually international federations of national and regional professional NGOs). Being in Official Relations with WHO enables such NGOs to observe proceedings and to "make a statement of an expository nature" at the invitation of the chair (WHO 2000d), usually confined to a short period at the end of a session. The terms of participation of NGOs remained strongly contested throughout the negotiation process, but there were some moves to ease or accelerate these narrow parameters. Following an open consultation held by Canada and Thailand, member states approved recommendations to accelerate the process of accreditation and allow NGOs in official relations access to open working groups. WHO's Executive Board also agreed to admit NGOs into provisional official relations with the WHO, a status that would be revised yearly throughout the FCTC process (WHO 2001).

An innovative exercise in granting a voice to civil society organisations was the holding of public hearings in October 2000, the first time WHO had undertaken such an exercise. Though clearly a limited form of informal participation, and arguably primarily a sop to tobacco manufacturers and producers bemoaning their exclusion from the FCTC process, it did enable a total of 144 organisations to provided oral testimony, while 500 written submissions were received (WHO 2001b).

The involvement of CSOs in the FCTC process was greatly enhanced by the formation and development of the Framework Convention Alliance (FCA). At the two working group meetings that preceded the formal negotiations of the INB, civil society participation had been largely confined to high-income country NGOs and international health-based NGOs (Collin, Lee and Bissell 2002). The FCA was formed as a loose international alliance to support the development and ratification of an effective FCTC (www.fctc.org), served to increase communication between CSOs already engaged, and sought to systematically reach out to and support new and small CSOs, particularly in developing countries. By February 2003 the FCA encompassed more than 180 NGOs from over 70 countries, and had established itself as an important lobbying alliance. Coordinated via the FCA, NGOs in official relations were able to exploit their limited access to fulfil significant lobbying, educational and monitoring roles. The expertise accumulated within the FCA became a key resource, particularly in progressive alliance with the African and South East Asian regions. Additionally, a few prominent advocates were occasionally included within the official delegations of member states (Collin, Lee and Bissell 2004).

The impact of civil society in the final negotiations was, however, significantly hampered by increasing unease among member states opposed to a powerful text. The designation of most negotiating sessions of the final INB as informal provided a simple mechanism for the exclusion of NGO participants; a reduction of access and transparency reportedly supported by delegations including the United States and China (Framework Convention Alliance 2003).

The United Kingdom and the FCTC

The ambiguity that characterises the Blair administration's record on domestic tobacco issues is also evident in its role within the FCTC negotiations. The official support for international

tobacco control measures is clearly evident, with both the departments of Health and International Development making an early formal commitment to the development of a convention. The Secretary of State for Health was given lead responsibility for the negotiations, the Foreign Office having overall responsibility for the conclusion and implementation of its obligations, while the Treasury, DTI, sport and regional ministries were recognised as having an interest in it (FCO 2004). Delegations were formally led by the UK's permanent representative in Geneva but were dominated by health officials (supplemented by a continuous presence from Customs and Excise and on one occasion by two officials from DfID). The UK was generally credited as among the most progressive states in recognising the significance of tobacco control to development, being prominent behind the European Commission's willingness to "support developing countries wishing to address tobacco control, by using existing instruments of development cooperation" (European Commission 2003).

Conversely, however, the UK did not play the prominent supportive role of the likes of Canada, New Zealand and Australia, and British contributions were the source of occasional unease among those pressing for a strong convention. The task of assessing the UK's contribution is complicated by the rather opaque and chaotic nature of the European Union's role in FCTC proceedings. The European Commission negotiated on behalf of member states in areas covered by European law, while in other areas an agreed position was typically agreed by member states and advanced by the country holding the Presidency. Having undergone the traumatic rejection of a comprehensive advertising ban by the European Court of Justice, European positions were typically cautious and consistently characterised by a refusal to move beyond the confines of the *acquis communautaire*. While attention focused on Germany as the principal brake on the development of progressive EU positions, the suspicion remained that several member states including the UK were quietly willing to let Germany be the public face of broader obstructionism (Collin and Gilmore 2002; Gilmore and Collin 2002).

To the extent that specifically British concerns could be disentangled from the European position, it appeared that the UK successfully led opposition to the abolition of duty free sales. The existence of duty free sales serves both to undermine the effectiveness of taxation in reducing tobacco consumption and to facilitate smuggling, a broader area in which the British position was perceived by participants as being weak. While the UK never received the opprobrium attached to the US as a persistent defender of the interests of tobacco companies, it did appear that on such issues the government recognised the interests of UK-based companies as mitigating against the primacy of on health concerns.

A less qualified appraisal can be given to the record of civil society organisations based in the UK. Notably prominent was ASH UK, a particularly strong contributor to the development of the Framework Convention Alliance. ASH served as a key repository of expertise in the development of influential reports and line-by-line analyses of draft text. It is also worth highlighting the contribution of Christian Aid as perhaps the only leading development NGO to significantly engage with tobacco issues during the negotiation period.

Conclusion

Though the FCTC has received an impressive number of signatories (168) it has not yet received the 40 ratifications necessary for it to enter into force, the total currently standing at 36 (WHO 2004b). The UK has still not ratified, having initially anticipated the EU countries doing so simultaneously, though regulations have been drafted to amend the one minor feature of secondary legislation necessary for full implementation (FCO 2004).

The FCTC process has represented a remarkable exercise in international multisectoral collaboration to develop a form of health governance capable of addressing a critical issue for global health. Unsurprisingly, however, there remains sufficient ambiguity about the prospects and trajectory of the FCTC and some disquiet about aspects of its negotiation. Analysis of the FCTC process can therefore yield diverse assessments of its insights into and lessons for the relationship between health and foreign policy communities.

