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Conflict and Resolution On Politics of Tobacco Control in Indonesia

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ABSTRACT

Even though the Indonesian government and members of parliament have been strongly urged by the general public and international organizations to ratify the Framework Convention on Tobacco Control (FCTC), Indonesia is the only country in Asia that has still not ratified the FCTC. This study sought to analyze the roles and personal interests of the players involved, as well as current conflicts and ways in which resolutions had been achieved. This exploratory research included descriptive analysis carried out through 'analysis of policy' as a review of written sources including books, journals, constitutional laws, and related articles from electronic media. The results of the analyses show that governmental considerations delaying the ratification of tobacco control legislation include that the tobacco industry has long been a source of direct income for a significant portion of Indonesians. These include tobacco farmers and their families, workers at tobacco factories, and other informal sectors supporting the tobacco industry. The industry's strength and other financial considerations such as taxes and advertisements are also factors. The dynamic process of tobacco control in Indonesia has been fraught with conflicts and resolutions, and this will continue because of political processes corresponding to vested interests and power struggles. The fights and tussles resulting from both these aspects have been a source of ongoing conflict. However, delays in the ratification of the FCTC can also be seen as a form of resolution because they have served as a meeting point where the interests and power positions of various actors can be upheld.

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INTRODUCTION

Efforts to control tobacco around the world have encountered much opposition, including resistance to implementation in Indonesia. This global movement was initiated by the World Health Organization's (WHO) Framework Convention on Tobacco Control (FCTC) in 2003. However, due to various governmental considerations, Indonesia has not yet signed this international agreement (WHO, 2015).

Based on a WHO report in 2008, Indonesia ranks third among the countries with the largest smoker population (4.8%) in the world, after China (30%) and India (11.2%) (Ministry of Health, 2012; WHO, 2008). Based on a 2013 report, *Riset Kesehatan Dasar* (*Riskesdas*), smoking by Indonesians aged 15 years old and over increased between 2007 and 2013—from 34.2% to 36.3%. Daily active smokers fall mostly within the 30 to 34-year-old age group (33.4%) and include more men (64.9%) than women (2.1%). The data show that 1.4% of smokers are aged 10–14 years old, and 32.3% are in the lowest quintile group of wealth indices. A tendency has also been found toward increased numbers of current smokers among adolescents aged 15–19 years old, rising from 18.8% in 2007 to 20.3% in 2010 (Ministry of Health, 2012).

Tobacco consumption creates potential health problems in the future. Researchers have found proof that harmful content in tobacco products leads to various diseases such as strokes, lung tumors, coronary heart disease, and chronic obstructive pulmonary disease (Ministry of Health, 2016). Achadi et al. (2005) estimated tobacco-related deaths at 10% in Indonesia—about 200,000 deaths annually—while, in 2010, tobacco-related deaths were put at 12.7% (Kosen, 2007).

Various studies have shown that the economic losses resulting from health problems caused by tobacco consumption are higher than the economic benefits of the tobacco industry and its products. For example, Indonesia's Ministry of Health reported that, in 2010, the government's expenditures in tobacco-related communities reached 231.27 trillion rupiahs (Rp). However, the total national revenue from tobacco taxes in the same year was only Rp55 trillion. The percentage of per capita spending on cigarettes was 11.91%, greater than milk and eggs (2.25%), health (2.02%), education (1.88%), and meat (<1%). (Ministry of Health, 2016). According to the Central Bureau of Statistics (BPS), filter *kreteks* (clove cigarettes) accounted for a high percentage of the cost of commodities that contributed to national poverty in 2014 (BPS, 2014).

Indonesia is the only Asian country that has not signed the FCTC (WHO, 2010). Many observers mention that the Indonesian government's position on this issue has weakened tobacco control efforts. Although national policies have been established that are similar to those of the WHO's FCTC, such as higher cigarette taxes, *kawasan tanpa rokoks* (KTRs) (smoke-

free areas), and restrictions on tobacco advertising, sponsorship, and promotion, these regulations and their enforcement are not yet optimal. Thus, the tobacco control movement has not been able to deal with problems in various sectors, which are increasingly widespread and detrimental due to increased tobacco consumption. Indonesia is still a tobacco importer and manufacturer with a significant share of the tobacco industry's market. In addition to the country's own traditional cigarette producers, who make up a large part of tobacco companies, Indonesia has become a haven for the industry's international investors such as Philips Morris.

