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THE WHO FRAMEWORK CONVENTION ON TOBACCO CONTROL:

A CASE STUDY IN FOREIGN POLICY AND HEALTH – A VIEW FROM BRAZIL

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The paper describes the uniqueness of the WHO Framework Convention on Tobacco Control (FCTC) as the first international treaty negotiated under the auspices of the World Health Organization (WHO). It outlines the distinctive features of the FCTC and explains why three crucial elements of this international treaty – the shift in perspective, the priority of health over trade, and the recognition of the role of civil society – are new dimensions on the diplomatic scene. Furthermore, the paper highlights the role that Brazil played in the negotiations that resulted in the FCTC. It contextualizes the 1988 citizen's constitution and analyses its importance for the adoption of the FCTC.

Key Words

Brazil, Framework Convention on Tobacco Control, international treaty, health and foreign policy, health and trade, paradigm shift, participation of civil society, right to health, tobacco control.

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The WHO Framework Convention on Tobacco Control (FCTC) is an international treaty designed to reduce tobacco-related deaths and diseases. It was adopted at the 56th World Health Assembly (WHA) in May 2003.

According to the World Health Organization (WHO), tobacco use is the leading cause of preventable deaths in the world. The numbers are staggering: 4.9 million deaths per year, 70 per cent of which occur in developing countries. No other consumer product is as dangerous, or kills as many, as tobacco. The growing recognition of these facts sets the scene for governments to adopt an international binding instrument with a view to protect all peoples from the devastating impact of tobacco consumption.

The FCTC has some unique features. It is the very first treaty negotiated under the auspices of WHO. Article 2 of the WHO Constitution enables it to propose conventions, agreements and recommendations in accordance with its objective: the attainment by all peoples of the highest possible level of health. But since its inception in 1948, WHO had never made use of the provision. It may be argued that never before was there a clearer need to take collective action against such

[1] The paper was presented at the first high-level symposium on Global Health Diplomacy and Negotiating Health in the 21st Century: current issues and future challenges held on 22-23 March 2007, Geneva. At that time, the author was Special Adviser for International Affairs to the Brazilian Ministry of Health. The author has been designated as first Brazilian Ambassador to Burkina Faso in 2008.

a serious and widespread threat to the health of the population at large, as firmly established by scientific evidence.

This is another feature of the FCTC: scientific evidence infuses the text with unquestionable credibility, which is what should be expected from a WHO initiative. The statement from the preamble that scientific evidence has established unequivocally that tobacco consumption and the exposure to tobacco smoke causes death, disease and disability is quite a striking one, particularly when compared with statements found in other international agreements carefully crafted to avoid finger-pointing. It seemed as if science was screaming for action. Something had to be done and it was natural that WHO took the lead.

A third feature of the FCTC is its demand reduction design. The 1961 Single Convention on Narcotic Drugs, the 1971 Convention on Psychotropic Substances, and the 1988 Convention against the Illicit Traffic in Narcotic Drugs and Psychotropic Substances are all supply reduction designed. The FCTC consists of 11 parts. The main core is found in Part III, where measures relating to the reduction of demand for tobacco are listed: price and tax measures to reduce the demand for tobacco; protection from exposure to tobacco smoke; regulation of the contents of tobacco products (with a view to setting guidelines for testing and measuring the contents and emissions of tobacco); regulation of tobacco product disclosures (with a view to requiring the tobacco industry to disclose information on the contents and emissions of tobacco); packaging and labelling of tobacco products (with the aim, on the one hand, of preventing misleading information regarding the harmful effects of tobacco and, on the other, of ensuring the labelling of health warnings); education, communication, training and public awareness; tobacco advertising, promotion and sponsorship; and demand reduction measures concerning tobacco dependence and cessation.

It is true that the FCTC also has a whole part – Part IV – dedicated to supply reduction. But even there, the nature of the proposed measures is quite distinct: elimination of the illicit trade in tobacco products (this is perhaps the only component of the FCTC that enjoys full support from the tobacco industry); prohibition of sales to and by minors; and provision of support for economically viable alternative activities.

The interesting thing about demand reduction – as opposed to supply reduction – is that what is required is a new way of looking at things, a change of mind or a shift in perspective. For the individual, a change of mind might refer to a new way of setting the balance. Is taking risks more important than playing it safe? Is income more important than a good job? Is a careless ride in life more important than a healthy lifestyle? For States, the shift in perspective would be of a different nature.