Each of the models of relationship identified by McInnes and Lee can be regarded as capturing aspects of the FCTC process, admittedly with significantly varying success.

(i) Supplicant

A core element in WHO's efforts to build support for the FCTC was to make the case that tobacco control was both cost effective and could contribute to development and economic growth. Gaining the support of the World Bank was critical in framing the terms of discourse within which the FCTC was developed. It could reasonably be argued, however, that the strategic need to develop and maintain the support of economic agencies and ministries also imposed significant constraints on the ability of the FCTC to address the impact of trade liberalisation on tobacco consumption in developing countries. The penultimate draft of the text, for example, explicitly subordinated the FCTC to trade agreements. While the vast majority of developing countries and civil society groups supported the inclusion of language that would protect the FCTC from challenge within WTO, such a position received no significant support among high income countries and was never advocated within WHO's Tobacco Free Initiative.

(ii) Trojan Horse and Trojan Mice

While much the least persuasive account of the relationship between health and foreign policy communities within the FCTC, this model finds distorted echoes in the depiction of the FCTC offered within the tobacco industry and among some liberal commentators. Martin Broughton, then chairman of BAT, depicted the FCTC a "New Colonialism" that sought to "impose the values of the developed world on the developing countries … hindering the socio-economic advancement of the developing world by seeking to undermine their comparative advantage" (Broughton 2001). The support of the World Bank drew particular antipathy from the right, with *Curbing the Epidemic* dismissed as "not an decent economic study, but a document for crusaders" (Tren and High 1999). In similar vein, Roger Scruton lengthily bemoaned what he identified as the WHO's abandonment of its mandate in favour

of "proposing a world-wide socialist programme, and using the concept of a human right to imply that there is a moral and political duty to impose it" (Scruton 2000).

(iii) Partnership

This type of interpretation offers the most idealised interpretation of the FCTC, and accords strongly with how WHO has sought to depict the process of its development. It provides what might be termed the hagiography of the FCTC. Jennifer Prah Ruger has recently highlighted the FCTC as an example of how global health institutions should develop coordinated and integrated links with other institutions:

> *Through the FCTC, ministries of health and health-related associations, such as physicians groups, are united with ministries of finance, economic planning, taxation, labour, industry, and education as well as with citizen groups and the private sector, to create a multisectoral national and international tobacco-control effort. The FCTC represents a growing trend in development policy towards an alternative paradigm that is broad, integrated, and multifaceted. (Prah Ruger 2004)*

(iv) Public health as an independent actor

While the partnership model is by no means without merit, the view of public health as an independent actor seems better suited to describing the dynamics and character of the FCTC process, particularly as it relates to the involvement of and tensions with other sectors. At the global level, WHO sought the support of other UN agencies and particularly the World Bank for its health agenda. Nationally, the breadth of measures likely to be included within the FCTC required substantial inter-departmental collaboration. In both arenas the FCTC provides encouraging instances of public health being able to attract support from traditional sources of hostility. Nonetheless, the FCTC remained a health initiative, and the engagement of other policy communities was more partial than a partnership model might imply.

It is necessary to exhibit some caution in drawing broader lessons from the FCTC, since in many respects it appears sui generis, reflecting both the scale of resources it required and the distinctive nature of tobacco control as a health policy issue. As colourfully described by the Brundtland-appointed Committee investigating tobacco industry influence within WHO:

> *Tobacco use is unlike other threats to global health. Infectious diseases do not employ multinational public relations firms. There are no front groups to promote the spread of cholera. Mosquitoes have no lobbyists.* (Zeltner *et al* 2000)

Yet tobacco control is not entirely alone, particularly among non-communicable disease, in the level of organised opposition that significant policy interventions can expect. Recent development s in tobacco control and particularly the FCTC illustrate in a particularly acute form the tensions between public health and competing policy objectives.

It might reasonably be hypothesised that health concerns are less likely to decisively shape government policy when impacts are perceived as primarily international rather than domestic. On an issue such as tobacco control, where influential conflicting interests are frequently evident, this might lead to tensions between the character of domestic and foreign

or trade policy. Most starkly, this could be evident in a desire to reduce tobacco consumption at home while lending active support to the global expansion by tobacco companies. As most starkly formulated by former US Vice-President Dan Quayle, "Tobacco exports should be expanded aggressively because Americans are smoking less" (Hammond 1998).

The politics of the FCTC certainly suggest broad strategies by which public health can broaden support for its objectives among other policy communities. Developing an appropriate evidence base can be considered a pre-requisite for building such cross-over appeal. The established scientific consensus on the health impacts of tobacco use is clearly relevant here, but the emphasis is rather on the success of WHO, the World Bank and a number of civil society groups in producing policy-relevant research demonstrating that proposed interventions were both beneficial to public health and advanced other agendas. The FCTC process also demonstrates the necessity of forceful and highly committed leadership, and the departure of Brundtland therefore raises concerns about its further development. Additionally, while the relationship between WHO and civil society was often fraught, the negotiations again demonstrated both the importance of developing a more inclusive policy process and the constraints on doing so within a state-centric institution.

Less encouragingly, the experience of the FCTC highlights the scale of the challenge confronting public health in seeking to engage effectively on a multisectoral basis. Given the strength of the evidence base regarding the impact of trade liberalisation on tobacco consumption, the failure to address the implications of the WTO for key tobacco control within the final text seems perverse. This is particularly so given the clear support of an overwhelming majority of developing countries for the inclusion of 'health over trade' language. The development of the FCTC clearly highlights the strategic value of engaging with the dominant political and economic consensus, but accepting its confines does also impose substantial constraints.

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