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EXPLORING THE DIFFERENCES IN TOBACCO POLICY BETWEEN THE UNITED KINGDOM AND THAILAND

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INTRODUCTION

Currently, about 1.3 billion people globally use tobacco products, leading to 8 million deaths per year.¹ The burden of tobacco-related death and illness makes tobacco regulation a priority for policy makers and public health organizations. Globally, the distribution of tobacco users skews towards low- and middle-income countries, with 80 percent of tobacco users living in one of these regions.² Just as the prevalence of tobacco use by country is not uniform, neither are tobacco regulations.

Tobacco regulation, or tobacco control, refers to a group of policies that rule over tobacco manufacturers, distributors, sellers and individuals. Each country or region has its own set of policies that govern consumer access to tobacco products, and these policies have a direct impact on tobacco use profiles. In general, more onerous regulatory frameworks are

1. "Tobacco," World Health Organization, May 27, 2020. <https://www.who.int/news-room/fact-sheets/detail/tobacco>.

2. Ibid.

CONTENTS

Introduction	1
Tobacco-use Demographics	1
WHO MPOWER Guidelines	2
Taxation	3
Possible Reasons Smoking Rates Are Still High	4
Conclusion	5
About the Authors	6

associated with lower levels of tobacco use among a country's population. However, not all regulatory frameworks are created equal, and even the countries most praised for their tobacco regulations do not always see large reductions in tobacco use among their populations.

For example, The United Kingdom and Thailand are both praised for their regulation of tobacco. Both countries are parties to the World Health Organization (WHO) Framework Convention on Tobacco Control (FCTC), an international treaty that signals a country's commitment to regulatory strategies that decrease demand for tobacco products and promote the highest standards of health for their populations.³ However, the two countries have taken very different approaches to tobacco control, especially regarding novel tobacco products such as electronic nicotine delivery systems (ENDS), which include e-cigarettes and heat-not-burn products.

TOBACCO-USE DEMOGRAPHICS

Many differences in the tobacco-use landscape exist between Thailand and the United Kingdom, extending beyond regulation. Of course, all comparisons must be interpreted with the recognition that Thailand is a middle-income country, while the United Kingdom is a high-income country, a difference that indirectly affects many regulatory decisions and demographic characteristics. Nevertheless, the two countries prove instructive for considering the differing effects of regulation. However, before discussing regulatory differences, it is important to center the analysis in the demographics of tobacco use in each country.

3. See, e.g., Framework Convention on Tobacco Control, WHO Framework Convention on Tobacco Control, (World Health Organization, 2003). https://treaties.un.org/pages/ViewDetails.aspx?src=TREATY&mtdsg_no=IX-4&chapter=9&clang=en; "Chapter IX: Health," *United Nations Treaty Series* vol. 2302, May 21, 2003. https://www.who.int/fctc/text_download/en.

The United Kingdom is recognized as an exceptional example of tobacco use surveillance and monitoring, as they measure smoking prevalence and demographics annually via nationally representative surveys.⁴ Since 2011, smoking rates have been slowly declining, decreasing from 20 percent in 2011 to about 15 percent in 2018.⁵ By gender, a higher proportion of men (16.5 percent) in the United Kingdom smoke than women (13 percent).⁶ There are also disparities by socio-economic status: a quarter of people working in manual occupations smoke, whereas only a tenth of people in managerial or “professional” occupations smoke.⁷ Smoking is most prevalent among people ages 25-34.⁸ The United Kingdom has been most successful at decreasing smoking rates among young adults ages 18-24, seeing a 9 point reduction in their smoking rate between 2011 and 2019.⁹

Similarly, Thailand has implemented many tobacco control policies supported by international public health organizations, including the WHO; however, their tobacco use surveillance programs are less consistent than those in the United Kingdom. Additionally, according to population-based surveillance surveys, Thailand’s smoking rates have declined much more slowly. In 2011, about 21 percent of the Thai population smoked combustible cigarettes and—according to the most current nationally representative data—by 2017 the rate had only decreased to 19 percent.¹⁰ Another difference between the smoking rates in Thailand and the United Kingdom is the prevalence of smoking among women. As in the United Kingdom, fewer women smoke than men, however women smoke at much lower rates in Thailand. Based on 2014 data, only 1.8 percent of women in Thailand smoke, as compared to 35.8 percent of men.¹¹ Another key difference between the two nations is that many Thai smokers use roll-your-own combustible cigarettes instead of commercially manufactured products. According to analyses of the 2014 data, 54 percent of Thai smokers smoke at least one roll-your-own cigarette per day and 16 percent smoke more than 11 per day, suggesting almost exclusive use of roll-your-own products.¹²

4. “Issue: Consumption,” The Tobacco Atlas, last accessed Sept. 16, 2020. <https://tobaccoatlas.org/topic/consumption>.