Tobacco is a huge industry. It has been interwoven into national economies through the workings of trade for a very long time, so much so that there is an ingrained belief that is a powerhouse when it comes to business and employment. Since it is legal, there is no way such an industry can be supply reduced. The thing about tobacco though is that it is bad for health. The question then arises naturally: tobacco or health? If the answer is tobacco, the balance weighs more on the side of business and employment. If the answer is health, then the balance weighs more on the other side. A change of perspective would be to value people more than any other thing or, to put it bluntly, to favour health over trade.

The first paragraph from the preamble of the FCTC states that the parties are determined to give priority to their right to protect public health. This is important because it highlights a key aspect of the relationship between foreign policy and health. During the late 19th and early 20th centuries, foreign policy and health were tied up with quarantine restrictions due to disease outbreaks. International agreements were hammered out with a view to eschewing the consequences of trade disruptions. Trade, not health, was at the centre of diplomatic

[2] The priority given to the right to protect public health in the FCTC resonates with the principle crafted somewhat earlier in the context of the 4th World Trade Organization Ministerial Meeting in Doha, according to which the TRIPS Agreement does not and should not prevent members from taking measures to protect public health.

business. The FCTC changed that with a shift in perspective. Foreign policy, it seems, must now be developed with a view to taking into consideration the impact on health[2].

If you would like to know what the FCTC is about without having to go through all the intricacies of the approved text, then you could just concentrate on Part II. Here, the objective, the guiding principles, and the general obligations are all spelt out in a concise manner. It is actually the Convention in a nutshell.

The aim of the FCTC is simply to protect present and future generations from the health consequences of tobacco consumption and exposure to tobacco smoke.

The guiding principles of the FCTC are the need to inform the population of the health consequences of tobacco consumption; the need for strong political will; the need to foster cooperation to assure implementation; the need to adopt multisectoral measures to reduce consumption; the recognition of liability and compensation; the recognition of the importance of technical and financial assistance; and the role of civil society in achieving the objective of the Convention.

The general obligations of the States are the development, implementation and constant updating of tobacco control strategies; the protection of those strategies from commercial and vested interests; the establishment of cooperation mechanisms for the implementation of the Convention; and assistance in raising the necessary financial resources.

What is perhaps new in an international agreement is the emphasis on the role of civil society in achieving the objective of the Convention. Groups of ex-tobacco consumers that come to realize, perhaps due to enfeebled health, the dangers of tobacco consumption; groups of relatives of ex-tobacco consumers who, deprived of their loved ones, are of the opinion that the industry should be taken to court; groups of health professionals who think it is their duty to stop the scourge of tobacco use; and groups of parents concerned with the powerful advertising that the industry uses to lure the young and inexperienced. This is not an exhaustive list, but certainly one that should be taken seriously when considering how to craft and push forward texts that may eventually become national legislation. Different groups in civil society come together as an interested party in the process of implementing an international treaty. It is as if civil society, as an interested party – and certainly an unstructured one – becomes a player on the international stage.

Demand reduction – or the need for a shift in perspective; the right to protect public health – or the priority of health over trade; and the emphasis on the role of civil society in achieving the objective of the Convention – or the coming of age of civil society as a player on the international stage. These are perhaps the elements of the FCTC that set it apart from other treaties. Do they mark a trend? Are they to be found in other yet-to-be-agreed treaties? Are they unique and only justified in the FCTC? These are all relevant questions that may follow the presentation of the FCTC, but there is one that is perhaps of a more profound and fundamental nature: what is the impact of the FCTC on the making of foreign policy?

The question arises because the shift in perspective, the priority of health over trade and the recognition of the role of civil society in ensuring implementation – as crucial elements of an international treaty – are new to the diplomatic scene. This is exactly what makes it interesting. Everything that is genuinely new promotes change. Foreign policy is changed by the inclusion of genuinely new elements in an international treaty. What does this all mean?

Nowadays, it is recognized that in a globalized and interdependent world, global health has a profound impact on all nations. It is therefore becoming accepted that health be a point of departure and a defining lens to examine key issues of foreign policy and development strategies[3]. This is where the shift in perspective comes into play.

[3] See the Oslo Ministerial Declaration, 'Global health: a pressing foreign policy issue of our time', as well as 'Foreign policy taking up the challenges of global health: a background note', available at www.thelancet.com.