The policies of the WHO's FCTC that have been ratified by most countries worldwide have not been accepted by the government of Indonesia. Indonesia's conditions and the government's concerns have, therefore, resulted in a deadlock. The government is apprehensive about the nature of international treaties that will bind and limit trade if they are in opposition to national conditions and strategies. The present study, therefore, sought to analyze the roles and personal interests of the players involved, including current conflicts and ways in which resolutions have been achieved in Indonesia's tobacco control policies.

METHOD

This exploratory research constituted a policy study based on descriptive analyses conducted in 2014. The unit of analysis was tobacco control policies in Indonesia. This study used 'analysis of policy' through government policy documents and the results of other research, which was critically reviewed.

Information was gathered from many sources such as the constitution, laws and regulations, including books, journals, and related articles from electronic media using the keywords "politics of tobacco control" and "FCTC," which were this research's main focus. All data and findings were examined using policy analysis of the roles and personal interests of the players involved in tobacco control policy in Indonesia.

RESULT

Tobacco Consumption and Adverse Effects

The literature reveals that Indonesia's tobacco consumption and prevalence ranked fourth among the countries with the highest tobacco consumption globally in 2009. The number of cigarettes consumed has tended to increase, rising from 182 billion cigarettes per year in 2001 to 260.8 billion in 2009 (Ministry of Health, 2012).

The poorest households spent an average of 12% of their monthly expenditures on tobacco in 2010. Spending on tobacco is second only to rice and/or cereals. By comparison, expenditures on eggs and milk only amounted to 2% of household spending. Up to 63.6% of households have members who have taken up smoking habitually. Unfortunately, tobacco expenditure has no

known benefits and even increases the risk of severe health problems (Fachry, 2011; Ministry of Health, 2012).

The 2006 Global Youth Tobacco Survey (GYTS) in Indonesia provided data on youths' tobacco use. This report showed that more than 1 in 10 students (12.6%) smoked cigarettes, with the prevalence among boys (24.5%) significantly higher than among girls (2.3%). More than 9 out of 10 students (92.9%) had seen many advertisements for cigarettes on billboards during the previous month, and more than 8 in 10 (82.8%) had seen multiple advertisements for cigarettes in newspapers or magazines (Aditama et al., 2008). Study of several countries showed that the prevalence of second-hand smoke was highest in Indonesia, Chile, Kiribati, and Argentina. The prevalence of adult tobacco use in these countries was 29.0% in Indonesia, 28.8% in Chile, 42.6% in Kiribati, and 19.8% in Argentina, which is high by international standards (Xi et al., 2016).

Based on references collected by Achadi et al. (2005) and the Ministry of Health (2012), kreteks are preferred by 88% of Indonesian smokers, which comprises 30–40% cloves that contains eugenol—a compound linked to acute, chronic, and behavioral health effects when inhaled. Another adverse health effect of kreteks are hundreds of possible different additives put in the "sauce" to maintain the flavor. Moreover, many domestic cigarette companies do not perform tar and nicotine tests in their laboratories. The tobacco industry promotes misleading information that covers up health hazards with claims about product differentiation in low nicotine and tar levels, as well as additional flavors such as mint.

An emerging prevalent phenomenon among Indonesians is that the adverse selection is aggravated in households and workplaces by people's habit of using "cigarette money" to replace money tips, providing cigarettes for various social gatherings such as celebrations and meetings. Indonesians also give cigarettes to traditional clerics as a sign of gratitude and share cigarettes with, and offer them to, guests and friends as a symbol of solidarity and a way to communicate mutual support, especially in rural communities.