5. Danielle Cornish et al., “Adult smoking habits in the UK: 2018,” Office for National Statistics and Public Health England, July 2, 2019. <https://www.ons.gov.uk/people-populationandcommunity/healthandsocialcare/healthandlifeexpectancies/bulletins/adultsmokinghabitsingreatbritain/2018>.

6. Ibid.

7. Ibid.

8. Ibid.

9. Ibid.

10. “Thailand Smoking Rate 2000-2020,” Macrotrends, last accessed Sept. 29, 2020. <https://www.macrotrends.net/countries/THA/thailand/smoking-rate-statistics>.

11. “List of Statistical Tables (Smoking Behaviour),” National Statistical Office of Thailand, last accessed Sept. 29, 2020. http://web.nso.go.th/en/survey/health/data/Cigarette_Ful_14.pdf.

12. Ibid.

WHO MPOWER GUIDELINES

In 2007, as part of their tobacco free initiative, the WHO introduced a framework of tobacco control policies known as MPOWER, which are defined as: “[A] set of six cost-effective and high impact measures that help countries reduce demand for tobacco.”¹³ The MPOWER guidelines suggest that countries implement the following policies: monitoring tobacco use and prevention policies; protecting people from tobacco smoke; offering help to quit tobacco use; warning about the dangers of tobacco; enforcing bans on tobacco advertising, promotion and sponsorship; and raising taxes on tobacco.¹⁴

Globally, nearly half of all countries have implemented at least one of the MPOWER tobacco control measures.¹⁵ With combustible cigarette consumption declining worldwide, it is easy to assume that the implementation of MPOWER measures has led to this trend, and it is likely that they have had some positive effect.¹⁶ Nevertheless, although these policies may seem straightforward, they are far from a panacea for decreasing demand for tobacco products and eliminating the harms associated with tobacco use.

The WHO scores countries’ adoption of MPOWER policies as complete, moderate, minimal or no policy uptake. Both Thailand and the United Kingdom come close to complete implementation of the MPOWER framework and receive favorable evaluations from the WHO.¹⁷ The two nations win praise for their complete uptake of tobacco use monitoring procedures, smoke-free policies, health warnings on tobacco packaging and taxation of tobacco products. However, the United Kingdom’s ban on portrayal of tobacco use in mass media and policies that made cigarettes less affordable over the prior decade put its alignment with the MPOWER framework above Thailand’s uptake.¹⁸ Neither the United Kingdom nor Thailand received a “complete” designation for implementation of cessation programs or advertising bans.¹⁹

Despite what seems like similar implementation of the MPOWER framework, Thailand and the United Kingdom

13. “MPOWER measures,” World Health Organization, last accessed Sept. 17, 2020. <http://www.emro.who.int/tfi/mpower/index.html>.

14. Ibid.

15. Ibid.

16. “Consumption,” The Tobacco Atlas, last accessed Sept. 17, 2020. <https://tobaccoatlas.org/topic/consumption>.

17. “Country profile: United Kingdom of Great Britain and Northern Ireland,” *WHO report on the global tobacco epidemic, 2019: Offer to help quit tobacco use*, World Health Organization, July 26, 2019. https://www.who.int/tobacco/surveillance/policy/country_profile/gbr.pdf?ua=1; “Country profile: Thailand,” *WHO report on the global tobacco epidemic, 2019: Offer to help quit tobacco use*, World Health Organization, July 26, 2019. https://www.who.int/tobacco/surveillance/policy/country_profile/tha.pdf?ua=1.

