The Tobacco Industry and Secondhand Smoke: Lessons from Central and South America

Joaquin Barnoya, MD, MPH; Stanton A. Glantz, PhD

For more than 20 years the tobacco industry has considered secondhand smoke to be a threat to its viability. In this article, we describe why secondhand smoke is important to tobacco control and how the tobacco industry's ''Latin Project'' sought to prevent the creation of smoke-free workplaces and public places in Central and South America. Eliminating secondhand smoke exposure not only reduces the risk of cardiovascular and other diseases, but also creates an environment that substantially reduces smoking and cigarette consumption among smokers. The ''Latin Project'' was initiated in 1991 by Philip Morris and British American Tobacco and managed by the law firm Covington & Burling. The project assembled a network of well-placed physicians and scientists to divert the attention away from secondhand smoke toward other indoor air pollutants. As proven in Central and South America, the tobacco industry has manipulated the secondhand smoke issue in order to avoid the development of smoke-free environments. Sub-Saharan Africa, facing an epidemiologic transition similar to the one experienced by Central and South America, should be aware of tobacco industry tactics. Further delay in implementing smoke-free environments will only increase the burden of cardiovascular disease in both areas of the world. (*Ethn Dis*. 2003; 13[suppl2]:S2-88–S2-90)

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From the Center for Tobacco Control Research and Education, Cardiovascular Research Institute, Institute for Health Policy Studies, University of California, San Francisco.

Address correspondence to Stanton A. Glantz, PhD; Professor of Medicine; Box 1390; University of California; San Francisco, CA 94143; 415-476-3893; 415-514-9345 (fax); glantz@medicine.ucsf.edu

Introduction: Role of Secondhand Smoke

By 1978 the tobacco industry had recognized public concern over the effects of secondhand smoke on nonsmokers as a more potent threat to the industry than knowledge that smoking kills smokers.[1,2] The reason for this is that growing awareness of the dangers of secondhand smoke undermines the social acceptability of smoking and leads to the creation of smoke-free workplaces and other environments that make it easier for people to stop smoking.[3] Data from the United States and other Western countries indicate that a smoke-free workplace is associated with a 29% drop in cigarette consumption,[3] a much larger effect than can be obtained with traditional cessation efforts directed at individual smokers.[4]

These effects are particularly important for heart disease.[5–9] Unlike cancer, which responds slowly to changes in smoking behavior, changes in the risk of a heart attack begin immediately following smoking cessation[7] (and, presumably, exposure to secondhand smoke). In addition, despite the fact that cardiovascular diseases are the leading cause of death among smokers, the public and medical professionals cite lung cancer as the leading cause of death among smokers.[10,11] Cardiovascular diseases are also the leading cause of death among those exposed to secondhand smoke, accounting for the deaths of approximately 48,000 of the 53,000[12] nonsmokers, compared to 3,000 who die from lung cancer annually in the United States.

Secondhand smoke increases the risk of death from heart disease by about 30%.[13] Although this increased risk seems high compared with the dose (nonsmokers receive only about 1% of the dose of smoke as smokers), the mortality effect is as much as one third that of active smoking. Several biological mechanisms by which secondhand smoke increases the risk of heart disease have been described and include: decreased oxygen transport capacity of the blood; increased platelet aggregability; decreased ability of the cardiac muscle to convert oxygen into adenosine triphosphate; endothelial damage and loss of endothelium-dependent vasodilation; increased level of LDL cholesterol and decreased level of HDL; and increased production of harmful free radicals.[14–18] With only 30 minutes of exposure, secondhand smoke affects platelet function and cardiac endothelial function in nonsmokers to the level of that of active smokers.[14,17,19]

Given the lack of smoke-free environments in many parts of the world, the number of individuals exposed to secondhand smoke is much larger than the number of active smokers.[20,21] Promoting smoke-free environments is one way to reduce heart disease, through 3 pathways: 1) nonsmokers are no longer exposed to secondhand smoke; 2) smokers have an easier time quitting and thus reduce their risk of heart disease; and 3) fewer people begin smoking because the social acceptability of smoking is reduced.