Conflicts Related to Components of Tobacco Control

Tobacco Control Regulation in Indonesia. Conflicts related to tobacco control, such as the evaluation of trade-offs between the pros and cons of tobacco control, have proved significant in the process of drafting tobacco control regulations. This led to the loss of a clause on tobacco control in Health Law No. 36/2009. This law, on curbing the adverse health impacts of tobacco was rejected and replaced with more general government tobacco control regulations. A paragraph on tobacco control simply disappeared from the Health Law shortly before it was to be enacted. This was the start of a long struggle to pass legislation on tobacco as an addictive substance.

Another conflict arose over discrepancies between regulation of the

Indonesian government No. 109/2012, the *Surat Keputusan Bersama* (SKB*)* (The Joint Degree) the Ministry of Health and the Ministry of Home Affairs's regulation No. 188/2011 protocol on cigarette sales in shopping centers and tobacco advertising in the street. This conflict has meant that Indonesia has not yet signed the FCTC due to a deadlock at the presidential level. However, the FCTC's concepts were adopted in the Ministry of Health's SKB and the Ministry of Home Affairs' regulation No. 188/2011 on Non-Smoking Areas. This is a compromise solution: controlling tobacco's impacts by adopting concepts from the FCTC.

Price and Tax Measures. The policies on controlling tobacco prices and tax measures in Indonesia include Law No. 28/2009 on Regional Taxes and Levies. The rules are as follows:

- Article 94: The provincial tax revenue referred to in Article 2 Paragraph 1 is earmarked for districts and/or cities in the provinces concerned with provision of services, so 70% of cigarette tax receipts are submitted to these districts and/or cities.
- Article 29: The cigarette tax rate is set at 10%, and this tax is taken into account in the determination of national tariffs.
- Article 31: At least 50% of the cigarette tax revenue, both at the provincial and district and/or city level, is allocated to fund public health services and law enforcement by competent authorities.

Cigarette production has continued to increase in Indonesia, but the contribution of the tobacco industry and farms to the gross domestic product was only 1.45% in 2008. The cigarette excise tax has increased over time from 40% in 2006 to 52% of the minimum retail price in 2012. However, this rate is still far from the WHO recommendation of an excise tax of 70% (Ahsan & Wiyono, 2007; Ministry of Health, 2012).

Increasing cigarette prices by raising the excise tax is a win-win solution because state revenues increase and consumption of cigarettes falls, which is better for the public's health. Based on other study/studies it is known that every 100% increase in tax would reduce consumption by 4% in developed countries and 8% in developing countries. In addition, the increase in cigarette prices due to higher excise taxes is primarily felt by the poor and adolescents (Ahsan & Wiyono, 2007; Ministry of Health, 2012).

In Indonesia, the cost of tobacco consumption in 2005 was Rp167.1 trillion (USD18.5 billion), including direct costs to households and indirect costs due to loss of productivity caused by early death, illness, and disability. This is five times higher than the cigarette tax income of Rp32.6 trillion (USD3.62 billion) (Kosen, 2007). Indonesia's policies on tobacco product prices make them cheaper than in developed countries. Furthermore, no regulation

expressly prohibits the sale of cigarettes to minors or bans tobacco production and sales of tobacco in public places. In addition, no clear criminal provisions are stipulated for violations of tobacco control policies.

Comprehensive Bans on Advertising, Promotion and Sponsorship

Comprehensive bans on tobacco advertising, promotion, and sponsorship can include such restrictions as no cigarette advertising in the street and the inclusion of images about the impacts of smoking on health. Bans also stop tobacco companies from selling, advertising, promoting, and sponsoring in public places and community activities. However, in Indonesia, cigarette advertising on television and other social media is still allowed as long as tobacco companies mention smoking's impacts on health, showing the effects of this addiction on television and in the print media. Moreover, no restrictions exist on the sale of cigarettes to children.