18. Ibid.

19. Ibid.

diverge in their response to ENDS. The WHO's position on ENDS is that they are unsafe, harmful to health and should be banned or regulated like combustible cigarettes.²⁰ In line with this position, Thailand implemented a complete ban on ENDS in 2014, which punishes possession with a large fine or arrest and jail time.²¹ Conversely, the United Kingdom has taken a more permissive approach to regulating ENDS, even embracing them as a cessation device.²² Public Health England summarizes their position on regulation by saying: "Regulations need to balance the risks of e-cigarettes with their potential benefits—and achieve key aims of reducing smoking and continuing to avoid uptake of e-cigarettes by non-smokers."²³

In some ways ENDS regulation within the United Kingdom mirrors combustible cigarette regulation, however, the nation still recognizes that e-cigarettes are significantly less harmful than ENDS.²⁴ Regulations of ENDS that mirror those of combustible cigarettes include minimum age of purchase laws that prevent people under the age of 18 from purchasing ENDS and bans on print, broadcast and online advertisements.²⁵ Additionally, ENDS products must meet safety and quality standards, disclose their ingredients and meet labeling and packaging requirements.²⁶

TAXATION

One key component of MPOWER is taxation of tobacco products. The 2019 WHO Report on the Global Tobacco Epidemic states: "Taxes should be raised significantly and periodically to reduce the affordability of tobacco products."²⁷ The WHO further indicates that tax increases should be sub-

stantial enough to overcome inflation and economic growth, thus making products less affordable year-over-year.²⁸

Between 1970 and 2020, the Thai government raised taxes on commercially made combustible cigarettes numerous times, however, tax increases were mostly limited to cigarettes rather than other types of combustible tobacco products.²⁹ Given that smoking rates have not decreased as greatly as expected, it is possible that rather than encouraging smokers to quit, these taxes are instead pushing consumers to roll-your-own tobacco, which is just as harmful as commercially produced combustible products. Of the tax revenue received from tobacco, only 2 percent is earmarked for the Thai Health Promotion Foundation (ThaiFund), which spends 6 percent (0.24 billion Thai Baht) of its annual budget on tobacco control.³⁰

The United Kingdom historically taxed tobacco starting in the 17th Century.³¹ The current rate of tobacco duties within the United Kingdom is dependent upon the type of product purchased. For example, the rate for a packet of 20 cigarettes is 16.5 percent of the retail price plus £4.57—an additional 20 percent value added tax (VAT) is applied to the pre-tax retail price after the tobacco duty.³² Whereas roll-your-own tobacco is taxed at £5.87 for a 25g packet.³³ The tax increase on the roll-your-own tobacco was implemented in part to decrease monetary incentives to switch from combustible cigarettes to roll-your-own tobacco as a cheaper alternative.³⁴ In general, cigarette tax increases were tied to inflation rates starting in the 1990s, being somewhere between 1 and 5 percent over the annual inflation rate.³⁵ Unlike Thailand, United Kingdom does not specifically earmark the revenues received from the tobacco excise taxes.

20. See, e.g., "E-cigarettes," World Health Organization, Jan. 29, 2020. <https://www.who.int/news-room/q-a-detail/e-cigarettes-how-risky-are-they>; "Electronic Nicotine Delivery Systems and Electronic Non-Delivery Systems (ENDS/ENNDS)," Delhi, India: Conference of the Parties to the WHO Framework Convention of Tobacco Control Seventh Session, Nov. 7-12, 2016, p. 6. https://www.who.int/ctct/cop/cop7/FCTC_COP_7_11_EN.pdf.

21. "Foreign Travel Advice: Thailand," GOV.UK, last accessed Sept. 23, 2020. <https://www.gov.uk/foreign-travel-advice/thailand/local-laws-and-customs>.

22. Smokefree, "E-cigarettes/vapes," United Kingdom National Health Service (NHS), last accessed Sept. 17, 2020. <https://www.nhs.uk/smokefree/help-and-advice/e-cigarettes#:~:text=In%20the%20UK%20e%2Dcigarettes,harmful%20constituents%20in%20cigarette%20smoke>; Ann McNeill, et al., "Evidence review of e-cigarettes and heated tobacco products 2018: executive summary," Public Health England, March 2, 2018. <https://www.gov.uk/government/publications/e-cigarettes-and-heated-tobacco-products-evidence-review/evidence-review-of-e-cigarettes-and-heated-tobacco-products-2018-executive-summary>.

23. Ann McNeill, et al., <https://www.gov.uk/government/publications/e-cigarettes-and-heated-tobacco-products-evidence-review/evidence-review-of-e-cigarettes-and-heated-tobacco-products-2018-executive-summary>.

24. Ibid.

25. Smokefree. <https://www.nhs.uk/smokefree/help-and-advice/e-cigarettes#:~:text=In%20the%20UK%20e%2Dcigarettes,harmful%20constituents%20in%20cigarette%20smoke>.

26. Ibid.

27. WHO report on the global tobacco epidemic, 2019: Offer to help quit tobacco use, World Health Organization, July 26, 2019, p. 106. <https://apps.who.int/iris/bitstream/handle/10665/326043/9789241516204-eng.pdf?sequence=1&isAllowed=y>.