Up until now, we have been living in a trade centred-world. Remember how international agreements were developed in order to avoid disruptions in trade. Trade was understood to be the engine of development, and the riches of nations depended on it. So it was natural that all efforts should focus on trade, especially foreign policy. Today, the overprotection of intellectual property rights through the so-called TRIPS-plus bilateral agreements creates an unequal relationship between property rights and consumer rights that favour trade over health. This trade-centred world could be called Ptolemaic (from Claudius Ptolemy's earth-centred world in which the sun and the planets revolve around the earth). The change in perspective would be a health-centred world that could be called Copernican (from Nicolaus Copernicus's astronomical sun-centred world in which the earth and the planets revolve around the sun). The Doha Declaration on Trade and Public Health, the FCTC and the recent Oslo Ministerial Declaration are all examples of this shift in perspective, which could be called a Copernican shift or a paradigm shift.

The precedence of health over trade is what the Doha Declaration, the FCTC and the Oslo Declaration are all about. Using health as a lens to examine foreign policy is extraordinary in the sense that is a genuinely new way of handling international issues. It also explains many of the recently adopted WHA resolutions, especially in the area of access to drugs.

The participation of civil society in pushing forward the health agenda explains the understanding of health as a defining lens – the priority of health over trade. It is also the motor that drives the shift in perspective in setting the agenda – the Copernican shift.

The FCTC is the product of all these new developments on the international scene. It is also an example of how domestic policy has to give so as to comply with international commitments carried out under the spell of the Copernican shift.

Brazil was an important element in the negotiations that resulted in the FCTC. How was this possible given that Brazil is a major exporter of tobacco leaf and one of the leading exporters of tobacco products in the world? In order to understand this, it is necessary to explain some fundamentals of the Brazilian public health system.

The Brazilian constitution of 1988 defines social security as a set of actions that have to be taken by the state and which are aimed at guaranteeing the right to health, social insurance and social assistance. Health is the responsibility of the Ministry of Health, social insurance that of the Ministry of Social Security – which, in Brazil, is responsible retirement pensions, disability insurance, etc. – and social assistance the Ministry of Social Development. In Brazil, three different ministries are therefore responsible for the concept of social security.

The Ministry of Health is accountable for the federal management of the public health system[4] through the formulation of health policies and the setting of norms. The ministry is responsible for half the total public health expenditure[5], but does not get directly involved in health actions, which are the responsibility of the states and municipalities.

Brazil's public health system is known as the Unified Health System (UHS). It was established in 1990 as a consequence of the adoption of the 1988 constitution, the first constitution after the military regime, which ruled from 1964 to 1985.

The term 'unified' must be clarified in order to better understand the public health system. Before 1990, Brazil's health system – both public and private – was composed of the following four subsystems:

[4] Brazil is a federal state made up of 26 states and the federal district. Brazil has 5,561 municipalities of varying sizes and populations. The federal government structure is replicated at the state and municipal level. The Ministry of Health, for example, is part of the federal structure. Its counterparts at the state and municipal level are the state secretary of health and the municipal secretary of health respectively. In a sense, Brazil has 5,588 health ministers.

[3] Public health expenditure in Brazil is tax-dependent. According to the law, 12 per cent of all federal state revenues are to be directed to the National Health Fund. States must contribute 12 per cent of all state revenues, while municipalities must contribute with 15 per cent of all municipal revenues.

→ **Subsystem 1** – integrated by the Ministry of Social Security and by a network of private healthcare institutions. This subsystem guaranteed healthcare for those who worked in the formal economy, that is, for those who had a percentage of their salary deducted as health insurance.
→ **Subsystem 2** – represented by the Ministry of Health, which basically took care of vertical programmes for the control of malaria, tuberculosis, mother and child care, mental health, and epidemiological and sanitary surveillance, among others.
→ **Subsystem 3** – consisting of public servants and military healthcare institutions.
→ **Subsystem 4** – with its state and municipal healthcare institutions.

In this set-up, it was the Ministry of Social Security that had the lion's share of the total financial resources allocated to health, which came, as indicated, from a proportion of the salaries of the formal labour force. Two points must be retained from this: firstly, the health system was highly concentrated in the hands of the private sector. The network of private care institutions that mushroomed under the Ministry of Social Security's sphere of influence absorbed almost all the resources that came from the labour force. The second point to be retained is that the health system considered, in the main, only those who made contributions to it – that is, the formal labour force. In a country like Brazil, with its history of social exclusion and inequities, this translated into the fact that a very large section of the population did not have any kind of right to health since it was not incorporated into the formal economy.

The end of the military regime opened the doors of democracy and allowed the participation of all those that had been deprived by the rule of exception. It is in this context that the 1988 constitution – the citizen's constitution – was adopted.

For the first time in Brazil's history, the constitution dedicates four of its articles to health. The right to health is enshrined in the following terms: "health is the right of everyone and the duty of the state." This formula consists of two parts.