The tobacco industry has understood this dynamic and acted proactively to prevent concern over secondhand smoke from spreading into Europe, Asia, and the developing world. As seen in Central and South America and illustrative of worldwide efforts, the industry has established a network of physicians, scientists and "experts" to contest the evidence and lobby against smoke-free policies.

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"THE LATIN PROJECT": TOBACCO INDUSTRY'S SUCCESS IN PREVENTING SECONDHAND SMOKE REGULATIONS

By conducting a systematic search of tobacco industry documents available on the internet and at the Guildford Tobacco Document Depository in England, we recently presented the tobacco industry's secret strategy to anticipate and derail secondhand smoke regulations in Central and South America.[22] Since 1991, British American Tobacco and Philip Morris, through its Washington-based law firm Covington & Burling began "The Latin Project." This project was initiated "in anticipation of, rather than in reaction to, the full-force arrival of the ETS (environmental tobacco smoke, referred to as secondhand smoke by the industry) issue to Central and South America."[23]

The project was financed by British American Tobacco (60%) and Phillip Morris (40%) and by 1993 included 13 consultants from 7 countries in Central and South America. Consultants were well-placed physicians and scientists from Guatemala, Costa Rica, Venezuela, Chile, Brazil, Argentina, and Ecuador. To avoid any direct involvement with the industry, and to insulate the consultants from accusations of being allied with the industry, Covington & Burling lawyers made all the contacts and payments on behalf of the industry. Covington & Burling defined consultants' duties to include: writing letters and editorials to newspapers; writing articles related to secondhand smoke and health for press and scientific journals; participating in scientific conferences as speaker or attendee; conducting media interviews; and monitoring smoking and health activities. Consultants also conducted indoor air pollution studies, which minimized the problem of secondhand smoke. Study results were used to brief government officials in hopes of avoiding legislation that restricted secondhand smoke regulations. The consultant was also asked to serve as a "troubleshooter to defuse a particular situation in which the tobacco industry should not be directly involved."[24]

The best example of the industry's success is Argentina, where tobacco industry consultant Dr. Carlos B. Alvarez's efforts were successful in influencing President Carlos Menem to veto an anti-tobacco bill.[22] Studies conducted by consultants were also presented in a tobacco-industry-funded regional symposia attended by the media. The consultants' argument, as dictated by the industry, was that secondhand smoke is a problem of rich countries, not of poor countries, which were faced with other health issues, such as immunization coverage and air pollution caused by burning fuels.

LESSONS FOR SUB-SAHARAN AFRICA

In Central and South America, through "The Latin Project," the tobacco industry was successful in contributing to halting the creation of smoke-free environments, and thus a lack of awareness of effective measures for controlling the cardiovascular epidemic. Indeed, aggressive tobacco control programs that concentrate on creating smoke-free environments have had a major impact on smoking behavior. Because heart disease risk responds so quickly to changes in smoking behavior, it was possible to demonstrate (in California) that the tobacco control program led to large and rapid changes in heart disease mortality.[8,9,25] From "The Latin Project" we learned how a network of well-placed consultants can drive public, as well as health professional, opinion away from such relatively simple and cost-effective measures to protect nonsmokers from the toxins in secondhand smoke. Public health officials need to be vigilant in detecting and exposing similar efforts in other parts of the world.

Central and South America and Sub-Saharan Africa share similar health profiles. Both are beginning to experience the double burden of disease, noncommunicable (mainly stroke and heart disease) and communicable diseases. One particular difference between Central and South American and sub-Saharan Africa is that, in the sub-Saharan region, communicable diseases are still the number one cause of death as a result of the AIDS epidemic. In Central and South America, as in the rest of the world, non-communicable diseases now surpass communicable diseases. In Central and South America, the tobacco industry successfully kept health advocates focused on communicable diseases to divert attention away from the number one cause of non-communicable disease mortality, tobacco.[26] Further delay in adopting and enforcing cost-effective tobacco control measures, particularly smoke-free environments, will only increase the burden of coronary heart disease for 2 regions that already suffer from poor health indicators.

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