28. Ibid.

29. "Tax policies on Tobacco products in Thailand: The way forward," World Health Organization, 2011. <https://apps.who.int/iris/bitstream/handle/10665/205961/B4732.pdf?sequence=1&isAllowed=y#:~:text=In%201992%2C%20the%20rate%20of,the%20way%20forward%206%20respectively>.

30. "Country profile: Thailand." https://www.who.int/tobacco/surveillance/policy/country_profile/tha.pdf?ua=1.

31. Rodrigo, "The rise of tobacco taxation," WritePass, Dec. 16, 2016. <https://write-pass.com/journal/2016/12/what-is-the-history-of-uk-tobacco-taxation-policy-what-are-the-outcomes-from-the-past-to-date/#:~:text=Excise%20tax%20on%20tobacco%20was,tax%20harmonization%20within%20the%20EEC>.

32. "Tobacco duties," The Office for Budget Responsibility, last accessed Sept. 17, 2020. <https://obr.uk/forecasts-in-depth/tax-by-tax-spend-by-spend/tobacco-duties/#:~:text=the%20rate%20on%20cigarettes%20is,3.13%20for%20a%2025g%20packet>.

33. Ibid.

34. Alice Grahns, "Fag End Budget 2020—Cost of cigarettes to go up £12.73 a pack from 6pm tonight as Chancellor hikes tobacco tax," *The Sun*, March 11, 2020. <https://www.thesun.co.uk/money/11141836/budget-2020-cost-cigarettes-tobacco-tax/#:~:text=SMOKERS%20will%20pay%20an%20extra,rate%20of%201.8%20per%20cent>.

35. Excise Social Policy Group, "Report on Tobacco Taxation in the United Kingdom," World Health Organization, 2013. https://www.who.int/tobacco/training/success_stories/en/best_practices_united_kingdom_taxation.pdf.

Furthermore, data from the United States indicates that tobacco taxes are not uniformly effective at discouraging smoking behavior. Data from the 2001-2015 Behavioral and Risk Factor Surveillance Survey in the United States show that tobacco taxes are most strongly associated with decreases in smoking among young adults (ages 18-24) and weakest decreases among low-income individuals.³⁶ In Thailand, and most other countries, where smoking behavior is generally established by a person's early twenties, increased taxes to discourage young people from taking up smoking are reasonable, as long as taxation does not drive these consumers to another combustible product.³⁷

Nevertheless, there is a strong, negative association between smoking and income in Thailand, which may indicate that tobacco taxes alone are not effective at targeting the majority of smokers, who tend to be of lower socioeconomic status.³⁸ The construct of "affordable luxury" is one possible explanation as to why smokers from lower socioeconomic status are less affected by price elasticity. Lower-income individuals consider smoking to be an opportunity for self-indulgence when other alternatives are cost prohibitive and increasing taxes on cigarettes may reinforce the perception of smoking as an affordable luxury.³⁹

POSSIBLE REASONS SMOKING RATES ARE STILL HIGH

While the United Kingdom and Thailand have both seen a successful decrease in smoking rates in recent years, the reason smoking rates remain high may be due to the demographics of smokers. For instance, the rate of smoking is much higher among men in Thailand while the rate of smoking is divided more evenly across genders in the United Kingdom. However, a review of the literature found no differences in cessation success between men and women, hence the gender differences in themselves are unlikely to explain the differential success of tobacco prevention and cessation efforts

36. Michael S. Sharbaugh et al., "Impact of cigarette taxes on smoking prevalence from 2001-2015: A report using Behavioral and Risk Factor Surveillance Survey (BRFSS)," *PLoS One* 13:9 (September 2018). <https://journals.plos.org/plosone/article?id=10.1371/journal.pone.0204416>.

37. Suchunya Aungkulanon et al., "Smoking prevalence and attributable deaths in Thailand: predicting outcomes of different tobacco control interventions," *BMC Public Health* 19:1 (2019). https://bmcpublihealth.biomedcentral.com/articles/10.1186/s12889-019-7332-x#:~:text=The%20annual%20smoking%20initiation%20rates,0.8%20and%200.1%25%2C%20respectively.&https://apps.who.int/iris/bitstream/handle/10665/272690/wntd_2018_thailand_fs.pdf?sequence=1.