The first part states that health is the right of everyone, and not just of the members of the formal economy. Casual urban workers and rural workers – who were previously excluded – are now all welcomed into the system. Even unemployed people are included through the formula "the right of everyone". The first consequence of the opening of the gates to all the people was the concentration of all health matters into the Ministry of Health, since it was a public entity with a public mission and a public view. This is the origin and the explanation of the word 'unified' in the term 'unified health system'. The Ministry of Health would be responsible for health; the Ministry of Social Security would look after social insurance; and a new ministry, the Ministry of Social Development, would take care of social assistance. This also explains the concept of social security through the lens of three different ministries.

The contributions that went to pay for health services were redirected from the Ministry of Social Security to the Ministry of Health. This immediately gave the latter enormous financial and political clout.

The second part of the constitutional formula – "the duty of the state" – gives health a state policy status, and no longer a sectoral policy status. This is a genuinely new development in Brazilian history. Health is no longer the concern of a small, insignificant ministry in the governmental structure. In fact, it is now highlighted as a state policy, managed by a ministry with great political and financial power in the Brazilian governmental structure.

The constitution further establishes the participation of civil society in formulating the health policy as a guiding principle. One may ask how the participation of civil society is established. The answer is through the creation of health councils at federal, state and municipal level[6]. One must remember that the constitution came at the end of a regime of exception, where the forces of democracy were kept at bay. The unleashing of these forces was therefore as natural as gra-

[6] The Federal Health Council, the State Health Council (CONAS), and the Municipal Health Council (CONASEMS)

vity. Health councils are deliberative organs acting in the formulation of strategies and in the control and execution of health policy, including in its economic and financial aspects. They are composed of government officials (25 per cent), health providers and health professionals (25 per cent), and users (50 per cent). This strong participation of civil society in the workings of health policy is also genuinely new in Brazil.

When health is elevated to the status of a state policy, and is combined with the essential role of civil society in the making of that policy, the result is a democratic health policy. This, again, is quite unique.

This, therefore, is the revolution[7] that occurred in Brazil in the area of health. When a handful of sanitarians decided to tackle the question of tobacco control, they found in place a structured system that could be used in a very effective way. The question these sanitarians asked was quite simple: how to fuse tobacco control into health policy and make it a national programme. The answer was straightforward: sensitize state and municipal health secretaries to the nature of the problem and propose a very pragmatic solution from the health perspective. Make full use of the inherent structure of the UHS and ensure that the health councils (CONAS and CONASEMS) are an active part of that plan. Establish partnerships with schools, universities and workplaces.[8]

Once tobacco control became part of health policy, it immediately became a state policy. In the sense that diplomacy is the defence of national interests – and there is no denying that health as a state policy is a national interest – it followed naturally that Brazilian foreign policy included, among its objectives, a leading role in the FCTC negotiations. In fact, the role of Brazilian diplomacy in the FCTC negotiations was a natural corollary of its tobacco control programme. It was a natural reflection of domestic policy in foreign policy. The main elements of the Brazilian tobacco control programme – its domestic policy – are very similar to the ones that set the FCTC apart from other international treaties: the shift in perspective, moving from a system where the Ministry of Health was almost invisible to a system where it occupies centre stage; the need to highlight the priority of health over trade (remember that Brazil still is a major trader in tobacco products); and the crucial role of civil society in formulating and monitoring the tobacco control programme.

What is the impact of the FCTC on the making of foreign policy? What is the impact of health issues on foreign policy? Should diplomats become sanitarians, and sanitarians diplomats? Definitely not. Diplomats should be diplomats, just as sanitarians should be sanitarians. Diplomats, though, may find the language of sanitarians quite strange and alien to their everyday experience. It is therefore the duty of sanitarians to guide them through the intricacies of the health domain in order to help define the issues where there is common ground between foreign policy and health. It is the duty of diplomats to develop opportunities for the sanitarians to explain the world of health to them and to highlight possible interconnections between foreign policy and health.

The FCTC was as opportunity for both diplomats and sanitarians to cooperate in a very fruitful way. It is certainly not the only one, as the recent papers from the Oslo meeting of the seven foreign ministers of Brazil, France, Indonesia, Norway, South Africa, Senegal and Thailand show. The challenge is there.

[7] Revolution as a shift or in the sense of a Copernican shift

[8] It should be noted that, in the case of tobacco control, it was the government that had to involve civil society, even if civil society was already involved in the UHS. In the case of HIV/AIDS, it was the other way round: civil society had to move the government.