Bans on the operations of the cigarette industry and the transformation of farms of other agricultural products into tobacco farms are opposed by local government, the cigarette industry, tobacco farmers, and workers in the tobacco supply chain. No national strategy yet exists to involve central and local government in protecting the local economy from the effects of moving away from tobacco farming and closing cigarette factories. The economic strength of the tobacco industry, including lobbying at the national and regional levels, is extremely strong. Most districts' income involves contributions by the tobacco industry. Most major tobacco companies also practice corporate social responsibility, ranging from scholarships, sponsorship of community activities, and construction of health facilities. Currently, the tobacco industry's roadmap includes only offsetting smoking's impacts on health by building healthcare facilities.

Clean Air Legislation

Before the FCTC, Indonesians took the initiative in some areas to prohibit smoking in public places. However, the law enforcement officials and local government's commitment is still extremely weak, as evidenced by many officials who violate the law themselves. After the FTCT was finalized, Government Regulation No. 109/2012 and the Ministry of Health's SKB No. 188/2011 were issued in Indonesia. Based on data from the Ministry of Health (2012) and a study of several regions in Indonesia (Sulistiadi, 2014), it becomes clear that various regions began drafting regulations or declaring smoke-free areas. The regulations stated that schools, workplaces, public places, medical facilities, places of worship, and public transportation were non-smoking zones. However, no penalty was specified for individuals who smoked in these areas.

Thus, non-smoking area regulations are not accompanied by penalties for people smoking in non-smoking zones, and the regulations cannot be enforced (Ahsan & Wiyono, 2007). This is due to the strong influence of a permissive tradition in which

smokers think of smoking as a human right, while the protection of non-smokers' rights has still not become a public concern. In addition, not all districts and/or cities in Indonesia have local regulations for smoke-free areas (i.e., KTRs). Based on research in several districts and cities, Sulistiadi, (2014) noted that the presence or absence of tobacco farming in the area significantly influenced the presence or absence of KTR policy implementation.

Public Education and Information

Public education and information is offered by mobilizing anti-smoking campaigns in public places. Indonesians thus hear about protocols and guidelines through anti-tobacco campaigns by the Ministry of Health such as Regulation No.28/2013 about health warnings and health information. Public service announcements present the impacts of smoking on health by showing its negative effects on television and in print media (as implemented Government Regulation No.109/2012 also became a legal requirement for warning pictures in cigarette packages).

DISCUSSION

Tobacco control policies in Indonesia are not only important for Indonesians but also internationally. Tobacco control policies, of which one component is the current KTR regulations, cannot be enforced only through the health sector's efforts but instead must involve all stakeholders and potential players (Sulistiadi, 2014). In low and middle-income countries (LMICs), advocates and government regulators' attempts to control tobacco use have been frustrated, for the most part, by transnational tobacco companies and their supporters. One reason tobacco is so difficult to control is that the associated political economy has yet to be adequately understood and addressed. Tobacco control is complicated by the powerful political and economic forces connected to cigarette production and sales. Therefore, a political economy analysis is needed to help formulate strategies that promote policy adoption and implementation (Bump & Reich, 2013).

The present study's results show that the deadlock on the signing of the FCTC in Indonesia is at the presidential level, indicating that Indonesia is not ready to sign the FCTC. The governmental considerations delaying the ratification include that the tobacco industry has long been a source of direct income for a significant portion of Indonesians. These include tobacco farmers and their families, workers at tobacco factories, and other informal sectors supporting the tobacco industry. This industry's strength and other financial considerations such as tax and advertisements are also factors.

Based on a study across several countries (Hiilamo & Glantz, 2015), researchers found that FCTC ratification increased the odds that LMICs would have FCTC compliant health warning labels by 2013. The odds of FCTC compliance increased by a factor of 1.31 for each year after FCTC ratification.

Indonesia's Ministry of Health Decree No. 188/2011 and Government Regulation

No. 109/2012 were a compromise solution meant to address the need to control tobacco's impacts by adopting the FCTC's concepts. However, the government should not delay the signing of this treaty in a bid to protect national interests, tobacco farmers, and state revenues derived from tobacco products.