38. Nattinee Jitnarin et al., "Socioeconomic Status and Smoking Among Thai Adults: Results of the National Thai Food Consumption Survey," *Asia Pacific Journal of Public Health* 23:5 (2011), pp. 672-681. <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5826657/>.

39. Ieva Reine et al., "Does the association between ill health and unemployment differ between young people and adults? Results from a 14-year follow-up study with a focus on psychological health and smoking." *Public Health* 118:5 (2004), pp. 337-345. <https://www.sciencedirect.com/science/article/abs/pii/S003350603002592?via%3Dihub>.

in the United Kingdom versus Thailand.⁴⁰ Therefore, it is possible that other individual factors could be responsible.

Another potential reason is that MPOWER may not be the ultimate tobacco control framework that many think it is. One challenge of MPOWER is that full implementation has become the primary goal in many countries, including Thailand. However, in their haste to pass regulations that comply with the MPOWER framework, many tobacco control advocates seem to confuse the success in passing regulation with success in decreasing negative health outcomes. That is to say, the value of full MPOWER implementation is low if countries cannot document a decrease in smoking rates associated with this set of policies.

That said, MPOWER still has some value. Taxation, monitoring, denormalization, advertising bans and cessation resources are vital tools in tobacco control, yet there are also limits to their effectiveness. Perhaps, these tools become less effective as smoking rates decrease. Specifically, the Diffusion of Innovation Theory describes how populations adopt a new idea, product or behavior.⁴¹ In context to tobacco control, this model demonstrates how MPOWER may become less effective as smoking rates decrease.

The Diffusion of Innovation Theory approximates a bell curve with five phases that progress over time. The first portion of the bell curve represents innovators and early adopters, those who are more prone to change their behaviors before the average person. The second portion of the bell curve represents the majority, people more skeptical of change, and those who are harder to sway using regulatory and communication strategies alone. "Laggards" make up the final, most change-averse piece of the curve, and account for about 16 percent of the population.⁴² When considering smoking, especially in western countries, it's easy to associate the archetypical Laggard with the population who continues to smoke, despite decades of tobacco control messaging and regulation. In the case of Thailand, where smoking rates have decreased more slowly than in the United Kingdom, regardless of the uptake of MPOWER regulations, the Diffusion of Innovation Theory makes a case that there is a distinct point where greater implementation of MPOWER regulations does not lead to proportional decreases in smoking rates. The rationale for the diminishing return of the tobacco control efforts among Laggards is that as group, they are more resistant to social influences and mass media

40. Philip H. Smith, et al. "Sex/gender differences in smoking cessation: a review." *Preventive Medicine* 92 (2016), pp. 135-140. <https://www.sciencedirect.com/science/article/abs/pii/S009174351630189X?via%3Dihub>.

41. Everett Rogers, *Diffusion of Innovations* (Free Press, 1995).

42. Ibid.

communications. In general, they are more persuaded by personal influences and communications.⁴³

Of course, the Diffusion of Innovation Theory has limits. In the case of smoking rates, it is possible that some smokers simply do not want to stop smoking and present as laggards because of this. As an addictive behavior, smoking presents an additional barrier to behavioral change. One of the key components of the MPOWER framework is providing nationally available cessation resources. ThaiHealth receives the equivalent of nearly \$120 million per year from the revenue generated by a 2 percent tax on tobacco products that is earmarked for tobacco control efforts.⁴⁴ However, it seems as though the cessation programs implemented from this spending are not highly effective. In 2016, ThaiHealth launched a three-year, smoking cessation program, and when the program ended in 2019, only 6 percent of the 3.3 million smokers enrolled in the program quit smoking for at least 6 months.⁴⁵ In contrast, in the United Kingdom all tobacco tax revenue goes to the general fund, and funding for tobacco control is allocated from the general budget. In 2015, the United Kingdom spent around £200 million on tobacco control efforts, which is a much higher per capita amount than Thailand.⁴⁶ However, cessation programming is one of the areas where both the United Kingdom and Thailand do not receive a “complete policy” implementation rating from the WHO’s MPOWER measures.⁴⁷

The key difference in cessation programming within the two countries is that in the United Kingdom e-cigarettes are considered to be cessation aids and are the most popular method to quit combustible tobacco use.⁴⁸ In contrast, Thailand is one of the 41 countries that ban e-cigarettes.⁴⁹ Moreover, one of ThaiHealth’s main communication objectives is a focus on the dangers of ENDS products, whereas U.K. messaging acknowledges health risks associated with

ENDS products, but clearly articulates that they are significantly safer than combustible tobacco products.

The availability of ENDS products in United Kingdom offers a plausible explanation as to why the smoking rates in the United Kingdom are lower than in Thailand where they are banned. If we consider the limitations of the MPOWER framework to reach laggards, the United Kingdom’s allowance of ENDS offers an alternative to smokers who may not be ready or willing to quit smoking combustible cigarettes. In fact, the United Kingdom model may potentially amplify the effects of other MPOWER strategies such as tax increases. Although even tobacco control advocates acknowledge that price increases are not the most effective tobacco control strategies as implemented, we can assume a differential impact of tobacco excise taxes in the United Kingdom versus Thailand.⁵⁰ In the United Kingdom, the price increase in cigarette excise tax may cue a smoker to switch to a less harmful alternative. This is because the psychological costs of switching to e-cigarettes such as personal or social enjoyment of smoking are minimal but there is the perceived gain of reducing personal harm. Increased price of combustible tobacco products could be another motivating factor to make the switch: a cigarette smoker may not want to pay an increased price when a product that offers the same benefits as well as harm reduction is available. The net result is a decrease in the rate of cigarette smoking and downstream improvements in morbidities associated with smoking combustible tobacco products.

In contrast, a smoker in Thailand does not have an option to switch to a less harmful product. Therefore, the psychological costs of quitting smoking may outweigh the financial benefit, making cessation unlikely. Instead, Thai smokers may switch to lower cost combustible alternatives like roll-your-own tobacco, a cheaper brand or in fact ignore the price increase altogether. Thus, the smoking rates would remain the same, and there would be no benefit to the overall health.

CONCLUSION

Comparisons between two countries on different continents, with different cultures and different affluence are often wrought with inaccuracies. In this case, both the United Kingdom and Thailand implemented the MPOWER framework to reduce smoking rates of combustible tobacco, and to an extent, employed similar tobacco control strategies. However, while the rate of smoking has been steadily decreasing in the United Kingdom, decreases in the smoking rates in Thailand have been stagnant. Although cultural and demographic factors may explain the difference in the

43. Ibid.

44. “Cracking Down on Lighting Up: Thailand’s Campaign for Tobacco Control,” Center for Global Development, 2015. <http://millionssaved.cgdev.org/case-studies/thailands-campaign-for-tobacco-control>.

45. “Situation Report of Tobacco Consumption in Thailand 2019,” Tobacco Control Research and Knowledge Management Center, 2019, pp. 112-113. <http://www.trc.or.th/th/media/attachments/2020/07/19/...-2562.pdf>; “Global Adult Tobacco Survey (GATS): Thailand Country Report,” World Health Organization, 2009. <https://apps.who.int/iris/bitstream/handle/10665/205138/9789290223535-eng.pdf>.

46. “Representation to the 2015 Spending Review,” All Party Parliamentary Group on Smoking and Health, October 2015. <http://ash.org.uk/wp-content/uploads/2019/12/Representation-to-the-SR2015.pdf>.

47. “Country profile: United Kingdom of Great Britain and Northern Ireland.” https://www.who.int/tobacco/surveillance/policy/country_profile/gbr.pdf?ua=1; “Country profile: Thailand.” https://www.who.int/tobacco/surveillance/policy/country_profile/tha.pdf?ua=1.

48. “Health matters: stopping smoking—what works?,” Public Health England, last accessed Sept. 17, 2020. <https://www.gov.uk/government/publications/health-matters-stopping-smoking-what-works/health-matters-stopping-smoking-what-works>.

49. “E-Cigarette Ban & Regulation: Global Status as of February 2020,” Global Center for Good Governance in Tobacco Control, Feb. 24, 2020. <https://gggc.world/2020/02/24/e-cigarette-ban-regulation-global-status-as-of-february-2020>.

50. Stanton A. Glantz, “Tobacco taxes are NOT the most effective tobacco control policy (as actually implemented),” Center for Tobacco Control Research and Education, Jan. 11, 2014. <https://tobacco.ucsf.edu/tobacco-taxes-are-not-most-effective-tobacco-control-policy-actually-implemented>.

effectiveness of the tobacco control strategies, it is also possible that the MPOWER framework becomes less effective once smoking rates reach a threshold where most of the current smokers could be considered laggards. The United Kingdom's approach to cessation which endorses harm reduction through the use of safer alternatives to combustible cigarettes stands in contrast to the Thailand policy of banning e-cigarettes and messaging against their use. It is likely this differentiating factor that moved the smoking rates down in the United Kingdom.

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