Indonesia needs to implement a cost-effective policy of tobacco control consistently, in order to reduce smoking's negative impacts on its citizens' health and the economy. Population-level tobacco control interventions have the potential to benefit more disadvantaged groups (Thomas et al., 2008). According to experts, sufficient evidence exists for the effectiveness of increased tobacco prices and excise taxes in reducing overall tobacco consumption and the prevalence of tobacco use, as well as improving public health. Higher taxes are effective in reducing the deaths, diseases, and economic costs associated with tobacco use. The positive impacts on health are even greater when some of the revenues generated by tobacco tax increases are used to support tobacco control, the promotion of healthy habits, and/or other health-related activities and programs (Chaloupka et al., 2010; Chaloupka et al., 2012).

For example, in Ukraine, the higher tobacco excise taxes imposed since 2009 and 2010 have significantly reduced tobacco consumption and encouraged public health and fiscal gains (Ross et al., 2012). In Mexico, taxes representing 59% of cigarettes' total price were imposed in 2006. Researchers have shown that price is a statistically significant factor in households' decisions to smoke or not and in decisions about how many cigarettes to smoke. Each 10% increase in the price of cigarettes results in a 5.2% decrease in the number of cigarettes smoked (Jimenez-Ruiz et al., 2008).

Indonesia needs to learn from other countries' experiences of implementing tobacco control policies. Information about the effectiveness of tobacco control policies include studies of Brazil's efforts over the last 15 years. That country's government has promoted a national network for disseminating knowledge on the harmful effects of tobacco and mobilizing tobacco control efforts through building the capacity for, and development of, partnerships between health offices of municipality, media, and civil society organizations. This movement has created a national critical mass and a social environment supportive of strong improvements in tobacco control (de Almeida et al., 2008).

The California Tobacco Control Program was also associated with significant declines in cigarette consumption among daily smokers over 35 years old, which led to a drop in tobacco-related health conditions. An annual decline in the average number of cigarettes was observed among daily smokers of 20.41 cigarettes per year (Al-Delaimy et al., 2007). Countries with more effective tobacco control programs have seen higher reductions in smoking and, consequently, in smoking-related mortality. Because both longer duration and higher intensity of smoking (i.e., amount of tobacco

smoked per day) are associated with an increased risk of tobacco-related diseases, (Islami et al., 2015).

The WHO's FCTC demonstrates that global political will exists to strengthen tobacco control and thus save lives. This convention is often called the most powerful tool in the fight against tobacco-related morbidity and mortality. As the world undergoes the long-predicted transition from communicable to non-communicable diseases as the greatest health burden, seminal ideas, processes, and outcomes such as the FCTC can be used to inform decision-making and policy-making (Lien & DeLand, 2011; WHO, 2011).

Another important lesson from the FCTC is that success depends directly on the vision, courage, leadership, commitment, political will, and integrity of people, governments, civil society, and organizations. These have been entrusted with the task of turning the concept of an international treaty on global health into reality. Successful implementations of this treaty likewise need the continued commitment of all players (Nikogosian, 2010). The political process also requires a system that includes the actors involved in policy and interest groups (Sulistiadi, 2014). For instance, researchers in China have recommended that, to promote more effective tobacco control policies, any conflicts of interest must be eliminated that inhibit the public health functions of China's State Tobacco Monopoly Administration (Wan et al., 2012).

One obstacle to the FCTC's implementation is political and economic opposition led by the powerful tobacco industry (Warner, 2008). Thus, tobacco control in Indonesia will likely not move forward until the government evaluates and strengthens the existing laws, considers passing new stronger laws, and develops protocols for enforcing all laws (Aditama et al., 2008).

CONCLUSION

The dynamic process of tobacco control in Indonesia has been fraught with conflicts and resolutions. This situation will continue because of political processes that reflect vested interests and power struggles. The fights and struggles involving these forces have been a source of constant conflict. However, Indonesia's delay in ratifying the FCTC can also be seen as a resolution because this deadlock in the process represents a meeting point where the interests and power positions of various actors can be maintained.

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